



Juvenile-Specific Treatment for Problematic Sexual Behaviors

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Table of Contents

Context	3
Research on adult sex offenders does not apply to juveniles	3
Clinical standards of care	5
Assessment	5
Assessment Using OYAS	6
Assessment Using YLS/CMI	6
Case Planning	7
Risk-Needs-Responsivity Model (RNR)	7
Good Lives Model (GLM)	7
Family Engagement	8
Treatment Modality	9
Reentry	11
Reentry and Employment	11
Reentry and Family Reunification	12
Evidence supports two therapeutic models	13
Sex Behavior Treatment Program, DJJ	13
Treatment Stages	13
Treatment Continuity	13
Multisystemic Therapy (MST)	14
MST, Generally	14
MST and Young Women	17
Cognitive Behavioral Therapy (CBT)	18
CBT and PSB-CBT, Generally	18
PSB-CBT-A, specifically	20

Context

In September 2020, California chaptered Senate Bill 823 (“SB 823”), which shifts custodial responsibilities over adjudicated youth from the Department of Corrections and Rehabilitation, Division of Juvenile Justice (“DJJ”) to local counties, beginning in July 2021. Prior to this shift, youth adjudicated for problematic sexual behaviors under Welfare and Institutions Code § 707(b) were served by DJJ’s Sex Behavior Treatment Program. Under SB 823, however, counties are directed, either alone or in concert with jurisdictions within the same region, to develop local treatment options that are age-appropriate, evidence-based, trauma-informed, and culturally responsive. The purpose of this document is to provide an overview of extant evidence that is specific to the youth population.

Impact Justice has prepared this review for the counties of Alameda and Contra Costa, whose population of youth adjudicated for problematic sexual behaviors comprise 10% and 15% of their respective DJJ populations. In general, the current landscape of research on juvenile-specific interventions is remarkably limited—but nevertheless provides important insights that may be valuable for localities as they consider treatment options pursuant to SB 823. To facilitate this consideration process, this document is structured by topic area and contains citations of, and excerpts from, key articles by respected experts and practitioners in the field.

Research on adult sex offenders does not apply to juveniles

Evidence derived from studying adult offenders should not be applied to the youth population. For more than a decade, scholars have been arguing against the conflation, whether explicitly or implicitly, of the adult and youth populations that are justice-system-involved due to problematic sexual behaviors. These scholars argue that popular perceptions do not align with the facts (Letourneau & Miner); that these misperceptions produce poor outcomes (Chaffin); and, that evidence demonstrates stronger effects for less punitive interventions, contrary to historical models (Kim, Benekos & Merlo).

Letourneau, Elizabeth J. and Michael H. Miner (2005). “Juvenile Sex Offenders: A Case Against the Legal and Clinical Status Quo.” *Sexual Abuse: A Journal of Research and Treatment* 17(3): 293-312. doi: 10.1007/s11194-005-5059-y

Authors’ Abstract: “The past two decades have seen a movement toward harsher legal sanctions and lengthy, restrictive treatment programs for sex offenders. This has not only been the case for adults, but also for juveniles who commit sex offenses. The increased length and severity of legal and clinical interventions for juvenile sex offenders appear to have resulted from three false assumptions: (1) there is an epidemic of juvenile offending, including juvenile sex offending; (2) juvenile sex offenders have more in common with adult sex offenders than with other juvenile delinquents; and (3) in the absence of sex offender-specific treatment, juvenile sex offenders are at exceptionally high risk of reoffending. The available data do not support any of the above assumptions; however, these assumptions continue to influence the treatment and legal interventions applied to juvenile sex offenders and contributed to the

application of adult interventions to juvenile sex offending. In so doing, these legal and clinical interventions fail to consider the unique developmental factors that characterize adolescence, and thus may be ineffective or worse. Fortunately, a paradigm shift that acknowledges these developmental factors appears to be emerging in clinical areas of intervention, although this trend does not appear as prevalent in legal sanctions.”

Chaffin, Mark (2008). “Our Minds Are Made Up—Don’t Confuse Us With the Facts: Commentary on Policies Concerning Children With Sexual Behavior Problems and Juvenile Sex Offenders.” *Child Maltreatment* 13(2): 110-121. doi: 10.1177/1077559508314510

Author’s Abstract: “This commentary examines four common policy-relevant perceptions of teen and preteen sex offenders—high risk, ‘specialness,’ homogeneity, and intransigence. Each perception is contrasted with long-standing as well as more current scientific facts. It is argued that public policies for these youth have been fundamentally driven by misperceptions, resulting in a set of well-intentioned but ultimately flawed policies and practices that are unlikely to deliver either child protection or juvenile justice benefits. These include federal and state policies pertaining to public registration and notification, community management, institutional placement, treatment approaches, and treatment standards. The research evidence about these juveniles is considerably more positive than current policies or clinical practices might suggest, and reflects a sharp disconnect between popular policy-relevant perceptions and the facts as we know them about these diverse cases.”

Kim, Bitna, Peter J. Benekos, and Alida V. Merlo (2016). “Sex Offender Recidivism Revisited: Review of Recent Meta-analyses on the Effects of Sex Offender Treatment.” *Trauma, Violence, & Abuse* 17(1): 105-117. doi: 10.1177/1524838014566719

“[C]ommunity-based treatments compared to institutional treatments have a larger effect in reducing recidivism”

— Kim, Benekos & Merlo (2016)

than institutional treatment is proven to reduce recidivism.”

From text: “Based on the results, sex offender treatments for adolescents compared to adults have a larger effect in reducing recidivism. . . . In addition, the most recent meta-analyses demonstrate that community-based treatments compared to institutional treatments have a larger effect in reducing recidivism. The findings seem to support legislative reforms that would authorize more sex offender treatments in the community rather than relying on institutional treatments. Given the punitive approaches that have characterized the criminal justice system, these changes may be unlikely. Nonetheless, the evidence demonstrates that if the public and elected officials were committed to reducing recidivism, community treatment rather

Clinical standards of care

ASSESSMENT

Clinical standards of care support empirically validated assessments, adaptive case planning and treatment, direct family involvement, and a focus on reentry. Evidence shows that empirically validated risk assessment tools can be valuable in identifying needs, assessing progress, and informing discharge decisions. The tools currently utilized by Alameda and Contra Costa Counties—the OYAS and YLS/CMI tools, respectively—are generally effective for youth with problematic sexual behaviors. However, research indicates that (1) risk assessments should be administered frequently, and (2) practitioners should be discouraged from overutilization of professional overrides, which demonstrably erode the tools’ validity.

Righthand, Sue, Gina Vincent and Rachael M. Huff (2017). “Assessing Risks and Needs,” in Sue Righthand and William D. Murphy (eds.), *The Safer Society Handbook of Assessment and Treatment of Adolescents Who Have Sexually Offended*. Global Institute of Forensic Research.

From text: “It is important to remember that risk assessment is not simply an event, but a process. Following initial and baseline assessments, ongoing reassessments are necessary for monitoring treatment progress and adjusting case and treatment plans, as indicated, to ensure their effectiveness. Further, risk assessments at discharge from community-based or residential treatment programs are necessary to evaluate the extent to which criminogenic treatment needs have been resolved or whether additional interventions are warranted. Regardless of when an initial assessment is conducted and which assessment tools are used, risk and needs assessment reports should emphasize that findings represent *current* functioning and circumstances. The importance of periodic reassessments, responsive to developmental and situational fluctuations and current needs, requires emphasis. The short ‘shelf life’ of the report, generally considered six months depending on the youth’s age and circumstances, should be underscored.”

“The importance of periodic reassessments, responsive to developmental and situational fluctuations and current needs, requires emphasis.”

— Righthand, Vincent & Huff (2017)

Assessment Using OYAS

Papp, Jordan, Christina A. Campbell, William T. Miller (2019). “Validation and examination of the Ohio Youth Assessment System with juvenile sex offenders.” *Criminology & Public Policy* 19(2): 433-450. doi: 10.1111/1745-9133.12464

Authors’ Abstract: “In this study, we examined the use of an actuarial risk assessment tool—the Ohio Youth Assessment System-Disposition Tool (OYAS-Disposition Tool)—with juvenile sex offenders. Specifically, the main goals of the study were to (a) examine the predictive validity of the tool with sex offenders and (b) explore the nature of the use of professional discretion used to override the tool. The sample consisted of 3,235 youth from a large juvenile county court in the Midwest. The results indicated that the OYAS-Disposition Tool was a significantly better option for predicting general recidivism for sex offenders than it was for non–sex offenders. The tool was also an effective method for predicting sexual recidivism. Most importantly, however, the use of professional overrides significantly reduced the ability of researchers to apply the tool to predict new court petitions and adjudications to nonsignificant levels. Finally, several justifications were commonly used for overrides: treatment needs, offense seriousness, and use of an alternative sex-offender–specific assessment.”

Assessment Using YLS/CMI

Schmidt, Fred, Sarah M. Sinclair and Solveig Thomasdottir (2016). “Predictive Validity of the Youth Level of Service/Case Management Inventory with Youth who have Committed Sexual and Non-Sexual Offenses: The Utility of Professional Override.” *Criminal Justice and Behavior* 43(3): 413-430. doi: 10.1177/0093854815603389

Authors’ Abstract: “The predictive validity of the Youth Level of Service/Case Management Inventory (YLS/CMI) and the use of professional override were examined in a matched sample of youth who committed sexual (n = 204) and non-sexual (n = 185) offenses. Based on the actuarial score, the YLS/CMI obtained moderate to strong levels of predictive validity for non-violent, violent, sexual, and technical recidivism in both samples of youth. Probation officers always used override to increase risk level classification and did so at a high level for both sexual (n = 151; 74.0%) and non-sexual (n = 77; 41.6%) offending youth. There was a detrimental impact on the predictive validity of the YLS/CMI for youth who received an override adjustment, regardless of offending category. These preliminary findings suggest that the application of override should be carefully considered on instruments such as the YLS/CMI.”

CASE PLANNING

A preponderance of research refers to at least one of two related, but distinct, orientations to case planning: the risk-needs-responsivity (RNR) model and the good lives model (GLM). Broadly, the former involves scaling services to match identified needs, where the latter involves motivating treatment with a goals-and-outcomes frame. Both orientations provide utility and, moreover, can be integrated with one another.

Risk-Needs-Responsivity Model (RNR)

Land, Robert, Norbert Ralph, Lucinda Rasmussen, L. C. Miccio-Fonseca, Gerry Blasingame (n.d.). “Guidelines for the Assessment and Treatment of Sexually Abusive Juveniles.” California Coalition on Sexual Offending [CCOSO].

“Current research suggests that differing levels of intensity and duration of treatment and supervision are required by different juveniles in order to most effectively reduce recidivism while maintaining cost effectiveness.”

— Land, et al. (n.d.)

From text (citations omitted): “There is a limited but growing literature base which suggests that use of the risk, needs, and responsivity principles of human service can be useful in case planning for juveniles who are involved with the criminal justice system. . . . Current research suggests that differing levels of intensity and duration of treatment and supervision are required by different juveniles in order to most effectively reduce recidivism while maintaining cost effectiveness. Those juveniles who have the highest risk and needs have the greatest room for change, while lower risk juveniles may be managed at a lower level of care. Discerning the juvenile’s level of risk for re-offense sexually or otherwise, his particular dynamic needs associated with general delinquency, and a comprehensive case plan that is responsive to the individual and his family clearly represents one aspect of implementation of evidence based practices.”

Good Lives Model (GLM)

Fortune, Clare-Ann, Tony Ward, and Bobbie Print (2014). “Integrating the Good Lives Model with Relapse Prevention: Working with Juvenile Sex Offenders,” in Daniel S. Bromberg and William T. O’Donohue (eds.), *Toolkit for Working with Juvenile Sex Offenders*. doi: 10.1016/B978-0-12-405948-1.00016-5

From text (citations omitted): “The Good Lives Model has been proposed as an alternative approach to the risk-based approaches, such as the RNR. It is an approach that incorporates the major RNR principles yet extends the scope of rehabilitative efforts to include individual personal priorities as well. The GLM is a strengths-based approach to offender rehabilitation

first proposed by Ward and Stewart in 2003, and which has been subsequently further developed by Ward and his colleagues. As stated above, the RNR and GLM are not necessarily mutually exclusive models. Ward has suggested the GLM has the capacity to integrate components of treatment which may not be adequately addressed by the RNR model, such as the development of the therapeutic alliance, increased agency (e.g., self-direction), and motivation to commit to treatment, and desistance from further offending.”

FAMILY ENGAGEMENT

Research finds that family involvement in the treatment process garners large positive effects. See also “Multisystemic Therapy,” infra. However, families experience substantial barriers to engagement. Jurisdictions are encouraged to evaluate their policies and practices on the macro level and collaborate with families to “troubleshoot” barriers on the individual level.

Yoder, Jamie R., Jesse Hansen, Christopher Lobanov-Rostovsky and Donna Ruch (2015). “The Impact of Family Service Involvement on Treatment Completion and General Recidivism Among Male Youthful Sexual Offenders.” *Journal of Offender Rehabilitation* 54(4): 256-277. doi: 10.1080/10509674.2015.1025177

Authors’ Abstract: “Few studies have systematically evaluated outcomes of services for youth with sexually problematic behaviors. Evaluations are particularly sparse for youth receiving family-oriented treatment despite an increased emphasis on family in healing and rehabilitation contexts. There are common approaches to family inclusion that have been argued by field professionals as ‘best practice,’ and this study quantitatively investigates the usefulness of such approaches. With support from the state Sex Offender Management Board, data were collected from probation files of male youth adjudicated of a sexual crime (N = 81). Logistical regression models revealed that youth with greater family service involvement were almost three times more likely to successfully complete treatment and youth living in an in-home placement were 73% less likely to reactivate. Inherent implications suggest that family is a protective factor and community-based, family-oriented services ought to occur uniformly.”

“[Y]outh with greater family service involvement were almost three times more likely to successfully complete treatment and youth living in an in-home placement were 73% less likely to reactivate.”

— Yoder, et al. (2015)

Yoder, Jamie Rae and Samantha Brown (2015). “Challenges Facing Families of Sexually Abusive Youth: What Prevents Service Engagement?” *Victims & Offenders* 10(1): 29-50. doi: 10.1080/15564886.2013.875969

From text (citations omitted): “Families are overwhelmed with stress, are inadequately prepared, and experience subjective barriers. These contexts lead to a crisis state, and consequently families are unable or unwilling to engage in treatment. . . The experience mirrors aspects of the family stress theory that explore the accumulation of stress, poor resources, and adverse perception and meaning as critical variables that impel families into crisis and maladaptation. . . Recognizing there are ongoing barriers that prevent involvement in services, it is suggested that family treatment should be mandated for families with an identified need, and treatment funds should be apportioned accordingly. Even with some policies streamlining funding for family services, families continue to struggle affording high-priced treatment. Reallocating funds to evidence-informed services such as family-oriented interventions will reduce high-priced system reentry resulting from ineffective services.”

Powell, Kevin M. (2017). “Engaging Adolescents and Families,” in Sue Righthand and William D. Murphy (eds.), *The Safer Society Handbook of Assessment and Treatment of Adolescents Who Have Sexually Offended*. Global Institute of Forensic Research.

From text (citations omitted): “Proactively gathering information and developing practical solutions to potential barriers should be a focal point from the very first phone call with families. These discussion with families should explore practical barriers (e.g., transportation challenges; financial concerns) and perceptual barriers to engagement (e.g., attitudes about mental health treatment). It can also be beneficial to ask caregivers about their past experiences in youth services, both good and bad, and use this information to create a positive therapeutic environment.”

TREATMENT MODALITY

Professional standards of care suggest that treatment should be multimodal in its delivery. Jurisdictions should note, however, that group-based therapies, when it is possible to implement them, can provide important prosocial benefits to the overall treatment.

Association for the Treatment of Sexual Abusers [ATSA] (2017). “ATSA Practice Guidelines for Assessment, Treatment, and Intervention with Adolescents Who Have Engaged in Sexually Abusive Behavior.

From text: “Practitioners recognize that services are delivered using a variety of modalities, including psycho-educational, group, individual, family, and multi-systemic approaches matched to the adolescent’s and family’s intervention needs and responsivity factors.”

Worling, James R. and Calvin M. Langton (2016). "Treatment of Adolescents Who Have Sexually Offended," in Douglas P. Boer (ed.), *The Wiley Handbook on the Theories, Assessment and Treatment of Sexual Offending*. doi: 10.1002/9781118574003.wattso057

From text (citations omitted): "Group therapy is an important intervention, however, as it provides an opportunity for prosocial, imitative behaviour, group cohesion, the instillation of hope, and sense of universality, all of which can be powerful tools to address such goals as the development of prosocial sexual knowledge, values, and attitudes, the enhancement of emotional intimacy skills, and developing an understanding the impact of sexual abuse, for example. As noted earlier, deviant sexual arousal, if present, and the sharing of detailed accounts of past sexual crimes may best be addressed in individual treatment."

Yoder, Jamie R., George S. Leibowitz and Leanne Peterson (2016). "Parental and Peer Attachment Characteristics: Differentiating Between Youth Sexual and Non-Sexual Offenders and Associations With Sexual Offense Profiles." *Journal of Interpersonal Violence* 33(17): 2643-2663. doi: 10.1177/0886260516628805

From text (citations omitted): "In bolstering peer attachment for youth, specific interventions in group therapy sessions can begin to focus on developing pro-social interpersonal skills and positive peer attachments through team building and trust activities. Such a group therapy focus has potential to simultaneously enhance youths' parental and peer attachment. Another peer-based approach could be implemented in schools or communities where youth and peers are socialized. These are practical contexts from which to identify social isolation or inept relationships and enhance interactions among pro-social peer networks."

REENTRY

Research suggests that reentry planning should occur as soon as possible, with step-down to community occurring as soon as clinically feasible. Planning should ensure continuity of clinical services and should facilitate attachment to employment. If the victim is a family member of the youth, family reunification should occur gradually, if at all, and should be principally guided by clinical staff.

Hunter, John A. (2012). "Management and Treatment Methods," in Eileen P. Ryan, Daniel C. Murrie and John A. Hunter (eds.), *Juvenile Sex Offenders: A Guide to Evaluation and Treatment for Mental Health Professionals*. doi: 10.1093/med:psych/9780195393309.003.0008

From text: "Youth should be stepped down to community care as soon as clinically feasible. Such decisions should be made on the basis of observed treatment progress and formal assessment of risk and need. Transitional services need to be effected prior to the youth's discharge. Continuity of service in service delivery is critical to successful community reintegration efforts and minimization of the risk of relapse. This is why the discharge planning process should be a collaborative process that involves the youth, his or her family, the referring agency, the residential treatment provider, and community professionals who will be assuming case management responsibilities."

"Continuity of service in service delivery is critical to successful community reintegration efforts and minimization of the risk of relapse."

— Hunter (2012)

Reentry and Employment

Van den Berg, Chantal, Catrien Bijleveld, Jan Hendriks, and Irma Mooi-Reci (2014). "The juvenile sex offender: The effect of employment on offending." *Journal of Criminal Justice* 42(2): 145-152. doi: 10.1016/j.jcrimjus.2013.09.001

Authors' Abstract: "In many countries, sex offenders are treated as a special group of offenders, requiring special criminal justice responses and treatment modalities, presuming they are at high risk of re-offending. These special measures limit them in entering adult roles, especially employment. At the same time, such adult roles have been found to reduce offending risk in general offenders. We aim to investigate whether employment reduces offending rates in juvenile sex offenders' (JSO). Using longitudinal data on a Dutch sample of 498 JSO, we investigate employment and offending careers in JSO. A hybrid random effects model is used to investigate within-individual changes of employment quality and employment stability on offending. We also investigated whether the effects differ for child abusers, peer abusers and group offenders, who have different background profiles and for whom employment effects could be less. We first show that JSO enter the labor market at relatively young ages, with stagnating participation rates from age 25 on, and numerous and short-lived employment contracts. In spite of these fractured careers, employment is associated with a decrease in

offending. We found no difference for offender types in the effect of employment on offending. We conclude that for JSO, employment decreases offending. Policies aimed at guidance towards employment, or the inclusion into conventional society, may be effective for JSO.”

Reentry and Family Reunification

Page, Jacqueline and William D. Murphy (2017). “Community Reentry and Family Reunification,” in Sue Righthand and William D. Murphy (eds.), *The Safer Society Handbook of Assessment and Treatment of Adolescents Who Have Sexually Offended*. Global Institute of Forensic Research.

“Approaching reunification from a continuum perspective allows the reunification process to be adapted to the needs of the individual family’s situation and circumstances.”

— Page & Murphy (2017)

being involved in activities with the family, or spending holidays and special occasions together as a family. The continuum approach allows for the youth to be an active member of the family despite not living with the family. The approach supports healing through decisions that are based on what is healthy and in the best interest of the victim, the sibling who sexually abused, and the family as a whole.”

From text: “Approaching reunification from a continuum perspective allows the reunification process to be adapted to the needs of the individual family’s situation and circumstances. Rather than an all-or-nothing approach, the continuum approach ranges from no contact to full reunification, with the sibling who sexually abused returning home and living with his or her victim. In some cases, contact between the sibling who sexually abused and the victim is clinically supported, but full reunification may not be possible or premature. While the reunification process begins in joint therapy sessions, it is hoped that the process will progress past therapy sessions to encompass the family being together—although this doesn’t necessarily mean the victim and sibling who sexually abused living in the same house. Family together may include spending supervised social time together, both the victim and sibling who sexually abused

From text (citations omitted): “While the removal of some youth who sexually abuse from the home and/or community may be necessary because of the youth’s risk and treatment needs, or because one or more victims are in the home, inherent within the removal is the challenge of when and how the youth returns to his or her community or home. . . . The literature suggests that planning for community reintegration needs to begin at the time of removal and that youth need adequate services and supervision when returning to the community and home. In addition, families need to be involved and receive appropriate services and support while the youth are in a placement and when they return home. It is important to recognize that there is little to no research specific to reentry with adolescents who sexually abuse.”

Evidence supports two therapeutic models

Research supports two therapeutic models – multisystemic and cognitive behavioral – with distinct approaches, though the multisystemic model may be more suitable for young women.

SEX BEHAVIOR TREATMENT PROGRAM, DJJ

While there has been no formal evaluation of DJJ’s model—or, none that are publicly available, at any rate—we do know how the program is structured [[URL1](#)] [[URL2](#)]:

- Clinical Framework
- CBT-Based Treatment
- Risk-Need-Responsivity Framework
- Strengths-Based, Forward-Focused Orientation
- Developmentally-sequenced stage work
- Group work designed to leverage influential factors throughout process
- Addresses multiple learning styles & promotes individual creativity/autonomy

Treatment Stages

1. **Autobiography:** Explore your past and begin to understand how past events may have influenced your decision-making and behavior so that you can begin to plan to successfully move forward.
2. **Responsibility & Accountability:** Begin to take personal responsibility and become accountable for your past and current behaviors.
3. **Attachment, Loss, and Early Connections:** Begin to understand the relationship between bad and sad things that have happened in your life and your thoughts, feelings, and behavior. You will begin to heal from the past, and learn new healthy ways to manage your thoughts, feelings, and behaviors.
4. **Behavior Patterns & Restorative Justice:** Learn more about the effects of your behaviors on yourself and others and demonstrate progress in making positive behavioral changes.
5. **Effective Decision-Making:** Learn more about the way you think and make decisions. Demonstrate healthy thinking and decision-making skills.
6. **Reentry Planning & Good Life Goals:** Demonstrate the ability to achieve your Re-Entry and Good Life goals, to be a good citizen, and to learn new skills which could help you be successful in the community.
7. **Moving On:** Continue to demonstrate the positive changes you have made, prepare for the end of your SBTP (sex behavior treatment program), and prepare for your future.

Treatment Continuity

- Interplay of thoughts, behaviors, & affect
- Good Life Plan and Re-Entry Planning
 - Life: Having basic needs met; caring for physical health, safety

- Knowledge: Feeling that you have sufficient information and understanding of yourself and the world
- Friendship: Having close connections to family, peers, romantic partners, or other individuals
- Community: Possessing a sense of belonging to a larger group of individuals with shared interests
- Happiness: Overall feeling of contentment with life
- Creativity: Having the ability to express self in unique ways that bring meaning
- Healthy Living Curriculum
 - Orientation: Multiple intelligence; assessment of sexual beliefs
 - Psychological Development: Stages of development; normal brain development
 - Psycho-social Development: Adolescent development; five parts of human sexuality
 - Healthy Communication: Three parts of face-to-face communication; communication styles
 - Non-sexual Relationships: Components of a strong relationship
 - Trauma and Development: Trauma and brain development
 - Healthy Sexuality: Respect, responsibility, recognition, relationship
 - Myths, Facts, and Sexual Health: Bodies, STDs, contraception
 - Sexuality and the Law: Sexual harassment, Megan's Law, Jessica's Law
 - Bringing It All Together

MULTISYSTEMIC THERAPY (MST)

Broadly, Multisystemic Therapy (MST) uses a social-ecological approach to treatment that grounds interventions in the interwoven systems of family, peer, school, and community. Research demonstrates its overall effectiveness in meeting youths' needs and reducing recidivism—possibly more so than prevailing cognitive-behavioral models—but individual success varies by the relationship between the youth and their caregiver as well as the relationship between the caregiver and the youths' probation officer.

MST, Generally

Letourneau, Elizabeth J., Scott W. Henggeler, Charles M. Borduin, Paul A. Schewe, Michael R. McCart, Jason E. Chapman and Lisa Saldana (2009). "Multisystemic therapy for juvenile sexual offenders: 1-year results from a randomized effectiveness trial." *Journal of Family Psychology* 23(1): 89-102. doi: 10.1037/a0014352

Authors' Abstract: "Despite the serious and costly problems presented by juvenile sexual offenders, rigorous tests of promising interventions have rarely been conducted. This study presents a community-based effectiveness trial comparing multisystemic therapy (MST) adapted for juvenile sexual offenders with services that are typical of those provided to juvenile sexual offenders in the United States. Youth were randomized to MST (n = 67) or treatment as usual for juvenile sexual offenders (TAU-JSO; n = 60). Outcomes through 12 months

postrecruitment were assessed for problem sexual behavior, delinquency, substance use, mental health functioning, and out-of-home placements. Relative to youth who received TAU-JSO, youth in the MST condition evidenced significant reductions in sexual behavior problems, delinquency, substance use, externalizing symptoms, and out-of-home placements. The findings suggest that family- and community-based interventions, especially those with an established evidence-base in treating adolescent antisocial behavior, hold considerable promise in meeting the clinical needs of juvenile sexual offenders.”

Borduin, Charles M., Cindy M. Schaeffer and Naamith Heiblum (2009). “A Randomized Clinical Trial of Multisystemic Therapy With Juvenile Sexual Offenders: Effects on Youth Social Ecology and Criminal Activity.” *Journal of Consulting and Clinical Psychology* 77(1): 26-37. doi: 10.1037/a0013035

Authors’ Abstract: “A randomized clinical trial evaluated the efficacy of multisystemic therapy (MST) versus usual community services (UCS) for 48 juvenile sexual offenders at high risk of committing additional serious crimes. Results from multiagent assessment batteries conducted before and after treatment showed that MST was more effective than UCS in improving key family, peer, and academic correlates of juvenile sexual offending and in ameliorating adjustment problems in individual family members. Moreover, results from an 8.9-year follow-up of rearrest and incarceration data (obtained when participants were on average 22.9 years of age) showed that MST participants had lower recidivism rates than did UCS participants for sexual (8% vs. 46%, respectively) and nonsexual (29% vs. 58%, respectively) crimes. In addition, MST participants had 70% fewer arrests for all crimes and spent 80% fewer days confined in detention facilities than did their counterparts who received UCS. The clinical and policy implications of these findings are discussed.”

Borduin, Charles M., Richard J. Munsch, David V. Wagner and Erin K. Taylor (2011).

“Multisystemic Therapy with Juvenile Sexual Offenders: Development, Validation, and Dissemination,” in Douglas P. Boer, Reinhard Eher, Leam A. Craig, Michael H. Miner and Friedemann Pfafflin (eds.), *International Perspectives on the Assessment and Treatment of Sexual Offenders: Theory, Practice, and Research*. doi: 10.1002/9781119990420.ch13

Authors' Abstract (abbreviated): “Public concern about sex crimes is very high and has led to state and federal mandates for harsher sentences and other sanctions such as mandatory notification policies and sexual offender registries. Although arrests for sexual crimes are relatively rare, accounting for less than 1% of all arrests, these crimes are among the most devastating to victims. Youths under the age of 18 years account for approximately 20% of all arrests for sexual crimes, not including prostitution. Unfortunately, although juvenile sexual offenders consume much of the resources of the criminal justice, education, and mental health systems, few if any empirically supported interventions exist to treat these youths. Research suggests that juvenile sexual offenders have more in common with other delinquents than is generally assumed and, like other offenders, experience problems in multiple domains, including family, peer, and school contexts. In addition, approximately 92% of juvenile sexual offenders also commit nonsexual crimes. One promising approach is multisystemic therapy (MST). The primary purpose of this chapter is to present the empirical rationale for the application of MST to the treatment of juveniles who have committed sexual offenses as well as the features of MST that make it well-suited for treating this clinical population.”

“Research suggests that juvenile sexual offenders have more in common with other delinquents than is generally assumed and, like other offenders, experience problems in multiple domains, including family, peer, and school contexts...”

— Borduin, et al. (2011)

Henggeler, Scott W., Elizabeth J. Letourneau, Jason E. Chapman, Charles M. Borduin, Paul A. Schewe, and Michael R. McCart (2009). “Mediators of Change for Multisystemic Therapy With Juvenile Sexual Offenders.” *Journal of Consulting and Clinical Psychology* 77(3): 451-462. doi: 10.1037/a0013971

Authors' Abstract: “The mediators of favorable multisystemic therapy (MST) outcomes achieved at 12 months postrecruitment were examined within the context of a randomized effectiveness trial with 127 juvenile sexual offenders and their caregivers. Outcome measures assessed youth delinquency, substance use, externalizing symptoms, and deviant sexual interest/risk behaviors; hypothesized mediators included measures of parenting and peer relations. Data were collected at pretreatment, 6 months postrecruitment, and 12 months postrecruitment. Consistent with the MST theory of change and the small extant literature in this area of research, analyses showed

that favorable MST effects on youth antisocial behavior and deviant sexual interest/risk behaviors were mediated by increased caregiver follow-through on discipline practices as well as decreased caregiver disapproval of and concern about the youth's bad friends during the follow-up. These findings have important implications for the community-based treatment of juvenile sexual offenders."

Bustnay, Tali Gur (2019). "Group Intervention with Parents of Juvenile Sex Offenders."
Journal of Child Sexual Abuse 29(3): 278-294. doi: 10.1080/10538712.2019.1639093

Author's Abstract: "This article presents a short-term psycho-educational group therapy model of 14 bi-weekly 90-minute meetings with parents of male juvenile sex offenders. The program is used by youth probation services in Israel as part of a multi-systemic treatment program. The group was designed for parents whose children had been convicted of a variety of sex offenses in a juvenile court, and who had been referred to the youth probation service for court-ordered treatment. The group therapy was aimed at involving the parents in the therapeutic process, promoting the offenders' rehabilitation, and to maintain the improvement achieved through the treatment. The results show that the combination of emotional support, provision of information and knowledge, and parental guidance can empower the parents to be a supportive, directive authority in supervising their children, thereby helping to prevent their recidivism to sexually offensive behavior."

Dopp, Alex R., Cameron M. Perrine, Kathryn E. Parisi, Morgan A. Hill, and Michael F. Caldwell (2020). "Evidence-Based Assessment and Treatment Approaches for Adolescents Who Have Engaged in Sexually Abusive Behavior," in Jean Proulx, Franca Cortoni, Leam A. Craig, and Elizabeth J. Letourneau (eds.), *The Wiley Handbook of What Works with Sexual Offenders: Contemporary Perspectives in Theory, Assessment, Treatment, and Prevention. doi: 10.1002/9781119439325.ch15*

From text (citations omitted): "In sum, MST-PSB has produced significant reductions in youths' SAB in multiple clinical trials and is capable of producing a positive economic impact. These findings are especially noteworthy when considering methodological rigor; these studies are all randomized clinical trials, and MST-PSB was superior to the current 'gold standard' treatment (CBT-RP) in two trials. However, some caution is warranted, because MST-PSB model developers have been involved in the clinical and/or research operations of all published trials."

MST and Young Women

Frey, Lisa L. (2017). "Adolescent Females Who Have Sexually Abused," in Sue Righthand and William D. Murphy (eds.), *The Safer Society Handbook of Assessment and Treatment of Adolescents Who Have Sexually Offended. Global Institute of Forensic Research.*

From text: "There are no ESTs that have been specifically developed for adolescent females who sexually abuse, although multisystemic therapy for problematic sexual behavior (MST-PSB) shows promise. . . MST-PSB may be an effective treatment model to consider for female

adolescents who sexually abuse due to its dual focus on youth's socio-ecological context (i.e., family, school, neighborhood, community, culture), a need emphasized by the gender responsive literature as crucial to the treatment of female adolescents, and their specific sexual behavior problems.”

COGNITIVE BEHAVIORAL THERAPY (CBT)

Broadly, Cognitive Behavioral Therapy (CBT) uses a psycho-social approach to treatment that targets the linkages between distorted thoughts, feelings, and behaviors and aims to develop coping strategies that can disrupt those linkages. Research demonstrates its effectiveness, cost-effectiveness, and durability over the long term—but scholars note that the positive effects are “small to moderate.”

CBT and PSB-CBT, Generally

Worling, James R., Ariel Littlejohn, and David Bookalam (2010). “20-Year Prospective Follow-Up Study of Specialized Treatment for Adolescents Who Offended Sexually.” *Behavioral Sciences and the Law* 28: 46-57. doi: 10.1002/bsl.912

Authors' Abstract (citations omitted): “Most follow-up investigations of the effectiveness of specialized treatment for adolescents who have offended sexually have not included a comparison group. Furthermore, the average length of most previous studies is approximately 5 years. This investigation is a 10-year extension of our prospective, 10-year follow-up study of specialized treatment. Recidivism data (criminal charges) were collected from a national database for 148 adolescents who had offended sexually. Adolescents were between 12 and 19 years of age (M = 15.5; SD = 1.5) at assessment, and the followup interval spanned from 12 to 20 years (M = 16.23; SD = 2.02). Relative to the comparison group (n = 90), adolescents who participated in specialized treatment (n = 58) were significantly less likely to receive subsequent charges for sexual, nonsexual violent, and nonviolent crimes. These data add to the growing body of research supporting the effectiveness of specialized treatment for individuals who have offended sexually.”

Dopp, Alex R., Peter Munday, Jane F. Silovsky, Michael Hunter and Alexandra Slemaker (2020). “Economic value of community-based services for problematic sexual behaviors in youth: A mixed-method cost-effectiveness analysis.” *Child Abuse and Neglect* 105. doi: 10.1016/j.chiabu.2019.104043

Authors' Abstract: “Problematic sexual behavior in youth represents a significant public health problem in need of evidence-based treatments. Unfortunately, such treatments are not available in most communities. This study used a mixed quantitative-qualitative approach to investigate the economics of the implementation of Problematic Sexual Behavior – Cognitive-Behavioral Therapy (PSB-CBT), an evidence-based treatment for problem sexual behaviors in youth. We used cost-effectiveness ratios (CERs) to compare the direct and indirect costs of PSB-CBT to

self- and caregiver-reported youth clinical outcomes (i.e., problem sexual behavior as well as secondary behavioral health problems). CERs represented the cost of achieving one standard unit of change on a measure (i.e., $d = 1.0$). The design and interpretation of those quantitative analyses were informed by qualitative themes about program costs and benefits that were derived from interviews with 59 therapists, administrators, and stakeholders. CERs (i.e., \$ per SD) were \$1,772 per youth for problem sexual behavior and ranged from \$2,867 to \$4,899 per youth for secondary outcomes. These quantitative results, considered alongside the qualitative perspectives of interviewees, suggested that the implementation of PSB-CBT was cost-effective. The results were robust to uncertainty in key parameters under most, but not all, conditions.”

Winokur, Marc, Desiree Rosen, Keri Batchelder and Deborah Valentine (2006). “Juvenile Sexual Offender Treatment: A Systematic Review of Evidence-Based Research.” Report for the Applied Research in Child Welfare Project, Colorado State University.

From text (citations omitted): “According to the results, there is a small to moderate positive effect of treatment on the recidivism rates of JSO. Specifically, juveniles who complete a cognitive-behavioral treatment program are less likely to commit a sexual or nonsexual re-offense than are juveniles who do not receive treatment, receive an alternative treatment, or do not complete treatment. Thus, the studies in the evidence base ‘provide empirical support for the belief that the majority of juvenile sex offenders are amenable to treatment and achieve positive treatment outcomes.’ The sparse results from the subgroup analyses indicate that cognitive-behavioral treatment is effective in both community and residential settings.”

Dopp, Alex R., Cameron M. Perrine, Kathryn E. Parisi, Morgan A. Hill, and Michael F. Caldwell (2020). “Evidence-Based Assessment and Treatment Approaches for Adolescents Who Have Engaged in Sexually Abusive Behavior,” in Jean Proulx, Franca Cortoni, Leam A. Craig, and Elizabeth J. Letourneau (eds.), *The Wiley Handbook of What Works with Sexual Offenders: Contemporary Perspectives in Theory, Assessment, Treatment, and Prevention*. doi: 10.1002/9781119439325.ch15

From text: “Overall, results to date support PSB-CBT as a valuable and economically viable intervention for youth with SAB. It is currently the only empirically supported CBT-based treatment for this population. However, it is important to note that PSB-CBT has never been directly compared to CBT-RP in a research trial, and that information from mediators and moderators of PSB-CBT is not currently available.”

PSB-CBT-A, specifically

Jenkins, Carrie S., Julia R. Grimm, Emily Knight Shier, Simaya van Dooren, Elizabeth R. Ciesar, Kathryn Reid-Quinones (2020). "Preliminary findings of problematic sexual behavior-cognitive-behavioral therapy for adolescents in an outpatient treatment setting." *Child Abuse & Neglect* 105. doi: 10.1016/j.chiabu.2020.104428

Authors' Abstract (abbreviated): "The lack of empirical support for interventions commonly used to treat adolescents with problematic sexual behaviors (PSB) has led to restrictive policies and interventions largely based on perceptions of these youth as younger versions of adult sex offenders, without consideration for developmental and etiological differences between populations. Th[is] study examined outcomes for 31 adolescents who completed Problematic Sexual Behavior – Cognitive Behavioral Therapy for Adolescents (PSB-CBT-A) at a Children's Advocacy Center between 2013 and 2016. Adolescent PSB-CBT-A treatment completers demonstrated a trend towards statistical significance in reduction of PSB on the YSBPI from 5.33 (SD = 6.86) at pre-treatment to 0.17 (SD = 0.41) at completion. Additionally, significant reductions in caregiver-reported youth internalizing and externalizing problems were associated outcomes of completing PSB-CBT-A ($t(13) = 5.00, p < .001$ and $t(13) = 2.34, p = .036$, respectively). The promising results achieved in this study support further exploration of low-intensity outpatient treatment interventions for adolescents with PSB."