Risk Assessment in Child Sexual Abuse Cases

Jill S. Levenson and John W. Morin

Despite continuing improvements in risk assessment for child protective services (CPS) and movement toward actuarial prediction of child maltreatment, current models have not adequately addressed child sexual abuse. Sexual abuse cases present unique and ambiguous indicators to the investigating professional, and risk factors differ from those related to physical abuse and neglect. Incorporation of research on risk factors specifically related to sexual offender recidivism into existing CPS risk assessment models may improve the ability to assess the risk of future sexual maltreatment to children. This article reviews the literature on risk factors for sexual offense recidivism and discusses their relevance and application to CPS assessment models. An evidence-based model for assessing risk in child sexual abuse cases is proposed.

Jill S. Levenson, PhD, MSW, is Assistant Professor of Human Services, Lynn University, Boca Raton, LA. John W. Morin, PhD, is Executive Director, Center for Offender Rehabilitation and Education, Fort Lauderdale, FL.

0009–4021/2006/010059–24 $3.00

During the past 20 years, child sexual abuse increasingly has been recognized as a significant social problem with complex and far-reaching consequences for victims, families, and society. According to the National Center on Child Abuse Prevention Research, 223,650 alleged child victims of sexual abuse were reported to child welfare agencies in 1997 (Wang & Daro, 1998). Surveys have found that as many as 23% of adults report they were sexually abused before the age of 18 (Finkelhor, Moore, Hamby, & Straus, 1997).

Generally, child protective service (CPS) agencies are the entry point through which sexual abuse cases are reported, investigated, and referred for intervention. In their role of protecting children from future harm, CPS workers are centrally involved in the process of determining whether reports of abuse can be substantiated and police or family court involvement is warranted (Drake & Johnson-Reid, 2000).

While most states use risk assessment protocols that consider some empirically derived factors to help child welfare workers make child safety decisions, these protocols have not clearly identified and separated sexual abuse risk factors from those related to other types of abuse (Camasso & Jagannathan, 2000; English, 1996). In recent years, however, sexual violence researchers (Epperson, Kaul, Huot, Hesselton, Alexander, & Goldman, 1999a; Hanson & Bussiere, 1996, 1998; Hanson & Thornton, 1999) have contributed important new data on risk factors and risk prediction specifically related to sexual assault and abuse. Incorporation of sex offender recidivism research in existing CPS risk assessment models may improve the ability to assess the risk of future sexual maltreatment to children.

Background

Since the 1980s, researchers have been making important strides in identifying risk factors predictive of physical child abuse and neglect (Baird, 1988; Doueck, English, DePanfilis, & Moote, 1993;

Johnson & L'Esperance, 1984; McDonald & Marks, 1991; Weedon, Torti, & Zunder, 1988). Risk factors have been found to fall into several broad categories, including child characteristics, parental characteristics, environmental factors, and parent–child interactions. The variables identified as most predictive include the age and vulnerability of the child and the perpetrator's access to the child (Weedon et al., 1988). To some extent, these factors have informed the consensus-based risk assessment models commonly used by CPS agencies, in which workers assess client characteristics described in the research literature and then exercise their own clinical judgment about the risk of future abuse or neglect (Baird & Wagner, 2000; Baird, Wagner, Healy, & Johnson, 1999). Many researchers (Baird, 1997; Baird & Wagner, 2000; Baird et al., 1999; Camasso & Jagannathan, 2000; Gambrill & Shlonsky, 2000; Ruscio, 1998), however, have expressed concern that consensus-based instruments generally demonstrate poor reliability and validity.

In a comparative study of the use and effectiveness of CPS risk assessment models conducted collaboratively by the National Center on Child Abuse and Neglect and the National Council on Crime and Delinquency, Baird (1997) addresses the weak reliability of risk assessment in child welfare. He notes that although many states use assessment instruments that include factors derived from literature reviews, these factors typically have not been validated against outcome data. He also finds that when CPS workers even recieved instruction in using consensus-based risk assessment systems, in the field they primarily rely on their own experience, intuition, and interviewing skills.

Ruscio (1998), in a review of studies examining the efficacy of decisionmaking by child welfare workers in placing children in foster care, finds that 48% of placements were unnecessary and 45% of children needing placements were left in their homes. He contends that the variability of knowledge, education, and experience of child welfare workers limits their ability to use available decisionmaking protocols effectively, and that child welfare workers need structured tools to improve their assessment abilities.

Ruscio also argues that poor reliability has been endemic in child welfare decisionmaking and proposes that proper statistical analyses of risk factor data could help to generate more reliable predictions. This process, known as the actuarial method, estimates the likelihood of a certain outcome by referring to the known (actual) outcomes of individuals with similar characteristics, and is more accurate than clinical judgment (Grove & Meehl, 1996; Grove, Zald, Lebow, Snitz, & Nelson, 2000; Swets, Dawes, & Monahan, 2000a). Baird (1997; Baird et al., 1999) suggests that until reliable, valid decisionmaking systems are used, the current debate surrounding the efficacy of child protection and family preservation programs is futile.

Child welfare research since the mid-1990s, in fact, has began to move in the direction of using empirically derived and actuarial risk assessment models. Virtually absent from this movement, however, is a focus on factors related to child sexual abuse; researchers have focused instead on physical abuse and neglect. Camasso and Jagannathan (2000), for example, measure the reliability and validity of the Washington State Risk Assessment Matrix in their study of 239 cases involving 640 children. Ultimately, only allegations of physical abuse, lack of supervision, neglect, and family or child problems were considered in their analysis. Camasso and Jagannathan report that "sexual abuse was a relatively rare event...and demonstrated virtually no relationship to the other types of abuse or neglect. For these reasons, sexual abuse cases were deleted from our model test" (p. 885). In Baird and Wagner's (2000) comparison of three risk assessment instruments, only 7.9% of the nearly 3,000 sample cases included a substantiated index investigation of sexual abuse. Their outcomes were defined with no apparent control for abuse type. Thus, the ability of any of the three models studied by Baird and Wagner to predict future sexual abuse is unknown.

CPS risk assessment models have traditionally included parental, child, and environmental factors. Outcomes are generally measured by the recurrence of abuse or neglect of a child (Gambrill &

Shlonsky, 2000). In sexual abuse cases, however, a child's risk for sexual abuse clearly depends on the presence of an adult with a proclivity to sexually molest children. Yet, the CPS risk assessment literature reveals a virtual absence of reference to research on risk factors related to sexual offenders. The authors suggest, therefore, that current risk assessment protocols are simply not applicable to child sexual abuse, and offer ideas for improvement.

Problems in the Assessment of Child Sexual Abuse Cases

Unlike physical abuse and neglect cases, in which injuries and parental characteristics are fairly evident, sexual abuse cases present unique and ambiguous indicators to the investigating professional. Sexual abuse occurs and thrives in secrecy, and children molested by family members or caretakers (usually male) may be unlikely to disclose the abuse because of fear, loyalty to the abuser, or a belief that they contributed to the abuse (Summit, 1983). Children often recant allegations when they see that the disclosure has created a crisis for the family (Summit, 1983). Because children are confused and embarrassed by sexual activity, they frequently disclose abuse in an unconvincing fashion. Their statements are often tentative, contradictory, and minimizing (Sorenson & Snow, 1991), rendering their accusations easily dismissed by both the accused and investigators. Children's statements are the most important evidence in sexual abuse cases, yet many CPS workers are not properly trained in forensic interviewing practices that maximize children's credibility and minimize the risk of confusion or suggestibility (Reed, 1996). Moreover, the most common types of child sexual abuse, fondling and oral sex, rarely cause physical injury, so corroborating medical evidence of sexual abuse is unusual (Faller, 1993). Although workers may be trained to recognize behavioral and emotional indicators of sexual abuse in children, most of these indicators are not exclusive to sexual abuse but can be seen in children traumatized by a range of events. A child victim probably will not demonstrate for

the CPS worker the one type of behavior most often linked to sexual abuse—sexualized behavior (Friedrich, Fisher, Dittner, Acton, Berliner, Butler, Damon, Davies, Gray, & Wright, 2001)—and the adults most likely to have witnessed such behavior (those under investigation) most likely will not report it.

Child molesters rarely use violence or overt force and usually do not need to even threaten children to attain compliance and secrecy (Salter, 1995). One of the bitter ironies of child sexual abuse is that the perpetrator, even as he or she is molesting the victim, may be the person who most meets the needs of that child for attention, affection, and nurturing, and the child may be closely bonded to the abuser. Even as molesters entrap victims in a silent conspiracy of shame and guilt, their "grooming" of their victim by giving him or her special attention and privileges appears in many respects to be loving and caring. Thus, the behaviors, interactions, and dynamics typically assessed in a CPS investigation of physical abuse or neglect will not apply to sexual abuse, and in many cases, they will actually be inversely related to the risk of sexual abuse. For instance, a child who appears to be well-cared for, who appears unafraid of the alleged molester, or who produces an unclear description of sexual abuse may be erroneously assessed as not at risk for future sexual harm. If the worker focuses on environmental factors such as poverty; parental factors such as mental illness, parenting skills, or substance abuse; and negative parent–child interaction patterns as primary indicators, then sexual abuse can easily go undetected.

Ironically, the indicators most commonly assessed in child protective service investigations may not be only irrelevant, but misleading in sexual abuse cases. In one study involving nearly 29,000 sex offenders, a number of factors commonly assessed in traditional CPS models were among those that did not correlate with repeated sex offending (Hanson & Bussiere, 1998). For instance, low social class ($r = .05$) appeared to be unrelated to sexual recidivism, as did a past history of substance abuse problems ($r = .03$) and alcohol abuse problems ($r = .00$). History of general psychological problems was also unrelated to recidivism ($r = .00$). Low intelligence and poor

social skills, often assessed and considered risk factors for physical abuse and neglect, showed nonsignificant correlations with sexual recidivism. In the authors' view, these uncorrelated factors are particularly significant, because a CPS caseworker interviewing an alleged perpetrator may be potentially biased by clients who present as intelligent, middle class, nonaddicted, and generally well-adjusted—all characteristics that are statistically unrelated to reoccurring sexual abuse.

Risk Assessment of Sex Offenders

Clearly, the ability to assess risk for future sexual abuse is predicated first on the ability to accurately identify indicators of sexual abuse and substantiate that sexual maltreatment has occurred. Risk assessment of sex offense recidivism focuses on the identification of risk factors for *reoccurring sexual abuse* by those already convicted, not for the confirmation of abuse in an initial investigation. In CPS cases where there is substantial evidence that some inappropriate sexual behavior has occurred already and the goal is to assess the likelihood of future abuse, familiarity with what is known about sex offenders—child molesters in particular—will assist in identifying relevant risk factors for future abuse.

Risk factors for sexual recidivism fall into two main categories (Hanson & Bussiere, 1998; Roberts, Doren, & Thornton, 2002). The first relates to *sexual deviance.* In the sex offender literature, the words "sexual deviance" narrowly refer to sexual fantasies and behaviors involving an assault on or unwanted sexual behaviors toward a noncon-senting person (e.g., exhibitionism, voyeurism, child molesting, or rape). Sexual deviance refers both to the sexual attraction (to the targeted victim or the act itself or both) and the resulting sexual arousal. Although the strength of deviant attractions can vary among sex offenders, CPS workers should consider sexual deviance to be functionally equivalent to a sexual orientation.

The second cluster of risk factors centers around *psychopathy,* a combination of interpersonal, affective, and behavioral characteristics

(Hare, 1999) related to, but not identical to, antisocial personality disorder. Risk factors are typically classified as either *static* (historical or demographic and, therefore, unchangeable), or *dynamic* (changeable).

Static Risk Factors

Without question, the most profound contribution to the field of risk assessment of sexual offense recidivism has been the meta-analysis, sponsored by the Canadian government and conducted by Karl Hanson and Monique Bussiere (1996, 1998), of 61 recidivism studies involving almost 29,000 sexual offenders. In examining more than 70 variables hypothesized to be related to reoccurring sex offense, the meta-analysis identified both the factors that significantly correlate with recidivism and those that do not.

For the most part, the meta-analysis focused on static factors. Factors that correlated with sexual recidivism included sexual arousal to children (phallometrically measured) (r = .32), any deviant sexual preference (r = .22), prior sex offense arrests or convictions (r = .19), age of offender (young) (r = .13), any prior offenses (including nonsexual) (r = 13), male child victim (r = .11), any unrelated victims (r = .11), never having been married (r = .11), early onset of sex offending (r = .10), and diversity of sexual crimes (r = .10) (Hanson & Bussiere, 1996, 1998). Most of the variables showed small to moderate independent correlations with recidivism, rendering no variable sufficiently related to recidivism to justify its use in isolation (Hanson & Bussiere, 1998). However, stepwise regression of combined variables produced a substantially larger correlation of .46 for sexual recidivism (Hanson, 1997).

Dynamic Risk Factors

Research into dynamic risk factors has identified variables that can be changed and, therefore, can modify risk level. Unsurprisingly, access to victims increases the likelihood of reoccurring sexual abuse (Hanson & Harris, 1998). The individuals most likely to

recidivate also display poor social supports; attitudes tolerant of sexual assault, sexual entitlement, or preoccupation; intimacy deficits; negative social influences; and poor self-management strategies (Hanson & Harris, 1998, 2001). Although a history of substance abuse is not related to sexual offense recidivism (Hanson & Bussiere, 1998), Hanson and Harris (1998) find that ongoing substance abuse problems were common among recidivists. Recidivists tend to show an increase in anger and subjective distress just prior to recommitting an offense (Hanson & Harris). These types of dynamic risk factors can be best used to assess the timing and imminence of reoffense (Hanson & Harris, 2001).

Another dynamic factor related to reoccurring sexual abuse is failure to complete sex offender treatment (r = .17) (Hanson & Bussiere, 1998). This factor relates to men who begin sex offender treatment but either quit or are terminated by the treatment program. Hanson and Bussiere note, "Reduced risk could be due to treatment effectiveness; alternately, high-risk offenders may be those most likely to quit, or be terminated, from treatment" (p. 358). Hanson and Harris (1998) note that high-risk offenders generally were less cooperative with probationary and CPS supervision requirements, including treatment, and speculated that attrition from treatment may be an indicator of lack of motivation for change or antisocial tendencies, or both. Treated sex offenders, however, have been found to recidivate at significantly reduced rates (Hanson, Gordon, Harris, Marques, Murphy, Quinsey, & Seto, 2002).

Application of Sex Offender Research to Practice

In general, knowledge of these risk factors can help CPS workers and other practitioners to improve risk-related decisions in CPS cases, become informed consumers of sex offender evaluations, and relay relevant information to judges. Hanson and Bussiere's meta-analysis (1998) provided a comprehensive integration of data on sexual recidivism risk factors that can facilitate empirically based child safety decisions. The general caveat on such an application is

that recidivism risk factors can *not* establish the presence or absence of sexual abuse in an initial investigation, but rather assess the risk of reoffense by identified sexual perpetrators. It would be ludicrous, for example, to suggest that because an accused sexual abuser is young, or unmarried, or has little social support, or is angry, he must be a sex offender. Initial confirmation of allegations must be based on the evidence adduced by the police, medical personnel, and CPS investigators. In many cases a psychosexual assessment (including polygraphy) by a mental health professional who is specially trained in the evaluation of sex offenders may help clarify the risk posed by the sexual abuser. Whenever child sexual abuse is confirmed, the sexual abuser should not be allowed to reside with children. Whenever possible, the offender should be removed from the home rather than the victim or other children. In all substantiated child sexual abuse cases, risk factors for reoffense are directly applicable.

If the accused perpetrator is arrested and convicted, additional assessment techniques become available. Sex offense specific actuarial instruments can be applied to convicted offenders to generate an estimate of the likelihood of reoffense. Several actuarial risk assessment instruments have been developed to use with this population, adding structure to decisionmaking protocols. By combining empirically derived risk factors into scales, then weighting (e.g., through multiple regression analysis) and testing the scales for predictive validity, researchers (Epperson, Kaul, Huot, Hesselton, Alexander, & Goldman, 1999b; Hanson, 1997; Hanson & Thornton, 1999; Harris, Rice, & Quinsey, 1993) have developed actuarial instruments explicitly for predicting risk of reoccurring sexual offense. Scoring a convicted sex offender on these instruments allows for the estimation of the likelihood for sexual recidivism by referring to the recidivism rate of other convicted sex offenders with the same score. A qualified professional specializing in the evaluation or treatment of sex offenders should do the actuarial assessment of sexual abusers.

In many cases, however, substantial evidence of abuse is uncovered but prosecutors decide not to pursue criminal adjudi-

cation, because they are unsure they can prove the case beyond reasonable doubt (e.g., no medical evidence exists, or the victim has recanted or provided inconsistent information). In such cases, family courts and child protection agencies will be responsible for restricting the nonadjudicated sexual abuser's access to children and making decisions about permanency for the children. Federal law allows child abusers to pursue reunification with their children, while at the same time defining sexual abuse as egregious and permitting the expedited termination of parental rights in some cases (see the Adoption and Safe Families Act, 1997).

Assessing risk for reoccurring sexual abuse will be relevant in cases where visitation or reunification is being considered and a permanency plan must be developed. Such assessment also is important in cases in which a known sex offender has gained access to other children (e.g., remarriage to a spouse with children). Knowledge of which factors identify high risk sex offenders can help distinguish those cases in which rehabilitation of the offender and planning for family safety (Levenson & Morin, 2001) can be pursued reasonably from those cases in which the risk of reoffense will remain unacceptably high regardless of intervention. Knowledge of risk indicators also may prevent the investigator from being distracted by either the presence or absence of false risk factors (i.e., those assessed in physical abuse and neglect).

Static Risk Factors in Assessment

Among true risk factors that will be known during initial CPS assessment, the most important is prior sex offenses, which correlates at $r = .19$ with sexual recidivism (Hanson & Bussiere, 1996, 1998). Importantly, Hanson (1997) finds that not only prior convictions were predictive of new offenses, prior *charges* for sex offenses also were predictive. Thus, any previous accusations of sexual abuse may signal a pattern of sexually abusive behavior. Previous allegations that were not substantiated should never be dismissed out of hand as "false" or "fabricated," but should be explored to determine why they were not confirmed. Many cases

are unsubstantiated, or, in some states, "uncertain" or "indicated," because not enough evidence is obtained to rule a case as confirmed. Regardless of their disposition, past allegations should be considered a risk factor.

A related factor involves the diversity of indicators of sexual deviance. Sex offenders tend not to be specialists. Many studies (Abel, Becker, Cunningham-Rathner, Mittleman, Murphy, & Rouleou, 1987; Abel, Becker, Cunningham-Rathner, Mittleman, & Rouleou, 1988; Freeman-Longo, 1985; Freund, 1990) find that sex offenders often have multiple paraphilias. More than half of sex offenders have sexually assaulted both adult and minor victims (Abel et al., 1988; Heil, Ahlmeyer, & Simons, 2003). Thus, any history of rape, exhibitionism, or voyeurism, including any charges for such crimes, signals the possibility of a pattern of sexual deviance and increased risk of child sexual abuse. Any indicator that the confirmed abuser has engaged in a variety of sexual crimes increases the risk of recidivism (Hanson & Bussiere, 1998). Moreover, the fact that a prior allegation of sexual deviance occurred many years before the current allegation does not render the prior one irrelevant, because the early onset of sexually deviant behavior also is a risk factor for continued sex offending (Hanson & Bussiere, 1998).

A pattern of criminality, failure to conform to social norms, deceitfulness, lack of remorse or empathy, and impulsivity across a range of social settings suggest antisocial qualities. Such traits may render a person undeterred by the threat of punishment, less likely to inhibit sexual aggression, and more likely to obtain sexual gratification opportunistically (Quinsey, Lalumiere, Rice, & Harris, 1995). Among individuals with deviant sexual preferences, antisocial personality disorder and psychopathy can increase the likelihood of sexual reconviction (Hanson & Bussiere, 1998; Quinsey et al., 1995).

Although most CPS sexual abuse referrals will involve incestuous or intrafamilial cases, offenses in which the alleged offender is outside of the victim's family indicate an extrafamilial, predatory pattern of offending that signals high risk (Hanson &

Bussiere, 1996; 1998). Research has consistently found that extrafamilial sex offenders reoffend at significantly higher rates than pure incest offenders (Hanson & Bussiere, 1998; Hanson, Scott, & Steffy, 1995; Prentky, Lee, Knight, & Cerce, 1997; Quinsey et al., 1995). In general, stepfamilies and even stable cohabitation living arrangements are considered "familial." However, sexual abuse by stepparents or live-in paramours within the first two years of cohabitation should be considered extrafamilial offenses (Hanson, 1997). These situations raise the possibility that the abuser pursued a relationship with the nonoffending parent in order to gain access to the children.

Hanson and Bussiere (1998) find that never-married perpetrators had higher rates of sex offense recidivism. Such abusers may be uncomfortable with adult intimacy and may seek opportunities to develop "relationships" with children. These offenders may be skilled at manipulating adults in order to gain access to youngsters, including befriending or initiating relationships with mothers in an attempt to infiltrate families with children.

The preference for male victims correlating significantly with risk for reoffense (Hanson & Bussiere, 1996, 1998) suggests that boys, in some cases, will be at increased risk for sexual abuse. Although research has consistently found that boys are victimized at lower rates than girls (Finkelhor, 1984; Finkelhor et al., 1997), sex offenders with male victims are more likely to recidivate (Hanson & Bussiere, 1998) have multiple victims (Abel et al., 1987). Therefore, sexual abuse cases involving boys must be carefully assessed and the likelihood of other potential victims explored. Furthermore, 20% of sex offenders have assaulted victims of both genders (Abel et al., 1987); therefore, the fact that a molester abused a child of one gender does not imply that an opposite-sex child is not at risk.

Hanson and Bussiere (1998) find that younger sex offenders (under age 25) recidivate at higher rates than older offenders. A more recent study, however, finds that extrafamilial child molesters showed little decline in risk until after age 50 (Hanson,

2002). Incestuous offenders under 25 who molested younger siblings, cousins, or other family members had the highest rates of recidivism, but they may represent a distinct group from parent–child incest offenders. The peak frequency of incest occurred in the late 30s, corresponding with increased access to youngsters through one's own children or the children of family members (Hanson, 2002).

In summary, static factors for sex offense recidivism that should be considered by CPS workers when considering reunification or visitation as a permanent plan include prior charges, convictions, or accusations of sex offenses; variety of sexual deviance; criminality, antisocial personality, or psychopathy; extrafamilial victims; male victims; and no apparent history of marriage or intimate relationships with peers. Middle-aged and young adult offenders appear to be at highest risk for repeated incest.

Dynamic Risk Factors in Assessment

Dynamic risk factors can be monitored by CPS caseworkers and changes may signal that offending is imminent and immediate interventions are needed. It is clear that any sex offender who is living with children should be considered at increased risk for reoffense (Hanson & Harris, 1998). This type of living arrangement should be cautiously considered and allowed only after the offender has engaged successfully in a qualified sex offender treatment program and when a nonoffending adult lives in the home to supervise contact at all times. "Supervised" contact implies that the chaperone believes past sexual abuse occurred, recognizes the potential for future harm, and understands the importance of close supervision (Levenson & Morin, 2001). Supervised contact between sexual perpetrators and potential victims should always occur within the eyesight of a chaperone who believes that the potential for sexual abuse exists, that careful supervision is critical, and that protective intervention may become necessary (Levenson & Morin).

Offenders who maintain antisocial peer relationships or who are isolated from prosocial supports should be seen as at increased risk for reoccurring sexual abuse (Hanson & Harris, 2001). Offenders who continue to display attitudes that tolerate or condone sexual assault (e.g., "sometimes children initiate sex"; "teens are old enough to consent") also represent an ongoing risk to children. Evidence of sexual entitlement or preoccupation (use of pornography or Internet sex activities), or poor self-management strategies (e.g., erratic employment, failure to meet financial obligations, nonsexual arrests) make it unlikely that an individual will have the control to avoid inappropriate sexual opportunities and prevent reoccurring sexual offense (Hanson & Harris, 1998, 2001). Hanson and Harris (1998) found that ongoing substance abuse problems were common among recidivists. Because substance use can impair judgment, lower inhibitions, and interfere with impulse control, it may be a particularly important factor to consider when monitoring ongoing risk.

Probation, community supervision, and the restrictions regarding access to children that typically follow a conviction will usually limit the convicted sex offender's opportunity to reoffend. Conversely, risk is increased when offenders have unsupervised access to children and their behavior has not been sanctioned. Risk would likely be greatest, then, in cases where an abuser is living with children, court-ordered restrictions have not been imposed, or no sanction for the abuser's past behavior exists (Levenson & Morin, 2001). Recidivists have been found to be less cooperative with probationary and CPS supervision (Hanson & Harris, 1998). Thus, resistance to conditions of probation or CPS, or poor treatment reports, may be indicative of increased dynamic risk.

Treatment effect historically has been methodologically difficult to establish with sex offender populations (Furby, Weinrott, & Blackshaw, 1989) and, therefore, it often has not been clearly associated with reduced recidivism rates. Treatment failure, however, has been found to correlate ($r = .17$) with reoccurring sexual

abuse (Hanson and Bussiere, 1998). Hanson and Bussiere (1998) surmise that this result could be due to treatment effectiveness, or, alternatively, lack of motivation among high-risk offenders to become engaged in treatment and therefore become more likely to quit or be dismissed by the treatment provider. Other researchers have found that while dropping out of treatment did not increase recidivism risk, being terminated from treatment did (Epperson et al., 1999a).

A recent meta-analysis conducted by leading researchers in the field of sexual violence in a collaborative project found reductions in both sexual recidivism and general recidivism when cognitive-behavioral relapse prevention treatment approaches are evaluated with methodologically sound research designs (Hanson et al., 2002). The 43 studies reviewed included 9,454 subjects. Overall, treated groups sexually recidivated at a rate of 12% compared with a 17% recidivism rate for untreated control groups. Cognitive-behavioral treatment programs reduced sexual offense recidivism from 17.4% to 10%, decreasing recidivism by almost 40% (Hanson et al., 2002). Recidivism rates were based on an average 46-month follow-up period. Thus, evidence is increasing that such treatment should be considered integral to any case plan leading toward visitation or reunification with a known or suspected sexual abuser.

The treatment–failure risk factor appears to relate to two separate questions: (1) Is the offender willing and able to comply with addressing his or her problem of sexual deviance in therapy?; and (2) Has anything about the offender changed since he or she committed the offenses that would diminish the risk of reoffending? (Doren, 1998) Any individual with a history of sexual assault is capable of repeating that behavior. Until such an individual admits the problem and genuinely addresses it through successful completion of a qualified treatment program, there ordinarily will be little reason to believe that his or her risk for reoffending is significantly diminished. Offenders who either refuse to engage in treatment, who comply only superficially with treatment, or who

are unwilling to relinquish their denial of their offenses and their sexual deviance have a poor treatment prognosis (Levenson & Macgowan, 2004; Macgowan & Levenson, 2003). Offenders who either quit treatment or are terminated by the treatment program may be displaying antisocial tendencies in addition to denial and low motivation for change (Hanson & Bussiere, 1998). A qualified sex offender treatment program should, at a minimum, address issues of accountability, victim empathy, relapse prevention, cognitive restructuring, and enhancement of intimate relationships (Marshall, Anderson, & Fernandez, 1999; Morin & Levenson, 2002).

At the same time, it is important to note that *The Practice Standards and Guidelines for Members of the Association for the Treatment of Sexual Abusers* (2001) states that sexual abusers "continue to pose some level of risk for reoffending even after completing treatment or supervision" and that reunification should not be recommended for offenders who "deny their offenses, are noncompliant with treatment or supervision requirements...or are at moderate to high risk for reoffending based on competent evaluation" (p. 26). Sexually abusive behavior is a learned or acquired behavioral disorder, not a disease that can be "cured." Sex offenders represent a diverse and heterogeneous group, and risk varies widely among them. Completing sex offender treatment means only that an individual acknowledges sexual deviance and understands how to use the tools and strategies that can help maintain control of the abusive behaviors if he or she so chooses (Levenson & Morin, 2001).

Dynamic risk factors that can be assessed by CPS workers monitoring sex offenders under protective supervision include the inability of the nonoffending parent in the home to properly supervise and implement safety plans; lack of cooperation with probation and CPS conditions; continued antisocial behavior; attitudes tolerant of sexual assault, poor self-regulation, or sexual preoccupation; ongoing substance use; and treatment failure. Dynamic factors are best used to assess the imminence of reoffense.

Implications for Child Welfare Practice and Research

In this era of unprecedented demand for accountability by child welfare agencies, social service systems increasingly need to deliver empirically based assessments and interventions. Media attention to high profile child abuse cases, particularly those seen as "failures" of the system to protect children, should inspire child welfare practitioners and administrators to employ the most effective assessment and intervention strategies available. In recent years, an emphasis on evidence-based practice has emerged in the social services professions, encouraging integration into practice the best available empirical evidence from systematic research (Gibbs & Gambrill, 1999). The authors have suggested in this article that the data on sex offense recidivism offer an empirically sound foundation from which to move toward evidence-based practice in protecting children from sexual abuse.

Indicators of sexual abuse in children are complex and ambiguous. Currently available models for assessing risk for physical abuse and neglect are, at best, irrelevant, and, at worst, dangerously misleading in sexual abuse cases. Sexual abuse in general, and, more specifically, perpetrator factors related to the risk of repeat sex offending have been virtually ignored in the development of CPS risk assessment protocols. The authors propose that risk assessment of future child sexual abuse can be improved using empirically derived risk models. Integrating empirically validated risk factors for sexual offense recidivism in child welfare assessment protocols would enable practitioners to make statistically guided decisions leading, presumably, to increased child safety.

The authors have briefly noted that when use of actuarial instruments to assess the likelihood of reoccurring sexual abuse is appropriate (e.g., when the abuser has been convicted of a sex offense), such instruments provide valuable information. These instruments are widely used in such contexts as sexual predator civil commitment, Megan's law, and sentencing decisions, and they have largely supplanted clinical judgments of future dangerous behavior. This movement is supported by a substantial literature

confirming the superiority of statistical techniques over clinical judgment in predicting outcomes in a variety of applications (Grove et al., 2000; Grove & Meehl, 1996; Monahan & Steadman, 2001). For example, in a review of a meta-analysis of 136 studies comparing actuarial methods with clinical judgment by a variety of professionals concerning a range of medical, behavioral, and mental health predictions, Grove and Meehl (1996) found that 64 favored the actuarial instrument, 64 showed approximately equivalent accuracy, and only 8 favored the clinician. Experience of the clinician seemed to make no difference in predictive accuracy. Actuarial methods can improve the accuracy of predictions by standardizing factors that have been identified as key diagnostic features and setting statistical thresholds for decisionmaking (Swets et al., 2000a; Swets, Dawes, & Monahan, 2000b). In advocating for more widespread use of actuarial methods to inform decisionmaking protocols, Grove and Meehl (1996) argue that using the less scientific of two prediction procedures in the development of social policy and social services is not only inefficient, but also unethical.

Emerging data in the CPS literature suggest that, as in other fields, actuarial assessment produces more consistent and more accurate predictions (e.g., Baird et al., 1999; Baird & Wagner, 2000). Baird (1997; Baird et al., 1999) maintains that actuarial instruments can estimate future behavior more accurately than even the most experienced individuals. When applicable, such models should play a central role in decisionmaking in child welfare, where errors can have potentially devastating effects on children, families, and society for generations to come. Future research should include the development of a risk assessment tool specific to incestuous sexual abuse. Recidivism outcome studies (as measured by new CPS reports) could help to determine the usefulness of such an instrument, as well as the effect of a sexual-abuse-specific risk assessment protocol suggested here.

Including sex offender risk assessment curricula in child welfare training programs would improve workers' decisionmaking ability by clearly distinguishing risk assessment of sexual abuse from that of physical abuse and neglect. By emphasizing the factors most

relevant to reoccurring sexual offense and increasing awareness of the ways in which positive offender presentations can spuriously influence findings, workers can be made more sensitive to the insidious and deceptive dynamics of child sexual abuse. By effectively assessing risk, limited fiscal resources can be efficiently directed into less restrictive interventions for lower risk cases and appropriate placement and treatment interventions in higher risk cases.

The former Surgeon General released a position paper declaring sexual abuse a public health problem (Satcher, 2001). A societal move toward a public health model of preventive intervention might be best hastened by child advocates. Public policy and child welfare practice that is informed by interdisciplinary research can help improve both clinical and community interventions designed to enhance the safety of vulnerable children. Of course, continued research in the development of effective treatment intervention programs for both perpetrators and victims also will assist in halting the intergenerational cycle of child abuse.

References

Abel, G. G., Becker, J. V., Cunningham-Rathner, J., Mittleman, M. S., Murphy, M. S., & Rouleou, J. L. (1987). Self-reported crimes of nonincarcerated paraphiliacs. *Journal of Interpersonal Violence* 2, 3–25.

Abel, G. G., Becker, J. V., Cunningham-Rathner, J., Mittleman, M. S., & Rouleou, J. L. (1988). Multiple paraphilic diagnoses among sex offenders. *Bulletin of the American Academy of Psychiatry and the Law 16*(2), 153–168.

Adoption and Safe Families Act, Public Law 105-89 (1997).

Association for the Treatment of Sexual Abusers. (2001). *Practice standards and guidelines for members of the Association for the Treatment of Sexual Abusers.* Beaverton, OR: Author.

Baird, S. C. (1988). Development of risk assessment indices for the Alaska Department of Health and Social Services. In T. Tatara (Ed.), *Validation research in CPS risk assessment: Three recent studies* (pp. 85-139). Washington D.C.: American Public Welfare Association.

Baird, S. C. (1997). *Child abuse and neglect: Improving consistency in decision making.* (NCCD Focus, August). San Francisco: National Council on Crime and Delinquency Focus.

Baird, S. C., & Wagner, D. (2000). The relative validity of actuarial- and consensus-based risk assessment systems. *Child and Youth Services Review* 22(11/12), 839–871.

Baird, S. C., Wagner, D., Healy, T., & Johnson, K. (1999). Risk assessment in child protective services: Consensus and actuarial model reliability. *Child Welfare 78*(6), 723–748.

Camasso, M. J., & Jagannathan, R. (2000). Modeling the reliability and predictive validity of risk assessment in child protective services. *Child and Youth Services Review* 22(11/12), 873–896.

Doren, D. M. (1998). Recidivism base rates, predictions of sex offender recidivism, and the "sexual predator" commitment laws. *Behavioral Sciences and the Law 16*, 97–114.

Doueck, H. J., English, D. J., DePanfilis, D., & Moote, G. T. (1993). Decision-making in child protective services: A comparison of selected risk assessment systems. *Child Welfare 72*(5), 441–454.

Drake, B., & Johnson-Reid, M. (2000). Substantiation and early decision points in public child welfare: A conceptual reconsideration. *Child Maltreatment, 5*(3), 227–235.

English, D. J. (1996). The promise and reality of risk assessment. *Protecting Children 12*(2), 9–13.

Epperson, D. L., Kaul, J. D., Huot, S. J., Hesselton, D., Alexander, W., & Goldman, R. (1999a). *Final report on the development of the Minnesota sex offender screening tool - revised (MnSOST-R).* Paper presented at the 17th annual conference of the Association for the Treatment of Sexual Abusers, Vancouver, Canada.

Epperson, D. L., Kaul, J. D., Huot, S. J., Hesselton, D., Alexander, W., & Goldman, R. (1999b). *Minnesota sex offender screening tool - revised (MnSost-R): Development performance, and recommended risk level cut scores.* Unpublished manuscript.

Faller, K. C. (1993). *Child sexual abuse: Intervention and treatment issues.* Washington, DC: U.S. Department of Health and Human Services.

Finkelhor, D. (1984). *Child sexual abuse.* New York: The Free Press.

Finkelhor, D., Moore, D., Hamby, S. L., & Straus, M. A. (1997). Sexually abused children in a national survey of parents: Methodological issues. *Child Abuse & Neglect 21*, 1–9.

Freeman-Longo, R. E. (1985). Incidence of self-reported sex crimes among incarcerated rapists and child molesters. *Unpublished manuscript.*

Freund, K. (1990). Courtship disorder. In W. L. Marshall, D. R. Laws & H. E. Barbaree (Eds.), *Handbook of sexual assault: Issues, theories, and treatment of the offender.* New York: Plenum.

Friedrich, W., Fisher, J., Dittner, C., Acton, R., Berliner, L., Butler, J., Damon, L., Davies, W., Gray, A., & Wright, J. (2001). Child sexual behavior inventory: Normative, psychiatric, and sexual abuse comparisons. *Child Maltreatment 6*(1), 37–49.

Gambrill, E., & Shlonsky, A. (2000). Risk assessment in context. *Child and Youth Services Review 22*(11/12), 813–837.

Gibbs, L., & Gambrill, E. (1999). *Critical Thinking for Social Workers: Exercises for the Helping Professions.* (Rev. ed.). Thousand Oaks, CA: Sage Publications.

Grove, M. G., & Meehl, P. E. (1996). Comparative efficiency of informal and formal prediction procedures: The clinical-statistical controversy. *Psychology, Public Policy and Law 2*(2), 293–323.

Grove, M. G., Zald, D. H., Lebow, B. S., Snitz, B. E., & Nelson, C. (2000). Clinical versus mechanical prediction: A meta-analysis. *Psychological Assessment 12*(1), 19–30.

Hanson, R. K. (1997). *The development of a brief actuarial scale for sexual offense recidivism.* Ottawa, ON: Department of the Solicitor General of Canada.

Hanson, R. K. (2002). Recidivism and age: Follow-up data from 4,673 sexual offenders. *Journal of Interpersonal Violence 17*(10), 1046–1062.

Hanson, R. K., & Bussiere, M. T. (1996). *Predictors of sexual offender recidivism: A meta-analysis.* (No. 1996-04). Ottawa, ON: Department of the Solicitor General of Canada.

Hanson, R. K., & Bussiere, M. T. (1998). Predicting relapse: A meta-analysis of sexual offender recidivism studies. *Journal of Consulting and Clinical Psychology 66*, 348–362.

Hanson, R. K., Gordon, A., Harris, A. J. R., Marques, J. K., Murphy, W., Quinsey, V. L., & Seto, M. C. (2002). First report of the collaborative outcome data project on the effectiveness of treatment for sex offenders. *Sexual Abuse: A Journal of Research & Treatment 14*(2), 169–194.

Hanson, R. K., & Harris, A. J. R. (1998). *Dynamic predictors of sexual recidivism.* Ottawa, ON: Department of the Solicitor General of Canada.

Hanson, R. K., & Harris, A. J. R. (2001). A structured approach to evaluating change among sexual offenders. *Sexual Abuse: A Journal of Research & Treatment 13*(2), 105–122.

Hanson, R. K., Scott, H., & Steffy, R. A. (1995). A comparison of child molesters and nonsexual criminals: Risk predictors and long-term recidivism. *Journal of Research in Crime and Delinquency 32*, 325–337.

Hanson, R. K., & Thornton, D. (1999). *Static 99: Improving actuarial risk assessments for sex offenders.* (No. User report 1999-02). Ottawa, ON: Department of the Solicitor General of Canada.

Hare, R. D. (1999). *Without Conscience: The disturbing world of psychopaths among us.* New York: Simon & Shuster.

Harris, G. T., Rice, M. E., & Quinsey, V. L. (1993). Violent recidivism of mentally disordered offenders: The development of a statistical prediction instrument. *Criminal Justice and Behavior 20*, 315–335.

Heil, P., Ahlmeyer, S., & Simons, D. (2003). Crossover sexual offenses. *Sexual Abuse: A Journal of Research & Treatment 15*(4), 221–236.

Johnson, W., & L'Esperance, J. (1984). Predicting the recurrence of child abuse. *Social Work Research and Abstracts 20*(2), 21–26.

Levenson, J. S., & Macgowan, M. J. (2004). Engagement, denial, and treatment progress among sex offenders in group therapy. *Sexual Abuse: A Journal of Research & Treatment 16*(1), 49–63.

Levenson, J. S., & Morin, J. W. (2001). *Treating nonoffending parents in sexual abuse cases: Connections for family safety*. Thousand Oaks, CA: Sage Publications.

Macgowan, M. J., & Levenson, J. S. (2003). Psychometrics of the Group Engagement Measure with male sex offenders. *Small Group Research 34*(2), 155–169.

Marshall, W. L., Anderson, D., & Fernandez, Y. (1999). *Cognitive behavioural treatment of sexual offenders*. Hoboken, NJ: John Wiley & Sons.

McDonald, T., & Marks, J. (1991). A review of risk factors assessed in child protective services. *Social Service Review, March*, 112–132.

Monahan, J., & Steadman, H. J. (2001). Violence risk assessment: A quarter century of research. In L. E. Frost & R. J. Bonnie (Eds.), *The evolution of mental health law* (pp. 195–211). Washington, D.C.: American Psychological Association.

Morin, J. W., & Levenson, J. S. (2002). *The Road to Freedom*. Oklahoma City, OK: Wood and Barnes Publishing.

Prentky, R. A., Lee, A. F., Knight, R. A., & Cerce, D. (1997). Recidivism rates among child molesters and rapists: A methodological analysis. *Law and Human Behavior 21*(6), 635–659.

Quinsey, V. L., Lalumiere, M. L., Rice, M. E., & Harris, G. T. (1995). Predicting sexual offenses. In J. C. Campbell (Ed.), *Assessing Dangerousness: Violence by sexual offenders, batterers, and child abusers* (pp. 114–137). Thousand Oaks, CA: Sage Publications.

Reed, L. D. (1996). Findings from research on children's suggestibility and implications for conducting child interviews. *Child Maltreatment 1*(2), 105–120.

Roberts, C. F., Doren, D. M., & Thornton, D. (2002). Dimensions associated with assessments of sex offender recidivism risk. *Criminal Justice and Behavior 29*(5), 569–589.

Ruscio, J. (1998). Information integration in child welfare cases: An introduction to statistical decision making. *Child Maltreatment 3*(2), 143–156.

Salter, A. (1995). *Transforming Trauma.* Thousand Oaks, CA: Sage Publications.

Satcher, D. (2001). *The Surgeon General's call to action to promote sexual health and responsible sexual behavior.* Washington, D.C.: U.S. Department of Health and Human Services.

Sorenson, T., & Snow, B. (1991). How children tell: The process of disclosure in child sexual abuse. *Child Welfare 70*(1), 3–15.

Summit, R. C. (1983). The child sexual abuse accommodation syndrome. *Child Abuse & Neglect 7*, 177–192.

Swets, J. A., Dawes, R. M., & Monahan, J. (2000a). Psychological science can improve diagnostic decisions. *Psychological Science in the Public Interest 1*(1), 1–26.

Swets, J. A., Dawes, R. M., & Monahan, J. (2000b, October). Better decisions through science. *Scientific American*, 82–87.

Wang, C. T., & Daro, D. (1998). *Current trends in child abuse reporting and fatalities: The results of the 1997 annual fifty state survey.* Chicago: National Center on Child Abuse Prevention Research.

Weedon, J., Torti, T., & Zunder, P. (1988). Vermont Division of Social Services family risk assessment matrix research and evaluation. In T. Tatara (Ed.), *Validation research in CPS risk assessment: Three recent studies.* (pp. 3–43.). Washington D.C.: American Public Welfare Association.