



## Juvenile Sex Offender Treatment: How are We Doing and Where are We Going?

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The literature pertaining to characteristics, patterns, and the treatment needs of juveniles who have committed a sexual offense has come a long way since its inception many years ago; however, there continues to be much to learn. The early literature contains numerous descriptions of extant treatment programs for juvenile offenders and promoted specific components for treatment or the context for which treatment was provided, (Becker, 1988; Elliot, 1987; Fillmore, 1987; Groth, Hobson, Lucey, & St. Pierre, 1981). Compared to what we now know about adults who have committed sexual offenses, what we know about juveniles pales in comparison. This is likely due in part to the reality that the literature encompasses very few systematic clinical or research trials evaluating the effectiveness of specific protocols for this population. Furthermore, we do know that this population of offenders is a heterogeneous group, (Barbaree, Marshall, & Hudson, 1993), and from a developmental standpoint, many changes are occurring at a rapid rate, making it all the more difficult to pinpoint specifics across groups of offenders.

Adult literature dates back more than 20 years. When a young person committed a sexual offense back then, it was seen as an experimental or developmental curiosity (Veneziano & Veneziano, 2002). Furthermore, much of the

theory and research on juvenile offenders to date has focused more on the person and neglected to explore and understand the behavior and the psychosocial developmental context for which these behaviors occur (McCuish & Lussier, 2017). This perspective may lend itself to the many misconceptions evident in the scientific community and society that those juveniles who commit a sexual offense are destined to a life of sexual crime and are predators who need to be managed and punished. More recent scientific evidence contrasts with this perspective, and a meta-analysis looking at recidivism rates among juvenile sexual offenders found sexual recidivism to be relatively low, with an average of 12.2% and a range from 1.6% to 29.9% (McCann & Lussier, 2008). However, we do know that juveniles who commit sexual offenses account for 20% of all sexual assaults and 50% of all childhood sexual abuse (Barbaree & Marshall, 2006). Given the devastating impact that sexual assault and sexual abuse have on the victims, families, and communities, there is a need to determine the right balance between understanding the real risk and treatment needs with the specific offender typologies while, at the same time, not underestimating the impact these offenses and behaviors have in society.

## Historical and Current Treatment Practices

In 1988, the National Adolescent Perpetrator Network (NAPN), established a task force to begin to determine a set of guidelines for the treatment goals when it comes to treatment for juveniles who have committed a sexual offense. Some of these goals included (NAPN, 1988):

- Accepting responsibility for behavior.
- Identifying a pattern or cycle of sexual offending behavior.
- Learning to interrupt this cycle.
- Exploring one's own victimization or history of abuse.
- Learning to empathize with the victim.
- Reducing deviant sexual arousal.
- Developing a positive self-identity.
- Understanding the consequences of sexual offending.
- Exploring family dynamics that may have contributed to sexual offending.
- Challenging cognitive distortions that support sexual offending.
- Developing appropriate social skills.
- Addressing substance use problems.
- Preventing relapse.

Since then, we continue to learn more about the characteristics, typologies, dynamics, and treatment needs of juveniles who have committed a sexual offense, and despite knowing these youth are not "mini-adults," many of these same treatment practices have remained. Juveniles who commit these types of crimes are a heterogeneous group, and the variables that contribute to sexual offending are complex, diverse, and sometimes misunderstood despite well-intentioned efforts. In 1993, NAPN modified its goals for treatment; they mostly have remained the same with a few specific updates on some of the goals so that they are more defined with respect to the juvenile's treatment needs.

## Current Treatment Best Practices

The Association for the Treatment of Sexual Abusers (ATSA) has developed a set of practice guidelines for those working with juveniles who have committed a sexual offense (2017). These guidelines are updated, have incorporate the things we have learned about the treatment needs of juveniles over the years, and are inclusive in terms of our current understanding of the etiology and maintenance of juvenile sexual offending. Included in our most recent understanding of treatment needs for juveniles who have committed a sexual offense are:

*“... promoting safety while facilitating prosocial and developmentally appropriate skill development, using evidence-based interventions that match presenting risk and needs, including caregivers and other positive supports, addressing risk and protective factors across the adolescent’s natural ecologies (e.g., family, peers, school), occurring in the natural environment when possible to allow the adolescent and his/her caregivers to practice skills and use social supports in real-life situations, tailoring approaches to match individual characteristics and circumstances of the adolescent (e.g., developmental status, learning styles, gender, culture); and addressing sexually abusive behavior problems as well as other conduct problems” (ATSA, 2017).*

As mentioned previously, juveniles who commit sexual offenses are a heterogeneous group, and many contributing factors lead to the commission of their offenses. An effective treatment program for this population would include not only treatment protocols pertaining to the factors that led to the offense, but also goals that will contribute to the young person’s overall health and well-being. A survey conducted by McGrath, Cumming, Burchard, Zeoli, & Ellerby (2010) identified over 700 outpatient and residential treatment programs for juveniles who commit sexual offenses. The use of evidence-based practices has increased over the past several years, however this is anecdotal information based on subjective reports from program staff and not verified using an objective standard. It has been estimated that only 5% of serious juvenile offenders receive evidence-based treatment (Henggeler & Schoenwald, 2011). This is likely due in part because of the difficulty of conducting randomized clinical trials as well as the known barriers to dissemination of evidence-based protocols, (Spoth & Greenburg, 2005).

In a more recent review of evidence-based treatments for juveniles who have committed a sexual offense, Dopp, Borduin & Brown, (2015) yielded 1621 studies to be reviewed for inclusion/exclusion and found that only 10 met criteria for their current review. All the studies examined some form of cognitive behavior therapy (CBT) or multisystemic therapy (MST) for problematic sexual behavior. The results suggest that there is a large gap between research and practice in the treatment of juveniles who commit sexual offenses, and despite the fact that CBT is the most widely used method in programs around the U.S., research to date provides limited support for its effectiveness with this population. This could be due to several factors, such as:

- The overall number of studies using randomized trials being surprisingly low (n=4).
- The variability in the delivery of CBT as a protocol in practice.
- The delivery of CBT in juvenile treatment programs appears to differ very little to that of CBT used with adult's who have committed sexual offenses.
- The identification of specific aspects of the CBT protocols that are contributing most significantly to change in this population.

Multi-systemic therapy for problem sexual behavior (MST-PSB) has demonstrated significant effects on the recidivism of juveniles in committing sexual offenses in three randomized clinical trials, which can be viewed in the aforementioned study, yet has not been studied outside of the research developers, and it continues not to be widely used when compared to CBT (Dopp et al., 2015). Another study reviewed three treatment approaches for working with juveniles who commit sexual offenses; CBT, MST and dynamic approaches using a psychodynamic therapy method. All show promise when the approach is well-organized, delivered by trained and supervised staff, and specific for juveniles who have committed a sexual offense (Vizard, 2013).

## Future Direction

There is considerable room for the development of evidence-based treatments for juveniles who have committed a sexual offense. A comprehensive view of risk factors, development, typology or offender sub-type, protective factors, family considerations, and attachment styles should be considered in the design and assessment of these protocols. Partnerships between clinical scientists, practitioners, and community stakeholders will be essential in the development, implementation, promotion, and dissemination of these evidence-based treatments. There are several components of treatment need for this population that is largely understudied, and the more we understand the risks, needs, and developmental factors, the more effectively we can inform and guide treatment programs and allocate resources accordingly.

## Author Biography:

Brenda Frye earned a B.A in Psychology at the University of Minnesota, an M.Ed. at the University of Minnesota, and a Ph.D. in Clinical and Forensic Psychology at Palo Alto University. Her research interests are around risk-taking and decision-making in adolescence and young adulthood, understanding the way perception and neuro-biological processes may play a role in aggression, impulsive behaviors, sexual offending and anxiety/stress, and uncovering ways to intervene early. She has served in academic, consultative, and director roles in university settings, on research projects, and community-based and residential treatment programs. Additional professional interests include consultation activities such as the trainings she provided for Substance Abuse Foundation (SAF) in Barbados, West Indies on evidence-based treatment practices for co-occurring disorders for women, clinical supervision, and program development. She teaches and conducts training on topics related to forensic psychology, research methods, treatment of sexual offenders, trauma informed practice, and anxiety disorders.

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