ADOLESCENT SEX OFFENDER TREATMENT EFFECTIVENESS: A META-ANALYSIS

by

Terri Zelch Galicia

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TERRI ZELCH GALICIA

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Approvals:

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Thesis Advisor Date

[signature] 3/12/97

Committee Member Date

[signature] 3/6/97

Committee Member Date

[signature] 3/12/97

Dean of Graduate Studies Date

ABSTRACT

A meta-analysis of research literature published since 1978 was undertaken to assess the amount of change and efficacy associated with the treatment of adolescent sex offenders in institutional, residential, and community-based settings. An extensive literature search produced over 300 sources. All of the sources were coded and selected for inclusion based on established criteria. Eighteen of these studies representing 1,411 adolescent sex offenders were included in the meta-analysis.

An analysis of the database involved converting study findings to a common metric called an effect size. Effect sizes were studied across several variables to reveal patterns and establish findings regarding the effectiveness or ineffectiveness of adolescent sex offender treatment.

The meta-analysis of effects (N = 1,411) from 18 studies showed an average effect size of (Cohen d = .49), which indicated a moderate level of effectiveness. Adolescents in treatment programs that implemented group and family interventions in a community-based/outpatient setting showed the best potential for positive outcomes. The results were supportive of a multisystemic modality of treatment. The results for offenders (14.5 to 15 years of age) were more positive than those for offenders (15.6 to 18.2 years of age). Studies conducted in the earlier years (1986 to 1991) achieved a greater effectiveness rating than

studies conducted in the later years.

Limitations of the study, implications for the juvenile justice system, and treatment planning were discussed. An appendix that categorically lists 340 sources that address adolescent sex offender issues is included.

Overall, it appeared that adolescent sex offender treatment is moderately effective, although this conclusion must be moderated by the fact that effect sizes were heterogeneous. Recommendations for future research include a call for more long-term follow-up studies with thorough reporting practices.

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This Masters Thesis is lovingly dedicated to my father, William Richard Zelch. He would have been very proud of his only child.

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CHAPTER I

INTRODUCTION

There are few studies of adolescent sex offenders that focus on treatment program outcomes. Further, the selection of samples used to measure treatment outcomes varies widely from study to study. In reviewing the literature, it became evident that many studies were dependent upon small samples, used no control or comparison groups, and few replicated the measures used by others. It was therefore an important challenge to judge the efficacy of treatment programs for adolescent sex offenders to establish what types of treatment interventions are successful.

According to the literature, adolescent sex offenders who receive treatment have a good chance of returning to the community safely (Fillmore, 1987, p. 98). Since treatment is the means to provide rehabilitation for this population, treatment effectiveness should be paramount.

With the use of meta-analysis a measurement of treatment effectiveness for the adolescent sex offender through a quantitative integration of the findings of individual studies meeting specified criteria was investigated. Knowing which treatment methods are effective can assist professionals in designing new programs or modifying existing ones. For the purpose of this study, all the studies relevant to the issue of adolescent sex offender treatment effectiveness were reviewed and then at least one indicator from each of the studies was analyzed to address

the question of which components of treatment contribute to successful outcome.

It should be noted that terms and definitions for adolescent sex offenders vary from study to study. For the purpose of this thesis the term adolescent sex offender was utilized.

Statement of the Problem

Published research regarding adolescent sex offenders is distributed among hundreds of journals and chapters in books. The topic is the same but the research methods, the measurements, the samples, and the definitions vary widely from study to study. This research assumed the task of finding some consistency among the literature published on adolescent sex offender treatment interventions over the past eighteen years. Defining what knowledge this broad base of literature has produced concerning the effectiveness of treatment for these adolescents was an important endeavor.

The mathematician David Hilbert said, "the importance of a specific work can be measured by the number of previous publications it makes superflous to read" (Glass, McGaw, & Smith, 1981, p. 11).

Meta-analysis integrates research results from existing common studies for the purpose of cumulating the findings to establish facts. Even though there are numerous studies on the adolescent sex offender, there are no definitive answers. Most of the studies call for more research to

answer lingering questions. Therefore, by providing a quantitative integration of the findings of individual studies on the effectiveness of adolescent sex offender treatment in institutional, residential, and commmunity-based settings, it was anticipated that these findings will generate an empirical basis for a standard of care for the adolescent sex offender. Also, the findings can clarify what should and should not be expected of treatment programs while helping professionals identify and evaluate treatment impact.

Importance of the Problem

Nationally there are over 800 programs specifically for treating the adolescent sex offender (National Adolescent Perpetrator Network, 1988), an increase of 780 programs since 1982. This growth indicates an awareness of society to respond to the deviant sexual behaviors of these youth. The proliferation of institutional, residential, and community-based programs offering treatment to adolescent sex offenders requires an examination of the research done to assess their effectiveness. Thus, addressing treatment effectiveness can provide an assessment of the amount of change and the differences associated with various treatment programs.

It has been established that 58.4% of adult male sex offenders first offended sexually as an adolescent (Abel, Mittleman, & Becker, 1985). This makes a strong case for taking seriously the treatment of the adolescent sex

offender who is at risk of becoming an adult sex offender. Other rationales for studying this population include the following:

1. Estimates suggest that approximately 20% of all rapes and between 30% and 50% of child molestations are perpetrated by adolescent males (Becker, Kaplan, Cunningham-Rather, & Kavoussi, 1986).

2. Abel et al. (1985) claimed that the average adolescent sex offender will without treatment go on to commit 380 sexual crimes during his lifetime.

3. In 1983, Ageton estimated that over 500,000 adolescents commit sexual assaults every year. This figure most likely underestimated the total offenses because her definition for offenses was limited to "the use of force in committing acts that involve sexual parts of the body" (p. 92). This defintion excluded acts of exposing, voyeurism, obscene phone calls, and other "hands off" offenses.

An important reason for the increase of research since 1986 (see Table 1) focusing on the adolescent sex offender stems from studies conducted with adult sex offenders that address treatment efficacy. If treatment is effective in reducing sexual offending behavior then treatment of adolescent sex offenders could go a long way toward reducing the impact of sexual assault in society.

Definition of an Adolescent Sex Offender

Problems of defining adolescent sexual offending are frequently mentioned in the literature because societal

expectations in terms of cultural, religious, and individual attitudes of what constitutes normal versus deviant sexual behaviors are often conflicting. Until the 1980s little attention was given to adolescent sex offenders whose behavior was often explained as "sexual curiosity or experimentation" (Knopp, 1985, p. 6). A "boys will be boys" attitude prevailed (Ryan, Lane, Davis, & Isaac, 1987, p. 385).

Table 1
Adolescent Sex Offender Published Literature

	Journal Articles	Books	Total
1978	1	0	1
1979	6	1	7
1980	3	0	3
1981	7	2	9
1982	5	1	6
1983	8	3	11
1984	8	3	11
1985	10	5	15
1986	16	3	19
1987	17	6	23
1988	28	5	33
1989	26	9	35
1990	21	5	26
1991	21	9	30
1992	23	6	29
1993	17	10	27
1994	16	3	19
1995	20	4	24
1996	11	1	12
Totals	264	76	340

Today the term adolescent sex offender is used interchangeably in the literature for juvenile sex offender, youthful sex offender, teenage sex offender, adolescent child molester, adolescent rapist, and pre-adolescent sex offender. Sexual offense statues are variously titled: criminal sexual conduct (e.g., rape, child molestation),

intrafamilial sexual abuse (e.g., sibling abuse), and lewd and lascivious communication (e.g., obscene phone calls). Since the legal definition of a sexual offense varies from state to state, the clinical definition established at the Kempe National Center in Denver by Ryan and Lane (1987) was used. The authors define the adolescent sex offender as "a youth, from puberty to legal age of majority, who commits any sexual act with a person of any age, against the victim's will, without consent, or in an aggressive, exploitative or threatening manner" (p.385).

In 1989, the American Correctional Association published The State of Corrections: Proceedings ACA Annual Conferences 1989 and classified sexual offenses committed by adolescents as "hands on" and "hands off" offenses. Steen and Monnette (1989) addressing the conference defined the following behaviors:

> [hands off] Obscene phone calls, exhibitionism (with or without masturbation), voyeurism (with or without masturbation), lewd photography or film taking or showing, fetish associated burglary (e.g.,stealing female underwear); [hands on] Varied degrees of child molestation, from fondling, french kissing, or body rubbing a younger child to digital penetration, fellatio, cunnilingus, intercourse, sodomy, or penetration of the victim with a foreign object, and rape and other aggressive forced sexual acts (p. 205).

Characteristics of Adolescent Sex Offenders

A National data base of 1600 youth referred to 90 specialized treatment programs across the country provides a characteristic base of the adolescent sex offender. According to The Revised Report from the National Task Force on Juvenile Sex Offending (1993), the characteristic base of the adolescent sex offender includes the following:

> the age range of these youth is 15-19 with a median age between 14 and 15; less than 10% are female. More than 60% of the offenses include penatrating acts; more than one third involve physical force; and more than 90% are perpetrated against someone the youth had a relationship with (i.e., relative, acquaintance, baby-sitter, etc). Median age of victims is seven years with three times as many female victims reported as male. Socio-demographic data are similar to the general population (p. 7).

According to Stenson and Anderson (1987) most adolescent sex offenders have chaotic family situations, histories of sexual abuse, and tend to be passive or socially isolated. They have difficulty with school performance and peer relationships. Overall, they tend to have younger friends. Personal characteristics include low self-esteem and feelings of powerlessness. They also lack appropriate skills to deal with anger and aggressiveness (p. 95).

Treatment Issues

Sexual offending by adolescents will not decrease without some type of intervention by the juvenile court. (Bengis, 1986). Therefore, determining treatment outcomes for this population is closely tied to community safety and can be viewed as a public safety issue. Unlike other treatment programs such as drug treatment, where some recidivism is expected; the expectation of adolescent sex offender treatment is no recidivism. Since effective treatment can be expected to lower recidivism rates it is in the best interest of all concerned for effective treatment programs to be identified.

Becker and Kaplan (1988) reported that while many specialized programs have been developed to treat the adolescent sex offender there is a lack of "systematic development and testing of their approaches and outcomes" (p.106). Many factors contribute to the lack of research in the area of adolescent sex offender treatment effectiveness. The following presents a list of treatment issues regarding research on adolescent sex offenders:

1. As of 1988, there were no controlled outcome studies designed to evaluate the effectiveness of treatment programs for the adolescent sex offender (Prentky, 1988, p. 216).

2. Due to ethical reasons there is no research that compares adolescent sex offenders who have completed treatment with adolescents who have had no treatment (Nagayama Hall, Hirshman, Graham, & Zaragoza, 1993, p. 225).

3. Studies including matched comparison groups are sparse (Davis & Leitenberg, 1987, p.422).

4. As of 1988, all of the published literature regarding the treatment of adolescent sex offenders has been limited to program descriptions (Salter, 1988) and uncontrolled program evaluations (Borduin, Henggler, Blaske, & Stein, 1990).

5. There are no published studies that systematically compare female and male adolescent sex offenders (Ray & English, 1995) and,

6. Vizard, Monck, and Misch (1995) stated "despite a decade's experience of developing sophisticated assessment procedures and therapeutic interventions with [adolescent sex offenders], there appears to be little agreement about measures of the key components of treatment" (p. 742).

Treatment outcome studies have been conducted in diverse ways. In conducting a meta-analysis a point specific selection criteria for inclusion is needed for the findings to be aggregated. Meta-analysis also makes allowances for the above mentioned inconsistencies. The process for selection criteria was detailed in Chapter 3.

Summary

The most urgent reason for evaluating the efficacy of treatment programs for adolescent sex offenders is the fact that a considerable number of these youth will go on to a lifetime of sexual offending. Clinical and juvenile justice professionals need to know which treatment modalities are

the most effective in order to select a treatment regime for the adolescent sex offenders in their care. These offenders need to be taken seriously and the identification of treatment programs for those at risk for reoffending must be priority.

Davis et al (1987) stated, "only when a concerted effort has been made . . . will we have the rudiments of a scientific enterprise with something to contribute beyond popular opinion and clinical impressions" (p. 426). In sum, if sexual offending by adolescents is to be reduced, then the focus must be on treatment efficacy for those youth who are at a risk for reoffending.

CHAPTER II

THE LITERATURE REVIEW

Published research regarding adolescent sex offenders is distributed among hundreds of journals and chapters in books. For the purposes of conducting a meta-analysis the literature search must be extensive. Chapter 3 contains detailed information of the process of searching the literature and is part of the methodology in conducting a meta-analysis. The present chapter focuses on what the literature revealed regarding adolescent sex offender treatment effectiveness.

A review of the relevant literature leads to the conclusion that there is a definite lack of published empirical data on adolescent sex offender treatment efficacy. As reported in Chapter 1, there are numerous treatment programs for adolescent sex offenders but few treatment providers have published treatment outcome data. Davis et al. (1987) noted that "controlled comparisons between treatment and no treatment and between one form of treatment and another . . . do not exist" (p. 424). They contend " the only alternatives left to consider are reports of outcome statistics from a series of subjects" (p. 425). The literature uncovered no such studies and more importantly no meta-analysis of adolescent sex offender treatment effectiveness. One meta-analysis of adult sex offender treatment was located and provided the impetus for this thesis (Nagayama Hall, 1995).

The aim of this thesis was to identify research that assessed the effectiveness of treatment for adolescent sex offenders and then report the meta-analytical findings. This thesis sought to provide findings for some of the following questions:

1. Does participation in treatment reduce sexual reoffending in adolescent sex offenders?

2. Does participation in treatment facilitate a change in attitudes regarding deviant sexual arousal?

3. Which forms of treatment are most effective?

4. Which forms of treatment are most effective with which type of adolescent sex offender?

5. Has treatment efficacy improved over the past several years?

Barbaree, Marshall, and Hudson (1993) contend "the literature contains very few reports of systematic research evaluating the effects of different treatment approaches" (p. 244). Further, in many published articles outlining guidelines for the treatment of adolescent sex offenders it is cautioned that the efficacy of these treatments have not been tested (Rowe, 1988; Camp and Thayer, 1993). Therefore, the answers to the above questions are not known. It was the intention of this thesis to provide some direction toward those answers by integrating those studies that do exist.

One important finding of the literature review that has direct implications on this study is the fact that there

appears to be little agreement about the measures of treatment outcome and few studies replicate the same approach. Consequently, outcome studies have been approached in diverse ways. It was not unusual to find comparison groups drawn from delinquents who have not committed a sexual offense. Also, the selection of sample groups varied widely on a number of variables such as treatment settings, type of offense, and victim characteristics.

In reviewing the literature it became evident that many studies utilize small samples, lack control groups, and vary widely in measures of success. Smith and Monastersky (1986) reasoned "so little is known about why juveniles reoffend that therapists may be relying on 'irrelevant information' in their predictions of risk" (p. 136). A typical study of treatment effectiveness presented an adolescent sex offender treatment program and reported improved behavior as a successful indicator of treatment without any statistical data to support the claim. Borduin et al. (1990) affirmed that the treatment literature primarily covered descriptions of programs and uncontrolled evaluations. Overall, research issues most commonly studied were the characteristics of the adolescent sex offender, their social environment, and their family environment (Becker et al., 1988).

Research that focuses on treatment outcome is imperative because effective treatment can reduce reoffending. Nevertheless, there was a serious lack of such

research. Sexual assaults committed by adolescents are widespread in our society (Breer, 1987: Davis et al., 1987; Nanjuddappa, Rios, Mio, & Verleur, 1987; Smets, & Cebula, 1987; Lombarbo, & DiGiorgio-Miller, 1989; McConaghy, Blaszczynski, Armstrong, & Kidson, 1989; Scavo, 1989; Becker, 1990; Sapp & Vaughn, 1990; Camp et al., 1993). Clearly, empirical research on the effectiveness of treatment for adolescent sex offenders was scarce.

Several points deserve consideration. First, recidivism rates and self-report measures were utilized most often as outcomes. However, few long term follow-up studies measured recidivism and the self-report measures that were utilized presented methodological problems. Second, studies lacked control groups and matched comparison groups as reliable measures. Third, very few studies compared treatment modalities. Finally, very little empirical research identifies which components of treatment contribute to successful outcome.

Camp et al. (1993) reports the following regarding adolescent sex offender literature:

1. Virtually all reported adolescent sex offenders are male; females account for less than 5% of all reported cases.

2. In recent years, group treatment (composed of adolescent sex offenders who have been charged with a sexual offense) has replaced individual and family treatment as the most common treatment.

3. Whether group treatment is the most effective modality has yet to be substantiated. Outcome studies (if they exist) are often ambiguous and empirically inconclusive.

4. Distinctions between violent and non-violent offenders have become common, primarily in the interest of creating more homogeneous treatment groups. Non-violent offenders are often referred to as molesters.

5. Most violent offenders are removed from the community prior to receiving treatment, while adolescent molesters are generally treated in outpatient settings (p. 192).

Among the treatment modalities revealed in the literature search the most frequently described approach was group therapy. Group treatment for adolescent sexual offenders seeks to improve social skills, anger management, and sexual knowledge. There is a general consensus that group therapy is the treatment of choice for adolescent sex offenders (Breer, 1987; Davis et al., 1987; Lakey, 1994). The rationale for group therapy as an effective means of treating adolescent sex offenders was based on peer pressure being a motivating factor in pressuring adolescent sex offenders to admit and confront their offending behavior (Lakey, 1994, p. 760).

Three basic therapeutic models cited frequently were psychological therapy, behavioral therapy, and biological treatment. Psychological therapy is the treatment of

adolescent sex offenders through psychological methods with an emphasis on victim confrontation, value clarification, psychodrama, and sex education (Camp et al., 1993). Behavorial therapy is primarily concerned with the reduction of abnormal sexual arousal. Behavioral therapies as explained by Sapp et al. (1990) include: aversive conditioning, covert sensitization, masturbatory satiation, orgasmic reconditioning, modeling, role play, and use of the penile plethsymograph. Biological treatment operates from the assumption that abnormal sexual aggression results from hormonal imbalances. While biological treatment was mentioned often in the literature it was discussed in the context of its infrequent use with adolescents because of ethical considerations.

Other treatment modalities appearing with considerable frequency consisted of the following: multisystemic treament, cognitive-behavioral treatment, social skills training, peer group counseling, and family systems therapy. The literature indicated that many programs appear to utilize an eclectic approach involving several types of intervention. One study identified 338 techniques being implemented with adolescent sex offenders (Sapp & Vaughn, 1990). In Juvenile Sexual Offending: Causes, Consequences, and Correction (1993), Ryan and Lane reported on a 1988 national survey of treatment providers (see Table 2). This survey of 323 respondents depicts the diversity of treatment modalities utilized with adolescent sex offenders.

Table 2
Treatment Used With Juvenile Sex Offenders by 323 Respondants

Treatment Modality	Number	%
Victim Empathy	304	94%
Sex Education	298	92%
Communications	295	91%
Anger aggression management	291	91%
Assertiveness training	279	90%
Frustration tolerance/Impulse control	261	86%
Conflict resolution	249	81%
Positive prosocial sexuality	249	77%
Sex role stereotyping	240	74%
Victim apology	234	72%
Values clarification	227	70%
Relaxation techniques/Stress management	225	70%
Cognitive distortions	220	68%
Pre-assault/assault cycle	215	67%
Fantasy work	209	65%
Thinking errors	207	64%
Journal keeping	202	63%
Sexual transmitted diseases	185	57%
Waiving of confidentiality	181	56%
Relapse cycle	178	55%
Aftercare planning	174	54%
Personal victimization/trauma	172	53%
Homosexuality/homophobia	143	44%
Alcoholics anonymous	140	43%
Employment/vocational issues	138	43%
Addictive cycle	135	42%
Covert sensitization	122	38%
Masturbatory training	81	25%
SAR(Sexual attitude reassessment)	78	24%
Adult children of alcoholics	75	23%
Masturbatory satiation	66	20%
Modified aversive behavior rehearsal	63	20%
Masturbatory (orgasmic) conditioning	59	18%
Sex arousal measures (plethysmography)	52	16%
Polygraph	51	16%
Antipsychotic medication	49	15%
Minor tranquilizers	47	15%
Sexual arousal card sorts	42	13%
Olfactory (foul odors) conditioning	33	10%
Shaming	32	10%
Biofeedback	25	8%
Depo-Provera	23	7%
Faradic (electric shock) conditioning	11	3%
Group Therapy	288	89%
Individual Therapy	283	88%
Family Therapy	267	83

Note. From Juvenile Sex Offending: Causes, Consequences, and Correction (p. 29) by G. Ryan and S. Lane, 1993.

The major thrust of adolescent sex offender treatment is to prevent reoffending in a significant number of youth. The challenge lies in the search for effective treatment. This can best be achieved when evaluation is integrated into all treatment outcome studies. Until such time it will be impossible to say with any certainty if adolescents who are released from treatment present a lesser risk to society than when they first offended.

CHAPTER III

METHODS SELECTION AND DESIGN

Meta-analysis is a quantitative method of integrating a body of literature dealing with a specific question (Glass et al.,1981). Brown and Brown (1987) cited the following advantages for using meta-analysis as a methodology:

1. it uses quantitative methods for organizing and extracting information from large data bases;

2. it helps eliminate bias in study selection by not prejudging research results;

3. it uses all information by transforming study findings into commensurable expressions describing the magnitude of experimental effect;

4. it detects statistical interactions by studying the covariation between findings;

5. it studies features that are quantitatively defined and measured; and

6. it seeks general conclusions aimed at practical simplicity (p. 339).

The meta-analysis offers an overall assessment of study results that reanalyzes data found in original research and arrives at a common measure for all of the studies included in the meta-analysis. The effect size (ES) estimates the amount that a treatment group differs from a control or comparison group following treatment. The Glassian method does not require the assumption that effect sizes are constant across studies and it uses much of the available

information from individual studies. Analysis of the results explains the relationship between type of treatment and treatment efficacy for the purpose of arriving at a quantitative estimate of program impact. Whereas the unit of analysis in a single study is a subject, in meta-analysis, the unit of analysis is the individual study.

This study focuses on evaluations of adolescent sex offender treatment appearing in the literature from 1978 to 1996. Studies were included if they met the following criteria:

1. The study was conducted between 1978 and 1996.

2. The study was in published form and found in a professional journal or book.

3. The study presented evaluation and treatment as applied to adolescent sex offenders.

4. The study included a control or comparison group.

5. The study presented outcome data in the form of recidivism or self-report measures.

6. The study provided data in a form that enabled a meta-analysis of the results.

The Literature Search

An important aspect of conducting the meta-analysis was a comprehensive literature search that qualified selection and evaluated all studies on adolescent sex offender treatment outcome even though only a small percentage of all the located literature was used in the analysis.

Unpublished data was excluded from the study for

reasons cited by Cook (1992): unpublished studies may be methodologically weak and "their inclusion will compromise the validity of a meta-analysis" (p. 2749). Further, another problem is obtaining a full representative sample of unpublished material. Therefore, only published material was included in the present study as they typically report statistically significant effects (Rosenthal, 1991b).

It is important to include a detailed description of the literature search for it can enable the reader to judge the comprehensiveness and representativeness of the sources. Also, it can assist future reviewers to broaden the review without duplicating it. The reader must judge whether the studies being reviewed in a meta-analysis represent all or most of the existing literature on the topic of adolescent sex offender treatment.

The best protection against any bias regarding the literature search is a thorough description of the procedures used to locate the studies. Glass et al. (1981) concludes:

> documenting the methods used in finding research literature takes more space than custom traditionally allocates to describing one's search. How one searches determines what one finds; and what one finds is the basis of the conclusions of one's integration of studies. Searches should be more carefully done and documented than is customary (p.61).

From 1978 to the present a total of 340 published sources were located. Journal articles totaled 264 sources and books or a chapter within a book totaled 76 sources, all of which deal with the adolescent sex offender. Appendix A contains a categorical list of all 340 published sources.

The following electronic databases were utilized: (a) via Maagnet (Younstown State University, Maag Library), ERIC, PsychInfo, Periodical Abstracts, Article First, World Cat, Book Review Digest, and SocioFile; (b) via MIRLYN (University of Michigan, Shapiro Library), WILS, RLIN, JSTOR, American Psych Asso.

Manual indexes searched included: Criminal Justice Abstracts; Criminal Justice Periodical Index; Criminology, Penology, and Police Science Abstracts; Sociological Abstracts; Psychological Abstracts; Social Science Index; Bureau of Justice Statistics; and Uniform Crime Reports.

Key words used in the search included the following terms: adolescent sex offender, juvenile sex offender, youthful sex offender, teenage sex offender, adolescent molester, adolescent child molester, adolescent rapist, female adolescent sex offender, female sex offender, sexually deviant youth, violent adolescent offender, aggressive adolescents, juvenile assaulters, juvenile delinquents, and adolescent sexual assaulters. An overall search of the key word, adult sex offender was used to assess whether a section was included that addressed adolescents. This was the case found most often in books

that devoted one or more chapters to the adolescent sex offender.

If an abstract was acquired, the next step was obtaining the full text. If the text was an article and not in bound form at the library or a book not held in circulation, a request to interlibrary loan was processed either through the computer or in written form. If the item was held in circulation it was duplicated in its entirety. Books were either checked out of the library or the section/chapter applying to adolescent sex offenders was duplicated.

All items unable to be obtained through Maag Library were located and duplicated at Shapiro Library at the University of Michigan, Ann Arbor.

Upon location of each article or book, the bibliographic reference was searched to obtain items not identified in the computer or manual search. When no new citations were found the search was considered exhausted.

The process of locating research published in 1996 presented a challenge. At the time of the search many listing were not yet entered into electronic databases or manual indexes. This was remedied by searching through the most prominent journals in the current periodical section of the library. Several articles were located and retrieved in this manner.

The task of finding everything written on this topic was particularly frustrating. Published research regarding

adolescent sex offenders is distributed among hundreds of journals and chapters in books. The most conscientious effort will no doubt be less than perfect.

Definition of Terms

For the purposes of this study the following terms are defined as follows:

1. Setting.
   (a) Institutional setting refers to a Sexual Behavior Clinic, a Sex Abuse Institute, or an Adolescent Sex Offender Inpatient Psychiatric Unit.
   (b) Residential setting refers to a Juvenile State-Operated Correctional Facility, or an Adolescent Sex Offender Treatment Program in a residential setting.
   (c) Community-Based/Outpatient setting refers to court-based programs, mental health counseling centers, diagnostic centers, and day treatment programs.
2. Treatment Modalities.
   (a) Pyschological treatment interventions utilize individual, group, and family therapy. They include insight-oriented psychotherapy and multisystemic therapy.
   (b) Behavioral treatment interventions are primarily concerned with the reduction of or change in abnormal sexual arousal. They include adverse conditioning, covert sensitization, cognitive-

behavioral therapy, social skills training, and utilization of the penile plethysmograph.

3. Outcome Measures.

   (a) Recidivism outcome measures consist of retrospective evaluations of case data, follow-up (e.g., reoffense data, rearrest history, subsequent referrals, and adult outcome). All studies related recidivism to treatment efficacy.

   (b) Self-report outcome measures offer a broad range of techniques that include deviant arousal patterns, personality characteristics as assessed by the MMPI or the Jessness Inventory Classification System, psychological adjustment, response to treatment, and reports from parole officers.

4. Groups.

   (a) Treatment group refers to the adolescent sex offenders included in the experimental group.

   (b) Comparison group can be composed of the following:

   * delinquent or violent non-sex offending youth,
   * a sub-group of adolescent sex offenders (peer offender, rapist, or child molester) or (offense against a male versus offense against a female,

* different types of treatment received, or
* different treatment settings.
* Note, a study can have more than one comparison group.)

(c) Control group refers to one of the following:
* Non-court involved adolescents,
* adolescent sex offenders not receiving treatment or on a waiting list,
* adolescent sex offenders assigned to nonsex offender specific treatment, or
* pretest-posttest design.

Coding of the Studies

Careful selection of studies is an important step of conducting a meta-analysis and was accomplished by classifying and coding each individual piece of literature (see Appendix B). The studies were coded according to procedures described by Hunter & Schmidt (1990). This process was similar to gathering data in a primary research study. Detailed coding was performed to obtain as much information as possible regarding the study characteristics. The variables coded were: sample characteristics (age, gender, and racial composition); treatment characteristics (whether the setting was institutional, residential, or community-based/outpatient) and (modality, mode, duration and intensity of the treatment); and methodological characteristics of the study (type of research design utilized and method of assignment into groups). The coded

outcome variables were recidivism and different methods of self-report.

Classifying and coding the studies enabled assessment, correlation, and relationship of study characteristics to be analyzed. The significance of coding the study characteristics was "to relate the properties of the studies to the study findings" (Glass et al., 1981, p. 70).

Instrumentation

A meta-analysis can have different "levels of ambition" (Olsen, 1995). This thesis summarized published results and presented what those results suggest in the aggregate. Glassian meta-analysis techniques were used to calculate effect sizes (Glass et al. 1981). "The individual study was the unit of analysis, with one effect size estimate obtained per study to prevent any single study from disproportionately contributing to the results" (Nagayama Hall, 1995, p. 803). Coding the studies was an important part of the instrumentation and was discussed in the above section, Coding of the Studies.

Two separate methods were used to assess program effectiveness. First, standardized effect sizes were calculated for each study. The unit of observation was a result from a given study. The Glassian meta-analytic approach involves transforming the findings of individual studies to some common measure. The original data for each unit of analysis in a study were not used, instead, the unit of analysis was the study itself. The reported statistics

(t values, F values, means, standard deviations, chi square values, and the like) were tranformed into r values or d values using the formulas developed by Hunter and Schmidt (1990).

An explanation of effect sizes is required to enable a better interpretation of the findings that are presented in Chapter 4. Videka-Sherman (1988) explains effect sizes as follows:

> effect size computation transforms individual study results into a standardized, quantitive score that can be compared across studies. Individual study results are means, standard deviations or percentages of success reported in a study (p. 327).

The statistical computations of effect size were calculated using the Pearson-product moment correlation coefficient, r or if the focus of the study was on differences among two or more groups of subjects, effect size was estimated by calculating Cohen's d. Interpretation of effect size were categorized following Cohen's guidelines:

> values of r= .10 and d= .20 can be considered small,
>
> values of r= .30 and d= .50 can be considered medium, and
>
> values of r= .50 and d= .80 can be considered large (Markus, Lang, & Pettigrew, 1990, p.208).

The advantage of the Glassian method of calcualting

effect sizes is that it does not require the assumption that effect sizes are constant across all studies.

The second method that was used to assess program effectiveness is often referred to as a ballot box or vote counting method (Glass et al., 1981). An overall effectiveness rating was assigned to each study based on the overall conclusions of the researcher(s). This rating was either positive effects, negative effects, or no effects. If the researcher(s) concluded that the program produced an overall positive effect, the study was assigned an overall rating of positive. The number of studies falling into these three categories was tallied and the category with the most "votes" was assumed to give the best estimate of treatment effectiveness.

Once effect size and significance levels were identified and calculated it was the aim of this thesis to arrive at factors that explained similarities and differences that could provide the answers as to why a treatment program was effective or ineffective. Chapter 4 reports the findings of applying the above described methodologies to the literature and the subsequent analysis of the selected studies.

CHAPTER IV

ANALYSIS AND FINDINGS

The literature search yielded over 300 documents of which 264 were professional journal articles. After a thorough examination of all retrieved literature, all but 18 studies were eliminated. Studies were excluded primarily because of the lack of sufficient data.

The 18 studies selected for meta-analysis in this thesis employed various methodologies. Three studies compared their treatment groups with non-sex offending peers (McCraw & Pegg-McNab, 1989; Brannon & Troyer, 1991; Rubinstein, Yeager, Goodstein, & Lewis, 1993). Two studies addressed the comparison of adolescent sex offenders with a male victim against adolsecent sex offenders with a female victim (Becker, Kaplan, & Kavoussi, 1988; Hunter & Santos, 1990). Two studies compared types of treatment, multisystemic and individual therapy (Borduin, Henggler, Blaske, & Stein, 1990), and covert sensitation and imaginal desensitization (McConaghy, Blaszcynski, Armstrong, & Kidson, 1989). Two studies used treatment and comparison groups that focused on the type of offense, sex offense against a child versus perpetrator of rape (Hagan & Cho, 1996), and sex offense against peers versus sex offense against a child (Carpenter, Peed, & Eastman, 1995).

Two controlled studies evaluated adolescent sex offender treatment. One control group received treatment not specific to sex offenders (Lab, Shields, & Schondel,

1993), and one control group received no treatment but were placed on a waiting list (Hains, Herrman, Baker, & Graber, 1986). Two other controlled studies used a pretest-posttest design (Graves, Openshaw, & Adams, 1992), and (Borduin, Mann, Cone, Henggler, Fucci, Blaske, & Williams, 1995).

The next five studies differed in the following respects:

1. a study comprised of a treatment group of adolescent sex offenders and a control group of adolescents admitted to a psychiatric unit (Herkov, Gynther, Thomas, & Myers, 1996);

2. a study comprised of a treatment group of adolescent sex offenders, a comparison group of adolescent males convicted of a non-sexual offense, and a control group of non-court involved adolescents (Porter, 1990);

3. a study consisting of a treatment group of adolescent sex offenders and two comparison groups that included adolescent males charged with a violent offense and adolescent males charged with a non-violent offense (Oliver, NagayamaHall, & Neuhaus, 1993);

4. a study consisting of a treatment group of adolescent sex offenders and three comparison groups which included confrontational non-sex offenders, confrontational plus sex offender, and neither confrontational or sexual offender (Kempton & Forehand, 1992); and

5. a study that evaluated ten treatment programs using a treatment group of adolescent sex offenders and several

comparative variables such as: institutional versus community treatment, history of sexual abuse versus no history of sexual abuse, previous offenses versus no previous offenses, denial versus blame issues, and age at the time of offense (Kahn & Chambers, 1991).

Sample

The 18 studies that comprise the sample of this meta-analysis encompasses a total of 1,411 subjects. The average age of the subjects was 15.4 years (SD = 1.4) with a range between 8 and 19 years of age. Of the 18 studies, 16 reported results for males with 2 reporting mixed (male and female) populations. Where ethnicity was reported subjects were 59% White, 32% Black, 5% Hispanic, and 4% Other. The average number of subjects for all studies was 78.36; 17 studies had 40 or fewer subjects and six studies had 100 or more subjects. Of the 1,411 youths, 880 were experimentals and 494 were comparison or control subjects.

The following is a breakdown of the treatment settings across all studies: institutional settings = 6; community-based or out-patient settings = 4; residential settings = 2; mixed settings = 3; and not reported = 3. Ten studies used self-report as outcome measures and eight used recidivism. Assignment into groups was computed as follows: random assignment = 6, matching = 6, convenience = 2, and not reported = 4. The majority of studies used a combination of data collection methods that included psychological assessment, physiological assessment, archival, observation,

survey, and various inventories and instruments. Table 3 summarizes the descriptive characteristics of the 18 studies that comprise the sample.

Table 3
Descriptive Sample Characteristics

ST	N	M/AGE	M	F	W	B	O	ASSG	SETTING	TXTYPE	EXP	CON	COM	OUTC	DATA
1	24	15.6	x		1	16	7	mat	com-b	cog-be	x		x	s-r	psyp
2	30	15.6	x		-	-	-	ran	-	beh	x	x	x	s-r	prji
3	36	18.2	x		10	21	5	mat	inst	sst	x		x	s-r	mcmi
4	126	14.8	x	x	88	38	-	ran	mix	mst	x	x	x	recd	m/m
5	150	-	x		pr	-	-	ran	com-b	-	x			s-r	ji
6	155	14.2	x		pr	-	-	conv	mix	sot	x	x		recd	arch
7	221	14.7	x	x	174	26	21	-	mix	mix	x		x	recd	arch
8	83	15.1	x		38	45	-	mat	inst	multi	x		x	s-r	cblc
9	45	16.5	x		-	-	-	-	inst	id/cs	x		x	recd	arch
10	77	15	x		23	37	16	-	inst	multi	x		x	recd	clin
11	17	17	x		11	6	-	conv	inst	psyed	x	x		s-r	mix
12	90	14	x		-	-	-	mat	outp	multi	x		x	s-r	psyR
13	74	15.2	x		-	-	-	-	res	multi	x	x		s-r	mmpi
14	100	15.7	x		-	-	-	mat	inst	multi	x		x	recd	arch
15	30	15.7	x		pr	-	-	ran	-	sst	x	x		s-r	mix
16	110	16.6	x		-	-	-	ran	-	apg	x		x	recd	pts
17	27	15.7	x		-	-	-	mat	res	cog-be	x		x	s-r	phys
18	16	14	x		10	6	-	ran	outp	mst/it	x		x	recd	obs

Note.
ST=STUDY NUMBER
N=SAMPLE SIZE
M/AGE=MEAN AGE
M=MALE/F=FEMALE
W=WHITE/B=BLACK/O=OTHER
ASSG=ASSIGNMENT TO GROUP
SETTING=TREATMENT SETTING
TXTYPE=TREATMENT TYPE
EXP=EXPERIMENTAL GROUP
CON=CONTROL GROUP
COM=COMPARISON GROUP
OUTC=OUTCOME
MAT=MATCHING
RAN=RANDOM
CONV=CONVENIENCE
COM-B=COMMUNITY
INST=INSTITUTIONAL
RES=RESIDENTIAL
OUTP=OUTPATIENT
ARCH=ARCHIVAL/RETROSPECTIVE DATA
PSYR=PSYCHOLOGICAL/RORSCHACH
PSYS=PHYSIOLOGICAL
MIX=MORE THAN ONE METHOD OR TYPE
PR=PREDOMINANTLY
- = NOT REPORTED/NO DATA
COG-B=COGNITIVE BEHAVIOR
BEH=BEHAVIORAL
SST=SOCIAL SKILLS TRAINING
MST=MULTISYSTEMIC
SOT=SEX OFFENDER TREATMENT
MULTI=MULTI-COMPONENT
PSYED=PSYCHO-EDUCATIONAL
ID=IMAGINAL DESENSITIZATION
CS=COVERT SENSITIZATION
APG=ADLERIAN PEER GROUP
MST/IT=MULTISYSTEMIC/INDIVIDUAL
S-R=SELF REPORT
RECD=RECIDIVISM
PSYP=PSYCHOPHYSICAL
PRJI=PROJECTIVE INSTRUMENTS
MCMI=MILLION CLINICAL MULTIAXIAL
M/M=MULTI-AGENT/MULTI-METHOD
JI=JESSNESS INVENTORY
CLIN=CLINICAL
PTS=POINT-IN-TIME SURVEY
OBS=OBSERVATION

Appendix C presents detailed informational data of the 18 studies comprising the meta-analytic results. The information presented in the appendix includes the study number assigned by this researcher and the following: sample size, gender, age range and mean age, sample groups, assignment to groups, measurement, treatment modality, duration and intensity, outcome, findings, and overall conclusions. The appendix should provide a means for easy reference to a specific study, whereas the above table provides an all-inclusive representation.

The following table presents publication dates of the 18 studies that were included in the meta-analysis.

Table 4
Summary of Studies by Date

Publication Date	Number
1986	1
1988	1
1989	2
1990	3
1991	2
1992	2
1993	3
1995	2
1996	2

The publication dates of the 18 selected studies ranged from 1986 to 1996. All but one of the 18 studies were published in professional journals with one study being a chapter in a book.

It is important to note in 1988, Becker stated, "there are no controlled outcome studies designed to evaluate the effectiveness of treatment programs for adolescent sexual offenders" (216). Contrary to Becker's statement, one study

(Hains et al.,1986) was located that was a controlled outcome study that evaluated a psychoeducational group treatment program for adolescent sex offenders.

Results of the Vote Counting

Table 4 presents the findings from the vote counting method of analysis for the 18 studies.

Table 5
Vote Counting Method Results

Study #	Positive Effect	Negative Effect	No Effect
001	x		
002	x		
003	x		
004	x		
005		x	
006		x	
007	x		
008		x	
009		x	
010	x		
011	x		
012			x
013	x		
014	x		
015	x		
016			x
017	x		
018	x		

Positive Effect = 12
Negative Effect = 4
No Effect = 2

The majority of the studies reported positive effects and four reported a negative effect, while only a small proportion reported no effect. These findings suggest a distinction between positive effects and sample size. Nine of the 12 studies with an overall positive effect had a sample size of less than 77 subjects with an average sample size of 36.77. The remaining studies with a positive effect

had 126, 221, and 100 subjects, respectively. Two of these were controlled studies utilizing pretest-posttest design. The four studies in the no effect category averaged 130.25 subjects, and the two studies with negative effects averaged 152.5 subjects.

The vote counting method was used to complement the results of the meta-analysis, the objective being to synthesize these results with the meta-analytic results to provide a benchmark for validity. Further, if a study did not yield a computable effect size then the vote counting result provided an estimate of effect size. This enabled all studies meeting the criteria to be aggregated. In the present study one of the 18 studies was given an effect size estimate based on the vote counting result. This was done because statistical analysis was unable to be calculated.

Results of the Meta-Analysis

Treatment effect sizes expressed in Cohen's d for each of the 18 studies are reported in Table 6. The effect size distribution was then examined for patterns regarding the efficacy of adolescent sex offender treatment. Effect size was unable to be calculated statistically for study 011. Consequently, an effect size was estimated using the positive rating from the vote counting tabulation to arrive at an effect size of .72 (the effect size mean of all positive rated studies).

Table 6
Summary of the Effect Sizes

Study	Date	N	Effect size d
001	1988	24	0.67
002	1990	30	0.77
003	1995	36	0.42
004	1995	126	0.44
005	1993	150	0.15
006	1993	155	-0.05
007	1991	221	0.88
008	1992	83	-0.24
009	1989	45	-0.18
010	1993	77	1.21
011	1986	17	.72*
012	1989	90	.32
013	1996	74	.65
014	1996	100	.05
015	1992	30	.57
016	1991	110	.73
017	1990	27	.34
018	1990	16	1.32
		T=1,411	M=0.49

Note. N = sample size
T = total
M = mean
* = estimated

The correlations between the vote count and the meta-analytical effect sizes are uniform. The overall effect size of .49 is considered a small effect size according to Cohen's guidelines. It is important to note that .50 is considered a medium effect and this study acknowledges a medium effect overall rating for the meta-analytical results. Further, a theory of Cook et al. (1992) contends "if the values in the effect size distribution are tightly clustered around the mean then that mean is a reasonable representation of the outcome of each and all of the studies" (p.38). Table 7 presents the effect size distribution of the 18 studies included in the meta-analysis.

Table 7
Effect Sizes Clustered Around the Mean

Range	Effect size of the studies	
-.30 to -.20	-.24	
-.19 to -.10	-.18	
-.09 to -.00	-.05	
.01 to .10		
.11 to .20	.15	
.21 to .30		
.31 to .40	.32, .34	
.41 to .50	.42, ,44	Mean=.49
.51 to .60	.57	
.61 to .70	.65, .67	
.71 to .80	.72, .73, .77	
.81 to .90	.88	
.91 to 1.00		
1.01 to 1.10		
1.11 to 1.20		
1.21 to 1.30	1.21	
1.31 to 1.40	1.32	

Interpretation of the Findings

Effect sizes across studies were heterogeneous and display mixed results, even though the majority of effect sizes were positive and in two case over 1.00 magnitude. It has been determined that methodological differences among studies are the source of heterogeneity. Less than half of the studies employed designs with good internal validity. A number of characteristics of the studies might affect the results and those limitations are discussed in Chapter 5.

It is at this point of the meta-analysis that patterns within the studies were analyzed. The study results were compared across a number of dimensions including: outcome measures, group assignments, treatment settings, treatment modalities, differences among subgroups, and the date of publication. Dividing studies into categorical groups can

sometimes lead to homogeneity of results within the groups (Markus et al., 1990, p. 217). It is important to note that none of the findings were related to female adolescent sex offenders. Of the 1,411 total sample size of the 18 studies only 11 are females, therefore, any generalizations are impossible.

Outcome Measures

An important difference existed in the form of outcome measures. Table 8 represents the effect sizes of the studies based on recidivism and self-report outcome measurements.

Table 8
Effect Sizes for Studies Using Recidivism and Self-Report

Study	Date	n	Effect size
		Recidivism	
004	1995	126	.44
006	1993	155	-.05
007	1991	221	.88
009	1989	45	-.18
010	1993	77	1.21
014	1996	100	.05
016	1991	110	.73
018	1990	16	1.32
		T=850	M=.71
		Self-Report	
001	1988	24	.67
002	1990	30	.77
003	1995	36	.42
005	1993	150	.15
008	1992	83	-.24
011	1986	17	.72
012	1989	90	.32
013	1996	74	.65
015	1992	30	.57
017	1990	27	.34
		T=561	M=.44

The data revealed that studies using recidivism (n = 8, M = .71) as an outcome measure have a significantly larger effect size than those studies using self-report (n = 10, M=.44) as an outcome measure. This was an anticipated result and one that generally has been accepted in the literature.

The study (018) with the largest effect size was based on recidivism outcome (es = 1.32) but is not a fair representation because of the small sample size (n = 16), the smallest sample size of all analyzed studies. A more representative example of a recidivism study reporting a medium effect size (es = .88) was study 007 with a large sample size (n = 221), the largest sample size of all analyzed studies. Statistically significant findings of this 1991 study included the following:

1. adolescents who utilized verbal threats in the commission of their offense showed a higher rate of reoffending sexually than those who did not threaten their victims.

2. adolescents who blamed their victims for their crime had a higher rate of sexual reoffending than those who did not, and

3. of the eight adolescent sex offenders in the study who completely denied their offense(s) none reoffended sexually.

In this study, Kahn et al. (1993) acknowleded "this [study 007] represents the first attempt of its kind to

empirically assess those variables directly related to efficacy of treatment for adolescent sex offenders" (p. 197). The most important finding of the study confirms the idea that community-based/outpatient treatment is as effective as incarceration and gives needed support to specialized adolescent sex offender treatment as an alternative to incarceration.

Study 010 had a large effect size (es= 1.21) and a sample size of 77. This study involved the longest follow-up period (8 years) and according to the authors was the first study to follow a group of adolescent sex offenders into adulthood. The finding that impacts treatment was the realization that all of the sexually assaultive adolescents who went on to commit multiple sexual offenses as an adult had been sexually abused as children. Further, most of the abuse had been by a female, in most cases the mother. This finding implied that treatment programs need to address sexual abuse issues and engage the family in the treatment process.

The recidivism study with the smallest analyzed effect size (es = .05) and a postive rating was study 014. While the study reported significant results for adolescents who had completed treatment; those results indicated that there was no evidence that the committing offense is a predictor of reoffense risk. In other words, adolescent child molesters and adolescent rapists did not differ in their likelihood to reoffend. The authors recognized a lack in

treatment aftercare as a shortcoming in the treatment of adolescent sex offenders. The remaining studies that used recidivism outcomes ranged in effect sizes from -.18 to .73.

Within the group of studies utilizing self-report as a measure of outcome, study 001 (n = 24, es = .67) examined the differences between adolescents who sexually victimized a male and adolescents who sexually victimized a female by measuring erectile response to deviant cues. The study concluded a cognitive-behavioral treatment approach significantly decreased deviant sexual arousal for those adolescents who victimized a male. It is important to note that adolescents who sexually offended a female also experienced decreased deviant sexual arousal but not significantly. The treatment consisted of verbal satiation, cognitive restructuring, covert sensitization, social skills training, anger management, sex education, and relapse prevention.

The other nine studies utilizing self-report outcome range in effect sizes from -.24 to .77 and in contrast to the recidivism studies display a more representative effect size distribution. But, on the whole, recidivism presented a more effective way of reporting outcome based on mean effect size (.71 versus .44).

Depending on the interpretation of the data, the outcome of treatment effectiveness for adolescent sex offenders based on recidivism can be viewed in more positive terms than outcome based on self-report. On the other hand,

it could be viewed as an incentive to strive for better programs.

The eight computations of recidivism outcome revealed two instances where effect size exceeded 1.00 and an additional two times where effect size was larger than .50. In terms of the direction of results, two of the eight effect sizes displayed negative results and tended to confound any evaluation of treatment effectiveness based on recidivism outcome measures.

Studies with a Control Group

Six of the 18 studies used a control group totaling a sample size of 432 adolescents and an overall mean effect size of .52, a smaller than expected result. None of the six studies had an individual effect size greater than .77. This finding suggests that controlled studies did not have greater positive results than studies consisting of comparison groups. Studies using one comparison group had an overall effect size of .44 and studies using more than one comparison group had an overall effect size of .82.

An example of a study using more than one comparison group was study 013 (n = 74, es = .65) that compared three types of adolescent sex offenders. The adolescent sexual abuser group consisted of adolescents who engaged in fondling, exhibitionism, or oral sex with a victim at least five years younger than the offender. The adolescent rapist group was composed of offenders who had forced vaginal sex with a victim (any age). The adolescent sodomy group were

those offenders who attempted or engaged in anal intercourse with a victim (any age). If the adolescent was adjudicated for more than one offense, the more serious offense determined the group assignment. Sodomy was the most serious offense followed by rape and abuse. This study demonstrates the value of using comparison groups to assess treatment efficacy as the researchers of this study concluded "treating this diverse group of young offenders as a homogeneous lot might lead to unclear or misleading research results and inconsistent intervention outcome" (Herkov et al., 1996, p. 88)

Age of Offender

The analysis of who might benefit more from treatment was determined by using the mean age of the adolescent sex offenders in each study. Nine of the studies included adolescents with a mean age range from 14 to 15.5 years (n = 942, es = .51) compared to eight studies that included adolescents with a mean age range of 15.6 to 18.2 years (n =319, es = .44). This analysis suggested that the older the subject, the less likely the treatment intervention will be effective. Although the effect size of .51 for the younger group (14 to 15.5) is not significantly greater than the effect size of .44 for the older group (15.6 to 18.2), when viewed in terms of the sample size (942 as compared to 319), it appears that the offenders in the younger range were more amenable to treatment.

Group Assignment

Table 9 contains studies in which group assignment was analyzed. The table lists studies that reported random, matched, and convenience assignment into groups. Of the 18 studies, three did not report how assignment to groups was implemented.

Table 9
Effect Sizes for Random, Matched, and Convenience Assignment

Study	Date	N	Effect Size
		Random	
002	1990	30	.77
004	1995	126	.44
005	1993	150	.15
015	1992	30	.57
016	1991	110	.73
018	1990	16	1.32
		T=462	M=.66
		Matched	
001	1988	24	.67
003	1995	36	.42
008	1992	83	-.24
012	1989	90	.32
014	1996	100	.05
017	1990	27	.34
		T=360	M=.26
		Convenience	
006	1993	155	-.05
011	1986	17	.72
		T=172	M=.34

Random group assignment with an overall mean effect size of .66 included four of six studies with effect sizes greater than .50. Six studies using matched group assignment revealed only one study with an effect size greater than .50 and .26 as the overall mean. Only two studies used convenience as group assignment and revealed an effect size of .34. Random assignment appeared to have some

impact on treatment evaluation in the reviewed studies based on effect size analysis.

Treatment Setting

Table 10 consists of studies categorized according to type of treatment setting. Three studies were excluded due to inadequate data or mixed settings.

Table 10
Effect Sizes for Community-Based/Outpatient, Residential, and Institutional Settings

Study	Date	N	Effect Size
	Community-Based/Outpatient		
001	1988	24	.67
005	1993	150	.44
007	1991	221	.88
012	1989	90	.32
018	1990	16	1.32
		T=501	M=.67
	Residential		
013	1996	74	.65
015	1992	30	.57
016	1991	110	.73
017	1990	16	.34
		T=230	M=.57
	Institutional		
003	1995	36	.42
008	1992	83	-.24
009	1989	45	-.18
010	1993	77	1.21
011	1986	17	.72
014	1996	100	.05
		T=358	M=.33

Community-based/outpatient treatment studies had an effect size of .67 and residential reported an effect size of .57. Based on the larger sample size (501 as compared to 230 for residential) community-based/outpatient treatment settings appeared to have more impact than institutional or residential treatment. Findings from this investigation

contradict the common assumption that institutional settings offer the most efficacious means of treating the adolescent sex offender. It is important to note, this admittedly tentative finding does not suggest that treatment should not be applied in institutional settings.

Treatment Duration

Unfortunately, an inadequate number of studies assessed the effectiveness of treatment based on the duration of treatment. The majority of studies did not report the amount of time spent in treatment in conjunction with the intensity of the treatment. The cumulative effect of the studies that did report distinct treatment duration and intensity (n = 4, es = .32), did not indicate successful treatment. Study 001 presented the most comprehensive description of the components of a structured cognitive-behavioral intervention based on intensity of treatment (8 x 30 mins. of verbal satiation, 4 x 75 mins. of group therapy, 4 x 75 mins. of social skills training, 4 x 75 mins. of anger management, and 2 x 75 mins. of relapse prevention). However, the duration of the treatment program was not addressed. This study's effect size of .67 combined with the small sample size of 24 render any conclusions tenuous.

Three studies reported a mean duration of treatment and proved to be more representative in that all used recidivism as an outcome measure and had sample sizes over 100. The cumulative effect size for these three studies was .68. Study 004 (n = 126, es = .73), study 007 (n = 221,

es = .88) and study 016 (n = 110, es = .44) expressed treatment duration in mean hours, median sessions, and mean months, respectively. Therefore, any interpretation would be problematical and it can be concluded that research needs to address this dimension.

Chronological Analysis

An analysis of effect sizes for studies published in each individual year reveals no propensity for more effective treatment in the more recent years. The first nine studies in chronological order reported a mean effect size of .62 as compared to the second nine studies in chronological order that yeilded an effect size of .35. It is possible that treatment effectiveness has decreased over time but it is probably more likely that evaluations have become more rigorous. Upon closer inspection of the studies conducted in the first nine years it was discovered that they frequently used recidivism, random assignment, and community-based/outpatient treatment; all of which proved to be more effective in categorical comparisons. Subsequently it would appear that treatment effectiveness was more successful in the earlier years (1986 to 1991).

Treatment

The treatment mode used most often was group therapy. Eleven of the 18 studies implemented group intervention (es = .50) and three studies utilized a combination of group and family treatment (es = .85) suggesting that treatment is

more effective if the family of the adolescent sex offender is engaged in the intervention.

Overall the 18 studies varied widely in the treatment modalities used with this population. Three studies indicated treatment success with cognitive-behavioral intervention (es = .28) and two studies reported the effectiveness of multisystemic treatment (es = .88). The effect size coupled with sample size of cognitive behavioral (n = 32, es = .28) and multisystemic (n = 71, es = .88) implies that multisystemic treatment of adolescent sex offenders is superior to cognitive-behavioral treatment.

Other studies yielding greater than .50 effect sizes were 007, 016, and 011. Study 007 (n = 221, es = .88) described specialized sexual deviancy therapy, a combination of group and family intervention. Components of specialized sexual deviancy therapy included confrontation, sex education, anger management, social skills training, development of victim empathy, and behavioral techniques to alter deviant arousal (Kahn et al., 1991). Study 016 (n = 110, es = .73) assessed the effectiveness of an Adlerian approach to peer group treatment. Treatment consisted of group intervention strategies emphasizing individual honesty, acceptance of responsibility, community service projects, problem-solving activities, interpersonal openness, and an indepth focus on correcting past deviant life styles (Brannon et al., 1991). Study 011 (n = 17, es = .72) evaluated a psycho-educational group program that

focused on teaching sexual knowledge, improving psychological attitudes, problem-solving training, and moral judgment training (Hains et al., 1986). Study 014 yielded the smallest positive effect size (n = 100, es = .05), the treatment intervention was confrontive group psychotherapy with goals aimed toward breaking through denial and taking responsibility for the offense committed.

The two studies that implemented cognitive-behavioral intervention only received a small cumulative effect size of .28 with a combined total of only a 32 sample size. Therefore, the finding that cognitive-behavioral treatment was less effective should be interpreted cautiously. The possibility that this treatment could be effective might be hampered by inadequate sample size. The programs in this category implemented techniques that focused on sexual impulse control and reduction of deviant arousal. Penile erectile responses were recorded using the plethysmograph. Therapy included verbal satiation in which audio tapes of the adolescent sex offenders fantasy are played repeatedly. Satiation can be masturbatory or non-masturbatory. Covert sensitization also involved the use of audio tapes consisting of stages of the sexual fantasy leading up to consequences and escape. The youth's erectile response was gauged during the playing of the audio taped stimuli (Becker et al., 1988; Hunter et al., 1990). These techniques have been successful with adult sex offenders and offer promise in the treatment of adolescent sex offenders (Hunter et al.,

1990).

It is encouraging that the study yielding the greatest effect size 1.32 combined group and family therapy (overall es = .85) and utilized multisystemic treatment (overall es = .88). Otherwise, the small sample size (n = 16) would make any generalizations unsubstantial.

A description of multisystemic treatment is appropriate as it appears to be the most effective modality according to the meta-analytical results. The multisystemic approach to treatment consists of the following:

> Treatment addresses intrapersonal (cognitive) and systemic (family, peer, school) factors. Therapy attempts to remedy defects in the adolescent sex offenders cognitive processes (denial, empathy, distortions), family relations (family cohesion, parental supervision), peer relations (developing age-appropriate peer relations with girls and boys), and school performance (Borduin et al., 1990, p. 109).

Unfortunately, six of the 18 studies assessed treatment effectiveness using only a description of treatment as being multi-component. These studies had a cumulative effect size of .48 and included one study with an effect size of 1.21 and another with .88 effect size. Five of the six studies claimed to have success treating adolescent sex offenders but failed to detail what intervention they implemented. These studies could have contributed significantly to the

findings of this meta-analysis and may be the source of effect size heterogenity.

Overall Analysis

A medium effect size was acknowledged for the overall rating of the meta-analytical results. Recidivism is considered to be the better predictor of treatment effectiveness as compared to self-report outcome measures. Random assignment of groups appeared to be the best method within this group of studies. Community-based/outpatient treatment settings were found to have more impact than do institutional or residential treatment settings. Studies conducted in the more recent years proved to be less effective than studies conducted from 1986 to 1991, a finding that was not anticipated.

The most encouraging finding was related to treatment. Efforts to involve the family in the treatment process appear to be more effective than treating the adolescent sex offender without the family component. This finding is the most promising relating to treatment effectiveness, especially considering that community-based/outpatient treatment settings were shown to be the more effective of the treatment settings. Adolescents return to their environment (i.e., family and community) after treatment terminates. It is practical and logical to engage the family in the treatment process and maintain the adolescents ties to the community.

CHAPTER V

DISCUSSION

This research investigated the effectiveness of adolescent sex offender treatment utilizing a meta-analytical format. Eighteen studies of treatment outcome employing various methods of research design were included in the analysis selected from the inital 340 sources. Applications of the methods described in this study frequently encountered complications due to missing data, publication bias, methodological shortcomings, and researcher bias.

All of the findings in this meta-analysis are suggestive not conclusive. Allen, D'Alessio, and Brezgel (1995) confirm, meta-analysis provides "relevant and probative but not conclusive evidence in support of, or in denial of, . . . theories" (p. 275). A single meta-analysis cannot provide definitive answers. However, the analysis can clarify certain factors associated with adolescent sex offender treatment effectiveness.

Limitations of the Study

While there are several limitations to this study and all meta-analysis in general, it can be argued that meta-analysis is methodologically sounder than most currently used research approaches. Most of the limitations of meta-analysis are common to other research methods. Also, many of these other methods may have further limitations that are

not present in a meta-analysis. In other words, all research is severely hampered by limitations and meta-analysis is no exception.

Findings from this meta-analysis were limited by several factors. A major criticism of studies being compared in a meta-analysis stems from the fact that the studies differ from one another. This point can be countered by noting studies that are the same do not need to be compared since they would have the same findings. Only studies that are somewhat different need to be compared. Hunter et al., (1990) contend "meta-analysis does not analyze studies, it analyzes study results, (i.e., numbers). Any set of numbers can be compared, averaged, or otherwise analyzed without logical contradiction" (p. 516).

Publication bias is a limiting factor in conducting a meta-analysis. When large portions of research literature are omitted the possibility of bias exists. The present study did not include unpublished studies. Those that criticize the exclusion of unpublished studies suggest that a meta-analysis using only published studies will show results more statistically significant and with larger effect sizes since it can be concluded that published studies are more methodogically sound. Published sources tend to contain studies that worked; in contrast, it can be said that unpublished studies tend to be more methodologically weak. The greatest problem with including unpublished studies is in obtaining them. Therefore,

omitting numerous studies is a possiblility. To deal with publication bias, this meta-analysis clearly states what type of literature was reviewed and then gave a detailed description of the literature search.

Another limitation of this meta-anlaysis is the methodological shortcomings in many of the reviewed studies. Several studies failed to report important methodological aspects that could have added valuably to the results. It was the original intent of this thesis to examine only controlled outcome studies with more than three years follow-up. That approach would have yielded a sample of only three studies. Including studies with less than desired methodologies to increase the database is recommended. The patterns found would be more likely to be valid than a pattern found in two or three unflawed studies (Hunter et al., 1982, p. 151). Glass, et al. (1981) acknowledged "many weak studies can add up to a strong conclusion" (p. 221). However, it is important to consider that methodological shortcomings did compromise these results and prevent definitive conclusions on adolescent sex offender treatment efficacy.

Researcher bias can present serious limitations in the interpretation of the meta-analytical results. Meta-analysis is subjective and based on the findings reported. A second reviewer could use the exact same studies and report different findings. In addition, two researchers could select different sets of studies from the same

database using different subjective inclusion criteria. The best way to overcome this serious limitation is to hold all subjective decisions to the scrutiny of others by detailing the literature search, inclusion criteria, coding procedure, and characteristics of the studies. Despite the care taken in selecting studies, this study could still be criticized for failing to include more studies.

The final limitation of this meta-analysis involves the level of ambition utilized by this reviewer. Some meta-analyses take into account mean and standard deviation. This study focused on mean only and then divided the data into subsets to reveal patterns. Hunter et al. (1990) claimed "the weakest meta-analysis is equal to or better than the ideal narrative review" (p. 528). The authors also contend that the mean in studies that report standard deviation can be very misleading. In addition this meta-analysis could have been subject to more rigorous testing.

In sum, the methodological shortcomings and the subjective decision-making that are a part of all meta-analyses are cause for speculation of the accuracy of the findings. These factors are implied in the reported findings and all interpretation must be made accordingly. The research designs of the 18 studies aggregated in this meta-analysis played a major role in the findings reported.

Implications

Few types of offenses committed by adolescents elicit stronger reactions than sexual offenses. Findings

indicating a better success rate for community-based/outpatient interventions have implications for the juvenile justice system. The juvenile justice system traditionally incarcerates adjudicated adolescent sex offenders in correctional facilities. Juvenile court judges are hesitant to allow adolescent sex offenders to remain in the community for treatment (Steen et al., 1989, p. 204). In light of the finding that treatment for adolescent sex offenders that includes a family component appears to be more effective is consequential to juvenile justice professionals because it is impossible to engage the family in treatment if the youth is incarcerated.

Adolescent sex offender treatment as a condition of probation in a community setting might result in greater successes for certain types of offenders. In the case of the victim being a sibling of the offender, this would necessitate the adolescent sex offender being placed in a foster home or with a relative where there are no young children.

The adolescent sex offender should not remain solely a juvenile justice problem. Coordination with mental health agencies and social service agencies are needed. Treatment providers need to keep the juvenile justice system aware of the youths progress in treatment and to report a lack of effort toward treatment goals. Further, a coordinated effort could increase the chances of long term follow-up being conducted.

Treatment planning that combines an adequate level of supervision and proper treatment can go a long way towards reducing reoffense risk. Juvenile courts need to be apprised of clinical risk factors for reoffense in order to base their decisions for placement of the adolescent sex offender into a treatment setting. In general, community-based/outpatient treatment seems most appropriate for first time offenders of a non-violent act.

In sum, all adolescent sex offenders need treatment, but not all adolescent sex offenders need the same type of treatment. Although community-based/outpatient treatment cannot be provided to all adolescent sex offenders, those most suited should be treated in the community. In this way, the family can be more readily engaged in the treatment process.

Recommendations for Future Research

The present meta-analysis has shown that adolescent sex offender treatment has a medium effectiveness, but little is still known about why some interventions are more successful than others. More studies with extended follow-up and detailed program descriptions are needed. Another topic for future researchers to consider is the controversial issue of studies comparing adolescent sex offenders who receive treatment with adolescent sex offenders who do not receive treatment. The common argument is that it is unethical to withhold treatment from an adolescent sex offender. Nagayama Hall (1995) presented an interesting response, he

claims it is "socially responsible and ethical to [withhold treatment from an adolescent sex offender] do so" (p.225). His rationale was that the treatment being withheld has not been proven effective.

An important issue that needs to be addressed in future research is a distinction of adolescent sex offenders who are repeating treatment. No studies provided information regarding those adolescents who already had treatment and were involved in the study as a result of reoffending. Also, it would be important to know if any of adolescents had failed a prior treatment program. These issues would certainly have an impact on treatment effectiveness.

A replication of this study with stricter criteria for inclusion and a higher level of ambition for the meta-analysis could further clarify the generalizations of these findings. Reserved for future reviews are the many issues surrounding the limitations of this meta-analysis. As more studies appear in the literature, future meta-analyses of adolescent sex offender treatment effectiveness might do well to concentrate on one outcome measure. However, the findings from this study should help refine the focus of future research.

There are numerous treatment programs implementing dozens of treatment modalities, but availability of programs is not enough. More research needs to evaluate outcomes using long term follow-up data. Programs need to be evaluated not just put into operation without determining if

they work as intended.

Conclusions

Over the past eighteen years sexual offending by adolescents has become a critical issue gaining the attention of researchers. The aim of this thesis was to use meta-analysis to examine the available published research addressing treatment outcome for adolescent sex offenders. Both vote count and effect size measures were utilized to assess treatment efficacy.

The vote count results suggested that treatment effects were primarily positive. The results of the effect size calculations presented heterogeneous results but certain findings provided insight to selected aspects of treatment effectiveness.

Group interventions such as multisystemic and specialized sexual deviancy treatment with a family component in a community-based/outpatient setting with younger offenders appeared to be most effective. Studies conducted prior to 1992 appear to have greater results with regards to treatment effectiveness than do the studies conducted in the more recent years. Overall, the results of this meta-analysis are encouraging in that adolescent sex offender treatment was found to be moderately effective on several variables.

Rather than viewing this meta-analysis as the final test of adolescent sex offender treatment efficacy, these findings should be interpreted not as what is known but in

how the findings were obtained and can be improved upon. Hopefully, the number of evaluative research studies of adolescent sex offender treatment effectiveness should increase over the next several years.

Finally, the analyzed data in this study are important because they demonstrate the usefulness of evaluating treatment effectiveness and prove it is possible to obtain representative data on adolescent sex offenders. Stevenson, Castillo, and Sefarbi (1990) and Bengis (1986) agree "total cure" is not a realistic goal for adolescent sex offenders. Reduction and control of deviant behavior is a more realistic target.

APPENDIX A

QUICK REFERENCE GUIDE AND

CATEGORIZED SOURCES OF THE DATABASE

QUICK REFERENCE GUIDE

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APPENDIX B

THE CODING SHEET

CODING SHEET

Study I.D. #_____ Year _____ Country _____

First Author _____

Source of Data _____

Type of Study: Experimental _____ Survey _____
Descriptive _____ Lit Review _____
Case Study _____ Other _____

Sample: Size _____ Treatment _____ Control _____
Comparison _____ None _____

Group Assignment: Randon _____ Matching _____
Convenience _____ Not reported _____

Data Collection: Self report _____ Questionnaire _____
Archival _____ Observation _____
Psychological Assessment _____
Physiological Assessment _____
Interview _____ Other _____

Treatment Setting: Institutional _____ Residential _____
Community-based _____ Other _____
Outpatient _____ None _____

Treatment Modality: _____

Treatment Mode: Group _____ Individual _____
Family _____ Combination _____

Treatment:
Duration _____ Intensity _____

Sample Characteristics: Male _____ Female _____
Age Range _____ Mean age _____
Race _____

Outcome Measure: Recidivism _____ Self report _____
Other_____

Overall effectiveness rating: (author's interpretation)
Positive effects _____ Negative effects _____
No effects _____ Not reported _____

Comments _____

_____

_____

APPENDIX C

INFORMATIONAL DATA OF THE 18 STUDIES INCLUDED IN THE META-ANALYSIS

STUDY 001: BECKER, KAPLAN & KAVOUSSI, 1988.
SAMPLE SIZE: 24 MALES.
AGE RANGE/MEAN: 13-18 (15.6).
SAMPLE GROUPS: 11 ASO w/ MALE VICTIM.
13 ASO w/ FEMALE VICTIM.
ASSIGNMENT TO GROUPS: MATCHED.
MEASUREMENT: EXAMINED DIFFERENCES BETWEEN GROUPS (PSYCHOPHYSICAL ASSESSMENT - ERECTILE RESPONSE).
TREATMENT MODALITY: MULTI-COMPONENT
OUTCOME: PRE/POST TREATMENT SEXUAL DEVIANCY.
FINDINGS: COGNITIVE-BEHAVIORAL TREATMENT IS EFFECTIVE IF ASO HAS MALE VICTIM.
OVERALL: SIGNIFICANT DECREASE OF DEVIANT SEXUAL AROUSAL TO PHYSICAL COERCION CUES PRE AND POST TREATMENT AS MEASURED BY PENILE PLETHYSMOGRAPHY FOR ASO w/ MALE VICTIM. FOR THOSE ASO w/ FEMALE VICTIM THERE WAS A DECREASE BUT IT WAS NOT STATISTICALLY SIGNIFICANT.

STUDY 002: PORTER, 1990.
SAMPLE SIZE: 30 MALES.
AGE RANGE/MEAN: 13-18 (15.6).
SAMPLE GROUPS: 10 ASO.
10 ADOLESCENT OFFENDER-NONSEX OFFENSE.
10 ADOLESCENT NON-COURT INVOLVED.
ASSIGNMENT TO GROUPS: RANDOM.
MEASUREMENT: EXAMINED DIFFERENCES BETWEEN GROUPS (PROJECTIVE INSTRUMENTS AND SELF REPORT QUESTIONNAIRES).
TREATMENT MODALITY: INSIGHT-ORIENTED AND BEHAVIORAL
OUTCOME: POST TREATMENT PSYCHOSOCIAL SKILLS.
FINDINGS: ASO MORE IMPAIRED PSYCHOSOCIALLY,PSYCHOLOGICALLY, AND DEVELOPMENTALLY THAN OTHER GROUPS. ASO NOT FOUND TO BE A SUBSET OF DELINQUENTS BUT A UNIQUE GROUP.
OVERALL: SIGNIFICANT DIFFERENCES BETWEEN GROUPS. INSIGHT-ORIENTED AND BEHAVIORAL TREATMENTS HAVE LITTLE IMPACT BUT LONG TERM TREATMENT THROUGHOUT THE ADOLESCENTS DEVELOPMENT IS SUGGESTED.

STUDY 003: CARPENTER, PEED, & EASTMAN, 1995.
SAMPLE SIZE: 36 MALES.
AGE RANGE/MEAN: 17-19 (18.25).
SAMPLE GROUPS: 16 ASO w/ PEER VICTIM.
20 ASO w/ CHILD VICTIM.
ASSIGNMENT TO GROUPS: MATCHED.
MEASUREMENT: EXAMINED DIFFERENCES BETWEEN GROUPS (MILLION CLINICAL MULTIAXIAL INVENTORY (MCMI).
TREATMENT MODALITY: MULTI-COMPONENT
OUTCOME: PERSONALITY CHARACTERISTIC DIFFERENCES OF THE TWO GROUPS.
FINDINGS: TREATMENT SHOULD BE SPECIFIC TO PERSONALITY TRAITS
OVERALL: SIGNIFICANT DIFFERENCES BETWEEN THE GROUPS AND THEIR TREATMENT NEEDS SHOULD BE BASED ON PERSONALITY DIFFERENCES.

STUDY 004: BORDUIN, et al., 1995.
SAMPLE SIZE: 126 MALES.
AGE RANGE/MEAN: 12-17 (14.8).
SAMPLE GROUPS: 70 ASO RECEIVING MUTISYSTEMIC TREATMENT.
56 ASO RECEIVING INDIVIDUAL TREATMENT.
ASSIGNMENT TO GROUPS: RANDOM.
MEASUREMENT: EXAMINED DIFFERENCES BETWEEN GROUPS (MULTI-AGENT AND MULTIMETHOD ASSESSMENT BATTERY).
TREATMENT MODALITY: MUTLTISYSTEMIC (MST), INDIVIDUAL (IT).
OUTCOME: PRE/POST. INSTRUMENTAL OUTCOME=TREATMENT IMPACT. ULTIMATE OUTCOME=RECIDIVISM (3.95yrs.).
FINDINGS: MST, LOWER RISK FOR REARREST (26.1%).
IT, HIGHER RISK FOR REARREST (71.4%).
OVERALL: SIGNIFICANT EFFECTIVENESS ESTABLISHED FOR MST. PRODUCED LONGSTANDING CHANGES IN YOUTH'S CRIMINAL BEHAVIOR.

STUDY 005: OLIVER, NAGAYAMAHALL, & NEUHAUS, 1993.
SAMPLE SIZE: 150 MALES.
AGE RANGE/MEAN: RANGE NOT REPORTED (15).
SAMPLE GROUPS: 50 ASO.
50 ADOLESCENT VIOLENT OFFENDERS (NONSEX).
50 ADOLESCENT OFFENDERS (NONSEX-NONVIOLENT).
ASSIGNMENT TO GROUPS: RANDOM.
MEASUREMENT: EXAMINED DIFFERENCES BETWEEN GROUPS (JESSNESS INVENTORY (JI).
TREATMENT MODALITY: NOT REPORTED.
OUTCOME: BACKGROUND AND PERSONALITY DIFFERENCES OF GROUPS.
FINDINGS: EARLY TREATMENT INTERVENTION CAN BE PREVENTATIVE ASO LEAST DEVIANT OF GROUPS AFTER ASO TREATMENT, A FINDING THAT IS CONTRAST TO THE RESULTS OF MOST ADULT SEX OFFENDER STUDIES.
OVERALL: NO SIGNIFICANT DIFFERENCE IN GROUPS REGARDING AGE, I.Q., OFFENSE HISTORY. FAILED TO DELIVER INTENDED OUTCOME.

STUDY 006: LAB, SHIELDS, & SCHONDEL, 1993.
SAMPLE SIZE: 155 MALES.
AGE RANGE/MEAN: AGE RANGE NOT REPORTED (14.2).
SAMPLE GROUPS: 46 ASO RECEIVING SEX OFFENDER TREATMENT.
109 ASO RECEIVING NONSEX OFFENDER SPECIFIC TREATMENT.
ASSIGNMENT TO GROUPS: CONVENIENCE.
MEASUREMENT: EXAMINED DIFFERENCES BETWEEN GROUPS (RETRO-SPECTIVE DATA).
TREATMENT MODALITY: SEX OFFENDER TREATMENT (SOT).
NONSEXUALLY SPECIFIC TREATMENT (NSOT).
OUTCOME: TREATMENT IMPACT VIA RECIDIVISM (3yrs.).
FINDINGS: SOT, 2.2% SEX REOFFENSE, 24% ANY REOFFENSE
NSOT, 3.7% SEX REOFFENSE, 18% ANY REOFFENSE
OVERALL: SOT TREATMENT NO BETTER AT REDUCING RECIDIVSM THAN TRADITIONAL TREATMENT HOWEVER, LOW RECIDIVSM IN BOTH GROUPS SUGGEST TREATMENT OF ANY KIND IS NEEDED. FAILED TO DELIVER INTENDED OUTCOME.

STUDY 007: KAHN, & CHAMBERS, 1991.
SAMPLE SIZE: 221 MIXED, (210 MALE AND 11 FEMALE).
AGE RANGE/MEAN: 8-18 (14.7).
SAMPLE GROUPS: PROPORTIONS NOT REPORTED.
ASSIGNMENT TO GROUPS: NOT REPORTED.
MEASUREMENT: EXAMINED DIFFERENCES OF TEN TREATMENT PROGRAMS (RETROSPECTIVE EVALUATION).
TREATMENT MODALITY: TEN TYPES OF SPECIALIZED SEXUAL DEVIANCY THERAPY (SSDT).
OUTCOME: RECIDIVISM (28.1 months, MEAN).
FINDINGS: SSDT SHOULD BE USED AS AN ALTERNATIVE TO INCARCERATION, SEXUAL REOFFENSE VERY LOW (7.5%) ANY REOFFENSE HIGH (44.8%).
OVERALL: SIGNIFICANT DIFFERENCES ESTABLISHED. COMMUNITY-BASED TREATMENT AS EFFECTIVE AS INCARCERATION. NONSEXUAL REOFFENSE RISK SHOULD BE STRONGLY CONSIDERED IN ADDITION TO SEXUAL REOFFENSE.

STUDY 008: KEMPTON & FOREHAND, 1992.
SAMPLE SIZE: 83 MALES.
AGE RANGE/MEAN: 11.2-18.7 (15.11).
SAMPLE GROUPS: 7 ASO.
32 CONFRONTATIONAL NONSEX OFFENDER.
9 ASO CONFRONTATIONAL.
35 ADOLESCENTS, NONSEX AND NONCONFRONTATIONAL.
ASSIGNMENT TO GROUPS: MATCHED.
MEASUREMENT: EXAMINED DIFFERENCES BETWEEN GROUPS (CHILD BEHAVIORAL CHECKLIST (CBCL).
TREATMENT MODALITY: MULTI-COMPONENT.
OUTCOME: BEHAVIORAL AND EMOTIONAL DIFFICULTY DIFFERENCES OF GROUPS.
FINDINGS: ASO HAVE FEWER EXTERNALIZING AND INTERNALIZING PROBLEMS.
OVERALL: ASSESSMENT ISSUES SHOULD BE GIVEN SERIOUS CONSIDERATION PRIOR TO TREATMENT. ONLY PARTIAL SUPPORT FOR INTENDED OUTCOME.

STUDY 009: McCONAGHY, BLASZCZYNSKI, ARMSTRONG, & KIDSON, 1989.
SAMPLE SIZE: 45 MALES (ADULT).
AGE RANGE/MEAN: 14-19 (16.5) AT TIME OF OFFENSE.
SAMPLE GROUPS: PROPORTIONS NOT REPORTED FOR TYPE OF SEXUAL OFFENSE.
ASSIGNMENT TO GROUPS: NOT REPORTED.
MEASUREMENT: TREATMENT RECEIVED AS AN ADOLESCENT.
TREATMENT MODALITY: IMAGINAL DESENSITIZATION (ID).
COVERT SENSITIZATION (CS).
OUTCOME: RECIDIVISM.
FINDINGS: ADOLESCENTS SEXUAL ACTVITY IS MORE DIRECTLY RELATED TO SEX DRIVE THAN ARE ADULTS.
OVERALL: TREATMENT DURING ADOLESCENCE IS SIGNIFICANTLY MORE LIKELY FOR REOFFENSE THAN TREATMENT AS ADULTS. CS THERAPY LESS EFFECTIVE THAN ID THERAPY BUT NOT SEEN AS CONTRIBUTORY IN REDUCING RECIDIVISM.

STUDY 010: RUBINSTEIN, YEAGER, GOODSTEIN, & LEWIS, 1993.
SAMPLE SIZE: 77 MALES.
AGE RANGE/MEAN: AGE RANGE NOT REPORTED (15).
SAMPLE GROUPS: 19 ASO.
58 ADOLESCENT VIOLENT OFFENDERS (NONSEX).
ASSIGNMENT TO GROUPS: NOT REPORTED.
MEASUREMENT: EXAMINED DIFFERENCES BETWEEN GROUPS (CLINICAL DATA, PERSONAL INTERVIEW).
TREATMENT MODALITY: MULTI-COMPONENT.
OUTCOME: ADULT CRIMINAL OFFENSES, RECIDIVISM (8yrs.).
FINDINGS: ASO=37% SEX REOFFENSE AND 89% VIOLENT REOFFENSE. VIOLENT OFFENDER=10% SEX OFFENSE AND 69% VIOLENT REOFFENSE.
OVERALL: ASO SIGNIFICANTLY MORE DANGEROUS AS ADULTS THAN ADOLESCENT VIOLENT OFFENDERS (NONSEX).

STUDY 011: HAINS, HERRMAN, BAKER & GRABER, 1986.
SAMPLE SIZE: 17 MALES.
AGE RANGE/MEAN: 16-18 MEAN NOT REPORTED.
SAMPLE GROUPS: 9 ASO RECEIVING TREATMENT.
8 ASO RECEIVING NO TREATMENT (WAITING LIST).
ASSIGNMENT TO GROUPS: CONVENIENCE.
MEASUREMENT: EXAMINED DIFFERENCES BETWEEN GROUPS, PRE/POST INTERVENTION ASSESSMENT (SEXUAL KNOWLEDGE ASSESSMENT, PSYCHOLOGICAL ASSESSMENT, PROBLEM-SOLVING ASSESSMENT, AND MORAL JUDGEMENT ASSESSMENT).
TREATMENT MODALITY: PSYCHO-EDUCATIONAL GROUP (P-EG).
OUTCOME: SELF-REPORT.
FINDINGS: ASO RECEIVING P-EG IMPROVED PROBLEM SOLVING AND SEXUAL KNOWLEDGE WITH POSITIVE TRENDS IN ATTITUDE.
OVERALL: P-EG EFFECTIVENESS SIGNIFICANT.

STUDY 012: McCRAW, & PEGG-McNABB, 1989.
SAMPLE SIZE: 90 MALES.
AGE RANGE/MEAN: 11.6- 17.11 MEAN NOT REPORTED.
SAMPLE GROUPS: 45 ASO.
45 NONSEX OFFENDERS.
ASSIGNMENT TO GROUPS: MATCHED.
MEASUREMENT: EXAMINED DIFFERENCES BETWEEN GROUPS (RORSCHACH SCORES).
TREATMENT MODALITY: MULTI-COMPONENT.
OUTCOME: PERSONALITY DIFFERENCES OF GROUPS.
FINDINGS: ASO ARE BASICALLY DELINQUENT.
OVERALL: NO SIGNIFICANT DIFFERENCES BETWEEN GROUPS.

STUDY 013: HERKOV, GYNTHER, THOMAS, & MYERS, 1996.
SAMPLE SIZE: 74 MALES.
AGE RANGE/MEAN: 12-18 (15.27).
SAMPLE GROUPS: 59 ASO (19-RAPE, 18-SODOMY, 22 ABUSERS).
15 NONSEX OFFENDERS.
ASSIGNMENT TO GROUPS: NOT REPORTED.
MEASUREMENT: EXAMINED DIFFERENCES BETWEEN GROUPS IN PSYCHOPATHOLOGICAL AND PSYCHOLOGICAL DISTURBANCES (MMPI AND DIAGNOSTIC INTERVENTION FOR CHILDREN AND ADOLESCENTS-REVISED).
TREATMENT MODALITY: MULTI-COMPONENT.
OUTCOME: DIFFERENCES IN ASO SUBGROUPS (RAPE, SODOMY AND ABUSERS).
FINDINGS: TREATMENT SHOULD INCLUDE PSYCHOTROPHIC MEDICATION.
OVERALL: SIGNIFICANT DIFFERENCES BETWEEN SUBGROUPS. MMPI FOUND TO BE MORE USEFUL WITH ASO THAN ADULT SEX OFFENDER.

STUDY 014: HAGAN, & CHO, 1996.
SAMPLE SIZE: 100 MALES.
AGE RANGE/MEAN: 12-19 MEAN NOT REPORTED.
SAMPLE GROUPS: 50 ASO w/ PEER VICTIM.
50 ASO w/ CHILD VICTIM.
ASSIGNMENT TO GROUPS: MATCHED.
MEASUREMENT: EXAMINED DIFFERENCES BETWEEN GROUPS (RETROSPECTIVE DATA).
TREATMENT MODALITY: MULTI-COMPONENT.
OUTCOME: RECIDIVISM (2 TO 5 yrs.).
FINDINGS: NO SEX REOFFENSE AND HIGH NONSEX REOFFENSE.
OVERALL: CONFRONTIVE GROUP THERAPY SIGNIFICANTLY REDUCES SEXUAL REOFFENSE RISK.

STUDY 015: GRAVES, OPENSHAW, & ADAMS, 1992.
SAMPLE SIZE: 30 MALES.
AGE RANGE/MEAN: 12-19 (15.7) EXPERIMENTAL GROUP.
13-18 (15.1) CONTROL GROUP.
SAMPLE GROUPS: 18 ASO RECEIVING SOCIAL SKILLS TRAINING (SST).
17 ASO RECEIVING NO SST.
ASSIGNMENT TO GROUPS: RANDOM.
MEASUREMENT: EXAMINED DIFFERENCES BETWEEN GROUPS IN SOCIAL SKILLS (SOCIAL CONFIDENCE, COMMUNICATION, PROBLEM SOLVING).
TREATMENT MODALITY: SST.
OUTCOME: PRE/POST ASSESSMENT DIFFERENCES IN GROUPS.
FINDINGS: SST COMBINED WITH THERAPY AS OPPOSED TO THERAPY ALONE IS BETTER TREATMENT OPTION.
OVERALL: SST SIGNIFICANTLY IMPROVES CERTAIN SOCIAL SKILLS BUT NOT A GENERALIZATION EFFECT.

STUDY 016: BRANNON, & TROYER, 1991.
SAMPLE SIZE: 110 MALES.
AGE RANGE/MEAN: 13-18 (16.6).
SAMPLE GROUPS: 53 ASO.
57 ADOLESCENT OFFENDERS (NONSEX).
ASSIGNMENT TO GROUPS: RANDOM.
MEASUREMENT: EXAMINED DIFFERENCES BETWEEN GROUPS (POINT-IN-TIME SURVEY).
TREATMENT MODALITY: ALDERIAN APPROACH TO PEER GROUP TREATMENT.
OUTCOME: COMMUNITY READJUSTMENT.
FINDINGS: POST-RELEASE BEHAVIOR OF ASO MAY NOT PRESENT AS GREAT A RISK TO COMMUNITY AS PUBLIC HAS BEEN LED TO BELIEVE AS RECIDIVISM REPORTED ONLY 2%.
OVERALL: PEER GROUP TREATMENT IS AS EFFECTIVE AS SPECIALIZED SEX OFFENDER TREATMENT.

STUDY 017: HUNTER, & SANTOS, 1990.
SAMPLE SIZE: 27 MALES.
AGE RANGE/MEAN: 13-17 (15.75).
SAMPLE GROUPS: 12 ASO w/ PREPUBESCENT MALE VICTIM.
15 ASO W/ PREPUBESCENT FEMALE VICTIM.
ASSIGNMENT TO GROUPS: MATCHED.
MEASUREMENT: EXAMINED DIFFERENCES BETWEEN GROUPS DEVIANT SEXUAL AROUSAL (PHYSIOLOGICAL ASSESSMENT OF PENILE CIRCUMFERENCE).
TREATMENT MODALITY: COGNITIVE-BEHAVIORAL (CB), INSIGHT-ORIENTED (IO).
OUTCOME: PLETHYSMOGRAPHIC PEAK SCORES FROM DEVIANT CUES.
FINDINGS: ASO w/ PREBUBESCENT FEMALE VICTIM (33.5%) AND ASO w/ PREBUSCENT MALE VICTIM (39.15%) REDUCTION IN OVERALL AROUSAL TO DEVIANT CUES.
OVERALL: COGNITIVE-BEHAVIORAL PROCEDURES OFFER CONSIDERABLE PROMISE IN TREATMENT OF ASO.

STUDY 018: BORDUIN, HENGGLER, BLASKE, & STEIN, 1990.
SAMPLE SIZE: 16 MALES.
AGE RANGE/MEAN: AGE RANGE NOT REPORTED (14).
SAMPLE GROUPS: 8 ASO RECEIVING MULTISYSTEMIC TREATMENT (MST).
8 ASO RECEIVING INDIVIDUAL TREATMENT (IT).
ASSIGNMENT TO GROUPS: RANDOM.
MEASUREMENT: EXAMINED DIFFERENCES BETWEEN GROUPS (OBSERVATION).
TREATMENT MODALITY: MST AND IT.
OUTCOME: RECIDIVISM (21 to 49 months). MEAN (37 months).
FINDINGS: ASO RECEIVING MST HAD RECIDIVISM RATES OF 12.5% FOR SEX REOFFENSE AND 25% FOR NONSEX REOFFENSE. ASO RECEIVING IT HAD RECIDIVISM RATES OF 75% FOR SEX REOFFESE AND 50% FOR NONSEX REOFFENSE.
OVERALL: MULTISYSTEMIC TREATMENT SIGNIFICANTLY MORE EFFECTIVE IN REDUCING SEX REOFFENSES BUT SMALL SAMPLE SIZE REQUIRES CONCLUSION BE CONSIDERED TENTATIVE.

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