

What were we thinking? Five erroneous assumptions that have fueled specialized interventions for adolescents who have sexually offended

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Abstract

Since the early 1980s, five assumptions have influenced the assessment, treatment, and community supervision of adolescents who have offended sexually. In particular, interventions with this population have been informed by the assumptions that these youth are (i) deviant, (ii) delinquent, (iii) disordered, (iv) deficit-ridden, and (v) deceitful. There is very little research to support these beliefs, however, and some researchers and clinicians have long pointed out that adolescents who commit sexual crimes are heterogeneous and that there is no typical profile. Indeed, many adolescents who commit sexual crimes display healthy sexual interests, are prosocial in their orientation, are not psychiatrically disordered, can be described by many strengths and protective factors, and are open regarding past sexual crimes and their sexual interests. If the goal of intervention is to help adolescents to prevent future offenses, then it is essential for all involved in their care to be more critical of these erroneous assumptions that have influenced the field for the past several decades.

Keywords

Adolescent sexual offending, sexually abusive behavior, , sexual offense assessment and treatment, juveniles who sexually offend

Since the offending act is an exercise in power and control perpetrated by an anti-social, conduct-disordered, manipulative, deviant person, descriptors of the treatment of choice include confrontation, insistence on accountability for the offending behavior, a punitive rather than therapeutic orientation, and a focus on self-disclosure and the acquisition of strategies to prevent relapse" (Goocher, 1994, p. 244)

With a description of treatment such as the one provided above by Goocher (1994), it would not be surprising to learn that, in some jurisdictions, adolescents who have committed sexual crimes have routinely been removed from their homes – regardless of the nature of their crimes – subjected to polygraph and penile plethysmograph (PPG) examinations, aggressively and repeatedly confronted regarding the details of their past sexual crimes, and asked to engage in punishment-based behavioral procedures – designed for adults – that are intended to alter their presumed deviant sexual arousal. In some parts of the world, such as the U.S., adolescents who offend sexually have also been subjected to registration and community notification laws in the hopes of protecting people from being victimized by these youth (Zimring, 2004).

This has not how professionals have always viewed adolescents who have committed sexual crimes, however. Indeed, in some of the earliest academic reports from the 20th century, it was pointed out that these youth are in fact heterogeneous with respect to many different variables and that there was no singular treatment goal or approach that would universally apply for youth who have engaged in this behavior (e.g., Atcheson & Williams, 1954; Doshay, 1943; North, 1956; Waggoner & Boyd,

1941). This view seemed to change fairly quickly in the early 1980s, however, when it was more widely recognized that many adults who offended sexually began offending sexually as adolescents (e.g. Abel, Mittelman, & Becker, 1985; Longo & Groth, 1983). Given that there were already well-established assessment and treatment procedures developed for adults who offended sexually, many of the early treatment programs for adolescents mimicked adult programs – with a particular focus on the assessment and punishment of deviant sexual arousal and confrontational approaches to extract details of past sexual offenses (Knopp, 1982). This blind application of the adult-based assessment and treatment approaches of the day was likely attributable to the fact that the sexual crimes committed by adolescents looked behaviorally similar in nature to the sexual crimes committed by adults, despite the fact that there are rather obvious and critical developmental differences regarding not only sexual functioning (e.g., Bancroft, 2006; Bukowski, Sippola, & Brender, 1993) but, more importantly, the cognitive process that impact social and emotional functioning (Steinberg, 2010).

It is argued herein that, since the early 1980s, five assumptions have fueled the assessment, treatment, and management of adolescents who have offended sexually. These assumptions are referred to herein as the “5 Ds”: (1) deviant, (2) delinquent, (3) disordered, (4) deficit-ridden, and (5) deceitful. Although there have been some shifts in thinking over the past three decades, and there are many locations in the world where youth who have offended sexually are not subjected to polygraphs and PPGs, placed on public registries, or asked to partake in untested, punishment-based procedures to alter

sexual interests, these beliefs unfortunately continue to inform clinical practices and laws in many jurisdictions. This is particularly unsettling, however, given that there is very little empirical support for these assumptions.

■ They Are All Sexually Deviant, Aren't They?

Perhaps the assumption that has had the most influence on the assessment and treatment of adolescents who offend sexually is the notion that they can all be characterized by deviant sexual interests: i.e., sexual interests in prepubescent children and/or sexual violence. A brief perusal of treatment manuals, textbooks, and journal articles written in the 1980s and 1990s would certainly lead one to believe that all adolescents who have offended sexually are sexually deviant. For example, Perry and Orchard (1992) stated that a goal for all adolescents who offend sexually is to “learn more appropriate sexual preferences” (p. 64). Lahey (1994) explained that “other important treatment issues involve changing deviant sexual fantasies and masturbatory practices” (p. 758). Similarly, in their description of treatment, Hunter and Santos (1990) concluded that “insight-oriented approaches for the treatment of these youth are of limited value... key components include the reduction of deviant arousal via satiation therapy and the use of covert sensitization” (p. 240).

Furthermore, in the 1993 National Task Force Report from the National Adolescent Perpetrator Network (National Task Force on Juvenile Sexual Offending), it was pointed out that every sexually abusive youth should understand the role of sexual arousal in their sexual offending and should reduce their deviant sexual arousal. The American Academy of Child and Adolescent Psychiatry (Shaw, 1999) also argued that decreasing deviant sexual arousal is an integral component of treatment for all youth who have offended sexually. It should not be surprising, therefore, that most specialized treatment programs for adolescents in the UK and the Republic of Ireland (Hackett, Masson, & Phillips, 2006), and in Canada and the U.S. (McGrath, Cumming, Burchard, Zeoli, & Ellerby, 2010), address deviant sexual interests in some fashion.

It should be stressed, however, that there is very little evidence to support the assumption that most adolescents who offend sexually actually have deviant sexual interests. Looking at research where investigators have used the penile plethysmograph (PPG), a tool developed to assess adult male sexual interests (Freund, 1991), Seto, Lalumière, and Blanchard (2000) reported that only 25% of the adolescent males in their investigation demonstrated maximal sexual interest in prepubescent children. With an overlapping and augmented sample, Seto, Murphy, Page, and Ennis (2003) noted that just 30% of adolescent males who had offended sexually responded equally or more to child stimuli during PPG assessments.

In two investigations using clinician ratings, it was also found that a minority of adolescent males who offended sexually could be described as evidencing deviant sexual interests. In the first study (Worling, 2004), structured ratings from several clinicians who used the Estimate of Risk of Adolescent Sexual Offense Recidivism (ERASOR; Worling & Curwen, 2001) were examined, and it was found that only 36% of the participants were rated as having sexual interests in prepubescent children and/or sexual violence. A majority of the adolescents in that investigation were residents in a residential treatment center in the Northern U.S. designed to address the needs of high-risk youth. More recently, in a prospective validation study of the ERASOR (Worling, Bookalam, & Littelljohn, 2012) it was found that only 39% of adolescent males who had offended sexually were rated by a number of different clinicians as demonstrating sexual interest in prepubescent children and/or sexual violence.

There was one investigation in which the authors concluded that 60% of the adolescents studied had deviant sexual fantasies at the outset of the study and that this somehow increased to 90% after 3 months in treatment (Aylwin, Reddon, & Burke, 2005). It is critical to point out, however, that the authors considered it *deviant* if adolescents were fantasizing about the staff in the residence – regardless of the age of the staff and the nature of the sexual fantasy. As such, it is unclear what proportion of self-reported fantasies in that investigation actually involved prepubescent children or sexual violence.

Overall, therefore, the available research indicates that, depending on the sample studied, approximately 60-75% of adolescent males who have offended sexually are, in fact, maximally sexually interested in consensual activities with age-appropriate partners. Although deviant sexual arousal likely plays a role in the etiology and/or maintenance of adolescent sexual offending for *some* adolescents, there are obviously other factors to consider such as intimacy deficits, antisociality, and access and opportunity, for example. This is not to minimize the role of deviant sexual interests altogether, as it is clear that some adolescents who have offended sexually are clearly sexually interested in prepubescent children and/or sexual violence, and there is evidence to suggest that deviant sexual interest is a risk factor for adolescent sexual recidivism (Worling & Långström, 2006).

In their meta-analysis, Seto and Lalumière (2010) found that, relative to adolescents who committed nonsexual crimes, adolescents who offended sexually were more likely to be characterized by “atypical sexual interests.” It is important to point out, however, that there was significant heterogeneity in effect sizes in their analysis and that this factor was made up of several diverse variables, including prior sexually abusive behaviors, sexual preoccupation, and cross-dressing, for example. Furthermore, although the moderate effect size informs us

that adolescents who offend sexually are more likely to have “atypical sexual interests” relative to adolescents who offend nonsexually, it does not give us any indication of the absolute level of “atypical sexual interest” in either group.

Do All Sexually Abusive Youth Demonstrate Deviant Interests?

During the second year of my career in this field, in the late 1980s, I had the good fortune to learn some valuable lessons from an adolescent client. In particular, I was working with an adolescent who had sexually abused two younger female siblings. After a number of months during which we had worked on goals such as awareness of the impact of sexual offending, repairing the sibling relationships, increasing his sense of responsibility/accountability, enhancing his interpersonal intimacy with peers, enhancing his relationship with his mother (his father was not involved in his life), and reducing the impact of his early childhood trauma, I unfortunately assumed that I should perhaps address his presumed deviant interest in children. I taught him the finer points of covert sensitization, as outlined in various contemporary texts (e.g., Carey & McGrath, 1989; Maletzky, 1991), and the youth managed to produce an audiorecording of a single session for our next meeting. In particular, his recording included a 3 minute sexual offense script, a 3 minute punishment script, and then a 3 minute reward/relaxation script. While listening to the audio recording, not only was I suddenly horrified to think that I had actually asked this 16-year-old to make a recording of his deviant sexual thoughts, but I started to wonder about potential problems related to privacy and security of the recording. I also wondered about the fact that this homework assignment could perhaps unwittingly reinforce deviant fantasies. Fortunately for both of us, I also noticed that the youth's recorded voice sounded quite inauthentic during the first few minutes. When I asked him about this during our next meeting, he informed me that he was actually inventing a sexual fantasy regarding a young child, as he has never been sexually aroused by young children. He added that he felt that we had a good working relationship, and he was afraid that I would terminate his therapy if he did not make up a deviant sexual interest in prepubescent children and told me that he actually never had such an interest.

I was very fortunate that this adolescent taught me three important lessons early on in my career: (a) the therapeutic alliance is incredibly important, (b) not all adolescents who have offended against young children are sexually aroused by young children, and (c) treatment techniques designed for adults have the potential for iatrogenic harm when applied to adolescents. I was also fortunate that the program that I have worked at for the past 25 years started out as a treatment program for adolescent survivors of sexual abuse – not as a treatment program for adult males who offended sexually.

As such, most of the assessment and treatment approaches that were utilized there – even in the 1980s and 1990s – were sensitive both to adolescent development and trauma.

The Treatment of Adolescent Sexual “Deviancy”

In my recent review of the literature (Worling, 2012), I pointed out that punishment-based approaches are the most common treatment described in the literature for addressing deviant sexual arousal. The majority of these behavioral treatments were actually developed for use with adult males, and there are many questions regarding their use with adolescents. Take masturbatory satiation (Marshall, 1979), for example. With this procedure, an adult client is instructed first to masturbate to a nondeviant sexual fantasy. He or she is then instructed to immediately attempt to masturbate to one of his or her deviant sexual fantasies. The assumption underlying this approach is that the masturbatory behavior immediately following climax is going to be unpleasant and, as such, the individual will gradually associate his or her deviant sexual fantasy with a significantly diminished drive state (Maletzky, 1991). Given that the refractory period for adolescent males can be extremely short (Bancroft, 2009), it is possible that this procedure could actually serve to *strengthen* an adolescent's deviant fantasies. It is also crucial to point out that there are no controlled investigations of the effectiveness of this treatment for youth aged 12 to 18.

Another treatment approach designed to extinguish deviant sexual arousal among adult males is aversive behavioral rehearsal (Wickramasekera, 1976). This technique has also been called “shame aversion therapy” (Serber, 1970), and clients engaged in this treatment are taught to pair their deviant sexual fantasies with intense shame and/or anxiety. Presently, approximately 15% of treatment programs in the USA for adolescents who have offended sexually employ this technique (McGrath et al., 2010). Not only is there is no empirical support for this technique with adolescents, but there is a general consensus amongst professionals that shame actually *inhibits* treatment effectiveness for individuals who have offended sexually by increasing defensiveness and social withdrawal (e.g., Association for the Treatment of Sexual Abusers, 2001; Bumby, Marshall, & Langton, 1999; Jenkins, 2005; Proeve & Howells, 2002; Ward, Day, Howells, & Birgden, 2004; Worling, Josefowitz, & Maltar, 2011). Other punishment-based techniques designed for adult males who have offended sexually, such as covert sensitization (Cautela, 1967), minimal arousal conditioning (Jensen, 1994), and olfactory aversion (Colson, 1972), are also still utilized with adolescents to reduce their deviant sexual arousal (McGrath et al., 2010), despite the fact that there are no controlled investigations of their efficacy with this age group – or of their potential for iatrogenic harm.

In addition to techniques designed to punish deviant sexual interests, there are also some behavioral procedures that have been developed to enhance nondeviant sexual interests. Procedures such as orgasmic conditioning (Maletzky, 1991) or orgasmic reconditioning (Marquis, 1970), for example, require the individual to masturbate to nondeviant fantasies and/or imagery. As in the case of punishment-based procedures, however, there have been no controlled investigations of the positive (or negative) impact of these approaches with adolescents, despite the fact that some programs continue to utilize them (McGrath et al., 2010).

Of course, there are also a number of ethical concerns regarding the use of any behavioral techniques with adolescents to alter sexual interests. For example, is it ever appropriate to use masturbation in treatment for adolescents who have offended sexually? How can treatment materials and homework tasks be safeguarded during treatment? How can a therapist ensure compliance when a client is utilizing masturbatory procedures? At what age can a youth truly consent to these procedures? Given that adolescents are still developing and refining their sexual interest and identities (Bancroft, 2006), how can one safeguard against potential iatrogenic harm? What about the possibility that we might inadvertently be encouraging an adolescent to create and reinforce deviant sexual scripts?

Another popular approach in the treatment of deviant sexual is thought stopping, or urge suppression (e.g., Hunter, 2011; Kahn & Lafond, 1988). With this technique, the adolescent is taught procedures to push a deviant sexual thought out of conscious awareness by thinking of an aversive experience or by picturing a distractor such as a stop sign, for example. In their reviews of the literature regarding the effectiveness of thought stopping, Johnston, Ward, and Hudson (1997) and Shingler (2009) pointed out that there is often an ironic rebound effect such that thoughts that are consciously suppressed in psychological treatment approaches actually tend to intrude more frequently, and more intensely, than had the thought-suppression intervention not been used in the first place.

An alternative to teaching adolescents strategies to suppress deviant sexual thoughts and urges is to teach clients mindfulness-based approaches where they can learn simply to notice the thoughts and to let the thoughts pass without acting on them. Some may believe that this is a novel application of mindfulness-based cognitive therapy; however, this treatment approach was actually a component of some of the earliest specialized treatment programs (e.g., Steen & Monnette, 1989). Although there has not yet been any research regarding the effectiveness of this approach with adolescents who have offended sexually, there have been supporting findings using mindfulness-based cognitive therapy with adolescents to cope with stress (e.g., Biegel, Brown, Shapiro & Schubert, 2009) and impulsivity (e.g., Semple, Lee, Rosa, & Miller, 2010). Singh et

al. (2011) recently employed a multiple-baseline investigation with a small sample of adult males with an intellectual disability who had offended sexually against children, and they demonstrated that mindfulness-based approaches impacted significantly on deviant sexual arousal. Given that mindfulness-based approaches do not involve punishment, masturbation, or shame, and that there is no evidence to suggest that they would result in a rebound effect, they are likely to be more readily embraced by both clients and therapists relative to punishment and thought-stopping procedures, and particularly if they can be supported with empirical evidence.

Medication is also used by a number of treatment programs to reduce deviant sexual arousal for adolescents (McGrath et al., 2010); however, there has yet to be a double-blind trial of any medication for this purpose. In their review, Bradford and Federoff (2006) stressed that there may be undesirable side effects if adolescents are prescribed medications that have been used to control sexual behaviors in adults. They also pointed out that most regulatory bodies do not currently recognize the use of medication to reduce deviant sexual interests.

Alternative Approaches to Treating Deviant Sexual Interests in Adolescents

Given that (a) most adolescents who have offended sexually do not evidence deviant sexual interests, (b) there is no clear empirical support regarding treatment techniques aimed at reducing deviant sexual arousal for adolescents, and (c) there are significant ethical concerns regarding the use of thought-stopping procedures and behavioral approaches to shape sexual interests, an alternative approach to address deviant interests, if present, is to build skills for sexual health (Worling, 2012). In other words, given the relative plasticity of sexual arousal patterns during adolescence (Bancroft, 2006), there is a very real possibility that nondeviant sexual interests can be strengthened if adolescent clients see the possibility of forming emotionally and sexually intimate relationships in their future. Some of the elements that are necessary to achieve this goal include prosocial sexual attitudes, positive knowledge regarding human sexuality, self-regulation and decision-making skills, increased self-efficacy, and hope in a healthy future. It should be stressed that many of these elements have long been addressed in specialized treatment for adolescents who have offended sexually (e.g., Steen & Monnette, 1989). Some adolescents who display deviant sexual interests may also have significant barriers to achieving interpersonal intimacy, such as social anxiety, or dysfunctional beliefs regarding interpersonal relationships. In addition to skill building, therefore, it is also important to reduce barriers such as these.

In answer to our first question, then, it should be clear that adolescents who have offended sexually are not all sexually deviant. Indeed, from the extant

research, it would appear that most of these youth are most sexually interested in consenting activities with age-appropriate partners. Naturally, some adolescents will evidence deviant sexual interests, and this is a risk factor for continued sexual offending. Despite the fact that many treatment programs utilize behavioral techniques to alter sexual interests, there is no evidence that they are actually effective with adolescents. More importantly, there is a danger that these techniques could be harmful. For an adolescent who demonstrates sexual interest in young children and/or in sexual violence, it may be best to use mindfulness-based approaches while simultaneously building the skills necessary for a healthy sexual future.

■ They Are All Just Delinquent, Aren't They?

Is it not the case that adolescents who have offended sexually have broken the law and, therefore, that they should simply be viewed as delinquent or antisocial youth? Is there really a need for specialized assessment and treatment approaches? Do we not need simply to apply generic tools and approaches designed for antisocial youth? There are some (e.g., Letourneau & Miner, 2005; Milloy, 1998; Zimring, 2004) who argue that there is little that is unique to adolescents who have offended sexually and, thus, they question the wisdom of tailoring assessment or treatment specifically for youth who have committed sexual crimes. In support of this argument, it is often pointed out that there is research to suggest that there are few, if any, differences between youth who offend sexually and youth who offend nonsexually (e.g., Caldwell, Ziemke, & Vitacco, 2008). For example, Lewis, Shankok, and Pincus (1979) reported no significant differences on a host of variables and test scores when they compared a sample of 17 adolescents who had offended sexually with 61 adolescents who had offended violently. Similarly, McCraw and Pegg-McNab (1989) found no differences in personality scores when they compared 45 adolescents who offended sexually to 45 adolescents with nonsexual charges. Recidivism statistics (e.g., Caldwell, 2007) have also been used to point out that, when adolescents who have offended sexually are charged with new crimes following treatment, they are more often charged with nonsexual crimes. It is essential, however, to be mindful of the fact that most survivors of a sexual crime never report their victimization to authorities (e.g., Brennan & Taylor-Butts, 2008).

In an effort to determine if there is anything that differentiates adolescents who commit sexual crimes from those who commit nonsexual crimes, Seto and Lalumière (2010) conducted a meta-analysis with studies where investigators compared youth with sexual offenses to youth with nonsexual offenses. In support of the argument that adolescents who offend sexually are not particularly unique, there were certainly a number of variables where there were no significant differences be-

tween groups, such as antisocial attitudes, family relationship problems, heterosocial skills deficits, general psychopathology, and nonabusive sexual experiences. These findings would support the generalist argument that adolescent sexual offending is simply a product of some underlying antisocial process. However, Seto and Lalumière also found many important differences between the groups. For example, youth who offended sexually were significantly more likely than youth who offended nonsexually to be characterized by atypical sexual interests, socially isolation, increased exposure to sexual media, a lower self-esteem, elevated anxiety, and a history of sexual, physical, and emotional abuse. Furthermore, those youth with nonsexual offenses were more likely than those who offended sexually to associate with delinquent peers, use illegal drugs/alcohol, and have a more extensive criminal history. These aggregate findings certainly support the argument that adolescents who have sexually offended are significantly different from those who offend nonsexually on a number of important dimensions.

Of course, it is not argued here that all adolescents who offend sexually share the characteristics outlined by Seto and Lalumière in their meta-analysis. Some adolescents who offend sexually will share many markers of general delinquency, such as antisocial attitudes, diverse criminal history, substance use, academic underachievement, poor self-regulation, etc. However, there are many other adolescents who have offended sexually who show very few markers of antisociality – aside from their sexual offending behaviors. Indeed, researchers have found that there are distinct subgroups of adolescents who offend sexually where antisociality is one of the key variables that differentiates the groups (Smith, Monastersky, & Deisher, 1987; Richardson, Kelly, Graham, & Bhate, 2004; Worling, 2001). In these three investigations, it was found that there was one subgroup where an antisocial orientation was the predominant characteristic; however, there were several other subgroups where antisociality was not prevalent. Indeed, in each of these investigations where subgroups were formed on the basis of personality test data, researchers found that there were subgroups where a prosocial orientation was predominant.

Research regarding risk assessment is also supportive of the notion that there are key characteristics that differentiate adolescents who offend sexually from the more general population of adolescents in conflict with the legal system. Although a number of risk factors for sexual recidivism, such as impulsivity, antisociality, and social isolation, are also found in tools designed to predict general, adolescent criminal recidivism (e.g., Hoge & Andrews, 2011), there are several risk factors unique to continued sexual offending, such as deviant sexual interests, deviant sexual attitudes, and sexual preoccupation, for example (Worling & Långström, 2006). There have been a number of risk

assessment tools developed specifically to address the risk of sexual recidivism for adolescents, such as the ERASOR (Worling & Curwen, 2001), the Juvenile Sex Offender Assessment Protocol (J-SOAP-II; Prentky & Righthand, 2003), the Juvenile Risk Assessment Tool (J-RAT; Rich, 2007), and the Juvenile Sexual Offense Recidivism Risk Assessment Tool-II (JSORRAT-II; Epperson, Ralston, Fowers, DeWitt, & Gore, 2006). It has been found that measures designed specifically to predict adolescent sexual recidivism perform better relative to more generic measures of criminal and/or violent behavior in youth (Viljoen, Mordell, & Beneteau, 2012).

It is not being argued here that adolescents who sexually offend are prosocial save their sexual crimes. Rather, there are simply no data to support the assumption that they are all antisocial, or even that most of them can be described as characteristically delinquent. As in the case of deviant sexual interests discussed above, it is important for those working with adolescents who have sexually offended to determine whether or not an antisocial orientation is present in each case. If an adolescent who has offended sexually does have many markers of delinquency (e.g., affiliation with delinquent peers, substance use, procriminal attitudes), then treatment and management efforts should obviously be aimed at addressing these issues. Otherwise, this would not be necessary, and there could possibly be iatrogenic harm if prosocial youth are required to participate in interventions designed to target criminogenic factors for antisocial youth.

■ They Are All Psychiatrically Disordered, Aren't They?

It must be a natural assumption for the layperson that a teenager who has committed a sexual crime must have a psychiatric disorder of some kind, and particularly if the youth has offended sexually against a young child. Why else would he or she have committed such a heinous act? Surely it is not the case that “normal” adolescent males and females would ever commit sexual crimes? There must be some mental disorder that leads a teen to commit a sexual crime.

Becker, Kaplan, Cunningham-Rathner, and Kavoussi (1986) reported on the psychiatric diagnoses given by one practitioner to 19 adolescent males referred to a state psychiatric institute as a result of incest offenses. It was found that 14 of the adolescents had some type of psychiatric diagnosis, with 12 of these youth qualifying for a diagnosis of Conduct Disorder. The next most common diagnosis was Attention Deficit Hyperactivity Disorder (ADHD), and this was identified for five (26%) of the participants. Galli et al. (1999) similarly reported on psychiatric diagnoses given to 22 adolescent males who had offended sexually and who had been recruited from residential treatment programs. As in Becker et al. (1986), Conduct Disorder was diagnosed for most of the participants (16 of 17). However, 100% of the participants in this

investigation were also diagnosed with Pedophilia, and 71% (12/22) were diagnosed with ADHD. This result contrasts sharply with Mazur and Michael (1992) in their follow-up investigation with 10 adolescents who had offended sexually, where they found that none of the participants met diagnostic criteria for a paraphilia. Likewise, in their review of adolescents seen at a psychiatric hospital in Canada, Saunders and Awad (1988) stressed that “the vast majority of adolescent sexual offenders do not fit the criteria of paraphilia” (p. 575).

The prevalence and nature of psychiatric diagnoses for this population appear to vary considerably depending on the sample that is selected and the diagnostic processes that are employed. Furthermore, very few, if any, authors have reported on the reliability/validity of the diagnostic tools that have been utilized, most investigations have relied on a single diagnostician, and samples of adolescents have been very small. It is also unclear in most of this research whether or not diagnosticians have been blind to the criminal status of the youth.

In the meta-analysis completed by Seto and Lalumière (2010), there was little evidence to suggest that adolescents who offend sexually can be described using specific psychiatric diagnoses, relative to other adolescents involved in the criminal justice system. Although the authors of the small studies cited above describe adolescents who offend sexually as highly conduct disordered, there was no evidence to suggest that those who offend sexually are any more antisocial than those adolescents who commit nonsexual crimes. Indeed, as noted above, Seto and Lalumière found that those adolescents who offended *nonsexually* were significantly more likely to have markers of antisociality, such as a more extensive criminal history, associations with delinquent peers, and drug/alcohol use. Furthermore, although adolescents who offended sexually are more likely to exhibit heightened anxiety (not necessarily an anxiety disorder, per se) and low self-esteem, there were no differences between groups with respect to general psychopathology.

Once again, as in the case of both deviant sexual interests and delinquency, there is no empirical support for the notion that adolescents who offend sexually are all psychiatrically disordered. Adolescent sexual offending is a behavior that reflects a choice that the youth has made; it is not a function of a disorder, a disease, a condition, or an illness. Of course, there may well be a psychiatric diagnosis for some youth who have offended sexually, and the ability to accurately describe a mental disorder should lead to more appropriate and effective treatment. For example, given the increased prevalence of sexual, physical, and emotional abuse relative to youth who have offended nonsexually, it would not be surprising to learn that some adolescents who have offended sexually experience Posttraumatic Stress Disorder. Likewise, given that there is a subgroup where a delinquent orientation is predominant, there will be some adolescents who offend

sexually where a diagnosis of Conduct Disorder is clearly evident, and particularly for those youth who end up in correctional settings.

■ They Are All Just Deficient-Ridden, Aren't They?

After reading many assessment reports prepared at various agencies throughout North America since the 1980s, one might certainly believe that adolescents who offend sexually can be described only by the long list of deficits that have been catalogued during an assessment. This is, perhaps, a result of a focus on risk, disorder, and deviance that has pervaded this work. Of course, this may also have been the result of the nature of the crime, as it may be particularly difficult for some evaluators to look for strengths and assets in individuals who have committed sexual crimes.

This focus on deficits has been prevalent in professional publications for several decades, and the most commonly cited characteristic of adolescents who offended sexually is that they have a deficit with respect to social skills. For example, in their treatment guidelines, Groth, Hobson, Lucey, & St. Pierre (1981) stated that “juvenile sexual offenders need instruction in regard to developing effective social skills and communication skills with age mates” (p. 266). Similarly, Stops and Mays (1991) pointed out “that adolescent sex offenders have at their core, deep-seated feelings of inferiority, inadequacy, a lack of self-confidence, and immaturity” (p. 101). Although the assumption that adolescents who offend sexually are deficient in their social skills was very often forwarded in the 1980s and 1990s (e.g., Bagley & King, 1990; Burnett & Rathbun, 1993; Graves, Openshaw, & Adams, 1992; Groth & Lored, 1981; Saunders, Awad, & Levene, 1984; Stenson & Anderson, 1987; Stevenson & Wimberley, 1990), a time when many treatment programs were being developed, there are still some authors who make this assumption (e.g., Hunter, 2011). Not surprisingly, treatment manuals have been replete with instructional exercises for ameliorating this supposed deficit in social skills. Of course, social skill deficits are no more prevalent in populations of adolescents who commit sexual crimes relative to adolescents who offend nonsexually (Seto & Lalumière, 2010), and there are subgroups of adolescents who have offended sexually who are actually quite skilled socially (Richardson et al., 2004; Smith et al., 1987; Worling, 2001).

Perhaps another reason that clinicians have focused so heavily on risks and deficits is a result of the fact that most of the research has been focused on these topics, at the expense of a focus on strengths, protective factors, and resiliency. This is not unique to the field of sexual offending, as research into general criminal behavior has been aimed almost exclusively on the identification of factors that predict risk rather than on the identification of protective factors that predict desistance from reoffending. This preoccupation with risk-only factors in risk

assessment tools, which also influenced my original efforts (Worling & Curwen, 2001), has likely resulted in inaccurate judgments by evaluators and therapists (e.g., Miller, 2006; Rogers, 2000). Farrington (2007) has stressed that researchers should enhance the accuracy of violence risk assessments by also identifying factors that are predictive of desistance.

Unfortunately, there have been very few investigations designed to identifying protective factors for adolescent sexual recidivism. In 1998, Bremer developed the Protective Factors Scale to assist with placement decisions for youth who had offended sexually; however, this tool has not been subjected to empirical scrutiny. There has, on the other hand, been some initial work regarding the identification of protective factors for general youth violence. Preliminary, multi-site research from the Centers for Disease Control and Prevention (Hall, Simon, Lee, & Mercy, 2012) suggests that factors such as academic achievement, prosocial peer relationships, positive family management, and attachment to school may operate to reduce the onset of general youth violence. These authors stress, however, that firm conclusions regarding protective factors cannot be drawn at this time given the paucity of research at this point.

The Structured Assessment of Violence Risk in Youth (SAVRY; Borum, Bartel, & Forth, 2006) is a widely-used, risk assessment tool that contains 24 risk and 6 protective factors. Although there is preliminary evidence from investigations with adolescents to suggest that these protective factors are related to desistance in general criminal recidivism (Rennie & Dolan, 2010) and violent recidivism (Lodewijks, Ruiter, & Doreleijers, 2010), the SAVRY protective factors are *not* related to desistance of adolescent sexual recidivism (Schmidt, Campbell, & Houlding, 2011; Spice, Viljoen, Latzman, Scalora, & Ullman, 2012). This suggests that there are unique protective factors that are predictive of desistance for adolescent sexual reoffending. This is not surprising given that there are unique risk factors for adolescent sexual recidivism (Worling & Långström, 2006). Possible protective factors for adolescent sexual recidivism include factors that are both sexual offense-specific (e.g., prosocial sexual interests, prosocial sexual attitudes, and prosocial sexual environment) and sexual offense-related (e.g., compassion for others, emotional intimacy with peers, and positive problem-solving skills) (Worling, 2013).

A Shift in Focus: Strengths and Protective Factors

In addition to the recent empirical quest to identify protective factors for adolescent sexual recidivism (e.g., Spice et al., 2013; Worling & Langton, 2013), there has also been a more conscious shift towards strength-based approaches; in part, perhaps, as a result of the Good Lives Model (Ward, 2002; Ward & Stewart, 2003). According to this model, the goal of treatment is to provide the individual with the

means to achieve primary human goods, which are conditions that would allow one to achieve an enhanced sense of well-being and purpose, such as happiness, creativity, spirituality, and knowledge, for example. This model has recently been examined with specific reference to adolescents who have offended sexually (Chu, Hoh, Zeng, & Teoh, 2013); however, it is important to stress that a strength-based approach has been advocated for many years in work with this population.

More specifically, despite the unfortunate focus on deviance, disorder, deficit, and deceit that has plagued the field, many programs have also simultaneously stressed the need to build positive self-regulation skills (Lee & Olender, 1992), social skills (Margolin, 1983), positive sexual knowledge (Becker, 1990), and healthy family relationships (Steen & Monnette, 1989), for example. Indeed, Rich (2006) remarked that the need to enhance relationship skills, self-regulation, self-agency, and decision making has long been part of treatment programs that have taken a more holistic and integrated view of youth who have sexually offended in contrast to those programs that have had a more myopic focus on the sexual offending.

In sum, it is obviously not the case that adolescents who sexually offend can be described only by their deficits. It may be, once again, that the nature of the crime has propelled researchers and clinicians to focus almost exclusively on deficits rather than on assets and protective factors. Alternatively, this orientation may be more reflective of the assumption that these youth are inherently deviant, delinquent, disordered, and deceitful. Efta-Breitbach and Freeman (2004) remarked that, although some current treatment goals are consistent with a strength-based approach that would foster resilience in adolescents who have offended sexually, there is dire need to more methodically understand and promote resilience and competence and focus on strengths and positive behaviors.

■ They Are All Deceitful, Aren't They?

In speaking about treatment for adolescents who commit sexual offenses, Margolin (1983) remarked that “the need to control others pervades the offender’s every social interaction. The most prominent symptom of this compulsion to control is his [sic] proclivity to lie” (p. 3). In a similar vein, Perry and Orchard (1992) stated that “adolescent sex offender work is very demanding and stressful. Clinicians are working with clients who attempt to deny, minimize, or rationalize the extent of their problems” (p. 29). According to Barbaree and Cortoni (1993), “the first stage in treatment targets denial and minimization and successful completion of this stage is a prerequisite to successful treatment” (p. 255).

It should not be surprising, therefore, that there is typically a call for clinicians and probation officers to be diligent in their efforts to confront the denial and minimization of these adolescents to ensure

that they will come clean with the details of their past sexual crimes and/or their current sexual deviance (e.g., Bethea-Jackson & Brissett-Chapman, 1989; Ferrara & McDonald, 1996; Kahn & Lafond, 1988; Lakey, 1994; National Task Force on Juvenile Sexual Offending, 1993; Sermabeikian & Martinez, 1994; Shaw, 1999; Way & Balthazor, 1990). This demand for adolescents to acknowledge all details of their past sexual offending and current sexual deviance is likely based, at least in part, on the prevailing sentiment that one must first acknowledge a problem before it can be treated. Of course, it may also reflect the difficulty that some practitioners have separating the person from the behavior; the need to use aggressive confrontation, shame, and punitive approaches may simply reflect anger towards the youth for the criminal sexual behavior.

Without minimizing the significant harm that can result for the survivor and his or her family, it is important to note that a sexual crime is likely to lead to significant shame, embarrassment, and guilt for the adolescent who has offended – in addition to significant personal, family, legal, and social consequences. It would be unusual, therefore, to expect any individual to readily provide a detailed account of past sexually abusive behaviors and/or current deviant sexual thoughts and fantasies – especially at the outset of a relationship with another individual. As such, minimization and denial are likely a natural phenomenon connected to the nature of the crime, rather than a pathological characteristic of the adolescent who has offended sexually.

Given this push for adolescents who have offended sexually to confess all of the details of their past sexual crimes, it should not be surprising to find that many authors have advocated for therapists to use confrontational approaches in treatment to break through denial and minimization (e.g., Baird, 1991; Burnett & Rathbun, 1993; Goocher, 1994; Groth et al., 1981; Hird, 1997; National Task Force on Juvenile Sexual Offending, 1993; Perry & Orchard, 1990; Sermabeikian & Martinez, 1994; Smets & Cebula, 1987). In their review of the literature, however, Marshall et al. (2003) pointed out that a confrontational approach is actually likely to *increase* defensiveness and resistance for individuals who have offended sexually. Marshall et al. suggested instead that the best approach to address minimization and denial in treatment is to supportively challenge individuals when necessary rather than to use a confrontational approach. They also noted that research points to the fact that therapeutic interventions are actually more effective when the therapist is empathic, warm, genuine, and rewarding.

Getting to the “Truth”

The view that adolescents who offend sexually lie and deceive is perhaps best exemplified in the U.S. where 50% of treatment programs presently use the polygraph (McGrath et al., 2010). McGrath et al. pointed out that this represents a marked increase

in the use of the polygraph in recent years, as only 22% of treatment programs for adolescents who offended sexually used the polygraph in the U.S. in 1996. Chaffin (2011) has stressed that the polygraph is seldom used with youth in the U.S. who commit nonsexual crimes, and that there are actually very few countries outside of the U.S. where the polygraph is utilized with any adolescents. Chaffin (2011) and Prescott (2012) have outlined a number of significant concerns regarding the use of the polygraph with adolescents who have offended sexually. In addition to the complete lack of empirical support for the reliability and validity of the approach, they also underscore the significant potential for harm to the adolescent including the coercive nature of a polygraph examination and the replication of an abusive experience, the increased likelihood of false confessions in an effort to satisfy program requirements, and the dubious ethics that result from the use of an interrogation procedure with youth in compulsory treatment.

The argument that is often forwarded in support of the utility of the polygraph is that this procedure will result in the identification of survivors of sexual abuse who have previously been unknown to authorities. There have been only two published studies with adolescents where this issue has been examined. In the first paper, Emerick and Dutton (1993) reported that adolescents disclosed an average of almost one ($M=0.98$) new victimized individual as a result of a polygraph examination. In a similar investigation, Van Arsdale, Shaw, Miller, and Parent (2012) also found that adolescents who had offended sexually disclosed an average of almost one ($M=0.73$) new survivor of sexual abuse based on a polygraph examination. Although some might argue that these data support the use of the polygraph with this population, this result should be contrasted with research supporting the fact that adolescents are more likely to disclose new information within the context of a trusting therapeutic relationship. For example, Baker, Tabacoff, Tornusciolo, and Eisenstadt (2001) found that adolescents in specialized treatment disclosed an average of 3.3 new victimized individuals during the course of discussions with their treatment providers. Prescott (2012) also emphasized the fact that survivors of sexual abuse should be free to disclose when and how they choose and that some may not wish to be identified via the results of a polygraph examination.

With this pressure for youth to acknowledge details of past sexual crimes, it is also important to highlight the fact that there is presently no empirical evidence to support the notion that it is necessary for future sexual health for adolescents to acknowledge all of the details of all past sexual crimes. This is not, of course, to suggest that adolescents need not take responsibility for their sexual offending behaviors. Most practitioners would agree that it is important for an adolescent to acknowledge that he or she has offended sexually and that it is ideal if

they can be open regarding the identity of the people whom they have abused and take responsibility for how they have harmed others. However, there is just no scientific rationale for impelling youth to confess all of the details of all of their sexual crimes.

Perhaps this focus on deception and denial has also somehow been related to the assumption that adolescents who are denying their past sexual offending are also at higher risk of reoffending sexually. A number of risk-assessment guidelines (e.g., Prentky & Righthand, 2001; Ross & Loss, 1988) list denial of sexually abusive behaviors as a risk factor; however, there is no research to support the notion that denial at the point of assessment is predictive of sexual recidivism for adolescents (Worling & Långström, 2006; but also see Rich, 2009). Indeed, there is actually some evidence to suggest that those adolescents who offend sexually and who are categorically denying past offenses may actually be at a reduced risk of reoffending sexually relative to those adolescents who are acknowledging their crimes (Kahn & Chambers, 1991; Långström & Grann, 2000; Worling, 2002).

Honesty by Self-Report in Treatment

The notion that individuals who offend sexually are naturally prone to deception and dishonesty is perhaps best contradicted by the available research regarding the assessment of deviant sexual interests. A layperson would naturally assume that individuals who have offended sexually would be reluctant to be open regarding a sexual interest in prepubescent children and/or sexual violence; however, authors of the available research suggest otherwise. For example, with a sample of men who offended sexually against children, Laws, Hanson, Osborn, and Greenbaum (2000) found that self-reported sexual interests obtained via a card-sort procedure were more accurate than penile plethysmograph (PPG) data in identifying the gender of victimized individuals. In a similar study, Day, Miner, Sturgeon, and Murphy (1989) found that self-report data from a questionnaire regarding sexual thoughts, feelings, and behaviors could accurately classify men according to the gender of their children whom they abused.

Looking at research with adolescents, Seto et al. (2000) reported that the self-report of a majority of youth acknowledging a sexual interest in children during an interview was subsequently supported by objective PPG examination. Similarly, Worling (2006) found that self-report indices and procedures were able to identify those adolescents who sexually abused children. Using a self-report questionnaire, Daleiden, Kaufman, Hilliker, and O’Neil (1998) also reported that adolescents who offended sexually disclosed significantly more deviant sexual behaviors relative to both adolescents who offended nonsexually and adolescents with no criminal histories. These studies each lend support for the idea that adolescents in treatment for sexually abusive behavior are able to engage honestly and that

self-report is a valuable and viable means by which to learn about the sexual behaviors and interests of youth in treatment.

To answer to our final question, then, it is not always the case that adolescents who offend sexually lie and deny. Indeed, it would appear that many of these youth are able to identify previously undisclosed sexual crimes within the context of a trusting therapeutic relationship, and many are also forthcoming with respect to their sexual interests when evaluators use structured, self-report procedures. There is also no compelling evidence to suggest that it is necessary for adolescents to disclose all of the details of their past sexually abusive behaviors, or that denial is predictive of continued sexual offending. When adolescents are struggling to acknowledge information that is likely to lead to shame, embarrassment, and significant personal, legal, and familial consequences, it is important that professionals employ supportive rather than confrontational approaches.

Conclusion

Interventions with adolescents who have committed sexual crimes have been influenced for the past several decades by the belief that these youth are inherently sexually deviant, delinquent, disordered, deficit-ridden, and/or deceitful. This is likely related, in part, to the rather blind application of the adult-based techniques and approaches that were popular in the 1980s. It should be no surprise, therefore, that many of these adolescent have been removed unnecessarily from their homes, confronted aggressively regarding the details of their past sexual crimes, wired up to physiological measurement devices that have questionable scientific merit, and subjected to untested interventions designed to alter presumed deviant sexual interests.

There are likely some professionals who believe that the nature of the crime merits such an aggressive and punitive approach, that these youth have forfeited many of their human rights as a result of choosing to commit a sexual crime, and that we should not be particularly concerned about subjecting these youth to assessment and treatment techniques that have little to no scientific credibility. However, there is considerable danger if we let these assumptions persist and thereby influence our responses to adolescent sexual offending. Indeed, as outlined in this paper, these assumptions can lead to questionable interventions that may actually increase the risk of continued sexual offending. Take, for example, untested behavioral interventions designed to decrease deviant arousal that could inadvertently establish and strengthen novel, deviant sexual scripts; or consider a polygraph interrogation that could result in heightened fear, false confessions, and/or an unnecessarily protracted stay in a specialized residential program.

There will obviously be some adolescents who have offended sexually who display deviant sexual interests, and those who are also antisocial, deceitful,

disordered, and who have a number of significant deficits. However, it is clear from the available research that there are many adolescents who commit sexual crimes who have age-appropriate sexual interests and who are prosocial, forthcoming regarding past offending and current sexual interests, without psychiatric disorder, and who have many strengths and putative protective factors. As a result, it is critical that professionals examine the unique strengths, risks, and needs of each adolescent and tailor treatment and supervision, if necessary, accordingly (Worling & Langton, 2012). Furthermore, it is important that we choose assessment and treatment approaches that have been developed with sensitivity to adolescent cognitive, social, and emotional development. Of course, it is also essential that we select approaches that have an empirical basis and that do not risk iatrogenic harm.

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