INTRODUCTION

Juveniles with sexual behavior problems (JSBP's) who commit sexual acts against another constitute a significant threat to public safety and welfare (Karakosta, 2015; Rehfuss et al., 2013). Juveniles adjudicated for sex offenses are often mandated to participate in treatment programming specifically addressing sexual behavior problems (Karakosta, 2015; Underwood & Knight, 2006). Juveniles with sexual behavior problems represent a special public concern for treatment providers in the community and juvenile justice administrators. Interventions for JSBPs tend to be based upon the goals of public safety and victim protection (Crump et al., 2013). In essence, the aim of treatment is often to reduce recidivism rates, or rates at which juveniles re-offend.

According to the Federal Bureau of Investigation, 14.3 percent of forcible rapes and 17 percent of other inappropriate sexual behavior perpetrated by youths under the age of 18 (Crump et al., 2013). It was estimated that 20 percent of sexual assaults and 30 to 50 percent of child molestations are committed by juveniles under the age of 18, according to a report in 2000 (Crump et al., 2013). Additionally, many adjudicated juveniles with sexual behavior problems admit to committing their first offense at approximately 12 to 15 years of age (Crump et al., 2013). Research has revealed that half of convicted adults with sexual behavior problems reported the initiation of their sexually abusive behaviors in adolescence (Underwood, Robinson, Mosholder, & Warren, 2008).

While much research is focused on the important goal of reducing recidivism rates of juvenile sex offending, Rehfuss et al. (2013) contends that few studies have measured the effectiveness of juvenile sex offender treatment programs in addressing the psychosocial needs relevant to characteristics consistent with juvenile sex offenders. Not only is the goal of treatment and rehabilitation to protect the community, it is also important to increase the quality of life and social skills of adjudicated juveniles with sexual behavior problems. Karakosta (2015) expressed that a failure to adequately examine treatment programs that address sexual behavior problems, as well as increase positive psychosocial changes, undervalues the juvenile

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problems appears to differ between juvenile arrestees, juveniles brought to court, juveniles assessed by the court, and incarcerated

has suggested that JSBPs do suffer from a significant range of mental health and substance use disorders (Apsche et al., 2004). In addition, JSBPs who have committed child molestation or rape, have a higher risk of recidivating for both sexual offenses and non-sexual crimes (e.g. vandalism, arson, theft; Harris et al., 2003; Underwood et al., 2008).

Trauma, childhood abuse, and adverse childhood experiences increases the possibility of youth externalizing their symptoms and engaging in various types of antisocial behavior. This is possibility is even greater for juvenile sex offenders. Additionally, juvenile sex offenders tend to experience more internalizing problems, related to emotional problems, social deficits, and behavioral/adaptive problems. It may be even more problematic for juveniles with sexual behavior problems in residential or secure-care facilities. As such, these highlight the need for sex offender treatment programming to be able to address some of these underlying psychosocial factors.

Common Interventions

The general tenets of Juvenile justice administrators include rehabilitation, control, and custody. These emphases have led to the need to implement best-practice and evidence-based treatment interventions to juvenile offenders (Underwood and Knight, 2006). Estimates indicate that 50 to 70% of juvenile offenders have diagnosable mental health issues and may need services not merely specific to their offense (Teplin, Abram, & Washburn, 2013; Underwood and Knight, 2006; Underwood and Washington, 2016). In essence, JSBP's present with other internalizing mental health problems not directly correlated with the sexual offense (i.e., depression or anxiety). Additionally, many incarcerated youth, including juvenile sex offenders, may have learning or intellectual disorders, or may have been exposed to adverse childhood experiences or significant traumatic events (Bailey et al., 2007; Boonmann et al., 2015; DeLisi et al., 2017). Finally, the interpersonal and behavioral deficits commonly associated with juvenile sex offenders, suggest that treatment must provide some development of prosocial skills.

An intervention program consisting of cognitive-behavioral interventions within a multisystemic (or integrated) approach carried out within an institutional setting, may best allow for justice to maintain its tenets of retribution, deterrence, and rehabilitation. A multisystemic treatment approach may include, individual, group, and or family therapy within various types of settings (residential or community). A mixture of these treatment modalities (to include individual, group, and family therapy) has been deemed an effective approach in addressing the various emotional, social, and behavioral needs of juveniles with sexual behavioral problems (Borduin et al., 2009; Letourneau et al., 2009; Rehfuss et al., 2013; Karakosta, 2015). Literature on the treatment of juveniles with sexual behavior problems indicates that cognitive behavioral models show the greatest effectiveness for offenders involved in multidimensional programs (Underwood and Knight, 2006). Additionally, a cognitive-behavioral framework allows for therapeutic facilitators to integrate multiple interventions that address various issues related to the juvenile offender's ability to change (Underwood & Knight, 2006; Efta-Breitbach & Freeman, 2004; Rehfuss et al., 2013; Borduin et al., 2009; Karakosta, 2015).

The Integrated Sex Offender Treatment Program Model

The Louisiana Office of Juvenile Justice (OJJ) recognized in 2008 that there was no standard level of care or collaboration on the best-practice treatment of juveniles with sexual behavior problems within the legal system (Crump et al., 2013). TheLouisiana OJJ found that juveniles with sexual behavior problems received inconsistent or confusing care, and that youth may have spent much time in secure-care when a less restrictive setting would have been optimal (Crump et al., 2013). Additionally, due to community care limitations, the continuity of care for juveniles with sexual behavior problems was often inadequate (Crump et al., 2013). In efforts to carry out the mission of effective care and limited harm, the OJJ has reserved secure-care for offenders with a greater risk of reoffending, and community-care for offenders who pose a lesser risk (Crump et al., 2013). In 2008, the Louisiana OJJ received a grant award to address concerns related to assessment, placement, and treatment of adjudicates juveniles with sexual behavior problems (Crump et al., 2013).

As a result, a modified comprehensive integrated treatment Program—Louisiana Sex Offender Treatment Program (LSOTP)—for juveniles adjudicated for sexual offenses in Louisiana was developed. Juveniles in secure-care receive comprehensive psychosexual assessments, and those with lower risk levels receive treatment in a clinic-based format (i.e., they are placed in general population dorms with juveniles adjudicated for non-sexual offenses). Individual and group therapy is provided to juveniles with sexual behavior problems one to two times weekly and family therapy is provided monthly (Crump et al., 2013). Higher risks JSBPs receive individual, group and family therapy with more intensity, frequency, and duration. Group therapy is conducted in three phases of 12 to 16 weeks each. The Louisiana Sex Offender Treatment Program (LSOTP) consists of four stages of care that address, social skills, impulse control, healthy sexuality/relationships, masculinity, anger management, empathic understanding, relapse prevention, and aftercare.

This program is a multi-faceted treatment process that takes the sex offender through an initial phase of screening and assessment, through behavioral health treatment interventions, leading to admission for successful discharge from the program. Behavioral health treatment interventions utilized within the program include (1) individual counseling and case management, (2) family interventions, and (3) crisis intervention services. Individual counseling targets individual behavioral deficits, distortions, and developmental needs and fosters the skills required by individual residents to manage and cope with different persons, places, and situations. Individual case management helps map out individual responses in crisis situations, reinforces the use of behavioral management skills and addresses other needs that are not appropriate for group skills training. Family interventions are designed to engage family members or legal guardians in the treatment process. Mental health providers inform the resident's family about placement in the program and encourage participation in the treatment process in person or via telephonic conference. Crisis intervention services are also available on a continuous basis to any resident who is experiencing acute distress. The program was designed to enhance recognition of appropriate sexual boundaries and bolster emotional stability and self-control, addressing the various problem areas relevant to juveniles with sexual behavior problems.

Purpose of the Study

This study examinedwhether juveniles with sexual behavior problems receiving LSOTP services at two secure-care facilities experienced positive changes in psychosocial factors over time. This study is the initial portion of a larger longitudinal study and the purpose of this study was to determine if there are significant positive changes in juvenile sex offender's reported levels of anxiety, depression, and cognitive distortions after receiving 13 weeks of LSOTP services. This was done in order to track the longitudinal impact of receiving LSOTP services and provide guidance for future studies with the Louisiana Sex Offender Treatment Program. Specifically, it was hypothesized that juveniles with sexual behavior problems involved in LSOT programming would: (1) Experience a decrease in reported depression symptoms from Time 1 to Time 2,

depression, and cognitive distortions after participants had received 13 weeks of LSOTP services. Table 1 provides a summary of Dependent-Samples t-test results.

Data Screening/Diagnostics

related to rape and molestation after 13 weeks of treatment. This was

evaluate the validity and reliability of the use of Bumby Cognitive Distortion Scales with youth in secure-care facilities. This study achieved demonstrable success using the Bumby Rape Scale even though it was designed specifically for adults and is commonly used in clinical treatment settings with youth offenders. The limited success with the Bumby Rape Scale, along with observed comprehension and attentional difficulties, indicate that some attention to the applicability with this population should be explored in future studies.

As a complement to the quantitative analyses being conducted on the impact of LSOTP services in secure-care facilities, a more qualitative study design is recommended. Aphenomenological-qualitative design would provide an opportunity to explore meaningful experiential information that focuses on participants' experiences and their interpretation of their experiences while receiving LSOTP services. A study as such, would explore the relationship between noted experiences and family, medical, personal, and criminal histories. Thus, the obtained information would provide meaningful interpretation of the individuals receiving LSOTP services in a secure-care setting.

Implications

Given the variety of theoretical approaches to treatment interventions for JSBPs and the various treatment options available to practitioners, the need for empirical evidence supporting the efficacy of such treatments is apparent. This study offers some empirical evidence for the efficacy of LSOTP services across time in the state of Louisiana, specifically in the management of anxiety and rape-related cognitive distortions relevant to youth with sexual behavior problems. As such, the first implication of this study for treatment providers is to support the validity of LSOTP services as a relevant treatment approach for anxiety and rape-related cognitive distortions in Louisiana secure-care facilities.

There is a wide spectrum of sexual offense charges, from Lewd and Lascivious Conduct, to more serious charges of Rape. Additionally, for juveniles with sexual behavior problems in secure-care, their criminal charges may consist of a clear sexual assault or be accompanied by crimes in other areas. Awareness of the nature of charges when providing treatment with juveniles with sexual behavior problems would be helpful. The nature of the charges likely suggests some differences in psychological profile, risk factors, and demographic influences. It is also important to note that the exhibited sexual behaviors may differ from the charges the youth was adjudicated for. Some juveniles may have committed more heinous crimes, than reflected by the actual charges due to the plea-bargaining process. Additionally, secure-care facilities are the most restrictive environment and often a last choice, thus providers may want to account for historical sexual behaviors that may exist with youth. As mentioned by Karakosta (2015), treatment providers need to be aware that youth conduct may be divergent from actual legal charges.

Of grave importance, is the need for providers to understand the difference between maladaptive sexual and criminal behaviors that are sexually problematic in nature. Essentially, treatment providers should be able to differentiate between sexual behaviors that are merely maladaptive and deviate from social norms, versus those that are violations of the law. This consideration is implicative for treatment planning and issues related to governing ethics.

A final implication of this study is that factors such as depression and anxiety have been linked to JSBPs and those who commit sex crimes. These psychological factors may not be causally connected, or may only be partially related. For example, this study found anxiety was relevant to this sample of JSBPs, but depression may not have been. Additionally, the secure-care setting can often be anxiety-provoking and depending on length of time in the environment or exposure to restrictive environments as such juveniles in secure facilities may in general exhibit heightened levels of anxiety. Regardless of treatment training, providers should be able to identify symptoms of anxiety and depression so appropriate and timely services can be provided. Essentially, individuals providing treatment to JSBPs in secure-care facilities should have adequate training to accurately diagnose mental health conditions or accurately identify problematic psychological factors underlying the juvenile's condition.

CONCLUSION

The results of the study provide reasonable support for the integrated approach offered through the LSOTP in the treatment of juvenile sex offenders with anxiety and rape-related cogntive distortions. This study demonstrates that sexually maladaptive behaviors based on rape-related cognitive distortions are amenable to improvements and accompanying heightened anxiety is amenable to reduction for juvenile sex offenders within the LSOT program. The observations made via this research study contributes to the growing body of empirical evidence supporting the use of integrated, multisystemic treatment approach to address some of the psychosocial needs of juveniles with sexual behavior problems. The measures used in the study indicate, with a small to medium effect size, that juvenile sex offenders receiving LSOTP services in secure-care facilities experience improvements in anxiety level and cognitive distortions related to rape. This research supports the use of LSOTP services with juvenile sex offenders in secure-care facilities to bring about significant improvements in intrapersonal and interpersonal factors consisted with maladaptive sexual behaviors, to include perceptual misconceptions and anxiety.

REFERENCES

Apsche, J.A., Evile, M.M., & Murphy, C. (2004). The thought change system an empirically based cognitive behavioral therapy for male adolescent sex offenders. *The Behavior Analyst Today, 5*(1), 101-107.

Bailey, S., Whittle, N., Farnworth, P. & Smedley, K. (2007), A developmental approach to violence, hostile attributions, and paranoid thinking in adolescence. *Behavioral Science & The Law,* 25: 913–929.

Berenson, D. & Underwood, L.A. (2001). A resource guide: Sex offender programming in youth correction and detention centers. Council For Juvenile Correctional Administrators (CJCA) & The Federal Office of Juvenile Justice Delinquency Prevention (OJJDP):Washington, D.C.

Boer, D.P. (2013). Some essential environmental ingredients for sex offender reintegration. *International Journal of Behavioral Consultation and Therapy,* 8(3), 8-11.

Boonmann, C., Nelson, R., Dicataldo, F., Jansen, L., Doreleijers, T., Vermeiren, R. et al. (2015). Mental health problems in young male offenders with and without sex offences: a comparison based on the MAYSI-2. *Criminal Behaviour and Mental Health*.

Boonmann, C., Grisso, T., Guy, L.S., Colins, O.F., Mulder, E.A., Vahl, P., et al. (2016). Childhood traumatic experiences and mental health problems in sexually offending and non-sexually offending juveniles. *Child and Adolescent Psychiatry and Mental Health*, *10*, 45.

Borduin, C.M., Schaeffer, C.M., & Heiblum, N. (2009). A randomized clinical trial of multi-systemic therapy with juvenile sexual offenders: Effects on youth social ecology and criminal activity. *Journal of Consulting and Clinical Psychology, 77*, 26–37.

Bumby, K.M. (1996). Assessing the cognitive distortions of child molesters and rapists: Development and validation of the molest and rape scales. *Sexual Abuse: A Journal of Research and Treatment, 8,* 37-54.

Cale, J., Lussier, P., McCuish, E., & Corrado, R. (2015). The prevalence of psychopathic personality disturbances among incarcerated youth: Comparing serious, chronic, violent and sex offenders. *Journal of Criminal Justice, 43*, 337–344.

Cauffman, E. (2004). A statewide screening of mental health symptoms among juvenile offenders in detention. *Journal of the American Academy of Child and Adolescent Psychiatry, 43*, 430-439.

Crump, Y., Underwood, L.A., & Dailey, F.L. (2013). Louisiana office of juvenile justice's comprehensive statewide approach to treating juveniles with sexual behavior problems. *Corrections Today (September/October)*, 60-84.

Cuellar A.E., McReynolds, L.S., Wasserman, G.A. (2006). A cure for crime: Can mental health treatment diversion reduce crime among youth? *Journal of Policy Analysis and Management, 25*, 197-214.

DeLisi, M., Alcala, J., Kusow, A., Hochstetler, A., Heirigs, M., Caudill, J., et al. (2017). Adverse childhood experiences, commitment offense, and race/ethnicity: Are the effects crime-,race-, and ethnicity-specifc? *International Journal of Environmental Research and Public Health, 14*, 331-342.

DeLisi, M., Kosloski, A.E., Vaughn, M.G., Caudill, J.W., & Trulson, C.R. (2014). Does childhood sexual abuse victimization translate into juvenile sexual offending? *New Evidence. Violence and Victims, 29*, 620–635.

Drury, A.J., Heinrichs, T., Elbert, M.J., Tahja, K.N., De-Lisi, M., & Caropreso, D.E. (2017). Adverse childhood experiences, paraphilias, and serious criminal violence among federal sex offenders. *Journal of Criminal Psychology*.

Efta-Breitbach, J., & Freeman, K.A. (2004) Recidivism and resilience in juvenile sexual offenders: An analysis of the literature. *Journal of Child Sexual Abuse, 13*, 257–279.

Fox, B.H., Perez, N., Cass, E., Baglivio, M.T., & Epps, N. (2015). Trauma changes everything: Examining the relationship between adverse childhood experiences and serious, violent, and chronic juvenile offenders. *Child Abuse & Neglect, 46*, 163–173.

Geradin, P. & Thibaut, F. (2004). Epidemiology and treatment of juvenile sexual offending. *Pediatric Drugs Journal, 6(2)*, 79-91.

Harris, G.T., Rice, M.E., Quinsey, V.L., Lalumiere, M.L., Boer, D., & Lang, C. (2003). A multisite comparison of actuarial risk instruments for sex offenders. *Psychological Assessment, 15(3)*, 413−425.

Hunter, J.A. (2004). Developmental pathways in youth sexual aggression and delinquency: risk factors and mediators. *Journal of Family Violence, 19(4)*, 233−242.

Karakosta, O. (2015). The effectiveness of the ISOTP with juvenile sex offenders in residential care. Available from Dissertations & Theses @ Regent University; ProQuest Dissertations & Theses Global.

Knight, C. (1990). Use of support groups with adult female survivors of child sexual abuse. *Social Work, 35(3)*, 202−206.

Letourneau, E.J., Henggeler, S.W., Borduin, C.M., Schewe, P.A., McCart, M.R., Chapman, J.E., et al. (2009). Multisystemic Therapy for Juvenile Sexual Offenders: 1-Year Results from a Randomized Effectiveness Trial. *Journal of Family Psychology : JFP : Journal of the Division of Family Psychology of the American Psychological Association (Division 43), 23*(1), 89–102.

Levenson, J.S., Willis, G.M. & Prescott, D.S. (2016). Adverse childhood experiences in the lives of male sex offenders: Implications