Section 4: Treatment

Use Slide #1: Treatment of Juvenile Sex Offenders

As you are all aware, treatment is a key component of a comprehensive approach to juvenile sex offender management. So, over the next couple of hours, I am going to highlight some of the key issues involving treatment interventions for sexually abusive youth.

The goal of this component of the training is not to make specialized clinicians out of any of you, or to go into great detail about specific aspects of treatment. Rather, the aim is to provide you with a broad overview of treatment for these youth, and to give you a sense for some of the emerging research and practice relative to juvenile sex offender treatment.

Use Slide #2: Key Topics for the Treatment Section

We will begin by discussing trends specifically related to the availability of specialized programs for juvenile sex offenders, as well as some changes that have occurred in the juvenile justice landscape that relate to rehabilitation overall. Then I will provide you with the "big picture" of what juvenile sex offender treatment often "looks like," by highlighting the common goals of treatment and the underlying frameworks and modalities that are often used to help youth and their families achieve these goals. After that, we will review the areas that are typically targeted in juvenile sex offender treatment programs. Before wrapping up this section, I will draw your attention to some areas that pose challenges to practitioners in the field and, in some instances, are very controversial. And finally, we will end with a brief synopsis of some of the follow-up data and treatment outcome literature for sexually abusive youth.

Goals

At the end of this section of the curriculum, participants will be able to understand:

- National trends relative to treatment programming for juvenile sex offenders;
- How changes in the juvenile justice system in recent decades have affected intervention approaches for juvenile sex offenders;
- Common components and targets of juvenile sex offender treatment, including treatment goals, program philosophies and theoretical models, and treatment modalities;

- Challenges and controversies related to juvenile sex offender treatment; and
- What the current available literature tells us about treatment outcomes for juvenile sex offenders.

Part I: Program Availability and Settings

You may be surprised to learn that juvenile sex offender treatment is – relatively speaking – a new area of focus within juvenile justice. In fact, as we mentioned earlier during the training, it was not all that long ago that some behaviors which we would now consider to be sexually abusive were chalked up to being "just a phase" or were excused with a "boys will be boys" way of thinking.

And because these youth were not receiving much attention in the field, only a handful of specialized treatment programs existed for them. In fact, it has been reported that in the early 1980s, there were only 20 identified programs for treating juvenile sex offenders.[1] That's pretty amazing, isn't it?

Once professionals' attention to juvenile sex offenders began to increase, however, the number of treatment programs for these youth increased dramatically.

Use Slide #3: Availability of Juvenile Sex Offender Treatment Programs Nationwide

So when the Safer Society Foundation began to formally survey programs across the nation a few years later – in 1986 – there were nearly 350 juvenile sex offender treatment programs.[2] And over the past several years, the number of programs providing treatment for juvenile sex offenders has continued to grow. The most recent survey indicates that there are now well over 900 juvenile sex offender programs across the country![3]

Use Slide #4: Program Settings for Juveniles: Community vs. Residential

Program Settings

As you can see, most of these treatment programs for youth are community-based, although there are a sizable number of residential or institutional treatment programs as well. Together, these programs provided treatment to nearly 20,000 sexually abusive youth during the year that they were surveyed.[4] It is interesting to note, however, that although residential settings accounted for only about one-fourth of all of the juvenile sex offender treatment programs, *nearly half* of those 20,000 youth were treated in those residential programs!

Certainly, we know that not all juvenile sex offenders need to be sent to a residential or institutional setting to receive treatment, but we also know that not all youth can be safely treated in the community. But how do we determine which youth should be treated in a residential program, and which can be allowed to remain in the community?

(ALLOW FOR AUDIENCE RESPONSES.)

That's right – many factors must be considered when making that determination. Remember, juveniles who commit sex offenses are a diverse and heterogeneous population. Some youth pose a greater risk than others, some youth have more treatment needs than others, some youth are more amenable to treatment than others, and some youth may have families that are more supportive and stable than others.

This highlights, once again, that because juvenile sex offenders are not all alike, assessments are very important for making informed decisions. And in this particular context, it is important that the individual risks and needs of each youth are assessed in order to make the most appropriate decision about the type of treatment setting that the youth needs and that will allow for victim and community safety. Remember, one size does not fit all!

To illustrate, a youth who evidences considerable behavioral disturbances or aggression, demonstrates longstanding or chronic patterns of sexual deviance, resides in a chaotic home environment, and has considerable treatment needs may be best served in a residential program. And if the youth suffers from significant mental health symptoms that cause him to be a danger to himself or others, an inpatient psychiatric setting may be warranted.

Conversely, a juvenile who seems to be more stable overall, has a supportive and structured home environment, has demonstrated a limited number of sexual behavior problems, and is motivated to change will probably be considered appropriate for treatment in the community.

Use Slide #5: Continuum of Treatment Settings

What this means is that treatment services for juvenile sex offenders should be available along a continuum, with community-based services on one end, and residential or even institutional or correctional treatment programs on the other end. Where any individual youth receives treatment – and the kinds of interventions that are used – should be based on the level of risk and needs of that youth. In addition, a youth's placement along that continuum of care may change over time, as his or her circumstances change, either for the better or for the worse.

For example, if a youth is placed in the community, but continues to have difficulty managing his behaviors and community safety is compromised considerably, then he may require a more restrictive or structured setting. On the other hand, when a youth who is initially placed in a residential program progresses in treatment, and the family needs are addressed sufficiently, it may be appropriate to allow him to return home to continue in treatment in the community.

Community-Based Treatment

As always, there are pros and cons for these alternatives. What are some advantages of providing sex offender treatment in a community-based program?

(ALLOW FOR AUDIENCE RESPONSES.)

Use Slide #6: Benefits of Community–Based Treatment

Yes, community-based treatment has a number of benefits. It allows a youth to remain with or close to home and family, continue attending school locally, develop or maintain prosocial peer relationships, and practice skills and competencies in his or her natural environment. And it is oftentimes less costly to provide community-based services.

But, there may be some "down sides" to community-based treatment as well. For example, in community settings, treatment may only be offered once or twice per week – so it tends to be less intensive. In addition, some youth who remain in the community may still have access to victims, or may be more vulnerable to high risk situations, and therefore cannot be safely managed within a community treatment context.

And in some instances, certain stakeholders' expectations for accountability, punishment, and community protection may not be fully met when the youth remains in the community and is not receiving intensive interventions.

Residential or Institutional Treatment

Some of the concerns with community-based treatment can be addressed through the availability of residential or institutional programming for juvenile sex offenders.

Use Slide #7: Benefits of Residential Treatment

Residential programs can provide a unique opportunity for youth to be "immersed" in more intensive treatment services and to be exposed to a therapeutic milieu around the clock. In addition, for youth who pose a danger to

themselves or others, the structured – and sometimes secure – environment provides for victim and community safety, and ensures that the youth is accountable at all times.

And for youth who have demonstrated an unwillingness to comply with treatment and supervision expectations in the community, placement in a residential or institutional setting can send a strong message to them and to others about the seriousness of the behavior, while still offering them the opportunity to address treatment needs that can ultimately allow them to return to the community.

What are some of the "down sides" of institutional or residential treatment?

(ALLOW FOR AUDIENCE RESPONSES.)

Yes, just as there are pros, there are also cons. On the negative side, residential and institutional programs are generally more costly than community-based services. And removing a youth from the community can be very disruptive, particularly when the youth is separated from potential positive community influences and roles within the family and school. In addition, there is a significant potential for these youth to be exposed to more deviant peers, which may impact their own development, progress, and adjustment, and which may actually undermine some of the benefits of residential treatment.[5]

Indeed, there is research indicating that in some circumstances, when youth are placed with other delinquent peers for the purposes of intervention, outcomes may be poorer and they may be more prone to recidivism.[6] This is a result of what has been termed "deviancy training," which can be so strong that it negates the potential positive impact of the treatment interventions. Overall, these findings may not be particularly surprising, given the broader body of research showing that youth who associate with negative or delinquent peers tend to continue getting into trouble over time.[7]

The potential for deviancy training in residential or institutional programs is a current concern in the field of juvenile justice overall – and in the juvenile sex offender management field specifically – which has led some professionals to question the common use of these types of placements for some youthful offenders.[8] In fact, because of the potential negative impact of aggregating youth for the purposes of intervention, some professionals may even have reservations about the usual practice of providing sex offender treatment to juveniles in a group context – regardless of whether it is in a residential or community setting. On the other hand, much of the research, albeit not well controlled research, that demonstrates positive outcomes from juvenile sex offender treatment has typically included programs that used a group modality.[9]

Presently, there is no "answer" to this controversy, and only further research will help provide more guidance for practitioners. Suffice it to say that the potential

for deviancy training should be considered when implementing treatment programs and reviewing placement options for youth.

One could speculate that deviancy training and the associated negative outcomes may be more likely to occur when there is no rehabilitative focus within the juvenile justice setting. In other words, simply "locking up" these youth with other delinquent or violent youth may be especially problematic. And we have concrete evidence that more punitive approaches – particularly absent any rehabilitative efforts – are not likely to lead to the desired results with youth in the juvenile or criminal justice system.[10]

This is a perfect lead into our next topic – the shifting philosophies within the juvenile justice arena that have occurred over time.

Part II: Rehabilitative Trends in the Juvenile Justice System

Before we go any further with a specific discussion about treatment for juvenile sex offenders, I'd like to spend a few minutes highlighting some broader trends that relate to treatment and rehabilitation in the juvenile justice system overall. Considering some of these historical shifts over time may help put our more current approaches with juvenile sex offenders into context, and may explain – at least to some degree – the increase in programming for juvenile sex offenders over the past several years. It is also salient given the issues involving deviancy training that we just outlined.

Juvenile Crime Wave and "Get Tough" Approaches

As you are probably aware, separate juvenile and family courts were initially established in large part because of the recognition that adolescents differ from adults, that adolescents may not necessarily have the same "criminal minds" as adults, and that the courts' responses to delinquent behavior should focus on the individual needs of the youth and their families. Providing treatment and other rehabilitative services was, therefore, a primary focus within earlier years of juvenile justice. Over time, however, some began to question whether or not the rehabilitative efforts of the juvenile courts were being effective in reducing crime among youth.

In particular, this became an issue in the late 1980s and during the mid 1990s, when there was a fairly sharp rise in violent crimes committed by juveniles – sometimes referred to as the "juvenile crime wave." And in response to this increase in youth-perpetrated violence, nearly all of the states in the country made sweeping changes to their juvenile statutes in what became known as a "get tough on juvenile crime" era.[11]

Use Slide #8: "Getting Tough" on Juvenile Crime

Among the typical reforms were reductions in the lower age by which youth could be tried as adults, elimination of the strict confidentiality guidelines for some juvenile court records and proceedings, the establishment of mandatory minimum sentence structures for juvenile crimes, and the reduction of judicial discretion in the juvenile and family courts.[12]

As a result of these widespread juvenile crime reforms, the emphasis on treatment and other rehabilitative services was largely replaced by a focus on punishment and incapacitation. And the responses from juvenile and family courts managing delinquency cases began to look much more like the responses from adult criminal courts. In fact, increasing numbers of youth were transferred to the adult courts for disposition. So, the rehabilitative philosophy shifted within the juvenile justice system, and the prevailing philosophy was to "treat juveniles like adults." Overall, it was believed that this would result in increased community safety.

Impact of "Get Tough" Approaches

In recent years, some of these reforms have been called into question because of concerns about the impact of these changes and whether or not community safety has been enhanced by them.[13] Generally, in order to examine the impact of these trends, researchers have compared the recidivism rates of juveniles who were transferred to the adult courts and subsequently received more punitive, adult-oriented, criminal court sanctions to similar groups of juveniles who remained under the jurisdiction of the juvenile and family courts and received juvenile-oriented dispositions. And what they found may be surprising to some of you.

Use Slide #9: Impact of Adult Dispositions on Youthful Offenders

Youth who received adult dispositions and sanctions recidivated much more often than youth remaining in the juvenile justice system, with some studies indicating that these youth were much more likely to recidivate – in some instances, having double the likelihood![14] In addition, these youth were successful for much shorter periods of time upon release from custody. In other words, they recidivated at much *faster* rates – twice as fast in some instances.[15] And when they recidivated, youth who received adult dispositions tended to commit more serious types of crimes.[16]

Also worth noting is that, compared to youth processed in the juvenile courts, youth who received adult dispositions were less likely to receive treatment and other rehabilitative services and were more likely to receive longer sentences.[17] Longer sentences of incarceration are certainly more costly, and do not appear to reduce recidivism significantly among juveniles – in fact, incarceration may be associated with increased recidivism.[18]

And sadly, researchers found that adult-processed youth are more likely to be victimized violently or sexually in adult facilities and are more prone to suicide.[19]

Taken together, it seems fairly evident, then – as these researchers concluded – that the shifts in the juvenile court philosophies and approaches did not produce the desired results. As a result, we've experienced a return to a more balanced approach to juvenile justice, with a goal of reducing recidivism by using methods and approaches that have been found to "work" with juvenile offenders. Many of you are probably familiar with this growing trend, which has been referred to a shift toward "evidence-based practices," or interventions that have been found to be effective in reducing recidivism with juveniles.

The Movement Toward Evidence-Based Rehabilitative Practices

Fortunately, there is a fairly considerable body of research that can provide guidance to juvenile justice practitioners and policymakers about what kinds of rehabilitative services can be most effective with juveniles. Through meta-analyses – whereby researchers combine multiple studies to determine the overall effect of various treatment approaches – several types of interventions have been found to "work" with juvenile offenders. And other approaches simply "don't work."

And although it is beyond the scope of this training to provide a comprehensive review of the range of interventions that "work" with juvenile delinquents in general, it might be informative nonetheless to highlight a few of them to give you a sense for what the research has shown. Moreover, some of these approaches may have some applicability to juvenile sex offender treatment.

Use Slide #10: Examples of Evidence–Based Interventions for Youth

Because of the good scientific evidence that exists for these three approaches, I'll highlight Wraparound Services, Functional Family Therapy, and Multisystemic Therapy. And then we'll continue our discussions about juvenile sex offender treatment specifically.

Wraparound Services

As its name suggests, the idea behind the wraparound strategy is to surround youth with a range of needed services in the community, ideally to prevent them from requiring a residential or institutional placement.[20] Generally speaking, with the wraparound approach, a case manager is responsible for identifying and brokering needed services for the youth and family. The case manager also tends to assume supportive, mentoring, and accountability or supervisory roles. Oftentimes, jurisdictions that utilize a wraparound approach rely on pooled resources and multidisciplinary collaborative teams comprised of key

stakeholders from social services, juvenile justice, and mental health agencies in order to serve these youth and their families more effectively.

Research suggests that wraparound approaches are very promising, as evidenced by improvements on many clinical and social variables, and with reductions in recidivism of nearly 15 percent.[21]

Functional Family Therapy

Another promising approach for youth – both in terms of prevention and intervention – is known as Functional Family Therapy (FFT), which addresses multiple areas associated with delinquency and which has a primary emphasis on the dynamics and structure within the family unit.[22] A key goal is to enhance the ability of the parents or caregivers to provide adequate structure, limits, discipline, and support. FFT has been used for over thirty years with delinquent youth and their families, and the research has consistently demonstrated that youth who participate in FFT have significantly lower rates of recidivism relative to comparison groups of youth receiving other interventions, such as individual therapy; in fact, researchers have found that FFT reduces recidivism by as much as 25 percent.[23] Because it is a relatively short-term intervention with low costs, FFT certainly appears to be a very cost-effective approach that "works" with juveniles.

Multisystemic Therapy

Yet another intervention that seems to "work" with delinquent and violent youth is Multisystemic Therapy (MST).[24] Similar to Functional Family Therapy, MST is an intensive, family-based treatment approach that is designed to address the multiple factors that are associated with delinquent or antisocial behavior, including individual, family, peer, and community influences. And because it is important that youth and their families learn to effectively function and become autonomous, the treatment plans are developed collaboratively between the family and the treatment provider – and MST interventions are delivered in the youth's natural environment: home, school, and community.

Some common goals for MST include improving family functioning, enhancing parenting skills, increasing the youth's associations with prosocial peers, improving school performance, and building upon community supports. The research indicates that these and other positive goals are often attained in a cost-effective manner; and that recidivism rates of youth are reduced by more than 30 percent.[25]

You may be aware that MST may be something that "works" with juvenile sex offenders as well.[26] Specifically, preliminary research revealed that when juvenile sex offenders and their families participated in MST interventions, family functioning, school performance, peer relations, and behavioral adjustment all

improved, and sexual and non-sexual recidivism rates were significantly lower than those for the comparison groups.[27] Near the end of this section of the training, we'll talk a bit more about this promising research with sexually abusive youth.

Cognitive-Behaviorally Based Juvenile Sex Offender Treatment

So as you have seen, there are a number of other interventions in the juvenile justice field that are supported by the research. And one of them – MST – has been applied to the treatment of juvenile sex offenders, but it is still relatively new as a strategy for these youth. The approach to treatment that has been used most often with juvenile sex offenders is the cognitive-behavioral model. Although well-designed and rigorous treatment outcome research on juveniles remains very limited, the available evidence seems to suggest that this approach can have a positive impact and may significantly reduce recidivism among these youth.[28] And that is, in the broadest sense, the overarching goal of sex offender treatment: to reduce future victimization.

Part III: Goals of Treatment and the Frameworks and Modalities to Meet These Goals

Common Treatment Goals

Beyond the most fundamental and broad goal of treatment – to reduce sexual victimization – what do you believe some of the more *specific* goals of juvenile sex offender treatment might be?

(ALLOW FOR AUDIENCE RESPONSES.)

Use Slide #11: Common Treatment Goals

That's right – there are several key treatment goals for juvenile sex offenders.[29]

- We don't expect youth to completely acknowledge all of their problem behaviors at the moment they enter treatment. Some level of denial is common and is probably normal. However, by participating in treatment over time, youth are expected to take full responsibility for their sex offending and other problem behaviors.
- Once youth "own" their behaviors, we ultimately hope that that they will be motivated to change them. As such, another important treatment goal for the youth involves identifying the various issues or factors that contributed to or are somehow associated with their sex offending and other problem behaviors. In some juvenile sex offender programs, this goal is referred to as identifying "red flags" or risk factors. Other programs refer to this goal as teaching youth to identify their "cycles" or "behavior chains" or

"pathways." Regardless of the specific terminology, the idea behind this goal is that there are oftentimes a number of different factors that, in combination, lead a youth "down the path" to sex offending or other problem behaviors.

- By identifying these contributing elements or risk factors, youth are better positioned to intervene in the future and stop themselves before going all the way "down the path." This is yet another common goal of treatment. In other words, we expect that youth will develop healthy coping skills that can offset these risk factors. So, when risk factors present themselves, or when the youth finds himself or herself going "down the path," so to speak, he or she is able to turn back.
- Another treatment goal for juveniles in sex offender treatment is that they will develop prosocial skills and competencies, including, for example, effective communication styles, positive ways in which they can express their feelings, consideration to the feelings of others, and healthy social interactions with others. The common thread that holds these issues together under this goal is that by acquiring these prosocial skills and competencies, youth will be more likely to become healthy, well-adjusted, productive, and successful as individuals, at school or work, with peers, and at home – all of which are linked to the last two goals that you see on this slide.
- As we have discussed already, it is important that juvenile sex offender treatment extends beyond a focus on the youth alone. Rather, treatment must address the multiple determinants of sex offending or delinquent behaviors. Therefore, additional goals of treatment are to assist youth with establishing positive peer relationships and to promote healthy family functioning.

You may have noticed that these treatment goals are not limited to issues of sexual deviance or sex offending. In fact, some of these goals are much more broad in nature. That's because juveniles who commit sex offenses are not simply "sex offenders." Such a label, even though we commonly use it, implies a very narrow view of these youth and their associated needs. And when you think about it, we don't tend to think of other youth in such a narrow way – defining them based on just one of the behaviors that they have exhibited – do we? And frankly, none of us would want to be defined by only one aspect of our behavior, would we?

(ALLOW FOR BRIEF RESPONSE OR REACTION FROM AUDIENCE.)

Put simply, we must consider these youth holistically, with an overarching goal of promoting healthy, well-adjusted youth. And when we expand our thinking to consider the "whole" person, rather than focusing only on their sex offending behaviors, the common targets of treatment appear less "sex offense-specific" in nature. In fact, because treatment is generally designed to promote overall

wellness among the youth who receive it, the phrase "sex offense-specific treatment" may actually be somewhat of a misnomer.

In many ways, truly comprehensive, holistic, and integrated interventions for juvenile sex offenders resemble more general delinquency-oriented approaches – but with an additional focus on sex offending behaviors. And actually, this makes a lot of sense when we consider the prior delinquent histories of these youth. Several studies have found that many juvenile sex offenders have had prior contact with the juvenile courts for non-sexual delinquency.[30]

Relatedly, the emphasis on more holistic treatment approaches makes sense in light of the non-sexual recidivism rates of these juveniles. In fact, you may be surprised to learn that, as a group, these youth tend not to recidivate with new sex offenses; rather, experts have reported that sexual recidivism rates are quite low for these youth, and that if and when they do recidivate, it tends to be for general delinquent, non-sexual behaviors.[31] This suggests that these youth are not simply "specialists" in sex offending.

Use Slide #12: These Youth Aren't "Specialists"

In one particularly interesting study,[32] researchers followed a large number of juvenile sex offenders throughout the remainder of their adolescence and into young adulthood to see how many of them committed new sex offenses versus other types of crimes. Over half of these youth had a prior history of non-sex offenses. And as you can see, a considerable proportion went on to engage in other kinds of *non-sexual* criminal behavior as adults. Only a very small percentage was re-convicted for new sex offenses as adults. However, of that small group of sexual recidivists, nearly three-fourths were *also* reconvicted of non-sexual offenses!

Since these youth do not appear to be "specialists," it makes sense that approaches to treatment are designed to be holistic and comprehensive, doesn't it? That way, we hope to lessen the potential not only for sexual recidivism, but also for other types of delinquent or criminal activity.

So let's talk, then, about how we attempt to help youth attain the goals that have been identified. In other words, what does treatment "look like" for these youth? What vehicles do treatment providers use to get them there? And what are the frameworks and approaches to sex offender treatment for juveniles?

Frameworks for Treatment

We'll start by reviewing the models commonly used as a foundation of juvenile sex offender treatment. As we discussed earlier, for the most part, treatment programming for juvenile sex offenders has been largely modeled after adult sex offender treatment programs.[33] Understandably, this has been the source of

quite a bit of controversy in recent years, given the growing recognition of some important differences between adult and juvenile sex offenders.[34] Indeed, it is very important that treatment programs for juveniles take into account these differences, as well as the developmental issues that are common during the period of adolescence.

And of course, it is important that treatment for these youth addresses the multiple determinants of their behavior problems. As I highlighted earlier, MST is a very good example of such an approach, and it appears to be a promising model for juvenile sex offender treatment. Yet only a handful of treatment programs for juvenile male sex offenders – less than 7 percent – report that their primary approach is multi-systemic in nature.[35] By far, most treatment programs, when listing the primary theory that drives treatment in their juvenile programs, endorse cognitive-behavioral approaches.[36] Many programs also report using relapse prevention frameworks for treating sexually abusive youth.[37] So let's talk about what those theoretical frameworks are all about.

Use Slide #13: Most Common Theoretical Frameworks Reported Nationwide

Cognitive-Behavioral

In the most broad and basic terms, cognitive-behavioral approaches assist individuals with changing patterns of thinking that are unhealthy or dysfunctional and that impact the way in which they ultimately feel and behave. The focus tends to be on the "here and now" of how one thinks, feels, and behaves – and less on trying to identify "root causes" of the person's behavior. In addition, cognitive-behavioral approaches focus on helping people develop and practice new skills and competencies. As such, cognitive-behavioral treatment is not simply "talk therapy," so to speak. Rather, it is structured and directive, and relies on the use of homework assignments so that clients are able to consider and practice strategies in the "real world," outside of treatment sessions.

Cognitive-behavioral approaches are effective for treating a range of symptoms and disorders including depression, anxiety, obsessive-compulsive disorders, eating disorders, relationship problems, and anger management difficulties – to name just a few. In fact, because of the extensive research support, the use of cognitive-behavioral interventions is often cited as a key to effective programming in criminal and juvenile justice systems.[38] And again, cognitive-behavioral treatment is currently the most popular model for sex offender treatment, and the one for which there appears to be the most research support.[39]

In the more traditional sense, the cognitive-behavioral framework for juvenile sex offender treatment has focused primarily on the youth alone. But as you know, it is also important to address other influences in the youth's life, such as peers,

environment, and family variables. This is probably one of the reasons that MST seems to have so much promise. So, in order to be more comprehensive in their approaches, the emphases in treatment programs should also address family and other environmental elements.

Relapse Prevention

Relapse prevention is a subset of the broader cognitive-behavioral framework. You may already know that relapse prevention was originally developed and found to be effective for addictive disorders such as gambling and substance abuse and, of course, it has since been applied to sex offender treatment.[40] Generally speaking, relapse prevention is designed around a "no cure" philosophy. In other words, treatment does not "fix" the person or make the problem behavior "disappear." Rather, relapse prevention is considered to be a long-term behavior management strategy.

Through relapse prevention treatment, sexually abusive individuals learn to identify a range of risk factors – which are often a combination of thoughts, feelings, and situations – that increase their likelihood of engaging in problem behavior in the future, and then they develop and practice effective coping strategies to deal with, or manage over the long-term, these risk factors.[41] Relapse prevention also helps people to effectively deal with the inevitable lapses, slip-ups, or near-misses that occur as they struggle with maintaining change.

For sex offender management, the relapse prevention model also includes an external, supervisory dimension, because it was recognized that relying solely on the individual offender to manage his or her behavior may not be sufficient, and that other supports should be put in place to assist the offender [42] We'll talk more about that component when we get to the supervision section.

I should note, though, that some experts have expressed concerns with some of the traditional applications of relapse prevention with juvenile sex offenders because of the "no cure" philosophy.[43] For example, given the research that suggests low sexual recidivism rates for these youth, emphasizing a "no cure" approach may be misleading in some ways. In other words, the strict application of the traditional relapse prevention model to juveniles may result in these youth being labeled as "incurable."

In turn, this may even cause people to believe that juveniles who commit sex offenses are destined to continue into adulthood, which we know is not the case. And it may cause youth to feel hopeless and reduce feelings of self-efficacy and optimism. Inadvertently, this could lead to a self-fulfilling prophecy. As a result, some practitioners who work with juvenile sex offenders have adapted the relapse prevention model to be more developmentally and socioecologically sensitive, including modifying the language, style, and approach to activities and

treatment tasks and reframing the "incurabilty" emphasis to avoid the potentially negative impact it may have on self-esteem, motivation, and confidence to make positive life changes in treatment.[44]

Which Framework Should be Used?

We've briefly discussed Multisystemic Therapy, the cognitive-behavioral approach, and relapse prevention as frameworks for providing treatment to juvenile sex offenders. And you may be wondering which one is the *best* to use with these youth.

Some experts have argued that there are insufficient rigorous and well-controlled studies of juvenile sex offender treatment approaches to indicate which models of treatment are most effective or more superior to others.[45] For now, in the absence of a comprehensive and well-designed series of empirical evaluations, we will focus our discussions around what seems to have the most support – albeit limited – and the model that most programs seem to be using. Keeping in mind the limitations and concerns of the field in its current state, the remainder of this section of the training will describe programming for juvenile sex offenders that is delivered within the cognitive-behavioral and relapse prevention framework.

Suffice it to say that as we continue to learn about these youth, their similarities to and differences from adult sex offenders, and the types of interventions that "work" – and work best – with these youth, it will be important that we adjust our approaches to treatment for sexually abusive youth.

Treatment Modalities

Let's spend just a few minutes discussing the vehicles by which treatment is provided within the cognitive-behavioral and relapse prevention framework.

Group Therapy

The most common treatment modality is the use of groups, with up to ten youth per group. Having more than that in a group can make the group more difficult to manage, and doesn't allow enough "air time" for each of the youth to be able to work through their issues when the group meets. Some groups are more traditional "therapy" groups, in which specially-trained mental health professionals use specific therapeutic techniques, strategies, and processes, and the dynamics of the group as a whole, as a means of addressing clinical issues.

Other groups are psychoeducational in nature, which means that the facilitator of the group – who may or may not be a mental health professional – provides instruction about specific topics or issues to the group. Although group members are often expected to relate to their own circumstances the information which is

being “taught,” the group is more didactic in nature. In other words, it appears much more like “classroom” instruction than a group therapy session.

Individual and Family Therapy

Although group treatment is the most common mode of clinical intervention with juvenile sex offenders, professionals in the field generally agree that treatment should also include individual and family therapy.[46] The use of individual and family interventions with youth is important for several reasons.

Use Slide #14: Multiple Modes are Important

- First of all, if treatment programs truly intend to be individualized, holistic, and comprehensive, it is probably unreasonable to believe that the range of needs of each youth can be adequately addressed within a group setting. The time factor alone must be considered. For example, given the number of participants in a group, it is hard to imagine that each youth will have sufficient time on a week-to-week basis to process all that they need to.
- Second, some issues may be too sensitive to discuss initially – if at all – within a group setting. For example, the group context may not be the best place to discuss a youth’s own victimization or his or her struggles with sexual identity. And certain types of family problems and dynamics within the family cannot be addressed effectively in the youth’s treatment groups.
- Third, responsivity factors may impact the ability of some youth to respond to the group format, or may not lend themselves to being addressed in a group. For example, for youth who have co-occurring mental health difficulties, these needs may be more effectively addressed outside of the group, as the group tends to be geared toward the common issues and needs of all of the group members.
- And we know that some youth – for a host of reasons – simply may not respond to a group format. Examples could be emotional immaturity or considerable behavioral disturbances. And of course, a youth’s level of intellectual or cognitive functioning may certainly limit the ability of the youth to understand, contribute to, or “keep up with” the other group members and the group process.
- Finally, let’s not forget that some professionals have concerns about group interventions in general because of the potential negative impact that may arise when aggregating delinquent youth for the purpose of intervention. For that reason, they may elect not to include certain youth in certain types of treatment groups, if they choose to use groups as a means of intervention at all.

Use Slide #15: Use of Various Modalities Nationwide

As you can see, it is very promising that the majority of juvenile sex offender programs across the country report that they do not rely exclusively on group as the only mode of treatment; rather, these treatment programs appear to use a more comprehensive and integrated approach by incorporating group, individual, and family interventions.[47] However, simply because these programs indicate that they use these modalities does not mean that they are used at a high frequency. In fact, the data suggests that the absolute numbers of hours of services provided on an individual or family basis remains very low, especially compared to units of service for group therapy.[48]

Part IV: Common Treatment Targets

By now, you've probably begun to get a sense for the areas that might be addressed in treatment, through group, individual, or family interventions, or some combination of these modalities. So this is probably a good time to discuss more specifically the common targets of treatment.

Common Treatment Targets

Broadly speaking, these issues have become common targets of treatment primarily because they are thought to be related either to the initiation of sex offending behaviors, related to the continuation of sex offending behaviors in the future, or both.[49] And as we just discussed, many of these targets are designed to increase adaptive, healthy, and prosocial functioning overall – not just in terms of a youth's *sexual* behaviors. As such, you will also note that the words "sex" or "sexual deviance" do not appear in most of the items on this list.

Use Slide #16: Common Treatment Targets

Responsibility-Taking

Of course, treatment programs for juvenile sex offenders focus on helping the youth take responsibility for his or her sex offending behaviors. It is hard to imagine that a youth can learn how to manage their sexual behavior problems – or any other problem behaviors, for that matter, if they don't first acknowledge that they have engaged in the behavior.

And again, it is common for youth to present to treatment professionals with some form of denial, such as denial that they engaged in the behavior at all, or a certain aspect of the offense. Or they may blame other people or other things for their offending behaviors, rather than taking full responsibility. So, offense accountability becomes an important focus of treatment.

Cognitive Distortions or Thinking Errors

Similarly, the majority of treatment programs for juvenile sex offenders address thinking errors, or cognitive distortions. In other words, even though many youth who commit sex offenses are probably aware that these kinds of behaviors are illegal or harmful, they engage in the behavior anyway. In order to do so, these youth often distort their thinking – beforehand, during, and afterward – to give themselves "permission" to commit the offense, to feel "okay" about doing something that they know is wrong, and to avoid considering the harm they are causing. These cognitive distortions take the form of minimizations, excuses, justifications, and rationalizations.

It is important to note that cognitive distortions are not unique to juvenile sex offenders or to sex offending behaviors. Rather, we all use cognitive distortions to allow ourselves to engage in certain behaviors, like "cheating" on a diet, driving in excess of the speed limit, or coming in late to work. For example, what are some cognitive distortions that you have used to allow yourselves to drive in excess of the posted speed limit?

(ALLOW FOR AUDIENCE RESPONSES.)

Yes, those are some very good examples. And again, it highlights that using cognitive distortions is a common practice for all of us. They key is to help youth identify these distorted ways of thinking, help them understand *why* they use cognitive distortions, and help them identify more adaptive and healthy ways of thinking.

Victim Empathy

Another similar emphasis in treatment involves victim empathy enhancement. This component of treatment is designed to assist youth with recognizing the short- and long-term impact of their abusive behaviors on victims and others. Part of victim empathy enhancement involves helping youth identify and anticipate emotions in others, engage in perspective-taking exercises in which they attempt to put themselves in the victim's shoes, so to speak, and more fully explore the types of reactions and feelings that their victims may have experienced. It is believed that if youth understand the harmful impact of their behaviors, they may be deterred from engaging in similar behaviors in the future.

Additional Intra- and Interpersonal Skills

Since we know that many juveniles who commit sex offenses have difficulties with interpersonal and intrapersonal skills, treatment programs also commonly target issues such as social skills, anger management, stress management, and problem solving. This may involve teaching youth to become more assertive and self-confident, helping them manage discomfort in social situations, working with

youth to identify healthy ways to express their emotions, and assisting them with managing conflict and solving the kinds of problems that may be encountered on a day-to-day basis.

Healthy Sexuality and Sex Education

In order to promote healthy sexuality, teach youth about sexual development, and provide important information about safe and responsible sexual practices, sex education is commonly provided in juvenile sex offender programs.

Relationship Skills

And along those lines, some programs provide interventions that are designed to help youth develop and maintain healthy relationships or enhance intimacy in relationships. Oftentimes, this involves helping youth recognize and understand that sex does not equal intimacy. Rather, intimacy is about closeness, sharing, emotional connectedness, and – in some ways – vulnerability. Helping youth learn to manage difficulties in relationships, such as jealousy and rejection, may be emphasized as well.

Healthy Masculinity

It is also important that adolescent males develop a healthy sense of masculinity, rather than holding more aggressive, hostile, and dominating beliefs about what it means to be a "man." Because some of these youth have been exposed to male-modeled violence and aggression, treatment programs should help youth "unlearn" the negative patterns of problem-solving, conflict resolution, and inequity in relationships.

Arousal Control

Remember that a key difference between adult and juvenile sex offenders is that deviant sexual arousal is less common among juveniles. That may be one reason that arousal control interventions tend not to be nearly as common as a target of treatment for youth in programs nationwide. Of course, for those youth who do appear to have deviant sexual interests or preferences, treatment programs will need to address them.

Trauma Resolution

Since a significant proportion of juvenile sex offenders have experienced trauma in their lives – for example, as a victim of physical, emotional, or sexual abuse themselves, or being exposed to maltreatment or domestic violence in the home – treatment programs for these youth often include interventions designed to address or resolve traumatic experiences.

It is important that a youth's own experiences with victimization are not used as an "excuse" for his or her offending behaviors. It may be, however, that by addressing their own victimization, youth may be better able to consider the impact of *their* offenses on *their* victims. In addition, through trauma resolution interventions, these adolescents can learn to develop healthy ways of dealing with the unpleasant or negative thoughts and feelings, rather than resorting to unhealthy outlets for expressing their thoughts and feelings.

Family Functioning

Finally, a critical target of treatment involves the family. As you know, it is important to consider youth within the context of their families and environments, and make sure that treatment addresses any concerns or needs that are identified. For some families, treatment may be necessary to help parents, caregivers, and others deal with the shame, guilt, or other emotional reactions that are common to these circumstances. And for other families, a focus of treatment may be on increasing their abilities to enhance communication skills, establish firm structure and limits, provide adequate supervision, and maintain healthy boundaries. Also, because many youth commit sex offenses against younger family members, family interventions will need to take into account the needs and interests of the victim, the dynamics of the family as a whole, and the potential for family reunification.

Use Slide #17: Treatment Targets in Programs Nationwide

So those are among the common targets of treatment for sexually abusive youth. And when we look at the data from the juvenile sex offender treatment programs across the country that responded to the most recent Safer Society Survey,[50] it is clear that the vast majority of the responding programs address those very issues. But just because treatment programs offer interventions to address these needs or deficits, it does not mean that every youth should receive each of these interventions The goal is to create an individualized treatment plan for each youth, and one that is based on good assessment information.

Process-Related Variables

Now that we've covered some of the important frameworks and content for treatment, I'd like to spend a few minutes talking about process-related issues. Remember, our style and approach when interacting with youth and their families can have either a positive or negative impact on their willingness to engage in assessment, treatment, and supervision processes.

For example, as we discussed during the assessment section of this training, working hard to develop a trusting and respectful professional relationship – in contrast to an adversarial and harsh relationship that is based on the power of your position – can enhance the likelihood that the youth and his or her family will

be willing to engage more fully in the process. And as a reminder, there are a couple of specific models of engaging clients – such as the Invitations to Responsibility and the Motivational Interviewing approaches – that can be helpful for tailoring your style to interacting with these youth and their families.[51]

Some of the same process-related considerations should be applied to our approaches to treatment, too, although for many years, some practitioners were not nearly as mindful of them. In fact, not all that long ago, it was fairly commonplace for treatment providers to use a very harsh confrontational style of interacting with sex offenders. Part of the underlying rationale seemed to be that sex offenders were incredibly resistant to intervention, and that in order to break through denial, get them to see how serious their crimes were, see the errors of their ways, and give them a "wake up" call, so to speak, it was assumed that the therapist needed to resort to an adversarial – and sometimes even shaming and hostile – approach. Perhaps there was a concern among professionals that using a more therapeutic tone might undermine the treatment process by minimizing the seriousness of the crimes and leaving the therapist vulnerable to manipulation by the offender.

Let's take a moment to think about this approach. How might an argumentative, loud, shame-inducing, and aggressive style impact youth that we are trying to engage in treatment? What messages might we be sending to them? And what are we modeling?

(ALLOW FOR AUDIENCE RESPONSES.)

That's right. Just from a rational or logical point of view, it doesn't seem that this would be an effective way of getting youth to become interested or invested in treatment, let alone talk about some of their most personal and shameful experiences. And we can hypothesize that this kind of approach might impact their self-esteem and their views of others, and cause them to become more resentful, angry, and hostile themselves. And in fact, we would be modeling disrespectful – and even abusive – communication styles. Yet, these are some of the very areas that we are expecting youth to change!

Use Slide # 18: Process–Related and Contextual Variables

Fortunately, there has been a growing recognition within the field that such an approach may not only be illogical and harmful – but also may result in poorer outcomes.[52] And some fairly new research confirms just that, with researchers finding that sex offenders showed better gains in treatment when the climate was more therapeutic and when sex offender therapists used warm, empathic, and respectful styles – in contrast to the more cold, hostile, and rejecting types of approaches.[53] For some reason – perhaps because of a perceived need to approach sex offenders differently – many sex offender treatment providers overlooked what the more general literature on therapeutic styles had been

telling us for years. And it has taken several years, along with some specific research on these contextual variables in sex offender treatment, to draw attention to the importance of process and style with this population.

Another key process-related approach that is worth noting involves the way in which goals and expectations are structured for youth in treatment. Historically, treatment programs focused primarily on the negative attributes of individuals and the use of escape and avoidance strategies as a means of preventing further sexual behavior problems. I'm sure you can imagine that if in treatment, a youth only hears about the things that are "wrong" with them and what they are restricted from doing, they may feel frustrated, resistant, or even hopeless. So, more recently, experts in the field have been suggesting that it is very important to help youth identify positive goals – or approach goals – that can help youth identify healthy direction, purpose, and meaningful life goals as a key part of the treatment process.[54] In so doing, treatment can help youth examine the kinds of attitudes, thoughts, feelings, and behaviors that have interfered with or can interfere with their ability to be successful and to attain these goals, and they can create strategies to address these barriers or obstacles.[55] The inclusion of approach goals is also very important when developing supervision strategies, as we will discuss a little bit later.

Part V: Current Challenges and Controversies

The field of juvenile sex offender treatment continues to evolve over time as new research and promising practices emerge. And it is certainly not without its challenges and controversies. For the next few minutes, I will highlight some of those issues.

For example, you'll recall that there is some concern about the potential negative impact of aggregating delinquent peers for intervention purposes. And as we noted earlier, significant questions have been raised about the seemingly uncritical application of adult treatment models to juvenile sex offender treatment. Similarly, there are criticisms about the tendency for some programs to use the same interventions, strategies, and approaches for *all* juvenile sex offenders – regardless of their age, developmental level, functional status, and even gender – using a "one size fits all" approach.

Special Populations

Juvenile Female Sex Offenders

We know that adolescent females can commit sex offenses, but does it make sense that treatment for them would look exactly like treatment for males? Why or why not?

(ALLOW FOR AUDIENCE RESPONSES.)

That's right. Of course, there are a number of significant differences between adolescent females and males. And we know from the literature on juvenile delinquency that there are some risk factors that are unique to adolescent girls.[56] And there is some evidence – although quite limited – to suggest that while there may be some common characteristics and treatment needs for juvenile female and male sex offenders, there are likely some critical differences that may have implications for gender-responsive treatment as well.[57]

Use Slide #19: Juvenile Sex Offender Programs for Females

As you can see, across the country there are quite a few programs that are providing treatment for juvenile female sex offenders.[58] The question is whether these programs are truly gender-responsive, or if they are simply delivering interventions that parallel treatment for juvenile male sex offenders.

Use Slide #20: Treatment Targets for Females vs. Males in Programs Nationwide

To illustrate, let's look again at the common targets of treatment for juvenile male sex offenders as reported by programs throughout the United States.[59] And when we place those common treatment targets for juvenile males side by side with the targets reported by the programs that treat juvenile *female* sex offenders, what do you see?

(ALLOW FOR AUDIENCE RESPONSES.)

Based on this information, it's pretty difficult to identify the extent to which programs approach treatment for juvenile female sex offenders differently than they approach treatment for juvenile males. Again, and unfortunately, there is a dearth of research and professional literature on the treatment of juvenile female sex offenders, and perhaps this lack of research is – at least in part – why there still seems to be so much overlap in programming for juvenile female and male sex offenders. However, this should not prevent programs from developing gender-responsive interventions based upon, at the very least, the ever-growing body of literature that outlines what we know about the unique risk and protective factors for adolescent girls in general.[60]

Use Slide #21: Future Directions for Juvenile Female Sex Offender Treatment

Certainly, additional research on the differential risk and protective factors for juvenile female sex offenders is necessary. And more research on their clinical characteristics and modus operandi could help guide our approaches to treatment for this special population. And, of course, for any of the gender-

responsive or other interventions that are provided, we need to conduct follow-up studies to evaluate treatment outcomes.

Children with Sexual Behavior Problems

Another special population that can be challenging for practitioners is the group of young, pre-pubescent children who evidence sexual behavior problems.

Use Slide #22: Treatment Programs for Children with Sexual Behavior Problems

As you can see, there are a sizable number of programs – just over 400 in total – that report providing treatment to children with sexual behavior problems, with the overwhelming majority of these being community-based programs.[61] Keep in mind that the focus of *this* particular training is on adolescents, generally those who are between 12 and 18 years of age. And we have deliberately *not* included discussions about young children with sexual behavior problems. This is to prevent any misperceptions or false assumptions that approaches to adolescents and young children should be the same.

Indeed, there are important differences between young children with sexual behavior problems and juvenile sex offenders that must be considered.[62] It is well beyond the scope of this training to review what we currently know about these children – such as the different etiological factors and developmental issues – or to attempt to explain the treatment approaches that have been developed specifically for these children. Suffice it to say that just as adolescents differ from adults, so, too, do children differ from adolescents.

I mention these young children now because of some of the limitations and challenges in the field overall. There is little research on these children, and very few studies that examine specialized treatment for them. And of great concern are the labeling of young children as "sex offenders" and our systems' subsequent responses to them.

Included in your participant packets are several references to additional resource materials about children with sexual behavior problems. And if you are working with these children, I would strongly encourage you to look further into this literature, if you have not already done so, as it can be very helpful for guiding your practices.

Pharmacological Interventions

You may be aware that there is a high prevalence of mental health disorders among youth in juvenile justice settings – and with juvenile sex offenders, co-occurring mental health difficulties are common as well.[63] This means that we

need to consider the implications of these critical issues on our work with sexually abusive youth.

Use Slide #23: Psychiatric Disorders and Juvenile Sex Offenders

- For example, when they enter the system, all juvenile sex offenders should be carefully screened for the presence of mental health difficulties – and receive a more thorough psychiatric assessment when warranted – to ensure that these symptoms or disorders are managed appropriately and effectively.
- And although it is not likely that psychiatric symptoms are directly linked to the initiation or continuation of sex offender behaviors for most juveniles, the presence of these symptoms may nonetheless impact the youth's ability to fully engage in and benefit from offense-specific treatment interventions.
- And in some instances, it is possible that sexually abusive youth may respond to certain types of psychotropic medications or pharmacological agents, either because they mitigate identified mental health symptoms or because they may help to manage sexual preoccupations or urges.[64]

Use Slide #24: Potential Pharmacological Interventions and Cautions

Selective Serotonin Reuptake Inhibitors (SSRIs)

Perhaps most commonly used with juvenile sex offenders is the class of medications known as Selective Serotonin Reuptake Inhibitors (SSRIs), which are generally used to mitigate symptoms of depressive, anxiety-related, and obsessive-compulsive disorders.[65] In addition to assisting with the reduction of obsessive or ruminating thoughts that contribute to depression and anxiety, these medications may also reduce other recurring thoughts or sexual preoccupations.

A common side effect of SSRIs is decreased sexual drive, which may be helpful for youth who have sexually compulsive behaviors. However, you should be aware that the Food and Drug Administration (FDA), which is responsible for approving and regulating the use of medications for specific purposes, has not sanctioned the use of SSRIs for sex offender treatment. Perhaps even more importantly, a recent health advisory was issued regarding the use of SSRIs with adolescents, because of the potential for increased self-harm and harm toward others among youth who have been prescribed SSRIs.

So, if these medications are to be considered with juvenile sex offenders – or adolescents in general – it is critical that a careful risk-benefit analysis is conducted by a qualified mental health professional.[66] And if used, increased

monitoring and precautions must be in place to ensure the safety of the youth and others.

Hormonal Agents

Another class of pharmacological intervention used with sex offenders – primarily with adults – is the group known as antiandrogens. These are hormonal agents that reduce the level of "male hormones" such as testosterone in the body and consequently lessen or eliminate sexual urges and desires. As such, some refer to their use as "chemical castration."

However, there are considerable concerns about the use of hormonal agents with juvenile sex offenders, primarily because they have not been rigorously tested on adolescents.[67] As a result, the short- and long-term side effects of these medications are not known. Nor is there an understanding of the impact of hormonal agents on adolescents' growth and development. For these reasons, although there may be a small subset of serious and persistent juvenile sex offenders for whom antiandrogens may be beneficial even despite the current concerns, the use of hormonal agents is quite controversial with juvenile sex offenders.[68]

Polygraphy and Treatment

As we discussed during the assessment section of this training, the polygraph has become increasingly common as a means of facilitating sexual history disclosures among youth.

Use Slide #25: Juvenile Programs Using the Polygraph Nationwide

In addition, as you can see in this slide, programs for sexually abusive youth also use the polygraph for monitoring compliance with treatment and supervision, and to further explore specific issues that may arise during the course of treatment.[69] However, the use of the polygraph with juveniles remains an area of controversy.[70]

For example, some practitioners question the need for the complete and total disclosure of all details of a youth's sexual history. Instead, it could be that having a broad understanding of a youth's patterns and offenses may be sufficient for assisting the youth with making progress in treatment and developing effective plans to manage his or her behavior. Further, we may reach a point of diminishing returns when it comes to trying to uncover every single detail pertaining to a youth's sexual history.

Other treatment providers, however, believe that the polygraph can be a helpful – if not vital – tool for treatment. This is because the polygraph may lead to additional disclosures about sexual deviance issues or sex offenses that had not

been previously detected. Some believe that "complete" disclosure must occur if treatment is to be most meaningful and effective.

In addition, some treatment providers believe that the true measure of a youth's commitment and progress in treatment can be revealed through his or her responses during a polygraph examination. As such, some programs require youth to submit to periodic polygraphs throughout the course of treatment to facilitate full disclosure, assess treatment progress, or explore treatment compliance – or some combination of these three uses. And in some juvenile sex offender treatment programs, youth may even be required to "pass" a polygraph in order to be considered for advancement to different levels of a program – or as a prerequisite for completing a treatment program.

Remember, however, as we noted previously, that there exist a number of concerns about the reliability and validity of the polygraph – particularly when used with juveniles.[71] And despite its growing popularity, caution should be exercised with its use. Presently, there is no empirical evidence indicating that "passing" a polygraph examination is associated with positive treatment gains or reductions in recidivism rates with juvenile sex offenders, or adult sex offenders, for that matter.

So, if the polygraph is going to be used in a treatment program, the results should never be used as the only criteria for making critical decisions such as treatment completion or release to the community.[72] Rather, the disclosures or other information gleaned from a polygraph examination should be considered as only one piece of information that should be substantiated by other sources when possible. And when concerns are identified from a polygraph examination, it signals the need to assess a situation further before responding decisively.

Furthermore, if and when a polygraph examination is used as part of a treatment program, the resulting information should be shared with the other key stakeholders involved in juvenile sex offender management so that collaborative and fully informed decisions can be made.

Part VI: Follow-Up Studies and Treatment Outcome Research

For people who work in the field of juvenile sex offender management, the question "Does treatment work?" is inevitably posed. This is a difficult question to answer, in part because there have been only a limited number of well-designed treatment outcome studies.

In an ideal research design, large groups of similar juvenile sex offenders would be randomly assigned to "no-treatment" and "treatment" conditions – and maybe even multiple treatment conditions. So, some youth would receive no treatment at all, other youth would receive intervention X, another group would receive intervention Y, and another group would receive intervention Z. Then all youth

would be followed for several years to identify reoffense rates both for new sex offenses and non-sex offenses. Any differences in the groups would be easier to attribute to the type of intervention provided, and it may be possible to identify the more superior intervention.

Unfortunately, these types of research designs have been almost non-existent with juvenile sex offenders thus far.

Follow-up Studies Without Comparison Groups

Most common are studies that simply follow juvenile sex offenders for a few years after receiving treatment to see how many of the youth reoffend. As a result, we are not necessarily able to determine the *impact* of treatment per se, because the treated youth are not being compared to another group of "untreated" juvenile sex offenders.

Nonetheless, something that has been helpful about these follow-up studies is that we have consistently seen very low sexual recidivism rates for juveniles who receive juvenile sex offender treatment. For example, in a recently published study, researchers followed 250 youth who received sex offender treatment within one state's juvenile justice facilities and were subsequently released to the community.[73] Recidivism was assessed in terms of re-arrests for new sex offenses, non-sexual crimes against persons, and property offenses. The average follow-up period was approximately five years.

Use Slide #26: Recidivism Trends for Treated Youth Released from Facilities

The sexual recidivism rate for youth in this study was only about five percent. These low sexual recidivism rates are very consistent with other follow-up studies of juvenile sex offenders.[74] Notice that the non-sexual recidivism rates – particularly non-sexual crimes against persons – were markedly higher than the sexual recidivism rates. This, too, is quite consistent with other research.[75]

Taken together, these research findings seem to indicate that youth who have received treatment recidivate sexually at very low rates, and that they appear to be much more likely to recidivate with a *non*-sex offense than with another sex offense. Remember, however, that because this particular study did not use a "no treatment" comparison group, we cannot be certain that the low recidivism rates are definitely and only because of the treatment. In fact, it could simply be the case that juvenile sex offenders – even without treatment – have low rates of sexual recidivism.

Follow-up Studies with Default Comparison Groups

Other researchers have included comparison groups so that we can better answer the "treatment impact" question. In most of the follow-up studies that have used "treatment" and "no-treatment" comparison groups, however, the youth were not randomly assigned. Rather, the comparison groups were pre-existing, or became comparison groups by default. For example, common comparison groups include youth who never entered treatment for some reason, dropped out of treatment before completing, or were terminated from treatment before completing.

This is not an ideal approach to developing comparison groups, but it is probably better than having no comparison group at all, because we can infer that at least *part* of any observed differences in outcomes may be related to the provision of treatment. I'd like to draw your attention to one such study.

Worling and Curwen (2000) attempted to examine the impact of community-based, cognitive-behavioral and relapse prevention treatment that also included individual and family interventions.[76] To do so, they compared treated versus untreated juvenile sex offenders, with an average follow-up period of over six years.

A unique feature of this study was that the researchers compared the two groups of juvenile sex offenders not only on sexual recidivism rates, but also in terms of recidivism with violent, non-sex offenses and non-sexual, nonviolent offenses. Recidivism was defined as a new charge.

Use Slide #27: Treated Versus Non–Treated Youth in a Community–Based Program

As you can see, the findings were quite promising. Specifically, the treated youth recidivated at lower rates than the untreated youth across all categories – for sexual, non-sexual violent, and non-sexual, non-violent offenses. And notice the very low sexual recidivism rate for these youth – only 5 percent. The sexual recidivism rate for the untreated group was nearly four times higher – 18 percent. Of course, one cannot help but notice that the recidivism rates for other types of behaviors were quite a bit higher. Again, this parallels the growing body of research demonstrating that sexual recidivism rates are low, and that if juvenile sex offenders do reoffend, it is more likely to be with *non*-sex offenses.

Remember, because the youth in this study were not randomly assigned to the "treatment" or "no-treatment" conditions, we cannot conclude with absolute certainty that juvenile sex offender treatment was the only reason that recidivism rates were lower. But given the consistency in findings like this across a number of similar studies, we do have reason to believe that treatment for these youth does have a positive impact.

In fact, some meta-analyses – again, studies that evaluate a number of studies collectively to identify overall treatment effects – have suggested that cognitive-behavioral approaches to juvenile sex offender treatment are associated with significant reductions in sexual and non-sexual recidivism.[77] Most studies in the meta-analyses do not have the ideal methodology – random assignment – and therefore we are somewhat limited in terms of the conclusions that can be drawn.

Follow-up Studies with Randomly-Assigned Comparison Groups

You'll recall that earlier we discussed some interventions for juveniles that have been found to "work" in reducing further delinquency among youth. We highlighted Wraparound Services, Functional Family Therapy, and Multisystemic Therapy. And you may also remember that I noted that there have been a couple of very promising treatment outcome studies involving Multisystemic Therapy with juvenile sex offenders specifically.[78] They are very good examples of well-controlled treatment outcome studies, because the researchers randomly assigned youth to the MST and comparison groups.

Use Slide #28: MST vs. Alternative Treatment

As you can see in this slide, the researchers found that juvenile sex offenders who received MST interventions reoffended at significantly lower rates than youth in the comparison groups, both in terms of sexual and non-sexual crimes. And because of the strong research design, it is easier to attribute the differences in outcomes to the specific interventions provided.

However, the sample sizes for these studies that used MST have been relatively small, so it will be important to look at MST with larger samples of juvenile sex offenders to see if similar results are found in the future. Nonetheless, MST does appear to be associated with very promising treatment outcomes with juvenile sex offenders. And since we have talked about how important it is to provide treatment that is comprehensive, holistic, and integrated – not just focusing on the youth's sex offending behaviors or the youth by himself – these positive treatment outcomes for MST with juvenile sex offenders make a lot of sense, don't they?

So, the question "Does treatment work?" has not been fully answered. In fact, it is pretty clear that we still have a long way to go before we fully understand the impact of treatment for juvenile sex offenders. It may be that there are different types of interventions that lead to reductions in recidivism, or different approaches that are better for different kinds of juvenile sex offenders.

At the same time, the current available evidence does seem to suggest that cognitive-behavioral approaches that include individual and family interventions,

as well as the MST approach, are associated with positive outcomes with these youth.[79]

Summary

We've covered quite a bit of information in this section, haven't we? So let's take a moment to summarize.

Use Slide #29: Summary of Key Points

First of all, it is important for us to recognize that the field of juvenile sex offender treatment is relatively new, and it is still developing. It wasn't all that long ago that there were only a handful of programs for juveniles! And now, there are hundreds of juvenile sex offender treatment programs across the country.

Second, we were reminded that in our desires to respond quickly to reduce juvenile crime, we must avoid the tendency to react punitively and to try to "treat youth more like adults." Rather, we must rely on the available literature that tells us "what works" in juvenile justice. And we highlighted a few examples of interventions – Wraparound Services, Functional Family Therapy, and Multisystemic Therapy – that have a great deal of promise for reducing recidivism among juveniles.

Third, we reviewed the common goals of treatment for juvenile sex offenders, and highlighted the most common frameworks and targets for treatment programs. We discussed just how important it is to keep in mind that these youth are not simply "sex offenders" and that we should strive to develop interventions that are holistic, comprehensive, and developmentally appropriate.

This led to the fourth major area that we discussed – current challenges and controversies. Once again, we emphasized that juvenile sex offenders are not the same as adult offenders, and that even within the juvenile sex offender population, there is considerable diversity. As such, the uncritical application of adult models and approaches, and the use of "one size fits all" programs are not appropriate for all youthful offenders, and tailored interventions must be used for special populations. We also talked about developmental considerations and controversies, specifically surrounding certain pharmacological interventions and the use of the polygraph.

And finally, we were again reminded that there is a long way to go with respect to evaluating the impact of juvenile sex offender treatment. We reviewed some of the evidence that seems to suggest that cognitive-behavioral approaches – as well as MST – are promising interventions for juvenile sex offenders. And we discussed the growing body of research that indicates that sexual recidivism rates for juvenile sex offenders is quite low, and that these youth do not appear to specialize in sex offenses. In fact, it is becoming evident that juvenile sex

offenses are not nearly as likely to commit additional sex offenses as they are to engage in other non-sexual, delinquent conduct.

A detailed list of references is included in your participant materials. Because this training is designed to provide an overview of the key issues, we strongly encourage those of you who are interested to explore these and other resources, keeping in mind that to provide treatment to juvenile sex offenders, specialized training and experience are critical prerequisites.

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[1] see, e.g., Knopp, 1982; National Adolescent Perpetrator Network (NAPN), 1993
[2] Knopp, Rosenberg, & Stevenson, 1986
[3] McGrath, Cumming, & Burchard, 2003
[4] McGrath et al., 2003
[5] see Dodge, Dishion, & Lansford, 2006 for a comprehensive review
[6] Dodge, et al., 2006
[7] Hawkins, Herrenkohl, Farrington, Brewer, Catalano, & Harachi, 1998; Kashani, Jones, Bumby, & Thomas, 1999; Lipsey & Derzon, 1998
[8] Chaffin, 2006; Chaffin & Bonner, 1998; Chaffin, Letourneau, & Silovsky, 2002; Hunter, Gilbertson, Vedros, & Morton, 2004; Letourneau & Miner, 2005
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