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THE EVALUATION OF JUVENILE REHABILITATIVE APPROACHES

by

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B.A., Arkansas Tech University, 2022

A Research Paper

Submitted in Partial Fulfillment of the Requirements for the
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RESEARCH PAPER APPROVAL

THE EVALUATION OF JUVENILE REHABILITATIVE APPROACHES

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Rylie Wheeler

A Research Paper Submitted in Partial

Fulfillment of the Requirements

for the Degree of

Master of Arts

in the field of Criminology and Criminal Justice

Approved by:

Dr. Breanne Pleggenkuhle, Chair

Graduate School
Southern Illinois University Carbondale
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TITLE: THE EVALUATION OF JUVENILE REHABILITATIVE APPROACHES

MAJOR PROFESSOR: Dr. Breanne Pleggenkuhle

The current research seeks to evaluate current juvenile rehabilitative approaches and analyze their effectiveness in reducing juvenile offending behaviors. The juvenile justice system is analyzed from a historical perspective beginning prior to the establishment of the juvenile justice system in the 19th century and leading to the current approaches of the 21st century. Developmental research has found that most juveniles will desist from delinquency on their own by naturally growing out of their offending behavior. However, when juveniles become involved in the justice system the opportunity to age out of offending behavior is limited. Recognizing this, the juvenile justice system is currently in a more rehabilitative approach focusing on the potential for juveniles to change their behaviors and using alternatives to incarceration. The current research evaluates these alternatives, more specifically juvenile probation, individual therapy (including cognitive-behavioral therapy, interpersonal psychotherapy, and psychodynamic therapy), group therapy, and family therapy (including multisystemic therapy, functional family therapy, and multidimensional family therapy). Findings conclude that juvenile probation is an ineffective alternative on its own and individual therapy as well as family therapy are highly effective in their designed goals and can reduce juvenile offending behaviors. Group therapy, however, was shown to be ineffective when high-risk delinquents were grouped together and more effective when high-risk delinquents were grouped with low-risk or nondelinquent youth. Future considerations suggest the juvenile justice system could aid in reducing juvenile offending behaviors by using effective alternatives, specifically therapies, to incarceration.

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CHAPTER 1

INTRODUCTION

The criminal justice system is a complex system that has many different approaches with different goals. One approach focuses on punishment that emphasizes individuals should face consequences and be held accountable for their offending behavior while also utilizing punishment as a deterrence. Alternatively, a second approach focuses on rehabilitation that emphasizes alternative treatment and intervention as the justice system recognizes individuals' potential to reform. This approach acknowledges the offenders' individual needs, focuses on the ability for offenders to change, and works on integrating offenders back into society.

Societies and individuals, including administrators and court actors, may differ in opinion on how crime and criminals should be treated and addressed, and the criminal justice system can vary depending on the values and goals of society. The correct approach to the criminal justice system is an ongoing debate and is apparent in the juvenile justice system as well. The juvenile justice system has undergone many reforms over the years as it seeks to find a balance between holding juveniles accountable for their offending behaviors and weighing in treatment and rehabilitation aspects.

Before the establishment of the juvenile justice system, juvenile delinquency was seen as an issue that would only be resolved by using punishment and punitive techniques therefore punishing juveniles was the focus for decades. However, as the first juvenile court system was established in 1899, the views changed to one that centered on child-saving techniques and focused on the individual's needs and rehabilitation. The juvenile system then shifted from this rehabilitative focus to a more punitive view with punishment and harsher sentences as the goal yet again. However, as the criminal justice system became more accepting of neuroscience,

finding that juveniles' brains are developmentally immature and different from adults' brains, the juvenile justice system returned to a rehabilitative goal once more. Currently, the juvenile justice system is in a more rehabilitative-focused approach that emphasizes treatment, such as individual, group, and family therapy, and diversion programs, such as community service, drug court, and probation, as alternatives to incarceration to reduce juvenile offending behavior by focusing on the juvenile's needs and diverting them from juvenile court.

The current research seeks to evaluate the current juvenile rehabilitative approaches and analyze their effectiveness in reducing juvenile offending behaviors. More specifically the research analyzes juvenile probation, individual therapy (including cognitive-behavioral therapy, interpersonal psychotherapy, and psychodynamic therapy), group therapy, and family therapy (including multisystemic therapy, functional family therapy, and multidimensional family therapy). Exploring the effectiveness of these rehabilitative approaches is essential for understanding how juvenile offending behaviors can be addressed and reduced in the future.

CHAPTER 2

THE JUVENILE JUSTICE SYSTEM IN A HISTORICAL PERSPECTIVE

The 19th Century

The juvenile justice system is a legal system specifically designed to address the needs of individuals who are typically under eighteen. Before establishing this formal juvenile justice system, Americans depended on closely-knit associations such as family, church, or social relations to manage criminal behaviors (Garlock, 1978). However, during the early 19th century industrialization began, creating an upsurge in the community population, and cities enlarged. The tight bonds of the community soon broke, and they were unable to control the deviance that spread throughout their communities. Immigration and poverty began taking place more rapidly and children began wandering the streets unsupervised while committing various crimes, such as stealing and sexually promiscuous acts, just to survive (Garlock, 1978; Shelden, 2005).

There was no separate court or jail for juveniles¹ therefore juveniles were sent to an adult facility where they mixed with adult convicts and learned to become career criminals (Ferdinand, 1991). The courts only had jurisdiction over juveniles if they committed a criminal offense however, many juveniles were participating in noncriminal misbehavior and becoming unruly, wayward, incorrigible, beyond the control of their parents, and participating in activities in an unacceptable manner (Ferdinand, 1991; Garlock, 1978). For the courts to take control over these situations, the doctrine *parens patriae* was utilized and became the foundation of the juvenile court as it enabled the civil courts to step in and take custody of the wayward children if their parents were deemed unfit (Ferdinand, 1991). However, there was no facility in place to control

¹ A juvenile refers to an individual who is under the age of eighteen. The term “juvenile” and “adolescent” are relatively recent concepts as children were earlier considered as “little adults”.

the noncriminal behavior in American cities and these problems would progress and become greater in the future if actions were not taken.

In response to juvenile offending behavior, a bill was passed in 1824 to establish the first correctional institution for young offenders in the United States that set out to save children from a life of crime and poverty. This institution was founded in New York in 1825 and was known as the *New York House of Refuge* (Shelden, 2005). The House of Refuge was a separate prison that received both criminal and noncriminal wayward juveniles intending to reform the youth and change their behaviors. There was the idea that if all wayward children could be incarcerated before they committed crimes, adult criminality would vanish from the city (Garlock, 1978). The House of Refuge aimed to reform juveniles by isolating them from society and teaching them the values of hard work, discipline, and obedience (Garlock, 1978). While some creators of the House of Refuge claimed this was a school and not a prison, others admitted the “main purpose of their institution was punishment” (Garlock, 1978, p. 359).

Juveniles who were confined in the houses were subjected to little schooling, strict discipline, control, and abuse, and were under strict military and corporal punishment (Shelden, 2005). Additional cities, such as Boston, Philadelphia, and Baltimore, soon adopted and constructed houses of refuge yet juvenile offending remained a problem. The houses were originally constructed for first-time youthful offenders and noncriminals however, older juveniles with longer histories of offending behavior were entering the overcrowded and poorly conditioned houses (Garlock, 1978; Shelden, 2005). The hardened juveniles negatively influenced younger noncriminal juveniles, leading to the creation of institutions that would cater only to younger noncriminal juveniles.

Unfortunately, the new institutions created for noncriminal juveniles used during the

1840s-1870s were still used to discipline harshly. Society believed that wayward children would become a dangerous community problem who needed to be restrained and reformed through incarceration to protect society (Garlock, 1978). Juveniles could be incarcerated through *parens patriae* for vagrancy, incorrigibility, truancy, or for disobeying their parents, running away from home, or committing actions close to criminal (Garlock, 1978). It became easier to separate juveniles from their families than it was to find ways to strengthen those families and the use of incarceration became an increasingly convenient way to institutionalize poor and noncriminal youth (Garlock, 1978). It was not until 1870 when the Supreme Court of Illinois declared that children had legal rights which led to states passing laws designed to protect the health, safety, and morals of children (Garlock, 1978). The juvenile justice system then began shifting from a punitive approach to a more rehabilitative approach to address the unique needs of juveniles.

Juveniles have unique psychological, emotional, and developmental needs (Abrams, 2013). A punishment or treatment that works for one individual may not work for another. Different needs require different levels of care (Underwood & Washington, 2016) and for a system to be effective, it must be individualized as much as possible (Matthew & Hubbard, 2007) and target a juvenile's specific needs (Tarolla et al., 2002). Therefore, this individualized approach was used to shape the course of the juvenile justice system's policies and practices over the next century (Abrams, 2013).

The 20th Century

The first juvenile court system was established in Cook County, Illinois in 1899, and by 1945 all states had established juvenile courts²(Ferdinand, 1991). The new court system had

² At this time there were only forty-eight states.

more jurisdiction that aimed to look at the character and social background of the juvenile to allow individualized treatment approaches that focused on their needs (Steinberg, 2009). The court viewed juveniles as vulnerable and utilized *parens patriae* as the grounds for decision making (Ferdinand, 1991). The new juvenile justice system was separate from the adult system and relied on a rehabilitative philosophy to rescue and reform youth (Soung, 2022). The court would aim to keep juveniles out of incarceration and use alternative techniques to humanize and personalize the court process which continued for a few decades (Schultz, 1973).

Although rehabilitation was the goal during the early 20th century, the treatment techniques “never reached the desired level of effectiveness” in rehabilitating delinquent youth and reducing juvenile offending (Snyder, 1999, p. 87). Skepticism then arose in the 1950s and 1960s about the effectiveness of the approach. The court agreed that if it could not effectively rehabilitate youth, then it must effectively administer punishments (Ferdinand, 1991). Therefore, beginning in the 1960s, the United States Supreme Court required that juvenile courts become more formal like adult criminal courts (Snyder, 1999). However, juveniles did not have the same rights that were afforded to adults charged with crimes and their cases lacked the fairness that is required as a part of due process under the Fourteenth Amendment to the U.S. Constitution (Steinberg, 2009).

As a response, in 1967 juvenile rights were expanded as the U.S. Supreme Court case *In re Gault* established that juveniles were entitled to many of the same rights an adult had in criminal court. *In re Gault* concluded that juveniles had constitutional rights such as the right to counsel, the opportunity to confront witnesses, the right against self-incrimination, the right to a transcript of the hearing, and a right to appeal the court’s decision (Nellis, 2011). However, the court agreed that a juvenile’s case should be kept out of the public therefore, in 1971, the U.S.

Supreme Court ruled in *McKeiver v. Pennsylvania* that a juvenile does not have a right to jury trials (Feld, 1990; Nellis, 2011). Although, when juveniles were given rights in *In re Gault*, the court treated them similar to adults and court proceedings led to harsher punishments.

This punitive approach was short-lived however, as in 1974 Congress passed the Juvenile Justice and Delinquency Prevention Act that emphasized noncriminals be removed from incarceration and juvenile offenders be handled outside of the court in community-based programs and be diverted from formal processing (Jenson & Howard, 1998). Juvenile justice policies that emphasized decriminalization and deinstitutionalization were adopted by all states between 1970 and 1985 with the goal of rehabilitation over punishment (Jenson & Howard, 1998). However, once again this alternative approach was temporary as the juvenile justice system shifted once more to a more punitive approach.

Towards the end of the 1980s, juvenile violent crime rates rose, specifically juvenile homicide, and media coverage of juvenile crime increased dramatically (Scott, 2013). Juveniles were portrayed as superpredators who were “remorseless creatures who roamed in gangs, maiming and killing without moral compunction and consider[ed] no consequences other than their own evil gratification” (Scott, 2013, p. 539), who were “morally vacant and lack[ed] impulse control or empathy” (Abrams, 2013, p. 732), had “absolutely no respect for human life” (Mills et al., 2015, p. 582), and were “unhinged from moral restraints, [who] would endanger the safety and well-being of everyone in their paths” (Mills et al., 2015, p. 581).

The public responded with outrage and fear, thought the juvenile justice system was ineffective in dealing with the crime problem, and demanded a response to the crime threat (Scott, 2013). Juvenile offenders had become the “enemies of society” and moral panics quickly

formed³ (Scott, 2013, p. 539). The media and politicians distorted perceptions about the threat of juvenile crime which made the public believe the most violent crimes were committed by poor, minority juveniles when in actuality, this was not the case (Scott, 2013). However, due to moral panics and fear, juveniles were now the target of severe changes in almost every state in how young offenders were charged, punished, and treated (Jenson & Howard, 1998; Scott, 2013). The goals of punishment outweighed rehabilitative considerations and it became easier to incarcerate juveniles and sentence them as adults.

Once stricter policies were enacted, the juvenile courts switched to determinate sentencing⁴, less attention was given to the specific needs of the juvenile, discretion became limited, mandatory minimum sentencing⁵ statutes were implemented, states had correctional administrative guidelines that must be followed, and the juvenile court began to mimic the adult criminal court (Abrams, 2013; Feld, 1990). Punitiveness and incarceration increased, and the court became more formal and enacted stricter punishments. Additional policies implemented minimized rehabilitative and community-based programs and expanded the offenses that qualified a juvenile to be treated as an adult (Abrams, 2013; Scott, 2013). In addition, sentences such as the juvenile death penalty and juvenile life without parole became more utilized as a

³ Moral panics appear when society feels that evildoers in society pose a threat to the moral order of society especially when a racial or ethnic group's behavior is seen as responsible for the social problem (Duxbury et al., 2018; Goode & Ben-Yehuda, 1994).

⁴ When a sentence is determinate, the length of imprisonment is set and there is a specific amount of time an offender must serve without the possibility of early release. Determinate sentencing rests on the idea that the purpose of sentencing is to assure the offenders receive the punishments they deserve (Tonry, 2019).

⁵ Mandatory minimum policies increased the expected sentence for individuals who committed a crime by limiting the sentencing discretion of the prosecutors and did not allow individual needs to be met (Shepherd, 2002). "A mandatory minimum sentence requires that an individual convicted of a given offense be incarcerated for at least the minimum term set by statute" (Luna, 2017, p. 117).

sentence for serious crimes and many juveniles were being locked away for life (Scott et al., 2015). The goal was not to meet the juvenile's needs, it was to criminalize young offenders and keep the public safe.

While the juvenile death penalty became more utilized, only twenty-two states permitted the juvenile death penalty and only seven states had sentenced a juvenile offender to death (American Bar Assoc, 2003). Between the years 1985 and 2003, twenty-two juvenile offenders were executed (Executions of juveniles, 2023). Texas (13), Virginia (3), and Oklahoma (2) executed more than one juvenile offender while Missouri, Louisiana, Georgia, and South Carolina executed one (American Bar Assoc, 2003; Executions of juveniles, 2023).

Alternatively, juvenile life without parole sentences dramatically increased during this time as a result of the sentencing policies adopted during the myth of the superpredator (Mills et al., 2015). Over two thousand individuals began serving a life without parole sentence for a crime they committed as a juvenile (Nellis, 2019) and twenty-eight states had enacted mandatory juvenile life without parole sentences (Teigen, 2023). These harsh punishments lasted until the start of the 21st century when the juvenile justice system began to shift once again.

The 21st Century

During the start of the 21st century, moral panics regarding juvenile criminals declined and juvenile crime dwindled as a political issue. However, after more than a decade of harsh penalties for juveniles, politicians and society realized the threat of superpredators and juvenile crime was not as great as it had appeared to be in the 1990s (Scott, 2013) as this idea never materialized (Mills et al., 2015). Many lawmakers and politicians began to rethink the punitive approach and with the help of adolescent brain development research, a rehabilitative approach reemerged in the 21st century.

While the study of adolescent brain development has a long history and has been around for decades, neuroscience had not played a major role in decisions about developmental differences between adolescents and adults within the criminal justice system before the court case *Roper v. Simmons* in 2005 (Steinberg, 2017). Neuroscience then became more accepted and influential in legal policy and practice. Society, politicians, and lawmakers were informed that juveniles were different from adults and that adult criminal punishment may not be appropriate (Scott, 2013). Instead of being labeled a superpredator and an enemy to society who could never reform, juveniles were being described as developmentally immature with the potential to reform.

Scientific research on adolescent brain development continued to show that the brain does not fully mature and develop until around age 25 (Brown, 2012). Before maturity, it is found that juveniles are biologically predisposed to impulsivity and unreasoned judgments and are susceptible to peer influence; they are also immature, emotional, and impulsive which makes them more susceptible to committing crimes (Abrams, 2013; Brown, 2012). A juvenile's mental abilities can also be affected, such as self-control, which allows them to take responsibility for their actions (Brown, 2012).

Advocacy groups and professional organizations drew on neuroscience research findings to support the argument that juveniles are developmentally different from adults and the juvenile justice system needed to shift back to a rehabilitative approach (Abrams, 2013). Rehabilitative alternative approaches were also inexpensive and the answer to strained financial budgets which led to many alternatives such as diversion programs and rehabilitative techniques becoming widely accepted (Abrams, 2013).

Law changes were also coming into effect on the federal level and the structure and

function of the adolescent brain served as a strong basis for three Supreme Court decisions in seven years regarding the extent of constitutionally acceptable punishments for juveniles (Scott, 2013). The first Supreme Court decision in *Roper v. Simmons* (2005) addressed whether a juvenile who committed an offense under the age of eighteen could be sentenced to death. The second Supreme Court decision in *Graham v. Florida* (2010) addressed whether a juvenile who committed a nonhomicide offense could be sentenced to life without parole, and the third Supreme Court decision in *Miller v. Alabama* (2012) addressed whether a juvenile who was convicted of homicide could be sentenced to a mandatory life sentence.

In all three decisions, the court's decision was largely guided by neuroscience research on adolescent's brain development and maturity when they concluded juveniles are less culpable than adults and are not fully developed with their reasoning or judgment, therefore do not deserve the death penalty, life without parole for nonhomicide offenses, or a mandatory life sentence for homicide offenses (Abrams, 2013; Scott, 2013). The court argued that a juvenile has the potential to change and concluded these three sentences were in violation of the Eighth Amendment's prohibition on cruel and unusual punishment and were unconstitutional for a juvenile (Abrams, 2013; Scott, 2013).

After the ruling in *Roper*, twelve states banned the death penalty in all circumstances, and eighteen banned it for people under the age of eighteen (Rovner, 2023). Additionally, due to the ruling in *Miller*, as of 2023, twenty-seven states and Washington, DC, have banned juvenile life without parole and in nine states that allow juvenile life without parole, no convicted offenders are serving this sentence (Rovner, 2023). However, there are additional states that do impose this sentence and in its national survey of life and virtual life sentences, The Sentencing Project found that within the remaining states that allow juvenile life without parole, 1,465 individuals

are serving a life without parole sentence for an offense they committed as a juvenile at the start of 2020 (Rovner, 2023).

While the Supreme Court does not dictate most juvenile crime regulations, changing the punitive attitudes toward young offenders led policymakers at all levels of government to rethink harsh punishment and incarceration and move towards different rehabilitative approaches (Scott, 2013). The idea was that juveniles cannot grasp the long-term consequences of their actions and cannot control their impulses and therefore cannot be held fully accountable for their actions (Steinberg, 2009). The legislative trend then moved away from punitive laws and states banned the juvenile death penalty and juvenile life without parole in many states (Scott, 2013).

Additionally, policies that were enacted allowed youths to receive different treatment, laws required an assessment of juveniles' competence to stand trial, reduced the number of youths confined to state institutions, shifted resources to community-based programs, incorporated measures of culpability, and aimed to keep youths in their communities (Scott, 2013; Steinberg, 2009). Juveniles were portrayed as individuals who could reform, therefore movements to adopt evidenced-based practices and therapy became more popular as courts were using alternatives to incarceration (Abrams, 2013) and within the last two decades, the juvenile justice system shifted back into a rehabilitative-focused system with a timeline shown in Figure 1.

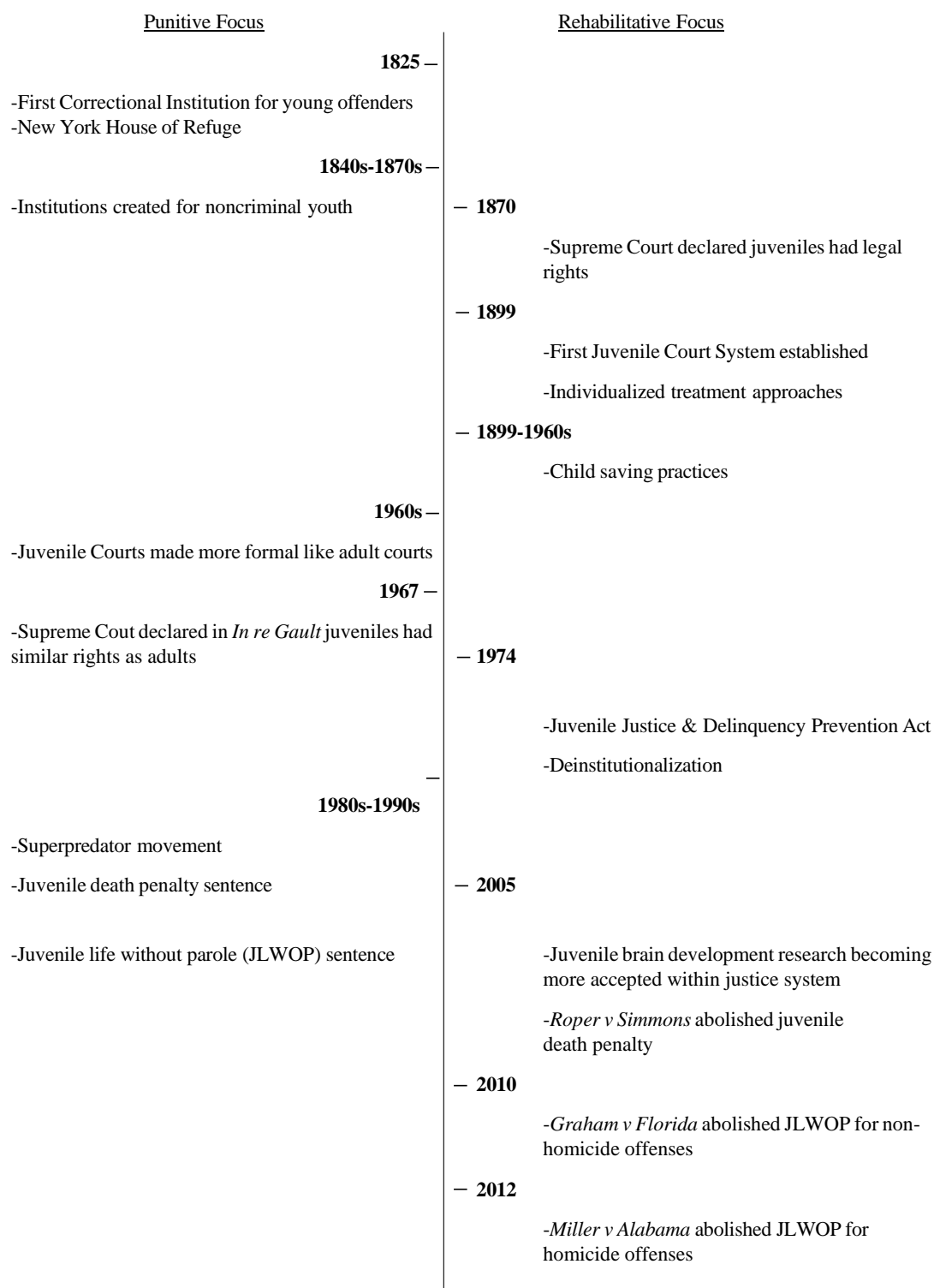


Figure 1

Juvenile Justice History Timeline

CHAPTER 3

JUVENILE SENTENCING

The juvenile justice system is regulated mainly by state law and may differ between states in the policies and practices that are enacted. However, the current general points of the system process are essentially similar: referral, intake, detention, adjudication, disposition, and release (Steinberg, 2009).

For a juvenile to begin their journey through the juvenile justice system there must be a referral to the system by law enforcement agencies, social service agencies, schools, parents, or probation officers (Hockenberry & Puzzanchera, 2020). The court process will be initiated when an agency or individual files a complaint alleging a juvenile participated in unlawful behavior or violated the law (Hockenberry & Puzzanchera, 2020). Law enforcement agencies are the primary source of delinquency referrals to juvenile court, typically by police arrest (Steinberg, 2009), and in 2018, 82% of all delinquency cases were referred by law enforcement (Hockenberry & Puzzanchera, 2020).

Once a juvenile is referred, arrested, or transferred from criminal court, there will be an intake decision where the case is screened by an intake department (Hockenberry & Puzzanchera, 2020; Steinberg, 2009). The intake department will look at the youth's age, prior history, the seriousness of the offense, and the youth's attitude to determine if the case should be processed, be dismissed, or if the juvenile should be diverted (Steinberg, 2009). If the case is dismissed, the individual is no longer involved in the juvenile court system and any legal action will be terminated. If the juvenile is diverted, the juvenile may be ordered to complete a diversion program that can provide services on an informal basis through the justice system so many juveniles can complete alternate requirements as opposed to being processed for

adjudication and incarceration (Mendel, 2018; Underwood & Washington, 2016).

Any alternative can be considered a diversion and there are many treatments and programs that fall under this form. More common forms of diversion programs include therapy, community service, drug court, and probation. When the juvenile is diverted, they do not continue through the juvenile court system, however, can be returned to court if they fail to obey the disposition (Steinberg, 2009). Diversion programs can also be provided on a formal basis if the juvenile is processed and adjudicated. Typically, younger juveniles are more likely to be informally processed and diverted (Mears et al., 2014) whereas youth with lengthy and serious prior records are more likely to be recommended for formal processing (Bishop & Frazier, 1996). If the juvenile is recommended for formal processing, they continue through the juvenile justice process.

When the juvenile is formally processed, the intake department must decide whether the juvenile should be sent home and return for trial or be detained in a temporary holding facility for 24 to 72 hours awaiting a court appearance (Shelden, 2005; Steinberg, 2009). Although, the use of detention for all juvenile offenses decreased by 52% between 2005 and 2018 (Hockenberry & Puzzanchera, 2020). During court, the judge will decide whether the juvenile will proceed through the justice process or if the case will be dismissed.

If the juvenile proceeds through the juvenile court, an adjudicatory hearing⁶ will be held to determine the guilt or innocence of the juvenile (Bishop et al., 2010). If the juvenile is found innocent, the case may be dismissed. If the judge determines guilt for the offense charged, the juvenile will become an adjudicated delinquent and the case will proceed to a disposition hearing

⁶ Adjudication hearings are typically conducted as bench trials where the judge has sole decision making and there is no jury.

(Hockenberry & Puzzanchera, 2020). In 2018, 52% (220,000) of the petitioned delinquency cases resulted in youth becoming formally adjudicated (Hockenberry & Puzzanchera, 2020).

With the current rehabilitative approach, at a disposition hearing, which is comparable to a sentence in criminal/adult court, the juvenile will be given a sentence that best fits their needs aimed to provide treatment, rehabilitation, or supervision (Steinberg, 2009). During a disposition hearing the judge has a range of discretion and can sentence a juvenile to therapy, diversion programs such as probation, or order the juvenile to be placed in incarceration (Steinberg, 2009). In 2018, of the formally adjudicated cases, 63% (139,000) received formal probation as the most severe disposition compared to 28% (62,100) placed in a form of a residential facility, and 9% (19,000) being ordered to pay restitution or a fine, participate in community service, or enter a treatment program (Hockenberry & Puzzanchera, 2020).

Given the range of discretion judges are given within the justice system, the judge has many opportunities to divert juveniles away from formal processing and place juveniles in alternative programs including therapy. There are many points within the sentencing process that are designed for possible alternatives as shown in Figure 2.

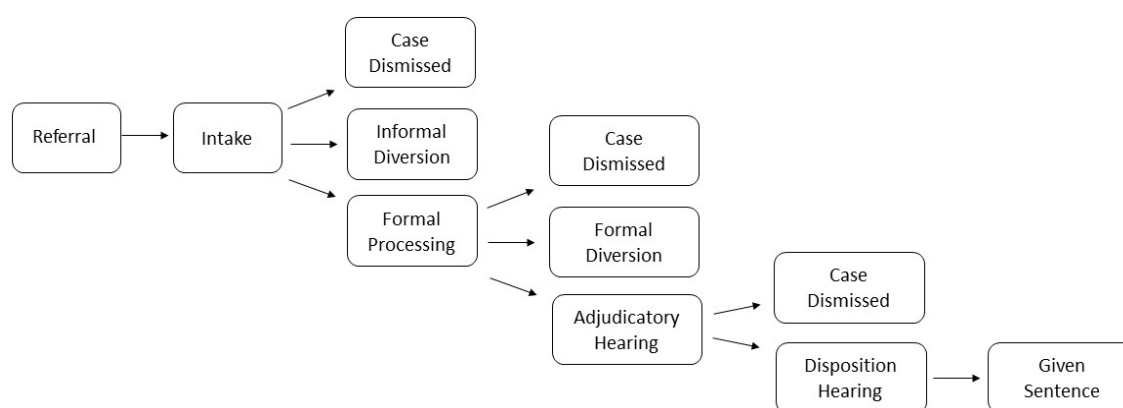


Figure 2

Juvenile Sentencing Flowchart

Keeping juveniles out of the juvenile justice system can have many benefits in reducing future juvenile offending. A meta-analysis conducted by Wilson and Hoge (2013) for example, examined seventy-three diversion programs assessing 14,573 diverted youth and 18,840 processed youth and found diversion programs were significantly more effective in reducing recidivism than conventional judicial interventions. Youths assessed as low-risk who were in diversion programs reoffended 45% less often than youth who faced formal court processing (Mendel, 2018; Wilson & Hoge, 2013).

Using diversion alternatives can be theoretically supported by the labeling theory that focuses on the negative consequences of labeling a youth as delinquent which creates an expectation of continued antisocial behavior (Wilson & Hoge, 2013). When juveniles are involved in the justice system, society places negative labels on delinquents, which leads to the juvenile becoming stigmatized, which can change their self-identity and how they view themselves (Akers et al., 2020). Stigmatization can lead to difficulties in maneuvering through society successfully and may lead to discrimination and limited opportunities. When this happens, the labeling theory suggests that individuals may accept the negative deviant label and become more delinquent (Akers et al., 2020). There are many consequences of labeling youth as delinquent once they are involved in the system therefore, diverting youth and keeping them out of incarceration and further into the system can reduce future harm, stigmatization, and labeling.

Currently, the juvenile system is in a more rehabilitative approach that aims to use treatment such as individual, group, or family therapy, and diversion programs as alternatives to incarceration. Commonly used forms of diversion programs for lower-level and first-time offenders include community service and drug courts with the most common diversion disposition being juvenile probation (NeMoyer et al., 2014).

Juvenile Probation

Juvenile probation is the oldest and the most widely used court-ordered service (Torbet, 1996) that was considered more important than any other element of the first juvenile system (Schultz, 1973). The use of juvenile probation spread to every state that enacted juvenile court legislation and by 1927 every state except Wyoming⁷ had a juvenile probation system (Schultz, 1973). Juvenile probation was a popular way to treat and supervise youths in the community for the first time, low-risk offenders, or as an alternative to incarceration for more serious offenders (Torbet, 1996). Today, probation can be described as the “workhorse” of the juvenile justice system (Mears et al., 2014, p. 186; Torbet, 1996, p. 1) as it is the most frequent sentence for a juvenile to receive in juvenile court (Mendel, 2018; Lipsey et al., 2006; Soung, 2022) and is considered a “critical function[] in the juvenile justice system” (Hsieh et al., 2016, p. 329).

Juvenile probation has many diverse functions including identifying the risks and needs of youth, providing monitoring and rehabilitation services, addressing school-based needs, and working closely with the court and the community to increase successful supervision outcomes (Hsieh et al., 2016). Juvenile probation was created under the rehabilitative framework that aims to keep juveniles out of incarceration and allow the juvenile to become reformed. Probation was designed to care for and address delinquency and youth’s problems in terms of personal, family, school, and social contexts while keeping the youth in the community (Hsieh et al., 2016).

Probation can be given both formally and informally and can be used as an alternative to court involvement, an alternative to incarceration, or as an aftercare system once juveniles are released from institutions (Steinberg, 2009). Juveniles can be formally placed on probation after

⁷ Alaska and Hawaii had yet to become states.

being adjudicated delinquent or youth who are not adjudicated delinquent can voluntarily agree to follow the rules and regulations of probation and if they complete their probation period, their case will be terminated without formal processing (Livsey, 2012).

While probation is the most common disposition for juveniles, it remains deeply flawed in both concept and execution (Mendel, 2018). Juvenile probation has been found to have “insignificant to poor and inequitable results for youth” and has failed to fulfill its mission of rehabilitating juveniles (Soung, 2022, p. 554). While probation has many advantages over incarceration, including lower operational costs, increased opportunities for rehabilitation, and reduced risk of criminal socialization, it has not been effective in reducing recidivism and in some cases may increase offending behavior (Labrecque, 2017). When evaluating different programs, Latessa et al. (2014) found that low-risk youth who were referred to probation⁸ had a greater likelihood of reoffending compared to youth who participated in any other program.

Juvenile probation practices vary from jurisdiction to jurisdiction and officer to officer. However, there are a few commonalities among probation practices that may lead to the ineffectiveness of the program. The core element of the probation experience involves a judge who imposes rules and requirements that a juvenile must follow along with a probation officer who then keeps tabs on the juvenile to monitor compliance (Mendel, 2018).

When placed on probation, the court establishes many rules and requirements the juvenile must follow that can be applied to fit the juvenile’s needs. Specific rules and requirements may include ordering the juvenile to remain in their house, submit to electronic monitoring, abide by a specific curfew, pay restitution or probation supervision fees, and participate in substance use,

⁸ In the research probation was defined as “[c]ourt ordered supervision of youth by probation officers that monitor compliance to the terms and conditions put forth by the court” (Latessa et al., 2014, p. 11).

mental health, educational, or additional treatment programs (Labrecque, 2017). Rules may also include stating the juvenile cannot associate with gang members, be truant, skip school, fail a drug test, and cannot miss appointments (Mendel, 2018; Steinberg, 2009). In some jurisdictions, juveniles are required to manage over thirty conditions of probation, which is “a near impossible number of rules for children to understand, follow, or even recall” (National Juvenile Defender Center, 2016 as cited in Mendel, 2018, p. 14) when their brain has not fully matured. Juveniles who are ordered to have more probation requirements tend to violate the conditions of probation more quickly, therefore, making it more difficult to complete the probation requirements (Dir et al., 2021).

NeMoyer et al. (2014) identified twenty-nine probation requirements imposed on juveniles, eighteen of which juveniles commonly failed to comply with and results showed that 52% of youths failed to comply with at least one probation requirement. Nearly half of the sample were sent to a residential facility after violating probation therefore concluding that probation fails to fulfill the goal of diverting youth from offending behavior and the number of requirements that are placed on juveniles should be reduced.

Probation allows juvenile offenders to remain in the community and continue school or work obligations if they follow court-ordered requirements (NeMoyer et al., 2014). However, if the juvenile fails to adhere to the rules and requirements, their probation is violated and may be revoked (Steinberg, 2009). A violation of probation can lead to rearrest, detention, and another hearing, which could lead to a new disposition and incarceration (NeMoyer et al., 2014; Mendel, 2018; Steinberg, 2009), as well as lead to a longer probation sentence which then increases the risk for more future probation violations and continuations in the system cycle (Dir et al., 2021). “Too many youth [are] confined for technical violations” (Mendel, 2018, p. 15) when many of

these violations are not criminal and nondelinquent in nature (Dir et al., 2021; NeMoyer et al., 2014). Therefore, Dir et al. (2021) suggest probation can become a delayed path to incarceration rather than being used as an alternative, thereby defeating the purpose of probation.

An additional core element of probation involves a probation officer who keeps tabs on the juvenile to monitor compliance. Probation officers then take on several roles including, officer, counselor, family therapist, and mentor (Soung, 2022). Often times probation officers do not receive adequate training in counseling or therapy yet are still expected to fill these roles. The level of skills necessary to achieve effective treatment are not universally available among all probation officers and the small proportion who are trained and skilled have excessive caseloads thereby making meaningful treatment services unavailable (Soung, 2022). While probation has been a commonly used alternative to incarceration, probation departments cannot limit their intake of probationers therefore officers are finding more youth on their caseloads (Torbet, 1996) and are unable to give adequate time to mentor and properly assess each juvenile.

Many juveniles who are placed on probation have behavioral issues that are rooted in past experiences such as abuse and neglect or substance abuse (Mendel, 2018). When probation officers have high caseloads and do not have the training or education necessary to properly address the situation, Mendel (2018) suggests these juveniles could be better served by human services systems. Stronger counseling alliances are linked to better outcomes with juveniles and programs (Matthews & Hubbard, 2007) therefore probation may become more effective in reducing juvenile offending behaviors if juvenile probation officer's caseloads decrease and/or juveniles who are placed on probation also participate in forms of therapy during their probation period (Mendel, 2018).

Probation on its own can be ineffective in rehabilitating youth and decreasing offending

behaviors, however, may be more effective when paired with individualized programs such as therapy that help with offending behaviors at the same time. Commonly used forms of therapy include individual, group, and family therapy.

CHAPTER 4

INDIVIDUAL THERAPY

As part of their formal or informal court-ordered treatment, a juvenile may be ordered to attend the most common type of intervention given on the individual level: individual therapy (Lipsey et al., 2006). Individual therapy is a form of mental health treatment where the juvenile works one-on-one with a trained therapist in a safe, caring, and confidential environment (California State University, 2023). Individual therapy allows for the juvenile to explore their feelings, beliefs, and behaviors, and better understand themselves to work towards a desired change (California State University, 2023). Common forms of individual therapy include evidence-based cognitive-behavioral therapy and interpersonal psychotherapy, as well as psychodynamic therapy.

Cognitive-Behavioral Therapy

Cognitive-behavioral therapy (CBT) is a commonly used evidence-based form of individual therapy that can be used for a range of psychological issues and there are many ways in which CBT can be delivered. CBT believes how a juvenile perceives or evaluates a situation can influence their thoughts, beliefs, or attitudes and affect how they will respond emotionally or behaviorally (National Mental Health Association, 2004). Juvenile offending behavior can be linked to the lack of thinking skills, such as appropriate problem-solving or self-control, that a juvenile possesses (McGlynn et al., 2013) as well as the lack of positive coping strategies (Mulder et al., 2011). Therefore, CBT can be used to target juveniles' behaviors and emotions and teach them alternatives to negative coping to reduce the severity of reoffending.

A crucial aspect of CBT is the emphasis on free choice where an individual is free to make their own decisions. CBT does not tell offenders how or what to think, instead, it teaches

them how to identify thought processes and create and increase positive patterns of thinking and behaviors (Lipsey & Landenberger, 2006). CBT works to improve interpersonal, social, and coping skills, self-control and anger management, and the ability to manage challenges and solve problems (Tarolla et al., 2002; Underwood & Washington, 2016).

Many juveniles who encounter the justice system have specific issues and needs, including mental health issues that are linked to offending behaviors (Pyle et al., 2016). Therefore, CBT can be adapted to meet a juvenile's specific needs and can be applied to a variety of problems including substance use, psychotic, personality, and bipolar disorders, as well as depression, anxiety, and aggression (Hofmann et al., 2012).

Over the years many studies have been performed to test the effectiveness and efficacy of cognitive-behavioral therapy and results show that CBT is among the most "promising rehabilitative treatments" for juvenile offenders (Lipsey et al., 2007, p. 4) and has a well-developed theoretical base that target criminal thinking. Research has shown CBT to have consistently significant effects in reducing recidivism for juvenile offenders (Landenberger & Lipsey, 2005; Lipsey et al., 2007; McGlynn et al., 2013).

Pearson et al. (2002), for example, conducted a meta-analysis of sixty-nine research studies on the effectiveness of cognitive-behavioral treatment in reducing recidivism for juvenile and adult offenders. They found that cognitive-behavioral programs were more effective in reducing recidivism than the standard behavioral approaches with a mean recidivism reduction for treated groups of around 30% (Landenberger & Lipsey, 2005; Pearson et al., 2002).

Landenberger and Lipsey (2005) concluded similar results after a meta-analysis of fifty-eight research studies on the effectiveness of CBT on recidivism was conducted. They found CBT was more effective in reducing recidivism than the control group with a mean recidivism

reduction of 25% compared to those in the control group. They also found that CBT reduced recidivism in high-risk offenders as well as in programs that included anger control and interpersonal problem-solving.

Additionally, Lipsey and Landenberger (2006) conducted a meta-analysis of fourteen studies on the effectiveness of cognitive-behavioral treatment in reducing recidivism for general offenders. The results concluded that cognitive-behavioral programs were more effective in reducing recidivism than the control group with a mean recidivism reduction of 27% which confirmed the findings of prior meta-analyses of the effects of CBT that have shown recidivism reductions by 20% to 30% (Lipsey & Landenberger, 2006; Wilson et al., 2005).

Studies have also found CBT to be effective in reducing future offending for youth from low socioeconomic status backgrounds and juveniles with depressive and anxiety disorders (Bogucki et al., 2021; Hofmann et al., 2012; Kaslow & Thompson, 1998; Underwood & Washington, 2016). It has also been effective in reducing externalizing behaviors (McGlynn et al., 2013) and improving social problem-solving and impulse control among violent juveniles (Sukhodolsky et al., 2004; Tarolla et al., 2002).

Interpersonal Psychotherapy

Interpersonal psychotherapy (IPT) is a time-limited, evidence-based treatment that has been recommended as a treatment of choice for major depressive disorders (Cuijpers et al., 2011). Over the years IPT has been modified for long-term treatment for different age groups and different types of mood and non-mood disorders to meet the individual's specific needs (Weissman & Markowitz, 1994). IPT differs from CBT as it focuses on improving current interpersonal relationships and addresses interpersonal feelings related to depression rather than enduring aspects of the individual's personality and cognition (Weissman & Markowitz, 1994)

and is conducted with a therapist one-on-one weekly for 12-16 weeks.

IPT is a well-established and widely used program (Bernecker et al., 2017) that has been found to be effective in reducing the occurrence and recurrence of depressive symptoms (Bian et al., 2022), has shown positive treatment results in improving the quality of life in an individual (Pu et al., 2017), and has shown improvement in the juvenile's overall social functioning and critical thinking skills and the individual's ability to think of alternative solutions to problems, try them, and use them adaptively (Mufson et al., 1999). Cuijpers et al. (2011) found clear indications for the efficacy of treating depression and concluded that IPT, as well as CBT, may be the best option for psychological treatment for depression. IPT has been found to be significantly more effective at reducing depression and depressive symptoms than the control or treatment-as-usual group at post-treatment and follow-up (Mychailyszyn & Elson, 2018; Pu et al., 2017).

IPT has shown positive efficacy treatment results in treating depression and depressive symptoms among juveniles. Unfortunately, research conducted solely on juveniles is sparse and there is limited to no research connecting IPT to reducing juvenile offending. Although, it may be predicted that IPT can help reduce juvenile offending given that depression and mood disorders have continuously been found in research to be a risk factor that increases the likelihood of juvenile offending and substance use (Daigle et al., 2007; Tarolla et al., 2002). Substance use has also been found to be a main predictor of delinquency (Simões & Matos 2008). Therefore, when juveniles have depressive symptoms, they may engage in substance use to cope with the psychological symptoms and as a result, delinquency can occur.

Depressive and mood disorders are associated with a host of negative behavioral outcomes, such as criminal behavior and substance use, which are prevalent in most juvenile

offenders (Belenko & Logan, 2003; Daigle et al., 2007). Depression and mental health conditions are overrepresented and are commonly found in the juvenile justice system with estimates suggesting 15% to 30% of these juveniles have a diagnosis of depression (Underwood & Washington, 2016). Therefore, targeting depression could alleviate potential substance use which could potentially alleviate future offending behaviors. However, no single risk factor can be attributed to offending behavior and multiple risk factors increase the odds of offending (Pyle et al., 2016). Florsheim et al. (2000) suggest that a reduction in depression alone is not enough to alter antisocial patterns of behavior. Therefore, while IPT is effective in reducing depression, more research is needed to accurately assess and conclude that IPT can aid in the reduction of juvenile offending.

Psychodynamic Therapy

Psychodynamic therapy (PDT) is a popular therapy approach that is based on psychoanalytic concepts that are interested in the thoughts and feelings of the unconscious mental process (Lewis et al., 2008; Shedler, 2010). PDT has the goals of extending beyond relieving symptoms to encourage positive psychological capacities and resources through self-reflection, self-exploration, and self-discovery and achieve psychological health that is free of thoughts and inner emotions (Shedler, 2010). PDT focuses on the expression, exploration, and discussion of the patient's emotions to explore their reasoning for avoiding troubling experiences. PDT can be both short and long-term and conducted once or twice per week. Short-term psychodynamic psychotherapy is widely practiced and typically has a maximum of forty sessions (Lewis et al., 2008) whereas long-term psychodynamic psychotherapy typically consists of at least fifty sessions and lasts at least one year (De Maat et al., 2009). During treatment, a therapist will identify recurring themes and patterns in the patient's thoughts, feelings, self-

concepts, relationships, and life experiences by focusing on interpersonal relationships and experiences, and resolving past trauma and conflict (Abbass et al., 2014; Shedler, 2010).

For many years there was reluctance to support the empirical research that would establish PDT as evidence-based as practitioners supported the use of cognitive behavioral therapy more (Midgley & Kennedy, 2011). However, there has been considerable research that supports the efficacy and effectiveness of psychodynamic psychotherapy for treating mental disorders, symptoms, and problems (Leichsenring et al., 2015; Midgley & Kennedy, 2011; Shedler, 2010; Steinert et al., 2017). Shedler (2010) found evidence from randomized controlled trials that showed PDT was equal to other forms of evidence-based treatments and those receiving PDT maintained therapeutic gains that also continued after the treatment ended.

Additional studies evaluating PDT for youth have shown similar results. Midgley et al. (2021) for example, conducted an updated systematic review building on the meta-analysis findings from Midgley and Kennedy (2011) that evaluated the efficacy and effectiveness of psychodynamic therapy for individuals aged 3 to 18 years old. The review identified eighty-two distinct studies that evaluated PDT for children with a history of child abuse, as well as a range of emotional, depressive, anxiety, behavioral, and personality disorders. Findings concluded there was increasing evidence suggesting the effectiveness of PDT in relieving disorders in youth, and younger children were shown to have a larger treatment response. PDT was also effective in reducing internalizing symptoms and was equally effective as comparison treatments.

Unfortunately, research on the effectiveness of PDT conducted on juveniles is sparse and has lagged behind (Midgley & Kennedy, 2011). Additionally, like IPT, there is limited to no research connecting PDT to reducing juvenile offending. Although, it may be predicted that PDT

can help reduce juvenile offending given that mental disorders are highly common among juveniles in the justice system and poor mental health has consistently been identified as a risk factor for juvenile offending (Barnert et al., 2015; Belenko & Logan, 2003; Underwood & Washington, 2016). Approximately 40% to 80% of incarcerated juveniles have at least one diagnosable mental health disorder that was apparent before incarceration (Pyle et al., 2016; Underwood & Washington, 2016). Mental disorders pose a barrier to the success of juvenile re-entry (Shelden, 2005) and create a greater risk of offending and re-offending behaviors (Underwood & Washington, 2016). Limited research shows PDT has the potential to be effective in reducing mental disorders, symptoms, and problems among juveniles which could help alleviate future criminal behavior. However, more research is needed to accurately assess and conclude that PDT can aid in the reduction of juvenile offending.

Individual Therapies Conclusion and the Risk-Need-Responsivity Approach

After examining the common forms of individual therapy, it has been found that individual therapy is highly effective in its designed goals and cognitive behavioral therapy can aid in reducing juvenile offending behavior. Cognitive-behavioral therapy has been found to be effective in teaching juveniles about their behavior and emotions to reduce offending behaviors in juveniles. Interpersonal psychotherapy has been recommended as a treatment of choice for depressive disorders and has been found to have significant effects on reducing depressive symptoms and psychodynamic therapy has been found to be effective in focusing on the thoughts and feelings of the unconscious mind to reduce mental disorders in juveniles. These individual therapies have been effective and the support for the effectiveness can be explained by the risk-need-responsivity approach due to individualized forms of therapy contributing to the risk and needs of juveniles.

The risk-need-responsivity (RNR) approach may be the “most popular framework in corrections for using risk assessment in decision-making” (Vincent et al., 2012, p. 551). The RNR approach has three main principles. The *risk* principle suggests the highest-risk offenders should receive the most intensive monitoring and services to reduce their offending behaviors while minimal monitoring should be provided for lower-risk cases (Dowden & Andrews, 1999). The *need* principle suggests that “the criminogenic needs of offenders must be emphasized and targeted” in interventions, such as targeting individual, family, or group risk factors that are specific to juveniles’ particular criminogenic needs (Dowden & Andrews, 1999, p. 439). The *responsivity* principle suggests that interventions need to consider the offenders’ specific characteristics that may affect their response to treatment (Vincent et al., 2012) and program delivery should match the learning styles of the offenders (Dowden & Andrews, 1999). By using the RNR approach programs, including individual therapy, can address the criminogenic needs of each juvenile to reduce future offending behaviors. Programs will become more effective in reducing juvenile offending behaviors if their program is based on an individualized approach that targets the specific factors that are driving the youth to offend (Andrews & Dowden, 2006; Dowden & Andrews, 1999; Matthew & Hubbard, 2007; Vincent et al., 2012).

Individual therapies can effectively individualize treatment by targeting the criminogenic needs of the juvenile. Juvenile offending behaviors can be linked to the lack of thinking skills and problem-solving skills a juvenile possesses as well as a lack of positive coping strategies. Cognitive-behavioral therapy aids in targeting these specific needs of the juvenile by improving interpersonal, social, and coping skills, self-control and anger management, and the juvenile’s ability to manage challenges and solve problems. CBT can also be adapted to target a juvenile’s specific mental health needs. Depressive and mood disorders are also associated with negative

behavioral outcomes such as criminal behavior and interpersonal psychotherapy targets this risk by working to improve current interpersonal relationships and address interpersonal feelings related to depression. Additionally, mental disorders are poor mental health have been a risk factor for juvenile offending therefore, psychodynamic therapy targets a juvenile's specific mental health need by encouraging positive psychological capacities through self-reflection, self-exploration, and self-discovery.

Based on the *responsivity* principle, the treatment should be designed to match the juvenile's characteristics which cannot be effectively accomplished without a client-therapist working alliance that develops a collaborative relationship to facilitate individualized positive change (Florsheim et al., 2000). There must also be a trusting, mutually respectful relationship provided by the therapist to ensure a safe environment for self-examination and personal growth (Florsheim et al., 2000; Matthew & Hubbard, 2007). Building a working alliance with youth is essential for addressing treatment needs and reducing delinquency and contributes to better program outcomes (Matthew & Hubbard, 2007). Every juvenile does not learn in the same way, therefore, when there is a stronger working alliance relationship, the therapist can fully understand the juvenile and how the juvenile may learn. Therapists should be appropriately trained in the interpersonal skills needed to develop these close-knit relationships to truly know and understand the juvenile (Matthew & Hubbard, 2007).

Individual therapy programs can be effective and can be useful in reducing juvenile offending behaviors due to these interventions continuing to target the specific criminogenic risk and needs of the juvenile and by creating an individualized approach.

CHAPTER 5

GROUP THERAPY

Counseling is the most common type of intervention that can be provided individually but can also be provided in a group setting such as group therapy. Group therapy is among one of the most widely used interventions due to being less punitive and restrictive (Tarolla et al., 2002) and is a form of psychotherapy where therapists treat a small group of juvenile delinquents together to promote personality and behavior change (Elias, 1980). Group therapy is conducted in a supportive environment where juveniles are experiencing social support and peer feedback and oriented toward interpersonal problem-solving that promotes positive exchanges (Tarolla et al., 2002). Programs provide daily discussions designed to reduce negative behaviors to promote client self-disclosure and honesty, modify a distorted self-image, encourage openness and acceptance of responsibility, introduce problem-solving techniques, activities, and community service involvement, and focus on past dysfunctional lifestyles (Tarolla et al., 2002). However, when therapy is conducted in a group, an individualized approach may become lost.

In the juvenile justice field, it is common to place problem youths together in groups with other deviant peers. For example, youth who abuse substances or who have conduct disorders may be assigned to group therapy or placed with similar youths in group homes (Dodge et al., 2007). Unfortunately, when delinquent youth are placed with other delinquent youth negative outcomes can result (Dishion et al., 1999). Instead of helping juveniles transition to a healthier lifestyle, a commitment to greater offending behavior may result (Dodge et al., 2007) which may become a risk of group therapy.

During group therapy, delinquent youth can be exposed to new delinquent peers which can increase their frequency of interaction which can increase the potential for negative

influences which can increase offending behaviors. This becomes a consequence of group therapy and group intervention as deviant peers are among the most potent risk factors in the development of antisocial and delinquent behavior (Barnert et al., 2015; Dodge et al., 2006; Mulder et al., 2011; Tarolla et al., 2002).

Research on the effectiveness of group therapy in reducing juvenile offending behavior has shown group therapy to be ineffective and, in some cases, increase offending behavior (Dishion & Andrews, 1995; Dodge et al., 2006; Dodge et al., 2007; Tarolla et al., 2002). Therapies that are given in groups show fewer positive results and are less effective than family or individual counseling approaches (Ang & Hughes, 2002; Baldwin et al., 2012).

Lipsey et al. (2006) found that peer group counseling approaches were 33% less effective than individual counseling approaches with behavior and participants worsening after the intervention, explaining that one-third of the positive effects of group therapy are offset by the adverse effects of therapy that is administered in a group context. Group therapy can be given as a peer group intervention that can increase problem behaviors (Gottfredson, 1987).

Feldman et al. (1983; as cited in Dodge et al., 2006) for example, randomly assigned high and low-risk boys to a group of only high-risk, only low-risk, or a group of both high and low-risk, which only contained one or two high-risk boys. The study found that high-risk boys who were assigned to an all-deviant peer group increased their rate of antisocial behavior. In contrast, high-risk boys who were assigned to the mixed group with low-risk boys decreased their antisocial behavior. The low-risk juveniles' antisocial behavior was not affected by only one or two high-risk individuals in the mixed group. The results suggest there can be negative effects when deviant youths are placed with additional deviant youth in a group setting and when there is a higher ratio of deviant youth, there will be adverse effects. Therefore, the results suggest that

treatments should minimize the amount of time a youth spends in a setting with more deviant peers (Dodge et al., 2006). The results also suggest group therapy can be beneficial if delinquent youth are placed with low-risk or nondelinquent youth, suggesting how group therapy is implemented matters.

Dishion and Andrews (1995) found similar results when randomly assigning high-risk youth and their families to a peer group intervention, parent group intervention, both peer and parent intervention, or neither intervention. Results concluded that within one year after treatment, parent interventions provided immediate beneficial effects while high-risk youths who were in a peer group reported higher conduct problems and tobacco use (Dishion & Andrews, 1995). Therefore, juveniles can become more deviant through association with deviant peers in peer groups.

Group interventions can also be given in group homes and may have similar negative effects (Ryan et al., 2008). Group homes are described as unsafe and unable to support healthy development that typically house six to nine juveniles in a community-based setting who are more likely to have prior involvement with the juvenile justice system (Ryan et al., 2008). Because group homes house delinquent peers there is a high potential for delinquency due to juveniles being separated from prosocial peers and exposed to other high-risk youth (Ryan et al., 2008). Ryan et al. (2008) for example, focused on 5,238 youth associated with group home placement and found that group homes significantly increased the risk of future arrest, and the risk of delinquency was 2.5 times greater for adolescents who were placed in at least one group home compared to youth in foster care settings.

Similarly, Ramchand et al. (2009) assessed 449 adolescent offenders who were placed in group homes and found negative effects after continuous follow-ups for seven years. Researchers

found that seven years after entering a group home, many individuals were still criminally active, almost half had spent time in jail or prison within ninety days of the seven-year assessment, substance abuse disorders persisted into adulthood, and more than half reported three or more symptoms of conduct disorder and mental health problems. Individuals were also at a competitive disadvantage for positive educational and employment outcomes (Ramchand et al., 2009).

Lipsey et al. (2006) suggest the residential arrangements themselves are most likely the source of negative peer effects on delinquency, not necessarily the treatment sessions and model. Weiss et al. (2005) suggest that if juveniles are at risk and in group therapy due to their delinquent behavior then they are more likely to already be associated with deviant peers therefore are more likely to associate with delinquent youth in the future regardless of their participation in group treatment. Weiss et al. also suggest that the time spent in group therapy sessions represents only a small portion of the juvenile's day therefore the impact of peers within treatment is limited. However, if this were the case, juveniles who participate in individual or family therapy due to their delinquent behavior would also be more likely to associate with delinquent youth in the future and additional therapies would also see perverse effects. However, research has continued to show individual and family therapy is effective in reducing juvenile offending behaviors suggesting the arrangement of therapy is significant. The ineffectiveness of deviant group arrangements can be theoretically explained by the social learning theory, as well as the effectiveness of nondeviant group arrangements.

Group Therapies and Social Learning Theory

Social learning theory can be used in any social behavior research. In the field of criminology, social learning theory refers to a wide range of deviant and criminal behavior

(Akers et al., 2020). The main assumption in social learning theory is that the learning process operates in a context of social structure, interaction, and situation, and produces both conforming and deviant behaviors given the environment and who individuals are exposed to (Akers, 2002).

Social learning theory relies on four major concepts: differential association, differential reinforcement, imitation, and definitions. The theory states that individuals are more likely to commit a crime when 1) the individual associates with others who commit, model, and support the violations of social and legal norms, 2) when the deviant behavior is reinforced over conforming behavior, 3) when the individual is more exposed to and observes more deviant than conforming models, and 4) when the individual's learned definitions are favorable toward committing deviant acts (Akers, 2002).

Social learning theory asserts that individuals learn to engage in crime through the exposure of definitions favorable to crime, typically through deviant peers. Definitions define an act as right or wrong, good or bad, desirable or undesirable, justified or unjustified (Akers et al., 2020), and the greater the extent one holds that approves of certain acts, the more one is likely to engage in them.

Offending behavior is learned and modified the same way conforming behavior is learned and modified (Akers, 2002). Therefore, individuals can associate and learn definitions favorable to violating the law, or associate and learn definitions favorable to conforming behavior. Individuals can also change over time and in different situations (Akers, 2002). Therefore, if individuals are exposed to more delinquent peers and delinquent definitions, they will begin to imitate the nonconforming behavior. Alternatively, if individuals are exposed to nondelinquent peers and nondelinquent definitions, they will begin to imitate the conforming behavior. Therefore, indicating group therapy may be ineffective when there is a higher ratio of deviant

youth within a group setting and effective when there is a higher ratio of nondeviant youth within a group setting.

Social learning theory and the relationship between social learning and delinquent behavior have received the widest empirical support of all the major theories of crime (Akers, 2002). There has been very little evidence that disproves this theory which can aid in understanding how group therapies are ineffective in reducing juvenile offending behaviors and how group therapies can be used to be effective in reducing juvenile offending behaviors. Peer influence is the most noticeable and strongest in juveniles therefore grouping deviant youth can be ineffective while grouping deviant youth with nondelinquent youth may be more effective.

CHAPTER 6

FAMILY THERAPY

Family therapy is a counseling intervention that is slightly different from individual and group therapy. Family therapy focuses on aiming to address, treat, and change the underlying family issues that contribute to a juvenile's offending behavior by resolving conflict and improving communication, support, and relationships within the family. Delinquency is not solely an individual problem but is also a family issue, therefore, should be addressed within family-focused interventions (Celinska et al., 2019) that are essential in preventing offending behaviors. Perkins-Dock (2001) suggests that offending behavior and recidivism rates will continue to be high as long as family interventions are not provided.

Parental neglect and poor parental support, supervision, attachment, and relationships, as well as the lack of love, attention, and positive role models, are all reoccurring risk factors that can lead to juvenile offending (Asscher et al., 2015; Barnert et al., 2015; Kenny et al., 2014; Mulder et al., 2011; Perkins-Dock, 2001; Simões & Matos 2008). Juveniles who do not have a strong relationship with their parents and feel unloved or neglected will see no reason to spend time with them and will "ultimately end up on the streets or in jail" (Barnert et al., 2015, p. 1368). In contrast, supportive family relationships and positive family communication have been important protective factors in reducing juvenile offending (Barnert et al., 2015; Simões & Matos 2008; Perkins-Dock, 2001). Therefore, the need for a positive, loving home environment with a strong parent-child relationship is necessary to reduce offending behavior and effective family interventions are critical.

Common forms of family therapy include multisystemic therapy, functional family therapy, and multidimensional family therapy as well as brief strategic family therapy and

multidimensional treatment foster care.

Multisystemic Therapy

Multisystemic therapy (MST) is an evidence-based intensive family and community-based intervention that aims to enhance the way youth function in homes, schools, and neighborhoods to increase prosocial behavior and address family and externalizing problems (Baglivio et al., 2014; Henggeler et al., 1999; Zajac et al., 2015). MST believes that an individual's behavior is influenced by multiple systems, therefore, treatment targets contributing offending behaviors at the individual, family, peer, and community levels (Henggeler et al., 1999). MST also collaborates with family members to target caregiving monitoring, supervision, consistency, cohesion, and support to emphasize family empowerment to produce long-term positive changes in problem behaviors (Zajac et al., 2015).

MST draws on additional effective treatments to address the specific needs of each family (Tighe et al., 2012). Therapists typically have caseloads of four to six families and are available 24 hours a day 7 days a week for the four-to-six-month treatment period (Henggeler, 2011).

MST has been found to be the most widely used evidence-based therapy (Baglivio et al., 2014) that has shown significant effects in reducing juvenile offending behavior among deviant and violent youth, youth with serious clinical problems (Schaeffer & Borduin, 2005), juvenile sex offenders (Borduin et al., 1990), substance-abusing juvenile offenders (Henggeler et al., 1999), and youth with antisocial behavior and serious problems (Tighe et al., 2012). MST has also achieved favorable outcomes in improving family relationships and communication (Henggeler, 2011) by increasing parents' confidence and skills.

Henggeler and colleagues (1986) for example, performed the first MST outcome study

that compared delinquent juveniles in family and alternative treatment to nondelinquent juveniles. After conducting pre- and post-treatment assessments, they found adolescents who received family treatment had significant decreases in conduct problems and association with delinquent peers, as well as greater involvement in family interactions and improved family relationships.

MST has also been found to be effective during long-term follow-up studies. At a 59-week follow-up, Henggeler et al. (1992) who randomly assigned eighty-four serious juvenile offenders and their families to MST or community service, concluded juveniles who received MST had fewer arrests and reduced incarceration by 64%. Families also reported increased family cohesion and decreased youth aggression in peer relations. At an 18-month follow-up, Timmons-Mitchell et al. (2006) who randomly assigned ninety-three juveniles to MST or treatment as usual in a real-world setting, found juveniles who participated in MST had significantly lower recidivism rate than the treatment as usual group who were 3.2 times more likely to be rearrested. Recidivism has also been found to decrease following MST treatment at a 2.4-year follow-up (Henggeler et al., 1993), and at a 4-year follow-up, MST produced a 63% reduction in arrests for violent and serious crimes (Borduin, 1995, as cited in Schaeffer & Borduin, 2005). Additionally, in one of the longest follow-ups, after 13.7 years, Schaeffer and Borduin (2005) found that individuals receiving MST had significantly lower recidivism rates, with a reduction of 54% in rearrests than individuals who participated in individual therapy.

While it has been found MST is effective in reducing juvenile offending behaviors and strengthening family relationships, most of the studies conducted on MST have been clinical random trials. A treatment program may show efficacy however vary in effectiveness. There are many challenges to successfully implementing a program and implementing MST in a real-world

setting has presented challenges (Henggeler, 2011). Within MST programs, therapists are available 24 hours a day 7 days a week and have small caseloads who perform treatment in homes and community locations. Unfortunately, this program differs dramatically from traditional mental health and juvenile justice services and may have more difficulty being implemented due to the program model (Henggeler, 2011).

Functional Family Therapy

Functional family therapy (FFT) was one of the first evidence-based treatments and has since become one of the most widely transported evidence-based family therapies that meet the specific needs of each juvenile and family (Henggeler & Sheidow, 2012; White et al., 2013). FFT is a family-centered approach that is often used for juveniles who are at risk for and/or presenting with delinquency, violence, substance abuse, conduct disorder, or disruptive behavior disorders (Underwood & Washington, 2016). FFT aims to modify family behavior by focusing on the relationships of the family and supporting positive communication as well as establishing and maintaining new patterns of family behavior to replace dysfunctional behaviors (Henggeler & Sheidow, 2012).

Youth may participate in FFT if there is a court-mandated referral to do so and be used as an alternative to incarceration or as a re-entry program for youth returning to the community following release from an institution (Littell et al., 2023). Therapists typically have caseloads of twelve to fifteen families and perform an average of twelve sessions over a 3-to-4-month period in a clinic, home, or community setting (Henggeler & Sheidow, 2012).

A key aspect of FFT is how the therapist reframes the youth's behavioral problems and focuses on the relational aspects of their behavior. The family's focus is shifted to discussing more positive, meaningful family relationships (Henggeler & Sheidow, 2012). FFT helps

families alter their conflicting behaviors to build a positive alliance that shifts away from negativity and blaming and helps families anticipate and address future problems if they emerge (Celinska et al., 2013).

Criticism of FFT has been sparse and research examining the effectiveness and efficacy of functional family therapy has shown this treatment to have consistent, positive effective results for juvenile offenders in reducing re-offending behavior, substance abuse problems, and future adult criminal behavior, and increasing parent-child relationships (Gordon et al., 1995; Hartnett et al., 2017; Underwood & Washington, 2016). Additionally, FFT treatment has a flexible structure that addresses individual needs and can be used for complex and multidimensional problems (Littell et al., 2023).

Much research studying the effectiveness and efficacy of FFT was performed soon after the treatment was implemented near the 1970s and showed promising results. The first studies focused on its impact on interactions and communication patterns among family members and the impact of FFT on delinquency and recidivism rates (Celinska et al., 2019). The research found that after FFT family members interacted more frequently with one another and for longer periods of time (Parsons & Alexander, 1973), and defensiveness decreased while supportiveness increased among family members who took part in FFT (Alexander et al., 1976).

Klein et al. (1977) found that youth who were randomly assigned to family programs demonstrated the lowest recidivism rate (26%) and lowest sibling court involvement (26%) as compared to no treatment (50% and 40%, respectively), alternative treatment (47% and 59%, respectively), and eclectic-dynamic family program (73% and 63%, respectively). Additionally, Gordon et al. (1988) found a statistically significant difference that after two and a half years those who received FFT treatment had a recidivism rate of 11% while those in the probation

comparison group had a recidivism rate of 67%.

More recent research conducted on FFT has also shown effective results in strengthening family relationships and reducing recidivism. Celinska and colleagues (2019) for example, evaluated 107 families of youth who were minor delinquents and status offenders and found that those participating in FFT had improved family functioning and decreased risks associated with offending. Youths were significantly less likely to be reconvicted for drug and property offenses and sanctions for technical violations one year after the program's completion compared to youth in individual therapy or mentoring programs (Celinska et al., 2019). Similarly, Hartnett et al. (2017) concluded that FFT was effective in reducing conduct problems and reoffending rates compared to control conditions or alternative treatments.

While FFT has been shown to be effective, how the therapist administers the treatment and the way the program is implemented matters. At 12 months post-treatment, Sexton and Turner (2011) studied the effectiveness of FFT compared to probation services and investigated the interactive effects of therapist model commitment. The research concluded that FFT was effective in reducing youth behavioral problems and had a higher likelihood of success for more difficult families only when the therapist followed the treatment model. Therapists who did not commit to the model had significantly higher recidivism rates than the control group whereas highly committed therapists had a statistically significant reduction of felony (35%), violent crime (30%), and misdemeanor recidivism (21%) compared to the control condition.

Multidimensional Family Therapy

Multidimensional family therapy (MDFT) is an evidence-based, family-based treatment that aims to address adolescents showing both substance abuse and/or antisocial behavior (Liddle, 2016). The intensive intervention program focuses on the juvenile's issues regarding

substance abuse disorders and delinquency, as well as the child-rearing skills, communication, relationships, and interactions between family members (van der Pol et al., 2017). MDFT believes that an individual's development is shaped by their interaction with their surrounding social contexts (van der Pol et al., 2017). Therefore, MDFT targets multiple risk factors that influence juvenile delinquency and substance abuse and aims to modify functioning by intervening with the juvenile and family members, and additional support networks, such as community, school, and juvenile justice officials (Filges et al., 2015).

MDFT has been designed to serve a broad group of adolescents with substance use disorders and diverse and complex behavior problems (van der Pol et al., 2017) and is flexible concerning duration, setting, and therapeutic methods. MDFT can be administered to the individual needs of the juvenile and family and can consist of twenty-five sessions over six months or twelve sessions over three months (Filges et al., 2015). To identify, address, and target underlying problem areas, symptoms, co-occurring disorders, and risk and protective factors, the therapist observes family interactions and conducts interviews with the juvenile, the family, the school, the court, and other mental health professionals (Filges et al., 2015) in a clinical, home, or community setting.

Research has consistently shown that MDFT is an effective treatment approach for reducing adolescent substance abuse, antisocial behaviors, and delinquency and improving family relations, and externalizing and internalizing symptoms (Liddle, 2016; Liddle et al., 2001; van der Pol et al., 2017). Research regards MDFT as one of the most effective treatment therapies for youth with substance abuse and delinquent behaviors due to the treatment's ability to work simultaneously with different systems and target multiple areas (Filges et al., 2015; Liddle, 2016).

van der Pol et al. (2017) for example, conducted a meta-analysis yielding 1,488 juveniles to examine the effectiveness of MDFT compared to other treatments in reducing juvenile substance abuse, delinquency, family malfunctioning, and externalizing and internalizing psychopathology. Findings indicated that juveniles with severe substance abuse and/or disruptive behavior benefited more from MDFT than comparison treatments. Age, gender, socioeconomic status, ethnic background, duration of therapy, and duration of the follow-up period did not seem to affect MDFT treatment. Similarly, Liddle et al. (2001) randomly assigned 182 juveniles who abused marijuana and alcohol to MDFT, group therapy, or multifamily educational intervention. Results indicated that while all programs were effective, MDFT showed superior improvement overall with a sharp reduction in drug use, and improved family prosocial functioning and academic achievement. Juveniles participating in MDFT also showed treatment gains during a six- and twelve-month follow-up.

The effectiveness of MDFT in improving substance abuse and family functioning is important in reducing future juvenile offending as family support, parenting practices, and the parent-child relationship are important predictors of juvenile drug problems and drug treatment success (Liddle et al., 2001). Parent and sibling substance abuse, parental attitudes that minimize the dangers of drug use, poor relationships, and inadequate child-rearing practices are closely linked to juvenile drug problems whereas parental monitoring and changes in parenting practices prevent, delay, and decrease drug use in juveniles (Liddle et al., 2001).

Substance abuse disorders can lead to a variety of behavior problems such as delinquency and family malfunctioning (van der Pol et al., 2017) and it has been found that substance abuse is a risk factor that can lead juveniles to further delinquent and violent behavior (Barnert et al., 2015; Hart et al., 2007; Simões & Matos, 2008). Therefore, MDFT being effective in reducing

substance use and familial problems is an important factor aiding in the reduction of future delinquent behavior.

Brief Strategic Family Therapy

Brief strategic family therapy (BSFT) is a time-limited family-based approach that has the goal of improving family relationships that may be directly related to youth's behavior problems (Perkins-Dock, 2001). BSFT is based on the idea that family provides the foundation for child development and is highly important in the lives of juveniles. BSFT is typically conducted in a clinical or home setting and lasts four months with an average of 12-16 sessions. Research has shown BSFT to be an effective treatment both short-term and long-term in reducing conduct disorders among youths and engaging families in treatment (Coatsworth et al., 2001), reducing re-offending behavior (Horigian et al., 2015), and reducing drug abuse and behavior problems, as well as improving family functioning (Szapocznik & Williams, 2000) and treatment retention (Coatsworth et al., 2001).

Multidimensional Treatment Foster Care

Multidimensional treatment foster care (MTFC) is an intensive program that provides community-based foster care alternatives to incarceration and group facilities (Henggeler & Sheidow, 2012) for adolescents with severe and chronic emotional and behavioral disorders (Underwood & Washington, 2016) with the goal of reuniting youth with their biological families. Adolescents are placed with trained, local, and supervised foster care families typically for six to nine months to engage the youth in prosocial peer activities, promote positive school performance, and disconnect the influence of deviant peers (Henggeler & Sheidow, 2012). MTFC places juveniles in a structured and supervised environment with positive encouraging adults while at the same time, therapists are preparing the youth's family to maintain treatment

success.

MTFC can adapt to create an individualized treatment plan and use additional family therapies as well as individual therapy and skills training (Henggeler & Sheidow, 2012). Therapists have a maximum caseload of ten juveniles and are available 24 hours a day 7 days a week and deliver services in foster or family homes, schools, and other neighborhood areas while maintaining daily contact with the foster parents (Leve et al., 2012).

Research has shown MTFC to be effective in reducing future delinquent and criminal behavior among youths with behavior problems (Henggeler & Sheidow, 2012; Underwood & Washington, 2016) for both males (Chamberlain & Reid, 1998; Eddy et al., 2004) and females (Chamberlain et al., 2007; Leve et al., 2005; Leve et al., 2012) and results were apparent during follow-up.

Family Therapy Conclusion

After examining the common forms of family therapy, it has been found that multisystemic therapy, functional family therapy, multidimensional family therapy, brief strategic family therapy, and multidimensional treatment foster care have been effective in their designed goals and in reducing juvenile offending behaviors.

Parental neglect and poor parental support, supervision, attachment, and relationships, are reoccurring risk factors that can lead to juvenile offending that family therapies work to target. When familial risk factors are present, they can create a breakdown in the bond between the parent and the child and based on the social bond theory, broken bonds may result in delinquency. Family therapies recognize the importance of a strong bond reducing delinquency as they work to target the specific needs of each juvenile and family member by targeting offending behaviors and strengthening family relationships. Additionally, family therapies may

be effective due to the approaches offering an individualized approach and utilizing conducting therapy in high dosages.

Multisystemic therapy for example addresses the specific needs of each family and offers an individualized approach to target juvenile misbehavior by focusing on contributing offending behaviors as well as family and externalizing problems. The therapist is also available 24/7 for the four-to-six-month treatment period for each juvenile and family. Functional family therapy also meets the specific needs of each juvenile and family by addressing risk factors and focusing on family relationships within twelve therapy sessions taking place over a three-to-four-month period. Multidimensional family therapy offers an individualized approach by aiming to address adolescents showing substance abuse and/or antisocial behavior and target the parent's child-rearing skills and the communication, relationships, and interactions between family members. MDFT offers flexibility concerning the duration, setting, and therapeutic methods and can be given in twelve sessions over three months or twenty-five sessions over six months to fit the specific needs of each juvenile and family. Brief strategic family therapy aims to improve family relationships and is conducted an average of 12-16 sessions over four months and can be given both short and long-term to fit the individual needs of the juvenile and family. Additionally, multidimensional treatment foster care offers care for juveniles with severe and chronic emotional and behavioral disorders. Juveniles are placed with foster care parents typically for six to nine months while at the same time, therapists are preparing the juvenile's family to maintain treatment successes. MTFC can be adapted to create an individualized treatment plan for each juvenile and family and therapist is available 24/7.

When family therapy targets the specific risk and needs of each juvenile and offers an individualized approach, the risk-need-responsivity model and the social bond theory can offer

theoretical support for the effectiveness and the use of family therapies.

Family Therapies and Social Bond Theory

Social bond theory was first proposed by Travis Hirschi who proposed delinquent acts result when an individual's bond to society is weak or broken (Akers et al., 2020). Four elements make up this bond: commitment, involvement, belief, and attachment. According to the bonds, when an individual is committed and invested in conventionality, the individual has more to lose if they commit delinquent acts; when an individual is involved in conventional activities, they are less likely to engage in delinquent acts; when an individual believes that the law and society's rules are morally correct and should be obeyed they are less likely to commit delinquent acts; and when an individual has a stronger positive bond to their parents or other adults/authority figures they are less likely to commit delinquent acts. Although, when these bonds are weak, the individual will be more likely to commit delinquent acts (Akers et al., 2020).

An attachment is created when the individual becomes close to others and has close ties to whom they admire and who care about their expectations (Akers et al., 2020). When a strong attachment is formed, the individual will begin to conform to the opinions and norms of those they are attached to and will be less likely to violate them. Hirschi emphasized within the social bond theory that the attachment to parents and parental supervision is important in controlling delinquency and maintaining conformity and as social bonds grow stronger, offending behavior lessens (Akers et al., 2020).

As juveniles age, there becomes a strong peer effect as they begin spending more time away from their family and associating with peers. If the juvenile has a weaker family bond and is exposed to delinquent peers, they are more susceptible to the influence of delinquent peers and offending behavior may result. However, if a juvenile has a stronger family bond, they are less

susceptible to the influence of delinquent peers. Therefore, the formation of close bonds and attachment to parents as well as parental supervision, family management, socialization practices, and consistent punishment are important in controlling delinquency and maintaining conformity (Sampson & Laub, 1997).

When bonds and attachments to the parents and family are stronger, delinquent behaviors will likely decrease. In addition, commitment, involvement, belief, and attachment are highly intercorrelated thus, the strengthening of one bond will likely be accompanied by the strengthening of another (Akers et al., 2020). Therefore, addressing and targeting these family attachments are important and beneficial in reducing future offending behavior as well as gaining more commitment and involvement later in society. Social bonds are an important protective factor in reducing future offending behavior (Belenko & Logan, 2003) and family therapies aim to address these issues and build relationships and communication among family members.

Social bond theory explains how family therapies are highly effective and more effective than alternative therapies, such as individual or group therapies, and why solely addressing individual needs may not be as effective in reducing juvenile offending behavior. Family therapies with the goal of building strong bonds and attachments can be beneficial in reducing juvenile offending behavior.

Unfortunately, engaging the whole family in treatment is one of the most challenging aspects of family treatment as families fail to interact, resist, or drop out (Perkins-Dock, 2001). Therefore, developing an intervention that can achieve the goals of family therapy without having the whole family present is important for future family therapy treatment (Perkins-Dock, 2001). Treatment can also engage family members by asking how the juvenile's behaviors affect them individually, allowing them to become more connected to the success of therapy.

Addressing parental problems and behaviors is also important in attempting to change behaviors within families (Belenko & Logan, 2003). Therefore, family interventions should assist parents with stress and mental health, substance abuse, or employment problems (Belenko & Logan, 2003).

CHAPTER 7

THERAPY CONCLUSION

After examining the common forms of individual therapy, individual therapy is generally highly effective in its designed goals. Each therapy approach targets the specific criminogenic risks and needs of the juvenile offender and performs an individualized treatment approach which can be effective due to the risk-need-responsivity approach. Cognitive-behavioral therapy is effective in targeting juvenile behaviors and emotions and teaching them self-control techniques and alternatives to negative coping and problem-solving, among many others that are linked to offending behaviors. Interpersonal psychotherapy is effective in reducing depressive symptoms in juvenile offenders that can be linked to offending behaviors, and psychodynamic therapy is effective in reducing mental disorders that can also be linked to offending behaviors.

After examining group therapy, group therapy can be both effective and ineffective depending on the treatment implementation. Group therapy may be ineffective when high-risk delinquents are placed with additional high-risk delinquents. Based on the social learning theory, when group therapy is conducted solely with delinquents, individuals learn to engage in crime through the exposure of delinquent peers. However, group therapy may be effective when high-risk delinquent juveniles participate in group therapy consisting of low-risk or nondeviant juveniles (Dodge et al., 2006). The social learning theory also suggests when individuals are exposed to nondelinquent peers they can begin to imitate their conforming behavior. Therefore, the implementation of group therapy matters.

After examining the common forms of family therapy, family therapy is highly effective in its designed goals as well as in reducing juvenile reoffending behaviors. Throughout the years there have been specific evidence-based models of family therapy developed for a range of

adolescent problems and these approaches among many others aim to reduce individual and family risk factors that can increase juvenile problems and continued offending behavior.

Multisystemic therapy has been found to be highly effective in reducing youth antisocial behavior and criminal activity in juvenile offenders. Functional family therapy has been effective in reducing recidivism, substance abuse problems, and future adult criminal behavior.

Multidimensional family therapy has been found to be effective in reducing substance abuse and antisocial behaviors and improving family relations and delinquency. Brief strategic family therapy has been effective both in short-and-long terms in reducing conduct disorders, recidivism, drug abuse, and in improving family functioning. Multidimensional treatment foster care has been effective in reducing future offending behaviors among youth with behavior problems.

When family therapies are compared to other forms of treatment, family therapies that focus on the family as a unit are preferred and are more effective than the alternative treatments (Baldwin et al., 2012; Perkins-Dock, 2001). Baldwin et al. (2012) for example, conducted a meta-analysis of twenty-four treatment studies of delinquency, conduct problems, and substance abuse comparing multisystemic therapy, functional family therapy, multidimensional family therapy, and brief strategic family therapy to either treatment as usual, an alternative therapy, including group therapy, psychodynamic family therapy, and individual therapy, or a control group and found that MST, FFT, MDFT, and BFST were more effective than treatment as usual and alternative therapies.

Woolfenden et al. (2002) found that family-based treatments, including multisystemic therapy and multidimensional treatment foster care, were more effective than individual or group treatment in reducing conduct disorders, delinquency, and rearrests. Similarly, Borduin et al.

(1995; as cited in May et al., 2014) found that four years after juvenile delinquents were treated with either MST or individual therapy, MST participants had a significantly lower recidivism rate (22.1%) compared to those who received individual therapy (71.4%).

Working with the family has had positive outcomes in reducing reoffending behavior in juveniles and family-focused programs are “essential in the prevention of delinquency and juvenile crime” (Perkins-Dock, 2001, p. 620) and can be theoretically supported by social bond theory. Family therapy can also be effective due to the risk-need-responsivity approach by targeting the specific criminogenic risks and needs of the juvenile and offering an individualized approach. However, engaging the whole family in treatment is one of the most challenging aspects of family therapy, therefore developing an intervention that can achieve the goals of family therapy without having the whole family present is important for future family therapy treatment (Perkins-Dock, 2001) as well as addressing parental problems and behaviors (Belenko & Logan, 2003).

CHAPTER 8

MOVING FORWARD

The juvenile justice system is a complex system that has many different approaches with different goals. One approach may focus on punishment while the other approach may focus on rehabilitation and there has been a long history of reforms attempting to find the best approach to address juvenile offenders. Currently, the juvenile justice system is in a more rehabilitative-focused approach that emphasizes treatment, such as individual, group, and family therapy, and diversion programs, including probation, as alternatives to incarceration to reduce juvenile offending behaviors.

Moving forward, the juvenile justice system could continue to use these effective rehabilitative techniques as alternatives to incarceration and court involvement in reducing juvenile offending behaviors and reintegrating offenders back into society. While incarceration has multiple goals and may be effective in control, discipline, order, security, and punishment (Fagan & Kupchik, 2011), incarceration is ineffective in reducing juvenile offending behaviors and likely does more harm than good (Lambie & Randell, 2013; Mallett et al., 2013; Mendel, 2011). Youth who are incarcerated are more likely to recidivate than youth who are supervised in a community-based setting or not detained at all (Holman & Ziedenberg, 2006) and 70% to 80% of youth incarcerated are rearrested within two or three years (Lambie & Randell, 2013).

Incarceration fails to meet the developmental and criminogenic needs of youth offenders and is limited in its ability to provide appropriate rehabilitation services to juveniles (Lambie & Randell, 2013). Incarceration leaves detrimental effects on all those involved and leaves long-lasting negative effects on a juvenile's psychological, developmental, and behavioral well-being as well as their mental health, psychical well-being, self, and self-worth (Beckett & Goldberg,

2022; Holman & Ziedenberg, 2006; Lambie & Randell, 2013; Tosouni, 2014). Mendel (2011) suggests incarceration should be reserved for youth who have committed serious offenses and pose a great risk to public safety as incarceration can be detrimental for low-risk offenders.

During incarceration, youth experience various types of abuse including staff and inmate violence, physical abuse, and sexual assault which can lead to continued criminal involvement upon release (Dierkhising et al., 2014). Incarceration also limits juveniles from a prosocial lifestyle and limits potential positive outcomes (Lambie & Randell, 2013). Juveniles are detached from law-abiding society and are attached to antisocial peers which can lead to negative outcomes (Bayer et al., 2009). Juveniles are also highly susceptible to peer influence and who they are incarcerated with influences their attitudes toward society, beliefs, aggressive behaviors, and emotional and social skills (Stevenson, 2017). Bayer et al. (2009) found peer effects can reinforce existing behavior and peers can increase knowledge about specific crimes therefore influencing juveniles to return to committing the crimes they already had some experience in upon release. When juveniles are placed in incarceration with peers with common histories, the creation and expansion of criminal networks may become the result (Bayer et al., 2009).

Current rehabilitative policies in the juvenile justice system focus on rehabilitating youth and diverting them from the formal juvenile court system and incarceration (Abrams, 2013). Probation is the most used disposition for formally processed cases however, due to the number of probation requirements placed on the juvenile, many juveniles violate probation requirements which can result in rearrest, detention, incarceration, or longer probation which ultimately can lead to continuations in the justice system cycle (Dir et al., 2021; NeMoyer et al., 2014; Mendel, 2018; Steinberg, 2009). Additionally, when probation officers have high caseloads, they are unable to adequately address the needs of each juvenile. Therefore, probation is ineffective on its

own, court-ordered requirements should be limited, and probation may be paired with a therapy program to help aid in reducing juvenile offending behaviors.

Therapies can be an effective alternative to incarceration with aiding in reducing juvenile offending behavior however, moving forward effective treatments must continue to be multidimensional in nature that target multiple risk factors (May et al., 2014; Mendel, 2011), be flexible and comprehensive, must be individualized to fit the specific needs, strengths, and weaknesses of juveniles and their families (Lambie & Randell, 2013; Tarolla et al., 2002), reduce the risk of negative peer exposure (Belenko & Logan, 2003), and be active in allowing the juvenile to be involved in their success (Belenko & Logan, 2003). Juveniles have unique psychological, emotional, and developmental needs (Abrams, 2013). A punishment or treatment that works for one individual may not work for another. Therefore, individualized programs are essential in effectively reducing juvenile offending behaviors.

Effective alternatives to incarceration, such as probation and therapy programs, should also be utilized due to most juveniles being adolescent-limited offenders who will naturally mature and desist from delinquency and grow out of their offending behaviors either on their own (Lambie & Randell, 2013; Moffitt, 1993) or with the right guidance (Nellis, 2011). Criminal behavior typically peaks in adolescents and declines gradually in older age groups and by the early 20s, the number of active offenders decreases by over 50% (Moffitt, 1993).

However, when juveniles become involved in the justice system, the opportunity for them to age out of offending behavior is limited (Lambie & Randell, 2013) and once a juvenile becomes involved in the juvenile justice system, there is a higher likelihood the juvenile will remain involved with the system into adulthood (Gilman et al., 2015). Therefore, Lambie and Randell (2013) suggest that it is only possible for a juvenile to grow out of delinquency if

alternative, more adaptive coping resources and strategies are developed where the juvenile can mature without being pulled further into the justice system (Mendel, 2018). A juvenile's brain is not fully developed therefore, how the system is placing juveniles during this critical maturation time is highly important and may have long-lasting effects. Therefore, to reduce offending behavior and future court involvement, whether formally or informally, juveniles could be placed in community-based and empirically supported interventions whenever possible (Lambie & Randell, 2013) and the use of therapy can be highly effective in reducing juvenile offending behaviors.

This research, however, does have limitations. To evaluate the effectiveness of juvenile rehabilitative approaches multiple research studies including meta-analyses and experimental designs were analyzed. When examining research studies, the study sample size and sample demographics were considered to offer more generalizable findings therefore, research designs with a low sample size were not selected to be used in this evaluation. This evaluation looked at a small sample of research studies therefore, meta-analysis research studies were preferred to offer an evaluation of more research studies however, data was limited when evaluating certain therapy programs. The research studies chosen to be analyzed were not randomly selected therefore this evaluation is not a random sample of all literature. Additionally, there is no single risk factor that can be attributed to offending behavior and multiple risk factors increase the odds of offending (Pyle et al., 2016) therefore while therapy programs can target multiple risk factors, there may be additional risk factors that therapy is unable to target. However, alternatives, including therapy programs, can offer a juvenile the ability to mature outside of the justice system while targeting certain offending risk factors.

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