Safer Society FOUNDATION

Working toward a safe society since 1982

A Developmental Model for Assessing Adolescents with Problematic Sexual Behaviors

Safer Society Continuing Education

When: November 19, 2025

Time: 11:00 am-2:15 pm ET

Norbert Ralph, PhD, MPH

THE CENTER FOR PROSOCIAL DEVELOPMENT

PROMOTING PROSOCIAL BEHAVIOR IN ADOLESCENTS AND YOUNG ADULTS, AGES 12 - 25

Presenter:

Norbert Ralph, PhD, MPH

- Clinical psychologist, Neuropsychologist, & Epidemiologist
- Fellow, Association for Treatment of Sexual Abusers; Board Member CalATSA
- Juvenile Treatment Representative, California Sex Offender Management Board
- Transformative Leadership Vanguard Program, University of Cincinnati Corrections Institute (2025).

- Formally Associate Clinical Professor, Family Practice, UC Davis
- Formally was psychologist working for Fresno Head Start, teen substance use program, and ADHD clinic in Modesto w/ UC Davis.
- Formally Coordinator, Sexual Responsibility Program & Alienist Panel Coordinator, DPH, C&C of San Francisco

- Director: Center for Prosocial Development, DBA, San Leandro, CA
- Contact information: Ph: 510-403-1830/Email. norbert.ralph@norbertralph.net

- Information presented has been "fact checked" but levels of evidence very. Contact the presenter for additional information. Don't take action based on this presentation; use usual sources of consultation and supervision. Content is relevant primarily to males, reflecting most research in the field. Presenter's research & perspectives used.


Goals for Presentation

Goals for Presentation

- A "Developmental Model" (DM) for assessment of youth with problematic sexual behaviors (YPSB) which includes:

- Judicial & Legal Basis for Developmental Model (DM)
- What is Evidence?
- DM Goals & Values
- Developmental Model
- A Developmental Model
- One Developmental Model for Assessment
- A State Developmental Model

Limitations of Presentation

Some research here, including the author's is from small sample of convenience populations, and results need to be replicated.

The presentation may be influenced by "confirmation bias" factors reflecting the presenter's perspective, including research on prosocial reasoning.

In this presentation tests, programs & books are mentioned but the presenter do not have any financial interest or benefits directly or indirectly from any of these products.

Most research described here is with males who are ~93% of youth adjudicated for sexual behaviors. Female population is important, but not much research (Finkelhor, Ormrod, & Chaffin, 2009).

Race and ethnicity important in assessment and treatment always.

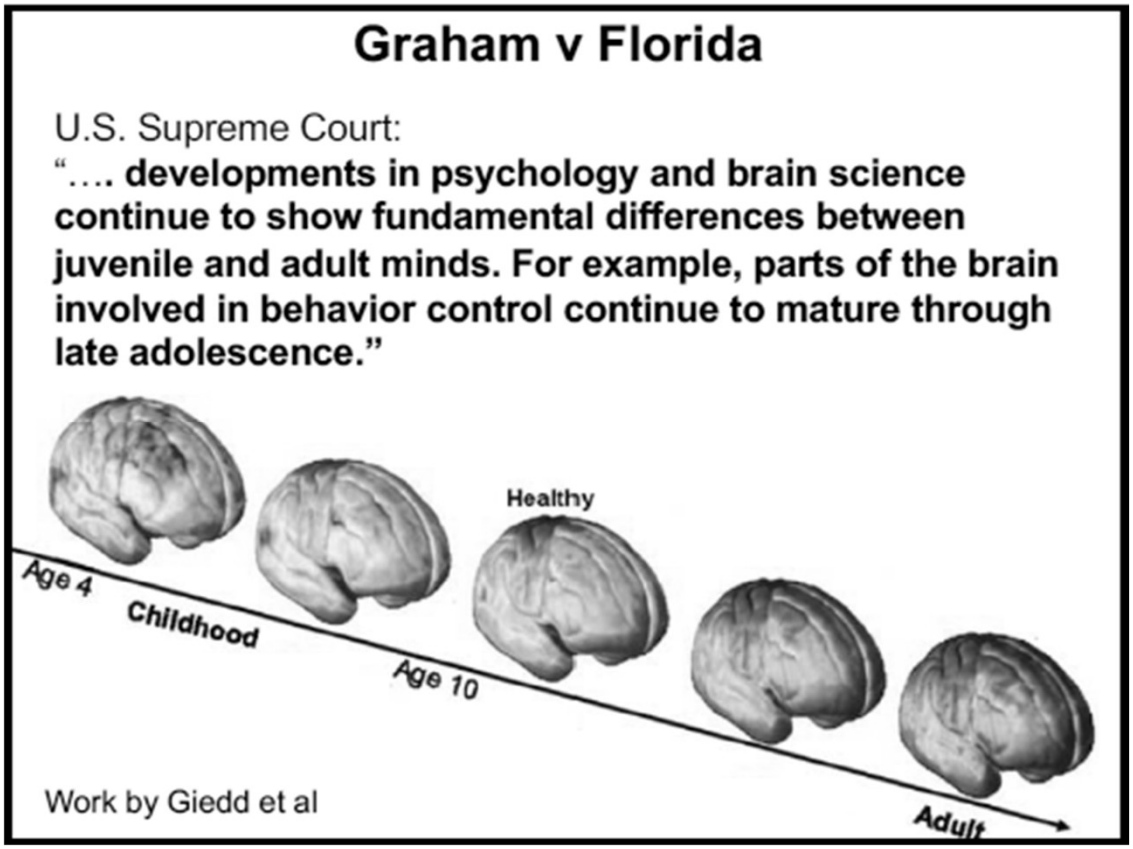
Judicial & Legal Basis for DM

Developmental Model "Baked-In"

Adolescence & Culpability

- The first juvenile court was created in Chicago in 1899.
- Juvenile courts were created to reflect the understanding that youth are developmentally different from adults — they are more impulsive, more responsive to peer influences, **BUT** more capable of change.
- Adolescents less "guilty" or culpable because of their age, immaturity, opportunities for further development.
- In the US, all states, territories, and tribal nations have juvenile courts or the equivalent.
- This system was designed to emphasize rehabilitation over punishment, recognizing that adolescents' behavior is shaped by ongoing brain development, treatment, prosocial opportunities, and environmental factors. Adult type sanctions/punishment are counterproductive for juveniles, associated with worse outcomes, and conflict with rehabilitation goals.

Graham V Florida



Juvenile Policy and Developmental Model (DM)

- Developmental Model (DM) aligns w/ Juvenile Justice Goals
- California Welfare & Institutions Code (§§ 202, 2024) and Judicial Council guidelines emphasize:
- Promoting positive development of youth
- Ensuring community safety
- Holding youth accountable in a fair and developmentally appropriate way that doesn't interfere with positive development.

- Texas laws and regulations which are similar (Texas: Family Code: Title 3. Juvenile Justice Code, Chapter 51. General Provisions.)

- California Sex Offender Management Board (CASOMB) Guidelines for Youth (2022): Core Goals:
  - 1. Promote public safety by reducing both sexual and general recidivism among youth.
  - 2. Support the prosocial development of youth to improve emotional, interpersonal, and occupational functioning.

- DM helps show what got in the way of a youth's positive development and what strengths and supports can help them grow now.

Juvenile Policy and Development

- Importance of Least Restrictive Placement
  - Youth should be placed in the least restrictive environment to promote prosocial development that protects public safety.
- Healthy development requires:
  - Age-appropriate education
  - Social interaction
  - Opportunities for skill-building and independence
  - Secure placements often reduce access to these developmental supports
- Adult-Style Punishment is Counterproductive.
  - Research (Lipsey et al., 2010) reports:
    - Adult sanctions don't work for youth
    - Punishment without a rehabilitative focus leads to higher reoffending
- Effective responses must balance:
  - Public safety
  - Prosocial development
  - Youth accountability

United Nations Convention on Rights of the Child

U.S. Juvenile Detention Practices and UN Children's Rights

•**Least Restrictive Placement**: UN guidelines (General Comment No. 24) state detention should be a *last resort*, strictly time-limited, and regularly reviewed. U.S. juvenile halls often default to restrictive placements, even when less severe options exist.

•**Right to Family Contact**: Article 9 emphasizes maintaining relationships with parents unless contrary to the child's best interests. Youth in detention are frequently separated from family without adequate visitation or support.

•**Protection from Violence**: Article 19 guarantees protection from all forms of violence. Detained youth often face physical and emotional harm in custodial settings.

•**Access to Education and Recreation**: Articles 28 and 31 affirm rights to education and play. Many juvenile facilities fail to provide age-appropriate schooling or recreational opportunities.

•**Developmental Needs Ignored**: Article 40 and General Comment No. 24 stress dignity, reintegration, and developmental appropriateness. Harsh confinement undermines these principles and does not promote positive development

United Nations General Assembly. (1989). *Convention on the Rights of the Child*.

What is Evidence?

DM uses quantitative, qualitative, multi-method & multi-informant evidence

Personal "Developmental Path"

- Background- Child adolescent psychologist.
- Fellowship Dept of Peds Children's Hosp Dallas in Adolescent Health Care. Physical & Psychosocial development.
- Favorite job was a psychologist with Fresno Head Start.
- Five years as a psychologist in teen chemical dependency program.
- 10 years coordinating an ADHD clinic for low-income Medicaid/MediCal children and teens.
- Did research on measure of psychosocial maturity, WUSCT.
- UC Berkeley MPH and fellowship in psychiatric epidemiology & evidence-based health care.

- Then started treating YPSB in 2001.
- A different world. Nowhere to be found evidence-based practice, physical/psychosocial/emotional developmental view of teens.
- Emphasis on sexual offending, offense cycle, relapse prevention.
- Did research on development of problem-solving schema in justice involved youth.
- Trained in Aggression Replacement Training & Moral Reconation Therapy- Promoting prosocial problem-solving.
- Developed and did research on Being a Pro- Easier to implement prosocial therapy.
    - Integrated developmental model and evidence-based practice.

Evidence Levels in Am Ac Peds Guidelines

Level	Evidence Quality	Typical Study Types	Example	% of AAP Recs
A	High	- Systematic reviews- Well-designed RCTs	Meta-analysis showing vaccines reduce pediatric hospitalization	10.6%
B	Moderate	- RCTs with flaws- Multiple consistent cohort/observational studies	Cohort studies showing helmet use reduces TBI in youth	47.5%
C	Low	- Single or inconsistent observational studies- Studies with major limitations	One study linking sugary drinks to behavior issues	27.1%
D	Very Low	- Expert opinion- Case reports- Theoretical reasoning	Recommendation based on pediatric expert panels	6.4%
X	Exceptional Circumstances	- Research not possible- Strong clinical consensus due to ethics or logistics	CPR for children in cardiac arrest	8.5%
(NR)	*Not Rated or Unclear*	- Evidence not graded or omitted from guideline	Background or explanatory statements in guidelines	

(Antommaria et al., 2025)

Evidence in DM

- “The perfect is the enemy of the good.” Voltaire’s Dictionaried Philosophique (1770):

- Requiring "perfect" evidence before acting can delay beneficial care. In evidence-based practice, clinicians often must act on good-enough evidence (moderate- or low-certainty studies, expert consensus) when higher-level data are lacking, especially if inaction could cause harm.

- "Evidence based medicine is the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients."
  --Sackett, et al. (1996). Evidence based medicine: What it is and what it isn’t.

- (American Psychological Association, 2002)
- (American Psychological Association Presidential Task Force on Evidence-Based Practice, 2006)

Evidence in DM

- Quantity or Quality: Why not both?
- Sticking up for **Quantitative Methods**: Value quantitative methods for children/teens child development measures used for Youth with Problematic Sexual Behaviors (YPSB)?
- ABAS-3 & Vineland-3 (adaptive behavior), cognitive, academic, psychiatric symptoms, moral/prosocial reasoning.
- Compare youth on reading level, adaptive behavior, psychiatric symptoms, or prosocial reasoning to other youth their age or specific clinical groups.
- Example: Knowing youth is depressed, and has 4th grade reading, is 16, yet has good problem-solving skills, does not have atypical or problematic sexual interests, all from standardized tests, is very useful.

Evidence in DM

- Sticking up for **Qualitative Methods**: Optimal strategy includes use of qualitative methods.
- Youth & collateral Interviews, behavioral observations, discussion of test responses and how they think to create a "picture" of the youth.
- Example: Prosocial reasoning measure or viewing time measure score quantitatively but then qualitatively follow-up with why the youth answered a given way.
- Important to gather detailed, qualitative information — including interviews, observations, life history, collateral input (from family, school, legal records) —helps us understand more effectively how youth thinks and functions: what to target and how.
- Optimal to Integrate Qualitative & Quantitative methods to test out or triangulate hypotheses.

Multimethod & Mixed-Method Improve Assessments

- Studies show that combining quantitative and qualitative methods (e.g., records, interviews, etc.) provides a fuller understanding of youth outcomes than relying on recidivism rates alone.

- Mixed-method designs reveal *how* and *why* interventions work, linking implementation quality, youth experience, and system practices to measurable change.

- Including youth and staff perspectives helps interpret data, identify barriers, and improve program fit and service delivery.

- Quantitative data show *what* changed; qualitative data explain *why*—essential for guiding effective interventions, policy and program design.

- **Supporting Studies:**
  (Sullivan et al., 2019)
- (Bond & Davidson, 2025)

"Takeaways" on Evidence

- In clinical decision-making, risk measures can provide useful information. But…
- For YPSB a goal of DM is a more detailed, nuanced (“pixelated”) picture of the youth and their life.
- ID strengths and challenges, identify realistic treatment targets, and best methods/approaches.
- Goal is to have enough info to guide treatment.

- Getting to know a patient is like learning a new language: at first you catch only fragments, but with time you grasp subtleties and rhythms.
- As fluency grows, you can respond more knowledgably, naturally, meaningfully, make treatment flow, and even rock & roll.


DM Goals & Values

Values of the Developmental Model (DM)

- Consistent with promoting prosocial development; emphasizes self-efficacy, transparency, and cultural, ethnic, and trauma sensitivity.
- Influenced by Dr. James Worling's approach and his ATSA training principles emphasizing care and time in informed consent.
- Collaborative, transparent, holistic, and developmentally oriented methods lead to stronger engagement and more accurate outcomes.
- Build structure that models respect, optimism, and collaboration for future treatment relationships.
- Take time and care with consent; explain clearly the purposes and uses of information.

Values of the Developmental Model (DM)

- Validate youth and family control over what they share; avoid pressure or coercion.
- Transparency increases honesty—similar to motivational interviewing methods.
- Direct, respectful questioning within clear boundaries improves information quality.
- Recognize developmental change—DM evaluations have limited duration, typically valid for about one year.
- DM goal is overall cognitive, social, academic, emotional maximum growth which is why we want comprehensive evaluation to assess areas for intervention.
- If we have too restrictive "conservative" disposition for youth, we may eliminate protective factors and opportunities for developing prosocial development.
- Bottom line: DM assessment's goal is prosocial relationships with developmental sensitivity and it has to model that in its approach.


Developmental Model (DM)

Risk Model in Evaluation

- In some types of adult evaluations for problematic sexual behaviors, the sole question posed to evaluators may be **Risk**, the danger of the individual to community safety.
  - In recent adult evaluation training the presenter discussed that their primary job as assessor was to assess the dangerousness of the individual.

- Because of the overwhelming influence of the R-N-R model, Risk evaluation is seen as primary factor that, for example, a court or probation may be interested in.

- Might this emphasis on Risk be an example of how the adult models/paradigms may predominate for juveniles, even when DM can be useful?

RNR and Juvenile General Offending

- Bijlsma, et al. (2025). Crime and Delinquency. Advance online publication.

- **Purpose**: Re-examined evidence for the RNR model within family-based interventions for juvenile delinquency. Addressed shortcomings in earlier reviews by applying stricter, theory-consistent coding of RNR principles.

- **Method**: Three-level meta-analysis. k = 31 studies, 71 effect sizes
- Family Interventions: Functional Family Therapy (FFT), Multisystemic Therapy (MST), Multidimensional Family Therapy (MDFT), Parent Management Training (PMT), Brief Strategic Family Therapy (BSFT), Other structured family skills programs.

- **Findings**: Overall small but significant positive intervention effect: $d = 0.38$ ($p < .001$)
  • Programs following any RNR principle showed larger effects, but none of the three principles (Risk, Need, Responsivity) significantly moderated outcomes.
- • Targeting antisocial recreation and adapting to age or cultural context significantly improved effectiveness.

- **Conclusion:** Empirical support for RNR principles in family Juvenile interventions remains limited.

RNR and Juvenile Sexual Offending

- **Low Recidivism Rates**: Research estimates that sexual recidivism among juveniles is low—often around **3–5%**, making it difficult to justify residential/secure interventions based solely on sexual risk.

- **Base Rate Problem**: With such low base rates, using present tools with moderate predictive accuracy (AUC ~0.70) has limited ability to distinguish true positives from false positives, leading to potential overclassification and unnecessary restrictions.

- **RNR Model Limitations**: Critics argue that the RNR model, may not be well-suited for juvenile sexual offenses due to:
  - Weak and inconsistent empirical support for risk factors specific to this group.
  - Limited predictive validity of tools like J-SOAP-II and JSORRAT-II.
  - Lack of integration of protective or developmental factors.

- **Alternative Perspectives**: This suggests the importance of developmentally informed, strengths-based approaches that emphasize rehabilitation and reintegration over risk containment.

Developmental Model

Developmental Model (DM)– A useful complement to Risk Model.

In a DM task shifts from “Risk Evaluator” (dangerousness of youth), to "Child Development Expert" (what can promote youth's positive development).

Focus on two issues:

1. Developmental Disruptors
   – Factors that interfered with prosocial development related to PSB.
   – Examples: trauma, family adversity, supervision challenges, pornography exposure, prosocial skill, ADHD or learning deficits.

2. Developmental Remediators
   – Factors that can restore the youth’s prosocial trajectory.
   – Treatment, social opportunities, protective factors, strengths, supports that promote healthy development.

Developmental Model & Science

- *Bronfenbrenner emphasizes that developmental science should focus on identifying processes that are "developmentally generative" or "developmentally disruptive," to better understand the conditions that promote healthy development.* (Bronfenbrenner & Morris, 2006)

- *Developmental science has three goals: to describe, explain, and optimize human development.* (Baltes et al., 1977).

- A core aim of developmental science is to understand both the processes that compromise positive development and the strengths and supports that can be mobilized to promote prosocial behavior and healthy functioning in youth. (Summary)
- *(*Lerner, 2018)

- *"The aim of resilience research is to understand how to promote positive development and competence, particularly under challenging conditions."*
- (Masten, 2014)

Risk Model

- Note of caution: In evaluating youth with very serious offenses (multiple, vulnerable or child victims, significant harm, use or threats of violence, etc.) we are obligated with imperfect measures to give our best opinions about public safety.

- Measures like the YLS-CMI, OYAS, SAVRY and PROFESOR, sexual interest measures, careful review of records, etc., interviews of youth and collateral sources, give us info re risk areas and interventions.

- Actual prediction of sexual risk may be problematic. Important to use general recidivism risk measures.

Use of Sexual Risk Tool for Youth

- Base rate of recid for YPSB= 3-5% → most are low risk by default.
  - At best juv sexual recid risk tools have medium effect size.

- Assume a risk measure using a cut-point which has Sensitivity & Specificity of 0.70.
  - Use 3% recidivism.

- Example with 10,000 screened using this hypothetical measure:
  - – True Positives: 210 (youth predicted as positive which are)
  - – False Positives: 2,910 (youth predicted as positive but aren’t)
  - – Positive Predictive Value (PPV): ~7% (1/15) chance the person has “it” if predicted.

- Identifying ”False Positives” may cause harm. Significant literature of harm of overtreatment.
  - Being "conservative" in treatment not useful- in fact harmful.

Juvenile Sexual Offending & Risk Measures

- An example JSORRAT-II.
- In Epperson & Ralston (2015), (sample n = 529 male youth aged 11-17) the reported AUC for predicting juvenile sexual recidivism was .70 (with 99% CI [0.60, 0.81]).
- Combine Sample Relative Risk Ratio, n= 1705.

Risk Level	Score Range	Recidivists /Selected	Recidivism Rate	Relative Risk Ratio*
1 Very Low	0	1/107	0.9%	0.1
2 Low	1–3	9/173	5.2%	0.6
3 Average	4–7	44/335	13.1%	1.4
4 Above Average	8–10	39/150	26.0%	2.9
5 High	11–18	37/78	47.4%	5.3

- Assume recidivism 3%.
- With these assumptions, what would be the utility of using this risk measure or comparable ones?

Juvenile Sexual Offending & Risk Measures

Evaluating JSORRAT-II or Comparable Tool

Criterion	What It Tells You	This Tool's Standing
Discrimination (AUC)	Can it separate high vs. low risk?	Yes (.70 = fair)
Calibration	Are predicted vs. actual rates aligned?	Table shows plausible alignment
Effect Size (RRR)	How much higher is risk across levels?	Good (up to 10–15× difference)
Base Rate Impact	Will it identify individuals who actually reoffend?	Limited (3% overall means even "high risk" often do not reoffend)
Policy Utility	Useful for prioritizing supportive resources, not placement or potentially adverse interventions.	Strong for triage/group risk

Because actuarial tools like the JSORRAT-II have low individual predictive accuracy, policy use is group-level triage for voluntary or supportive interventions, not dispositional or punitive decisions. The ethical justification rests on improving overall system efficiency and fairness—allocating services where, statistically, they can reduce harm—while always recognizing that individual predictions remain highly uncertain.

A Related ATSA Listserve Q

- As someone involved with juvenile assessments, I can see how risk measures, on a research or group basis, show differences. Statistics like the Relative Risk Ratio and AUC are fairly good, but not great. Given that recidivism rates are around 3–5 percent, it doesn't make sense to use these tools to make individual-level decisions that could have toxic, restrictive, or negative implications (e.g., transfer to adult court, long-term residential, or secure placement). The science simply isn't strong enough to justify that kind of decision-making.

- However, consider this: If you were a large probation department with funds available for supportive, non-punitive programs—such as family enhancement, case management, or skill-building services for youth and families—you couldn't provide them to everyone. In that case, might it make sense to prioritize or allocate those voluntary, non-restrictive supports to youth who score well above average on risk measures? My strong guess is that, for the right type of help, this approach could be effective if outcomes were tracked.

- From a policy perspective, these ideas may be important—particularly in shaping state guidelines or similar frameworks.

Is Prior Arrest a Risk Factor for PSB?

- **Ybarra & Mitchell, (2013) JAMA Pediatrics**
  - Youths aged 14 to 21 years (N=1058)
  - - 4% Attempted/completed rape or 9% other sexual violence
  - Perpetrators had greater exposure to violent X-rated content
- **Bonner, Walker, & Berliner (1999); Carpentier, Silovsky, & Chaffin (2006)**
  - PSB-CBT: 2% recidivism.
  - General population "comparison" group has 3% PSB.
  - Finding: Those treated with CBT-PSB, PSB rate ≱ PSB in general population.
- **Occurrence of PSB in general population may be as high as in youth with prior adjudication.**
  - Given findings should use recidivism risk measures for PSB?
  - Is adjudication for PSB a risk factor for another occurrence?
- **Do we want to make life changing decisions (detention, transfer to adult court, etc.) using risk measures for PSB?**

Making the Risk Model More Relevant

Sexual recidivism rates among youth are low (typically 3–5%), limiting the predictive utility of risk models for PSB. Alternatives exist.

TOTAL RECIDIVISM

- Total recidivism (including nonsexual offenses) is 6–8× higher, better outcome for risk-based assessment
- Risk assessment becomes more “actionable” when targeting general delinquency, not just sexual reoffending
- Validated tools like OYAS, YLS-CMI, and YASI are well-suited to assess broad criminogenic risk factors

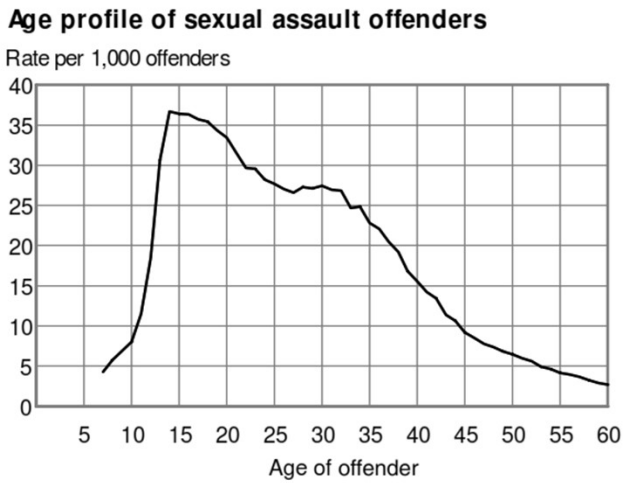
NON-ADJUDICATED PSB

- Non-adjudicated problematic sexual behaviors as outcome measures? 20% in residential settings.
- Prediction: Viljoen, et al. (2008) using JSORRAT-II NS, but (Ralph, 2015) found it predicted.

Physical Changes: The Rise of Super-Powers

- Teens literally develop superpowers in adolescence. Boys more than double in weight, triple in grip strength. (Tanner, 1962; Malina, et al., 2004).
- Testosterone levels In males increase 30-fold from ages 10 to 18.
- “Link between testosterone and aggression, but not with other behaviors or moods.” (Duke, et al., 2014, J of Adoles Health).
- Imagine a 10-year-old boy and then separately an 18-year-old boy both telling a 10-year-old girl to do something. Size and strength matter.
- Educate youth in the interpersonal impact of these changes.

Developmental Factors



- Steep age-related rise in offense rate related to developmental issues. (Snyder, 2002)

- Youth developmentally different from adults- Basis for juvenile justice system.
  - (California Sex Offender Management Board, 2022)

- Low sexual recidivism rates supporting developmental view and rehabilitation.
  - Meta-analytic studies id'd sexual recidivism around 3–5% (Caldwell, 2016; Lussier, et al., 2024).
  - General recidivism 7-10X higher.

- Practice guidance already embeds a developmental lens.
  - ATSA's adolescent (2017) practice guidelines direct broad, multidimensional, developmentally sensitive assessments that include strengths/protective factors and general risk—explicitly not adult models (Association for the Treatment of Sexual Abusers, 2017).

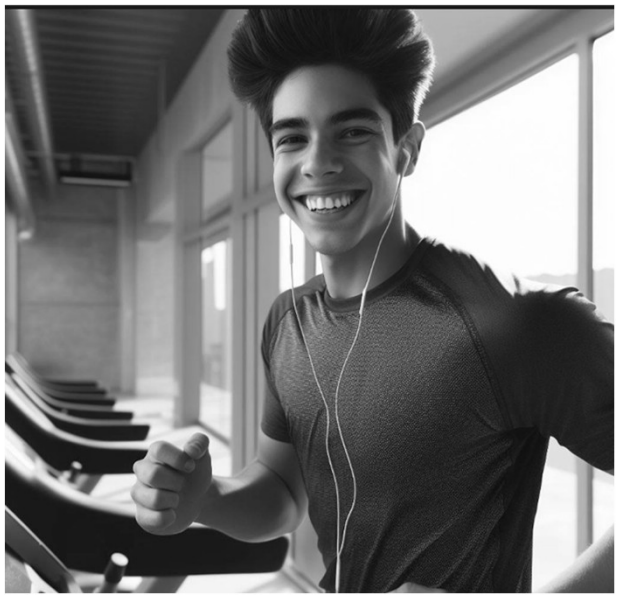
Plasticity: Neuropsychological and Developmental Research

- The large "treatment effect-size" observed in the juvenile delinquency literature regarding prosocial treatment methods is presumably related to this plasticity.

- Effect size **sex offense treatment**: Adolescent (-.51, Medium) vs. Adult (-.14). (Kim et al., 2016). **A meta-meta analysis** study. This supports the hypothesis that adolescents have greater brain plasticity & treatment is more effective.

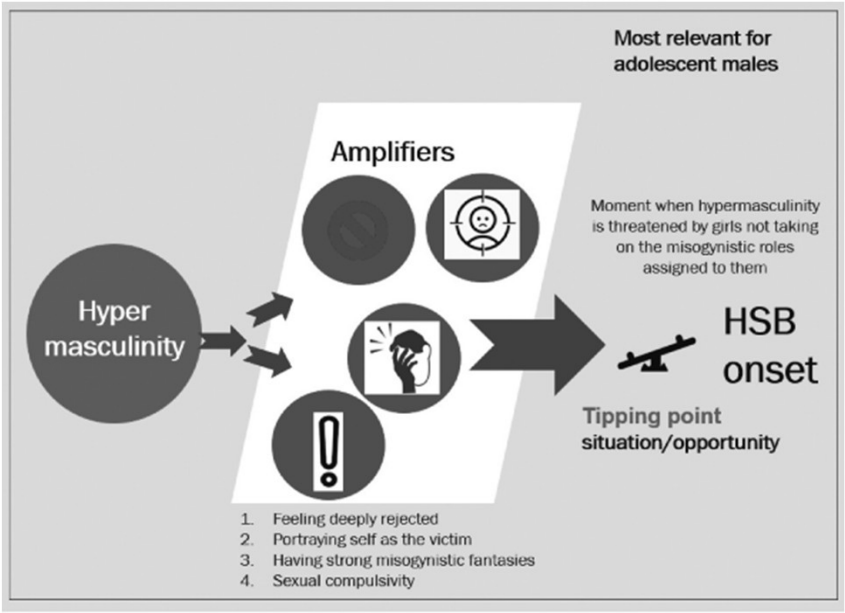
- Greater brain plasticity means youth are more treatable or "stretchable."

Prosocial Gym
Up your game



Why a Developmental Model

- McKibbin et al., 2024, in Pathways to Onset of Harmful Sexual Behavior (HSB) in an extensive literature review identifies developmental factors.
- They propose a developmentally oriented model:
  - (1) Driver – the psychosocial experience that sets a child on a path toward HSB onset.
  - (2) Flow – the movement over time of a child propelled by a driver.
  - (3) Amplifier – a risk factor that can increase the likelihood of HSB onset.
  - (4) Tipping point – situations or opportunities for HSB to occur in combination with an unconscious or conscious decision-making process or impulse.
  - (5) Onset – the moment in time when a child or young person first displays HSB.



Why a Developmental Model

- McKibbin et al., 2024, continued:

- They identify 10 Drivers:
  - Child sexual abuse victimization
  - Physical and emotional abuse
  - Living with domestic and family violence
  - Disrupted attachments
  - Sexual arousal
  - Antisociality
  - Pornography use
  - Inadequate sexual boundaries
  - Sexual attraction to children
  - Hypermasculinity

No scale developed to assess drivers.

Developmental Challenges

- Why a Developmental Model?

- Epperson & Ralston (2015), in statewide samples identified "Disruptor" factors which are high prevalence in YPSB youth & about **TRIPLED** recidivism.

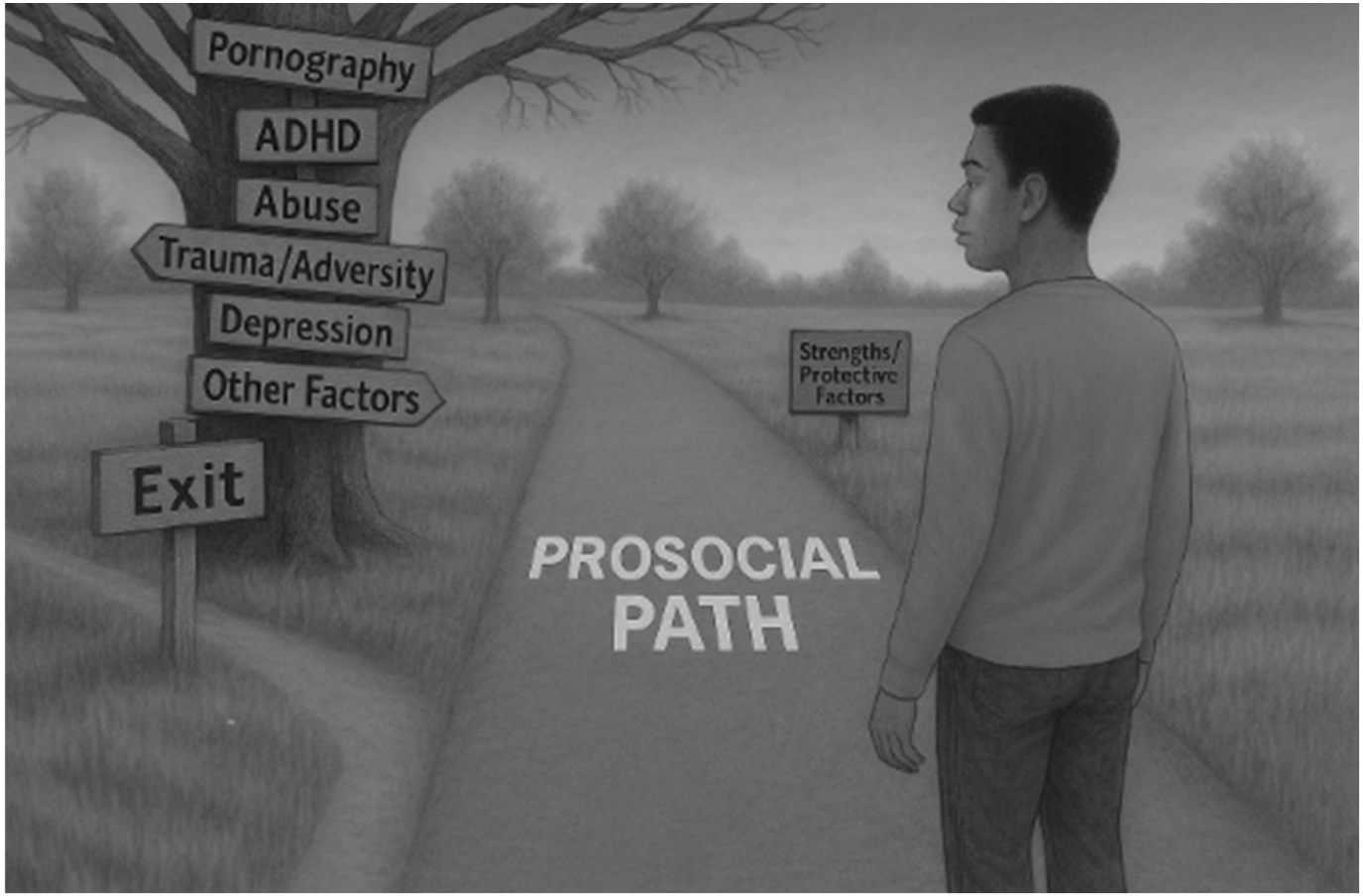
    - ADHD & related
    - Mood disorders
    - Sibling conflict
    - Parent conflict
    - Special ed
    - Sexual abuse
    - Physical abuse
    - School discipline
    - Prior delinquency

- Most successfully can be treated & risk for PSB presumably would be lowered.

- Assessing all major factors related to development. Why is a comprehensive developmentally-oriented model recommended?
    - In part because the only way to assess what got the youth off course developmentally and what might get them on course.

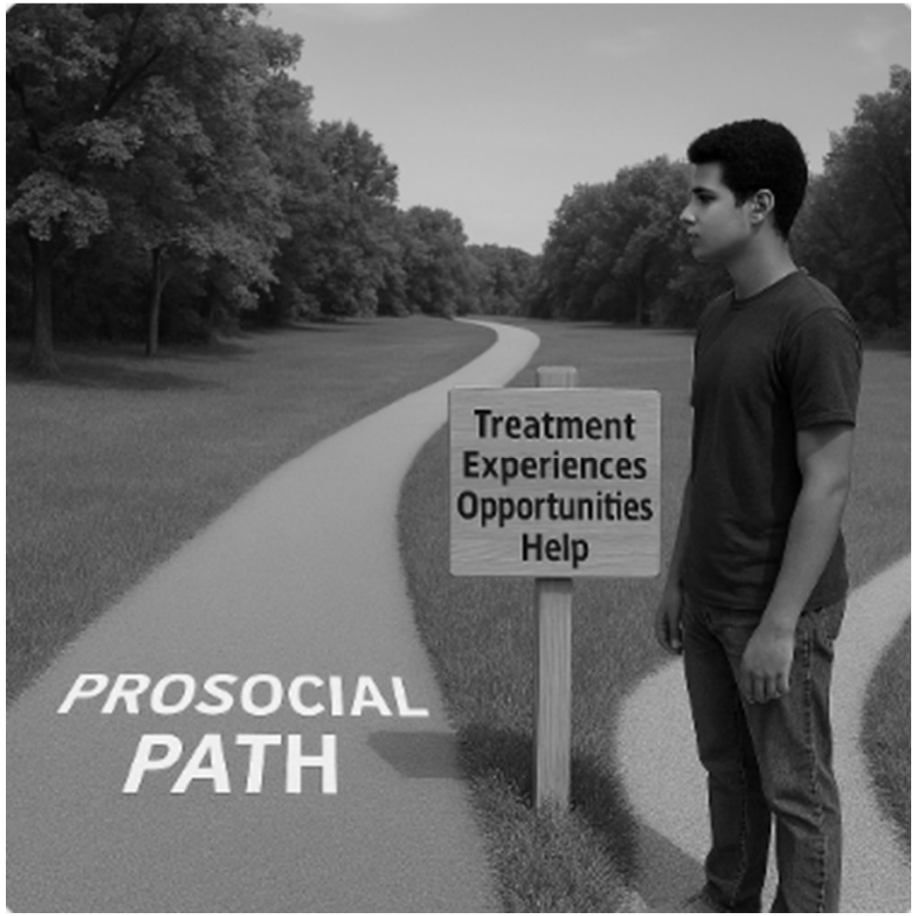
Pathways

- Disruptors to Prosocial Psychosexual Development



Prosocial Paths

- Remediators: Treatments, protective factors/strengths, practical help, prosocial experiences & interests---to get youth back on a Prosocial Path.




One Developmental Model (DM)
for Assessment

A Personal Model

- The San Francisco Alienist Panel had conducted court-ordered evaluations for over a decade.
- In 2006, I became the Coordinator of the Alienist Panel.

- Initial Challenges
- No ...
  - standards for evaluations.
  - procedures regarding commitment to taking on evaluations.
  - quality assurance standards.

- Problems
  - Delays
  - Quality concerns
  - Inconsistent assessments
  - No juvenile justice research/best practices
  - Few evidence-based recommendations

Developmental Model

- Early Approach to Assessment
  - At the time, I didn't yet conceptualize it as a Developmental Model but it was.
  - Implemented a comprehensive, holistic approach—not limited to criminogenic or risk factors.
  - Later developed a "Checklist" to ensure inclusion of key developmental and contextual factors.
  - Recognized the need for both quantitative and qualitative information to understand development.
  - Broader, integrative framework improved the basis for effective recommendations.
  - Recognized the need to assess all areas that shape prosocial development.

- Examples of Disruptors to Development
  - ADHD or attention problems
  - Reading or learning delays
  - Delays in prosocial reasoning or moral development
  - Adverse childhood experiences, trauma

- Key Idea:
  To promote prosocial outcomes, we must assess and treat every factor that contributes—directly or indirectly—to the youth's offending behavior and identify what derailed development and what can restore positive growth.

Checklist for Developmental Model

- Checklist for assessment was introduced to address limitations of reports.
  - Review of records.
  - Interview with probation.
  - Interview with mental health staff and records.
  - Interview with parent including developmental history.
  - Interview with youth.
  - Cognitive and academic assessment for youth.
  - Objective assessment of symptom & personality factors.
  - Rationale and evidence for DSM diagnoses.
  - Evidence based recommendations.
  - Time limits and qualifications of findings.
  - Special methods for neuropsych, competency, sexual offending, etc.

Consents & Interpersonal Factors in Developmental Model

- Influenced by Dr. James Worling's approach.
- Being collaborative, transparent, holistic, and developmentally oriented are not only positive human values—they lead to better assessment & outcomes.
- Build a structure that promotes collaboration and transparency, modeling future counseling relationships.
- Take time and care with the consent process.
- Explain the purposes and uses of information clearly- risks & benefits.
- Emphasize the family/youth's control over what they share and what they do not. They decide.
- This approach produces more accurate and meaningful information- like MI methods.
- When youth choice is validated, you aren't requiring or pressuring them, they are more likely to share important info.
- Ask directly and respectfully, while being fully transparent about how it will be used.
- DM evaluations have time-limited utility because of developmental change—typically valid for about one year.

Transparent Assessment Philosophy

- Prefer straightforward, respectful, face-valid methods.
- Ask directly about what you want to know (e.g., sexual interests, depression, etc. → ask about symptoms).
- Don’t presume response bias or dissimulation without evidence.
- Clarity and transparency yield more accurate, meaningful data.

Why Multimethod-Multi-Model

- Multi-Method, Multi-Informant Model
  - Combine testing, interviews, observations, and collateral input (parents, teachers, probation) for a full developmental view.
- Integrate findings to understand strengths, risks, and behavior patterns.

- Examples
  - Academic/Cognitive: Quick reading tests identify learning deficits linked to behavior.
  - Attention/Self-Regulation: Use multi-informant ADHD checklists plus observation or brief neuropsych measures.
  - Social Reasoning: Assess judgment and maturity through interviews, collateral input, and reasoning tasks.

- Purpose
  - Identify key developmental and contextual factors.
  - Guide interventions that reduce risk and support prosocial growth.
  - Multi-Method, Multi-Informant Model essential for DM.

Multi-Informant & Multi-Method Assessment in DM

Multi-informant/method approach shows incremental/construct validity across domains: A Psychological Bulletin review of 341 studies concludes that multi-informant assessments provide incremental contributions to predicting clinically relevant outcomes (diagnosis, treatment response), especially for observable concerns (e.g., disruptive/aggressive behavior). (De Los Reyes, Thomas, & Goodman, 2015).

- **Examples:**
  - **ADHD:** Combine **parent + teacher reports**, youth interview, behavior observation, and, when indicated, neuropsych testing.
  - **Reading Disorder:** Must include **direct reading/achievement testing**—rating scales alone are insufficient.
  - **Mood/Anxiety Disorders:** Youth self-report adds essential subjective data often missed by adults.

- Underlying condition is reflected and expressed in various ways and using multiple sources increase reliability and robustness of diagnosis. Parent–teacher–youth discrepancies reflect context, not error; integrating perspectives improves validity and guides targeted intervention.

References

(De Los Reyes & Langer, 2018)
(American Academy of Pediatrics, 2019)
(Mellard & Deshler, 2017)

Why Multimethod-Multi-Model:

(Ralph & Barr, 1989)

TABLE I
ADOLESCENT CHEMICAL DEPENDENCY PSYCHOLOGICAL RISK FACTORS*

	Clinical Interview & History	Parent/Family Interview	Personality Inventory	Behavior Checklist	Intelligence Test	Academic Achievement	Neuropsychological Test	Projective Test	Sentence Completion	Clinical Observation Over Time
Conduct Disordered Patterns										
Level of substance misuse, type of substances	VH	H	M	H	N	N	N	M	M	VH
Assimilation to a drug/delinquent subculture	VH	H	H	H	L	N	N	M	M	VH
Conduct disordered thinking (lying, denial, minimize, blame)	VH	H	H	H	M	N	N	VH	H	VH
Conduct disordered behavior (violates social rules, and rights of others)	VH	H	H	VH	N	N	N	H	H	VH
Family Factors										
Family structure/organization	M	M	L	N	N	N	N	M	L	VH
Family attachment	M	M	L	N	N	N	N	M	L	VH
Family substance abuse or psychiatric history	M	M	VL	N	N	N	N	M	L	VH
Psychiatric Factors										
Depression	VH	H	VH	VH	L	N	L	H	M	VH
Suicide risk	VH	H	VH	M	N	N	L	M	L	VH
Schizophreniform disorders	VH	H	H	L	M	N	L	VH	L	VH
Hyperactivity/ADD disorders	H	H	M	H	M	N	L	H	L	VH
Learning disabilities	M	M	VL	L	VH	VH	M	M	M	M
Anxiety/panic disorders	VH	H	H	M	L	VL	L	H	L	VH
Eating disorders	VH	H	H	M	N	N	N	L	VL	VH
Sexual and/or physical abuse	VH	H	H	N	N	N	N	M	VL	VH
Motivation for treatment	VH	H	M	N	N	N	N	VH	H	VH
Coping, defending, and problem solving capacity	VH	M	M	N	L	N	N	VH	M	VH

*Key: VH=very high; H=high; M=moderate; L=low; VL=very low; N=none.

One Model

- Records:
- Ask for probation, police, school, CPS, prior psych assessments: Everything in the probation file.

- Contract initially and agreement to pay for all record review, even 800 pages worth.

- Page 486 of 800 documenting brain tumor and radiation/chemotherapy at age 8.

- Secret Trick #1: Use OCR option in some software to make files searchable.

- Secret Trick #2: Ask for court order to include access to detention records including mental health notes.

One Model

- Collateral Contacts:
  - Probation officer: Can give additional and more current info besides records.
    - For example, youth is been doing great at school and last month.
  - For youth in detention or residential, essential to contact supervisory staff.
    - Youth is doing great, going to all rehab groups, but has a few bad days.

- Interview with Parents: Developmental history essential.
  - Secret Trick: 10 page developmental Q filled out before.
    - Then interviewed regarding answers.
    - Use Zoom and in -person flexibly.
    - For PSB, include section.

- Interview with youth:
  - Secret Trick: 6 page questionnaire/interview format.
  - For PSB, include section.

One Model

- Cognitive, neuropsychological, and academic assessment for youth:
  - Shipley Institute of Living Scale-2 & Wide Range Achievement Test-5/WRAT-5.
  - Shipley Vocabulary & WRAT-5 Reading average scores, but Abstraction and Math Computation, 5th percentile. Suspect learning disorder?
  - CNS VS and Cognistat- Easily administered neuropsych tests.

- Psychiatric symptoms:
  - Child Behavior Checklist, Youth Self-Report Form
  - Pediatric Symptom Checklist or Youth Report Form.

One Model

- Adaptive level, ADHD, trauma:
  - ABAS- Adaptive functioning re conceptual, social, and practical skill areas.
  - Primary Care PTSD Screen for DSM- Modified for adolescents.
  - Adolescent version of the ADHD Self-Report Scale/WHO.

- Prosocial Attitudes/behaviors:
  - Prosocial Attitudes Questionnaire- Parent/youth version. My pub, is beta.
  - Prosocial reasoning lower than normative population, consistent with residential treatment youth. Room for improvement.

One Model

- Production/projective measures:
- Roberts Apperception Test-2:
  - Storytelling TAT type test with 16 cards, objective reliable scoring system invalidation. Several variables, Problem Identification and Resolution (how they reasoned about social situations) highly predictive in one study with residential placement (AUC ≈ .90).
  - Analyze quantitatively and qualitatively.
  - Example: Above-average emotional complexity, integrating empathy, moral awareness, and insight into consequences. Themes of aggression, violence, illness, and parental conflict suggest stress exposure, yet moral reasoning remains internalized and consistent. Prosocial attitudes are strong. Family and peer portrayals indicate conflict and insecurity but also longing for connection and safety.

One Model

- Production/projective measures:
- Washington University Sentence Completion Test:
  - 18 item sentence completion. Excellent psychometric properties including juvenile justice predicting probation status. Can assess quantitatively and qualitatively.
  - Example. Functioning reflects Conformist (E4) level—rule-based, external reasoning, awareness of norms but limited reflection. Mood mildly negative yet stable; sadness and discomfort suggest sensitivity, not depression. Prosocial views include empathy and valuing education, though framed as duty. No antisocial themes. Family views traditional but conflicted. Problem-solving concrete, focused on cause and effect. Occasional emerging Self-Aware (E5) elements ("I can figure things out") show early independent thinking within largely literal, conventional responses.

One Model

- General Recidivism: General recidivism 7-10X higher than sexual recidivism.
  - Ohio Youth Assessment System & Structured Assessment of Violence Risk in Youth (SAVRY). Both include qualitative and multi-informant data, associated with improved effectiveness.
  - Langton, Worling, & Sheinin (2024) used SAVRY strengths including with YPSB.
    - Strengths have incremental validity over risk factor.

- **<u>Structured Assessment of Violence Risk in Youth (SAVRY)</u>**
- **Historical Risk Factors**
  - history of violence
  - history of nonviolent offending
  - early initiation of violence
  - past supervision failures
- **Social/contextual Risk Factors**
  - peer delinquency
  - peer rejection
  - coping challenges
  - parental management challenges
- **Individual/clinical Risk Factors**
  - negative attitudes
  - risk-taking
  - substance use
  - anger management
- **Protective Factors**
  - prosocial involvement
  - strong social support
  - strong attachment and bonds

One Model

- Sexual risk:
  - JSORRAT-II- You can use it in multiple jurisdictions to rate risk below/above baseline- most people don't know this.
  - ERASOR 2: Yep, Worling doesn't use it because of treatment philosophy, not because the outcome research isn't positive.
  - PROFESSOR: No research but has face validity and treatment philosophy. My view-- Its widespread use reflects move away from research basis. (We all love it.)

- Sexual interest/atypical/ problematic:
  - Adolescent Sexual Behavior Inventory-Parent & Self Report (ASBI-S)
  - Hypersexual Behavior Inventory-19 (HBI-19)
  - Pornography Consumption Inventory (PCI)
  - LOOK- Viewing time sexual interest measure

One Model

- Recommendations:
- Clearly related to assessment.
- Should be evidence-based consistent with the approach discussed above.
  - Only evidence-based recommendations have evidence that they really work.
- Practical and available and probability of being implemented reasonably.
- Should have buy-in from all parties including youth, family, probation, and courts.
  - Where possible, collaborative narrative for recommendations to promote development, not coercive.

Quantitative/Qualitative Methodology w/ Imperfect Test

• Prosocial Attitudes Questionnaire/Counselor
•(1. All 2. Most 3. Some 4. A Little 5. None/Not)

•1. Being OK with parents, teachers, or other adults telling them what to do.
•2. Do things their own way instead of following rules.
•3. They would rather get in trouble rather than be embarrassed in front of their friends.
•4. If they can't get what they want, they just get mad.
•5. If someone is annoying or bothering them, they just ignore them.
•6. Acting aggressive when someone is aggressive to them.
•7. Thinking rules are usually stupid.
•8. Plans ahead to avoid problems.
•9. What parents or teachers think is more important than what friends think.
•10. When others get mad at them, they let things cool off and don't get mad back.
•11. When things don't go their way, they can just let it go.

- Ralph (2015) independently developed a scale to measure prosocial attitudes and behaviors in juveniles- Prosocial Attitudes Questionnaire (PAQ).
- He assessed changes using a treatment method to increase prosocial reasoning using that scale.
- Statistically significant changes were found as a result of that intervention, that paralleled the dimensions described above by Steinberg and colleagues. The dimensions were:
  - Cooperation with adults and rules
  - Emotional control and regulation
  - Resistance to peer pressure
  - Planning and thinking ahead

An example

- Used in 2 peer-reviewed articles, and one ATSA poster session.
- Adequate inter-item correlation, discriminant and convergent validity adequate.
- 3 different clinical samples, and N=72 total.
- Many factors needed for test validity, notably, not only clinical sample, but a n=200+ sample from normative populations. Test still beta.

- Steps to use.
- Step 1: Quantitative: Score both versions using distribution from combined samples.
  - Youth Average: 2.3, Parent Average: 3.1

- Step 2: Face Validity: What average response means.

- Step 3: Qualitative: Youth and Parent explanation of responses. Information about why they responded and their rationale.

- Step 4: Use in recommendations.

Sexual History, Interests

- Use semistructured interview regarding sexual history and interests. Important not to forget details you may miss if don't have written protocol.

- Sexual interests: Challenge no well developed empirical measures?
  - What to do?
  - I use imperfect measures as best I can.
- Adolescent Sexual Behavior Inventory (Parent & Youth versions)
  - Use according to guidance In part, from primary author.
  - #1- Compare youth with published norms in article.
  - #2- Look at results qualitatively and face validity.
  - #3- Interview youth and parent to elaborate on responses for qualitative responses.

Viewing time measures: Use level of interest but also viewing time.

- Not normatively based with a reference population but if state of, looking at variability of interest for a given youth.
- Follow-up responses with clinical interview of, "Tell me why...." Integrating qualitative with quantitative findings.


A State Developmental Model

History: CCOSO (2013)

- California Coalition on Sexual Offending Guidelines for the Assessment and Treatment of Sexually Abusive Juveniles (Land, et al., 2013). I was co-author.
  - Comprehensive Assessment: Include multiple sources (records, interviews, testing) across life domains like family, peers, trauma, and mental health.
  - Dynamic Evaluation: Conduct assessments before, during, and after treatment to monitor changes in risk and adjust interventions.

CASOMB 2022 Guidelines

- California Sex Offender Management Board (CASOMB) Guidelines for Treating and Supervising Youth Who Have Committed a Sexual Offense (2022):
  - – Influenced by CCOSO 2013 (Land et al, 2013) and ATSA Adolescent Practice Guidelines (Association for the Treatment of Sexual Abusers, 2017).

- “A comprehensive psychological assessment should be completed, by a qualified licensed mental health provider, for the youth post-adjudication and pre-disposition." p 5.

- Address co-occurring psychiatric factors, cognitive/academic functioning, trauma history, and family dynamics.

- Use evidence-based, multidimensional assessments to identify risk levels, treatment needs, and protective factors.

- Reassess dynamic factors periodically to adjust treatment plans and monitor progress.

Comprehensive Assessments: Importance & Components

Was recommended policy but not mandated
- Legislation pending
- Some counties adopted Guidelines including in SF Bay Area

1. Goals:
- Identify risk levels, treatment needs, and responsivity factors
- Guides disposition and treatment planning with evidence-based practices

2. Components:
- Clinical interviews with youth and guardians
- Document reviews and collateral contacts
- Psychological tools administered by qualified providers

Reassessment, Cognitive/Mental Health, Risk Assessment

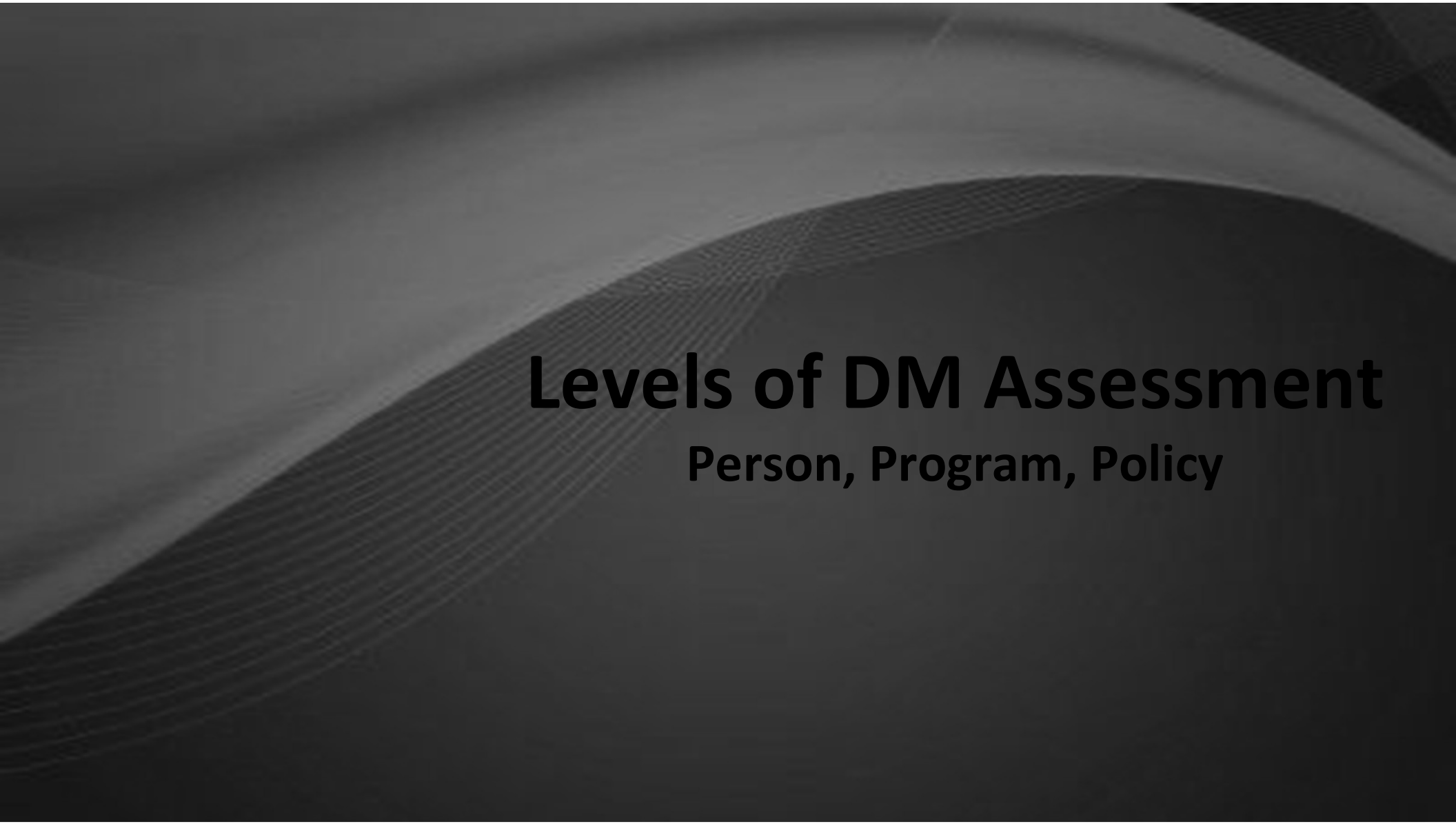
3. Reassessment & Dynamic Factors:
 – Ongoing reassessment of dynamic risk/protective factors
 – Adjusts treatment plans, some extending beyond probation periods

4. Cognitive & Mental Health Considerations:
 – High rates of learning & intellectual disabilities, ADHD, anxiety, mood disorders, PTSD, substance use
 – Need for thorough cognitive, academic, neuropsychological, and mental health assessments

5. Risk Assessment for Recidivism:
 – Use validated tools for sexual and general recidivism

CASOMB 2025 Revised Guidelines

- Revised 2025 Guidelines--in process.
- Greater emphasis on Developmental Model of assessment as complement to Risk Model.
- Development Disruptors but also Strengths/Protective Factors.
- Development Facilitators: Factors/Treatments to promote prosocial development.


Levels of DM Assessment
Person, Program, Policy

Levels of DM Assessment

- CASOMB Guidelines define what is adequate evaluation for YPSB. These can guide evaluation at the three levels: Person, Program, Policy.

- **Person Level (Indiv youth)**:
  - The Guidelines help define a psycho-social-sexual indiv assessment. Important to include aspects above.

Levels of Assessment

- **<u>Program Level (Program)</u>**:
- If all youth are evaluated using Person Model guidelines, Program-level instruments may provide valuable information about client characteristics and program outcomes.
- For example, using the PSB-CBT model through the NCSBY can track outcomes.
- Would that impress stakeholders and funding sources?

(Silovsky et al., 2018)

Child Behavior Checklist (CBCL)
Youth Self-Report (YSR)
UCLA PTSD Index (UCLA)
Youth w/ Sexual Beha Probs Invent (YSBPI)

Table 1. Mean and standard deviations of intake and exit measures of key outcomes for all youth.

	Site 1	Site 2	Site 3	Total
CBCL				
Intake *Internalizing*	58.6 (11.5)	58.7 (10.8)	57.2 (11.2)	58.5 (11.1)
Exit *Internalizing*	49.3 (10.0)	51.0 (11.7)	52.6 (10.3)	50.7 (10.9)
Intake *Externalizing*	57.4 (13.5)	61.0 (11.0)	56.0 (9.5)	59.2 (11.9)
Exit *Externalizing*	47.9 (9.6)	51.4 (9.8)	48.8 (9.2)	49.7 (9.7)
YSR				
Intake *Internalizing*	61.8 (10.0)	56.8 (10.6)	56.5 (10.4)	58.6 (10.6)
Exit *Internalizing*	54.3 (11.0)	51.4 (10.5)	51.2 (11.2)	52.4 (10.8)
Intake *Externalizing*	61.7 (8.7)	55.5 (11.2)	52.8 (10.5)	57.4 (10.7)
Exit *Externalizing*	56.2 (10.1)	52.4 (9.7)	46.5 (10.3)	52.6 (10.5)
UCLA				
Intake	21.8 (18.7)	23.9 (15.6)	17.5 (13.4)	22.0 (16.9)
Exit	18.3 (19.0)	13.2 (11.1)	11.2 (11.5)	15.0 (15.4)
YSBPI				
Intake	8.2 (7.8)	6.2 (6.6)	6.5 (6.6)	6.9 (7.1)
Exit	0.2 (0.5)	0.3 (1.4)	0.7 (2.0)	0.4 (1.4)

Levels of Assessment

- **<u>Policy Level (Statwide)</u>:**

- **CASOMB Oversight:** CASOMB may be given oversight over juvenile programs. Would permit statewide collection of data and examine the status of youth undergoing treatment**.**

- **Statewide Data Value:** Collecting test scores and recidivism for YPSB permit rational policy development and modifications.

- **Current Gaps:** We lack comprehensive statewide data, limiting accurate understanding of recidivism hindering rational policy development.

- **Improvement Potential:** Aggregated data could guide program and policy changes. Florida, with the world's largest juvenile justice database, demonstrates how system-wide questions can be addressed.

- **Key Principle:** "You can't manage what you can't measure." Without data, oversight and improvement remain constrained.

Questions from Participants?

The only "dumb" question is the one that was never asked.
-R. Bautista

Don't be afraid to ask the "dumb" question, everyone else will be relieved you had the guts to ask!
-S. Sandberg