The first article in this series noted the variety of methodological issues in the study of treatment effectiveness for adults who have committed sexual offenses, including problems with the operationalization of treatment outcome, sampling bias, and failure to consider sources of within study variance (e.g., treatment fidelity and other therapist factors). All the same limitations apply to the research on treatment of adolescents who have engaged in illegal sexual behavior (AISBs). The most commonly used approaches are derived from treatments for adults who have committed sexual offenses (Cognitive Behavioral Therapy and Relapse Prevention; McGrath, Cumming, Burchard, Zeoli, & Ellerby, 2010); other approaches are extensions of treatments designed for serious (non-sexual) adolescent offenders (Multisystemic Therapy). There is less research available on treatment outcomes with adolescents than adults, however a more optimistic overall picture emerges regarding the futures of these youth.

There is now a fairly large body of literature addressing treatment approaches for AISBs; however, that literature is dominated by descriptive papers, chapters, and books and most of the research has significant methodological flaws. As a result, the four meta-analyses published on the effectiveness of treatment specifically for AISBs include very few studies (14 studies, ter Beek et al., 2018; 8 studies, Kettrey & Lipsey, 2018; 9 studies, Reitzel & Carbonell, 2006; 10 studies, Walker, McGovern, Poey, & Otis, 2005). The largest of the meta-analyses found a significant, moderate treatment effect on officially-detected recidivism ($d = 0.37$), however there was no significant treatment effect after correcting for potential publication bias (ter Beek et al., 2018). There was no difference in effect based on the use of sexual, non-sexual, or any recidivism as the outcome measure. Kettrey & Lipsey (2018) similarly found no effect of treatment on sexual recidivism but did find a significant effect of treatment on general recidivism in their more restricted sample of studies. The choice of officially-detected recidivism as an outcome in these two meta-analyses may have limited the ability to detect true treatment effects; the use of self-report may result in greater variance in the outcome variable which in turn facilitates the detection of a treatment effect. Walker and colleagues (2005) considered several types of outcomes and found that studies using self-reported recidivism had a notably larger effect size ($r = 0.48$) than those that relied upon officially-detected recidivism ($r = 0.26$). Nonetheless, the small set of studies in these groups (three each) and the methodological limitations of the studies preclude any firm conclusions about the meaning of this difference.
Every meta-analysis conducted to date has lamented the poor quality of available studies and noted that the small samples and problematic methods limit the overall conclusions that can be drawn from the meta-analytic results.

The very low rate of sexual recidivism in this population likely contributes to the inability to detect a treatment effect. A meta-analysis of sexual recidivism rates including over 100 studies found a weighted mean sexual recidivism rate of 4.92% over an average of about 5 years of follow-up (Caldwell, 2016). The power to detect a reduction in recidivism when the base rate is less than 5% is vanishingly low. Furthermore, recent studies have an even lower weighted average sexual recidivism rate (2.75% in studies from 2000 – 2015; Caldwell, 2016). This may help explain the lack of effect after controlling for publication bias in ter Beek et al. (2018) as many of the included studies were published during this time; however, less than half of the studies included in the Kettrey and Lipsey (2018) meta-analysis were published in 2000 or later.

The inability to detect a reduction in sexual recidivism is not a reason to conclude that treatment for AISBs isn’t necessary or doesn’t work. AISBs share a number of problems with adolescents who engage in non-sexual offending (e.g., Fanniff, Schubert, Mulvey, Iselin, & Piquero, 2017; Seto & Lalumière, 2010) and are routinely found to have higher general recidivism than sexual recidivism rates (e.g., Caldwell, 2010; Fanniff, et al., 2017) demonstrating the need for intervention for many of these youth. Further, given this data, treatments that are effective for general adolescent offending populations are likely to be useful with most AISBs, the vast majority of whom do not present with persistent deviant sexual interests (e.g., van Wijk et al., 2007). Indeed, the only treatment approach classified as probably efficacious in a recent systematic review is Multisystemic Therapy for Problem Sexual Behaviors (MST-PSB, Dopp, Borduin, Rothman, & Letourneau, 2017).

MST-PSB is a community- and family-based model of service that directs the treatment of risks and needs using empirically-supported interventions with the ultimate goal being “to empower caregivers (and other important adult figures) with the skills and resources needed to address the youth’s problem sexual behaviors and other behavior problems” (Dopp et al., 2017, p. 635). Its classification as probably efficacious was based on demonstrated treatment effects on officially-detected recidivism as well as self- and parent-reported problem sexual behaviors (e.g., Borduin, Schaeffer, & Heiblum, 2009; Letourneau et al., 2013); that said, the other treatment effects of MST-PSB seem equally important given the low sexual recidivism rates of AISBs. MST-PSB been shown to reduce general delinquency, out-of-home placements, and association with delinquent peers as well as to improve maturity, bonding to peers, and academic performance (Borduin et al., 2009; Henggeler et al., 2009; Letourneau et al., 2013). Facilitating positive adjustment likely protects against future antisocial behavior – sexual or otherwise.

The most widely utilized approach to treatment for AISBs is Cognitive-Behavioral Therapy (CBT), often combined with Relapse Prevention (McGrath et al., 2010). Although there are also positive evaluations of the results of such treatment (e.g., Worling, Litteljohn, & Bookalam, 2010), the methodological limitations of CBT outcome studies precluded their classification as possibly or probably efficacious (Dopp et al., 2017). Notably, some of the best
available research demonstrating reductions in recidivism subsequent to CBT includes significant collaboration with families to target a variety of risk factors and clinical needs (e.g., Worling et al., 2010), providing further evidence that treatment addressing broader factors than individual sexual behavior is the most promising way to treat this population.

Over a decade ago, Letourneau and Borduin (2008) articulated an ethical imperative to conduct high-quality research to determine what treatments work for AISBs. The minimal research that met inclusion criteria for the Beek et al. (2018) and Kettrey and Lipsey (2018) meta-analyses indicate that this call to action has not been heeded. Despite the challenges of conducting such research, the necessity is undeniable. The amount of resources expended on treatment for AISBs, the deprivation of liberty they face given that they are often treated in residential settings, and the unknown efficacy of the treatment currently being provided to the vast majority of youth all point to the need for further study. Letourneau and Borduin (2008) noted “it is imperative that we ensure that treatment is effective at improving both instrumental and ultimate outcomes and that youth are not harmed in the process” (p. 301). They also noted the importance of developing new approaches to treatment of AISBs; some innovative approaches have been described in the literature but still require rigorous evaluation (e.g., Hunter, Gilbertson, Vedros, & Morgan, 2004; Prentky, Righthand, & Lamade, 2016).

There is reason for optimism that AISBs can lead productive, offense-free lives as adults (e.g., Fanniff et al., 2017; McCuish, Lussier, & Corrado, 2016; van den Berg, Bijleveld, Hendricks, & Mooi-Reci, 2014). Investment in the identification of effective treatments will help us achieve multiple goals: improving public safety, facilitating more cost-efficient intervention, and protecting youth from unhelpful services, unnecessary separation from support, and excessive deprivation of liberty.
References


