Sexual Abuse: A Journal of Research and Treatment

http://sax.sagepub.com/

Clinician's Perceptions of Indicators of Amenability to Sex Offender–Specific Treatment in Juveniles

Eva R. Kimonis, Amanda Fanniff, Randy Borum and Kevin Elliott

Sex Abuse published online 21 October 2010
DOI: 10.1177/1079063210384278

The online version of this article can be found at:
http://sax.sagepub.com/content/early/2010/10/20/1079063210384278

Published by:

http://www.sagepublications.com

On behalf of:

Association for the Treatment of Sexual Abusers

Additional services and information for *Sexual Abuse: A Journal of Research and Treatment* can be found at:

Email Alerts: http://sax.sagepub.com/cgi/alerts

Subscriptions: http://sax.sagepub.com/subscriptions

Reprints: http://www.sagepub.com/journalsReprints.nav

Permissions: http://www.sagepub.com/journalsPermissions.nav

Downloaded from sax.sagepub.com at UNIV OF SOUTH FLORIDA on December 30, 2010

Clinician's Perceptions of Indicators of Amenability to Sex Offender–Specific Treatment in Juveniles

Sexual Abuse: A Journal of Research and Treatment
XX(X) 1–19
© The Author(s) 2010
Reprints and permission: http://www.sagepub.com/journalsPermissions.nav
DOI: 10.1177/1079063210384278
http://sax.sagepub.com

Eva R. Kimonis[1], Amanda Fanniff[1], Randy Borum[1], and Kevin Elliott[2]

Abstract

Identifying and understanding the factors that predict treatment success is central to legal and clinical decision making about juveniles who commit sexual offenses. The current study surveyed 158 treatment providers who work with juvenile sexual offenders to explore empirically the construct of amenability as it relates to juvenile sex offender–specific treatment (SOST). Youths' unwillingness to alter deviant sexual interest/attitudes and unsupportive parenting were rated as strong indicators of *poor* SOST amenability, whereas the youths' motivation for change and belief in the efficacy of treatment, strong social support and positive attachments, and resilient personality traits were rated as strong indicators of *good* SOST amenability. Items distinctly rated as indicators of either *poor* or *good* treatment amenability (N = 48) were thematically grouped into internally consistent scales (α's ranging from .75-.87) reflecting several possible dimensions of amenability.

Keywords

amenability, juvenile justice, juvenile sexual offending, sexual offender, sexual offender–specific treatment

[1]University of South Florida, Tampa
[2]Florida State University, Tallahassee

Corresponding Author:
Eva R. Kimonis, PhD, Assistant Professor, Louis de la Parte Florida Mental Health Institute, Mental Health Law and Policy, University of South Florida, 13301 Bruce B. Downs Boulevard. MHC 2639, Tampa, FL 33612
Email: ekimonis@fmhi.usf.edu

Downloaded from sax.sagepub.com at UNIV OF SOUTH FLORIDA on December 30, 2010

Amenability to treatment is a critical component of the juvenile justice process. The juvenile justice system was established at the turn of the 20th century on the premise that young offenders have greater rehabilitative potential than adults, and therefore, their dispositions should emphasize treatment and intervention rather than punishment (Melton et al., 2007). With this focus on rehabilitation, "the central inquiry in a juvenile delinquency proceeding should be whether the child found delinquent is amenable to treatment" (Slobogin, 1999, p. 299). Amenability to treatment is routinely considered in decisions about whether a juvenile will be "transferred" to the jurisdiction of adult court (Slobogin, 1999); whether a juvenile can be safely rehabilitated in the community (e.g., in FL: for JSOs, Florida Statute 985.475; for nonsexual delinquents, Florida Statute 985.433); and more broadly in the context of dispositional bargaining and planning (Melton et al., 2007). The current study explores the meaning and determinants of amenability among juveniles adjudicated for sexual offenses.

Legal Definitions of Amenability

Despite the practical importance of amenability decisions, the construct is often poorly defined in the law or not defined at all (Slobogin, 1999), leaving evaluators with little legal guidance for their assessments. The landmark decision regarding juvenile's transfer to adult court, *Kent v. United States* (1966), included an appendix listing factors to be considered for these determinations. This list—or derivative language—has been subsequently codified in a number of jurisdictions (Slobogin, 1999); the appendix defines amenability as, "the likelihood of reasonable rehabilitation of the juvenile . . . by the use of procedures, services and facilities currently available to the Juvenile Court" (*Kent v. United States*, 1966, p. 567). Based on a review of state statutes and case law, Slobogin (1999) concluded that most jurisdictions' "foremost concern in determining amenability is whether intervention will reduce or eliminate recidivism," although some states acknowledge broader goals of treatment (p. 303). In addition, Slobogin (1999) identified the following factors considered in amenability determinations in one or more jurisdictions: (a) nature of the current offense, (b) prior offense history, (c) past treatment, (d) environment and personality, (e) willingness to participate in treatment, (f) availability of treatment, and (g) age. Nevertheless, amenability determinations involving juvenile offenders often do not make use of structured professional judgment tools, which would improve the consistency and accuracy of recommendations (Mulvey & Iselin, 2008).

Psychological Definitions of Amenability

In the behavioral sciences, definitions of amenability vary widely even within a given discipline. Amenability has been broadly defined, for example, as an individual's "ability to engage in treatment" (McGrath, 1991, p. 300) or "one's capacity to benefit from available treatment" (Loving & Patapis, 2007, p. 77). One theoretical model of treatment amenability defines the construct as *treatment readiness*, reflected in "the

Downloaded from sax.sagepub.com at UNIV OF SOUTH FLORIDA on December 30, 2010

presence of characteristics (states or dispositions) within either the client or the therapeutic situation, which are likely to promote engagement in therapy and which, thereby, are likely to enhance therapeutic change" (Ward, Day, Howells, & Birgden, 2004, p. 650). In this conceptualization, readiness for treatment is multifaceted; to be ready for treatment means that the person (a) is motivated (i.e., wants to, has the will to), (b) is able to respond appropriately (i.e., perceives he or she can), (c) finds it relevant and meaningful (i.e., can engage), and (d) has the capacities (i.e., cognitively, affectively, and behaviorally) to successfully enter the treatment program (Ward et al, 2004, p. 647).

Assessing Amenability in Juvenile Offenders

Mulvey and Iselin (2008) suggest that valid and reliable structured professional judgment (SPJ) instruments be created to allow relevant risk and amenability information to be more systematically considered prior to disposition. Deviations from the results suggested by such an instrument would have to be explained and justified. This process would reduce arbitrary decision making, but still allow probation officers or other legal actors to raise individual factors not explicitly addressed by the instrument. At least in theory, the juvenile justice system's mission is to create dispositions that are tailored to each youth's distinct rehabilitative needs (Connell, 1980; Horwitz & Wasserman, 1980). The SPJ approach combines the science of decision making with the individualized assessments long valued by the juvenile justice system (Mulvey & Iselin, 2008).

Although the use of psychometrically sound tools might improve recommendations to the court, currently there are few existing tools for evaluating treatment amenability. Several amenability measures have been designed for adult populations, including the Treatment Motivation Questionnaire (TMQ; Ryan, Plant, & O'Malley, 1995), the University of Rhode Island Change Assessment Scale (URICA, originally titled the Stages of Change Questionnaire; McConnaughy, Prochanska, & Velicer, 1983), the Corrections Victoria Treatment Readiness Questionnaire (CVTRQ; Casey, Day, Howells, & Ward, 2007), and the Quality of Motivation Questionnaire (QMQ; Martin, 1989). Most of these measures have initial evidence of predictive validity (TMQ, Ryan et al., 1995; URICA, Field et al., 2009; CVTRQ, Casey et al., 2007), but most have not been studied in samples of juvenile offenders (cf. Callaghan et al., 2005; LeGrand & Martin, 2001).

One promising instrument for assessing amenability in juvenile offenders is the Risk-Sophistication-Treatment Inventory (RST-I; Salekin, 2001). The RST-I is an interview-based rating system designed to assess factors relevant to transfer to adult court including risk, sophistication maturity, and treatment amenability. Fifteen treatment amenability items, comprising three subscales (a) Psychopathology, Degree and Type, (b) Responsibility and Motivation to Change, and (c) Consideration and Tolerance of Others, were derived from a survey of clinicians regarding the importance of various factors to amenability, in the context of juvenile transfer decisions (Salekin, Rogers, & Ustad, 2001). The RST-I has been found to have good reliability

Downloaded from sax.sagepub.com at UNIV OF SOUTH FLORIDA on December 30, 2010

and to be associated with outcomes such as decisions about transfer to adult court and with treatment-based measures of positive staff interaction and maintaining appropriate boundaries (Leistico & Salekin, 2003; Salekin et al., 2005). The RST-I, however, was not designed to assess amenability of juveniles to sex offender–specific treatment (SOST), and the authors are not aware of any studies to date supporting the utility of this instrument within this context.

Assessing Amenability in Juvenile Sex Offenders

Amenability evaluations are particularly important for juveniles adjudicated of sexual offenses (JSOs) because of their diverse and specialized treatment needs and the specific restrictions and policies that apply to them. JSOs are often required to participate in intensive, sex offender–specific treatment and are subjected to specialized social control policies based on the empirically questionable assumptions that they are a homogenous, high risk, deviant group (e.g., Chaffin, 2008; Letourneau & Miner, 2005). Properly assessing criminogenic needs, and matching those needs with effective, evidence-based interventions is an essential step to ensure that treatment interventions have the opportunity to reduce recidivism (Andrews, Bonta, & Hoge, 1990; Andrews, Bonta, & Wormith, 2006). This requires a specialized consideration of possible types of JSOs and of factors that may be less relevant to general juvenile recidivism but are critical for measuring a youth's readiness for SOST, such as deviant sexual interests, sexual compulsivity, sexual aggression, and attitudes supportive of sexual crime (Medoff & Kinscherff, 2006).

To date, there exists only one published tool designed specifically to evaluate SOST needs and progress among JSOs, the Treatment Progress Inventory for Adolescents Who Sexually Abuse (TPI-ASA; Oneal, Burns, Kahn, Rich, & Worling, 2008). Based on a literature review of empirically supported treatment practices and common elements of SOST for adolescents, the authors selected the following nine dimensions for the instrument: (a) inappropriate sexual behavior, (b) healthy sexuality, (c) social competency, (d) cognitions supportive of sexual abuse, (e) attitudes supportive of sexual abuse, (f) victim awareness, (g) affective/behavioral regulation, (h) risk prevention awareness, and (i) positive family caregiver dynamics. There is preliminary support for the internal consistency and construct validity of this tool (Oneal et al., 2008), although its utility within legal contexts has yet to be explored.

Although limited research exists for relevant assessment instruments, there is a small body of literature examining factors related to treatment completion in this population. Noncompletion may reflect dropping out of treatment or expulsion from a program because of noncompliance, disruptive behavior, or recidivism (Hunter & Figueredo, 1999) and is a serious and common problem experienced by providers of residential juvenile sexual offender treatment (Kraemer, Salisbury, & Spielman, 1998). Factors found to be associated with treatment noncompletion in prior research include (a) older age (Kraemer et al., 1998), (b) higher impulsivity (Edwards et al., 2005; Kraemer et al., 1998), (c) emotional/behavioral problems (Bremer, 1998), (d) sexual

Downloaded from sax.sagepub.com at UNIV OF SOUTH FLORIDA on December 30, 2010

maladjustment (Hunter & Figueredo, 1999), (e) denial (Eastman, 2005; Edwards et al., 2005; Hunter & Figueredo, 1999; cf. Bremer, 1998), (f) cognitive distortions (Eastman, 2005; Edwards et al., 2005), (g) poor self-concept (Eastman, 2005), (h) unwillingness to alter deviant sexual interests and attitudes, (i) callous/remorseless use of others, and (j) marked difficulty coping with negative affect (Edwards et al., 2005). Although treatment noncompletion is sometimes used as a proxy for poor amenability, there also may be youth who complete treatment programs, but experience little or no benefit, who are not captured by these analyses. Nonetheless, impulsivity and cognitive distortions are the factors most consistently associated with treatment failure and such factors are likely also associated with a broader conceptualization of amenability. These factors were also listed as risk factors that should routinely be included in forensic evaluations of JSOs described in a recent review (Medoff & Kinscherff, 2006).

Amenability Versus Risk

Risk for reoffending is a concept that is frequently conflated with amenability. Although overlapping, amenability and risk for reoffending are distinguishable concepts and judgments about each must be carefully balanced against the other (Mulvey & Iselin, 2008). Slobogin (1999) clarifies their link by suggesting that

> a juvenile's amenability to treatment depends on the extent to which: (1) those aspects of the juvenile's personality and environment (2) that contribute significantly to an increased risk of criminal behavior (3) can be ameliorated by age [21] through individual, family, or community-oriented intervention (4) that is available under the juvenile court system and applicable law. (Slobogin, 1999, p. 331)

Page and Scalora (2004) suggest that risk and amenability are so intertwined that risk assessments must include an assessment of amenability, as "risk cannot be adequately assessed without proper attention to an individual's willingness to engage in treatment and subsequent responsiveness to treatment" (p. 524).

In the search for factors relevant to SOST amenability, it may be useful to consider what is known about factors related to risk. One source of information might be empirically supported risk tools developed for use with general juvenile offender populations (e.g., SAVRY, Borum, 2006; YLS/CMI, Hoge & Andrews, 2002), and tools specific to juvenile sex offender populations (although these tools are still undergoing validation, e.g., ERASOR, (Worling, 2004) J-SOAP-II, Caldwell & Dickinson, 2009; Martinez, Flores, & Rosenfeld, 2007; Parks & Bard, 2006; Prentky et al., 2010; Righthand et al., 2005; Viljoen, Elkovitch, Scalora, & Ullman, 2009; Viljoen et al., 2008; Worling, 2004). Another source may be empirical research on juvenile sexual offense recidivism. Those studies indicate the importance of factors such as deviant sexual interests, prior criminal sanctions for sexual offending, multiple victims, offending against a stranger, social isolation, and uncompleted offense-specific treatment (Worling &

Downloaded from sax.sagepub.com at UNIV OF SOUTH FLORIDA on December 30, 2010

Långström, 2006). Other potentially important risk factors with less empirical support include problematic parent–child relationships, attitudes supportive of sexual offending, impulsivity, and an antisocial interpersonal orientation (Worling & Långström, 2006).

Many of these variables are incorporated into the risk assessment measures described above, and can provide some direction for factors to consider in attempting to elucidate the nature of amenability in this population, as amenability can be conceptualized as the likelihood that a youth's dynamic risk factors will change in response to intervention.

The Present Study

Understanding which factors affect the likelihood of successful treatment is important in making legal decisions relevant to treatment referral, making clinical decisions within the treatment context, and reducing juvenile sexual recidivism. To date, however, there has been very little empirical study of the factors affecting JSO-SOST amenability. Once those factors are identified, they might be incorporated into an assessment tool or instrument to facilitate more transparent and reliable assessment. As a first step toward filling this important gap, we conducted an empirical exploration of the construct of amenability as it relates to juvenile SOST. This was accomplished by surveying treatment providers' perceptions of factors indicating *poor* and *good* amenability to juvenile SOST. Because this study was designed to understand how practicing clinicians understand the construct of amenability, we did not impose a limiting definition. Our general conceptual approach was to regard juvenile SOST amenability as the likelihood that the young person would benefit from available psychosocial intervention in a way that significantly mitigated his or her critical, criminogenic needs or that directly reduced his or her risk of sexual reoffending. A list of 80 potential amenability factors (see Table 1) was generated from three sources: (a) empirical studies on treatment responsiveness (e.g., Looman, Dickie, & Abracen, 2005; Lukin, 1981); (b) items on risk-related instruments for juvenile offenders such as the Structured Assessment of Violence Risk in Youth (SAVRY, Borum, 2006) and the Estimate of Risk of Adolescent Sexual Offense Recidivism (ERASOR; Worling & Curwen, 2001); and (c) input from Dr. James Worling, one of the creators of the ERASOR. Items associated with risk were included as potential amenability factors because some variables that predict recidivism may also be associated with greater difficulty engaging in and successfully completing SOST.

Method

Participants

Participants for this study were recruited from the Association for the Treatment of Sexual Abusers (ATSA; www.atsa.com). ATSA is an international, multidisciplinary organization dedicated to the promotion of research and treatment of individuals who

Downloaded from sax.sagepub.com at UNIV OF SOUTH FLORIDA on December 30, 2010

Table 1. Mean and Modal Scores for Treatment Amenability Items

Items	*M*	*SD*	Mode
Unwillingness to alter deviant sexual interest/attitudes	1.32	.534	1
Parents not supporting sexual offense–specific assessment/treatment	1.46	.628	1
Antisocial interpersonal orientation	1.59	.601	2
Environment supporting opportunities to reoffend sexually	1.62	.655	2
Threats of, or use of, excessive violence/weapons during sexual offense	1.63	.601	2
Indiscriminate of victims	1.72	.647	2
Denial of any sexual offending	1.74	.675	2
Deviant sexual interest	1.75	.727	2
Low empathy and remorse, particularly regarding sexual misbehavior	1.76	.634	2
Attitudes supportive of sexual offending	1.76	.666	2
Attachment disorder	1.77	.562	2
Recent/current parental illegal substance use	1.86	.501	2
Diverse sexual assault behaviors	1.86	.653	2
Significant mental health concerns for the adolescent	1.86	.591	2
Fetal alcohol exposure	1.87	.472	2
Minimization of extent of past sexual offending	1.88	.653	2
Problematic parent–offender relationships/parental rejection	1.88	.529	2
Recent or current illegal substance use	1.89	.526	2
Negative peer associations and influences	1.90	.607	2
Ever sexually assaulted a stranger	1.91	.724	2
Significant mental health concerns for parent	1.95	.505	2
Poor self regulation of affect and behavior (impulsivity)	1.97	.709	2
Obsessive sexual interests/preoccupation with sexual thoughts	1.97	.751	2
Ever sexually assaulted an adult	1.97	.758	2
No development or practice of realistic prevention plans/strategies	1.98	.707	2
Prior incomplete sexual offense–specific treatment	1.99	.664	2
Lack of any sexual interest or inability to express any sexual interest	2.01	.553	2
Prior adult sanctions for sexual assault	2.04	.677	2
Lack of intimate peer relationships/social isolation	2.09	.629	2
High Stress family environment	2.11	.589	2
Parental history of sexual abuse	2.11	.604	2
Learning disability	2.12	.479	2
Interpersonal aggression	2.14	.583	2
History of emotional or physical neglect	2.15	.572	2
Parental marital distress	2.15	.441	2
Ever sexually assaulted two or more victims	2.15	.678	2/IR
Below average intellectual ability	2.17	.562	2
Ever sexually assaulted a male victim	2.19	.704	2/IR
Emotional abuse history	2.21	.538	2
Physical abuse history	2.22	.546	2
Posttraumatic distress	2.25	.556	2
Ever sexually assaulted a child	2.30	.708	2/IR

(continued)

Downloaded from sax.sagepub.com at UNIV OF SOUTH FLORIDA on December 30, 2010

Table 1. (continued)

Items	*M*	*SD*	Mode
Ever sexually assaulted the same victim two or more times	2.32	.759	2/IR
Negative internal affect such as depression, anxiety, loneliness, boredom, or frustration	2.38	.784	2
Youth is a registered sex offender	2.39	.755	2/IR
Problems related to anger	2.40	.658	2
Feelings of personal inadequacy	2.45	.790	2
Sexual abuse history	2.48	.562	2
History of sexual offenses against siblings	2.49	.711	2/IR
Current out-of-home placement in residential treatment	2.51	.739	2
Youth is transgender	2.56	.681	2/IR
Overwhelming shame regarding past sexual offending	2.60	.770	3
Youth is a member of a cultural minority group	2.67	.645	3/IR
No criminal charges for past sexual offenses	2.73	.785	3
Youth is gay, lesbian, or bisexual	2.83	.664	3/IR
School and community awareness of youth's sexual offenses	2.87	.753	3
Parent is a member of a minority group	2.91	.522	3/IR
Youth is male	2.95	.639	3/IR
Youth is female	3.11	.722	3/IR
Strong commitment to religion	3.19	.658	3
Above average intellectual ability	3.25	.591	3
Ability to function and react accordingly in a group setting	3.25	.850	4
High self-esteem	3.26	.611	3
Ability to accurately identify and describe one's own emotional experiences	3.37	.744	4
Active support of probation services	3.40	.599	3
Parental hope that offense-free future is possible	3.44	.528	3
Strong commitment to school	3.46	.569	4
History of engaging in prosocial activities	3.50	.530	4
Presence of one or more strong prosocial peer relationships	3.52	.515	4
Positive attitude toward authority	3.53	.555	4
Resilient personality traits	3.54	.674	4
Youth has hope that offense-free future is possible	3.59	.620	4
Parental belief in efficacy of therapy	3.61	.582	4
Youth believes in efficacy of therapy	3.63	.601	4
Ability to form trusting interpersonal attachment	3.69	.509	4
Strong attachment and bonds to at least one prosocial adult	3.76	.476	4
Parent/guardian willing to participate in youth's treatment	3.76	.491	4
Expresses/demonstrates motivation to change behavior	3.78	.431	4
Parent/guardian strongly supportive of sexual offense–specific assessment/treatment	3.78	.481	4
Strong social support	3.82	.424	4

Note: Mode presented is for items excluding irrelevant codings; however, items denoted with /IR have a modal response of irrelevant.

Downloaded from sax.sagepub.com at UNIV OF SOUTH FLORIDA on December 30, 2010

Table 2. Sample Question Instructions

Instructions: Please rate the extent to which this factor affects a youth's amenability to (or ability to derive substantial therapeutic benefit from) SOST and interventions. If you believe that a specific factor is irrelevant or completely unrelated to a youth's amenability to (or ability to derive substantial therapeutic benefit from) SOST and interventions, please rate that factor with a "U"			
This factor strongly suggests poor amenability to SOST	This factor somewhat suggests poor amenability to SOST	This factor somewhat suggests good amenability to SOST	This factor strongly suggests good amenability to SOST
1	2	3	4

have sexually abused or are at risk to abuse. ATSA's executive director distributed a brief study description and invitation to participate to all treatment providers affiliated with the organization. All listed individuals were invited by email, which included a link to the online survey described below. Members were given approximately 2 weeks to complete the survey. The online survey included screening questions to identify whether the treatment professionals had specific experience and expertise in delivering sexual offense–specific treatment to juvenile sexual offenders.

Procedure

All study procedures and instrumentation were approved by a university-based institutional review board. An online survey (using Qualtrics survey software) was developed for the purposes of this study. ATSA members interested in participating in the survey followed a link to the online survey consent form. This page provided information about the study and the option for continuing with the survey. In addition to screening questions, the survey included questions about nonidentifying demographic information (gender, ethnicity, education, experience offering expert testimony in court on JSO's amenability to SOST). This was followed by the list of 80 factors potentially related to JSO's amenability to SOST. Survey participants were instructed to rate all 80 amenability factors on a 4-point Likert-type scale from 1 (*factor strongly suggests poor amenability to SOST*) to 4 (*factor strongly suggests good amenability to SOST*), with scores of 2 and 3 somewhat indicative of poor and good amenability, respectively (see Table 2). A fifth rating option was provided as an indicator of *irrelevance* to amenability. Participants were not compensated for completing the study.

Results

A total of 158 ATSA members responded to the survey and the sample was roughly evenly split between men (n = 86; 54.4%) and women (n = 71; 44.9%). The majority of respondents reported their race/ethnicity as White (n = 141, 89.2%). Other ethnicities represented included African American (n = 5; 3.2%), Hispanic/Latino (n = 4; 2.5%), Asian/Pacific Islander (n = 1; .6%), and "Other" (n = 6; 3.8%). The master's degree was

Downloaded from sax.sagepub.com at UNIV OF SOUTH FLORIDA on December 30, 2010

the highest level of education attainment for a majority (n = 104; 65.8%) of the sample, followed by a doctoral degree (e.g., PhD, PsyD, n = 43; 27.2%), bachelor's degree (n = 7; 4.4%), "Other" (n = 2; 1.3%), and MD (n = 1; .6%). More than half of the respondents had been qualified and offered expert testimony in court on JSO's amenability to SOST (n = 83; 52.5%).

Of the 80 total items rated, the following six items were rated as irrelevant by more than half of the sample: "Youth is gay, lesbian, or bisexual (74.1%)"; "Parent is a member of a minority group (74.1%)"; "Youth is a member of a cultural minority group (74.1%)"; "Youth is male (70.3%)"; "Youth is female (65.8%)"; "Youth is transgender (63.3%)." Mean ratings, standard deviations, and modes for each item are presented in Table 1 (excluding irrelevant ratings).

Two items were rated as strong indicators of *poor* treatment amenability (i.e., average ratings below 1.5 and modal rating of 1; with a score of 1 indicating the factor is a strong indicator of poor amenability): "Unwillingness to alter deviant sexual interest/attitudes" and "Parents not supporting sexual offense–specific assessment/treatment." Twelve items were rated as strong indicators of *good* treatment amenability (i.e., average ratings above 3.5 and modal rating of 4; with a score of 4 indicating the factor is a strong indicator of good amenability): "Strong social support"; "Parent/guardian strongly supportive of sexual offense–specific assessment/treatment"; "Expresses/demonstrates motivation to change behavior"; "Parent/guardian willing to participate in youth's treatment"; "Strong attachment and bonds to at least one prosocial adult"; "Ability to form trusting interpersonal attachment"; "Youth believes in efficacy of therapy"; "Parental belief in efficacy of therapy"; "Youth has hope that offense-free future is possible"; "Resilient personality traits"; "Positive attitude toward authority"; and "Presence of one or more strong prosocial peer relationships."

A subset of items (N = 48) were used to create rational-thematic groupings. Twenty six *poor* treatment amenability items (mean rating below 2.0) and 22 *good* treatment amenability items (mean rating above 3.0) were selected for this analysis. Specifically, those items not clearly rated as indicators of *poor* or *good* treatment amenability (i.e., mean ratings between 2.0 and 3.0, indicating the factor was rated between being somewhat suggestive of poor amenability and somewhat suggestive of good amenability) were removed.[1] This subset of items was clustered conceptually into potential scales that might reflect domains of treatment amenability. Conceptual groupings were guided by (a) a consideration of rational-thematic similarities between items, (b) knowledge of the relevant scientific literature, and (c) consensus between the first and third authors. The internal consistency of treatment professionals' ratings of the items in these conceptually derived scales was subsequently analyzed using Cronbach's alpha to determine if treatment professionals rated such items similarly. A high alpha in this instance indicates that those who completed the survey rated the items similarly in terms of direction (poor or good treatment amenability) and strength of association with amenability (strongly related or somewhat related to amenability). Four scales were conceptualized for *poor* amenability (Table 3): Negative emotional adjustment/attachment (α = .75); aggravating offense characteristics (α =.82); negative treatment orientation/nonsupportive treatment environment (α =.84); and deviant sexuality (α =.79). Also,

Downloaded from sax.sagepub.com at UNIV OF SOUTH FLORIDA on December 30, 2010

Table 3. Reliabilities for Conceptually Derived Negative Treatment Indicator Scales

Negative emotional adjustment/attachment	Aggravating offense characteristics	Negative treatment orientation/unsupportive treatment environment	Deviant sexuality
α = .75 (*n* = 104)	α = .82 (*n* = 82)	α = .84 (*n* = 75)	α = .79 (*n* = 102)
α = .74 (n = 147)	*α = .83 (n = 149)*	*α = .76 (n = 145)*	*α = .75 (n = 149)*
Antisocial interpersonal orientation	Threats of, or use of, excessive violence/ weapons during sexual offense	Unwillingness to alter deviant sexual interest/ attitudes	Deviant sexual interest
Low empathy and remorse, particularly regarding sexual misbehavior	Indiscriminate of victims	Parents not supporting sexual offense–specific assessment/treatment	Attitudes supportive of sexual offending
Attachment disorder	Ever sexually assaulted a stranger	Environment supporting opportunities to reoffend sexually	Diverse sexual assault behaviors
Problematic parent–offender relationships/ parental rejection	Ever sexually assaulted an adult	Denial of any sexual offending	Obsessive sexual interests/ preoccupation with sexual thoughts
Significant mental health concerns for the adolescent		Minimization of extent of past sexual offending	
Fetal alcohol exposure		No development or practice of realistic prevention plans/ strategies	
Recent or current illegal substance use		Prior incomplete sexual offense–specific treatment	
Poor self-regulation of affect and behavior (impulsivity)		Negative peer associations and influences	
		Recent/current parental illegal substance use	
		Significant mental health concerns for parent	

Note: Italicized values indicate reliability coefficients when recoding "irrelevant" as a midpoint of 2.5.

two scales were identified for *good* treatment amenability (Table 4): Positive emotional adjustment/attachment (α = .75); and positive treatment orientation/supportive treatment environment (α = .87).

Downloaded from sax.sagepub.com at UNIV OF SOUTH FLORIDA on December 30, 2010

Table 4. Reliabilities for Conceptually Derived Positive Treatment Indicator Scales

Positive emotional adjustment/attachment	Positive treatment orientation/supportive treatment environment
α = .75 (*n* = 70)	α = .87 (*n* = 113)
α = *.70* (*n* = *147*)	α = *.87* (*n* = *147*)
Above average intellectual ability	Positive attitude toward authority
Ability to function and react accordingly in a group setting	Youth has hope that offense-free future is possible
High self-esteem	Youth believes in efficacy of therapy
Ability to accurately identify and describe one's own emotional experiences	Expresses/demonstrates motivation to change behavior
Strong commitment to religion	Active support of probation services
Strong commitment to school	Parental hope that offense-free future is possible
History of engaging in prosocial activities	Parental belief in efficacy of therapy
Presence of one or more strong prosocial peer relationships	Parent/guardian willing to participate in youth's treatment
Resilient personality traits	Parent/guardian strongly supportive of sexual offense–specific assessment/treatment
Ability to form trusting interpersonal attachment	Strong social support
Strong attachment and bonds to at least one prosocial adult	

Note: Italicized values indicate reliability coefficients when recoding "irrelevant" as a midpoint of 2.5.

Discussion

This survey shows that experienced JSO treatment providers agree on several key indicators—favorable and unfavorable—of juvenile SOST amenability. They also agreed that certain demographic variables appear not to be relevant to SOST success, including the youths' gender, parent and youth race/ethnicity, and youths' sexual orientation.

Providers identified a greater number of factors strongly indicative of *good* treatment amenability than factors indicating *poor* amenability. Attempts to identify rationally derived subgroupings of relevant amenability factors yielded six internally consistent scales. Those scales suggest there may be discernible domains of SOST amenability: (a) positive and negative emotional adjustment/attachment; (b) positive and negative treatment orientation/supportiveness of treatment environment; (c) aggravating offense characteristics; and (d) deviant sexuality. These preliminary results also suggest that the scope of factors currently considered in legal amenability determinations (see Slobogin, 1999) might be expanded.

Downloaded from sax.sagepub.com at UNIV OF SOUTH FLORIDA on December 30, 2010

Survey responses indicated that SOST providers believe peer and family factors (support, prosocial relationships, parents' belief in the efficacy of, and willingness to participate in, SOST) as well as characteristics of the juvenile (motivation, belief in the efficacy of therapy, resilient personality, positive attitude toward authority, and hope for the future) are positive indicators of a youth's amenability to treatment. These findings are consistent with prior research and clinical recommendations highlighting the importance of peer and family environment and support to successful JSO treatment (Henggeler et al., 2009; Medoff & Kinscherff, 2006; Oneal et al., 2008), and with the recognition of the importance of intrinsic motivation and self-efficacy in the broader offender (Ward et al., 2004) and clinical literature (e.g., Miller & Rollnick, 2002). The broader literature on insight and treatment compliance similarly suggests that offenders are more likely to comply with and to complete treatment when the intervention itself is not aversive and they believe that treatment will work (DiMatteo, 2004; DiMatteo, Haskard, & Williams, 2007; Gatti, Jacobson, Gazmararian, Schmotzer, & Kripalani, 2009; van Dulmen et al., 2007).

Clinicians in this survey rated a youth's resistance to change (i.e., to alter their deviant sexual interest or attitudes) and family's unwillingness to support sex offense–specific evaluation or treatment as strongly indicative of poorer amenability. Unwillingness to change deviant interests or attitudes has also been found to be related to treatment dropout (Edwards et al., 2005). Although no specific literature has addressed the effect of lack of parental support for treatment, it is unsurprising that treatment providers have found this to be a major impediment to successful treatment. Youths' attitudes and beliefs—which are affected by the attitudes of parents and treatment providers—appear to be strongly related to the youth's motivation and willingness to participate in and complete treatment.

Of significance here is the considerable overlap between the amenability factors identified in this study and risk and protective factors identified in the extant recidivism literature. It is possible that providers' perceptions about *poor* amenability to treatment were confounded by knowledge of risk factors for sexual or general recidivism in youth. An operational definition of amenability was not provided to respondents in this study because a primary aim was to empirically explore how practicing clinicians conceptualize the construct within the context of SOST with young offenders. As a result, it is possible that some providers perceived amenability as those factors resulting in the successful completion of treatment; others may have considered factors relevant to treatment readiness when rating items. Alternatively, clinicians may have observed that variables associated with risk in JSO and delinquent populations are also specifically associated with treatment response. Another possible explanation of the current results is that clinicians who responded to the survey may have been intuitively incorporating risk and amenability consistent with Mulvey and Iselin's (2008) discussion of the need to balance the two against each other. Thus, it is possible that the factors identified by clinicians as indicators of poor amenability reflect risks and needs of JSOs, whereas the factors identified as indicators of good amenability are

Downloaded from sax.sagepub.com at UNIV OF SOUTH FLORIDA on December 30, 2010

more consistent with amenability conceptualized as treatment readiness, motivation, and/or responsivity. Research examining the connection between those factors identified by clinicians as relevant to both treatment response and recidivism would clarify this relationship. Although it is possible that clinicians equated amenability with recidivism risk while completing ratings, we are fairly confident that our results are not purely an artifact of our measurement or a conceptual conflation on our part, but rather reflect substantive overlap among the constructs (see e.g., Salekin, Yff, Neumann, Leistico, & Zalot, 2002).

Overlap between constructs of amenability and risk suggests that youth who are rated as showing poor amenability to SOST would also be those who are potentially at greatest risk for recidivism and thus in greatest need of services according to the risk-need-responsivity model (Andrews et al., 1990, 2006). Identification of poor amenability should not be utilized to exclude high risk offenders from needed treatment; however, it is not sufficient for risk tools to simply identify youth at greatest risk for reoffending, thus in greatest need of services. If good amenability and poor amenability (or risks/needs) are orthogonal, as may be the case, evaluators must assess both constructs to determine the appropriate level of care as well as to develop individualized treatment plans. Amenability tools can provide complementary information to guide what types of intervention, and more specifically targets for interventions, will be most effective for a particular youth. Motivation and commitment to change may be conceptualized as one aspect of responsivity, and therapists thus should adjust treatment strategies to maximize the client's potential to learn and benefit from treatment accordingly (Looman et al., 2005; Ward et al., 2004). For example, motivation for change may be enhanced by pretreatment interventions such as motivational interviewing (e.g., for substance abuse and anxiety disorder treatment, Brown & Miller, 1993; Westra, Arkowitz, & Dozois, 2009). A pretreatment program designed to increase hope, self-efficacy, and readiness for change in incarcerated adult sex offenders has demonstrated preliminary evidence of increased readiness for change and self-efficacy as well as earlier parole and reduced nonsexual recidivism (Marshall, Marshall, Fernandez, Malcolm, & Moulden, 2008). Similar pretreatment programs, preferably targeting both the child and his or her parents/guardians, may enhance the ability of youth to benefit from SOST. Amenability tools can identify strengths and responsivity factors of the youth and his family that are more specific to positive treatment response, rather than factors related strictly to recidivism.

Although there is potential to misuse amenability tools to exclude youth from treatment as done in the past for those high on psychopathic traits, they can be used more constructively to identify those youth in need of specialized or more intensive forms of treatment. For example, the psychopathy field was dominated by therapeutic pessimism (Salekin, 2002) until relatively recently when research emerged demonstrating that even psychopathic individuals show positive treatment response when the treatment is intensive, individualized, and administered earlier in development when traits and behavior are more malleable (Caldwell, Skeem, Salekin, & Van Rybroek, 2006; Hawes & Dadds, 2005, 2007).

Downloaded from sax.sagepub.com at UNIV OF SOUTH FLORIDA on December 30, 2010

The results of the current study must be considered within the context of several study limitations. First, as mentioned above, clinicians were not provided with a specific definition of amenability within the survey. As a result, item ratings may be less consistent than if a standardized definition had been provided. Second, the identification of only two factors as strong indicators of *poor* amenability suggests that the study may have benefited from a broader selection of possible factors potentially relevant to poor amenability. Third, this was a convenience sample where treatment providers self-selected into the study and as such, results may not be reflective of the broader opinions and perceptions of providers of SOST to juveniles. Fourth, further validation of the structure of the conceptual scales when used to assess JSOs directly is needed.

This exploratory study attempts to fill an important empirical and practical gap in our understanding of treatment amenability in sexual offending youth. Youth adjudicated on sexual offenses face harsh and in some cases lifelong sanctions (e.g., placement on public sexual offender registries) which are applied based on judicial discretion in some jurisdictions (e.g., Arizona, ARS § 13-3825.J). In addition, placement decisions require balancing community safety needs with the possibility of iatrogenic effects associated with placement in a residential or secure facility (Medoff & Kinscherff, 2006). Therefore, it is especially important for evaluators and treatment providers to provide the courts with accurate assessments of JSOs' amenability to treatment to inform decisions about disposition. Mulvey and Iselin (2008) suggest that valid and reliable structured professional judgment instruments should be created to increase fairness and reduce arbitrariness in legal decision making about juveniles. These goals are consistent with the rehabilitative and individualized justice orientation of juvenile courts (*in re Gault*, 1967; *Kent v. United States*, 1966). It is equally important that researchers and practitioners guard against the misuse of such tools to identify "untreatable" youth, particularly given evidence for the negative consequences of labeling, greater malleability in youth, and evidence for positive change in even the most recalcitrant youth, those high on psychopathic traits (Lynam & Gudonis, 2004; Vidal & Skeem, 2007).

This study of clinician's perception about SOST amenability might lay a foundation for developing a structured professional judgment instrument for JSO assessments. Further research is needed, however, to determine whether the factors identified here can be reliably scored by clinicians and correspond to concrete and measurable treatment outcomes such as disciplinary infractions while in treatment, positive interactions with staff, active engagement in treatment activities, rule-abiding behaviors, changes in sexually deviant attitudes, interests, and behaviors, treatment dropout, and recidivism rates, among other factors. It is important that such studies be conducted in actual treatment settings for the reliability and validity of such tools to be evaluated directly in the contexts in which they will be utilized.

Declaration of Conflicting Interests

The authors declared no potential conflicts of interest with respect to the authorship and/or publication of this article.

Downloaded from sax.sagepub.com at UNIV OF SOUTH FLORIDA on December 30, 2010

Funding

The authors received no financial support for the research and/or authorship of this article.

Note

1. The item "Youth is a female" was excluded from scale construction because of low concordance between raters regarding the items' relevance to treatment amenability.

References

Andrews, D. A., Bonta, J., & Hoge, R. D. (1990). Classification for effective rehabilitation: Rediscovering psychology. *Criminal Justice and Behavior, 17*, 19-52.

Andrews, D. A., Bonta, J., & Wormith, J. S. (2006). The recent past and near future of risk and/or need assessment. *Crime & Delinquency, 52*(1), 7-27.

Ariz. Rev. Stat §13-3825(J) (2008).

Borum, R. (2006). *Manual for the structured assessment of violence risk in youth (SAVRY)*. Odessa, FL: Psychological Assessment Resources.

Bremer, J. F. (1998). Challenges in the assessment and treatment of sexually abusive adolescents. *Irish Journal of Psychology, 19*(1), 82-92.

Brown, J. M., & Miller, W. R. (1993). Impact of motivational interviewing on participation and outcome in residential alcoholism treatment. *Psychology of Addictive Behaviors, 7*, 211-218.

Caldwell, M. F., & Dickinson, C. (2009). Sex offender registration and recidivism risk in juvenile sexual offenders. *Behavioral Sciences & the Law, 27*, 941-956.

Caldwell, M., Skeem, J., Salekin, R. T., & Van Rybroek, G. (2006). Treatment response of adolescent offenders with psychopathy features: A 2-Year follow-up. *Criminal Justice and Behavior, 33*, 571-596.

Callaghan, R. C., Hathaway, A., Cunningham, J. A., Vettese, L. C., Wyatt, S., & Taylor, L. (2005). Does stage-of-change predict dropout in a culturally diverse sample of adolescents admitted to inpatient substance-abuse treatment? A test of the transtheoretical model. *Addictive Behaviors, 30*, 1834-1847.

Casey, S., Day, A., Howells, K., & Ward, T. (2007). Assessing suitability for offender rehabilitation: Development and validation of the Treatment Readiness Questionnaire. *Criminal Justice and Behavior, 34*, 1427-1440.

Chaffin, M. (2008). Our minds are made up—Don't confuse us with the facts: Commentary on policies concerning children with sexual behavior problems and juvenile sex offenders. *Child Maltreatment, 13*(2), 110-121.

Connell, P. (1980). Juvenile justice in the year 2005? *Journal of Clinical Child Psychology, 9*, 113-116.

DiMatteo, M. R. (2004). Variations in patients' adherence to medical recommendations: A quantitative review of 50 years of research. *Medical Care, 42*, 200-209.

DiMatteo, M. R., Haskard, K. B., & Williams, S. L. (2007). Health beliefs, disease severity, and patient adherence: A meta-analysis. *Medical Care, 45*, 521-528.

Eastman, B. J. (2005). Variables associated with treatment failure among adolescent sex offenders. *Journal of Offender Rehabilitation, 42*(3), 23-40.

Downloaded from sax.sagepub.com at UNIV OF SOUTH FLORIDA on December 30, 2010

Edwards, R., Beech, A., Bishopp, D., Erikson, M., Friendship, C., & Charlesworth, L. (2005). Predicting dropout from a residential programme for adolescent sexual abusers using pre-treatment variables and implications for recidivism. *Journal of Sexual Aggression, 11*, 139-155.

Field, C. A., Adinoff, B., Harris, T. R., Ball, S. A., & Carroll, K. M. (2009). Construct, concurrent and predictive validity of the URICA: Data from two multi-site clinical trials. *Drug and Alcohol Dependence, 101*, 115-123.

Gatti, M. E., Jacobson, K. L., Gazmararian, J. A., Schmotzer, B., & Kripalani, S. (2009). Relationships between beliefs about medications and adherence. *American Journal of Health-System Pharmacy : AJHP : Official Journal of the American Society of Health-System Pharmacists, 66*, 657-664.

Hawes, D. J., & Dadds, M. R. (2005). The treatment of conduct problems in children with callous-unemotional traits. *Journal of Consulting and Clinical Psychology, 73*, 737-741.

Hawes, D. J., & Dadds, M. R. (2007). Stability and malleability of callous-unemotional traits during treatment for childhood conduct problems. *Journal of Clinical Child and Adolescent Psychology, 36*, 347-355.

Henggeler, S. W., Letourneau, E. J., Chapman, J. E., Borduin, C. M., Schewe, P. A., & McCart, M. R. (2009). Mediators of change for multisystemic therapy with juvenile sexual offenders. *Journal of Consulting and Clinical Psychology, 77*, 451-462.

Hoge, R. D., & Andrews, D. A. (2002). *Youth level of service case management inventory user's manual*. North Tonawanda, NY: Multi-Health Systems.

Horwitz, A., & Wasserman, M. (1980). Formal rationality, substantive justice, and discrimination: A study of juvenile court. *Law and Human Behavior, 4*(1/2), 103-115.

Hunter, J. A., Jr., & Figueredo, A. J. (1999). Factors associated with treatment compliance in a population of juvenile sexual offenders. *Sexual Abuse: Journal of Research and Treatment, 11*(1), 49-67.

In re Gault, 387 U.S. 1 (1967).

Kent v. United States, 383 U.S. 541 (1966).

Kraemer, B. D., Salisbury, S. B., & Spielman, C. R. (1998). Pretreatment variables associated with treatment failure in a residential juvenile sex-offender program. *Criminal Justice and Behavior, 25*, 190-202.

LeGrand, S., & Martin, R. C. (2001). Juvenile male sexual offenders: The quality of motivation system of assessment and treatment issues. *Journal of Child Sexual Abuse, 10*(1), 23-49.

Leistico, A.-M. R., & Salekin, R. T. (2003). Testing the reliability and validity of the Risk, Sophistication-Maturity, and Treatment Amenability Instrument (RST-i): An assessment tool for juvenile offenders. *The International Journal of Forensic Mental Health, 2*(2), 101-117.

Letourneau, E. J., & Miner, M. H. (2005). Juvenile sex offenders: A case against the legal and clinical status quo. *Sexual Abuse: Journal of Research and Treatment, 17*, 293-312.

Looman, J., Dickie, I., & Abracen, J. (2005). Responsivity issues in the treatment of sexual offenders. *Trauma, Violence, & Abuse, 6*, 330-353.

Loving, J. L., & Patapis, N. S. (2007). Evaluating juvenile amenability to treatment: Integrating statutes and case law into clinical practice. *Journal of Forensic Psychology Practice, 7*(1), 67-78.

Downloaded from sax.sagepub.com at UNIV OF SOUTH FLORIDA on December 30, 2010

Lukin, P. R. (1981). Recidivism and changes made by delinquents during residential treatment. *Journal of Research in Crime and Delinquency, 18*(1), 101-112.

Lynam, D. R., & Gudonis, L. (2004). The development of psychopathy. *Annual Review of Clinical Psychology, 1*, 381-407.

Marshall, L. E., Marshall, W. L., Fernandez, Y. M., Malcolm, P. B., & Moulden, H. M. (2008). The Rockwood Preparatory Program for sexual offenders: Description and preliminary appraisal. *Sexual Abuse: A Journal of Research and Treatment, 20*(1), 25-42.

Martin, R. C. (1989). *The quality of motivation questionnaire*. Lee's Summit, MO: RCM Enterprises.

Martinez, R., Flores, J., & Rosenfeld, B. (2007). Validity of the Juvenile Sex Offender Assessment Protocol-II (J-SOAP-II) in a sample of urban minority youth. *Criminal Justice and Behavior, 34*, 1284-1295.

McConnaughy, E. A., Prochanska, J. O., & Velicer, W. F. (1983). Stages of change in psychotherapy: Measurement and sample profiles. *Psychoptherapy: Theory, Research, and Practice, 20*, 368-375.

McGrath, R. J. (1991). Sex-offender risk assessment and disposition planning: A review of empirical and clinical findings. *International Journal of Offender Therapy and Comparative Criminology, 35*, 329-351.

Medoff, D., & Kinscherff, R. (2006). Forensic evaluation of juvenile sexual offenders. In S. N. Sparta & G. P. Koocher (Eds.), *Forensic mental health assessment of children and adolescents* (pp. 342-364). New York: Oxford University Press.

Melton, G. B., Petrila, J., Poythress, N. G., Slobogin, C., Lyons, P. M., Jr., & Otto, R. K. (2007). *Psychological evaluations for the courts: A handbook for mental health professionals and lawyers* (3rd ed.). New York: Guilford Press.

Miller, W. R., & Rollnick, S. (2002). *Motivational interviewing: Preparing people for change* (2nd ed.). New York: Guilford Press.

Mulvey, E. P., & Iselin, A. R. (2008). Improving professional judgments of risk and amenability in juvenile justice. *The Future of Children, 18*(2, Juvenile Justice), 35-57.

Oneal, B. J., Burns, G. L., Kahn, T. J., Rich, P., & Worling, J. R. (2008). Initial psychometric properties of a treatment planning and progress inventory for adolescents who sexually abuse. *Sexual Abuse: Journal of Research and Treatment, 20*, 161-187.

Page, G. L., & Scalora, M. J. (2004). The utility of locus of control for assessing juvenile amenability to treatment. *Aggression and Violent Behavior, 9*, 523-534.

Parks, G. A., & Bard, D. E. (2006). Risk factors for adolescent sex offender recidivism: Evaluation of predictive factors and comparison of three groups based upon victim type. *Sexual Abuse: Journal of Research and Treatment, 18*, 319-342.

Prentky, R. A., Li, N.-C., Righthand, S., Schuler, A., Cavanaugh, D. J., & Lee, A. F. (2010). Assessing risk of sexually abusive behavior among youth in a child welfare sample. *Behavioral Sciences & the Law, 28*, 24-45.

Righthand, S., Prentky, R., Knight, R., Carpenter, E., Hecker, J. E., & Nangle, D. (2005). Factor structure and validation of the Juvenile Sex Offender Assessment Protocol (J-SOAP). *Sexual Abuse: Journal of Research and Treatment, 17*(1), 13-30.

Russell, C., Hathaway, A., Cunningham, J. A., Vettese, L. C., Wyatt, S., & Taylor, L. (2005). Does Stage-of-Change Predict Dropout in a Culturally Diverse Sample of Adolescents

Downloaded from sax.sagepub.com at UNIV OF SOUTH FLORIDA on December 30, 2010

Admitted to Inpatient Substance-Abuse Treatment? A Test of the Transtheoretical Model. *Addictive Behaviors, 30*, 1834-1847.

Ryan, R. M., Plant, R. W., & O'Malley, S. (1995). Initial motivations for alcohol treatment: Relations with patient characteristics, treatment involvement, and dropout. *Addictive Behaviors, 20*, 279-297.

Salekin, R. (2001). *Manual for the risk, sophistication, and treatment inventory*. Lutz, FL: Psychological Assessment Resources.

Salekin, R. T. (2002). Psychopathy and therapeutic pessimism: Clinical lore of clinical reality? *Clinical Psychology Review, 22*, 79-112.

Salekin, R. T., Rogers, R., & Ustad, K. L. (2001). Juvenile waiver to adult criminal courts: Prototypes for dangerousness, sophisticationâ€"maturity, and amenability to treatment. *Psychology, Public Policy, and Law, 7*, 381-408.

Salekin, R. T., Salekin, K. L., Clements, C. B., Leistico, A.-M. R., Grisso, T., Vincent, G., et al. (2005). Risk-Sophistication-Treatment Inventory *Mental health screening and assessment in juvenile justice*. (pp. 341-356). New York: Guilford Press.

Salekin, R. T., Yff, R., Neumann, C., Leistico, A., & Zalot, A. (2002). Juvenile transfer to adult courts: A look at prototypes for dangerousness, sophistication-maturity, and amenability to treatment though a legal lens. *Psychology, Public Policy, & Law, 8*, 373-410.

Slobogin, C. (1999). Treating kids right: Deconstructing and reconstructing the amenability to treatment concept. *Journal of Contemporary Legal Issues, 10*(299), 1-25.

van Dulmen, S., Sluijs, E., van Dijk, L., de Ridder, D., Heerdink, R., & Bensing, J. (2007). Patient adherence to medical treatment: A review of reviews. *BMC Health Services Research, 17*, 7-55.

Vidal, S., & Skeem, J. (2007). Effect of psychopathy, abuse, and ethnicity on juvenile probation officers' decision-making and supervision strategies. *Law and Human Behavior, 31*, 479-498.

Viljoen, J. L., Elkovitch, N., Scalora, M. J., & Ullman, D. (2009). Assessment of reoffense risk in adolescents who have committed sexual offenses: Predictive validity of the ERASOR, PCL:YV, YLS/CMI, and Static-99. *Criminal Justice and Behavior, 36*, 981-1000.

Viljoen, J. L., Scalora, M., Cuadra, L., Bader, S., Chavez, V., Ullman, D., et al. (2008). Assessing risk for violence in adolescents who have sexually offended: A comparison of the J-SOAP-II, J-SORRAT-II, and SAVRY. *Criminal Justice and Behavior, 35*(1), 5-23.

Ward, T., Day, A., Howells, K., & Birgden, A. (2004). The multifactor offender readiness model. *Aggression and Violent Behavior, 9*, 645-673.

Westra, H. A., Arkowitz, H., & Dozois, D. J. A. (2009). Adding a motivational interviewing pretreatment to cognitive behavioral therapy for generalized anxiety disorder: A preliminary randomized controlled trial. *Journal of Anxiety Disorders, 23*, 1106-1117.

Worling, J. R. (2004). The estimate of risk of adolescent sexual offense recidivism (ERASOR): Preliminary psychometric data. *Sexual Abuse: Journal of Research and Treatment, 16*, 235-254.

Worling, J. A., & Curwen, T. (2001). Estimate of risk of adolescent sexual offense recidivism (ERASOR; Version 2.0). In M. C. Calder (Ed.), *Juveniles and children who sexually abuse: Frameworks for assessment* (2nd ed., pp. 372-397). Dorset, UK: Russell House.

Worling, J. R., & Långström, N. (2006). Risk of sexual recidivism in adolescents who offend sexually: Correlates and Assessment. In H. E. Barbaree & W. L. Marshall (Eds.), *The juvenile sex offender* (2nd ed., pp. 219-247). New York: Guilford Press.

Downloaded from sax.sagepub.com at UNIV OF SOUTH FLORIDA on December 30, 2010