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Integrating research into practice: The *Forward-Focused Model* of adolescent sexual behavior treatment

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ABSTRACT

Knowledge of adolescents with sexual behavior problems has continued to grow over the past two decades, further differentiating the needs of this group from adult sex offenders. However, treatment programs based upon the current literature have yet to be fully articulated. In an attempt to address this gap between knowledge and practice, a comprehensive treatment program for adolescents with sexual behavior problems was developed: the *Forward-Focused Model*. The *Forward-Focused Model* is rooted in cognitive–behavioral theory, incorporates motivational approaches, and is developmentally-sensitive to address the unique needs of adolescents. This empirically-based model is introduced in this article.

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1. Introduction

Over the last decade, knowledge of clinical philosophies and methods for treating adolescents with sexual behavior problems has shifted dramatically. This is in large part due to a growing body of research dedicated to adolescent offenders (Mulder, Brand, Bullens, & Van Marle, 2010), to literature dedicated specifically to juveniles who have sexually offended (Caldwell, 2010; Calley, 2012; Chu & Thomas, 2010; Hendriks & Bijleveld, 2008; Lipsey, 2009; McCann & Lussier, 2008; Reitzel & Carbonell, 2006; Van Vugt et al., 2008; Viljoen, Elkovitch, Scalora, & Ullman, 2008), and to some degree, driven by an intent to better inform the treatment of this population. However, this is also due to substantial gains in knowledge of adolescent development and its implications in adolescent behavior and adolescent learning (Galvan, Hare, Voss, Glover, & Casey, 2006; Monahan, Steinberg, Cauffman, & Mulvey, 2009; Steinberg, 2009a). Indeed, how we think about the treatment needs of adolescents with sexual behavior problems today is vastly different than how treatment was conceptualized 10 years ago. This is largely because treatment of adolescents with sexual behavior problems has historically been guided by treatment protocols and practices designed for adult sex offenders often as a result of our severely limited knowledge of the unique differences between adolescents and adults who had sexually offended.

Some steps have been taken to re-conceptualize sexual behavior treatment in a developmentally-sensitive manner (Hunter, Gilbertson, Vedros, & Morton, 2004). In addition, an ecologically-based model that is both family-focused and developmentally-sensitive has been modified for use with adolescents with sexual behavior problems and initial results have demonstrated some degree of effectiveness (Letourneau et al., 2009). Other attempts to respond to the emerging knowledge of the distinct treatment needs of adolescents with sexual behavior problems have been limited to addressing key developmental issues, such as cognition (Van Vugt et al., 2008) and affect (Calley & Gerber, 2008). Others have proposed the expansion of models that were previously informed by adult treatment philosophies (Kahn, 2011; Ward, Mann, & Gannon, 2006). As a result, there continues to be a significant gap in the literature. This article serves as an attempt to begin to address this gap by introducing an empirically-informed treatment model specifically designed for adolescents with sexual behavior problems, the *Forward-Focused Model*. Before introducing the model, a brief summary delineating the significant changes in juvenile sex offender knowledge over the past 15 years is provided.

2. Review of the literature

2.1. Juvenile sex offender treatment: the past

Historically, the treatment of adolescents with sexual behavior problems was based on adult treatment models (Letourneau & Borduin, 2008). This was largely due to the fact that the body of knowledge that was initially established on sexual offending was specifically focused on adult offenders. As a result, this knowledge was used to inform our initial understanding of adolescent sex offenders as well as to guide treatment decisions and management of this group.

Whereas the models of adult sex offender treatment have evolved as new knowledge has been discovered, over the past several decades, these models have primarily included one or more of three components: a risk–need–responsivity (RNR) approach, relapse prevention strategies, and cognitive behavioral interventions. The RNR framework is based on the notion that an offender's risk level, criminogenic needs, and responsivity to various types of treatment and learning must each be assessed and used to inform treatment (Andrews & Bonta, 2010; Hanson, Bourgon, Helmus, & Hodgson, 2009). As a result, offenders with higher risk levels receive more intensive treatment than those with lower levels of risk while specific criminogenic and dynamic risk factors are addressed to remediate behavioral challenges and other deficits. Incorporating the responsivity principle means that treatment strategies are designed to meet the offender's motivational level, learning style, and culturally-based needs (Whitehead, Ward, & Collie, 2007). Whereas the RNR framework is used to guide assessment and treatment planning decisions for offenders, relapse prevention (RP) strategies are primarily focused on promoting effective self-management of offenders post-treatment (Schaffer, Jeglic, Moster, & Wnuk, 2010). As such, offenders are taught new coping methods and strategies during treatment to provide increased protection against recidivism following treatment and particularly, during community reintegration.

To some degree, because of the key objectives of both RNR and RP, cognitive–behavioral strategies have provided the primary therapeutic interventions for adult sex offender treatment. Cognitive–behavioral therapy (CBT) is based on the premise that the interplay of cognitions, behaviors, and affect contributes to the development of both adaptive and maladaptive behaviors. In addition, CBT is based on the assumption that individuals can learn new ways to effectively cope and as such, can become self-managing. With regard to the development of maladaptive behaviors in adult sex offenders, it has been suggested that this may have resulted from cognitive distortions (i.e., faulty thinking) and negative cognitive schemas (Keenan & Ward, 2000; Polaschek & Gannon, 2004; Polaschek & Ward, 2002). In addition, it has been suggested that affective deficits may be linked to a lack of empathic understanding or restricted emotional range (Ward & Beech, 2006; Yates et al., 2000).

RNR, RP, and CBT have provided us with essential tools to guide the treatment and management of adult sex offenders, and have to some degree, been empirically guided for its relevance to adult sex offending (Andrews & Bonta, 2010; Hanson et al., 2009; Losel & Schumaker, 2005). In addition, responding to the identification of specific cognitive and affective vulnerabilities related to adults who sexually offend, treatment programs for adult sex offenders have targeted empathy development and cognitive restructuring (Yates, Prescott, & Ward, 2010). Moreover, whereas affective work has primarily emphasized empathy development and expanding the offender's emotional range, interventions to promote effective cognitive functioning have emphasized the reduction and/or elimination of cognitive distortions and deviant thought patterns. In addition, some emphasis has been placed on the promotion of effective adult interpersonal functioning.

Because of the strong body of knowledge established on adult sexual offenders and the comparatively small body of knowledge on adolescents with sexual behavior problems that existed 15 years ago, it may have been a natural reaction to utilize the adult research to inform the treatment of adolescents with sexual behavior problems. In fact, the National Task Force on Juvenile Sex Offending coordinated by the National Adolescent Perpetrator Network (1993) recommended major areas that needed to be addressed in juvenile sex offender treatment, most of which were the same as those recommended for adult sex offenders. The recommendations included, but were not limited to, such issues as: Identification of the pattern/cycle of abuse, understanding the consequences of offending to self, victim and community, resolution of victimization in the history of the offender, understanding the role of sexual arousal, management of addictive qualities, identification and interruption of the cycle, development of empathy, and the development of relapse prevention skills. Despite the fact that two decades have passed since these recommendations were first promulgated, treatment of adolescents with sexual behavior problems has continued to be largely informed by these recommendations (Becker & Kaplan, 1993; Chaffin & Bonner, 1998; Letourneau & Borduin, 2008; Zimring, 2004). (It should be noted that the work of the Task Force has not been comprehensively updated since the recommendations were initially promulgated). In addition, similar to the clinical philosophy of adult sex offenders, treatment of adolescents with sexual behavior problems emphasized sexual deviance, re-conditioning of maladaptive behaviors, and relapse prevention, as well as the utilization of cognitive–behavioral strategies to address these and other major issues. As such, treatment based on cognitive–behavioral theory that emphasizes relapse prevention became the