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### Psychologist Perspectives on the Treatment and Assessment of Problematic Sexual Behavior in Neurodivergent Youth

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PSYCHOLOGIST PERSPECTIVES ON THE TREATMENT AND ASSESSMENT OF  
PROBLEMATIC SEXUAL BEHAVIOR IN NEURODIVERGENT YOUTH

A Dissertation

Presented to the Faculty of  
Antioch University New England

In partial fulfillment for the degree of  
DOCTOR OF PSYCHOLOGY

by

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April 2023

PSYCHOLOGIST PERSPECTIVES ON THE TREATMENT AND ASSESSMENT OF  
PROBLEMATIC SEXUAL BEHAVIOR IN NEURODIVERGENT YOUTH

This dissertation, by Emily R. Marhan, has  
been approved by the committee members signed below  
who recommend that it be accepted by the faculty of  
Antioch University New England  
in partial fulfillment of requirements for the degree of

DOCTOR OF PSYCHOLOGY

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## **ABSTRACT**

### **PSYCHOLOGIST PERSPECTIVES ON THE TREATMENT AND ASSESSMENT OF PROBLEMATIC SEXUAL BEHAVIOR IN NEURODIVERGENT YOUTH**

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Antioch University New England

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The following dissertation explored the subjective experience of mental health clinicians regarding their perceptions of providing treatment and assessment to neurodivergent youth (ND) who exhibited problematic sexual behavior (PSB). Prior to this study, scant research has been conducted pertaining to the treatment and assessment of youth who exhibit PSB, and less still on those with comorbid neurodivergence (Jones & Chaplin, 2017; Malovic et al., 2016; Pratt, 2013). This study utilized Interpretative Phenomenological Analysis to inform interpretations of participant responses collected through semi-structured interviews. Participants consisted of five licensed psychologists with experience providing assessment and/or treatment to both neurotypical and ND youth who displayed PSB. The outcome of the analysis resulted in the following overarching themes: (a) a comprehensive system of information gathering and assessment is indicated for evaluating ND/PSB youth; (b) there are several barriers to providing effective treatment for ND/PSB youth; (c) ND/PSB youth may benefit from treatment that emphasizes skill-building, sex education, and family inclusion in treatment. Each superordinate theme also included several subthemes, which are further explored with regard to existing research, along with clinical recommendations, study limitations, and recommendations for future research. This dissertation is available in open access at AURA (<https://aura.antioch.edu/>) and OhioLINK ETD Center (<https://etd.ohiolink.edu>).

*Keywords:* adolescent, youth, juvenile, neurotypical, neurodivergent, problematic sexual behavior, sexually abusive behaviors, sexual offending

## **Dedication**

To my grandmother, Betty, and my dear friend, Becca. I wish you both could have lived to see me finish this. Thank you for being there when I started.

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I would like to extend my sincerest gratitude to the following individuals for their invaluable role in the completion of my dissertation. First and foremost, I wish to thank Dr. Katherine Evarts for her support throughout my graduate program, and for her unwavering enthusiasm and commitment to my study and broader academic goals. I would also like to thank my committee members, Dr. Wendy Rotfort and Dr. Barbara Belcher-Timme. Their insight was essential to the current study, and their impact on my clinical development has been profound.

In addition, I am incredibly grateful to my participants, without whom this study could not have been possible. To each of them, I extend my sincerest thanks for their time, knowledge, wisdom, and kindness, and for furthering vital dialogue around the underlying topic.

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## **INTRODUCTION**

Adolescents who engage in problematic sexual behavior (PSB) face significant challenges in their development, and those who present with atypical neurological functioning are likely to cope with additional challenges, including increased rates of physical and sexual abuse, a lack of adequate sex education, impaired socialization, and difficulties with emotional and behavioral regulation (Blasingame, 2018; Fortune & Lambie, 2007; Griffiths, 2020). Such risk factors have implications for assessment and treatment, yet there is a paucity of empirical data focused on this population (Fortune & Lambie, 2007; Malovic et al., 2016). The experiences of mental health clinicians who assess and treat individuals in this population comprise a valuable source of information that can be used to develop treatment models for neurodivergent (ND) youth, or youth with atypical neurological development, who display PSB (ND/PSB).

## **LITERATURE REVIEW**

### **Definitions of Key Terminology**

In order to better understand this topic, several key concepts must be clearly defined. Adolescence describes a period of development that can begin as early as age 11 and extend to as late as 25 in terms of cognitive development (Greydanus & Omar, 2014), but for the purposes of this study, refers to youth between the ages of 13 and 17 (Pratt et al., 2007). Problematic sexual behavior (PSB) refers to nonconsensual behaviors that range in degree of physical and verbal contact, such as rape, exhibitionism, voyeurism, molestation, public masturbation, fondling, and verbal sexual harassment (Fortune & Lambie, 2007; Pratt et al., 2007; Ryan, 2010). Such behaviors occur between two or more individuals and are often deemed inappropriate based on discrepancies in age or cognitive capacity of the participants and/or a lack of mutual consent (Rich, 2011). Coercion, aggression, or manipulation may also play a role in gaining victim compliance.

These behaviors are distinct from developmentally appropriate sexual play, and as such do not include normative activities such as “playing doctor,” exposure, or experimental stimulation (Pruitt, 2016).

Previous studies used terms such as “special needs” (Fortune & Lambie, 2007) and “mental retardation” (Timms & Goreczny, 2002) to refer to a range of cognitive and neurological impairments that impact functioning (Fortune & Lambie, 2007). The *Diagnostic and Statistical Manual of Mental Disorders—Fifth Edition* (DSM-5) now categorizes such symptomatology as an intellectual developmental disorder (IDD), or intellectual disability, which can be defined as an intelligence quotient (IQ) two standard deviations below the mean, in conjunction with impairments in adaptive functioning (American Psychiatric Association, 2013). Adaptive functioning deficits are reflective of an underdeveloped capacity for independent functioning and personal responsibility and can include difficulty with communication, social engagement, and activities of daily living (Association for the Treatment of Sexual Abusers [ATSA], 2017).

A definition provided by the National Institute of Health (2016) states, “[Intellectual developmental disorders] are disorders that are usually present at birth and that negatively affect the trajectory of the individual’s physical, intellectual, and/or emotional development.” More specifically, intellectual disabilities impact an individual’s capacity for learning, problem solving, executive functioning, and social adaptability, while developmental disabilities can affect the nervous system, sensory system, and metabolism (National Institute of Health, 2016). Thus, for the purposes of this study, the term neurodivergent/neurodivergence (ND) is used to encompass the vast scope of intellectual and/or developmental disabilities a person may present with. Of note, individuals on the autism spectrum may or may not have a co-occurring intellectual impairment (American Psychiatric Association, 2013) but are to be included within

the frame of neurodivergence due to the range of social and communicative deficits that may be present (Weathington, 2020).

The definitions of both PSB and ND for the purposes of this study are intentionally broad in order to be fully inclusive of potentially relevant data. More specifically, research on this population, including clinically relevant applications, is difficult to synthesize due to an array of terminology used by authors to describe atypical cognitive/developmental functioning (e.g., learning difficulties, intellectual impairment, special needs; Allardyce & Yates, 2018; Blasingame, 2018) and PSB (e.g., sexual offending, harmful sexual behavior, deviant sexual behavior; Griffiths, 2020; Pratt et al., 2007). Therefore, the umbrella terms of ND and PSB have been selected with the intention to encourage participants with various backgrounds to speak to their experiences without being excluded based on their choice of terminology.

### **Prevalence and Societal Implications**

The engagement in PSB by juveniles is an area of concern critical to public health, safety, and policy, with adolescents responsible for approximately one-third of all sexual assaults against minors (ATSA, 2017). Specifically, youth under the age of 18 are suggested to account for 20% of sexual offense arrests, 20-30% of rape cases, and 27% of child sexual homicides (Greydanus & Omar, 2014). Behavioral, psychological, and social problems are particularly salient for youth who exhibit PSB (Fortune & Lambie, 2007), and these risk factors are further exacerbated by the presence of an intellectual and/or developmental disability (Van der Put et al., 2013). Learning disabilities, low verbal IQ, neurological deficits, social deficits, impaired judgment, and social isolation are not uncommon among youth who engage in PSB (Pruitt, 2016).

Youths with ND are suggested to be overrepresented, both as victims and perpetrators, among the criminal justice system, assessment referrals, and treatment services, yet underrepresented in literature and research (Malovic et al., 2016). The incidence of sexual offending behaviors among adolescents, in addition to a lack of research, lack of comprehensive sex education, and increased likelihood for histories of abuse, combine to make a compelling argument for optimal support of ND youths who display PSB, or who may be at risk of developing such behaviors (Griffiths, 2020). Therefore, a need for current research aimed at understanding the specific treatment and assessment needs of ND/PSB youths is indicated.

### **Neurocognitive Implications**

Adolescence represents a dynamic and fluid stage of neurodevelopment. Compared to adults, adolescents are highly susceptible to peer pressure, less future-oriented, less risk-averse, and less adept at regulating emotions and behaviors. Cognitive and developmental factors such as learning disabilities, executive functioning disorders, and autism spectrum disorders can further exacerbate social and behavioral problems associated with adolescence (ATSA, 2017). Neurodivergent youth who exhibit PSB present with unique challenges brought about by both their intellectual/developmental disability, as well as the physical and emotional turbulence that occurs during adolescent development, particularly puberty. During puberty, adolescents become curious about sex and may be searching for ways to explore their own, and others', bodies (Greydanus & Omar, 2014).

Puberty also has implications for cognitive functioning; NT youths in early adolescence tend to think in concrete, here-and-now ways and are less likely to understand long-term consequences for behavior (Greydanus & Omar, 2014). Approaching middle adolescence, cognition becomes more introspective, and youths develop a capacity for abstract reasoning and



critical thinking. In contrast, ND adolescents often have difficulty understanding abstract concepts, which suggests that they may have more difficulty interpreting laws and social norms (Greydanus & Omar, 2014; Lindsay, 2002). Additionally, cognitive misalignment with same-aged peers in ND youths suggests that they may relate more strongly to children who represent their developmental equivalents (Malovic et al., 2016).

### **Psychological Implications**

Neurodivergent youth who engage in PSB are more likely to have experienced adverse life events, including all forms of abuse, compared to their NT peers (Blasingame, 2018; Griffiths, 2020; Malovic et al., 2016). Sexual violence, in particular, disproportionately impacts ND youth. Children with cognitive deficits are 4.6 times more at risk for victimization (World Health Organization, 2021), often perpetrated by other ND individuals (Griffiths, 2020). Neurodiverse youth may also participate in self-victimization through the reenactment of their own sexual traumas, or as a result of not learning appropriate and safe sexual behavior (Griffiths, 2020; Malovic et al., 2016). Abuse, neglect, witnessing violence, impaired family functioning, alcohol and substance use in the home, and comorbid mental illness are contributing factors to developmental impairment and the increased likelihood of emerging PSB (Pratt et al., 2007; Pratt, 2013).

Such adversity in early childhood suggests an increased likelihood of disrupted attachment, which may have implications for the development of PSB throughout the lifespan. Infant attachment influences the ways individuals process and regulate emotion, relate to others, and develop the capacity for self-reflection (Siegel, 2012). In addition, early attachment fosters the capacity for learning social skills and achieving social competence, a lack of which may

serve as a risk factor for engaging in PSB (Rich, 2011). Indeed, disrupted and insecure attachment styles are suggested to be prevalent among youth who display PSB (Pruitt, 2016).

Attachment styles are also integral to the emergence of PSB, as quality of attachment directly impacts the development of social skills and competencies, including interpersonal interaction, social comprehension, empathy, self-regulation, and self-awareness (Marshall, 2010; Rich, 2011). As such, those with insecure styles of attachment may have difficulty connecting to others, tolerating discomfort, and modulating their behavior in response to unmet needs (Rich, 2011). Broadly, developmental trauma is likely to contribute to impairments in the neurobiological structures that regulate cognitive, emotional, and sensory processes. Such deficits in processing have implications for maladaptive behaviors, including PSB, and are consistent with insecure attachment (Creeden, 2004).

### **Sociocultural Implications**

Socially, sexuality among ND individuals has historically been unacknowledged and ignored (McCarthy, 1999). The levels of support that ND adolescents often need creates a less private, more regulated social life, adding nuance to the ways in which they learn about and develop their sexuality. A study by Frawley and Wilson (2016) found that parents and support providers of ND youth often functioned as gatekeepers of knowledge, limiting their access to information and opportunities to develop their sexual and social identities. The information that was provided tended to be biologically focused, rules-based, and heterosexually framed. As a result, these adolescents reportedly knew the “rules” but felt they were lacking the capacity for real-world application (Frawley & Wilson, 2016).

O’Callaghan and Murphy (2007) compared ND adults to NT adolescents and found that although the adolescents were more informed, both groups demonstrated relatively poor

knowledge pertaining to laws on sexuality, particularly those that protect vulnerable populations. These findings suggest that ND youths may be doubly disadvantaged when it comes to internalizing important knowledge that may help them protect themselves from abuse, as well as prevent them from potentially victimizing others. It is also worth noting that children who are unable to participate in a general education curriculum as a result of their cognitive limitations may receive no sex education at all, which has significant bearing on their ability to understand, and therefore consent to, sexual activity (Rainville, 2013).

Neurodivergent adolescents may be more likely to engage in PSB due to a limited capacity for understanding the nature of social interactions. For example, certain context clues (e.g., setting, victim's age) that inform what is socially appropriate are more likely to be misinterpreted or missed altogether (Timms & Goreczny, 2002). As a result, ND/PSB adolescents may be operating under an incorrect assumption that they are involved in a genuine romantic relationship. A lack of inclusive sex education and socialization as a result of a lifelong disability may create barriers to developing interpersonal skills and engaging in healthy formative relationships and sexual experiences (Hertlein et al., 2009).

## **Current Modalities**

### **Assessment**

Assessment measures are indicated for youth with PSB to estimate risk, prevent relapse, and inform treatment planning. The outcomes of these assessments have implications for significant decision-making processes, including juvenile justice, registration as an offender, transitional placements, family reunification, and community supervision (Allardyce & Yates, 2018; ATSA, 2017). There are several assessments designed for use with adolescent populations who exhibit PSB, although the validity of such measures remains inconsistent. At the time of the

present study, there are no known independent empirical tools specifically tailored for ND/PSB youth (Blasingame, 2018).

One measure designed for use with youths with PSB is the Adolescent Clinical Sexual Behavior Inventory (ACSBI). The ACSBI is a 45-item measure that includes a parent report form and juvenile self-report form that assesses a range of sexual behaviors in clinical populations. Of note, it was suggested to have limited reliability and weak internal consistency. In addition, it has been deemed insufficient for normative samples and therefore would not be appropriate for low-risk youth (Friedrich et al., 2004).

Another available measure is the Juvenile Sex Offender Assessment Protocol–Revised (J-SOAP-II), intended to estimate recidivism risk and inform placement decisions. The predictive validity of this measure is mixed, however. The inconsistency in results indicates that risk factors for PSB may fluctuate throughout adolescence; for instance, the J-SOAP-II may have greater predictive validity for youth ages 14-16 than for older adolescents. Still, there is little current research on the impact of developmental changes on recidivism risk, nor how such changes may affect assessment protocols (Wijetunga et al., 2018).

Viljoen and colleagues (2012) conducted a meta-analysis on adolescent sexual recidivism measures. In addition to the J-SOAP-II, these researchers also examined the Estimate of Risk of Adolescent Sexual Offense Recidivism (ERASOR), the Juvenile Sexual Offense Recidivism Risk Assessment Tool (J-SORRAT-II), and the STATIC-99, an adult risk assessment measure. Results of the meta-analysis suggested broad support for use of these tools in estimating adolescent sexual recidivism, albeit with potential challenges, including inconsistency across measures. In addition, juvenile-specific measures were not found to be more accurate than the

STATIC-99, nor was the STATIC-99 considered well-suited for use with adolescents (Viljoen et al., 2012).

In sum, the above measures are recommended over relying on clinical judgment alone, but they may not be sufficient for informing decisions regarding civil commitment or placement on registries. Further, adolescent norms are needed in order to reliably use the STATIC-99 with juvenile populations (Viljoen et al., 2012). Given the lack of standardized, validated tools for use with NT youth, let alone ND adolescents, evaluators are encouraged to utilize a systemic information-gathering strategy that includes clinical interviews with the child and their caregivers, record review, and actuarial inventories, such as the Sexual Behavior Screening Questionnaire (SBSQ; Blasingame, 2011).

## **Treatment**

In the 1980s, treatment for juveniles labeled as “sex offenders” was largely restrictive and influenced by adult treatment models. Contrary to current findings, these youth were perceived as high-risk and assumed to be lifelong offenders requiring intensive, long-term treatment (ATSA, 2017). As such, they were often referred to secure criminal justice or residential settings for 12–24-month periods. Treatment typically occurred in group settings in which describing the offense conduct, taking responsibility, and accepting accountability were often required for treatment completion. Notably, none of these interventions have been found to be significant predictors of sexual recidivism (Dwyer & Letourneau, 2011; Kettrey & Lipsey, 2018).

In the past few decades, treatment frameworks have shifted to include cognitive behavioral therapy (CBT), multisystemic therapy, psychoeducation, and psychotherapy delivered through individual, group, and family therapy formats. Within these frameworks, suggested interventions include addressing cognitive distortions, affect regulation, victim empathy, social

skills, self-esteem, impulse control, and relapse prevention. Such interventions are thought to minimize PSB through the development and enhancement of coping skills, adaptive behaviors, healthy relationships, and positive attitudes (Pruitt, 2016).

Additional treatment recommendations for ND youth include incorporating visual or experiential learning tools, social stories, and sex and relationship education. Of note, treatment measures that are structured around cognitive-behavioral or relapse-prevention strategies tend to be language-based, which may be a disadvantage to ND youths, given that they are more likely to present with verbal deficits (Creeden, 2004). For those on the autism spectrum, there is little empirical support for specific PSB interventions. However, behavioral approaches such as applied behavior analysis (ABA) for social skills and pivotal response training have resulted in positive case study outcomes. Finally, given the high rates of trauma among youth who display PSB, further research on the efficacy of trauma-informed approaches is warranted (Allardyce & Yates, 2018).

### **Statement of Purpose and Present Study**

The specific needs of ND/PSB adolescents regarding prevention and treatment are not adequately studied nor well understood in the field of psychology, in contrast to their adult counterparts (Jones & Chaplin, 2017; Malovic et al., 2016; Pratt, 2013). Research focusing on this population has been limited in part by variations in criteria for ND (Blasingame, 2018; Fortune & Lambie, 2007) and by samples that are often small in size and highly institutionalized (i.e., in correctional settings). These studies also lack distinction among variables such as IQ, severity of impairment, and comorbid mental illness (Lindsay, 2002).

Only within the last few decades has the field of psychology given consideration to the need for adolescent and child-specific assessment and treatment approaches for those who

exhibit PSB (Pratt, 2013). Few assessment tools have been validated for use with adolescent populations and fewer still for those with ND, suggesting that clinicians must rely heavily on professional opinion when interpreting data that have not been normed for the given population (Blasingame, 2018). Given the gravity of potential treatment decisions based, in part, on assessment outcomes, there is a need for empirically-based assessment standards for ND/PSB youth (Dwyer & Letourneau, 2011).

Traditionally, treatment models for adolescent offenders have been borrowed from adult models (Pratt et al., 2007; Rich, 2011). While positive outcomes have been recorded from the implementation of several methods (e.g., multisystemic therapy, ABA, CBT), there is little empirical data on *how* these interventions work, and for whom. There is also a lack of evidence regarding the impact of various cognitive and developmental factors on treatment efficacy. Thus, there is a growing need for current research that can assist in the development of treatment protocols with ND adolescents in mind (Creeden, 2004; Malovic et al., 2016).

The goal of the current study was to obtain an understanding regarding the specific needs of ND adolescents who display PSB that may be different from those of NT youth by interviewing mental health clinicians who have experience treating and assessing these populations. The perspectives of mental health clinicians who assess and treat adolescents who engage in PSB are essential to gaining clinical insight into how the field of psychology is providing treatment to these individuals, including potential treatment gaps. Such information could help inform the overall treatment and/or assessment approach with ND/PSB youth, and may have implications for treatment outcomes. By interviewing clinicians, this study aims to address the following research questions:

1. What are the experiences of mental health clinicians regarding their approach to providing assessment and/or treatment to ND youth who exhibit PSB?
2. What perceptions do mental health clinicians have about the assessment and treatment needs of ND youth regarding PSB, in comparison to their NT peers?

## **METHOD**

### **Research Design: A Phenomenological Qualitative Approach**

The current study was conducted using a phenomenological qualitative research design to explore the subjective perceptions among mental health clinicians who have experience providing treatment and/or assessment to NT and ND youths who exhibit PSB. Phenomenology was the framework of choice for this study, as the aim is to understand the essence of the phenomenon at hand and discover commonalities among the lived experiences of a group of individuals. The gathering of perspectives of mental health clinicians lends itself to interpretation of meaning to assess the ways in which the participants experience a given phenomenon (Creswell & Poth, 2018). An interpretive study based on individual perceptions and experiences, that can be analyzed for themes and applied more generally ideally contributes to the critical area of research on this topic.

### **Interpretative Phenomenological Analysis (IPA)**

Interpretative Phenomenological Analysis (IPA; Smith et al., 2009) was used to guide the current study. IPA can be understood as a method of analysis that focuses on the exploration of lived experiences according to phenomenology, hermeneutics, and idiography. Phenomenology refers to the study of lived experience and is concerned with examining rich descriptions of a person's perspective, as well as how they interpret their experiences. Hermeneutics refers to the theory of interpretation, and it includes a process of examining "hidden" (p.24) meanings to



bring forth a more complex understanding. Last, idiography can be understood as a lens through which depth of analysis can be applied to particular lived experiences to better grasp how a specific phenomenon has been understood in a given context. Thus, IPA integrates these three foundational principles to capture the essence of people's relationships to their worlds (Smith et al., 2009).

IPA is an iterative process of engagement and interpretation on the part of the researcher. It involves "making sense" of how the participants "make sense" of their experiences, a process known as double hermeneutics (Smith et al., 2009, p.35). Analysis begins with the researcher transcribing and rereading the data in an immersive process, during which time observations and reflections are continually noted. The researcher then uses these notes to develop and identify emergent themes. Following this, the researcher draws connections between themes and organizes them into labeled groups based on similarities (Smith & Shinebourne, 2012). This was the chosen method of analysis for the following study as it allows for the thorough exploration of the experiences of the participants while acknowledging the analytical impact of the researcher's own experiences on their interpretation.

### **Researcher Assumptions and Biases**

As is consistent with the chosen paradigm, a critical aspect of IPA is identifying and bracketing biases that I, as the researcher, will be necessarily bringing in to my research (Creswell & Poth, 2018; Smith & Shinebourne, 2012). The acknowledgement of such biases and assumptions is intended to create space for the experiences of the participants and inform the reader of factors that may have influenced the ways in which the participants' responses were analyzed and interpreted (Creswell & Poth, 2018). Therefore, acknowledgement of my own preconceptions functions as a part of the hermeneutic circle. Consistent engagement in

hermeneutic processes is intended to reveal the ways in which researcher and participant experiences influence one another (Smith et al., 2009).

Experiences that I bring to the research process include my previous training providing therapy to adolescents and individuals with a history of PSB. This clinical training has imparted upon me an awareness of the nuances surrounding the manifestation of PSB and an increased sensitivity to potential underlying or confounding factors. Based on my review of available literature and personal experiences, I formed some assumptions about what the findings of my study might conclude. For example, I believed that ND youths who display PSB have treatment and assessment needs that are different from that of NT youths. I also assumed that there are inadequacies in the assessment and treatment modalities that are currently used for ND adolescents who display PSB. Thus, I attempted to bracket these assumptions out and avoid the influence of them on my interviewing and analyzing research activities.

## **Participant Sample**

### **Purposeful Convenience Sampling**

As is theoretically consistent with the given research design, participants were selected purposively in order to best ascertain a common perspective of the given phenomena. Recruitment took place via word-of-mouth referrals among my own professional contacts in the mental health field, which included utilizing ListServes (Antioch University and New Hampshire Psychological Association ListServes). Contact with participants occurred through responses to the ListServ (Appendix A), or following an initial email inquiry (Appendix B).

Following the initial contact, emails were exchanged with participants to answer any questions they had about the study and provide an informed consent document (Appendix C). Participants electronically signed the consent form and returned it to me via email, with the

exception of two participants who printed and signed a hard copy, returning it to me via postal service. I then scheduled Zoom interviews with the participants who met inclusion criteria and wished to proceed. Participation was completely voluntary, and no incentive was offered for participating in the study.

### **Inclusion and Sample Size**

To meet the inclusion criteria of the study, participants had to be (a) 18 years or older; (b) currently working as a mental health clinician; and (c) experienced in providing treatment and/or assessment to both NT and ND youth who demonstrated PSB. It was also specified that PSB need not be the primary treatment target, though it did need to be significant enough to warrant specific interventions/assessments. There were no exclusion criteria related to race, ethnicity, gender, sexuality, socioeconomic status, or type of qualification/license held.

The sample size was kept relatively small in order to give each participant's perspectives the detailed and thorough examination they required. Further, the rigorous method of IPA is suggested to best fit no more than six cases before adjustments in the level of analysis should be made (Smith et al., 2009; Smith & Shinebourne, 2012). Given these considerations, I limited my sample size to four to six participants.

### **Participant Demographics**

Six mental health clinicians agreed to participate in the study. Of note, I conducted interviews with six individuals but chose to exclude one participant's interview from the data set as it did not provide relevant information for the purposes of the study. Specifically, the following factors appeared to impact the results of this excluded interview: (a) responses were given that did not answer the question at hand; (b) there was misalignment with language and concepts central to the purpose of the study; (c) all items were unable to be addressed due to

exceeding the time limit. I determined that the remaining five interviews provided sufficient information to address the research question and fell within an “ideal” range of participants for nomothetic inquiry.

Of the remaining five participants, two identified as male, and three identified as female. All participants were White. All participants were licensed psychologists in New England and had been in practice for at least two decades. Four of the participants had at least two decades of clinical experience with NT and ND youth with PSB. Three had experience providing both assessment and treatment. Additional details regarding the relevant demographic information of each participant can be found in Table 1.

**Table 1**

*Participant Demographics*

Participant #	Race	Gender / Pronouns	Years of Professional Practice	Years Treating Population	Degree	Location	Treatment / Assessment
1	White	Male/he series	2000-present	6	Psy.D.	NH	Assessment
2	White	Male/he series	1980-present	25	Psy.D.	MA	Treatment
3	White	Female/she series	1987-present	20	Psy.D.	MA	Both
5	White	Female/she series	1985-present	24	Psy.D.	NH/MA/CT	Both
6	White	Female/Declined to disclose	1984-present	38	Ed.D	CT	Both

### **Ethical Considerations, Informed Consent, and Confidentiality**

Participants who met eligibility requirements for the study were sent a consent form (Appendix C) via email. They were instructed to read through the form, provide their signature, and return it to me prior to their interview date. On the day of the interview, I discussed the consent form with the participants and spent time answering any questions they had to ensure they were comfortable proceeding.

All participants were assured of their confidentiality and anonymity. All participants provided written consent for the audio recording of the Zoom interviews. These audio recordings were stored on a password encrypted device that only I had access to, and they were destroyed upon completion of data analysis. The audio recordings were transcribed verbatim in a password-encrypted document. To ensure anonymity, participants' names were not included on any documentation of interview dialogue or notes. They were identified only by participant number throughout the research process.

### **Data Collection Methods and Interview Questions**

Data were gathered through semi-structured interviews in order to allow for in-depth exploration of each participant's experience. Interviews took place via the video call platform Zoom and ranged in length from 40-65 minutes. Each interview was digitally audio recorded and transcribed. The interviews were comprised of both prepared, uniform questions (Appendix D) and improvised questions related to participant responses. The inclusion of unscripted questions was designed to support the natural flow of conversation and enable me to follow relevant threads of dialogue that resulted in richer descriptions of unique participant experiences.

The content of interviews explored participants' (a) experiences providing treatment and/or assessment to both NT and ND youth who displayed PSB; (b) challenges they

encountered in the treatment/assessment process; (c) opinions regarding effective treatment/assessment strategies; (d) perceptions about the need for changes to methods of treatment/assessment, if applicable; and (e) perceptions about the need for changes in the mental health field in its approach to these youth, if applicable.

After the conclusion of all interviews, I sent each of the five participants a four-item demographic questionnaire via email (Appendix E). The questionnaire contained items relevant to gender identity, race, and years of experience. The purpose of these questions was to gather relevant background information that would be useful in interpreting each participant's individual responses, as well as contextualizing each set of responses within the participant cohort.

### **The Process of Data Analysis**

Interpretative Phenomenological Analysis (IPA) was used to analyze the data gathered through participant interviews. Through the use of this method, I explored each participant's individual account of their experience of providing assessment and/or treatment to youth with PSB, with particular focus given to descriptions of clinically-based needs of ND youth. Throughout analysis, I attended to both the unique aspects of each individual experience and potential emergent themes across narratives.

It is important to note that there is no singular prescribed method for conducting IPA (Smith & Nizza, 2022). Rather, IPA is best understood as a process of engaging with common processes and principles, which are then applied to the data through the lens of analytic focus (i.e., participants' subjective experiences). Consistent with the flexibility of this approach, I used the following steps outlined by Smith and Nizza (2022) as the scaffolding of my analysis: (a) reading and exploratory notes; (b) formulating experiential statements; (c) finding connections

and clustering experiential statements; (d) compiling the table of personal experiential themes; and (e) cross-case analysis.

### **Step 1: Reading and Exploratory Notes**

The first step of IPA involves gaining familiarity with the original data through an immersive reading and rereading process. I first listened to the audio recording of the interview while reading its corresponding computer-generated transcript. At this time, I corrected transcribing errors and checked for accuracy. I also made exploratory notes that included initial impressions and reflections and bracketed them in a separate notebook. Additionally, I paused and re-listened to audio segments to ensure that I was capturing the tone, inflection, and intention of each segment within the transcript as accurately as possible (Smith & Nizza, 2022; Smith et al., 2009).

### **Step 2: Formulating Experiential Statements**

The second step refers to a process of capturing a succinct summary of a given segment of text from the transcript. Such statements are simultaneously specific and conceptual in order to effectively convey the raw data while also revealing the psychological content of the text. This step requires meaningful engagement with the data to transform statements from purely descriptive to interpretative. The second step also facilitates condensation of the data, as the most salient segments (i.e., patterns) begin to emerge (Smith & Nizza, 2022).

### **Step 3: Finding Connections and Clustering Experiential Statements**

The third step serves to distill and synthesize the set of experiential statements. I utilized a process of abstraction, whereby I grouped similar statements to create clusters of thematic text. This process highlights similarities within statements as well as differences. During this step, certain statements may act as a “magnet” (p. 49), pulling other statements toward it and leading

to further thematic refinement (Smith & Nizza, 2022).

#### **Step 4: Compiling the Table of Experiential Themes**

Following the completion of Step 3, the clusters of experiential themes are organized into a table (Appendix F). Steps 1 through 4 are then completed for each consecutive case. Each case is treated independently, rather than in relation to previous cases (Smith & Nizza, 2022). In keeping with idiographic commitment, I attended to the potential influence of pre-established themes on emergent themes in subsequent transcripts. Therefore, I bracketed emerging assumptions in order to analyze each transcript as objectively as possible.

#### **Step 5: Cross-Case Analysis**

Following the individual analysis of each case, cases are then compared in a process of part-whole interpretation. During this stage, cases illuminate one another and connections can be drawn among responses. This step is nonlinear, and includes restructuring and rewording of themes as concepts come to light (Smith & Nizza, 2022).

After completing steps 1 through 4 for each interview, I searched for connections among emergent themes across cases. I also determined which emergent themes I would keep or discard. Given the volume of themes present at this stage, I sought to consolidate data while maintaining complexity. I took several factors into account in this decision-making process, including prevalence across cases and relevance to the research question. Themes that were not present in a majority of cases (i.e., three or more) were discarded. The remaining themes were clustered by similarity to form superordinate themes (Smith et al., 2009).

#### **Attending to Analyst Bias**

Throughout the entire process of data analysis, I continually referred back to my bracketed notes to consider whether my personal biases might have impacted my formulation of



emergent and superordinate themes. For example, I had hopes that the results of my study would bring awareness to the potential inadequacies in research on ND/PSB youth and highlight treatment and assessment needs. Therefore, I remained cognizant of the fact I may have been hypersensitive to perceived differences between NT and ND youth and less attentive to similarities. When evidence of differences arose thematically, I referred back to the original transcript and initial notations to discern whether the theme was adequately supported with data. Themes were only included if they were apparent across three or more cases, relevant to the research question, and had sufficient supporting evidence.

### **Quality Assurance**

Per Smith and colleagues (2009), I utilized Lucy Yardley's (2000) four principles to assess the trustworthiness of the findings of the study. The first principle, sensitivity to context, begins in the interview stage and is further carried out through the process of analysis. Establishing rapport, demonstrating empathy, and active listening and engagement are examples of how sensitivity to context is applicable to the interview process. Throughout data analysis, utilizing direct quotations, being explicit about which data points contributed to the overall findings, erring on the side of caution when making generalizations, and referencing existing research where applicable were some of the ways in which I incorporated sensitivity to context.

The second principle, commitment and rigor (Yardley, 2000), refers to the level of care and attention given by the researcher to the participants and the experiences they provide to the study. The principle of commitment and rigor becomes relevant in participant recruitment, whereby I selected individuals who met the criteria previously outlined and who were able to provide rich descriptions that answered the research questions. Thus, careful consideration and selection was implemented when inviting individuals to participate. During the interview

process, commitment and rigor were established by closely attending to participant responses and individually tailoring the dialogue to minimize the risk of valuable information being excluded as a result of not asking the right questions.

The third principle, transparency and coherence (Yardley, 2000), refers to a manner of presenting the findings in which the reader can clearly see the steps of analysis and how the responses collected informed the results. This includes providing tables to visually demonstrate the analytic process as well as identifying responses that were not included in the results and providing a rationale for their exclusion where applicable.

The fourth and final principle, impact and importance (Yardley, 2000), refers to the process of identifying and presenting data in a way that is “interesting, important, or useful” (Smith et al., 2009, p.183). I upheld this principle throughout analysis by engaging in an ongoing process of reflection to determine whether the findings would be perceived as interesting, important, or useful by the reader, and I only included themes that met these criteria.

### **Employing an Independent Auditor**

In addition to following Yardley’s (2000) four principles, I employed a researcher who was unaffiliated with the study to conduct an independent audit by reviewing the steps of analysis outlined above. The purpose of an audit is to search for and identify inconsistencies or discrepancies in the findings and to screen for the impact of researcher biases. Utilizing deidentified research materials, including notes, transcripts, and tables, the auditor seeks to establish a clear path from the beginning stages of analysis to the superordinate themes to thereby determine whether the conclusions drawn by the researcher are reasonable and reflective of the original data (Creswell & Poth, 2018; Smith et al., 2009).

The auditor for this study was a 31-year-old White ciswoman and licensed clinical psychologist (Psy.D.). This auditor utilized IPA in her own dissertation and was well-versed in the process of analysis and its theoretical underpinnings. After I completed Step 4 of analysis, I transferred my findings and deidentified materials to the auditor. She performed a careful review of the transcripts and documentation and provided feedback. Such feedback included relocating text segments that better supported previously established themes and adjusting the language of themes to better capture and reflect the phenomena described in quotations. She also reviewed text segments that I had found meaningful, but not thematic, to verify my decision-making process (i.e., exclude these data points) or suggest another remedy (e.g., add to existing theme).

Once the auditor and I were in agreement on all findings and reported themes, I then completed Step 5 of analysis and established superordinate themes from the identified emergent themes. At the completion of this step, I again sent relevant materials (e.g., Excel spreadsheet, tracking notes) to the auditor for review. In both stages of auditing, there was a significant degree of agreement between me and the auditor, demonstrating coherence in our understanding of the findings. The quality and rigor of the analytic process was improved through auditing, as the few areas of discrepancy mitigated the impact of biases on the findings and enhanced the overall meaning of interpretations.

## **RESULTS**

Interpretative Phenomenological Analysis (IPA) of the five semi-structured interviews resulted in the emergence of three superordinate themes. Each superordinate theme encompasses several subthemes (i.e., emergent themes) that arose across three or more cases. The superordinate themes and their corresponding subthemes can be found in Table 2.

**Table 2***Superordinate and Subthemes*

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**Theme 1: A comprehensive system of information gathering and assessment is indicated for evaluating ND/PSB youth.**

A comprehensive battery is indicated for addressing PSB with ND youth.  
 IQ should not be considered as fully representative of functioning and/or ability.  
 ND/PSB youth may present to assessment with barriers to information gathering.

**Theme 2: There are several barriers to providing effective treatment to ND/PSB youth.**

There is a lack of clinical recognition of PSB among pre-established patients.  
 There is a lack of acknowledgement of PSB as a worthy area of clinical intervention.  
 Stigma carries implications for treatment/availability of services.  
 There is a dearth of formal training or education provided.

**Theme 3: ND/PSB youth may benefit from treatment that emphasizes skill-building, sexual education, and family inclusion in treatment.**

Treatment for ND/PSB youth should emphasize education, skill-building, and social rules/boundaries.  
 There are inherent differences between conceptualizing and treating NT and ND youth.  
 Family involvement may have implications for treatment efficacy/outcomes.  
 The sexual health of ND youth is not adequately addressed in available curriculum.

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These superordinate themes were reflected in most participant narratives. It is of importance to note that the themes identified in this study are each just one possible account of the experiences of mental health clinicians who provide treatment and/or assessment to NT and ND youth who display PSB. These themes cannot, nor are intended to, cover all aspects of the participants' experiences. Rather, they were selected due to their commonality among three or more participant accounts, as well as their relevance to the present study.

Verbatim excerpts from the interview transcripts will be used to illustrate the results. It should be noted that some minor changes have been made in the presentation of these excerpts to improve readability. Minor hesitations, word repetitions, and utterances such as "umm" have been removed in most instances. Missing material is indicated by ellipses, and where information

has been added (e.g., to explain to what or to whom a participant is referring), it is presented within square brackets. All identifying information has been removed or changed, and the participants are identified by their participant number to protect anonymity.

### **Theme 1: A Comprehensive System of Information Gathering and Assessment is Indicated for Evaluating ND/PSB Youth**

The first superordinate theme is pertinent to the assessment of ND/PSB youth and encompasses the following subthemes:

- A comprehensive battery is indicated for addressing PSB with ND youth.
- IQ should not be considered as fully representative of functioning and/or ability.
- ND/PSB youth may present to assessment with barriers to information gathering.

These subthemes share an emphasis on aspects of the assessment process for ND/PSB youth. Each subtheme, with corresponding quotations, is described in detail below.

#### **A Comprehensive Battery is Indicated for Addressing PSB with ND Youth**

The first subtheme was reflected across cases, with the exception of one participant who did not provide assessment to youth with PSB. While there was variation between accounts, the four participants with relevant assessment experience described an in-depth assessment process that involved a number of measures. For example, Participant 1 described administering a battery including IQ, personality, and psychosexual elements:

Participant 1: I do a full IQ. I use the Milan series of the MACI and MPACI. I use the Reynolds series. I use the Beck series. I did, and do, just a complete psychological evaluation. And somewhere in there, I weave through questions about sexuality, and the MASOC questionnaire as well.

Participants 3 and 5 also described a comprehensive evaluative process. In addition, they discussed the importance of incorporating risk assessment measures into the assessment battery:

Participant 3: We use STATIC-99, ABLE. We had an assessment tool, this kind of assessment intake tool, that wasn't standardized, that was specific to the school.

Participant 5: I'll do an in-depth interview with parents. I think it's the ADOS I might use. But I also use the SRS which is the Social Responsivity Scale; only when it's applicable, sometimes it's not applicable. . . . But, with regards to the more standard sex offender measures, the STATIC-99-R.

Participant 6 also reported using a number of measures, in addition to an in-depth clinical interview and sexual history. In addition, Participant 6 referenced using risk assessments but was unable to recall the specific measure/s. Assessing the reading level of each patient was also heavily emphasized by Participant 6:

Participant 6: I always verify IQ. . . . My preference is to use the Stanford-Binet... I also always do the Woodcock-Johnson Achievement tests, because they're quick to do, and courts understand those.

Participant 6: I always do a clinical interview and then, depending on the case, I will do one of those standardized risk assessments for sexual offending. I can never remember the names and they all have alphabet soup for their titles. But I use at least one of those standards because it looks at the demographics . . . because I do an in-depth sexual history.

Participant 6: I think a missing piece for many evaluators is they don't look at the reading level. They don't look at what they comprehend.

All participants reported assessing multiple domains of functioning, including IQ, achievement, sexual history, adaptive functioning, personality, and risk. However, there was a significant degree of variability among specific measures used. There was also varying emphasis placed on different aspects of assessment, such as risk, sexual history, and reading level, which supports the current research on the importance of a comprehensive battery that assesses multiple domains of functioning (ATSA, 2017).

### **IQ Should Not Be Considered as Fully Representative of Functioning and/or Ability**

The second subtheme provided further support for the overarching superordinate theme, as it indicates the need for multiple sources of information and suggests an overreliance on IQ as

a measure of ability. As summarized by Participant 3, “A lot of old-school psychologists are like, ‘The IQ is the IQ.’ No, it isn’t.” Participant 2 described the potential for IQ to not accurately reflect an individual’s abilities and therefore impact the services they receive:

Participant 2: Most of the people that we work with that have problematic sexual behavior are actually a little bit more higher functioning than 70, but because of other neurocognitive factors that impaired their ability on test taking, but they had a whole bunch of skills that were much higher than people with intellectual disabilities. So, these are the people that fall through the cracks.

Participant 6 reflected similar potential outcomes due to the influence of IQ scores:

Participant 6: I have a theory that some of the guys in prison that we identify as having a learning disability actually have mild intellectual developmental disorder. And they passed for normal through most of school, or we educated them out of that mild level of intellectual developmental disorder, and now they’ve got an IQ of 71, so they don’t qualify for services . . . and now, because we’ve got this artificial number and we didn’t look at his functioning, we’ve got a problem.

Each participant noted the need to examine other variables when considering the IQ score of an individual. ND youth, in particular, may have abilities that are not fully accounted for in measures of IQ. Systemically speaking, these participants also noted the importance of IQ in determining whether an individual qualifies for certain services.

### **ND/PSB Youth May Present to Assessment with Barriers to Information Gathering**

Thematically, three participants identified barriers to information gathering, although there was variability in their accounts of which factors were most salient. For instance, Participant 1 discussed the impact of family members’ perceptions on the assessment process and highlighted the role of denial within the family system:

Participant 1: They’re referred to me as, “My son”—from the parents—“My son was found to have inappropriately touched a girl, and I don’t think it was a big deal, he was just exploring.” So to begin with, there’s a denial. And throughout the assessment there’s a denial.

Participant 5 described working with ND/PSB youth who present with confounding historical data. More specifically, she described how such youth are often misperceived across environments, which can have diagnostic implications:

Participant 5: So I'm looking for history and early development and things like that, and how they did or did not get treatment or were perceived as, "Oh, he's just stubborn," which happens a lot. Or they have 25 diagnoses because they can't figure out, you know, at age 10, that they're on the spectrum.

Participants 1 and 3 emphasized the importance of having as much information as possible prior to conducting an assessment, and identified challenges that can arise when information is unavailable:

Participant 1: The lack of information about the kiddo who comes to me is really the toughest part of assessing these kids.

Participant 3: One thing I think is helpful for clinicians too, especially if they're meeting with clients who come with testing or other information, if you can get ahold of that early on, it can be really helpful. . . . Usually they don't come to me with that stuff, but if they do, I get it as soon as I can. . . . And I mean, I think there will be a better connection if you're more informed. And sometimes you can't be.

## **Theme 2: There are Several Barriers to Providing Effective Treatment for ND/PSB Youth**

The second superordinate theme was pertinent to global needs of ND/PSB youth, with particular emphasis on treatment, and encompassed the following four subthemes:

- There is a lack of clinical recognition of PSB among pre-established patients.
- There is a lack of acknowledgement of PSB as a worthy area of clinical intervention.
- Stigma carries potential implications for treatment/availability of services.
- There is a dearth of formal training or education provided.

### **There is a Lack of Clinical Recognition of PSB Among Pre-Established Patients**

Three of the five participants referred to potential implications of PSB not being recognized in clinical settings among patients who may be receiving treatment for other



psychological concerns. As stated by Participant 2, “My guess is people are seeing people in individual therapy who have sexually problematic behaviors and [the therapists] don’t know. That’s not okay.” He further emphasized the importance of enhancing awareness among clinicians of this issue: “I believe that every psychologist needs to know . . . because they’re going to see it and miss it. And that’s just not right.”

Participant 3 similarly noted the potential for clinicians to fail to identify PSB among patients on their caseload. She also suggested the importance of clinicians inquiring about PSB as a matter of due diligence:

Participant 3: I think the clinicians today . . . also have to realize, even if they’re not knowingly working with offender populations, they might be. . . . But I think you have to ask, because if you’re not, if you don’t know that information and [are not] addressing it however the client wants to, you missed a key piece of work.

Participant 5 endorsed a lack of awareness of patients who exhibit PSB within hospital settings:

Participant 5: When I first started going into the hospitals, I would have units tell me, “Well, we don’t have anybody like that here.” Well, actually, you do.

Broadly, these participant accounts reflect a failure among treatment providers in various settings to identify and acknowledge PSB among current patient populations.

### **There is a Lack of Acknowledgement of PSB as a Worthy Area of Clinical Intervention**

Four of the five participants made note of a general lack of acknowledgement of PSB as a worthy area of clinical intervention within the field of psychology. Participant 1 described difficulty accessing services for patients due to a lack of willingness on the part of service providers to work with youth identified as having PSB:

Participant 1: We do have trainers in New Hampshire who will work with families, but I don’t know of any who will work with kids who have been found to be harmful in the sexually inappropriate manner, so I’m stuck.

Participants 2, 3, and 5 further addressed a lack of recognition, acknowledgement, and appreciation for PSB in psychology:

Participant 2: If somebody has problematic sexual behavior, they deserve good treatment, and I don't think it's viewed that way in the general field.

Participant 3: Recognition of, that this is a big issue and that this is a subset of the field that is really important.

Participant 5: I think generally it's an acknowledgement of it, first, that it's a worthy field.

Participant 5 spoke in greater detail about her experiences providing services to youth with PSB:

Participant 5: There were times early in my career where it was like, "Why do you want to work with *those people*?" Give me a break, this is exactly the people who need help. So the idea that it's a population that can't be helped, or they're not worthy, or whatever, because they have problematic sexual behaviors or they're destined to become adult sex offenders. . . . Those sort of uninformed, empirically unsound biases that could shape a person's career, when there's lots of need for this kind of work.

### **Stigma Carries Implications for Treatment/Availability of Services**

Three of the five participants referenced stigma in their interviews. Participant 2 identified stigma within the context of family treatment. He described clinician reluctance to include family members in treatment due to clinician discomfort around the topic of PSB:

Participant 2: I think with sexually offensive behavior, clinicians are a little bit more reluctant to do that, just because of stigma, because they're not comfortable talking about it. They're afraid that people are going to be offended.

Participant 5 reflected on the importance of language and spoke in detail about the stigma associated with labels commonly used when referring to patients who exhibit PSB:

Participant 5: Not "mentally ill sex offenders," not "those people," but to have a different context of understanding what we were talking about that was less stigmatizing than "sex offender," which is a very evocative label . . . in most systems . . . So there's a lot of work on that issue; stigma, over-pathologizing, over-estimating risk.

Participant 5: Once you identify [PSB] in the adolescent system, they're baked, I mean they're just cooked. They're labeled this particular way and it's very hard to get that label off.

Participant 5: [Being labeled a sex offender] is way beyond a personality disorder. It's even way beyond that, you know, he, in the context of psychosis, he killed somebody. This is the most pejorative thing that you can be. These are the lepers of our culture in such a way that there's very little space to change that idea.

Participant 5: [Stigma] is a huge barrier to appropriate services that discern risk in the best way possible and evidence-based best practice that we can apply that allows us to not paint everybody with the same brush, label them all incredibly dangerous, all that kind of thing.

Participant 3 referenced stigma within the context of larger society, including general perceptions about providing treatment to individuals who have demonstrated PSB:

Participant 3: The whole stigma of, why would you want to treat them, because they should just be thrown in jail. Or, you can't treat them, why are you even wasting your time? Or, what type of person would want to work with them? So the social stigma.

### **There is a Dearth of Formal Training or Education Provided**

Three participants shared their experiences of learning how to provide services to youth with PSB. Participants referenced a lack of training regarding both PSB and ND, and the need to seek independent/outside training. When asked about potential changes the field of psychology could make to better treat youth with PSB, Participant 1 said the following:

Participant 1: I'd like to have had training. Even at [graduate school], there was no such training in my assessment. . . . I learned by attending these conferences and taking advantage of people who are in the field.

Participant 2 noted the complexities involved when treating PSB in ND populations and the need for relevant training:

Participant 2: People need to get trained on neurodivergence. I think that's first and foremost. Just to understand that conceptually is critical, because you can't just walk in and treat somebody who has sexually problematic behavior who is neurodiverse. And if you don't understand neurodiversity, you just can't do it, because now it's playing two different ballgames. So again, that is critical to the doctoral-level training in the field of psychology. I never had any courses in it.

Participant 2: It'd be really nice if we had a doctoral course. And it's not covered anywhere, so in my education, I got nothing. I had to go to workshops to get outside

training. . . . I think the field needs to do tons and having every psychologist be—I mean, obviously they don't need to be expert, but they need to know the basics.

Participant 3 also shared her experiences of acquiring clinical knowledge and skills to work with ND/PSB youth:

Participant 3: It requires a lot of other learning. . . . I graduated 25 years ago, and it certainly wasn't information that I got in my program. There weren't classes on it. It was all information or learning that I had to do on my own outside of educational experience.

### **Theme 3: ND/PSB Youth May Benefit from Treatment that Emphasizes Skill-Building, Sexual Education, and Family Inclusion in Treatment**

The third and final superordinate theme was pertinent to treatment for ND/PSB youth and encompassed the following subthemes:

- Treatment for ND/PSB youth should emphasize education, skill-building, and social rules/boundaries.
- There are inherent differences between conceptualizing and treating NT and ND youth.
- Family involvement may have implications for treatment efficacy/outcomes.
- The sexual health of ND youth is not adequately addressed in available curriculum.

#### **Treatment for ND/PSB Youth Should Emphasize Education, Skill-Building, and Social Rules/Boundaries**

The first subtheme was reflected across four participant narratives. For instance,

Participant 2 described specific treatment strategies for working with ND/PSB youth:

Participant 2: As I often say, the population is not the problem . . . because it's not a difficult population to work with, at least in my experience, particularly if you explain and talk with them as human beings and explain what the rules are and why. And if they're unable to handle those rules, putting in restrictions, so that the rest of their life can be good.

Participant 2: We talk about asking . . . you know, “You must ask before you kiss.” And that becomes a whole treatment and a way of life.

Participants 3 and 6 further emphasized a concrete treatment approach:

Participant 3: The social cues, the boundaries, you have to explain that stuff to that population, because they don’t get it.

Participant 6: You’ve got to be very blunt. . . . I spend a lot of time correcting slang . . . and helping people with these disorders to better respect their bodies.

Participant 5 shared similar strategies within the context of specific treatment modalities:

Participant 5: You will never engage with a person on the spectrum if all you do is challenge them. You have to actually work more along the DBT console and you have to join where they are from their perspective, almost, and look at the world together, and then move toward changing that idiosyncratic, rule-based idea with them.

### **There are Inherent Differences Between Conceptualizing and Treating NT and ND Youth**

The second subtheme was found across three participant narratives. Participant 2 described the importance of communicating the differences between NT and ND youth in a consultant role within residential settings:

Participant 2: A lot of work around how to conceptualize somebody with autism who has sexually offensive behavior, and the differences in treatment between that and somebody who’s neurotypical because it’s two different, vast worlds.

Participant 2: That’s a whole different type of treatment that becomes more psychoeducation, that becomes more skill building, learning. Really talking about the legal system . . . that’s very different than somebody who understands all of that, at least conceptually, and then engages in a sexually problematic behavior. So it’s just very different treatment modalities of what you’re going to be doing.

Participant 2 also referenced differences specific to the conceptualization of PSB:

Participant 2: So an adolescent with autism who gets arrested for lewd and lascivious behavior because he’s out there, he gets sexually excited and starts masturbating because he sees something that is stimulating, well, that’s very different than somebody who is neurotypical and does that.

Participant 5 further elaborated on the differences between NT and ND individuals:

Participant 5: It's complicated when you, when you're born, and you are learning about social connection by your visual gauge being drawn to it and focusing on it and learning all those subtle cues as a neurotypical person, and not doing that as a neuroatypical person. Of course you're going to be different socially. Of course your brain is going to be wired differently. And of course it's going to have profound challenges and differences as you move into your social world, which is all around us like the air we breathe.

Participant 5: I'm saying that we do not honor their differences enough; we do not recognize how difficult it is to move in a highly social world when you are socially blind.

Moreover, Participant 6 named an area of focus that may not be adequately emphasized in treatment. Participant 6 stated, "Specific to the [non]neurotypical world, we've got to be much better at helping them to understand the risks."

### **Family Involvement May Have Implications for Treatment Efficacy/Outcomes**

Three participants reflected this subtheme in their responses. Participant 1 spoke to the importance of including family therapy in the recommendations section of an assessment report, stating, "So the result of my evaluation always includes family therapy." Participant 2 referenced the role of family therapy in treatment. More specifically, he emphasized the importance of including caregivers in treatment:

Participant 2: So you set up boundaries, and really engaging [caregivers] in a treatment and saying, this may not be forever. . . . Because, quite frankly, they're more important than the therapist often, because they're with [the adolescent] 24/7. The therapist sees somebody for an hour a week, maybe in group. So really engaging them in becoming part of the treatment, with the person in the room.

Participant 5 discussed the positive impact that early family support can have on ND/PSB youth:

Participant 5: Some of the clients have been seen by their parents and they've gotten treatment and they've been sort of moved along in a different way than someone who has had it not recognized at all, who has been told that they're just idiots and that they don't understand anything and they're stubborn and all those kinds of things.

## **The Sexual Health of ND Youth is Not Adequately Addressed in Available Curriculum**

**The final subtheme was represented in three participant accounts. Participant 1 reflected inadequate sexual education for both NT and ND youth:**

Participant 1: The neurotypical kid . . . isn't taught sexuality, rather is taught sex. . . . For the child who has autism, [education] is not approaching boundaries well enough, and for the neurotypical it's not even talking about sexuality.

Participant 5 referenced the societal and clinical tendency to either pathologize the normal sexual desires of ND individuals or to disregard their need for healthy sexual expression altogether:

Participant 5: Systemically, the notion tends to be that folks with any kind of disability within IDD services or within mental health services . . . either they have no sexual needs, or their sexual needs are pathologized and out of control. So they're either sort of disinhibited and dysregulated and hypersexual on one hand, or it doesn't matter and we don't talk about it with them.

Participant 6 also noted a lack of appropriate sexual education for ND/PSB youth and emphasized a treatment approach that includes thoughtful dialogue around healthy sexual expression and boundaries:

Participant 6: So what we're educating kids on sexually needs to be thoughtful. In terms of [non]neurotypical kids, assume that they're going to respond to their body first. And any information you've given them, if they respond to that at all, it's way down on their list.

Participant 6: I would first of all say, assume any adolescent you're seeing is sexually active. Make that assumption. However, do not make the assumption that that adolescent has accurate sexual information, because they likely don't.

## **DISCUSSION**

The current study examined five clinicians' perspectives regarding the treatment and assessment of ND/PSB youth. In this section, the meaning of the results is explored and expanded upon within the context of relevant literature. Implications for clinical work, study limitations, and suggestions for future research are additionally offered. Finally, concluding

thoughts summarize the overarching themes of the study, relevance of the findings, and my opinions on the findings and reflection as the researcher.

**Theme 1: A Comprehensive System of Information Gathering and Assessment is Indicated for Evaluating ND/PSB Youth**

Found across all participant accounts with assessment experience, this theme suggests the need for a well-rounded assessment process, including initial information gathering/intake, test selection, and administration. The rationale for comprehensive assessment is reflected by the subthemes; for instance, IQ alone is limited in its ability to illustrate an individual's level of functioning, particularly regarding ND individuals. Research suggests individuals with IDD may score on the extreme low end of standard IQ assessments, contributing to flooring effects and inaccurately reflecting the individual's true abilities (Sansone et al., 2014).

In addition, biopsychosocial factors associated with IDD are more highly correlated with specific cognitive strengths and weaknesses than with global IQ. Therefore, the same IQ score could represent vastly different cognitive and functioning profiles in individuals with IDD. Bertelli and colleagues (2018) recommend refraining from using language such as “intellectually below average” in favor of “neuropsychological characterization” to enhance interpretability and utility of IQ measures.

The lack of precision in the meaning of IQ scores for ND populations has potentially problematic implications due to the significance IQ scores hold. In most systems, an IQ of 70 or below is used to identify and diagnose an intellectual disability. Such a diagnosis is then used to inform the need for clinical and educational services (Sansone et al., 2014). Therefore, ND individuals may be treated according to an IQ score that may or may not accurately reflect their true needs, and is often insufficient for recommending specific treatment interventions or



accommodations. For instance, an individual with severe adaptive behavior concerns could maintain an IQ above 70, which would misrepresent their capacity for daily functioning. Therefore, this could have significant implications regarding their ability to obtain services (Bertelli et al., 2018). The emphasis on IQ indicates a discrepancy between systemic and clinical perceptions of ND youth, and suggests that clinicians should be explicit when discerning what the IQ does or does not mean for the individual.

The subthemes further indicate the potential for significant confounding variables when gathering data for ND/PSB youth. Participants identified such variables, including caregiver denial, complex diagnostic history, and a lack of historical data. In addition, Morrison (2022) noted that youth with ASD may be more likely to receive a personality disorder diagnosis than their NT peers. Thus, clinicians should pay particular attention to the impact of neurodivergence on an adolescent's personality development to improve the accuracy of differential diagnoses (Morrison, 2022). Both participant accounts and available research indicate the need for rigorous and multi-axial information gathering to account for as many diagnostically relevant factors as possible (Blasingame, 2018).

In addition to a comprehensive intake interview and review of records, a well-rounded assessment battery is clinically indicated (Blasingame, 2018). This process is emphasized in participant accounts; however, it is important to note the degree of variability within individual participant descriptions of their assessment battery. For instance, Participant 1 described IQ, personality, and psychosexual measures, while Participants 3 and 5 discussed risk measures, measures of adaptive functioning, and intake measures. Participant 6 endorsed use of risk measures and an in-depth sexual history, and emphasized the importance of assessing reading

level. While there was overlap in each account, participants differed in the degree of emphasis placed on domains of functioning.

Such variability of assessment measures may be beneficial, as it leaves room to tailor each battery to the individual patient. This is of particular importance given the indication for highly individualized assessment and treatment for ND/PSB youth (ATSA, 2017). Alternatively, inconsistency among clinicians could suggest a range of benchmarks being used by evaluators, as well as judges, social workers, and other entities involved in the decision-making process regarding treatment and/or criminal justice outcomes. Of note, ATSA (2017) guidelines recommend including measures of adaptive/functional behavior into assessment protocols of ND/PSB youth.

Interestingly, none of the specialized tests referenced in the literature were named by the participants (e.g., ACSBI, J-SOAP-II, ERASOR, J-SORRAT-II, SBSQ). This is likely due to the lack of standardization of measures specifically designed for youth who exhibit PSB (Blasingame, 2018; Wijetunga et al., 2018). One exception was the STATIC-99, used by Participants 3 and 5. Of note, current research suggests that the STATIC-99 has not been normed for adolescents and may lack sufficient reliability for assessing risk (i.e., overestimate; Viljoen et al., 2012). Thus, when comparing participant reports to current available literature, there appears to be a discrepancy between the research and actual clinical application. In other words, the tests suggested for use with this population may not be the tests that clinicians actually use.

It is important to recognize that clinicians have few options for test selection, given the weak reliability of these measures (Friedrich et al., 2004; Viljoen et al., 2012). These findings suggest a dearth of solid, evidence-based research for this population, which has implications for providing quality assessment and treatment for youth with PSB, particularly for those with

comorbid neurodivergence. As noted in the results, being labeled a sex offender/high-risk carries significant stigma and has the potential to follow an adolescent well into their adulthood, impacting educational, social, financial, and other aspects of their lives. Given the stakes of these assessments, it is imperative that measures of risk be normed and validated for the target population. This would require the psychological field to devote time and resources into thoroughly conducting and substantiating research on the assessment of ND/PSB youth.

Participants also reported difficulty gathering accurate information from caregivers. For instance, one participant noted that parents may present with denial regarding their child's behavior. Such reluctance from parents could be related to a number of concerns, including fear of their child being labeled as a sexual offender and subsequent feelings of hopelessness. They may also perceive the behavior as non-sexually motivated and therefore not wish to address the sexual component. Further, they may be reticent of judgment from the clinician. Indeed, many parents of ND/PSB youth have experienced shame from systemic resources and may appear defensive toward the evaluator. Thus, clinicians may find it beneficial to make a concerted effort to reduce parent anxiety and provide nonjudgmental reassurance to obtain buy-in and facilitate enhanced cooperation (Blasingame, 2011).

Participants also noted that ND/PSB youth frequently present with extensive diagnostic histories. According to Participant 5, this is likely a result of not being "seen" or perceived accurately throughout their development. Indeed, ND youth are more likely to be diagnosed with a personality disorder due to the impact of their disability on personality development (Morrison, 2022). This suggests that clinicians should broaden their awareness of neurodivergent presentations among youth, particularly regarding PSB. Considering neurodevelopment early on

may offer more clarity and reduce the likelihood of an adolescent carrying a misleading and potentially stigmatizing diagnosis.

**Theme 2: There are Several Barriers to Providing Effective Treatment for ND/PSB Youth**

The subthemes identified within this superordinate theme suggest that potential barriers to providing treatment begin prior to providing services to ND/PSB youth. For instance, two of the four subthemes reflect obstacles to preparing treating clinicians, in the form of inadequate intradisciplinary support and resources. A lack of acknowledgement of PSB as a worthy area of clinical intervention could suggest less awareness and encouragement around this subspecialty and inadvertently discourage budding clinicians from pursuing such work. In addition, the need for clinicians to intentionally seek out relevant training experiences may not only discourage potential providers but could also suggest a lack of standardized training experiences among practitioners.

In addition to not receiving specialized training, participants also expressed the need for doctoral programs to implement courses on ND/PSB within the general curriculum. This is particularly salient when considering a potential lack of recognition of PSB among pre-established patients. Indeed, Participants 2 and 3 alluded to potential ethical implications of providing services to ND/PSB individuals without having even a basic level of competence for facilitating interventions with this population. Therefore, the recommendation appears to be that training be available not only to those who wish to specifically pursue work with this population but to all mental health clinicians as part of generalist training.

Participants also note the impact of stigma as a barrier to receiving services among ND/PSB youth. Based on participant accounts, stigma can be identified along all stages of the treatment process, and indeed follow youth as they develop into adulthood. At the systems level,

stigma may impact the providers/systems who are willing to work with youth identified as having PSB. It may also attach labels to youth that may or may not accurately reflect their behaviors with respect to context, cognitive functioning, development, personality, mental health symptoms, and other factors.

In addition, such a label may affect outcomes, including influencing whether a youth receives treatment or becomes involved in the juvenile justice system. Indeed, Stevenson and colleagues (2015) suggest a high correlation between sexual crimes and biasing emotions such as fear, disdain, and disgust. Their research found that disgust, more than any other emotion, predicted negative reactions toward youth with sex offense histories and led to increased placement of juveniles on the sex offender registry. These findings occurred in spite of the fact that juveniles are significantly less likely than adults to recidivate and that empirical research advises of the counterproductive harm caused by sex offender registration policies (Stevenson et al., 2015).

### **Theme 3: ND/PSB Youth May Benefit from Treatment that Emphasizes Skill-Building, Sexual Education, and Family Inclusion in Treatment**

The third and final theme reflects strategies for improving treatment efficacy among ND/PSB youth. In order to appreciate the strengths of these strategies, it is critical to first acknowledge that there are fundamental differences between NT and ND youth with regard to conceptualization and treatment. In other words, having an understanding and an appreciation for the developmental capacity of the adolescent is essential toward conceptualizing their problematic sexual behavior in order to structure an effective treatment plan.

Different conceptualizations do not necessarily mean that certain treatment modalities would not be appropriate for both NT and ND youth with PSB. For instance, ATSA (2017)

supports “cognitive-behavioral, skills-based, and multi-systemic approaches that involve caregivers in treatment” for youth with PSB, regardless of neurodevelopment. However, it is important to recognize that factors such as developmental level, cognitive capabilities, and adaptive functioning may impact responsiveness to treatment. Therefore, certain treatment modalities (e.g., visual, experiential, simplified language) may be particularly effective with ND/PSB youth (ATSA, 2017).

One such strategy recommended by participants is an emphasis on skill building. This could include a wide range of skills, depending on the individual’s present level of functioning. For example, skills may include communication, reading social cues, establishing social rules, self-regulation, and sex education. With respect to sex education, there are several factors to keep in mind regarding ND/PSB youth. First, in contrast to their NT peers, they are unlikely to have learned healthy sexuality from their social environments as a result of prejudice, isolation, and barriers to opportunities for experiencing intimacy. In addition, their parents may be less likely to acknowledge their child’s sexual development, and therefore less likely to discuss healthy sexual functioning with their children (Blasingame, 2011).

Broadly, clinicians treating ND/PSB youth must be aware that neurodiversity presents several challenges that are potentially less relevant to NT/PSB youth; and, within the framework of neurodiversity is a vast range of functioning and abilities, meaning treatment should always be thoughtfully tailored to the individual. Such degrees of variability may include level of cognitive impairment, level of social interest, communicative abilities, emotional responsiveness, and mental age. Generally, clinicians should use concrete, simple language and utilize multimodal techniques (e.g., visual aids; Blasingame, 2011).

Participants also made note of the need for adequate sexual education for ND/PSB youth. While it is possible that some youth receive sex education in school, it likely would not include sexual safety, health and hygiene, and social aspects of sexuality that are critical to helping ND/PSB youth maintain safe and appropriate behavior (Blasingame, 2011). Providers should assess the extent of the youth's sexual knowledge and whether they understand potential consequences for PSB. They may also need explicit guidelines for how to discern between appropriate and inappropriate partners, which becomes further complicated when trying to differentiate between chronological age and mental age of potential partners. It is also important for clinicians to discuss ways for ND youth to express their sexuality in a non-problematic manner (ATSA, 2017).

Finally, participants noted the importance of family involvement in providing treatment to ND/PSB youth. Research supports this subtheme, suggesting that caregiver support can have a significant impact on treatment outcome (Blasingame, 2011). In addition, research suggests that caregiver sense of engagement is critical to maintaining family support. In fact, parental motivation to help their children subsequently increased youth response to treatment, in spite of obstacles including transportation, scheduling, and lack of service availability (Shields, 2020). Therefore, mental health providers should make a concerted effort to enhance caregiver motivation and engagement. One possible method for achieving this is to instill hope and provide education about the treatability of PSB (Shields, 2020). As noted by Participant 5, treatability is an often unacknowledged facet of PSB; not only in society but specifically in the world of psychology. Thus, it appears we must better educate each other as mental health providers, in order to better educate families, thereby increasing the likelihood of positive treatment outcomes for ND/PSB youth.

## **Limitations**

There are several limitations to consider with respect to the current study. First and foremost, it is important to acknowledge the homogeneity of the sample. All participants were White, practicing in New England, with doctoral degrees. As such, there is a lack of diversity among clinician perspectives and, therefore, an absence of information sensitive to cultural factors represented in these results. In addition, these participants collectively had decades of experience, which may or may not be reflective of new mental health professionals entering the field. Further, two participants specifically endorsed being somewhat removed from the most recent assessment protocols for this population.

In addition to the homogeneity of the sample affecting the generalizability of the results, the size of the sample also has such effects. Smaller sample sizes make it difficult to generalize assumptions about the appropriateness of the results for all mental health clinicians working with ND/PSB youth. However, qualitative research, with its in-depth analysis, necessitates a small sample size. Thus, there are inherent effects of the sample size on the generalizability of results in qualitative research.

Another limitation of the current study relates to the interpretability of questions. While, in many ways, this is a strength that allows for a range of perspectives, it also likely impacted the results of the study. For instance, there were several significant themes with many supporting statements that could not be included due to only occurring among two participant accounts. If given a more structured (e.g., forced choice) format, it is possible that these themes could have been more prevalent.



### **Directions for Future Research**

As mentioned, the small sample size suggested for IPA necessarily limits the generalizability of results. Therefore, a quantitative approach to exploring clinician's perceptions of assessment and treatment of ND/PSB youth is recommended. In addition, future research could delve more deeply into variations in need among subgroups of youth with PSB. For example, further discernment among neurodiverse populations, such as between those with ASD versus IDD, could be beneficial in identifying gaps in treatment and assessment for these youth. Additional research focused on female or transgender youth would be similarly useful. Specific to assessment, future efforts should focus on the effects of different adolescent age segments on PSB and risk assessment tools. Finally, research should continue to be conducted on available assessment tools to increase their reliability and efficacy with NT and ND adolescent populations.

### **Conclusion**

The current study analyzed the responses of five doctoral-level mental health clinicians regarding their perceptions of providing treatment and assessment to ND/PSB youth. The outcome of the analysis resulted in the following overarching themes: (a) a comprehensive system of information gathering and assessment is indicated for evaluating ND/PSB youth; (b) there are several barriers to providing effective treatment for ND/PSB youth; (c) ND/PSB youth may benefit from treatment that emphasizes skill-building, sex education, and family inclusion in treatment. Each of these themes yielded several implications for the mental health field.

The first superordinate theme reflected a clear need for comprehensive information gathering and a well-rounded battery for assessing ND/PSB youth. This theme also offered several recommendations to clinicians providing assessment, including the following: (a)

evaluators should consider the relative significance of IQ as it pertains to the individual and be explicit in communicating these findings; (b) evaluators should be nonjudgmental to mitigate parental anxiety and increase cooperation; and (c) clinicians should consider and rule out neurodevelopmental disorders during assessment. Based on participant responses in this category and available research, it can be gathered that there is no well-validated, empirically sound measure for evaluating and assessing risk with ND/PSB youth, nor is there a consistent approach to this task.

As illustrated by participant accounts, clinicians vary in their approach to assessment with ND/PSB youth. This, in my opinion, represents a strength of the field, wherein clinicians are able to individually tailor their testing protocol based on their familiarity with measures, clinical judgment, and the referral question. The most significant discrepancy arises when examining measures of risk. In stark contrast to measures for juveniles, adult risk measures are thoroughly researched, well-validated, and require training to utilize. The lack of a comparable measure for adolescents suggests an ethical concern for potential overestimation of risk.

The second superordinate theme illustrated the need for intradisciplinary support and education for providers of ND/PSB youth. Based on the emergent themes, I would summarize these findings by acknowledging that barriers to effective treatment for ND/PSB youth start in the mental health field. The absence of standardized training and education, combined with a general lack of awareness and appreciation for the intersection of neurodivergence and PSB among professionals, suggests ethical considerations regarding the quantity and quality of services available to ND/PSB youth. In addition, participants highlighted the tendency for individuals with PSB to be overlooked in a variety of mental health settings. Without proper

education on how to assess for PSB among pre-established patients, an individual could be actively involved in treatment yet engaging in a pattern of behaviors that could be causing harm.

Finally, the third superordinate theme provided support for multi-modal, integrative, and individualized approaches for enhancing treatment efficacy with ND/PSB youth. Participant responses and available literature offer a compelling argument for incorporating tailored sex education into treatment and prioritizing family involvement wherever possible.

Based on the above findings, I conclude with the following recommendations. Further research should be conducted to identify a reliable measure of risk for NT and ND youth with PSB, and additional training/education is indicated. In my opinion, such training need not be extensive. The goal should be to establish basic competence in treatment and assessment of neurodevelopmental and intellectual disabilities and the intersection of neurodivergence and high-risk behaviors, such as PSB. Addressing these recommendations could enhance our ability as mental health providers to ensure empirically based, ethical, and appropriate services for ND/PSB youth in our care and address our responsibility to promote community safety and minimize harm.

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**APPENDIX A: LISTSERV FLYER**

To Whom It May Concern,

My name is Emily Marhan, and I am currently a doctoral candidate in the Department of Clinical Psychology at Antioch University New England. I am conducting a study for fulfillment of my dissertation, under the supervision of my advisor, Dr. Katherine Evarts Rice. The purpose of my dissertation is to explore the perceptions of mental health clinicians who treat both neurotypical and neurodivergent adolescents who exhibit problematic sexual behavior.

Neurodivergence may include youth with intellectual or cognitive disabilities, Autism Spectrum Disorder, or other developmental disorders. Problematic sexual behavior refers to verbal or physical nonconsensual sexual acts perpetrated against another person. Such acts may or may not be the primary reason a client is seeking treatment, but should be significant enough that it warrants targeted treatment goals that address the behavior. If you have any interest in participating, please let me know, and we can set up a time to interview (approximately 45-60 minutes, audio recorded). If participation in this study is not feasible for you at this time, for whatever reason, I understand and greatly appreciate your time and consideration.

Sincerely,

Emily Marhan



**APPENDIX B: RECRUITMENT EMAIL**

Dear [ *insert name* ],

My name is Emily Marhan, and I am currently a doctoral candidate in the Department of Clinical Psychology at Antioch University New England. [ *insert shared contact name* ] referred me to you as a potential participant in the study I am conducting for fulfillment of my dissertation, under the supervision of my advisor, Dr. Katherine Evarts Rice. The purpose of my dissertation is to explore the perceptions of mental health clinicians working with adolescents, both neurotypical and neurodivergent, who exhibit problematic sexual behavior. If you have any interest in participating, please let me know, and we can set up a time to interview (approximately 45-60 minutes). If participation in this study is not feasible for you at this time, for whatever reason, I understand and greatly appreciate your time and consideration.

Sincerely,

Emily Marhan

## APPENDIX C: INFORMED CONSENT

You are invited to participate in a qualitative research study that seeks to explore clinician perspectives of treating neurodiverse adolescents who exhibit problematic sexual behavior. If you are currently working as a mental health clinician and have experience treating and assessing neurotypical and neurodivergent youth who display problematic sexual behaviors, you are eligible to participate in this study. This study is being conducted as a part of my dissertation fulfillment and will be completed under the supervision of my advisor, [DISSERTATION CHAIR].

1. **PURPOSE OF THE PROJECT:** This study seeks to investigate the specific needs of adolescents who display problematic sexual behavior, as well as compare the differences in need between those who are neurotypical and those who are neurodivergent. This study further seeks to explore the strengths and limitations of current methods of assessment and treatment and identify key considerations for future methods.
2. **PROCEDURES:** As a participant, you will be asked open-ended questions in the form of a one-on-one interview, not to exceed an hour in length. Some examples of questions you may be asked include, “What is your experience of treating adolescents who engage in problematic sexual behavior?”; “What is most challenging about treating ND youths who engage in problematic sexual behavior?”; “What changes would you like to see made to current assessment models?” You will not be asked to identify yourself and interviews will be recorded, transcribed, and analyzed qualitatively. Non-identifying quotes will be used.
3. **BENEFITS OF PARTICIPATION:** Although there are no expected direct benefits of your participation in this study, a potential benefit may be providing useful insight into ways of adapting available assessments and treatments. In addition, findings may better inform other clinicians of the different needs between neurotypical and neurodivergent adolescents (where applicable), which may improve therapeutic approaches with these youth, as well as further inform future treatment and assessment modalities.
4. **RISKS:** There are no anticipated risks regarding your participation in this study. A potential inconvenience will be the time it takes to complete the interview (45-60 minutes), conducted via Zoom or telephone.
5. **CONFIDENTIALITY & ANONYMITY:** The records of this study will be kept private, including audiotaped interviews, and only I will have access to the interview data. Any report of the study will include a deidentified description of your relevant work experience sufficient to provide context (e.g., licensed clinical social worker with five years’ experience treating adolescents in an inpatient setting). You are not asked to write your name or any other information that may identify you. Your responses will be kept confidential and stored on a password-encrypted computer owned by the primary researcher.

6. REFUSAL/WITHDRAWAL: Taking part in this study is voluntary. If you choose to be in the study, you can withdraw at any time without consequences of any kind.
7. DEBRIEFING: As there are no anticipated adverse consequences from participation, there will be no formal debriefing. However, if you have any questions about the study, please contact the primary researcher at [EMAIL].

If you have any questions regarding your rights as a research participant, you may contact [DISSERTATION CHAIR], Core Faculty of the Department of Clinical Psychology of Antioch University New England ([EMAIL]) or [NAME], Chair of the Antioch University New England Human Research Committee ([PHONE #]; [EMAIL]).

By signing below, I agree that I have read this information and have had the study purposes, procedures, risks, and benefits explained to my satisfaction. I agree to be recorded via audio recording device during the interview, and I acknowledge that the recording feature will not be turned on without my knowledge or verbal consent. My signature indicates my informed consent to participate in the study.

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Signature

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Date

## APPENDIX D: INTERVIEW QUESTIONS

- 1) Tell me a little bit about your professional background and experiences.
- 2) Please tell me about your experience working with adolescents who exhibit problematic sexual behavior.
  - a) Please tell me about your experiences specifically with those who were neurodiverse.
- 3) What has your experience been like treating NT and ND youth who exhibit problematic sexual behavior?
  - a) Most challenging?
  - b) Most rewarding?
- 4) Have you noticed any differences in the treatment needs of youth with intellectual or developmental disabilities, compared to their neurotypical peers?
- 5) What assessment measures have you used with these adolescents?
  - a) How would you describe your experience of working with this/those measure/s?
  - b) Are there any changes you would make to this/these measure/s to make it/them more accurate/effective?
- 6) What should clinicians be aware of when treating adolescents who display problematic sexual behavior?
  - a) With specific regard to those who are neurodiverse?
- 7) In your experience and opinion, what changes would you like to see made in the field of psychology in order to better treat neurodivergent youths who exhibit problematic sexual behavior?

**APPENDIX E: DEMOGRAPHIC QUESTIONNAIRE**

Racial Identity:

Gender Identity and Pronouns:

Years of Professional Practice (e.g., 1990-present):

Number of Years Working with Adolescents with Problematic Sexual Behavior:

## APPENDIX F: EXPERIENTIAL AND EMERGENT THEMES

Superordinate Theme	Emergent Theme
<p>A comprehensive system of information gathering and assessment is indicated for evaluating ND/PSB youth.</p>	<p>A comprehensive battery is indicated for addressing PSB with ND youth.</p> <p>IQ should not be considered as fully representative of functioning and/or ability.</p> <p>ND/PSB youth may present to assessment with barriers to information gathering.</p>
<p>There are several barriers to providing effective treatment for ND/PSB youth.</p>	<p>There is a lack of clinical recognition of PSB among pre-established patients.</p> <p>There is a lack of acknowledgement of PSB as a worthy area of clinical intervention.</p> <p>The stigma associated with PSB carries implications for treatment/availability of services.</p> <p>There is a dearth of formal training or education provided.</p>
<p>ND/PSB youth may benefit from treatment that emphasizes skill-building, sexual education, and family inclusion in treatment.</p>	<p>Treatment for ND/PSB youth should emphasize education, skill-building, and social rules/boundaries.</p> <p>There are inherent differences between conceptualizing and treating NT and ND youth.</p> <p>Family involvement may have implications for treatment efficacy/outcomes.</p> <p>The sexual health of ND youth is not adequately addressed in available curriculum.</p>

## APPENDIX G: EMERGENT THEMES AND SUPPORTING QUOTATIONS

Emergent Theme	Supporting Quotation
<p>A comprehensive battery is indicated for addressing PSB with ND youth.</p>	<p>I do a full IQ. I use the Milan series of the MACI and the MPACI. I use the Reynolds series. I use the Beck series. I did, and do, just a complete psychological, evaluation. And somewhere in there, I either weave through questions about sexuality . . . And the MASOC questionnaire as well.</p> <p>We use STATIC-99, ABLE. We had an assessment tool, this kind of assessment intake tool, that wasn't standardized, that was specific to the school.</p> <p>I'll do an in-depth interview with parents. I think it's the ADOS I might use. But I also use the SRS which is the Social Responsivity Scale . . . only when it's applicable, sometimes it's not applicable. . . . But, with regards to the more standard sex offender measures, the STATIC-99-R.</p> <p>I always verify IQ . . . my preference is to use the Stanford-Binet. . . . I also always do the Woodcock-Johnson Achievement tests, because they're quick to do, and courts understand those.</p> <p>I always do a clinical interview and then, depending on the case, I will do one of the standardized risk assessments for sexual offending. I can never remember the names and they all have alphabet soup for their titles. But I use at least one of those standards because it looks at the demographics . . . because I do an in-depth sexual history.</p> <p>I think a missing piece for many evaluators is they don't look at the reading level. They don't look at what they comprehend.</p>

IQ should not be considered as fully representative of functioning and/or ability.

And I mean, a lot of old-school psychologists are like, the IQ is the IQ. No, it isn't.

Most of the people that we work with that have problematic sexual behavior are actually a little bit more higher functioning than 70 but because of other neurocognitive factors that impaired their ability on test taking, but they had a whole bunch of skills that were much higher than people with intellectual disabilities, so these are the people that fall through the cracks.

I have a theory that some of the guys in prison, that we identify as having learning disability actually have mild intellectual developmental disorder. And they passed for normal through most of school, or we educated them out of that mild level of intellectual developmental disorder. And now they've got an IQ of 71, so they don't qualify for services . . . and now, because we've got this artificial number and we didn't look at his functioning, we've got a problem.

ND/PSB youth may present to assessment with barriers to information gathering.

They're referred to me as, "my son"—from the parents—"my son was found to have inappropriately touched a girl, and I don't think it was a big deal, he was just exploring." So to begin with, there's a denial. And throughout the assessment there's a denial.

And one thing I think is helpful for clinicians too, especially if they're meeting with clients who come with testing or other information, if you can get ahold of that early on, it can be really helpful. . . . Usually, they don't come to me with all that stuff, but if they do, I get it as soon as I can. . . . And I mean, I think there will be a better connection if you're more informed. And sometimes you can't be.

The lack of information about the kiddo who comes to me is really the toughest part of assessing these kids.



There is a lack of clinical recognition of PSB among pre-established patients.

So I'm looking for history and early development and things like that, and how they did or did not get treatment or were perceived as, "Oh, he's just stubborn," which happens a lot. Or they have 25 diagnoses, because they can't figure out, you know, at age 10 that they're on the spectrum.

My guess is people are seeing people in individual therapy who have sexually problematic behaviors and [the therapists] don't know. That's not okay.

I believe that every psychologist needs to know . . . because they're going to see it and miss it. And that's just not right.

I think the clinicians today . . . also have to realize, even if they're not knowingly working with offender populations, they might be. . . But I think you have to ask, because if you're not, if you don't know that information and [are not] addressing it however the client wants to, you missed a key piece of work.

When I first started going into the hospitals, I would have units tell me, "Well, we don't have anybody like that here." Well, actually, you do.

There is a lack of acknowledgement of PSB as a worthy area of clinical intervention.

We do have trainers in New Hampshire who will work with families, but I don't know of any who will work with kids who have been found to be harmful in the sexually inappropriate manner, so I'm stuck.

If somebody has problematic sexual behavior, they deserve good treatment, and I don't think it's viewed that way in the general field. Recognition of, that this is a big issue and that this is a subset of the field that is really important.

I think generally it's an acknowledgement of it, first, that it's a worthy field.

There were times early in my career where it was like, “Why do you want to work with those people? Why do you want to waste your talent on those people?” Give me a break, this is exactly the people who need help. So the idea that it's a population that can't be helped, or they're not worthy or whatever, because they have problematic sexual behaviors or they're destined to become adult sex offenders. . . . Those sort of uninformed, empirically unsound biases that could shape a person's career, when there's lots of need for this kind of work.

Stigma carries implications for treatment/availability of services.

I think with sexually offensive behavior, clinicians are a little bit more reluctant to do that. Just because of stigma, because they're not comfortable talking about it, they're afraid that people are going to be offended.

The whole stigma of, why would you want to treat them, because they should just be thrown in jail. Or, you can't treat them, why are you even wasting your time? Or, what type of person would want to work with them? So the social stigma.

Once you identify [PSB] in the adolescent system, they're baked, I mean they're just cooked. They're labeled this particular way and it's very hard to get that label off.

[Stigma] is a huge barrier to appropriate services that discern risk in the best way possible and evidence based best practice that we can apply that allows us to not paint everybody with the same brush, label them all incredibly dangerous, all that kind of thing.

Not “mentally ill sex offenders,” not “those people,” but to have a different context of understanding what we were talking about that was less stigmatizing than “sex offender,” which is a very evocative label . . . in most systems . . . So there's a lot of work on that

There is a dearth of formal training or education provided.

issue; stigma, over-pathologizing, over-estimating risk.

I'd like to have had training. Even at [graduate school], there was no such training in my assessment.

I learned by attending these conferences and taking advantage of people who are in the field.

I think a branch of a certification ought to be for neurodivergent kids.

People need to get trained on neurodivergence. I think that's first and foremost. Just to understand that conceptually is critical, because you just can't walk in and treat somebody who has sexually problematic behavior who is neurodiverse, and if you don't understand neurodiversity you just can't do it because now it's playing in two different ballgames. So again, that is critical to the doctoral level training in the field of psychology. I never had any courses in it.

I think the field needs to do tons and having every psychologist be - I mean obviously they don't need to be expert, but they need to know the basics.

It'd be really nice if we had a doctoral course. And it's not covered anywhere, so in my education, I got nothing. I had to go to workshops to get outside training.

It requires a lot of other learning. . . . I graduated like 25 years ago, and it certainly wasn't information that I got in my program. There weren't classes on it. It was all information or learning that I had to do on my own outside of educational experience.

Treatment for ND/PSB youth should emphasize education, skill-building, and social rules/boundaries.

We talk about asking . . . you know, "You must ask before you kiss." And that becomes a whole treatment and a way of life.

As I often say, the population is not the problem. It's the people who are treating them and the people who are responsible for them. Because it's not a difficult population to work with, at least in my experience, particularly if you explain and talk with them as human beings and explain what the rules are and why. And if they're unable to handle those rules, putting in restrictions, so that the rest of their life can be good.

The social cues, the boundaries, you have to explain that stuff to that population, because they don't get it.

You will never engage with a person on the spectrum if all you do is challenge them. You actually have to work more along the DBT console and you have to join where they are from their perspective, almost, and look at the world together, and then move towards changing that idiosyncratic rule-based idea with them.

You've got to be very blunt. . . . I spend a lot of time correcting slang . . . and helping people with these disorders to better respect their own body.

There are inherent differences between conceptualizing and treating NT and ND youth.

A lot of work around how to conceptualize somebody with autism who has sexually offensive behavior, and the differences in treatment between that and somebody who's neurotypical because it's two different, vast worlds.

That's a whole different type of treatment that becomes more psychoeducation, that becomes more skill building, learning. Really talking about the legal system. . . . That's very different than somebody who understands all of that, at least conceptually, and then engages in a sexually problematic behavior. So it's just very different treatment modalities of what you're going to be doing.

It's complicated when you, when you're born, and you are learning about social connection by your visual gauge being drawn to it and focusing on it and learning all those subtle cues, as a neurotypical person, and not doing that, as a neuroatypical person. Of course you're going to be different socially. Of course your brain is going to be wired differently. And of course it's going to have profound challenges and differences as you move into your social world, which is all around us like the air we breathe.

So an adolescent with autism who gets arrested for lewd and lascivious behavior because he's out there, gets sexually excited and starts masturbating because he sees something that is stimulating. Well that's very different than somebody who is neurotypical and does that.

Specific to the [non]neurotypical world, we've got to be much better at helping them to understand the risks.

I'm saying that we do not honor their differences enough; we do not recognize how difficult it is to move in a highly social world when you are socially blind.

Family involvement may have implications for treatment efficacy/outcomes.

So the result of my evaluation always includes family therapy.

So you set up boundaries, and really engaging [caregivers] in a treatment and saying, this may not be forever. . . . Because, quite frankly, they're more important than the therapist often, because they're with them 24/7. The therapist sees somebody for an hour a week, maybe in group. So really engaging them in becoming part of the treatment, with the person in the room.

Some of the clients have been seen by their parents and they've gotten treatment and they've been sort of moved along in a

The sexual health of ND youth is not adequately addressed in available curriculum.

different way than someone who has had it not recognized at all, who has been told that they're just idiots and that they don't understand anything and they're stubborn and all those kinds of things.

The neurotypical kid . . . isn't taught sexuality, rather is taught sex. . . . For the child who has autism, [education] is not approaching boundaries well enough, and for the neurotypical, it's not even talking about sexuality.

Systemically, the notion tends to be that folks with any kind of disability within IDD services or within mental health services . . . either they have no sexual needs, or their sexual needs are pathologized and out of control. So they're either sort of disinhibited and dysregulated and hypersexual on one hand, or it doesn't matter and we don't talk about it with them.

I would first of all say, assume any adolescent you're seeing is sexually active. However, do not make the assumption that that adolescent has accurate sexual information, because they likely don't.

So what we're educating kids on sexually needs to be thoughtful. In terms of [non]neurotypical kids, assume that they're going to respond to their body first. And any information you've given them, if they respond to that at all, it's way down on their list.

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