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**To treat or not to treat?**

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# General Introduction





## JUVENILE SEXUAL PROBLEM BEHAVIOR: DEFINITIONS AND TERMINOLOGY

The distinction between adequate and transgressive sexual behavior can be obscure and, therefore, subject of debate. Laws and mores have clearly differed through time, and still do culturally. In Western societies, the idea that children and juveniles are developing sexual beings is often alarming to adults, a common misconception that any sexual behavior displayed by children is inappropriate. Sexual development, however, is part of the total developmental process, and starts at birth. Pre-school children are naturally curious and exploratory, they explore their own bodies, and the bodies of others. Research indicates that 40-85% of children engage in at least some sexual behaviors or sexual play before the age of 13. When another juvenile is involved, these events are often recalled as positive or neutral if there was consent, and equality. During adolescence especially, juveniles actively experiment with sexuality and relations, discovering boundaries and developing their sense of self in relation to others (De Graaf, Mouthaan, & Van der Doef, 2014).

Problematic sexual behaviors in juveniles can range from relatively minor (e.g., excessive masturbation, verbal intimidation) to prosecutable acts (e.g., rape, child abuse; Sunday, 2016). Therefore, not all juveniles who display problematic sexual behavior automatically classify as offenders, since not all inappropriate sexual behaviors are illegal. Interactions without consent and equality, and with coercion (pressure or acts that deny free choice) are generally labeled 'abusive', and usually constitute an offense. From the perspective of treatment, this dissertation focuses on juveniles with harmful (coercive) sexual behavior, as well as on juveniles who have sexually offended. Depending on the subject of research, the term juvenile with transgressive, harmful or offensive sexual behavior will be used in different chapters. Harmful sexual behavior is operationalized as entailing all illegal sexual acts, as well as all other aggressive or coercive sexual behaviors. The common factor in the juveniles studied is their need for treatment to improve their level of functioning, and to prevent relapse into harmful behavior.

### Prevalence

Global estimates of the prevalence of juvenile sexual victimization (i.e., unwanted, coerced sexual contact) vary widely, from 0.1 percent to 71 percent. The mean prevalence, based on self-report, was estimated to be 12.7 percent (Stoltenborgh et al., 2011). In the Netherlands, national surveys have established that one in three juveniles is victimized sexually, with five to ten percent of Dutch juveniles experiencing unwanted oral sex or intercourse (Nationaal Rapporteur, 2014).

Perpetrators of juvenile sexual abuse have been found most likely to be male adolescents or adults (Långström, Grann, & Lindblad, 2000), known to the juvenile, and member of the same household (Romans, Martin, Anderson, O'Shea, & Mullen, 1996). In the United States, Finkelhor, Ormrod, and Chaffin (2009) found juveniles to account for one third (35.6 percent) of sexual offenders who had victimized a minor. Australian 2013 crime data showed juveniles to be responsible for 18 percent of all recorded sex offenses against juveniles and adults (Warner & Bartels, 2015). In the same year in the Netherlands, this figure was 14 percent (Statline, 2017). Of all sex crime suspects in the Netherlands, 25 percent were juveniles, 98 percent was male. Most of the total amount of transgressions reported were contact offenses (61%), and most suspects (75%) were acquainted to the victim (Nationaal Rapporteur, 2014).

Due to underreporting, official criminal records generally underestimate true prevalence rates of sex crimes (White, 2011; Wittebrood, 2006). In recent years, however, the reported prevalence of juvenile sex crimes has been declining (Caldwell, 2016; Van den Berg, 2015). In the Netherlands, 1,705 juveniles were suspected of a sexual offense in 2005, in 2015 this number had dropped to 350 (Statline, 2017). This declining trend was also visible in non-sexual offending and, therefore, to be considered generic (CBS, 2017). This fact points to less crimes being committed in general, therefore broader societal explanations may apply. An explanation for the drop in reported sexual offending specifically is a possible shift towards more anonymous, non-contact types of sexual transgressions on social media and internet (e.g., viewing of (child)pornography, sexting, sextortion), which have increased in recent years, and are reported less than contact offenses (Helpwanted, 2017). Also, in the Netherlands, since 2010, an adjudication for an offense is no longer a prerequisite for juveniles to receive mandated (secure) treatment. This may have had an effect on the number of persecutions; another (civil justice) pathway has become available when intensive treatment is deemed necessary (see also, 'treatment in the Netherlands').

### **Impact of sexual offending**

Prevention of sexual victimization is deemed important for society in general, and to be aimed at juveniles at risk of victimization and at juveniles at risk of sexual (re)offending (Nationaal Rapporteur, 2014). The psychological consequences of (juvenile) sexual victimization are substantial. Several researchers have found anxiety and trauma related disorders, chronic depression and developmental disorders, such as behavioral and attachment disorders in victims of sexual abuse (Amado, Arce, & Herraiz, 2015; Lindauer & Boer, 2012). A meta-review of the consequences of child sexual victimization (Nagtegaal, 2012), showed the additional problems of victims, as compared to non-victims, to be predominantly medical, psychological and/or sexual in nature, and of influence up until adulthood. Additionally,

victims of sexual violence were found to be at significantly higher risk for re-victimization compared to non-victims (Arrata, 2002; Nagtegaal, 2012), enhancing and/or maintaining the negative consequences of the abuse. For boys, these consequences include higher than average odds of displaying sexually offensive behavior later on in life (Salter et al., 2003; Jespersen, Lumiere, & Seto, 2009).

Juveniles with harmful sexual behavior generally (self)report specific treatment needs, indicating the presence of antisocial behavior problems, but also reporting internalizing and sexual problems (Fanniff & Kimonis, 2014; Seto & Lalumiere, 2010). Some of these treatment needs have been established as criminogenic, underscoring the importance of treatment as to prevent relapse. Different theoretical views have contributed to the understanding of the development of sexual problem behavior (e.g., biological, cognitive, behavioral, social learning, and integrative or multifactorial theories). In the following section, a concise overview of etiological theories, research findings supporting the theories, and their accompanying treatment interventions is offered.

### **Origins of harmful sexual behavior in juveniles**

(Social) learning theories (Bandura, 1977; Pavlov, 1927; Skinner, 1974) consider -sexual-transgressions to be a learned (i.e., conditioned or modeled) behavior, which consequently might be unlearned through the administration of adequate consequences and prosocial modeling. Research has indeed shown sexually offensive juveniles to have been more exposed to porn, to have experienced more sexual abuse than non-sexually offensive peers (Burton, 2008; Fanniff & Kimonis, 2014; Leibowitz, Burton & Howard, 2012; Seto & Lalumière, 2010), and their backgrounds in general to include sexual aggression (Awad & Saunders, 1991; Grabell & Knight, 2009; Kobayashi et al., 1995; Veneziano, Veneziano, & LeGrand, 2000), underpinning a possible learned aspect of harmful sexual behavior. Providing discouraging consequences to coercive (sexual) behavior or deviant arousal, modeling and promoting / rewarding adequate behaviors, have become regular (basic) corrective therapeutic interventions.

Developmental theories (Erikson, 1968; Freud, 1965; Piaget, 1928) have explained the development of dysfunctional behavior through experiences in earlier stages of development. These experiences, however, not (just) model dysfunctional behavior, as learning theories suggested, but lead to a delay in accomplishing developmental tasks. Developmental delay is theorized to have a profound impact on an individual's ability to complete subsequent, more complex tasks, such as starting or maintaining an intimate relationship. Thus, egocentric (sexually harmful) behavior in adolescence, or reduced empathic ability are viewed as a result of an 'askew development' or a lack of acquired social-emotional skills. A lack of social-emotional skills or developmental deficits are often found

in juveniles with sexually harmful behavior (Baarsma et al., 2016; Veneziano & Veneziano, 2002). Therefore, stimulating the acquirement of more adequate social-emotional skills and stimulation of (moral) development via psychoeducation and training, generally is part of treatment for juveniles with sexually harmful behavior.

Attachment theory (Ainsworth, 1989; Bowlby, 1966, 1973) has specified mechanisms by which early life trauma may affect the development of rigid interpersonal behavior patterns and creates (pervasive) intimacy deficits. According to attachment theory, internal working models (i.e., cognitive-affective representations) of early relationships shape self-image and the expectations one has of others. Self-confirmatory coercive interaction patterns may, therefore, develop when basic needs of (small) children are not met, or are violated (Hoeve et al., 2012). Attachment-based therapy focusses on restoring trust (via therapeutic relationships), improving self-image and counteracting these rigid interaction patterns. Miner and colleagues' (2008, 2010, 2016) research on attachment styles of juveniles with sexually offensive behavior has shown anxious attachment to be -albeit indirectly- related to sexually harmful behavior of juveniles against children. Also, sexually offensive juveniles have experienced more abuse and neglect (precursors of attachment problems) and portray more (social) anxiety than their non-sexually offensive delinquent peers (Leibowitz, Burton, & Howard, 2012; Seto & Lalumière, 2010). Especially for juveniles with harmful sexual behavior who have been victims of (sexual) abuse or neglect, restoring trust and intimacy via therapeutic relationships seems imperative.

Regarding the continuation of transgressive behaviors in general, cognitive theories added the element of 'thinking errors' or 'distortions' (Yochelson & Samenow, 1976). These cognitions depict harmful behaviors as acceptable, justifiable, or harmless and thus serve as a sustaining factor. Abel and colleagues (1989) found adult child abusers to frequently make use of these cognitions. Identifying and restructuring or challenging these thoughts has become a basic tenant in cognitive (group) treatment for juveniles with sexually harmful behavior. Theories that focus on addiction added the notion that sexually harmful behavior, due to its innate physiological rewards (arousal, orgasm, and tension reduction), might become a compulsive, ritualized pre-occupation, also known as hypersexuality (Carnes, 1983). Strategies of addiction treatment (e.g., peer group therapy and the identification of 'hotspots' for sexual arousal) have also been found useful to aid the 'breaking' of an addictive or compulsive cycle, and have since been incorporated in therapy for juveniles with sexually harmful behavior.

Lastly, social-ecological theory (Bronfenbrenner, 1979) drew attention to the fact that factors explaining or maintaining antisocial (sexual) behavior in juveniles occur across ecological systems in which juveniles are embedded (e.g., school / work, peer groups,

family). Bronfenbrenner therefore stressed the importance of creating change in the (supportive) context of juveniles with problem behavior, not -just- a change in the juvenile himself. Contextual approaches to reducing harmful sexual behavior by juveniles have since been developed.

The now dominant cognitive-behavioral treatment (CBT) paradigm combines the knowledge as described above. In this paradigm, sexually harmful behavior is seen as a form of social behavior, shaped and maintained by the social environment. The person portraying this behavior is regarded as the result of a complex interplay of biology, emotions, cognitions and motor behavior (Ward, Polaschek, & Beech, 2006). CBT incorporates diverse treatment strategies, flexibly responding to a juvenile's individual treatment needs and his specific social context.

### **Whom, What and How to treat?**

In 1974, Martinson published an influential essay, stating 'nothing works' in offender rehabilitation and recidivism prevention. This was reacted to by several scholars, proving, via reviews and meta-analyses, that 'not everything works for everybody' (Andrews, Bonta, & Hoge, 1990; Andrews, et al., 1990; Gendreau, Little, & Goggin, 1996; Gendreau, Smith, & French, 2006; Lipsey & Cullen, 2007; Lipsey & Wilson, 1998; Lösel, 1995; Smith, Gendreau, & Swartz, 2009), a much-needed nuance. Based on this work, the Risk-Need-Responsivity (RNR) model for offender rehabilitation was developed (Andrews, 1995; Andrews & Bonta, 2010; Andrews et al., 1990; Gendreau, 1996), which since has become the dominant paradigm in (juvenile) offender rehabilitation. Because of its scientific rigor and great practical use, the RNR model has also been applied in adjacent fields, such as mental healthcare (Lord, 2016; Skeem, Steadman, & Manchak, 2015).

The RNR model importantly states effective rehabilitation to follow three specific guidelines: 1) the risk principle, or whom to treat (i.e., intensive, mandated treatment has to be offered to juveniles at medium to high recidivism risk only), 2) the need principle, or what to treat (i.e., criminogenic treatment needs have to be addressed), and 3) the responsivity principle, or how to treat (i.e., treatment should make use of social cognitive learning strategies, such as CBT, and be tailored to the personality, learning style, and motivation of the juvenile concerned; Andrews & Bonta, 2010). Treatments adhering to these standards have been found to be more effective in reducing recidivism than treatments that do not (Bonta & Andrews, 2007). Via meta-analysis, Hanson, Bourgon, Helmus, and Hodgson (2009) have shown the RNR principles to also apply to adults and juveniles who have sexually offended. All three principles, and the challenges applying them to juveniles with harmful sexual behavior, will be discussed below.



## **Risk**

Research into recidivism risk factors for harmful sexual behavior in juveniles is hampered by low, and declining, rates of sexual recidivism by juveniles. Studies performed between the years 2000 and 2015 reported a weighted mean sexual recidivism rate of 2.75 percent (Caldwell, 2016). Most juveniles with sexual harmful behavior do not reoffend sexually (Cale, Smallbone, Rayment-McHugh, & Downling, 2016), and desistance is norm rather than exception (Lussier, Van den Berg, Bijleveld, & Hendriks, 2012); sexual transgressions by juveniles remain predominantly adolescence limited. To date, several specific risk factors for sexual reoffending by juveniles have, however, been established. Worling and Långström (2003), reviewed previous research and found sexual deviation (e.g., interest in prepubescent children or sexual violence), prior criminal sanctions for sexual assault(s), having made two or more victims, victimization of strangers, lack of intimate peer relationships/social isolation, and incomplete offense-specific treatment sufficiently empirically supported. Two other factors were deemed promising: poor relationship with parents and attitudes supportive of sexual offending. In 2011, Carpentier and Proulx examined 351 male adolescents who had sexually offended and found paternal abandonment, childhood sexual victimization, association with younger children, and having victimized a stranger to be associated with a higher risk for sexual recidivism. Christiansen and Vincent (2013), using a large sample of 39,249 juvenile offenders, of which 695 were juveniles who had offended sexually, added prior non-sexual offending, hands-off offending, offending against a child, younger age at time of initial offense, poor school performance and non-school attendance, and replicated prior sexual offending as risk factors for sexual reoffending. The risk factors found predominantly represent classifications of the juveniles' offenses (i.e., number of victims, type of victim, type of offensive behavior, number of previous arrests) or of their past (i.e., victimization, abandonment, non-treatment completion).

Non-sexual recidivism among juveniles with sexually harmful behavior is actually more common than sexual recidivism; in contemporary studies, 30 percent of juveniles with harmful sexual behavior relapse into non-sexual transgressions (Caldwell, 2016). The most influential established risk factors for generic delinquent behavior include an antisocial behavior pattern, antisocial attitudes and values, antisocial associates, and substance abuse (Andrews, Bonta, & Wormith, 2006). Juveniles with harmful sexual behavior displaying these characteristics are, therefore, considered at higher risk for (repeat) non-sexual transgressions. They, however, also tend to reoffend sexually more often (Chu & Thomas, 2010; Drew, 2013; Hissel et al., 2006; Parks & Bard, 2006). Risk factors for generic delinquent behavior are, therefore, usually included in sexual recidivism risk assessment and allocation practices.

Through systematic review of recidivism risk assessment tools for juveniles with harmful sexual behavior, Hempel, Buck, Cima, and Van Marle (2011) found none of the instruments reviewed (J-SOAP-II, J-SORRAT-II, ERASOR, JRAS, SAVRY, and PCL:YV) undisputed. Low sexual reoffending rates make recidivism hard to predict, most contemporary actuarial instruments seem to overrate the actual risk of reoffending in these juveniles. Hempel and colleagues (2011) therefore concluded that long term assessment of risk, based on characteristics in (developmental) transition, is not to be advised.

## Need

The RNR model specifically focusses on the prevention of recidivism by targeting dynamic risk factors, also referred to as 'criminogenic needs'. Many of the above mentioned risk factors for sexual reoffending, however, are considered static (not to be influenced by therapy) and, therefore, provide a relatively small foundation for treatment purposes. In general, juveniles with harmful sexual behavior have been found to differ from otherwise delinquent or antisocial juveniles by presenting more extensive histories of early sexual exposure / abuse and physical and emotional abuse or neglect, more atypical sexual interests, poorer social relationships, higher levels of anxiety, and lower self-esteem (Seto & Lalumiere, 2010). Fanniff and Kimonis (2014) additionally found a lower level of callous unemotional traits in juveniles with harmful sexual behavior. Thus, in general, these juveniles display higher levels of internalizing problems, than do juveniles with other types of transgressive behavior.

Typology research, furthermore, indicated juveniles with harmful sexual behavior to form a heterogeneous group regarding their treatment needs. Peer abusing juveniles and juveniles with a 'mixed offending pattern', which includes non-sexual problem behavior, have relatively more in common with non-sexual juvenile offenders than do juveniles with a child victim ( $\geq 5$  years younger and below the age of 12). The 'mixed' and 'peer victim' groups show higher levels of -antisocial- conduct problems (Drew, 2013; Leroux, Pullman, Montayne, & Seto, 2016). Intrapsychic problems seem dominant in juveniles with child victims (Hendriks, 2006). Notably, a relatively large group of juveniles with harmful sexual behavior does not report any intra- or interpersonal difficulties; they score within the normal range on psychosocial measures, possibly pointing to situational or developmental phase-bound explanations of harmful sexual behavior (Caldwell, 2010; Ryan, Leversee & Lane, 2010; Van Outsem, 2009; Worling, 2013). Contextual treatments may prove a better fit for these juveniles.

In sum, treatment needs relatively common in juveniles with harmful sexual behavior (e.g., low self-esteem, social anxiety), may not have been empirically established as criminogenic due to the low prevalence rate of sexual reoffending. Hence, treatment for juveniles with

harmful sexual behavior is usually not strictly limited to dynamic risk factors or criminogenic treatment needs, as proposed by the RNR model. Protective factors and non-criminogenic psychosocial treatment needs especially seem somewhat underexposed in the RNR model.

## **Responsivity**

In the RNR model, social learning strategies are advocated under the responsivity principle. As described, modern (established) treatments for juveniles with harmful sexual behavior make use of cognitive behavioral based treatment, incorporating social learning strategies, thereby generally adhering to the RNR model. Additionally, responsive treatment needs to adapt itself to the personality, learning style, and motivation of the individual juvenile in treatment. The heterogeneity of juveniles with harmful sexual behavior offers a challenge to the individual therapist. Protocolled treatments for juveniles with harmful sexual behavior need to be able to cope with very different juveniles with different treatment needs. David Prescott's motto 'personalize the manual, do not manualize the person' (personal communication) is well known and valued among therapists working with juveniles with harmful sexual behavior. Responsive treatment needs to be tailored to individual learning styles and motivations for change, which importantly may not overlap their assessed criminogenic treatment needs. CBT for juveniles with harmful sexual behavior needs to be able to address a very diverse set of possible underlying problems or social-psychological mechanisms and, therefore, make use of various treatment techniques. This may influence treatment integrity, which is thought of as an important prerequisite for treatment success (Lipsey, 2009).

In sum, (intensive, mandated) treatment should be aimed at those juveniles at high risk for sexual recidivism, but these juveniles are hard to identify prospectively, that is, at allocation. Treatment should be aimed at specific dynamic criminogenic needs, which may offer a restricted view on (the diverse) treatment needs of juveniles with harmful sexual behavior. In addition, delivering treatment responsively may affect treatment integrity.

## **Treatment in the Netherlands**

In the Netherlands, juveniles primarily in need of treatment for conduct problems are generally treated separately from juveniles primarily showing harmful sexual behavior. A broad spectrum of specialized treatments is available. A behavioral training order (Jonker, De Haas, Reijmers, Rekers, & Van Berlo, 2011) and specialized outpatient treatment (Hendriks, 2011) are the least intrusive and most frequently used types of specialized treatment offered throughout the country (Hendriks, 2013). These treatments are generally indicated for low to medium risk offenders, able to (safely) stay at home during treatment.

Juveniles in need of mandated treatment may be allocated to this type of treatment via one of two 'pathways', 1) via civil law and 2) via juvenile justice court. Dutch law on youth care (Hirsch Ballin, 2007) states that the invasion of fundamental children's rights, such as restricting freedom of movement, must be kept to a minimum and, therefore, is only applicable (by civil court order) if so advised by an authorized psychologist, who evaluates whether placement in a Secure Youth Care (SYC) facility is in accordance with the juvenile's treatment needs. For adjudicated juveniles (12 to 18 years of age at the time of the offense), mandated treatment in a Forensic Youth Care (FYC) facility is available. In accordance with the European Rights of Children (Council of Europe, 1996), only juveniles who pose the highest possible risk to society are to receive treatment in a maximum security residential facility (which is offered by an FYC). This policy generally adheres to RNR principles, basing allocation to intensive mandated treatment on levels of risk and treatment need. A third, community-based, treatment option, making use of both allocation pathways, is multisystemic therapy for juveniles with problem sexual behavior (MST-PSB; Dwyer & Letourneau, 2011). A description of the three treatment modalities is offered in following.

MST-PSB is aimed at adjudicated and non-adjudicated juveniles aged 10 to 18 years, who exhibit sexual problem behavior, have complex (family) issues, and pose a risk to society (Boonstra & Van der Rijken, 2010). Since MST-PSB is a community-based, at home treatment, the family system actively takes responsibility for safety issues. MST-PSB is based on regular MST, and targets youth and family problems within and between the multiple systems in which the family members are embedded. The overarching goal of MST is to empower parents and adolescents with the skills and resources needed to cope with their familial and extra-familial problems. Using treatment strategies derived from strategic family therapy, structural family therapy, behavioral parent training, and cognitive-behavioral therapy, MST addresses intrapersonal (e.g., cognitive), familial, and extra familial (e.g., peer, school, neighborhood) factors that are known to be linked with a juvenile's serious antisocial behavior, including sexual offending. If, and when, specific individual interventions are used to modify the juvenile's social perspective-taking skills, belief system, or attitudes believed to contribute to offending and the sexual assault cycle, the parent is reinforced as the change agent, and is directly involved in the intervention. The exact nature of interventions applied varies for each family, depending on their strengths and weaknesses (Borduin & Schaeffer, 2001). Contraindications for the Dutch MST-PSB program are an IQ < 70, acute psychiatric problems, and severe forms of autism (Boonstra & Van der Rijken, 2010).

Secure Youth Care (SYC) offers treatment to non-adjudicated juveniles (aged 12 to 18 years) with Severe Sexual Problems (SSP). During their stay, cognitive behavioral based group treatment is offered by youth care professionals, and monitored by a behavioral scientist. Social learning strategies are explicitly used to stimulate change, and the specific

interventions applied are tailored to the juvenile's treatment needs. At admittance, (criminogenic) treatment needs are assessed by means of the Juvenile Sex Offender Assessment Pack-Dutch version (J-SOAP-D; Bullens, Van Horn, & Van Eck, 2012), and used for treatment planning purposes. Group therapy 'Out of the Circle' (Koster & Tel, 2010), a central part of the treatment offered, focusses on the sexual misconduct. It assesses the cycle of sexual aggression (triggers, thoughts, behaviors, and consequences), and creates an individualized risk management plan. Individual therapy (as to address possible victimization experiences or trauma) may supplement the group treatment offered. The family system of the juvenile is actively involved in the treatment of the juvenile, furlough at home and family guidance is used to transfer skills and knowledge. Contraindication for placement is an IQ < 70; these juveniles receive treatment in a secure institution for the mentally disabled.

Forensic Youth Care is available for adjudicated juveniles (12 to 18 years of age at the time of the offense) with Severe Sexual Problems (FYC-SSP). Their measure (a 'PIJ-maatregel'; court ordered placement in a forensic institution for juveniles) is usually imposed for two years, and may remain imposed for a maximum period of six years. One year of aftercare (outpatient care and supervision) is also mandatory. At commencement of treatment, a behavioral scientist performs a comprehensive offense analysis, together with the juvenile, to determine treatment needs. For risk assessment purposes, tools such as the J-SOAP-D (Bullens et al., 2012) and the Structured Assessment of Violence Risk in Youth (SAVRY; Lodewijks, Doreleijers, de Ruiter & de Wit-Grouls, 2006) are regularly administered. A stay in FYC-SSP implies treatment through YOUTURN, a comprehensive, phased, cognitive behavioral based method (Stuurgroep YOUTURN, 2009) that focuses on all developmental tasks for adolescents (Erikson, 1968). YOUTURN is supplemented with group therapy 'Out of the Circle' (Koster & Tel, 2010) and individual therapy. The juvenile's family system is involved in treatment, family guidance is used to transfer skills and knowledge. Contraindication for placement is an IQ < 70, these juveniles receive treatment in a forensic very intensive care (VIC) treatment group for the mentally disabled.

Notably, the three (mandatory) treatment options available (MST-PSB, SYC-SSP, and FYC-SSP) are all theoretically aimed at a small group of very problematic juveniles that are deemed at risk for sexual recidivism. Clear indication criteria that adequately distinguish between these treatment types, however, are lacking.

## STUDY AIM

This dissertation aims to contribute to the knowledge on treatment of juveniles with sexually transgressive behavior. It provides insight into current allocation practices, reviews contemporary research on the effects of treatment, and further specifies what individual treatment needs are most common and most successfully targeted in treatment.

## Samples

This dissertation uses two Dutch samples:

1. A sample of 86 juveniles who received MST-PSB, SYC-SSP, or FYC-SSP treatment for harmful sexual behavior between January 2010 (when all three types of treatment were operational) until April 2012, and for whom comprehensive background information was coded and a risk assessment instrument; J-SOAP-D (Bullens et al., 2012) was (retrospectively) scored.
2. A sample of 36 juveniles who received MST-PSB, or SYC-SSP treatment for harmful sexual behavior between February 2012 (when measurements started) up until October 2015, and completed the Adolescent Sexual Abuser Project Assessment Measures-Dutch Revised version (ASAP-D; Van Outsem, Beckett, Bullens, Vermeiren, Van Horn, & Doreleijers, 2006) at admission and at completion of treatment.

Furthermore, this dissertation (quantitatively) reviews primary studies on juveniles with sexually transgressive behavior reporting on the effect of treatment on recidivism, including 13 independent samples, with 77 effect sizes and 1,726 participants, and primary studies on juveniles with sexually transgressive behavior reporting on the effect of treatment on psychosocial functioning, including 31 independent samples, with 362 effect sizes, and 1,342 participants.

## DISSERTATION OUTLINE

Central aim of this dissertation is to determine what 'type' of juvenile with harmful sexual behavior should be treated by what 'type' of intensive, mandated treatment, aimed at which individual treatment needs. Are there differences in approach or effects that could guide allocation of these juveniles to better matched care? How can treatments improve their results by incorporating contemporary research findings into their practices? The following sub-questions were formulated, which are answered in the corresponding chapters:

*Chapter 2.* Were juveniles with harmful sexual behavior in intensive, mandated treatment in the Netherlands, allocated according to RNR principles? What are (main) characteristics of the juveniles in intensive, mandated treatment?

*Chapter 3.* Is treatment of juveniles with harmful sexual behavior effective in reducing recidivism? Do participant, treatment or study characteristics moderate this effect?

*Chapter 4.* Is treatment of juveniles with harmful sexual behavior effective in improving psychosocial functioning? Do participant, treatment or study characteristics moderate this effect?

*Chapter 5.* What are the effects on psychosocial functioning obtained by intensive, mandated treatment for juveniles with harmful sexual behavior in the Netherlands and how may treatments improve their results?

This dissertation closes with a general discussion on the main findings, practical implications, limitations, and recommendations for future research (Chapter 6).