BETTER TOGETHER
2018 ATSA Conference | Thursday October 18 | 3:30 PM – 5:00 PM

T-48

Denial in Adolescents

Denial/Disclosure in Adolescent Sexual Offenders: Measurement and Management

David J. Kolko, PhD
Eunice Torres, MS
Jon Hart, MS
University of Pittsburgh School of Medicine

Introduction

Much has been written about the types of explanations and justifications that sexual offenders may use to account for their offending behavior, or the large number of offenders who deny the experience or their role in it altogether (Langton et al., 2008). On the one hand, rigorous reviews suggest clearly indicate that neither denial nor minimizations of sexual offending behavior is a predictor of sexual recidivism Ybarra & Thompson (2017). However, treatment programs and probation officers continue to target denial/disclosure and to use progress in this process as a indicator of treatment success.

In working with juvenile sexual offenders for the past 20 years, our outpatient program has sought to operationalize, assess, and target these types of responses in a formal clinical interview designed to solicit the youth's views about their level of involvement and responsibility in their referral incident. In this study, we document the rates of denial, minimization, and full disclosure at intake and discharge, as well as at two intervening timepoints. We also examined key predictors of denial/disclosure, discharge outcomes, and recidivism data through a 3-year follow-up. This allowed us to examine these pathways or trajectories of disclosure over time. We also incremental benefit of using subsequent denial/disclosure status over pre-treatment denial status alone.

Participants

The participants in the current study included 200 males adjudicated for a sexual offense and court-ordered to participate in an outpatient treatment program. This treatment program is offered by the Services for Adolescent and Family Enrichment program at Western Psychiatric Institute and Clinic in collaboration with the Special Services Unit of the Allegheny County Juvenile Probation Department (hereafter the SAFE/SSU Program). This program has been described in detail previously (Kolko, Noel, Thomas, & Torres, 2004). Female offenders (n = 2) and youth with no recidivism data (e.g., n = 9) were excluded from all analyses.

The average age of the JSOs in this study was 15.46 (*SD* = 1.96) with a range from 10 years, 11 months to 20 years, 11 months. A total of 14 juveniles (8% of total sample) were age 18 or 19 at the time of their intake into the treatment program. In such circumstances, the youth committed the referral offense prior to his 18th birthday. Some data regarding race and ethnicity was not recorded (*n* = 37), but those who reported primarily indicated they were White, non- Hispanic (47%) or Black, non-Hispanic (45%). Only 2% of youth indicated Hispanic ethnicity, 1% were Asian/Pacific Islander, 4% were biracial, and 1% categorized themselves as Other. Very few participants had a prior nonsexual (9%) or sexual (1%, *n* = 2) conviction.

Based on legal records, the juveniles in this sample had an average of 1.22 victims each, with a range from 1 to 8 and a mode of 1 (86% of juveniles). The victims of these youth ranged from 2 to 74 years of age. When using the age of the youngest victim for offenders with multiple victims, the average victim age was 9.81 years (*SD* = 4.55). The majority of juveniles had only female victims (73%), with almost a quarter offending against only males (23%) and only 4% offending against both females and males. Very few juveniles offended against a stranger (3%), 27% offended against a biological relative, and the remainder offended against acquaintances or nonbiological relatives. A substantial minority of the participants (n=187) were diagnosed upon intake (using the K-SADS-PL, see below) with a disruptive behavior disorder (43%), with 35% of the sample meeting criteria for attention deficit hyperactivity disorder, 8% for conduct disorder, and 12% for oppositional defiant disorder. Other mental health diagnoses were less common (7% met criteria for an anxiety disorder, 3% for an affective disorder, 2% for a substance use disorder). Overall, 73% of the sample met diagnostic criteria for at least one mental health diagnosis.

Program Orientation and Assessment Procedures

Juveniles adjudicated for a sexual offense were referred to the SAFE/SSU treatment program based on a judge's decision that the juvenile required sex offender–specific treatment and could be treated safely in the community. Each family was invited to participate in a separate, completely voluntary research protocol which was approved by the University of Pittsburgh Institutional Review Board. Both parental consent and youth assent were required for use of the data for research purposes. The intake and discharge assessments were part of the routine treatment protocol and were completed by all juveniles who entered treatment. Recidivism data were collected from official juvenile court records at approximately 1 year, 2 years, and 3 years after discharge from the program.

Measures

Participants in the study completed a wide range of measures (see Kolko et al., 2004). Only those used in the current analysis are reviewed here.

Predictor variables. The following predictor variables were collected at the intake assessment or from legal data obtained prior to the intake assessment.

Parental Education. The intake packet includes information about parental education. Parental education was dichotomized as high school or less and more than high school.

Prior Arrest. A dichotomous variable reflecting any prior arrest will be used rather than a continuous measure of number of arrests because the vast majority of youth had either zero or one prior arrest.

Recipient of social assistance*.* The intake packet includes information about whether the family receives social assistance. A dichotomous variable reflecting any receipt of social assistance (medical, welfare, other types of social assistance) will be used.

Abuse history. Parent- and self-report will be examined based on specific items from the *Adolescent Clinical Sexual Behavior Inventory (ACSBI*; Friedrich, Lysne, Sim, & Shamos, 2004). The ACSBI "was designed for use in a clinical sample to assess sexual risk tasking, nonconforming sexual behaviors, sexual interest, and sexual avoidance/discomfort" (Friedrich et al., 2004, p. 241). In three individual items on the ACSBI (Items 47, 48, and 49), participants and their parents were asked to rate the likelihood the participants experienced physical, sexual, and emotional abuse on a scale from 0 (*not likely*) to 4 (*definitely*). These scores were dichotomized into *no abuse* (score of 0) or *possible abuse* (score of 1 to 4) based on parent report and child report separately.

Social skills. To test information regarding social competence and peer problems were drawn from two measures.

Social competence. For those youth whose parents completed the CBCL, groups are compared on the Social Competence scale. The Prosocial scale of the SDQ was not combined with the Social Competence scale due to significant differences in item content.

Social/peer problems. In addition, as was done regarding the externalizing and internalizing scales, the CBCL Social Problems and the SDQ Peer Problems scales were standardized and then combined into one variable. These two scales are moderately highly correlated (r = .59; Goodman & Scott, 1999).

Victim characteristics. Victim characteristics, including the gender of victims, the presence of a biological relationship between victim and offender, and whether there was any anal or genital contact during the offense were coded from legal documentation provided by the court to test

Antisocial behavior**.** Antisocial/Impulsive behavior were measured using the *Juvenile Sex Offender Assessment Protocol-II* (Prentky & Righthand, 2003) . The J-SOAP-II has evidence of reliability and construct validity, although further research is needed to establish predictive validity for sexual reoffending (Caldwell & Dickinson, 2009; Caldwell, Ziemke, & Vitacco, 2008; Elkovitch et al., 2008; Martinez, Flores, & Rosenfeld, 2007; Parks & Bard, 2006; Prentky, Harris, Frizell, & Righthand, 2000; Prentky et al., 2010; Righthand, Prentky, Knight, Carpenter, Hecker, & Nangle, 2005; Viljoen et al., 2008). Items are rated from 0 to 2 to reflect the degree of presence or absence of information assessed in the time, with higher scores representing more dysfunctions. At this point, there is no empirically supported method of using cutoff scores or weighting items (Rightland et al., 2005), so the total score was used in the present study.

Prior arrests. The legal data includes information about prior court involvement and any prior arrests. A dichotomous variable reflecting any prior arrest will be used rather than a continuous measure of number of arrests because the vast majority of youth had either zero or one prior arrest.

Underreporting of symptoms or distress*.* Juveniles completed the TSCC (Briere, 1996). The TSCC was developed to provide a self- report evaluation of current trauma-

related symptoms or distress in children and adolescents (ages 8-16) who have been exposed to unspecified traumatic events. Given the high likelihood of underreporting by many juveniles participating in intake evaluations for a court- ordered treatment program, scores on the Underreporting scale of the TSCC will also be investigated.

Offender report of amount of responsibility for the sexual offense. The percent responsibility was collected at intake, 3 months after intake, 6 months after intake, and at discharge. The percent responsibility for the sexual offense was obtained from the juvenile using the Juvenile Sexual Abuse Interview (JSA). The Juvenile Sexual Abuse Interview is a clinical interview completed with the child/adolescent and parent(s) individually. During the JSA interview the sexually inappropriate behaviors are discussed with the child/adolescent. The child is asked to rate the amount of responsibility they take for the offense on a scale of 0 to 100.

Parent Report of Child's Involvement in Sexual Offense. The parent is also asked about the sexual offense and asked to rate their child's involvement in the offense on a 3-point ordinal scale (denies the child was involved, admits some involvement but not sure about the details, admits full involvement).

Outcome variables. Treatment outcome was rated by the clinician and the probation officer at the time of the discharge assessment. Recidivism data was collected at 1 year, 2 years, and 3 years following discharge.

Treatment outcome (clinician rated). Success in treatment was rated by the treatment clinician when the client completed the treatment protocol. The treatment clinician was asked to select the primary or most central reason for termination from the SAFE program among the three reasons (considerable symptom improvement and/SAFE specific treatment goals accomplished, symptoms partially or somewhat improved, or some progress towards goals; this level/type of treatment was not working; non-legal problem got worse/clinical deterioration: unresponsive).

Treatment outcome (probation officer rated).

Recidivism. At the time of this analysis, recidivism data were available for 191 juveniles. Recidivism was defined as either a charge or conviction for a sexual or a non-sexual offense. Recidivism data were collected from official juvenile court records at approximately the same time as the follow-up evaluations (1 year, 2 years, and 3 years after discharge from the program). Recidivism data were unavailable for 9 youth, either because their records were not able to be located. Overall, 22% of participants had any posttreatment charges or convictions for non-sex offense and 5% had any posttreatment arrests for sexual offenses. Information about subsequent treatment in residential facilities was not available; therefore, recidivism analyses do not account for time at risk in the community.

Results

Data analysis:

First, the breakdown of disclosure status in our sample was explored. Next, we tested associations between baseline risk factors and group membership. Chi-square tests and analysis of variance were used to determine which baseline characteristics were associated with disclosure status. Given the absence of empirical data regarding predictors of denial among adolescent sexual offender (Bonner et al 1998, Ryan 1998), we wanted to

explore the relationships between a number of predictor variables and disclosure status using variables that have been identified as relating to recidivism. As a final step, disclosure status was used to predict treatment outcome and recidivism.

Disclosure Status

As a first step, the distribution of our sample among the four disclosure ratings was examined. Of 233 participants with valid baseline disclosure status data, the following rates were endorsed: "No, I didn't do it" (75, 32.2%), "A little agreement" (67, 28.8%), "Mostly agrees" (53, 22.7%), "Fully admits" (38, 16.3%). Based on this relatively evenly distributed breakdown, no aggregations were used.

Baseline Differences with Disclosure Status

Associations between participant baseline characteristics and disclosure status are summarized in Table 1. Less disclosure was associated with higher rates of social assistance ($p < .074$) and younger victim age ($p = .084$). More extreme levels of disclosure ("No, I didn't do it" or "Fully admits") wer associated with higher rates of under-reporting ($p = .098$). Middling levels of disclosure ("a little agreement" or "mostly agrees") were associated with increased rates of penetration/intercourse during the referral incident ($p = .034$). No other baseline differences were observed.

Predicting Treatment Outcome with Disclosure Status

In the next stage of analyses, we addressed whether disclosure status was associated with measures of treatment outcome, service delivery, and satisfaction, as rated by the treatment clinician and by the probation officer. There were no differences associated with customer satisfaction, length of service, referral upon discharge, or PO-reported gains in treatment. Less disclosure was associated with formal placement in a residential setting during treatment ($p = .045$), not completing treatment (i.e., leaving prematurely; $p = .032$), and no-shows/noncompliance as a reason related to termination ($p = .061$).

Predicting Non-Sexual and Sexual Recidivism with Disclosure Status

In the final stage of analysis, we addressed if disclosure status was associated with non- sexual and sexual recidivism at 3 years post-treatment. There were no significant relationships. Overall, the rates of non-sexual and sexual recidivism were 20.6% and 4.7%, respectively.

Discussion

We will include in our discussion the following results and implications: 1) is denial a meaningful treatment target and, if so, in what way; 2) how can we measure and incorporate youth reports of denial/disclosure over the course of treatment; and 3) what can be done to minimize denial and enhance participation in treatment?

Learning Goals:

- Participants will learn what the research literature says about the role of denial/disclosure
- Participants will understand how to ask questions to assess level of responsibility for an incident
- Participants will learn about the type of patterns of denial/disclosure and how they relate to outcomes following treatment

Table 1: Baseline comparisons across disclosure status

	Total	No I didn't do it			A little agreement			Mostly agrees			Fully admits			
Pre Variable	*N*	*N*	*Mean/%*	*SD*	*N*	*Mean/%*	*SD*	*N*	*Mean/%*	*SD*	*N*	*Mean/%*	*SD*	*p*
CAge1 Demog_1: Child's Age	233	75	15.7	1.9	67	15.6	2.0	53	15.5	2.0	38	15.1	2.2	0.502
CMinority1 Demog_1: Child's CMinority status? (y/n)	232	75	54.7%		66	50.0%		53	43.4%		38	55.3%		0.591
FamInfoSocAsst_Any1 FamInfo_1: Social Asst: Any Kind? (y/n)	174	60	80.0%		52	61.5%		35	65.7%		27	55.6%		0.074
FamInfoPar1Edud1 FamInfo_1: Parent1: Edu - Dich	179	62	53.2%		52	59.6%		38	55.3%		27	48.2%		0.797
FamInfoPar1MaritalD1 FamInfo_1: Parent1: Marital - Dich	179	62	38.7%		52	36.5%		38	42.1%		27	33.3%		0.903
PTSDTrauma8_1 PTSD_1: Witness domestic violence? (y/n)	225	73	36.0%		63	41.0%		52	38.0%		37	46.0%		0.755
PTSDTrauma9_1 PTSD_1: Physical abuse? (y/n)	227	73	22.0%		65	25.0%		52	17.0%		37	24.0%		0.794
PTSDTrauma10_1 PTSD_1: Sexual abuse? (y/n)	226	73	14.0%		64	6.0%		52	17.0%		37	22.0%		0.138
CDFdbd1 CDF_1: Any DBD dx? (y/n)	230	74	37.8%		66	42.4%		53	37.7%		37	46.0%		0.818
TTSCunc1 TSCC_1 (t-score): Under-reporting Impair (y/n >=70)	213	72	29.0%		61	13.0%		46	15.0%		34	24.0%		0.098
SDQpCBCext1 SDQpCBC_1: Extern	207	69	54.8	13.9	56	58.0	15.2	49	53.8	11.0	33	54.0	11.6	0.349
CDFAxisIVSocialAny1 CDF_1: Any social/peer problems on Axis IV?	230	74	20.0%		66	20.0%		53	17.0%		37	22.0%		0.952
CDFAxisIVEducAny1 CDF_1: Any educ/school problems on Axis IV?	230	74	51.0%		66	58.0%		53	49.0%		37	54.0%		0.809
LegalPriorConvNonSex1 Legal Data_1: # Prior Non-Sex Convictions	222	74	0.1	0.7	65	0.4	1.1	49	0.2	1.2	34	0.3	0.9	0.584
PSDPcu1 PSDP_1: Callous-Unemotional	171	59	4.1	2.3	43	3.8	2.4	38	4.1	1.9	31	4.1	2.2	0.885
APQpm1 APQ_1: Poor Monitoring	173	60	17.9	5.1	49	18.0	5.6	38	17.0	4.8	26	17.2	6.1	0.758
Legalanym1 Legal Data_1: Any male victims?	228	73	26.0%		65	23.1%		53	26.4%		37	32.4%		0.788
LegalVicAge1aug Legal Data_1: Victim's age (age youngest if >1 victim	228	75	9.6	5.4	65	10.6	3.8	53	9.2	4.1	35	12.4	12.2	0.084
LegalVicBio1 Legal Data_1: Bio relationship b/w offender and victim?	228	71	26.8%		66	27.3%		53	20.8%		38	34.2%		0.565
LegalRepeat1 Legal Data_1: Repeated?	194	60	27.0%		57	42.0%		46	35.0%		31	39.0%		0.355
LegalVicMult1 Legal Data_1: Multiple victims?	228	71	16.9%		66	16.7%		53	15.1%		38	15.8%		0.993
Legalpinto1 Legal Data_1: Any pen/inter (y/n)? - Overall	221	72	34.7%		62	54.8%		51	54.9%		36	36.1%		0.034

David J. Kolko, PhD, ABPP, is Professor of Psychiatry, Psychology, Pediatrics, and Clinical and Translational Science, at the University of Pittsburgh School of Medicine, and serves as Adjunct Staff in the Section of Behavioral Health at Children's Hospital of Pittsburgh. He is Director of the Services for Adolescent and Family Enrichment (SAFE; www.safessu.pitt.edu) Program, a collaborative treatment program for children and adolescents adjudicated of a sexual offense and who are maintained in the community (Pittsburgh, PA). The program has worked closely with probation offices from the Juvenile Court since 1998. Dr. Kolko is board certified in Child and Adolescent Psychology by the American Board of Professional Psychology. He is also a Fellow of the Society for Child and Family Policy and Practice (Div. 37), the Society of Clinical Child and Adolescent Psychology (Div. 53), and Trauma Psychology (Div 56) of the American Psychological Association. His treatment research interests include the study and treatment of child abuse/family conflict, child behavior disorders/antisocial behavior, including firesetting and sexual offending, and the integration of pediatric behavioral health services in primary care practices and family health centers

BETTER TOGETHER

2018 ATSA Conference | Thursday October 18 | 3:30 PM – 5:00 PM

Working with Denial in the Treatment of Sexually Abusive Youth and Adults

Phil Rich, EdD, LICSW
Specialized Consultation, Training, and Supervision

The presentation will address denial in treatment, including what we mean by denial and the "spectrum" of denial, and how we may understand denial and minimization, recognizing that denial serves a clear function for the client in treatment. It will consider what denial may mean for engagement in treatment, what denial may represent for those in denial, and how to approach and engage "deniers" in treatment, as well as whether it is possible to work with those who are denial of a sexual offense or other forms of sexually harmful behavior.

Learning Goals:

At the conclusion of this presentation, participants will…

- Understand the nature of denial as a risk and treatment factor
- Understand the conceptual range of denial and possible reasons for client denial
- Understand the potential impact of denial on the treatment process, and how to work with clients in denial

Phil Rich presents, trains, and consults nationally and internationally, specializing in work with sexually abusive youth. Phil holds a doctorate in applied behavioral and organizational studies and a master's degree in social work and has been a licensed independent clinical social worker for over 36 years. He was the Clinical Director of the Stetson School for 13 years, a large a residential treatment center in Massachusetts treating children, adolescents, and young adults who have engaged in sexually abusive or sexually troubled behavior, and is the author of several books that describe the assessment and treatment of sexually abusive youth, as well as multiple chapters, papers, and articles that address work with adult and sexually abusive youth and forensic work in general, and the four "Stages of Accomplishment Workbooks for Sexually Abusive Youth. " He is a Fellow of the Association for the Treatment of Sexual Abusers, the juvenile practice representative on the ATSA Executive Board, the chair of ATSA's Juvenile Practice Committee, as well as being a member of several other Boards that serve the needs of sexually abusive youth and public safety.