Juveniles Who Sexually Offend: Recommending a Treatment Program and Level of Care

R. Gregg Dwyer, MD, EdD[a,b,*], Elizabeth J. Letourneau, PhD[c]

KEYWORDS

• Juveniles • Sexual offending • Evaluation
• Risk assessment • Treatment

Sexual offending by juveniles has been a significant problem in the United States for many years. Based on national victimization data, approximately one-quarter (26.3%; n = 42,151) of single perpetrator rapes are committed by adolescents.[1] Based on 2008 national arrest data, adolescents account for 15% (n = 2505) of forcible rapes and 18% (n = 11,029) of sex offenses other than forcible rape and prostitution.[2] These figures are consistent with the study of sex crimes against children that estimated that adolescents commit 23% of all sex offenses, 4% of offenses against adults, 33% of offenses against all ages of children, and 40% of offenses against victims less than 6 years of age.[3] When minors are the victims, 35.6% had juvenile perpetrators, with 1 out of 8 offenders being younger than 12 years.[4] Police involvement in such cases increases significantly when juveniles who sexually offend are aged 12 to 14 years and then plateaus. Offenders in middle and late adolescence tend to be more likely to have victims who are teenagers rather than preteens.[4]

HISTORICAL ATTITUDES

From early on, juveniles who sexually offended were viewed as mini-adults in terms of offending cause and risk and, therefore, treatment approaches. This in part was

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[a] Forensic Psychiatry Program, Department of Psychiatry and Behavioral Sciences, Medical University of South Carolina, Charleston, SC, USA
[b] Sexual Behaviors Clinic and Lab, Department of Psychiatry and Behavioral Sciences, Medical University of South Carolina, Charleston, SC, USA
[c] Department of Psychiatry and Behavioral Sciences, Family Services Research Center, Medical University of South Carolina, Charleston, SC, USA
* Corresponding author. Forensic Psychiatry Program, Department of Psychiatry and Behavioral Sciences, 29-C Leinbach Drive, Charleston, SC 29407.
E-mail address: dwyer@musc.edu

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because of the observation that some paraphilic adult offenders began offending during adolescence, which led to the misconception that unmodifiable, traitlike characteristics (eg, deviant arousal patterns) were at the root of all sexual offending.[4] Programs for juveniles originated in the late 1980s and early 1990s that essentially replicated adult treatment models. There was a belief that juveniles who committed sex offenses were destined to become adult sexual predators and therefore should be treated as adults in terms of treatment content and setting, with the latter often being a secure placement.

The 1993 Revised Report from the National Task Force on Juvenile Sexual Offending cemented the view that juveniles who sexually offend were predestined to become adult sex offenders. Thus, treatment was intended to facilitate control of (rather than elimination of) abusive behaviors.[5] It was assumed that treatment had to be sex offense specific and be conducted in groups composed entirely of youths who had sexually offended. At the time, confrontational approaches were common in adult programs and hence were also introduced with juveniles. Elimination of offense denial was a requirement for community placement and/or treatment completion. Programs often combined aspects of psychodynamic, cognitive, behavioral, and educational approaches, and others focused exclusively on addressing deviant arousal.[5] However, work on identification and breaking of the cycle of offending was a common goal. Again, this was an outgrowth of the adult approach that was based on a substance abuse treatment model. Duration of treatment of juveniles was generally expected to be 12 to 24 months and often in criminal justice or private residential settings.[5]

Since 1986, the Safer Society Press has published results from 9 sex offender treatment provider surveys.[6] These surveys provide a snapshot of clinical practices in the United States and (most recently) Canada, with results separated by client gender, age (adult, adolescent, child), and treatment setting (community based or residential). Based on these surveys and other reviews (eg, American Academy of Child and Adolescent Psychiatry[7]), cognitive-behavioral therapy within a relapse-prevention framework (CBT-RP) quickly became and remains the dominant theory on which treatment programs for juveniles who sexually offended were developed.

Thus, more than 85% of programs serving adolescent boys indicated that cognitive-behavioral theory was one of the primary theories guiding their programs, with relapse prevention the next most frequently endorsed theory, followed by psychosocial-educational theory. Consistent with these theories, which emphasize youth-level deficits as the primary drivers of juvenile sexual offending, treatment targets nearly always included social skills training, improving victim awareness and empathy, taking responsibility for the offense, problem solving, and intimacy/relationship skills building.

Treatment modalities have also included occasional use of medications such as antiandrogens and selective serotonin reuptake inhibitors, occasional individual psychodynamic therapy, and family therapy.[8]

Because of the numerous treatment targets and mix of treatment modalities that comprise typical programs, the duration of community-based treatment is 14 months and programs require an average of 182 hours for completion (excluding aftercare or booster sessions).[6] However, many of the individual youth deficits targeted by programs do not consistently map onto the treatment or criminogenic needs of these youth. For example, neither offender denial nor level of victim empathy predict recidivism, yet both are nearly universally targeted in treatment programs. Research on adults who have sexually offended suggests that the inclusion of noncriminogenic needs dilutes treatment effectiveness,[9] as does mismatching treatment dose with individual risk level.[10] One study showed that lower-risk adult sex offenders benefited