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Applying a Mixed Methods Approach to Understanding and Evaluating the Effects of Family Treatment among Sexually Abusive Youth

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Applying a Mixed Methods Approach to Understanding and Evaluating the Effects of Family Treatment among Sexually Abusive Youth

A Dissertation

Presented to

the Faculty of the Graduate School of Social Work

University of Denver

In Partial Fulfillment of the Requirements for the Degree

Doctor of Philosophy

by

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Advisor: Kimberly Bender, PhD
Abstract

Families are frequently identified as a risk for supporting and perpetuating sexually abusive behavior among youth. Traditionally, the field has focused on deficits of families rather than considering them as a resource to promote change. Although emerging literature strongly argues the need to target families in the healing process, treatment initiatives rarely follow suite, and research has failed to comprehensively document the effectiveness of family-inclusive treatment. Knowing there are several gaps in literature, the current study was conducted to investigate the process of engagement in treatment, understand the nuances of family treatment, and to uncover positive outcomes associated with family involvement. An embedded mixed methods design was carried out in collaboration with the Colorado Sex Offender Management Board. Quantitative data were collected from probation files of adjudicated youth (N = 85) in three different Colorado jurisdictions, and qualitative data were collected from approved Colorado treatment providers (N = 19). Rigorous data analyses techniques were employed, including a qualitative Grounded Theory approach using structural, values, and focused coding schemas to analyze qualitative data and logistic regression models to analyze quantitative data. Qualitative results reveled the high level of stress among families and underscored the therapeutic relationship and treatment components as reciprocal provisions of treatment, whereby one is contingent upon the other for ethical service
delivery. Quantitative logistic regression models demonstrated that youth with greater family service involvement (measured on a continuous scale composed of constructs of family therapy, multi-family group, family multi-disciplinary team, informed supervision, and family reunification) were three times more likely to successfully complete treatment than those who did not receive any family services. A conceptual model emerged that revealed strategies to move families through the treatment process. Inherent implications suggest that: crisis prevention initiatives are important to avert high levels of family stress; current treatment frameworks should be revised to include family protective factors; critical mechanisms of change should be tested quantitatively; and family services should occur uniformly. Overall, future research steps should detail a manual for how to pragmatically move families through the treatment process, test the effectiveness of that manual, and then disseminate effective methods to the provider community.
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Chapter One: Introduction

Social problem: Sexually abusive youth

Sex is largely perceived as a taboo topic in American culture (Ryan, Leversee, & Lane, 2010a). When a person commits a sex crime, it can have damaging effects on the victim, impacting self-esteem, daily functioning, and lifestyle (Brown & Finkelhor, 1986; Resnick, 1993). The offense may also have a negative impact on the offender and his and her family, where they are perceived as problematic, deviant, or abnormal, they and their families are often held personally responsible for the crime, and the crime results in increased legal, educational, and social service interventions (Letourneau, 2006; Ryan, Leversee, & Lane 2010a; Steele & Ryan, 2010). It is also a fear that sex offenders are at risk for becoming long-term, chronic, and deviant members of society (Steele & Ryan, 2010). Because of these deleterious consequences for both the victim and offender, sex offending has become a serious social concern (Ryan, Leversee, & Lane 2010a).

As efforts are made to deter or ameliorate the problem, public safety and security become paramount (Davis & Leitenberg, 1987; Lobanov-Rostovsky, 2010). With the emergence of heinous sexual crimes committed against children in the 1990’s and early 2000’s and because sensationalized media coverage intensified the effects, the public is acutely aware of the threat that sex offenses pose (Lobanov-Rostovsky, 2010). As a result of these highly publicized events, American society has garnered widespread generalizations and myths concerning types of offenders and level of risk. Sex offenders,
irrespective of developmental, contextual, interpersonal, or environmental differences are depicted as extremely dangerous (Chaffin, 2008; DiCataldo, 2009; Lobanov-Rostovsky, 2010). These pervasive sentiments have lead to adverse effects for juveniles and their families (Chaffin, 2008; DiCataldo, 2009).

Fear, punishment, and restraint are common responses to sexual abuse (Lobanov-Rostovsky, 2010). Because adult sex offenders have typically reported that their offending behaviors began during adolescence (Longo & Groth, 1983), policies were instituted that promoted a methodical response to preventing sex offending behavior into adulthood including prosecution, legal accountability, mandatory treatment, earlier intervention, and adjudication (Lobanov-Rostovsky, 2010). As well intentioned as these approaches were in addressing the problem with juveniles, it soon became more common to use punitive approaches as a mode of response (Lobanov-Rostovsky, 2010). A “trickle down phenomenon” was built into treatment in effort to apply adult based sanctions to adolescents committing similar crimes (Longo & Prescott, 2006). Sex offender treatment has operated under the assumption that juveniles will have similar re-offending trajectories as adults, punitive reactions will prevent future offenders, and deviant behaviors are unchangeable (Letourneau & Miner, 2005; Caldwell, 2007).

As more knowledge is surfacing and research is evolving, the field is responding accordingly with a more rehabilitative treatment philosophy. Research continues to dispel commonly held myths that the majority of sexually abusive youth are dangerous criminals (Reitzel & Carbonell, 2006; Worling & Curwen, 2000). Recidivism studies consistently find significantly lower sexual re-offending rates for juveniles, and even
lower rates upon successful completion of treatment (Reitzel & Carbonell, 2006; Ryan, Leversee, & Lane, 2010a; Vandiver, 2005; Worling & Curwen, 2000).

With research illuminating these stark differences, the field has begun to recognize that sexually abusive youth are more like general delinquent youth than adult sexual offenders (Ryan, 2010b). Typologies have been established for sexually abusive youth (Ryan, Leversee, & Lane, 2010a), and many youth do not fall into a pedophilia (Gunby & Woodhams, 2010) or a callous and un-emotional category (White, Cruise, & Frick, 2009); rather they are categorized as having psychosocial deficits or internalizing symptoms (Hunter et al., 2003; Hunter, 2006; 2008), having delinquent or externalizing behavior problems (Miner et al., 2010), or a co-occurring mental disorder (Cavanaugh, Pimenthal, & Prentky, 2008; Leversee, 2010a). Furthermore, the field is increasingly recognizing the need to consider integrating fundamental systems, such as the family, into treatment in effort to address contributing factors and ultimately re-shape beliefs, attitudes, and behavior patterns among youth and their families (Ryan, 2010c).

Despite the move towards a rehabilitative treatment philosophy, many challenges remain. Some youth are resistant to treatment, remain in denial, or minimize the offense. Also of concern is the fact that the largest portion of juvenile offenses involves abuse of younger children as opposed to boundary or harassment offenses on peers or adults (Ryan, Leversee, & Lane, 2010a). With this, the field continuously attempts to strike a balance between containment and rehabilitation, with a focus on public and community safety.

**Definition of deviant sexual behavior and abuse.** Behavior is considered to be deviant when it goes against societal norms of a particular culture (Barbaree & Marshall,
There are significant disparities between cultures related to deviant sexual behavior, particularly pertaining to juveniles, and often times cultural values and norms dictate acceptable and unacceptable sexual behaviors (Steele & Ryan, 2010). Specifically in American culture, society endorses the attitude that any sexual behavior exhibited in childhood or adolescence is taboo (Martinson & Ryan, 2010). America has been known to function under a “protective paradigm” where parents shield their children from sexual knowledge or exploration of any kind (Martinson & Ryan, 2010, p. 32). Contrary to what society may believe, children have sexual capacities and express sexual desire and interest. Therefore, developing an understanding of the “normal” developmental course of “healthy” or “appropriate” sexual behavior is often necessary (Martinson & Ryan, 2010).

However, complications lie in establishing comprehensive agreement on what deviant sexual behavior looks like during this evolving developmental period (Barbaree & Marshall, 2008), as the malleability of sexual arousal patterns during adolescence suggests that even strong deviant arousal patterns change over time (Worling, 2012). Furthermore, only a small percentage of adolescents even appear to have deviant sexual arousal related to their inappropriate sexual behaviors (Worling, 2012). Even so, some standards have been developed in effort to define youth sexual deviance. One well accepted definition is: youth sexual deviance is when children under the age of eighteen engage in abnormal sexual behaviors that are uncommon for their developmental stage (Barbaree & Marshall, 2008), and a common form of sexual deviance is a sexual offense committed by a youth.
A person who committed a sexual crime under the age of eighteen who has been adjudicated in a criminal court for the offense may be labeled a “sexually abusive youth” or also referred to as a “juvenile sex offender” (Barbaree & Marshall, 2008). Sex crimes are defined as “sexually abusive behavior committed by a person that is perpetrated against the victim’s will, without consent, and in an aggressive, exploitative, manipulative, or threatening manner” (Ryan, 2010a, p. 3). However, the acts alone should not be a conclusive factor in assessing behavior. Defining sexual abuse is not always easy and clear. Other considerations such as relationships, impact, age, consent, coercion, and equality must be taken into account (Ryan, 2010a). In evaluating sexual behavior among juveniles, it is important to consider whether sexual behavior was welcome, consent was received (age of consent varies by state), level of force, and modus operandi. Furthermore, the issue gets even more complex when age is taken into account. As the age difference narrows, the relationship, dynamics, and intrusiveness of the behavior requires extensive appraisal. Also, proving inequalities between the youth is another consideration in defining abuse. If there are not clear physical, cognitive, and emotional inequalities among youth, it can compound the assessment (Ryan, 2010a). As such, unbiased and in-depth evaluations are required to make determinations of abuse.

**Types of offenses.** There are a variety of different offenses that juveniles commit. Molestation is a type of offense that includes “touching, rubbing, disrobing, sucking, exposure to sexual materials, or penetrating behaviors” (Ryan, 2010a, p. 3). Rape has been defined as an unwanted sexual behavior that uses force and often includes “oral, anal, or vaginal and digital, penile, or objectile penetration” (Ryan, 2010a, p. 3). Hands-off offenses include exhibitionism, or exposure of genital regions, frottage, or rubbing
against others, peeping/voyeurism, or watching others without their consent, fetishism, or
masturbating in one’s underwear, stealing items of clothing, or urinating on a victim, and
“obscene communication”, or technological means of sexual harassment (Ryan, 2010a, p. 3). Male adolescents who offend peers and adult females tend to be more aggressive and
violent, and are more likely to commit nonsexual crimes, compared with juveniles who
offend against children; these youth have been found to have deficits in psychological
functioning and offending behaviors tend to be less aggressive (Hunter et al., 2003; Hunter, 2006).

Prevalence

Examination of frequency, degree, and duration of youth sex crimes can inform
better understanding of this heterogeneous group. Some literature suggests that juveniles
commit upwards of 60% of all child sexual abuse (Longo & Prescott, 2006). Other, more
conservative estimates suggest that juveniles are perpetrators of approximately 30% of all
child sexual abuse (Ryan, 2010e). The Center for Sex Offender Management indicates
that approximately one-fifth of all rapes and one-half of all sexual child molestation can
be accounted for by juveniles (Hunter, 1999). Official record data from recent years has
more succinctly highlighted the frequency, trends, and characteristics of sex crimes
committed by juveniles.

Official record data. The Office of Juvenile Justice and Delinquency Prevention
indicates that 15% of all persons arrested for forcible rape in 2009 were juveniles under
the age of eighteen (2012a). The total number of juvenile arrests in 2009 for forcible rape
was 3,100 (OJJDP, 2012a). This rate has declined throughout the years with forcible rape
perpetrated by juveniles decreasing every year since 1991, when it was at its peak
(OJJDP, 2012a). In 2009, the arrest rate for forcible rape by juveniles had reached its lowest level since 1980 (OJJDP, 2012a). OJJDP also reports that 17% of all persons arrested for a sexual offense (other than forcible rape) in 2009 were juveniles under the age of eighteen (2012a). The total number of juvenile arrests in 2009 for sex offenses was 13,400 (OJJDP, 2012a). This trend has also declined throughout the years with arrests for juvenile sex offenses decreasing 23% since 2000 (OJJDP, 2012a).

**Demographic characteristics of sexually abusive youth.** Juvenile males contribute to the majority of sex crimes committed by youth. Although only 2-4% of all adolescent males have committed a sexually assaultive behavior (Barabee & Marshall, 2008), males account for 91-93% of all the reported juvenile sex crimes (Ryan, 2010e). This is consistent with reports that females account for an estimated 2-11% of incidents of sexual offending (Righthand & Welch 2004). Literature provides estimates for specific offenses committed by males, where adolescent males are responsible for 20% of all rapes and 30-50% of all child molestation (Barabee & Marshall, 2008).

Official record data reveals that among youth with an open criminal court case for forcible rape during 2009, 28% were African American youth, 3% were American Indian youth, 1% were Asian youth, and 68% were White youth. Similarly, among youth with an open criminal court case for other sexual offenses (other than forcible rape), 32% were African American youth, 1% were American Indian youth, 1% were Asian youth, and 66% were White youth (OJJDP, 2012a). This data corresponds with other literature that suggests that Caucasian males are the pre-dominant group responsible for the majority of sexual offenses (Ryan & Lane, 1997).
**Victims.** The majority of victims of sex crimes committed by juveniles are children (Ryan, 2010a; Longo & Prescott, 2006). Ages of sex abuse victims can vary, but research shows that victims are on average between 7 and 8 years of age (Ryan & Lane, 1997). Sexually abusive youth often perpetrate on victims who are younger, and the majority of victims are relatives or acquaintances (Longo & Prescott, 2006; Ryan, 2010a). In fact, research has estimated that upwards of 45% of the victims are siblings or other family members living in the same household (Ryan, 2010a). Although more rare, offenses on strangers are often times more violent in nature (Woodhams, Gillet, & Grant, 2007). Girls are the most common targets for juvenile sex crimes, however some studies indicate that boys represent up to 25% of victim samples (Righthand & Welch, 2004). Earlier data supports this research, indicating that girls are most commonly victims of juvenile sex offenses (Ryan & Lane, 1997).

**Under reporting.** Official record data and other research may offer conservative measures of sexual offense because statistics may grossly underestimate the “real” problem of juvenile sex offending. Primarily because offenders fear exposure and victims harbor feelings of guilt, trauma, and anxiety, youth offenders and victims tend to under report incidents of sex offending (Ryan, 2010e). Victim self-reported sexual abuse is a common method by which many sex crimes committed by juveniles are uncovered. Even still, the reliability of self-reporting has been speculated (Stinson, Sales, & Becker, 2008). Many authors have argued that self-report data are biased and involve deliberate depiction, socially desirable results, and distorted beliefs from those reporting (Stinson, Sales, & Becker, 2008).
Under reporting also occurs when there are limitations in methodological approaches. Many samples of sexually abusive youth, including the above mentioned official record data are drawn when the offender was arrested, currently in detention, probation, in treatment, and has been adjudicated of the offense. Thus, these samples only incorporate youth that were detained which markedly fails to account for all those who are not apprehended (Stinson, Sales, & Becker, 2008).

**Risk factors**

It is important to understand those factors that increase youths’ risks for offending or re-offending so such factors can be targeted in assessment and treatment. Because sexually abusive youth are a heterogeneous group, there are a variety of risk factors that contribute to the initiation and continuation of inappropriate sexual behavior (Worling & Langstrom, 2008). Moreover, properly labeling youth with appropriate level of risk without bias and judgment can inform objective and impartial treatment responses (Worling & Langstrom, 2008).

It has been assumed that sexually abusive youth were comparable to adult sexual offenders in regards to risks they posed to society (Ryan, 2010b; Vandiver, 2005). With research now proving that juveniles reoffend substantially less than adults (Vandiver, 2005; Worling & Curwen, 2000; Reitzel & Carbonell, 2006), sexually abusive youth are more likely to have characteristics that mirror those of general juvenile delinquents (Ryan, 2010b). Inquiry into the differences and similarities between juvenile sexual offenders and non-sexual offenders helps to identify salient risk factors. Determining what factors distinguish juvenile sex offenders apart from their non-sexual offender counterparts may illuminate risk factors pertinent to each group (Seto & Lalumiere,
The two groups may also share similar risk factors because of the likeness between them (Ryan, 2010b).

**Static, stable, and dynamic factors.** Static risk factors (factors that are unchangeable), stable risk factors (factors that have potential to change but are life spanning), and dynamic risk factors (factors that are situational and can change at anytime) should be considered when conducting youth assessments (Longo & Prescott, 2006; Ryan, 2010b; Rich & Longo, 2003). Evaluating static or historical components can foster understanding of early life experiences influencing behavioral development (Leversee, 2010b) and necessitate empathetic and non-blaming techniques throughout treatment (Longo & Prescott, 2006). Inquiry into static factors explaining sexual offending initiation has therapeutic implications, but dynamic factors are critical for determining continuation of behavior and should be incorporated as targets for intervention (Ryan, 2010b; Rich & Longo, 2003). For example, specific characteristics of families have been viewed as both static and dynamic risk factors, in that family systems issues (such as mental health, communication and boundary difficulties, and substance abuse) may contribute to offending, but caretakers and other extended family members may have protective factors (and they may be engaged in treatment with the youth) that mitigate risk factors and the trajectory of sexually behavior (refer to the family typologies in Chapter Two); Leversee, 2010b). Furthermore, identifying characteristics rooted in stable risk factors may be beneficial for altering youth functioning (Ryan, 2010b). Nevertheless, all three risk factor typologies are relevant to sexual abuse outcomes and are included in rigorous risk assessments to inform etiology and make determinations of factors that can decrease the chance of recidivism.
Family as a risk factor

Professionals have argued that factors putting youth at risk for inappropriate sexual behavior originates during early life experiences and that the family environment can account for this manifestation (Baker et al., 2003; Ryan, 2010c). Accordingly, family is considered to be a notable dynamic variable in explaining sex offending behavior and can be considered a risk factor for future re-offense (Ryan, 2010c; Righthand & Welch, 2004; McMackin et al., 2002; Baker et al., 2003; Worling & Langstrom, 2006). It is not to suggest that family environments cause sexual behavior problems, but rather there are family circumstances, dynamics, and characteristics that make youth more vulnerable to sexually acting out.

Risk factors influencing initiation of sexual offending: Unique family factors.

When comparing sexually abusive youth to general delinquent youth, research has identified unique family factors that contribute to sex offending. For example, juveniles who derive from families that tell more lies and are involved in more taboo behaviors are at a greater risk to sexually offend than to be delinquent (Baker et al., 2003). A large meta-analysis also demonstrated that there are differences according to early familial trauma experiences, where sexually abusive youth (compared to general delinquent youth) have been exposed to more maltreatment, particularly physical and sexual abuse (Seto & Lalumiere, 2010). In fact, sexual victimization may be a critical risk factor (Leibowitz, Laser, & Burton, 2011). Within samples of youth who sexually offend, sexually victimized youth (compared to youth who were not sexually victimized) have more severe antecedents of trauma and family dysfunction and exhibit more adjunct sexual aggression, sexual arousal, and criminal behavior (Burton, Duty, & Leibowitz,
Moreover, indirect forms of maltreatment are experienced more frequently, where exposure to nonsexual violence and emotional abuse and neglect was found to be higher among families of sexually abusive youth compared to families of juvenile delinquents (Seto & Lalumiere, 2010). These findings point to the importance of recognizing that some risk factors may uniquely contribute to sexual offending behavior.

**Family factors influencing initiation of sexual offending: Common risk factors.** Conversely, other research suggests that sexually abusive youth originate from family systems comparable to juvenile delinquents. In fact, sexually abusive youth and juvenile delinquents share many family characteristics that put them at equal risk for offending (Seto & Lalumiere, 2010). The above-mentioned meta-analysis was unable to find definitive differences among sex offenders and general delinquents in regards to early family experiences, where family dysfunction (including communication problems, family substance abuse, and family criminality) was found to be common between both groups (Seto & Lalumiere, 2010). The findings do not suggest that family dysfunction (and its potential to interact with other variables) does not explain the occurrence of sex offending (Seto & Lalumiere, 2010), but underscores the presence of common risk factors present among both groups (Van Wijk et al., 2006; Ryan, 2010b). It may be that there are similar developmental pathways leading to different behaviors, and it is therefore inaccurate to assume sexually abusive youth are a distinct group (Smallbone, 2006).

Research has suggested that there are many other family factors that increase the likelihood that youth will engage in sexual offending behaviors. Youth who originate from families characterized by high stress and dysfunction (Righthand & Welch, 2004) in
the form of caregiver instability or inconsistency, a weak parent-child bond, premature exposure to sexual concepts, high-risk environment for sexual abuse or exploitation, and limited resources for family coping upon abuse disclosure puts them at an increased risk to be sexually abusive (Barbaree & Langton, 2006). Family chaos, parental marital discord, parental absence or neglect, and history of abuse within the family are additional markers of risk for sexually abusive behavior (McMackin et al., 2002). Furthermore, sexual risk factors within the family (including incest or sexual deviance) have been found to be associated with the development of sex offending behaviors (Ryan, 2010c).

Although some forms of early trauma differentiate sexually abusive youth from general delinquent youth, trauma has been found to be a widespread risk factor. Experiencing familial trauma and maltreatment in the form of victimization, witnessing abuse, or indirect maltreatment will increase the likelihood that youth will sexually offend (McMackin et al., 2002; Veneziano & Veneziano, 2002; Seto & Lalumiere, 2010). Trauma is so pervasive that in some samples, 95% of sexually abusive youth had endured some type of traumatic experience (McMackin et al., 2002).

Family separation and disruption in care is another risk factor that can lead to the initiation of sex offending (Ryan, 2010c; Righthand & Welch, 2004). Many youth are living outside of the home at the time of offense (McMackin et al., 2002), where residential placements, foster care, adoptions, and placements with extended relatives are commonplace (McMackin et al., 2002; Ryan, 2010c). Research has previously declared that 50% of juvenile sex offenders report some type of parental loss (subjective accounts of divorce, displacement from the home, lack of attachment, death, or hospitalization).
(Ryan & Lane, 1997). In one sample, only 28% of juveniles were living with both biological parents at the time of the offense (Ryan, 2010c).

**Family factors influencing continuation of sexual offending.** Undoubtedly, family is a prominent risk factor predicting the initiation of sex offending behavior. It has also been identified as a risk factor that can influence the continuation of sex offending (Ryan, 2010b). Youth are at a greater risk for sexual recidivism when relationships with parents are unstable (Worling & Langstrom, 2006). How youth perceive these relationships are also important. Youth may internalize various feelings surrounding parental relationships, including anger, abandonment, depression, or loneliness (Worling & Langstrom, 2006). The more youth report feeling rejected from parents, the more likely they are to reoffend sexually (Worling & Curwen, 2000). These relationships may place them at a higher risk for violent re-offenses. In a meta-analysis analyzing risk factors for future offending, Lipsey & Derzon (1998) argued that certain aspects of poor parent-child relationships, such as low-warmth, low parental involvement, punitive discipline, and negative attitudes towards the child were related to violent sexual and non-sexual recidivism. Additionally, a highly stressful environment is family factor that has been found to influence both sexual and non-sexual violent re-offending (Lipsey & Derzon, 1998).

Clearly, there are factors within families that have been identified as risks for supporting and perpetuating sexually abusive behavior. As research has increasingly demonstrated the risk families pose, risk assessment guidelines now account for discorded parent-child relationships (Leversee, 2010b). Many risk assessments currently include family dynamics and relationships as an important variable that can be targeted in
treatment (Leversee, 2010b). With assessment literature strongly arguing the need to target family in healing process, treatment initiatives need to follow suit (Ryan, 2010c). The treatment process can be enhanced through the inclusion of family factors considered by the literature as dynamic and risky. Adapting treatment in this way is crucial if the field seeks to move away from a containment philosophy in which adult based models are applied to a highly vulnerable population.

**Alternative risk factors**

Although families may poses characteristics that are risk factors for sexual behavior problems, there are numerous other variables that can be attributed to the manifestation of the behavior. A plethora of other factors have been linked to inappropriate sexual behaviors, such as personal characteristics and temperament (Becker, 1998), cognitive behavioral patterns and maladaptive coping styles (Ryan, 1989), or learning sexual concepts through exposure or personal victimization (Burton, 2003). Individual factors such as deviant sexual interests (Worling & Curwen, 2000), prior criminal sanctions (Langstrom, 2002), having more than one victim (Worling, 2002), being impulsive (Rich, 2001), having an attitude that is suggestive of blaming the victim (Thornton, 2002), and social factors such as having limited social contacts, poor social skills, weak relationships with peers, and overall social isolation (Lipsey & Derzon, 1998; Kenny et al., 2001) have further been identified as risk factors (Worling & Langstrom, 2006).

**Family as a protective factor**

Protective factors are referred to as inherent youth characteristics, environmental supports, or the availability of external resources to buffer against risks (Jenson & Fraser,
Families can be perceived as a protective factor that not only safeguards youth from engaging in sexual offending behaviors, but also mitigates the effects of such behaviors (Worley et al., 2011). Research has shown how positive parent-child relationships, parental monitoring, supervision, consistent discipline, and open discourse surrounding family values are protective factors that can avert unhealthy behaviors (Ary et al., 1999; Kumpfer & Alvarado, 2003). Although research is lacking in identifying specific family protective factors that prevent sexually abusive behavior, which can be correctly attributed to the overwhelming attention to family as a risk, some professionals have begun to recognize inverse risks as protective factors (Worley et al., 2011). Literature has illuminated factors such as family cohesion, positive interaction patterns, and healthy family functioning as characteristics that may serve as protective factors for these youth (Worley et al., 2011). However, because most of the research focuses on the risk posed by families, the field has sparingly acknowledged the idea that families poses characteristics that can prevent or reduce inappropriate sexual behavior. This dissertation argues that families not only have protective capacities, but that they are a crucial protective factor needed to guide youth through treatment.

**Interface of risk and protective factors**

A risk and resiliency framework explains how certain internal or external factors promote or constrain positive youth development (Jenson & Fraser, 2010). Although youth have certain factors that place them at greater risk for negative outcomes, they also have strengths and assets. To help youth adapt or recover from negative or stressful events, risk factors are reduced, and to mitigate risks, protective factors are enhanced (Laser & Nicotera, 2011). Although this interface is highly valued in aiding youth to
overcome adversity or maladaptive circumstances (Laser & Nicoterra, 2011), treatment
for sexually abusive youth has primarily been focused on reducing risks that include
sexual deviancy, inappropriate sexual thoughts, social isolation, antisocial behaviors,
predatory elements, level of coercion, or intimacy deficits (Miccio-Fonseca, 2011;

Work with families of sexually abusive youth can extend beyond merely
conceptualizing and reducing risk. Nuanced protective factors can be identified and
integrated into treatment to achieve a balanced approach that values both risk reduction
and asset enrichment. Protective factors inclusive of family cohesion, positive
interactions, family time, presence, or availability, and close connections (Worley et al.,
2011) can be enhanced so youth can draw on inherent family strengths to buffer from
existing risks. Valuing both perspectives in treatment is necessary to help youth
overcome sexual behavior problems.

Risk assessments

Risk assessments are used to determine how certain risk factors increase the
likelihood that the youth will re-offend (Caldwell, 2002; Prescott, 2005; Worling &
Langstrom, 2003). Linking those factors with a reduction in recidivism has important
treatment implications (Leversee, 2010b; Ikomi, 2008). Assessments are structured to
evaluate risk factors that ultimately determine what treatment setting is most appropriate,
the recommendations for continued supervision, estimations of length of treatment,
placement needs (often guided by risk level), static and dynamic risk factors, and to
estimate youth and family amenability to treatment (Leversee, 2010b). Assessment of
youth risk should continue throughout the course of treatment (Leversee, 2010b). Times
during which youth receive assessments are pretrial, presentence, post-adjudication, pre-release, termination of treatment, and monitoring or follow-up (National Task Force on Juvenile Sex Offending, 1993). A trained clinician executes the presentence evaluation and the risk level (low, medium, or high) is often ascertained at this time (Leversee, 2010b). The multi-disciplinary team often conducts the additional assessments as a method of managing and evaluating ongoing treatment (Leversee, 2010b).

Assessment protocols can occur in both actuarial and clinical form (Leversee, 2010b). Actuarial assessments are standardized assessment protocols whereas clinical assessments are risk assessments as measured by the clinical judgment of treatment providers. Actuarial assessment methods have been found to be superior to clinical assessments in the ability to predict re-offense (Caldwell, 2002; Garb, 1998; Grove et al., 2001), and arguments for the subjective nature of clinical assessments may dissuade professionals from using them (Hanson, 2000; Hoge, 2002; Prescott, 2005). Despite the wide use of actuarial methods, there are no empirically validated risk protocols for sexually abusive youth (Bumby & Talbot, 2007). Nevertheless, they continue to be used as the primary mode of predicting recidivism. Some of the widely used assessments include the Estimate of Risk of Adolescent Sexual Offense Recidivism (ERASOR) (Worling & Curwen, 2001) and The Juvenile Sex Offender Assessment Protocol (JSOAP II) (Prentky & Righthand, 2003; McGrath et al., 2003).

Although the goal is to assess for components that will most likely lead to re-offending (Leversee, 2010b), up until the past few decades, many assessments did not incorporate salient risk factors (Worling & Langstrom, 2003). However, with advances in field knowledge, many domains have been added to assessments to ensure they are both
comprehensive and individualized (National Task Force on Juvenile Sexual Offending, 1993; Righthand & Welch, 2001; Ryan & Lane, 1997), despite the challenges that arise in finding this balance (Leversee, 2010b). Comprehensive assessments incorporate domains inclusive of both static and dynamic influences, such as the family. Family development and history as well as current risks, assets, and functioning of the family are pertinent factors for all sexually abusive youth, and are included in risk assessments (Leversee, 2010b).

Risk assessments are vital because they ultimately play a role in how treatment is carried out. A framework that often guides treatment is “risk, need, and responsivity” (Andrews & Bonta, 2003; Andrews, Bonta, & Hoge, 1990; Leversee, 2010b, p. 202). This “risk principle” asserts that length and severity of treatment is structured around the risk indicated in the assessment (Leversee, 2010b, p. 202). Therefore, youth should receive a treatment approach that corresponds to their level of risk (Leversee, 2010b). So, knowing this, treatment should also strike a balance between individualized and comprehensive, and target both static and dynamic factors.

**Objectives and intentions of this dissertation**

This study aimed to identify how and why families are a particularly important system in the lives of sexually abusive youth. This dissertation focused on understanding not only successful outcomes of family treatment, but also the process by which families participate in treatment. Two methodological approaches were used in addressing areas of inquiry. This dissertation has been organized by research aims with subsequent research questions to address the aims. The first over-arching research aim guiding this study was, “Understanding the process of family-inclusive treatment.” Three research
questions were then formed to better understand how families progress through treatment. These questions were:

   Research question 1: “What prohibits family involvement in treatment?” This question has been answered through both quantitative and qualitative inquiry. This question seeks to understand families’ perceptions and reactions to the sex offense and the specific barriers that are present that deter their engagement in treatment. Understanding how families react to the sex offense has illuminated the extent to which this is a stress-producing event, and has clarified the meaning families place on the sex offense, how they cope with it, and how this may ultimately be a challenge of engagement.

   Research question 2: “How do providers engage families in treatment?” This question has been answered through qualitative inquiry into components that initiate involvement in treatment. The question sought to understand the strategies treatment providers use to overcome the challenges and get families engaged.

   Research question 3: “What does family treatment entail, and what factors are responsible for helping families progress through treatment?” This question has been answered through qualitative inquiry into treatment providers’ use of differing tools and techniques in helping families heal from the pain, overcome the hardship, and re-unite as one unit.

   The second overarching research aim is, “Understanding how families contribute to positive outcomes” Specifically, this aim addresses the following research question:

   Research question 4: “Are family services associated with positive outcomes?” This question has been answered through quantitative inquiry into the cumulative effect
of various treatment approaches predicting successful treatment completion and recidivism rates. This question has also been answered through qualitative inquiry into treatment providers’ perspectives of positive outcomes resulting from family treatment.
Chapter Two: Literature Review

This chapter will feature relevant literature that explores family typologies and distinctive family characteristics and dynamics. This chapter will also illuminate the various reactions to youthful offending, and some of the ways families may respond and perceive this event. The degree of stress families undergo as a result of the offense is understood through the context of Family Stress Theory (Hill, 1958; McCubbin & Patterson, 1983). This theory is a framework to ascertain a greater understanding of the problem. Because much of the literature on family dynamics, characteristics, and responses emphasize family deficits, families will be addressed from strengths-based approach in which they are argued to be a protective factor rather than a risk. Perceiving families in this manner suggests that they can be an agent for change. This section aims to not only enumerate the importance of family, but to also suggest that it is a critical system responsible for eliciting change. Therefore, current treatments modalities that have traditionally addressed individuals and groups along with intervention approaches for each will be outlined. This will be followed with a section that details some emerging approaches to integrate families into services.

Family typologies

Families of sexually abusive youth can be considered heterogeneous, composed of many different dynamics and environments (Ryan, 2010c). Although every family is unique, the field has increasingly acknowledged that families of sexually abusive youth
can be classified into categories. Typologies have been established by recognizing that there are specific patterns and traits common to families (Ryan, 2010c). The formation of typologies has advanced a more ample understanding of the context in which sexually abusive behavior has transpired. Moreover, literature has indicated that the degree to which these typologies are present among families is related to the severity of the offense (Ryan, 2010c). For example, youth deriving from families characterized by high amounts of rigidity or enmeshment are at a high risk for demonstrating violent and severe abusive behavior in their offending patterns (Smith & Monastersky, 1987). The different family typologies will be explored further including enmeshed and rigid families, disengaged families, and the “ideal” family. Another characteristic prominent in families of sexually abusive youth that does not necessarily qualify as a typology - the high prevalence of secrets – will also be discussed at length.

**Enmeshed and rigid.** Rigidity and enmeshment are reciprocal typologies, where rigid families are very enmeshed and enmeshed families are very rigid. There is a sense of “codependency” and insecurity that permeates the family system (Ryan, 2010c, pg. 152). Enmeshed families may be completely dependent on members in the system for their happiness and security. The parent-child relationships are frequently interchangeable, where children find themselves aberrantly exposed to adult material that is inappropriate for their age (Ryan, 2010c). In many of these families, the mother establishes an incongruous emotional connection with her son that encourages codependency (Ryan, 2010c). In these families, the sexually abusive youth is theorized to
commit the offense as a way to escape the mother and exert autonomy (Lankester & Meyer, 1986).

Certain families of sexually abusive youth are also very rigid, where they are secretive and isolated. Research has suggested that families of sexually abusive youth have extreme scores on adaptability on the FACES scale, indicating levels indicative of rigidity (Bischof, Stith, & Wilson, 1992). Rigid families have very poor boundaries, particularly when it pertains to sexual materials, where they may have many taboo behaviors in the home (Ryan, 2010c). In these families, members often depend on individuals within the family system for supports, rather than looking to the external environment (Ryan, 2010c). When others become involved in their lives, these families perceive this as “intrusive” and invasive (Ryan, 2010c, pg. 152).

**Disengaged.** Families of sexually abusive youth can also be disengaged or inattentive. Research shows that some families of sexually abusive youth demonstrate low scores on cohesion and family communication and satisfaction (Thomas & Olson, 2007), indicating high levels of disengagement. In these families, youth are left on their own and receive poor supervision and monitoring. Families like this often fail to institute rules, expectations, or control within the system (Ryan, 2010c). In fact, many disengaged families are the catalysts from which incest abuse occurs. Youth who derive from families with poor supervision and management are provided opportunity to commit sex offenses perpetrated on victims living in the home (Adler & Schutz, 1995; O’Brien, 1991).
Disengaged families frequently lack strong emotional bonds or relationships to individuals within the family system (Ryan, 2010c), with empirical support suggesting that these families have poor attachments (Smallbone & Dadds, 2000). Any relationships that are established are shallow or insecure and family members are not connected with one another. A variety of other factors may impinge on the disengaged families ability to form relationships with each other, including co-addictive behavior patterns (Ryan, 2010c). In this situation, many parents value the addictive behavior over the responsibilities of parenthood. In disengaged families, youth may sexually act out as a result of a lack of structure and as a way to form meaningful relationships with others (Ryan, 2010c).

The “ideal” family. The “ideal” family looks distinctly different than the above-mentioned typologies. These families often portray an exterior that is perceived by others to be “normal” or “perfect”. Many factors are stable in these families, including marriages, jobs, youth’s education, and living arrangements (Ryan, 2010c). It is often that these families are the most cooperative with the system and authorities to try to manage the family under a period of crisis marked by the sex offense (Ryan, 2010c).

It is soon after these families become engaged with services that maladaptive dynamics and operations within the family system become apparent. When problems arise in the family, they are not handled with openness and honesty. Rather, problem solving occurs in a feigning, superficial manner (Ryan, 2010c). Research also finds a high prevalence of parents of sexually abusive youth who have histories of victimization themselves (Kaplan, Becker, & Martinez, 1990). As a result, these parents in ideal
families fear exposure of previous abuse experiences; they choose to avoid exploration into the current abuse. Although many of these families are open and cooperative with becoming involved in treatment, progress in treatment can be difficult at first. When those walls are broken down, many of these families are successfully able to work through issues and indicate a positive experience in the treatment process (Ryan, 2010c).

**Family secrecy.** There are a variety of other characteristics inherent within families of sexually abusive youth, and one common characteristic is family secrecy. Families of sexually abusive youth can be rife with secrets. It is often pervasive and generational, where family members mask information about parents, grandparents, and family functioning (Ryan, 2010c). Youth who commit sexual offenses are frequently surrounded by secrecy, primarily because the abuse itself is a secret (Furniss, 1991). Youth have learned to keep certain behaviors discreet and many families have set this expectation for youth and the family system (Baker et al., 2003). Therefore, families may attribute to denial and minimization of the offense as a way to conceal their own problems (Baker et al., 2003).

Many of these families have various types of secrets, not necessarily exclusive to sex abuse. They can include substance abuse issues, other types of intra-familial abuse or maltreatment, mental illness, disabilities, work problems, criminal records, or social isolation (Ryan, 2010c). Holding onto these secrets is often a defense mechanism from exposure and societal judgment. Many families want to remain in denial that these issues have impacted family functioning, and other families believe that perpetual secrecy in the
family system is vital to maintain family structure (Ryan, 2010c). Keeping secrets within families can be a way for families relate and connect to one another (Herz-Brown, 1991).

**Reactions to offenses**

It is clear that the characteristics and dynamics of families of sexually abusive youth vary. The formation of family typologies suggests that families experience the sexually abusive behavior in unique ways. Many families report having a variety of negative emotions associated with the disclosure (Duane et al., 2002). Feelings and reactions to the sex offense can include shame, anger, and isolation (Nahum & Brewer, 2004; Duane et al., 2002). Other reactions can include feeling responsible or guilty for their child’s behavior (Zankman & Bonomo, 2004). In light of abuse disclosures, families can struggle with their own victimization issues and project their repressed feelings onto their child (Zankman & Bonomo, 2004). It is also common to see families that welcome approaches towards rehabilitating their children (Ryan, 2010c; Duane et al, 2002).

Research has suggested that parents undergo various “emotional stages” when their child’s sexual abuse is disclosed (Duane et al., 2002, p. 51), where they have a range of thoughts and feelings. The process may not occur in a uniform fashion among all families, but in general, they start out in a shocked and confused state (Duane et al., 2002). During this time, parents are merely grappling with the reality of the situation. Parents then begin searching, contemplating, and questioning the details of the offense (Duanne et al., 2002). Denial often manifests throughout this stage (Duanne et al., 2002). It is common for families to initially be in denial or severely minimize the offense. Families may make attempts to protect the perpetrator and completely reject the idea that
the offense ever occurred (Colorado Collaborative Partnership, 2005). This situation is further confounded when victims are living in the household, or when the abuse is incestuous (Colorado Collaborative Partnership, 2005). Families in this situation often find it difficult to support both the victim and offender and struggle with finding time, energy, and meeting the needs of both youth (Zankman & Bonomo, 2004).

After families have worked through their disbelief or denial, they begin to feel shameful about the abuse and blame themselves (Duane et al., 2002). During this phase, parents can feel incredible guilt and remorse for the offense, often taking on the role and assuming responsibility (Duane et al., 2002). Other parents may blame the child for the offense, and place the responsibility on them (Duane et al., 2002). This is often a stage of anger for many parents. Through this final process, parents are learning to accept the offense and work through feelings of helplessness and sadness (Duane et al., 2002).

Unmistakably, families have various reactions and experiences related to the sex offense. It may be that families are under an extreme amount of stress, their coping skills are feeble, their perceptions related to the offense are distorted, and as a result, family functioning is weakened. A more in-depth understanding of this experience of family stress can be looked at through the lens of Family Stress Theory. This theory and its application to understanding the problem of stress among families of sexually abusive youth is outlined further.

**Family Stress Theory**

**Development of the theory.** Understanding the manner in which families react to and cope with stress has received widespread attention from theorists (Hill, 1949). In fact,
prior to the full idealization of The *ABC-X Model of Family Stress*, Rueben Hill conceptualized how families experienced stress and subsequent crisis in his initial model of family crisis (1949). This model sought to understand stress by questioning the process by which families experience it. Any problem that the family undergoes can produce feelings of ambiguity, tension, and uncertainty in family roles (Hill, 1949). Accordingly, in his initial model, Hill hypothesized that there is a stress event that interacts with family’s resources that also interacts with the meaning the family associates with this event (Hill, 1949). The degree to which the interactions are seen as threatening ultimately determines if it will produce the crisis (Hill, 1949).

Historically, family development theories have concentrated on the family as a primary system that is able to operate as a unit, has special interaction patterns, and has unique reactions and adjustments to certain events (Mederer & Hill, 1983). However, prior to The *ABC-X Model of Family Stress*, family development theories failed to account for unforeseen external events and rather focused primarily on internal, normative, or ordinary events (Mederer & Hill, 1983). The *ABC-X Model of Family Stress* was developed as a way to explain severe, external, and chronic stressors that are large hurdles and adversities for families (Mederer & Hill, 1983).

The *ABC-X Model of Family Stress* was first developed by Reuben Hill in 1958 as a mechanism to understand how family systems navigate through stressful events and manage subsequent crisis situations (Hill, 1958). The theory gives emphasis to reactions and adjustment to different stressful life events. In this theory, families are part of a unified system, operating as a “transacting organization” (Hill, 1958, pg. 139). Families
often appear to be a “closed system” in which they operate together to handle conflicts. Families also function together to handle differences between members and among the external world, where many families are frequently opposed to external forces altering or re-shaping its structure (Hill, 1958). Although the family can be considered a system, it fails to operate as traditional organizations do. The associations are relatively unique where individual members are unable to move in or out of the system, and members are not required to earn acceptance from others. Age discrepancies among family members, various personality influences, and different methods of communication are arguments for its weak structural composition, which is easily penetrated by stress (Hill, 1958).

The ABC-X Model of Family Stress postulates that families can encounter a stressful life event (characterized by $a$), they have specific coping mechanisms, skills, and strategies to handle the event (characterized by $b$), and they have perceptions of the stressful event (characterized by $c$). The degree to which these events are negatively impact the family determines the level of crisis. The outcome of the situation is the family’s adaptation (characterized by $x$). Overall, family perceptions of the stressor and available resources to cope with it can mediate the impact of the stressful event on the outcome. The family’s ability to adapt can often depend as much on family perceptions and coping mechanisms as the severity of the stressor. Consequently, it is not necessarily the stressful event that signifies a crisis; rather it is the combination and interaction of the stressful event, family perceptions, and coping resources that ultimately determine the family’s adaptation or level of crisis it will cause (Hill, 1958).
**Extended Family Stress Theory.** The theory in its original form was modified and extended to account for the impact of cumulative stress over time (McCubbin & Patterson, 1983). A longitudinal study investigating families’ experiences as a result of their parents and partners captured as POW’s in the Vietnam War found that, over time, families experience stages of adjustment and attachment (McCubbin & Patterson, 1983). As a result, the original *ABC-X Model of Family Stress* was modified and referred to as the *Double ABC-X Model of Family Stress* to reflect the numerous stressful events that may pile up over time (McCubbin & Patternson, 1983). The theory was essentially revised to explain the effects of chronic and obstinate stressors that can leave families with long-term difficulties. The *Double ABC-X Model of Family Stress* will be used as a framework for understanding stress among families of sexually abusive youth and will simply be referred to as *Family Stress Theory* throughout this dissertation.

Family Stress Theory postulates that families can experience cumulative life stressors that can influence how the family adjusts, that resources may change over time as families learn to manage crisis situations, there are changes in definitions and meanings families place on the stress, and there are a range of outcomes as a result of these struggles. Families go through phases as they attempt to adjust and adapt and the stress, and the stress is often times chronic and persistent (McCubbin & Patterson, 1983). The theory will be described in detail further as these factors are explained and put into context.

**Stressors (A4 factor).** A stressor that has not been previously experienced by the family is referred to as the “crisis-provoking event” (Hill, 1958, pg. 140). The crisis-
provoking event, or stressor, is usually a detrimental experience that families undergo. Families are frequently ill prepared for, and have differing experiences of the event. The stressor can be characterized as a transition in the family system that has the potential to produce change (McCubbin & Patterson, 1982). The stressor can be internal or external, occurring from within the family or outside of the family. Stressful events can also be acute or chronic, where they either occur one time or are repeated (Hill, 1958).

Families have prior unresolved stress or multiple stresses that build up over time. For example, the unresolved stress could be a failed attempt to previously address the crisis situation. Furthermore, families can experience multiple stressors at once, so that not one stressor is solely being attributed to the crisis. This concept is referred to as “pile-up” and it is an advantageous extension to the model because it recognizes that repeated or ongoing challenges can impact coping skills and perceptions resulting in long-term complications in adapting to the stressful event (McCubbin & Patterson, 1983, pg. 11). There are five distinctive types of stress that can contribute to pile-up. These include initial stressors (the impact of the primary stressor on the family), normative transitions (evolving growth and development of family members), prior stressors and strains (residual strains that may be unresolved), consequences of family efforts to cope (the result of previous efforts in managing the crisis), and intra-familial and social ambivalence (uncertainty of the future) (McCubbin & Patterson, 1983).

**Resources (bB factor).** The ability of a family to manage the crisis often depends on the resources at their disposal. As a result of the stress, families may have new challenges and hardships within their external environment (Hill, 1958). These challenges
are often problematic for families to navigate, and when attempting to apply previously used resources and assets to overcome them, they are fraught with societal demands leading them to feel incredible frustration and disappointment. Internally, the stressful event may require the use of faculties that are temporarily inaccessible for many families. Families may not necessarily have the established emotional or psychological resources to cope with the stress, and those families that attempt to draw on recognized resources have difficulties using them to their full capability. Internal resources almost become “paralyzed” (Hill, 1958, pg. 141).

Family resources may also be fluid over time. External and internal resources may evolve and change as the family goes through the crisis situation. There are two types of family resources that may be of importance: “existing resources” and “expanded resources” (McCubbin & Patterson, 1983, pg. 14). Existing resources are currently integrated in the family system. They are used to regulate the likelihood that the family will enter into a state of crisis. The expanded family resources are new resources acquired by the family. These resources emerge as a response to the demands of the crisis or as pile-up occurs (McCubbin & Patterson, 1983).

**Perception and meaning (cC factor).** A key component embedded in Family Stress Theory is that families define, identify, and internalize the event as stressful. The family must give meaning to the event. The life stress will become a crisis if the family identifies it as such (Hill, 1958). The magnitude to which families experience the stress and the availability of resources are factors that may cause some families to perceive the stress as a crisis (Hill, 1958). Families perceive the situation by assessing the initial
stressor and pile-up of stressors, and the existing and expanding resources available to them to cope with the stressor. Families that are able to perceive the stress as a learning experience or way to grow may be more successful in adjusting to the stress. This usually involves re-defining the issues so they are manageable, reducing concentration on emotional encumbrances, and continuing family operations and development of family members. Therefore, re-working the perceptions and meaning of the stressful event has implications for increasing families’ ability to cope. Attempts to cope have included elimination of stressors, managing difficulties, maintaining integrity of the family system, acquisition of new resources, and changing family structure. Also, coping efforts are not only directed at the primary stressor, but they are targeted at the pile-up of stressors present in the family (McCubbin & Patterson, 1983).

**Adaptation (X factor).** The outcome is referred to as a crisis situation in which there is a shift in previous way of functioning or attempting to function with an added stressor (Hill, 1958). The functioning of the family may be severely impaired, where role changes are common. This adjustment to the crisis can be an extremely difficult transition for many families, and although not all families react similarly to the crisis, there is a clear disorganization of the family (Hill, 1958). Whether relationships are strained, tensions exist, arguments ensue, or family members are resentful, families undergoing a crisis are propelled on a “rollercoaster” ride of experiences (Hill, 1958, pg. 146).

Over time, families change the ways they adapt to the perceived crisis. The crisis is argued to be a variable that is ever evolving and changing. Families experience variations in the level it has debilitated them, the extent to which it has disrupted their
lives, and the extent to which it caused family system disorganization. Three factors are argued to be associated with how well a family adjusts including the “individual family members”, the “family system”, and the “community” (McCubbin & Patterson, 1983, p. 17), and demands and capacities are inherent within each one. Successful adaptation occurs when families can successfully balance the demands and embrace the capacities in each one of these systems over time. Maladaptation occurs when family efforts are futile in achieving a balance (McCubbin & Patterson, 1983).

Evidence for Family Stress Theory. Family Stress Theory has been empirically supported in the context of Army families. One study tested the relationships among primary variables in the model by employing Structural Equation Modeling with latent variables (Lavee, McCubbin, & Patterson, 1985). The results from this study support the theory, particularly as it pertains to the pile up concept in which stresses can accumulate and build up over time. The results also suggest that resources were useful in assisting families with adapting to strain (Lavee, McCubbin, & Patterson, 1985). The model has additionally been validated in the context of families struggling with children with Asperger’s (Pakenham, Samios, & Sofronoff, 2004), families undergoing divorce (Plunkett et al., 1997), and for families and stepfamilies experiencing remarriage (Crosble-Burnett, 1989), further revealing the versatility of this theory as an etiological explanation for how families undergo stress and a guide for intervention with families in a variety of fields.
Family Stress Theory applied to families of sexually abusive youth

Family Stress Theory is a way to better understand the processes by which families undergo the stress associated with a sex offense. The initial stress is when the sex offense surfaces and family members find out about the offense. Families may experience a range of different emotions and reactions such as fear, hurt, pain, guilt, blame, or denial. Multiple family stresses that can compound the offense include dealing with the system, attempts to engaging in treatment, family members fighting or role changes, explaining the offense to family members or friends, or grappling with demanding schedules. These factors can emerge and may be appropriately labeled the “pile-up”.

Families of sexually abusive youth may lack appropriate external and internal resources when responding to the demands of the stress. Some resources they may lack include support from their external world such as friends, community members, or family members. Other lacking resources feeling connected to the system or therapist. Even still, families may feel they are not equipped with the internal mechanisms to overcome this challenge. This process is emotionally, physically, and psychologically draining, so families may feel unprepared, and consequently, the lack of resources may impact their ability to cope with the offense. This can lead to associating the event with a negative meaning. Some families may perceive themselves negatively as a result of not being able to cope with what they perceive to be a large stress. They may view themselves as failures or disappointments. These unfavorable perceptions ultimately lead families to
perceive the stress as a crisis situation. Figure 2.1 represents a graphic depiction of the application of Family Stress Theory for families of sexually abusive youth.

Figure 2.1 Application of Family Stress Theory for Families of Sexually Abusive Youth

Although the theory provides a fitting etiological model of family experiences of stress and crisis, limited attention is given to areas for intervention. Establishing a point of intervention is important to support families towards recovery and out of a downward spiral of negative emotions, experiences, and processes. Intervention with families should start when they first experience the stress of the sex offense (Etgar & Shulstain-Elrom, 2009). However, in many cases, services and programming begin soon after families have endured the stress process and are involved in a state of crisis (Thomas, 2010). This is frequently after they have gone through the court process, are currently involved with the system, and are required or suggested to engage in treatment (Thomas, 2010).

Although services are argued to have the most benefit if they are integrated as early as
possible, interventions instituted during the crisis phase has also been argued to improve family adaptation and functioning post crisis (Thomas, 2010).

Thus, intervention with families during the crisis situation, or if possible, before, is crucial to ultimately make changes to the family structure and dynamics and assist them in positively adapting post offense (Ryan, 2010c). Altering deep-rooted perceptions and meanings about the sex offense by working through feelings, dynamics, and confounding factors is part of the treatment process by which families and youth can begin to heal. The graphic depiction has been adapted to incorporate areas for intervention and is illustrated in Figure 2.2.

Figure 2.2 Family Stress Theory and Points of Intervention

**Family as a strength**

With the majority of the literature and research highlighting the deficits and risks in families, it is understandable why there have been limited studies on the strengths of family systems among sexually abusive youth. It can be easy to get lost in the multitude
of risk factors that are present among many of these families and ignore the proficiencies they possess. All families have areas where growth is needed, but focusing primarily on deficits will not lead to healthy development (DeFrain & Asay, 2007). It is crucial to not only recognize and identify positive family characteristics, but to apply them advantageously. Facing adversity and challenge is a way in which families can truly begin to acknowledge strengths (DeFrain & Assay, 2007). Families can be argued to be a protective factor, where their strengths, competencies, and skills can be used to enhance the overall condition and outcomes within the system. Therefore, it is imperative to recognize the family system as a protective if they are ever to be considered a change agent for youth (DeFrain & Asay, 2007).

Research has suggested that families are important for both societal evolvement and youth development. Families can be considered to be the basic foundation of every society (DeFrain & Asay, 2007). Understanding families from this perspective advocates that healthy societies are formed from healthy families. From a systemic point of view, society takes steps to bolster families through various institutions such as education, religious bodies, communities, health and mental health organizations, and many social service agencies (DeFrain & Asay, 2007). Society has thus placed emphasis and value on the importance of families.

The importance of families can be understood through an ecological paradigm. The family system has a meaningful impact on youth through the course of their development. The role of the family is crucial in forming youths’ early perspectives, worldviews, beliefs, and values (Bronfenbrenner, 1979; Carter & McGoldrick, 1989).
The earliest ecological system in the youth’s life is their parents or caregivers (Laser & Nicotera, 2010). From the moment they enter the world, children’s immediate familial environment molds them. The development of youth is highly impacted by these familial experiences, where they can advance or hinder this process (Bronfenbrenner, 1979; Carter & McGoldrick, 1989). So, as youth mature, their perceptions and values continue to be shaped by family systems and parents (Bronfenbrenner, 1989). Through time, these experiences are internalized and adopted as a model that guides future behaviors and future relationships (Ryan, 2010c).

Knowing that the family system is important in shaping societal values and youth development, it is increasingly important to draw on strengths and competencies during the treatment process. Because the nature of the treatment process for the sexually abusive youth serves to rehabilitate and restore to a higher level of functioning for youth (Gerardine & Thibaut, 2004; Rich & Longo, 2003), efforts should be aimed at identifying areas where growth and evolution can transpire.

**Treatment**

To a large degree, the purpose of treatment is to reduce the likelihood that youth will further exhibit sexually harmful behaviors (Rich & Longo, 2003). Treatment is fundamentally rooted in principles of “risk, need, and responsivity” (Andrews & Bonta, 2003; Andrews, Bonta, & Hoge, 1990; Leversee, 2010b, p. 202) in which youth receive services that match with their independent level of risk. This is an overarching framework for understanding how evaluation and treatment are carried out (Andrews, Bonta, & Hoge, 1990). Based on the risk level derived from actuarial assessments, this framework
is used to identify the most crucial methods of intervention to target the level of risk. It is the ultimate goal to alter, reduce, or target those factors that lead to damaging outcomes. It is likewise an objective to deliver services that correspond with youth’s ability or motivation to complete them (Leversee, 2010).

While the “risk, need, and responsivity” framework guides how treatment ought to be conducted (Leversee, 2010), and some approaches are designed to address subjective risk levels, the interventions and modalities that are commonly employed should be met with caution (Ryan, Leversee, & Lane, 2010b). The initial goal in developing treatment interventions for sexually abusive youth was to specifically address the problem of sexual offending and abusive behavior. Services argued to be appropriate for symptom reduction have been derived from adult models (Saleh & Vincent, 2004; Thakker, Ward, & Tidmarsh, 2006; Bourke & Donohue, 1996; Ryan, Leversee, & Lane, 2010b), and treatment literature points to the absence of evidentiary support with these models (Bourke & Donohue, 1996; Metzner, Humphreys, & Ryan, 2009; Ryan, Leversee, & Lane, 2010b; Hunter & Longo, 2004). Randomized clinical trials have yet to be conducted to test the overall effectiveness of adult approaches for juveniles (Hunter & Becker, 1999). Furthermore, adult based models lack of consideration for youths’ developmental context (Metzner, Humphreys, & Ryan, 2009). Youth are continuously learning, developing, and adapting to their world (Laser & Nicotera, 2010), and currently treatments fail to incorporate elements that address youths’ evolving development.

The following section of the chapter will be devoted to understanding the current treatment approaches for sexually abusive youth. It will be organized according to how
sex offender specific treatment differs from a “holistic” model of treatment (Rich & Longo, p. 246). Then, over-arching treatment interventions such as sex offense cycle, cognitive behavioral approaches, and relapse prevention approaches and the effectiveness of those interventions will be discussed. Next, this section will outline different modalities that espouse those interventions. Finally, ways families can be incorporated into treatment and ensuing evidence of family-inclusive treatment will be addressed.

**Sex-offense specific treatment vs. a holistic model.** A treatment paradigm that is broadly espoused in service settings is one that focuses predominately on sex offender specific topics. Sex-offense specific treatment is a term that is used to refer to interventions that specifically focus on the youth’s sexual offending behaviors (Rich & Longo, 2003; Ryan, Leverage, & Lane, 2010c). This treatment approach is particularly oriented to resolve sexual offending behavior. Sex offense specific treatments contain approaches that are tailored towards addressing the presenting sexual behavior problem (Rich & Longo, 2003). The interventions are used to address explicit sexual offending behavior by focusing on reducing the sex offending behavior and “collateral” or “contiguous” influences that may have contributed to or sustained sexual offending behavior (Rich & Longo, 2003, p. 246; Ryan, Leversee, & Lane, 2010c). Depending on how they are employed, some of the sex-offender specific interventions are inclusive of the psycho-education techniques, the offense cycle, cognitive behavioral treatments, and relapse prevention treatments (Lane & Ryan, 2010), and will be further explored in the context of sex offense specific treatment and more broadly. Concepts specific to sex-offense interventions include sex education, sexual interest and sexual identity, fantasy
and arousal patterns, masturbation, sexual fixation, conditioning processes, and suppression (Ryan, Leversee, & Lane, 2010c).

Another treatment paradigm is one that treats the youth as a whole person. This type of treatment is referred to as a “holistic” model and is not merely focused on the sexual crime (Rich & Longo, 2003, p. 246; Veneziano & Veneziano, 2002). Rather, this treatment addresses overall youth well-being (Ward & Stewart, 2002) by integrating alternative concepts such as environment, trauma, mental health disorders, personal characteristics, attitudes, beliefs, social skills, and/or alternative behavioral or emotional conditions that have influenced and continue to influence the youth (Rich & Longo, 2003; Ryan, Leversee, & Lane, 2010b; Longo, 2008). A holistic model can be carried out through diverse intervention approaches (i.e. psychoeducation, cognitive behavioral, multi-systemic interventions, and relapse prevention interventions) and modality uses (i.e. family therapy, multi-family groups, individual therapy, or group therapy) (Rich & Longo, 2003). Incorporating other influencing systems in treatment, such as the family, is a way holistic interventions can be implemented (Rich & Longo, 2003). Therefore, many holistic approaches consider the family to be a systemic factor that can profoundly alter youth outcomes, so it is urged that they are engaged in treatment (Rich & Longo, 2003). Differing treatment interventions and modalities, and specifically family-inclusive treatment will be explored further.

**Treatment interventions**

**Offense cycle.** The offense cycle is a primary component of treatment that is rooted in the belief that behavior manifests in a cyclical and compensatory pattern (Lane
The first offense cycle was developed from understanding sexual behavior patterns described by youth who were rapists (Lane & Zamora, 1982). Since its initial formation, the cycle has since been adapted to reflect a variety of sexual behavior patterns and is a method by which other dysfunctional behaviors are understood (Freeman-Longo & Bays, 1989; Ryan, 1989). The sexual offense cycle is has been used as a primary treatment framework for over twenty years and is often considered to correspond with cognitive behavioral interventions and relapse prevention interventions by integrating elements of cognitive restructuring, understanding and altering maladaptive cognitions, and developing exit strategies to circumvent sexual recidivism (Ryan, Leverage, & Lane, 2010b).

The offense cycle is a way to conceptualize the persistence of sexual perpetration by youth (Metzner, Humphreys, & Ryan, 2009; Ryan, Leverage, & Lane, 2010b). It is a representation of the way in which youth cope, which is often a defensive coping style (Ryan, 2010f). The offense cycle is a concept used to help youth to recognize and internalize their sexual behavior patterns (Lane & Ryan, 2010; Ryan, Leverage, & Lane, 2010b). It explains how sexually acting out behavior is compensatory, where youth cyclically attempt to gain back control, feel better, or retaliate during times of increased stress (Ryan, 2010f). Simply, the pattern of behavior starts when something (early memory, person, event, situation, or circumstance) triggers the onset of emotional stress. This stress leads to a defensive reaction (reactions in which the individual tries to feel better), which then leads to a fantasy solution (an imagined behavior that a person would do to feel vindicated) (Ryan, 2010f). This fantasy solution eventually turns into a plan (or
the person plots out how they are going to carry out this fantasy), which ultimately leads youth to act out the fantasy (the sexual offense) (Ryan, 2010f). The cycle has is illustrated in Figure 2.3.

Figure 2.3 Sexual offense cycle (Lane & Ryan, 2010; Ryan, 2010f)

In treatment, youth learn to recognize their personal triggers, replace their defensive reactions with healthy coping, and interrupt the cycle at all points (Metzner, Humphreys, & Ryan, 2009; Ryan, Leverage, & Lane, 2010). The cycle is used as a risk management tool in increasing youth awareness of their subjective thoughts, reactions, and feelings that perpetuate the cycle. They then learn what high-risk situations, triggers, or stressors lead to their defensive coping and ensuing cycle (Lane & Ryan, 2010; Ryan, 2010f). The treatment provider and treatment team help youth identify risk factors specific to their lives that contribute to the behavior. Treatment is also focused on integrating helpful strategies including managing, escaping, reducing, substituting, or desensitizing current stressors to prevent a relapse (Ryan, 2010f).

Evidence supporting the offense cycle. The sexual abuse cycle as a whole has yet to receive empirical validation (Ryan, 2010f). The beliefs about the effectiveness of this
model are based generally on anecdotal evidence, opinions, and limited data (Rich & Longo, 2003). However, there are concepts embedded in the cycle that have been supported by research. For example, some studies have investigated the relationship between affect (lonely, anger, or isolated states) and sexual fantasies and sexual activities while engaging in fantasies (McKibben, Proulx, & Lusignan, 1994; Proulx, McGibbon & Lusignan, 1996). When examining an adult population or rapists and pedophiles, one study found that negative moods and affect were related to deviant sexual fantasies and increased the likelihood that individuals would engage in masturbatory activities while fantasizing (Proulx, McKibben, & Lusignan, 1996). Moreover, other studies have found that there are maladaptive coping styles among adults who sexually offend, where compared to violent offenders, sexual abusers were more likely to have ineffective and deviant ways of coping (Feelgood, Cortoni, & Thompson, 2005). Although these studies demonstrate evidence for some of the components of the sexual offense cycle, the research has largely neglected to study these components in relation to juveniles who have committed sexual crimes.

Cognitive behavioral interventions. Cognitive behavioral interventions are the most widely employed form of intervention in the treatment of sexually abusive youth (Reitzel & Carbonell, 2006; Ikomi, 2008; Ryan, Leversee, & Lane, 2010b; Veneziano & Veneziano, 2002). First developed by fusing two separate, but highly recognized therapeutic techniques, behavioral interventions and cognitive interventions (Beck, 1979), the cognitive behavioral approach was thought of as the best of both worlds (Rich & Longo, 2003). Cognitive behavioral approaches are ingrained in the notion that
behaviors are based in thoughts, ideas, and beliefs (Beck, 1979). Under this theory, pathological behavior results from dysfunctional thoughts (Beck, 1979).

In treating sexually abusive youth, cognitive behavioral interventions target the maladaptive or distorted cognitions surrounding sexual offending to make adaptations in future behaviors (Ikomi, 2008; Efta-Breitbach & Freeman, 2004). The goal of treatment is to restructure cognitive distortions and develop healthy thought processes and behaviors (Rich & Longo, 2003; Ikomi, 2008). Treatment providers help youth recognize and define their dysfunctional thoughts and behaviors while assisting them with developing new healthy, positive, and constructive cognitive concepts (Efta-Breitbach & Freeman, 2004; Rich & Longo, 2003). This intervention is compatible with facets of the sexual offense cycle, where it works to alter youths’ distorted cognitions that can perpetuate movement through the cycle (Efta-Breitbach & Freeman, 2004; Rich & Longo, 2003). The cognitive behavioral approach teaches youth healthy thought processes that prevent them from entering the cycle and sexually acting out (Ryan, Leversee, & Lane, 2010b).

Evidence of Cognitive Behavioral treatment. Research evaluating interventions for sexually abusive youth have focused on cognitive behavioral treatments as an approach linked to positive outcomes (Walker, McGovern, Poey, & Otis, 2004; Carpentier, Silovsky, & Chaffin, 2006). One particular meta-analysis with samples of 7 published articles and 3 unpublished dissertations from the years 1986 to 1997 evaluated the use of treatment approaches, and cognitive behavioral interventions were consistently linked to youth reported low recidivism and low deviant sexual arousal, and were found
to have the largest effect sizes (Walker, McGovern, Poey, & Otis, 2004). Despite the encouraging findings, the review lacked the inclusion of studies that were random-control trials (Walker, McGovern, Poey, & Otis, 2004).

Carpentier, Silovsky, and Chaffin (2006) conducted a prospective, randomized control study comparing 12 sessions of group CBT therapy with play therapy among children with sexual behavior problems (SBP) ($N = 135$). The analyses included a third comparison group ($N = 156$) without a history of SBP. After a ten-year follow-up, the CBT SBP group had significantly fewer future sex offenses than the play therapy group (2% and 10% respectively) (Carpentier, Silvosky, & Chaffin, 2006). The findings of this study support the use of short-term cognitive-behavioral therapy for children with sexual behavior problems, but has limitations in generalizing to adolescents.

In another study that examined treatment provider interpretations of the most widely used and most effective treatments for sexually abusive youth, the influence of cognitive behavioral therapy was addressed (Ikomi, Harris-Wyatt, Geraldin, & Rodney, 2009). Through the use of mailed questionnaires, this study sought to examine what treatments were most frequently used and to what extent (according to treatment provider reports) they were effective (Ikomi et al., 2009). The results demonstrated that cognitive behavioral therapy was the most widely used form of treatment and according to the treatment providers; it was the most effective approach in reducing future sex offending behaviors (Ikomi et al., 2009).

Despite the field’s strong allegiance to cognitive behavioral therapy, some research has suggested it may not be the only method that shows promise. A meta-
analysis examined nine published and unpublished documents from the years 1990-2003 (Reitzel & Carbonell, 2006). The results revealed that youth who received primary treatments (cognitive behavioral therapy, relapse prevention, combination, and psychoeducation) had substantially higher effect sizes and lower recidivism rates than those who did not receive any treatment (7.37% and 19.93% respectively) (Reitzel & Carbonell, 2006). Although it was anticipated that Cognitive Behavioral Therapy would demonstrate higher effect sizes than the other primary treatments, the findings failed to support this, suggesting that all of the treatments are equally valuable (Reitzel & Carbonell, 2006).

It is clear that the field endorses the use of Cognitive Behavioral Therapy as a best practice approach to targeting sexually abusive behavior problems (Carpentier, Silovsky, & Chaffin, 2006). Although there is some evidence to back up the continued use of this approach, it should be met with caution due to methodological limitations (Fanniff & Becker, 2006). The quality of this evidence can be speculated as some would argue the need to evaluate all cognitive behavioral therapies primarily through randomized control clinical trials (Bourke & Donohue, 1996; Fanniff & Becker, 2006) for the purpose of matching groups equally (Marshall & Marshall, 2007) and concluding the changes are attributed to the treatment (Hendriks & Bijleveld, 2008). The evidence is vague at best, and more rigorous evaluations of this approach and improved dissemination of these services will greatly improve the ability to make causal claims.

Relapse prevention interventions. The relapse prevention model, developed by Marlatt & Gordon (1985) was initially a framework for working with adults with alcohol
and drug addiction. However, it has been applied to sex offenders, and continues to be one of the most salient models in the treatment of juvenile sex offenders (Efta-Breitbach & Freeman, 2004). The relapse prevention model is a skill-based model in which youth recognize their triggers and high-risk situations that can lead to a relapse (Efta-Breitbach & Freeman, 2004; Thakker, Ward, & Tidmarsh, 2006). There are internal and external predisposing, precipitating, and perpetuating factors that can contribute to a relapse (Thakker, Ward, & Tidmarsh, 2006). As part of the intervention, youth begin develop appropriate exit or coping strategies to deal with external and internal factors influencing maladaptive behavior patterns (Efta-Breitbach & Freeman, 2004). The youth, in conjunction with their providers develop a relapse prevention plan to avoid a sexual re-offense (Rich & Longo, 2003). This intervention is highly compatible with the sexual offense cycle, as youth work to circumvent a relapse by formulating strategies and recognizing and reducing exposure triggers and high-risk situations that lead them to re-offend (Ryan, Leversee, & Lane, 2010b).

**Evidence of Relapse Prevention treatment.** The evidence for the use of relapse prevention interventions is mixed. Some literature supports this treatment and reveals it as a promising method of service delivery (Guarino-Ghezzi & Kimball, 1998; Ikomi, Harris-Wyatt, Geraldin, & Rodney, 2009; Reitzel & Carbonell, 2006). While other literature is speculative and questions the lack of rigor in the evaluations (Borduin & Schaeffer, 2001; Waite et al., 2005). So, although the relapse prevention model is argued to be a “best practice” approach for sexually abusive youth (Ertl & Mcnamara, 1997; Morenz & Becker, 1995; Veneziano & Veneziano, 2002), low-quality research has been
conducted in the way of proving this claim (Borduin & Schaeffer, 2001; Waite et al., 2005; Ertl & Mcnamara, 1997).

One study in particular examined the relapse prevention model through responses from treatment providers (Ikomi, Harris-Wyatt, Geraldin, & Rodney, 2009). This study (previously noted) evaluated provider’s subjective responses of the most frequently used and most effective interventions in reducing sex-offending behaviors (Ikomi, Harris-Wyatt, Geraldin, & Rodney, 2009). Therapists and workers indicated the second most frequently used intervention approach was the relapse prevention model (Ikomi, Harris-Wyatt, Geraldin, & Rodney, 2009). Additionally, they suggested that it is also the second most successful intervention in reducing re-offense rates (Ikomi, Harris-Wyatt, Geraldin, & Rodney, 2009).

Another evaluation of the relapse prevention model was carried out in California with an adult sex offender sample (Marques, Wiederanders, Day, Nelson, & Ommeren, 2005). Between 1985 and 1994 the California Department of Mental Health developed a proposal for an innovative relapse prevention treatment program. It was a quasi-experimental design that evaluated adult sex offenders in three groups: a relapse prevention group that received treatment in an inpatient setting and two other experimental groups who did not receive treatment in a prison setting (Marques, Wiederanders, Day, Nelson, & Ommeren, 2005). The findings revealed that the relapse prevention group who met their treatment goals re-offended at lower rates than the control groups (Marques, Wiederanders, Day, Nelson, & Ommeren, 2005).
It is apparent that the field has a long way to go towards developing quality effectiveness studies. The studies that are available leave room for debate on whether current interventions are evidenced based. Relapse prevention models, although widely accepted and employed, have rarely been studied in the context of sexually abusive youth (Borduin & Schaeffer, 2001; Waite et al., 2005; Ertl & Mcnamara, 1997). The absence of evidence for relapse prevention interventions provide further reason for the need to improve research initiatives to examine their true effect. It is also a justification for the need for continued exploration into alternative treatment strategies for this population.

**Treatment modalities**

The three most common modalities in juvenile sex offender treatment include individual treatment, group treatment, and family treatment (Rich & Longo, 2003). Although the three modalities are highly valued, individual and group treatment has traditionally received the most attention (Ikomi, 2008; Rich & Longo, 2003). However, providers who seek to integrate a holistic approach will utilize and value all three modes uniformly. Individual, group, and family treatment modes include intervention elements such as the offense cycle, cognitive behavioral therapy, and relapse prevention approaches (Ryan, Leveragee, & Lane, 2010b). Although these approaches can be utilized throughout each modality, the way in which they are disseminated may look different (Ryan, Leveragee, & Lane, 2010b). Furthermore, individual, group, and family treatments are independently unique and may integrate separate and distinct intervention components (Rich & Longo, 2003).
Individual treatment. Rehabilitative treatment approaches for sexually abusive youth have typically addressed youth individually (Rich & Longo, 2003; Thomas, 2010). Traditional treatment programs have favored initiatives that theoretically aim to reduce risk and come in the form of cognitive behavioral interventions (Terry, 2006; Ikomi, 2008; Powell, 2010; Walker et al., 2004) and relapse prevention interventions (Terry, 2006; Ikomi, 2008; Thakker, Ward, & Tidmarsh, 2006; Ryan, Leversee, & Lane, 2010b; Walker et al., 2004). However, additional intervention techniques can be utilized during individual work and include components such as the offense cycle, processing early trauma, safety planning, or victim clarification (the process of connecting the offender and the victim to make amends and pay restitution for the sexual offense (Mussack & Stickrod, 2002)) and the use of such techniques may vary according to clinician and client (Rich & Longo, 2003). Individual treatment typically occurs in the format of individual therapy through a one on one interaction between the therapist and the client (Rich & Longo, 2003).

Individual therapy. In individual therapy, the identified patient is the youth and treatment is tailored towards addressing individual issues (Rich & Longo, 2003). Treatment objectives and goals are determined through a conjoined effort by the therapist and youth. Upon establishment of such goals, the therapist customizes interventions to suit the individual needs of the youth (Ryan, Leversee, & Lane, 2010b). Individual therapy is used to support youth in expressing deep emotions, develop insight into their behaviors, and bringing personal problems to light (Rich & Longo, 2003). Some essential goals are to help youth establish empathy, reduce cognitive distortions, increase sexual
knowledge and attitudes about sexual behavior, and improve their overall self-esteem (Eastman, 2004). Other goals include helping the youth feel better and increase their functioning in society (Ikomi, 2008). Individual therapy sessions require active participation from youth to ensure therapeutic success.

During therapeutic sessions, youth and therapists process through the problems. This activity usually involves intensive discourse between youth and therapist that focus on task-specific goals or managing crisis (Kerr et al., 1992). Normally, processing occurs in a talk specific format, where youth are verbally expressing themselves (Longo, 2008; Rich & Longo, 2003). Talk therapy provides a platform where vulnerabilities are exposed, self-exploration occurs, and negative or positive feelings are revealed (Rich & Longo, 2003). Other forums can include experiential work, where therapy goes beyond communication through verbal means, so youth explore innovative ways of self-expression. In experiential work, or hands-on learning activities, youth build practical skills, individuation, and communicative capabilities (Longo, 2008). Both traditional talk therapies and experiential therapies include the above-mentioned interventions: offense cycle work, cognitive behavioral therapies, and relapse prevention strategies (Longo, 2008).

**Limitations in individual therapy.** Employing individual therapy as a stand-alone technique should be done so sparsely (Lundrigan, 2001). Because youth development, and in particular sexual behavior issues are not always attributed to one single factor, treatment approaches should embrace initiatives that, at least in part, consider additional influences (Lundrigan, 2001). It is argued that when used as a stand-alone approach,
individual therapy will not produce the same positive effects as a multi-modal approach (Lundrigan, 2001). As a caveat, individual therapy should only be administered under careful supervision and by professionals that have proper training to treat sexually abusive youth (Rich & Longo, 2003).

**Group work.** Treatment modalities for sexually abusive youth have also favored group work (Ikomi, 2008; Rich & Longo, 2003; Ryan, Leversee, & Lane, 2010b; Sawyer, 2000). Group treatment has been a predominant modality because of ease in disseminating information, bringing about change in youth, and instilling new ideas and behaviors (Marshall & Burton, 2010; Sawyer, 2000). Group therapy is argued to be an efficient means of providing services and encourages youth connections and support while affording opportunities for confrontation (Ikomi, 2008; Ryan, Leversee, & Lane, 2010b). Many treatment programs offer and require youth to attend some form of group while they are receiving services, and treatment interventions are inclusive of sex offense cycle work, cognitive behavioral interventions, and relapse prevention approaches may vary by group and clinician (Ikomi, 2008; Rich & Longo, 2003; Ryan, Leversee, & Lane, 2010b).

Group modalities are helpful because they create opportunities for youth to connect with other youth undergoing similar experiences (Marshall & Burton, 2010; Ryan, Leversee, & Lane, 2010b). A group context is beneficial for hearing stories, sharing with others, developing empathy for others, expressing emotions, and receiving practical feedback (Marshall & Burton, 2010; Ryan, Leversee, & Lane, 2010b). Moreover, groups are an efficient method by which youth can share growth and progress
with others; in this way, youth are role models and leaders for peers (Ryan, Leversee, & Lane, 2010b). Some activities in groups include homework, didactic instruction, videos, discussion, and role-modeling activities (Rich & Longo, 2003). There are many different types of groups and these differential formats can also have disparate goals.

**Types of groups.** One specific type of group is a content focused group. This group envelops psychoeducational components that are used to educate youth on healthy behaviors and ways to integrate they into their daily lives (Rich & Longo, 2003). The content focused group is oriented around behavioral change in which interventions are employed to teach youth basic ideas about thinking errors and offense cycles and how they play out in their individual lives (Ryan, Leversee, & Lane, 2010b). Another key aspect of this group is disseminating information surrounding unhealthy and healthy sexual behaviors. In the group context, youth learn healthy and appropriate ways of sexual expression (Rich & Longo, 2003). Youth also learn relapse prevention strategies both through educational facilitation and through application (Rich & Longo, 2003). The ultimate goal of content focused groups is to develop skills inclusive of cognitive coping, problem solving, and self-management through awareness and recognition (Rich & Longo, 2003).

Another type of group is known as a process-oriented group. This is a dynamic group forum in which youth unite to develop insight, establish interpersonal relationships, interchange ideas, and interact with one another in a meaningful way (Rich & Longo, 2003). Group members work together to discuss their sexual behavior experiences, personal and life experiences, feelings, and emotions, and by doing so,
develop communication and relational skills (Rich & Longo, 2003; Ryan, Leversee, & Lane, 2010b). In a process-oriented group, being a part of a team by providing support and help to others assists youth in developing healthy, pro-social, and constructive relationships (Rich & Longo, 2003). The goal of process-oriented groups is to develop interpersonal and social skills and affective coping skills (Rich & Longo, 2003).

**Limitations of groups.** Despite the abundance of practitioner and field support for group modality (O’Boyle, Lenehan, & McGarvey, 1999; Sawyer, 2000), the treatment literature acknowledges limitations in such an approach. There are times when using groups may be contraindicated (Dishion, McCord, & Poulin, 1999). For example, some professionals have suggested possible iatrogenic or contagious effects of group work in the delinquent youth population, where group modalities may increase the likelihood that youth will absorb negative messages received from peers and begin to exhibit similar maladaptive behaviors in their own lives (Dishion, McCord, & Poulin, 1999; Handwerk, Field, & Friman, 2001). Another potential limitation is that youth who are dissociative (Leibowitz, Laser, & Burton, 2011) may not benefit from specific accounts of other peer accounts of sexual abuse histories. Particularly important in the context of serving youth, groups are hypothesized to be associated with generating more harm than good (Dishion, McCord, & Poulin, 1999).

Invariably there are disparate limitations in both individual and group modalities, and research has yet to clearly reveal unyielding evidence for current intervention approaches. Knowing that sexually abusive youth are amenable to treatment; they are consistently less likely than their adult counterparts to recidivate after successful
completion of treatment (Ryan, 2010d), it is ethically sound to consider ways to improve the evaluation and dissemination of current services. Discerning treatment from a systemic perspective, where family is valued and assimilated into services, will support a holistic approach. Furthermore, studying the effects and outcomes of such services can inform research and advance treatment initiatives.

**Family treatment**

*The role of family in the treatment process.* In various sectors, including mental health, juvenile justice, and child welfare, family-inclusive treatment is seen as critical in making strides towards positive outcomes (Thomas, 2010). The field is increasingly acknowledging the need to emphasize families throughout treatment. Professionals making recommendations for ethically sound treatment have suggested that families be recognized and amalgamated into the process (Schladale, 2006). No matter the circumstance, all youth have derived from some type of family system (Ryan, 2010c), so whether work involves incorporating the biological family, current caregivers, extended family, foster family, or adopted families, reasonable efforts should be made to gain their support and participation (Thomas, 2010; Rich & Longo, 2003).

**Challenges of family-inclusive treatment.** Because of the recent surge of the field to recognize the influence of families, family treatment hasn’t received as much attention from research and literature as individual or group modalities. Family treatment for sexually abusive youth has been minimal and inconsistent compared to other treatment methods (Burton, Smith-Darden, & Frankel, 2006; Rich & Longo, 2003). Certain limitations and challenges lie in getting families on board with treatment.
Restricted resources may impact the ability to provide extensive treatment to both the youth and their families. Some providers are unable to fund family treatment, and in an effort to save time and money, in some cases, it has been omitted altogether (Rich & Longo, 2003). Moreover, some families may not be motivated to engage in treatment with their child (Ryan, 2010c). A lack of motivation can be a result of anger or resentment or difficulty making time (Rich & Longo, 2003). The lack of motivation may also stem from families and juveniles remaining in denial, or families perceiving the treatment as the youth’s responsibility and not one that involves the family system (Rich & Longo, 2003; Zankman & Bonomo, 2004). Other times, biological families may be absent from youths’ lives entirely as a result of death, incarceration, or abandonment, making it challenging, if not impossible to involve them (Ryan, 2010c; Rich & Longo, 2003).

Other families find it extremely difficult to navigate through the various obstacles that are present when undergoing the treatment process. There are many facets of the treatment process that require considerable time and energy. Youth are generally required to meet with various individuals at differing times and at different locations, which is often an added stress on parents (Zankman & Bonomo, 2004). Families may also feel embarrassed or fearful when discussing uncomfortable and taboo topics like sex. Parents may feel an overwhelming sense of anxiety when they are required to talk about sexual issues, particularly as it pertains to their child engaging in such behaviors. It is often times not easy, or the most pleasant activity for parents (Zankman & Bonomo, 2004).
Benefits of family-inclusive treatment. Although challenges do exist in getting families engaged, family treatment has been recognized as an avenue by which the overall system can be strengthened and family members can provide support to each other (Rich & Longo, 2003). Several benefits have been outlined throughout the literature. Family treatment can be beneficial in addressing and altering dynamic risk factors. Without the presence of family members in treatment, many dynamic risk factors may not be immediately addressed or they may not be given complete attention (Zankman & Bonomo, 2004). It has been suggested that treatment providers may have more success interrupting the sexual offense cycle if they have assistance from families of origin or those who are closest to youth (Zankman & Bonomo, 2004). Taking a systemic approach to sex offender specific treatment may be beneficial in helping youth recognize those patterns earlier and draw upon supports to provide reinforcements for youth as they progress in treatment and when they assimilate back into their natural environments (Zankman & Bonomo, 2004).

Families not only exhibit a significant influence over youth, but they are the system that has the most importance in decision-making processes (Ryan, 2010c; Worling & Curwin, 2000). Accordingly, because of the substantial influence families have over youth, they have the ability to make the therapeutic process more meaningful for them (Zankman & Bonomo, 2004). Research has shown how youth may display behaviors and attitudes analogous to their family’s behavior patterns (Hunter & Figueredo, 1999). Youth are more likely to have a positive attitude, an open mind, and
take more accountability for their treatment if family members are equally open to the treatment process (Hunter & Figueredo, 1999).

Finally, family treatment is important because families are a life-long system in youths’ lives, and it is crucial that treatment identifies patterns that contributed to or helped to maintain the dysfunctional behavior to improve familial relationships and ultimately reduce the likelihood of re-offending (Zankman & Bonomo, 2004). Although families in many cases are not directly responsible for the offense, understanding and attending to some of the environmental pre-existing conditions that prompted it can be empowering for many families (Sexto & Alexander, 2003). Also, because families will be monitoring and supervising their children beyond treatment, teaching skills for the future is crucial (Zankman & Bonomo, 2004). It is clear that family plays a central role in the lives of youth, so, exploring the impact of familial involvement in treatment is not only important, it is necessary.

**Incorporating families into treatment.** Understanding ways in which families are incorporated into treatment has not been well understood, and the need for family inclusion has been fraught with debate. Some professionals have argued that families should be amalgamated by any means necessary and others have argued that youth may not benefit from familial involvement (Ryan, 2010c; Baker et al., 2003). While the answer to this debate may depend on the family system, the field has recently begun to discuss methods by which family-inclusive treatment should transpire.

**Types of family services.** Scholarly work in the field has outlined different ways families are incorporated into services. For example, the literature identifies the
importance of informed supervision among family members, where they are responsible for ongoing supervision of their child’s behavior (Ryan, 2010c). This is a mandated piece of treatment for any youth currently living with their families or any youth returning home. Informed supervision requires that parents be taught to monitor, recognize high-risk situations and triggers, and intervene when necessary (Ryan, 2010c). Another service approach that includes families is their involvement in the multi-disciplinary team. Team meetings are used to collaborate with professionals, guardians, school members, and other individuals with vested interest in the case. The meetings are held to discuss treatment issues, progress in treatment, problems arising, to establish safety plans, and to work on family issues (Rich & Longo, 2003). Family reunification is another process of family treatment where youth living in an out of home placement will be returning home, and families are required to complete plans for contact with the victim, victim clarification, and steps to re-integrate the youth back into the community (Thomas, 2010).

**Family interventions.** Literature has identified ways in which families should be incorporated into the therapeutic process. It has been argued that there are many distinct intervention approaches, and their application is contingent on the needs of family system (Thomas, 2010). Interventions can consist of working through the sex offender cycle, cognitive behavioral approaches, relapse prevention approaches, or psycho-educational approaches (Thomas, 2010). One technique embedded in any one of these interventions involves uncovering elements within the family that could have contributed to the initiation of sexual offending (Barnes & Hughes, 2002). This includes understanding and
working through dynamics, interactions, and behavior patterns among the family (Rich & Longo, 2003). Often times, families and treatment providers work through denial, minimization, and blame at this point. Another core component of the work is disclosure, abuse of power, and exposing family secrets (Thomas, 2010). Moreover, treatment providers will integrate components of the sex offender specific treatment that youth are receiving into the family sessions so that families understand the youth’s cycle, triggers, and high-risk situations (Kolko et al., 2004; Thomas, 2010). Regardless of the intervention approach, many professionals recommend that the family be seen as the client and be recognized as a unified system. Addressing the family in this way demonstrates that the behaviors of each member are a function of the overall system (Bowen, 1978).

**Multi-systemic therapy.** An approach beginning to receive wide attention in the field is Multi-systemic therapy (Letourneau & Henggeler et al., 2009). MST is derived from socio-ecological model of development (Bronfenbrenner, 1979) that works with youth within individualized, family, community, and school systems (Henggeler & Borduin, 1990; Henggeler, Smith, Melton, 1992). MST provides services in the natural environment (home and community) 24 hours per day and 7 days per week for adolescents displaying a range of antisocial behaviors, including sexually abusive behaviors (Bourduin, Schaeffer, & Heiblum, 2009; Henggeler & Borduin, 1990; Letourneau & Henggeler et al., 2009). Multi-systemic therapy (MST) is one particular approach that is delivered in home and community settings that incorporates families and
various other systems in youths’ lives to target factors determined to put youth at risk by utilizing systems to change maladaptive behaviors (Henggeler & Sheidow, 2012).

Overall, MST is a strengths-based approach and attempts to address risk factors by helping youth and families identify the problem behavior while using the supports and strengths of each system (Thomas-Mitchell, Bender, Keshna, & Mitchell, 2006). Challenges within the family and problem behaviors are addressed through enhancing strengths in the systems (Henggeler & Boruin, 1990). A principal treatment goal is to impart parents with crucial skills to supervise and monitor youth to reduce the need for additional services and ultimately foster autonomy (Thomas-Mitchell et al., 2006). An additional goal of treatment is empowering parents to expand necessary support systems and remove any identified barriers to success in treatment (Thomas-Mitchell et al., 2006). While embracing independence and skill development, therapists promote conscientious and responsible behaviors in various settings (Center for the Study and Prevention of Violence, 2007). MST involves collaboration with teachers, coaches, parents, family members, community members, church leaders, and others to facilitate change (Thomas-Mitchell et al., 2006).

**Multidimensional family therapy.** Multidimensional family therapy (MDFT) is an approach that has begun to receive attention in the broader juvenile offending literature (Liddle, 2010). This approach uses an ecological framework in understanding behavioral problems of youth (Liddle, 2010). It is a systems perspective that considers the family to be a key factor in contributing to risky behaviors that can include offending and drug use (Liddle, 2010). Interventions specifically address relationships within youth,
their families, families and peer networks, and extra familial sources such as the school or justice system. The treatment is carried out through meetings with these interacting networks that address daily concerns with evolving goals to fit the needs of the system (Liddle, 2010).

**Family treatment modalities.** One predominant modality by which families are involved in services is family therapy. It is argued that family therapy is not merely a treatment modality, rather a unique method by which systemic problems and interpersonal dynamics are reconstructed (Stanton, 1988). Family therapy with families of sexually abusive youth could include work with immediate family members, extended family members, caregivers, couples, or parent and child dyads (Thomas, 2010). Family therapy could occur in the traditional outpatient or office setting, in-home, in the community, or in the residential setting (Thomas, 2010). Typical family therapy includes specialized work with youth and all relevant family members (Longo & Prescott, 2003). The ultimate goal of family therapy is to not only help families discover how the offense occurred and correct the behavior, but to also illuminate the family’s culpability and repair patterns of affect and cognition and dysfunctional or inadequate dynamics embedded in the system (Rich & Longo, 2003; Thomas, 2010).

Multi-family group therapy is an emerging modality in the field. Multi-family groups are a type of family therapy that is facilitated by a treatment provider and includes youth, parents or caregivers, and other youth and family members with shared experiences (Nahum & Brewer, 2004). The goal of multi-family group therapy is to bring families together to interact, build empathy, and ultimately produce change in family
systems. Within the groups, families work on improving community safety, improving supervision of youth, teaching offenders the concept of delayed gratification, developing empathy, instilling values of hope and hard work. The curriculum includes sex offender specific treatment concepts, the family’s role in treatment, understanding informed supervision and safety planning, introducing cognitive concepts, family dynamics and issues associated with the abuse, defining sexual abuse, understanding why youth sexually offend, how victims are impacted, and victim clarification (Nahum & Brewer, 2004).

**Evidence for family-inclusive treatment.** Although the field is gradually recognizing the value of family oriented treatment models, there is great variability in their application across service agencies (Ryan, 2010c). There is limited research demonstrating the process by which some of these intervention approaches are carried out with families of sexually abusive youth. Furthermore, little has been done in the way of exploring the association between family engagement in treatment and recidivism rates or other outcomes (Zankman & Bonomo, 2004). Therefore, as rigorous research studies are lacking, it is not known whether family dynamics are a single factor attributed to success or whether they interact with other factors in determining outcomes (Ryan, 2010c).

**Evidence: Family treatment with juvenile delinquents.** With the vast similarities between sexually abusive youth and general delinquent youth (Ryan, 2010b; Seto & Lalumiere, 2010), there are critical implications for families of sexually abusive youth if the effectiveness of family-inclusive treatment for delinquent youth can be properly ascertained and understood. Research has recognized the positive contribution family
makes in the treatment of juvenile delinquents (Mulder et al., 2012). It is well known that family risk factors such as poor parenting skills, criminal behavior in family, and history of abuse are linked with higher and more severe recidivism rates in general juvenile offenders (Mulder et al., 2012). Furthermore, family treatment has been shown to be more effective compared to individual treatment (Perkins-Dock, 2001). Research has long documented that there is a reduction in delinquent behaviors (measured by rearrests, recidivism, and truancy) when family therapy is used as a modality (Tolan et al., 1986).

One particular meta-analysis queried whether family-inclusive interventions improved youth behavior and resulted in positive long-term outcomes (Woolfenden, Williams, & Peat, 2009). The study reviewed randomized control trials focusing on family-inclusive interventions (treatments that primarily focused on targeting family in treatment) with an objective outcome measure (arrest rates), among adolescents who were classified as meeting criteria for conduct disordered (child behavior checklist tool) or characterized as delinquent (referral from juvenile justice or legal system because youth committed a serious crime two or more times) (Woolfenden, Williams, & Peat, 2009). The results revealed that youth were less likely to spend time in juvenile detention and be re-arrested one to three years after treatment as a result of family interventions (Woolfenden, Williams, & Peat, 2009).

Specific family-based interventions have been empirically validated for work with juvenile delinquents. Efficacy trials have demonstrated evidence of MST in improving family relationships, decreasing caregiver and youth symptoms, and decreasing arrest and incarceration by 50% through the course of 14 years (Schaeffer & Borduin, 2005).
Randomized control trials have also demonstrated that MST is useful in a sample of chronic violent offenders in improving family and peer relationships, and decreasing recidivism for youth in an out of home placement (Henggeler et al., 1997). Moreover, studies that examine therapist adherence to the MST protocol with juvenile offenders have found that when the model is used with fidelity, family relationships improved (measured by family cohesion, family functioning, and parental monitoring) and resulted in decreased delinquent peer associations and subsequent reduced delinquent behavior (Huey et al., 2000).

MDFT has also been shown to be effective in treating youth who use substances (Liddle et al., 2001). One randomized control study compared youth ($N = 182$) in MDFT, adolescent group therapy (AGT), and multifamily educational intervention (MEI). After a 12-month follow-up, the MDFT group demonstrated greater improvements in pro-social behaviors, school and academic performance, and family functioning (Liddle et al., 2001). The findings from this study support the use of MDFT for youth displaying substance use problems, and further research is needed to demonstrate effects for sexually abusive youth.

**Evidence: Family treatment for sexually abusive youth.** With research highlighting the effectiveness of specific intervention techniques in reducing criminal behaviors among general delinquent youth, it is important to thoroughly examine similar findings among sexually abusive youth. Although the outcome studies with sexually abusive youth are limited, the research that has been conducted is informative and has various implications for the field. One research study in particular has explored the
outcomes as a result of employing a specialized community based treatment known as the SAFE-T program. This program is tailored to the needs of the family and uses Cognitive-Behavioral and Relapse Prevention interventions in working with families (Worling & Curwen, 2000). The results from the study that collected data on 58 adolescent sexual offenders who participated in 12 months of the program (compared to 90 juvenile sex offenders in a comparison group) revealed that those who received SAFE-T treatment had significantly lower sexual, violent non-sexual, and non-violent offenses two to ten years post treatment (Worling & Curwen, 2000).

A mixed-methods study examined some non-traditional outcomes (those not related to recidivism or treatment completion) as a result of a community based psychotherapy treatment program that offers long-term support for families who experienced sexual abuse within the family system, or incest. The program is focused on reunification of the family and requires that families undergo extensive family therapy sessions, although the details of the therapy sessions are not specified (Thornton et al., 2008). The qualitative interviews were used to understand the lived experience of the treatment program while the quantitative component was a design that tested change pre-test and post-test (upon completion of treatment) among the participants. The results showed that participants noted better family communication and less conflict and quantitatively there were statistical differences of family functioning (Family of Origin scale was used as a standardized instrument) at post-test, where youth demonstrated significantly higher scores on constructs such as autonomy and intimacy (Thornton et al., 2008).
A specific intervention approach that has been evaluated with sexually abusive youth and their families is MST. One particular randomized control trial evaluated the effectiveness of MST compared to general sex-offender treatment (Letourneau & Henggeler et al., 2009). Various outcomes were evaluated at three different time points (pre-treatment, 6 months, and 12 months post recruitment). The results revealed that youth who received MST had reduced sexualized behavior problems, delinquency, substance use, externalizing behavior problems, and out of home placements (Letourneau & Henggeler et al., 2009). Subsequent studies have replicated these findings, and MST continues to be indicated as an evidenced-based intervention approach for sexually abusive youth. Another randomized control study examined long-term outcomes of MST with a 9-year follow up period. The results demonstrated reduced recidivism by 83% and decreased days that youth were incarcerated by 80% (Borduin, Schaeffer & Heiblum, 2009).

Outcomes

The last section of this dissertation focuses on understanding some of the common outcomes that are studied when ascertaining the degree to which treatments are effective or useful. There are many different outcomes professionals use to measure successful recovery among sexually abusive youth. Two primary outcomes, treatment completion and recidivism, have been highlighted by the literature as the best way to understand the extent to which youth have rehabilitated. Although outcomes are frequently used as points of recovery among sexually abusive youth, and with the exception of the
association between multi-systemic therapy and recidivism, they have rarely been studied in the context of evaluating the effects of family treatment for sexually abusive youth.

Treatment outcomes are suggested to be a measure short-term change that determines the ability of youth to successfully integrate therapeutic concepts into their lives and work towards a change process (Powell, 2010; Hendriks & Bijleveld, 2008). Additionally, successful treatment completion has implications for community and public safety (Eastman, 2005). Recidivism, or youths’ potential to re-offend, is argued to be one of the most significant markers of long-term change (Caldwell, 2010). Recidivism has been used as a primary measure of rehabilitation throughout the field, with professionals formulating assessments and gaging treatment strategies based on probability for re-offense (Ryan, 2011b).

**Treatment completion.** Treatment providers and multi-disciplinary team members will establish treatment completion as either successful or unsuccessful. Some youth, for whatever reason, may be un successfully terminated from treatment (Thomas, 2010). Negative termination can result from a lack of motivation, denial of offending, or psychopathic characteristics (Hendriks & Bijleveld, 2008). Research has documented that unsuccessful completion of treatment may fall anywhere between 14% (Eastman, 2005) and 25% of youth (Hendriks & Bijleveld, 2008). In some cases, youth may be prematurely terminated from treatment by way of external sources such as court orders, probation, case management decisions, or even insufficient funding (Thomas, 2010). This type of treatment completion is usually considered to be a neutral discharge. Other juveniles may successfully complete treatment, and discharge is based off of measurable
and objective changes in youth functioning (Thomas, 2010). Successful termination from treatment is typically based on youth’s capacity to undergo the stages of treatment, and internalize and alter maladaptive cognitions (Ryan Leversee, & Lane, 2010a; Eastman, 2005). Research suggests that approximately 75%-85% of sexually abusive youth who undergo treatment are successfully terminated (Eastman, 2005; Henriks & Bijleveld, 2008).

**Recidivism.** Recidivism rates indicate the proportion of youth who re-offend after completion of treatment. Recidivism can be in the form of sexual offenses or non-sexual offenses. Research has suggested that a majority of youth do not go on to recidivate upon successful completion of treatment (Ryan, 2010d). Moreover, youth are less likely to sexually re-offend than non-sexually re-offend, with the majority of research identifying a disproportionate number of sexual re-offense rates among sexually abusive youth (Reitzel & Carbonell, 2006; Vandiver, 2005; Worling, 2000). One large meta-analysis also identifies this pattern by examining recidivism rates across 63 data sets and following youth for an average of 59 months. The study uncovered that the mean sexual recidivism rate was 7% and the mean non-sexual recidivism rate is 43.4% across all of the studies (Caldwell, 2010).

Many have argued against the use of recidivism as an appropriate outcome measure due to several discrepancies (Caldwell, 2010). The definition of sexual recidivism may be inconsistent across different studies. Scholars continue to explain, define, and measure recidivism in dissimilar ways (Caldwell, 2010). For example, some define recidivism as new arrest rates, others as new conviction rates, and still others
define it as new court filings (Abbey, 2005). Furthermore, sexual violence often remains underreported and is frequently concealed by both victims and perpetrators (Abbey, 2005). So, both self-report data and official record data may be unreliable and may not capture undetected events (Caldwell, 2010). Ways in which recidivism is defined and measured is another disputed topic that can cause the data to be skewed. Measuring recidivism by arrests rates may result in capturing too many individuals, while measuring it by conviction rates may be too conservative (Abbey, 2005). Despite the problems associated with recidivism as a measure, it continues to be a criterion by which risk assessments are formed and is widely used to structure treatment (Caldwell, 2010, Reitzel & Carbonell, 2006; Vandiver, 2005; Worling, 2000).

Gaps in the research

Although the field is evolving to account for the important role of family and examining the impacts of including family in the treatment process, there continues to be gaps in the research. Clearly, MST is an emerging treatment intervention that unquestionably emphasizes the importance of taking a systemic approach to ameliorating sexually abusive behavior patterns. However, research continues to be limited in understanding how isolating and examining family as a singular system can be valuable. Many of the research studies broadly investigate systems and fail to specify how families in particular may shape outcomes (Ryan, 2010c). The majority of the current literature and research fails to view family-inclusive treatment from a strengths-based perspective.

The research has evaluated the deficits in families rather than understanding how they can be used as a resource. The field would greatly improve by incorporating a strengths-
based perspective to research initiatives that suggest that families are the single most important system impacting youth outcomes.

Moreover, research has yet to investigate the process by which families undergo treatment. The field has a limited understanding of the level of stress families are under. More knowledge is needed about why families are stressed and what factors compound it. Furthermore, insufficient research has been conducted that attends to the process by which families become engaged in treatment, the challenges of engagement, how families experience the treatment process, the components of family treatment, and how youth and families can overcome challenges to achieve successful outcomes. This dissertation seeks to address these specific gaps in the literature and contribute to the field profoundly in this way.
Chapter Three: Methodology

This chapter outlines the design and approach by which participants were recruited, data were collected, measures were utilized, and data were analyzed. The chapter first reviews the research aims and questions. Then, the partnership with the Colorado Sex Offender Management Board and the embedded mixed-methods design is discussed at length. As an overarching approach, the embedded mixed method design was applied for the purpose of understanding more about experiences of families of sexually abusive youth and their involvement in treatment. The embedded design outlines a methodical process of qualitative and quantitative inquiry into the process by which data were collected and analyzed. Some research questions were answered by one methodological approach, while the others were answered by incorporating both approaches.

The sampling and procedures are organized according to the flow of the embedded mixed methods design, whereby the quantitative methodological strand including sample, data collection, measures, and computations is outlined first as it was the first data strand to be collected. The qualitative methodological strand including the Grounded Theory approach, sample, recruitment, and data collection is discussed thereafter, as it was the second strand to be collected. Following the discussion of the respective methodological strands, data analyses are discussed at length. Again, using embedded mixed methods design to organize the structure of the analyses section, the
Research questions

Under the overarching research aim “Understanding the process of family-inclusive treatment” three subsequent research questions were formulated to understand how treatment progresses at each step. Research question 1: “What prohibits family involvement in treatment?” Research question 2: “How do providers engage families in treatment?” Research question 3: “What does family treatment entail, and what factors are responsible for helping families progress through treatment?” Under the second overarching research aim, “Understanding how families contribute to positive outcomes”, the fourth research question was formulated to identify ways families are used as a resource to facilitate positive outcomes. Research question 4: “Are family services associated with positive outcomes?”

Research process and design

Partnership with the Colorado Sex Offender Management Board. The dissertation research was conducted in collaboration with the Colorado Sex Offender Management Board (CSOMB), which is a Division of Criminal Justice (DCJ). The state of Colorado is at the forefront of studying ethically sound treatment approaches for sexually abusive youth (Ryan, 2010c). During the start of this dissertation, the CSOMB was examining state mandated standards and guidelines for treatment, assessment, and supervision of juveniles who were undergoing evaluation. The CSOMB evaluation was designed to assess the effectiveness of the standards by collecting quantitative data.
through reviewing probation files of youth adjudicated of sexual crimes. In addition to evaluating supervision procedures and polygraph testing, the CSOMB designed the quantitative study to capture the various treatment elements mandated by the standards, including treatment modalities, the use of victim clarification, concerns regarding treatment, recommendations for treatment changes, and the inclusion of family.

Because the focus of this dissertation was to understand and evaluate family treatment in the context of sexually abusive youth, the existing partnership with the CSOMB allowed the researcher to develop an independent project by utilizing family treatment variables available in the quantitative data. The researcher aimed to study the process of family treatment with a particular emphasis on understanding treatment components and the effects of family treatment. Upon reviewing the file review data and recognizing there was insufficient quantitative data available to address some of these aims, the dissertation design was modified to supplement available quantitative data with qualitative inquiry. Thus, the dissertation uses a mixed methods approach, identifying qualitative methods as the primary method of inquiry, and using existing quantitative file review data to supplement or triangulate findings for specific research questions.

After the quantitative data were collected, the CSOMB conducted focus groups to ascertain a greater understanding of the utility and impact of the standards among the individuals employing them, including probation officers, polygraph examiners, and treatment providers. The researcher assisted in facilitating the focus groups with the CSOMB for the purpose of supporting the existing evaluation and to gather preliminary information that was used to frame the qualitative strand of this dissertation. Thus,
emerging topics from the focus groups related to family structure and dynamics and involvement in treatment were considered as this researcher designed individual qualitative interviews for her dissertation. To further make qualitative data collection possible, the partnership with the CSOMB lead to the opportunity to access a statewide list of treatment providers who service sexually abusive youth. This process is expanded upon in the qualitative sample and procedures section. Data collection for this dissertation was done with approval from the University of Denver Institutional Review Board. An illustration of how the dissertation research diverged from the CSOMB state evaluation is displayed in Figure 3.1.

**Figure 3.1 Diverging processes: The state evaluation and dissertation research**


**Embedded design**

An embedded design was used to organize the methodology and is illustrated in Figure 3.2. The embedded design asserts that multiple strands are required to answer the research questions, to obtain a comprehensive picture of the problem, and to ultimately tie into the overall goal of the study (Creswell & Plano-Clark, 2011). The embedded
design is an approach in which data collection and analysis of qualitative and quantitative strands has been done within an overarching qualitative research design (Creswell & Plano-Clark, 2011). This design dictates the value placed on the strands and accentuates one strand as the primary method and the additional strand as secondary (Creswell & Plano-Clark, 2011). This dissertation emphasized the qualitative strand as primary because it is the method by which all of the research questions were answered. Even so, the quantitative strand was a highly valued method of inquiry into a few research questions.

As previously noted, data were collected during different phases. The quantitative data collection occurred one year prior to the collection of qualitative data. In the embedded design, the collection of quantitative data can occur before, during, or after the qualitative data collection (Creswell & Plano-Clark, 2011). Collecting data in this way allowed flexibility in determining the qualitative interview questions that could effectively address the intended research aims. Consequently, the gaps in available quantitative data necessitated qualitative data to produce more information thereby leading to a greater understanding of the overall problem.

After collecting quantitative and qualitative data, data analyses occurred, and both strands were analyzed during the same phase in the study. The data analyses process was organized such that qualitative data were used to answer all of the research questions, and for those questions where quantitative file review data were available, both strands were used to answer research questions. Two out of the four research questions were answered through both qualitative and quantitative inquiry. The degree to which the strand was
important for a particular research question depended entirely on the purpose of the question.

Figure 3.2 Embedded Design

Quantitative sample and procedure

This section will introduce the quantitative sample and procedures used in this dissertation. Although the quantitative sample was taken from the CSOMB state evaluation, the researcher was an integral part of a research team that worked to develop and test the collection forms and collect the data. The family variables available in the dataset were the primary focus of the quantitative portion of this dissertation.

Sample. The quantitative sample was taken from probation files of juveniles who had been adjudicated of a sexual offense in the state of Colorado. As previously mentioned, the CSOMB was conducting a research study to evaluate the state mandated standards, and permission was granted to this researcher by the CSOMB and the University of Denver IRB to examine the family variables available in this data set. In an attempt to capture the different state demographics, the CSOMB pulled files located in three different jurisdictions around the state including a Metro area, Mountain/rural
The CSOMB originally designed the quantitative study to include one group of files between July 1, 1998 and June 30, 1999 (Group 1) and another group of files (Group 2) between July 1, 2006 and June 30, 2007.

The sample size for the first group is $n = 53$ and the sample size for the second group is $n = 35$. The total sample size for the groups combined is $N = 88$. After the data were cleaned, three cases were deleted due to an extreme amount of missing data, leaving a total sample size of $N = 85$. The sample characteristics suggested that 76.5% of the youth were White, 12.9% were Hispanic, 1.2% were Native American, and 1.2% were Bi-racial. The mean age of the youth was 14.5 ($SD = 1.9$), and 90.6% of the sample were male and 9.4% of the sample were female.

**Data collection: File reviews.** Data in the form of youth file review were collected between September 2010 and April 2011. There were a total of four individuals, including the researcher who reviewed the files and entered information into data collection forms formulated by the CSOMB. The data collection forms contained questions that gathered information about the standards and guidelines for treatment and also included information pertaining to family treatment. Several meetings were held prior to data collection to confirm the accuracy of the data collection forms and fidelity checks were conducted to ensure inter-rater reliability among the individuals collecting the data. Additionally, prior to the data collection process, the individuals were debriefed on the location of certain variables in the files. Because data collection efforts were time-consuming, this allowed for greater ease in the process. The data collection took place in judicial buildings at three separate jurisdictions around the state.
**Data collection: Recidivism.** The Office of Research and Statistics furnished recidivism data separately from the data collected through case file review. The Office of Research and Statistics provided recidivism data on the youth in the files three years after they were discharged from treatment. The recidivism data were in the form of new court filings, and information was gathered on youth with or without new court filings for any new offenses, including any new sexual offenses. Because there is some controversy on ways to measure the occurrence and frequency of re-offending (Caldwell, 2010), it was decided by the CSOMB that using new court filings is an unbiased way to assess recidivism. Other measures of recidivism, such as conviction rates could under-estimate occurrences of recidivism, while arrests rates could potentially over-estimate occurrences of recidivism (Caldwell, 2010).

**Quantitative measures**

As quantitative measures were derived from CSOMB youth file reviews, the CSOMB operationally defined all quantitative measures. The files included demographic information on the juveniles, information on type of sentence, adjudicated offense, prior adjudications, as well as variables of interest that this dissertation sought to address such as living situation at time of arrest, placement information after adjudication, whether family was involved in the multidisciplinary team (MDT), family reunification, informed supervision, family therapy, multi-family group therapy, and treatment success. This information was located in the pre-sentence reports, treatment summaries and notes, progress reports, and discharge summaries within the files. The CSOMB formulated a
data collection form for the purposes of gathering the data by using these defined constructs as a guide in that process. The data collection form is attached in Appendix A.

**Family.** The Colorado Sex Offender Management Board defined family as “Parents or other adults who have custodial responsibility to care for the juvenile. It is broadly defined as providing the nurturance, guidance, protection, and supervision that promotes normal growth and development and supports competent functioning” (CSOMB, 2011, p. 12). Although “family” wasn’t necessarily a variable in the dataset, the definition of family was used as a guide for data collection and measurement.

**Independent variables.** The following measures represent the independent variables that were used in the quantitative portion of this dissertation. These variables were used to predict the outcomes. Only variables that revealed significant bivariate relationships were included in the final models. Under the broad umbrella category of *family service involvement*, there is a detailed description of the measures that make up this category. Other independent variables included in the analyses were measures of living situation such as *jurisdiction, placement, and change of placement*, and are outlined further.

**Family service involvement.** *Family service involvement* was used as a broad category to describe the six distinct ways youth had their families incorporated into treatment and included (a) family therapy, (b) multi-family group therapy, (c) caregiver in the multi-disciplinary team, (d) family member in the multi-disciplinary team (e) informed supervision, and (f) family reunification. A youth was considered to have had family service involvement if they received one or more of these services. For the
analyses, the separate variables were aggregated to create one variable labeled family service involvement.

Family therapy. Family therapy was defined as a type of family treatment that “addresses family systems issues and dynamics” (CSOMB, 2011, p. 36). Family therapy was indicated in the treatment notes and progress reports within the files. The scale developed by the CSOMB asked, “Did the juvenile’s family participate in family therapy?” The responses were 0 (no) and 1 (yes).

Multi-family group therapy. The CSOMB defined multi-family group therapy as a modality that “provides education, group process, and/or support for the parent and/or siblings of the juvenile” (CSOMB, 2011, p. 36). Multi-family group therapy was indicated in the treatment notes and progress reports in the files. The scale developed by the CSOMB asked, “Did the juvenile’s family participate in multi-family group therapy?” The responses were 0 (no) and 1 (yes).

Multi-disciplinary team. Multi-disciplinary team (MDT) was defined as a type of team collaboration where team members are involved in decision-making and manage and supervise the juvenile through the treatment. Families are considered an integral piece of the MDT (CSOMB, 2011). Individuals and professionals who were involved in the MDT were indicated in the treatment notes in the files. The MDT members were measured by 1) Treatment Provider, 2) Supervising Officer, 3) Polygraph Examiner, 4) Victim Representative, 5) DHS Caseworker, 6) Caregiver in any out-of-home placement, 7) Family Member, 8) GAL, 9) Other ____________. Two dummy variables were created from the multi-disciplinary team variable. This was done to capture youth with either
family or caregiver involvement or both. The first variable was created by dummy coding to indicate family involvement in the MDT (0=all other categories, 1=family). The second variable was created by dummy coding to indicate out of home caregiver involvement in the MDT (0=all other categories, 1=caregiver). Both dummy coded MDT variables were included when computing the overall family service involvement variable.

_Informed supervision._ Informed supervision is a training that family members receive to be able to supervise a sexually abusive youth. The CSOMB defined informed supervision as

The ongoing, daily supervision of a juvenile who has committed a sexual offense by an adult (usually a family member) who is aware of the juvenile’s history of sexually offending behavior, does not deny or minimize the responsibility for, or the seriousness of sexual offending, can define all types of abusive behaviors and can recognize abusive behavior in daily functioning, is aware of the laws relevant to juvenile sexual behaviors, is aware of the dynamic patterns (cycle) associated with abusive behaviors and is able to recognize such patterns in daily functioning, understands the conditions of community supervision and treatment, can design, implement, and monitor safety plans for daily activities, is able to hold the juvenile accountable for behavior, has the skills to intervene in and interrupt high risk patterns, can share accurate observations of daily functioning, and communicates regularly with members of the multidisciplinary team. (CSOMB, 2011, p. 16)

The treatment notes, progress reports, and termination summaries in the files indicated whether parents received informed supervision training. The scale developed by the CSOMB asked, “Did the juvenile’s family complete informed supervision therapy or training?” The responses were 0 (no), 1 (yes), and 9 (do not know).

_Family reunification._ Family reunification is the process by which juveniles living away from home reunite with families under the premise of decreased risk, relapse
prevention planning, and identification of support in the community (CSOMB, 2011). Family reunification information was indicated in the treatment notes, progress reports, and termination summaries. The scale developed by the CSOMB asked, “Did the juvenile participate in family reunification procedures?” The responses were 0 (no), 1 (yes), and 9 (do not know).

**Jurisdiction.** Jurisdiction was a variable in the quantitative data that was created according the judicial district area where the data were collected. The jurisdiction number was recorded on the data collection form. The jurisdiction number was transformed to indicate whether the jurisdiction reflected an urban jurisdiction (0=urban) or a rural jurisdiction (1=rural).

**Placement.** Placement indicates where youth were placed post adjudication. This information was determined by the treatment documents in the files indicating the setting and living situation of youth. The placement was recorded by circling one of the following 1) Out-patient/in-home, 2) DHS out-of home placement/foster care, 3) DYC correctional placement, 4) Other__________, 9) Do Not know. The placement variable was dummy coded to ensure enough cases per category. This dummy coded variable indicated if youth were living in an out of home placement (0=out of home) or living in-home placement (1=in home).

**Change in placement.** Change of placement was defined by youth moving placements during the course of treatment. This information was found in the treatment documents in the files and indicated if youth had moved and the reasons for the move.
The CSOMB scale asked, “Did the juvenile get moved to a different placement or living situation/arrangement?” The responses were 0 (no), 1 (yes), and 9 (do not know).

**Covariates.** The following measures describe the co-variates that were also used in the quantitative portion of this dissertation. These variables were used as controls and were important to include in the models because they can be arguably associated with the outcomes (Prescott, 2005; Worling, 2004).

**Gender.** The youths’ gender was defined as their biological makeup of male or female. The youths gender was coded as 0= male and 1= female.

**Age.** The youths’ age was defined as the number of years old they were at the time they were adjudicated. The youths’ ages were drawn from the cover page of the file that provided the number.

**Ethnicity.** The youths’ ethnicity was defined by their ethnic identity or race. Ethnicity was drawn from the cover page of the file that provided the specific category. The ethnicity variable was measured as 1) Anglo, 2) African American, 3) Hispanic, 4) Native American, 5) Asian, 6) Other, or 9) Do not know. To ensure enough cases per category, ethnicity was dummy coded to indicate non-White (0=non-White) or White (1=White).

**Risk level.** The youths’ risk level was defined as the “likelihood the youth will re-offend and the overall level of risk they pose to the community” (CSOMB, 2011, p. 23). The Colorado Sex Offender Management Board requires all youth to receive a pre-sentence evaluation that is conducted for the purposes of determining amenability for treatment, make recommendations for treatment, and assess the youth’s overall risk.
In conducting this report, the evaluators are required to use an actuarial tool for determining a level of risk, which includes, but is not limited to Sexual Offense Risk Assessment Guide (SORAG), Estimate of Risk of Adolescent Sex Offender Recidivism (ERASOR), or the Juvenile Sex Offender Assessment Procedure-II (JSOAP-II) (CSOMB, 2011). From this evaluation, youth receive a level of risk, which was measured as 1) Low, 2) Low-moderate, 3) Moderate, 4) Moderate-high, 5) High, or 6) Other.

**Mental health diagnosis.** The youths’ mental health diagnosis was defined as the presence of any DSM-IV diagnosis of a mental health condition. The youths’ mental health diagnosis was a previous diagnosis given to the youth by a mental health practitioner prior to the criminal behavior and adjudication. It was known if a youth had a diagnosis based on the pre-sentence evaluation when the youth was required to self-report this information. The CSOMB scale asked, “At the time of the offense or 6 months prior to the offense, did the juvenile have a mental health diagnosis?” The responses were 0 (no), 1 (yes), and 9 (do not know).

**Prior adjudications.** The prior adjudications were defined as whether or not the youth had any known adjudications before being charged with the current offense. This information was gathered from the pre-sentence evaluation in which the investigator was required to ask the youth if they had ever been adjudicated of another offense. The responses on the CSOMB scale were 0 (no), 1 (yes), and 9 (do not know).

**Type of sentence.** The type of sentence, which was defined as probation, a combination of probation and detention commitment (Department of Youth Corrections),
or just detention commitment (Department of Youth Corrections) was gathered from the cover page in the file that indicated the type of sentence they received. The responses on the CSOMB scale were 1) Probation, 2) DYC, 3) Other, and 4) Do not know. To ensure enough cases per category, type of sentence was dummy coded to indicate non-probation (0=other) or probation (1=probation)

**Dependent variables.** The following are measures are used as dependent variables in the quantitative portion of this dissertation: *Involvement in family therapy, treatment completion, and recidivism.* These variables were used as indicators of outcomes in three different models.

**Involvement in family therapy.** Although this particular variable was one of six variables used to indicate *family service involvement*, it was also used as an outcome to test what factors are associated with youth receiving family therapy. Certain factors (i.e. youths’ living situation) were hypothesized to influence the degree to which youth are involved in family services. Family therapy was used as the dependent variable as it is the type of family service that is implemented most frequently and consistently throughout treatment (CSOMB, 2011). Family therapy was defined as a type of family treatment that “addresses family systems issues and dynamics” (CSOMB, 2011, p. 36). Family therapy was indicated in the treatment notes and progress reports within the files. The scale developed by the CSOMB asked, “Did the juvenile’s family participate in family therapy?” The responses were 0 (*no*) and 1 (*yes*).

**Treatment completion.** The CSOMB defines treatment completion as the termination of sex offense specific treatment. Successful treatment is when youth
accomplish the pre-determined goals of sex offense specific treatment. Negative completion of treatment is the cessation of treatment that is due to lack of progress towards these goals (CSOMB, 2011). Treatment completion data were gathered from termination summaries that were written and determined by the treatment provider. The scale developed by the CSOMB indicated “Status at final treatment completion.” The responses were 0) *Positive completion of treatment*, 1) *Negative discharge/termination*. The treatment completion variable was reverse coded so positive completion of treatment was used as a reference point. The variable was reverse coded to indicate unsuccessful completion of treatment (0= *negative*) or successful completion of treatment (1= *positive*).

**Recidivism rates.** The CSOMB has defined recidivism rates as “The return to offending behavior after some period of abstinence or restraint. They are often re-offenses that are self-reported, convicted offenses, or by other measures” (CSOMB, 2011, p. 17). As previously discussed, recidivism was measured by assessing new court filings and was pulled at 3 years post-discharge. This was done so that youth in each fiscal year group were permitted the same amount of time to re-unify or acclimate to their communities, environments, and families. The number of times youth re-offended and the type of re-offense indicated by sexual offense, non-violent/non-sexual, and violent/non-sexual offense were recorded for every youth in the sample. The CSOMB developed a recidivism rate measure that included two variables. The first variable captured youths’ number of post-discharge offenses written as “How many post-discharge court filings has the youth had? _______” The second variable captured the type of offense that is committed and was written as “What type of post-discharge court filing did the youth
commit?” Non-sexual/Non Violent____, Non-sexual/Violent____, and Sexual____.

Because of the low number of cases in the sexual recidivism category, and the low variability in the number of re-offenses, the final variable included only the occurrence of an offense (i.e. whether or not youth recidivated, yes or no). Therefore, the post-discharge court filings were used as final variable and was dummy coded to indicate no recidivism (0=no recidivism) or recidivism (1 or more=recidivism).

Quantitative data computations and transformations

**Family service involvement.** Informed supervision, family reunification, family therapy, multi-family group therapy, family member in the MDT, and caregiver in the MDT were computed to create a new variable labeled family service involvement. The variables were added together to indicate if youth had received one or more types of family treatment. Each youth had a score that reflected how many family services they received, and the final variable used in the analyses was measured on a continuous scale ranging from 0 to 6. Only the data points that were available were included; any missing data points on any particular type of service were not totaled. Although this variable may under-represent the extent to which youth may have received services, it is the most accurate way to capture the available data. The goal of this computation was to add variability in the dataset and determine the effect of having one or more forms of family service involvement.

**Combining fiscal year groups.** The two fiscal year groups were combined in the analyses. Due to the low sample size in this study, the analyses required examining the groups simultaneously. Therefore, to justify combining the groups, chi-square tests were
run to determine any differences between the groups on the family variables of interest.

Preliminary chi-square and t-tests revealed little differences between the two groups on a variety of constructs including gender \((\chi^2(1, N = 81) = .44, p > .05)\), ethnicity \((\chi^2(1, N = 78) = 1.15, p > .05)\), type of sentence \((\chi^2(1, N = 81) = 1.9, p > .05)\), mental health diagnosis \((\chi^2(1, N = 78) = .05, p > .05)\), prior adjudications \((\chi^2(1, N = 79) = .72, p > .05)\), change of placement \((\chi^2(1, N = 75) = .11, p > .05)\), placement \((\chi^2(1, N = 76) = .53, p > .05)\), involvement in family therapy \((\chi^2(1, N = 85) = .60, p > .05)\), treatment completion \((\chi^2(1, N = 85) = 1.5, p > .05)\), and recidivism \((\chi^2(1, N = 84) = .17, p > .05)\). T-tests were used to test mean differences between fiscal year groups and age \((t(77) = .97, p > .05)\), family service involvement \((t(83) = 1.8, p > .05)\), and risk level \((t(67) = 1.5, p > .05)\). The results revealed that the fiscal year groups differed by jurisdiction \((\chi^2(1, N= 84) = 8.5, p < .01)\) and this finding could be attributed to the manner in which the files were pulled.

Overall, the results revealed that the groups share commonalities as they relate to a variety of constructs, and this provides rationale for combining the groups for the analyses. The results of the chi-square and t-tests are displayed in Table 3.1.

### Table 3.1 Chi-Square and t-tests tests of fiscal year groups

<table>
<thead>
<tr>
<th>Construct</th>
<th>Group 1</th>
<th>Group 2</th>
<th>(\chi^2)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>%</td>
<td>Frequency</td>
</tr>
<tr>
<td>Gender</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>51</td>
<td>96.2</td>
<td>26</td>
</tr>
<tr>
<td>Female</td>
<td>2</td>
<td>3.8</td>
<td>2</td>
</tr>
<tr>
<td>Ethnicity</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>45</td>
<td>86.5</td>
<td>20</td>
</tr>
<tr>
<td>Other</td>
<td>7</td>
<td>13.5</td>
<td>6</td>
</tr>
<tr>
<td>Jurisdiction</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rural</td>
<td>9</td>
<td>17.3</td>
<td>15</td>
</tr>
<tr>
<td>Urban</td>
<td>43</td>
<td>82.7</td>
<td>17</td>
</tr>
<tr>
<td>Type of Sentence</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Probation</td>
<td>44</td>
<td>83.0</td>
<td>23</td>
</tr>
<tr>
<td>Other</td>
<td>9</td>
<td>17.0</td>
<td>9</td>
</tr>
<tr>
<td>-----------------------</td>
<td>-----</td>
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<td>-----</td>
</tr>
<tr>
<td>Mental Health Diagnosis</td>
<td>24</td>
<td>51.1</td>
<td>15</td>
</tr>
<tr>
<td>Prior Adjudications</td>
<td>14</td>
<td>28.6</td>
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<td>Change of Placement</td>
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<td>Placement</td>
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<td>52.1</td>
<td>17</td>
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<td>Out of Home</td>
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<td>47.9</td>
<td>11</td>
</tr>
<tr>
<td>Involvement in Family Therapy</td>
<td>30</td>
<td>60.0</td>
<td>21</td>
</tr>
<tr>
<td>Treatment Completion</td>
<td>24</td>
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<td>19</td>
</tr>
<tr>
<td>Recidivism</td>
<td>23</td>
<td>43.4</td>
<td>12</td>
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</table>

<table>
<thead>
<tr>
<th>Mean</th>
<th>SD</th>
<th>Mean</th>
<th>SD</th>
<th>t</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>14.4</td>
<td>1.8</td>
<td>14.8</td>
<td>2.1</td>
</tr>
<tr>
<td>Family Service Involvement</td>
<td>2.3</td>
<td>1.2</td>
<td>2.7</td>
<td>1.2</td>
</tr>
<tr>
<td>Risk Level</td>
<td>3.18</td>
<td>1.3</td>
<td>2.73</td>
<td>1.2</td>
</tr>
</tbody>
</table>

*p < .05, **p < .01, ***p < .001

Sample characteristics. The quantitative sample \((N = 85)\) averaged 14.5 years of age \((SD = 1.9)\), were primarily male \((n = 77; 95.1\%)\), and were mostly white \((n = 65; 83.3\%)\). The majority of the sample lived in an urban area \((n = 60; 71.4\%)\) as opposed to a rural area \((n = 24; 28.6\%)\), were placed on probation \((n = 67; 78.8\%)\) as opposed to jail or another sentence \((n = 18; 21.2\%)\), and had no prior adjudications \((n = 59; 74.4\%)\). More youth lived in an in-home placement \((n = 42; 49.4\%)\) than an out of home placement and more youth changed placements during care \((n = 43; 50.6\%)\). Exactly half of the sample had a previous mental health diagnosis \((n = 39; 50.0\%)\). On average, youth’s risk level was 3.2 \((SD = 1.3)\) and families were involved in an average of 2.4 services \((SD = 1.2)\). The majority of the sample were involved in family therapy \((n = 54; 63.5\%)\), had successfully completed treatment \((n = 54; 63.5\%)\), and did not recidivate \((n = 49; 57.6\%)\). The sample characteristics are illustrated in table 3.2.

Missing data. Data missing from this data set can most appropriately be considered to be missing at random (MAR). The data can be considered to be missing at
random because after controlling for other variables, the data are not associated with the missing data distribution (Graham, 2009). So, conditioning the data allows for randomness to be detected (Graham, 2009). Statistical tests were run to verify the data were missing at random. The missing data were dummy coded (0=All Other Values; 1=Missing Data) and chi-square tests were run to determine if the missing data were related to the dependent variables (Meyers, Gamst, & Guarino, 2006). The chi-square tests revealed that whether data were missing was not statistically significant related to any of the outcomes. The MAR tests are displayed in Table 3.2.

The missing data associated with the variables gender ($\chi^2(1, N = 85) = .24, p > .05$), ethnicity ($\chi^2(1, N = 85) = 1.4, p > .05$), age ($\chi^2(1, N = 85) = 2.5, p > .05$), jurisdiction ($\chi^2(1, N = 85) = .58, p > .05$), mental health diagnosis ($\chi^2(1, N = 85) = .13, p > .05$), prior adjudications ($\chi^2(1, N = 85) = .51, p > .05$), placement ($\chi^2(1, N = 85) = .04, p > .05$), change in placement ($\chi^2(1, N = 85) = 3.4, p > .05$), and risk level ($\chi^2(1, N = 85) = .45, p > .05$) were not statistically significantly associated with the outcome of involvement in family therapy. The missing data associated with the variables gender ($\chi^2(1, N = 85) = 2.4, p > .05$), ethnicity ($\chi^2(1, N = 85) = .13, p > .05$), age ($\chi^2(1, N = 85) = .51, p > .05$), jurisdiction ($\chi^2(1, N = 85) = .58, p > .05$), mental health diagnosis ($\chi^2(1, N = 85) = .21, p > .05$), prior adjudications ($\chi^2(1, N = 85) = 3.7, p > .05$), placement ($\chi^2(1, N = 85) = 2.8, p > .05$), change in placement ($\chi^2(1, N = 85) = .21, p > .05$), and risk level ($\chi^2(1, N = 85) = .01, p > .05$) were not statistically significantly associated with the outcome of treatment completion. Finally, the missing data associated with the variables gender ($\chi^2(1, N = 84) = .09, p > .05$), ethnicity ($\chi^2(1, N = 84) = 1.7, p > .05$), age ($\chi^2(1, N = 84) = 1.7, p > .05$),
jurisdiction ($\chi^2(1, N = 84) = 1.4, p > .05$), mental health diagnosis ($\chi^2(1, N = 84) = 2.4, p > .05$), prior adjudications ($\chi^2(1, N = 84) = .19, p > .05$), placement ($\chi^2(1, N = 84) = 1.5, p > .05$), change in placement ($\chi^2(1, N = 84) = .42, p > .05$), and risk level ($\chi^2(1, N = 84) = .88, p > .05$) were not statistically significantly associated with the outcome of recidivism.

Research has suggested two distinct methods of handling missing data: deleting the missing data or replacing values (Kline, 1998; Little & Rubin, 1987). Because of the relatively small sample size, the low power afforded when deleting missing data, and the risk for bias (Tabachnick & Fidell, 2001; Fox-Wasylyshyn & El Masri, 2005), the most ethical approach in handling this missing data was to apply an imputation technique (Rose & Fraser, 2008; Howell, 2012).

**Multiple imputation.** Multiple imputation is a technique that is widely accepted as a solution for replacing missing data (Fox-Wasylyshyn & El Masri, 2005; Graham, 2009; Rose & Fraser, 2008; Schafer & Graham, 2002; Rubin, 1996). In this technique, the missing value is substituted with a predicted value based on the variables that are available while adding random error to each variable (Rose & Fraser, 2008; Howell, 2012). Prior to starting this process, the researcher must identify an “imputation model” or specify the variables that most accurately relate to the missing values (Rose & Fraser, 2008). The multiple imputation process generates new values for the missing values in an iterative process and creates multiple data files. Values that derived from “conditional probability distributions” use a technique known as Markov Chain Monte Carlo (MCMC) to substitute the missing values (Rose & Fraser, 2012, p. 172). Each data file is produced by different approximations of the values (Rose & Fraser, 2012). With the literature
suggesting that three to five data files are needed (Howell, 2012), this dissertation used five different data files for multiple imputations of the variables. The values in each data file were then averaged so that each missing data point was replaced with a final score indicative of a value that most accurately resembles what would have been a true score (Rose & Fraser, 2012; Howell, 2012).

Multiple imputation was implemented with the missing values optional add-on module in SPSS 21.0 (SPSS, Inc., 2012, Chicago, IL, www.spss.com). Due to the small sample size of this data set and the subsequent risk for bias and low power that results from further deleting missing data (Tabachnick & Fidell, 2001; Fox-Wasylyshyn & El Masri, 2005), multiple imputation techniques were applied to all variables with missing values. The missing data distribution and variables requiring multiple imputation techniques is displayed in Table 3.2. One major downfall for conducting multiple imputation on binary variables is that it alters the original value such that they become continuous probabilities (Rose & Fraser, 2012). For this dissertation, the changes in the level of measurement required the use of different bivariate statistical tests (i.e. t-tests as opposed to chi-square tests).

Table 3.2 Sample characteristics and missing data distribution

<table>
<thead>
<tr>
<th>Variable</th>
<th>Frequency (%)</th>
<th>Mean (SD)</th>
<th>Missing (%)</th>
<th>MAR Test ($\chi^2$)</th>
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<td></td>
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<td>Family Therapy</td>
</tr>
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<td>Gender</td>
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<td>.24</td>
</tr>
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<tr>
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<td>4 (4.7)</td>
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<td></td>
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<tr>
<td>Ethnicity</td>
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<td></td>
<td>7 (8.2)</td>
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<tr>
<td>Category</td>
<td>Count</td>
<td>Percentage</td>
<td>Mean</td>
<td>Standard Deviation</td>
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<tr>
<td><strong>Race</strong></td>
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<td>14.5</td>
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<td>13</td>
<td>15.3</td>
<td>6</td>
<td>7.1 (1.2)</td>
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<tr>
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*p < .05, **p < .01, ***p < .001

**Qualitative sample and procedure**

In this section, the qualitative sample and procedure is explained in more detail.

Following the flow of Embedded Mixed Methods design, the qualitative data were collected after the quantitative data and were collected independently of the CSOMB state evaluation. Because the majority of research questions were answered with qualitative data, it was important to collect and analyze the data with the upmost rigor.

**Sample.** With the University of Denver IRB approval, qualitative data were obtained by conducting individual interviews with approved treatment providers who have serviced youth sex offenders throughout the state of Colorado. The CSOMB maintains a list of providers from which the sample originated. The process by which treatment providers become approved is lengthy and challenging. The providers are
required to undergo various trainings, keep and maintain hours of clinical service, and re-apply to maintain their status every year. Because of the difficulty in becoming an approved provider, this sample is particularly valuable because it draws from devoted professionals with vast experience treating sexually abusive youth and their families. Not only can providers most accurately highlight the nuances of family treatment, but they can also provide a unique perspective on the meaningful experiences of families as they undergo the treatment process. For this reason, providers were chosen as the most appropriate sample.

**Recruitment.** As previously discussed, the CSOMB maintains a current list of all treatment providers around the state. The sample for the interviews was selected by attempting to recruit the entire list in an effort to reach all providers. There were approximately 150 treatment providers servicing youth around the state working in various sectors including outpatient, residential, and community service agencies. Recruitment occurred by directly contacting the providers by phone and e-mail. The providers were primarily contacted by e-mail, and phone contacts were made if potential participants had further questions related to the study. Phone contacts were also made in a few circumstances when e-mails were not valid. A snowball sampling method was also used to recruit participants through pre-existing relationships with professionals who used “word of mouth” techniques to gather more participants (Padgett, 2008, p. 54). Some participants were able to discuss the benefits of the study with other providers to elicit more excitement and more participation among those that had previously received an e-mail or phone contact but had not responded.
Upon contact, the researcher informed participants of the study and benefits associated with their participation, including the ability to inform practice and research for a highly vulnerable population. They were asked to participate in a semi-structured interview that took approximately 1 to 1 ½ hour to complete. The treatment providers received incentives in the form of a monetary gift of $30.00 for their participation in the interview. The providers were required to fill out an informed consent form and consented to being interviewed and audio recorded, and their responses were stored confidentially. When conducting analyses and writing the dissertation, the researcher replaced participant names and ages with aliases.

After several treatment providers agreed to participate, and upon interviewing 14 providers, the researcher began to approach saturation, where ideas and positions were recurring and redundant across participants (Padgett, 2008). It was then that the semi-structured interview guides were re-formulated to capture more in-depth and meaningful information from these common positions. After revising the semi-structured interview, the researcher then purposely sought to interview five more individuals who had been in the field over twenty years. This strategy allowed the researcher to gather information from individuals with a vast amount of practice experience and knowledge pertaining to the field. The total qualitative sample size was a “moderate” sample of 19 treatment providers (Padgett, 2008, p. 32).

**Data collection.** The qualitative data were collected by way of a semi-structured interview guide. As previously discussed, the researcher intended to study concepts that were not presented in the quantitative data, and this necessitated the use of qualitative
methods. The qualitative interview guide was formulated from emergent themes from focus group data. The CSOMB and the researcher conducted focus groups with a variety of multi-disciplinary team members including polygraph examiners, treatment providers, and probation officers. Four focus groups were conducted in three jurisdictions around the state. Emerging findings centered around concepts like families and treatment and included: Family dynamics, a lack of family involvement, challenges in getting families involved, difficulty understanding the system, and ways to improve service delivery for families.

The researcher developed the individual interview guide in collaboration with the CSOMB and her dissertation committee. The guide was composed of questions that focused on treatment provider perspectives and experiences in working with families of youth who have sexually offended. There were seven overarching questions that were asked of the treatment providers. These questions were: 1) What is your professional experience in treating sexually abusive youth? 2) What is your general treatment philosophy? 3) How would you generally describe families of sexually abusive youth? 4) What are the costs and benefits of incorporating families into services? 5) What are the barriers and challenges associated with getting families to engage in family services? 6) What does family therapy look like when it’s adapted for families of sexually abusive youth? 7) How can family services for families of sexually abusive youth be improved? The interview guide is attached in Appendix B. The location of data collection was contingent upon treatment provider location and availability. The researcher traveled to the location of the treatment provider and often conducted the interviews at their place of
employment. When travel was not possible, interviews were conducted and audio recorded over the phone.

**Data analyses**

Data analyses took place between August 2012 and November 2012 and the strands were analyzed during the same phase in the study. Qualitative methods were the predominate strand that answered all four of the research questions. As noted in the design section, the analyses occurred in such a way that any research questions warranting a mixed methods approach used the available quantitative data and the analyses were enhanced with qualitative methods. Furthermore, the degree to which the strand was important in answering a particular research question depended on the purpose of the question. For example, the first research question was posed with the knowledge that only a portion of the quantitative data could answer it, and upon running quantitative analyses, qualitative themes were able to augment and enrich the findings. The final research question was posed with the knowledge that more quantitative data were available to answer it, and was therefore answered largely through quantitative inquiry. However, this final research question was also reinforced and strengthened by the use of qualitative data. Therefore, methodological triangulation was achieved in answering these particular research questions (Padgett, 2008). The second and third research questions were answered exclusively with qualitative methods. In the following analyses section, the qualitative approach will be discussed at length followed by the quantitative approach.
**Qualitative Grounded Theory approach.** The qualitative approach that was used to organize the data was a grounded theory approach. A Grounded Theory approach is one that necessitates inductive coding and requires the researcher to use memo writing to record conclusions regarding the data. Grounded Theory integrates theoretical concepts while using the data to shape emerging themes to convey the overall findings (Padgett, 2008). The integration of pre-existing theories should not dictate the coding scheme. The coding may use ideas from the literature or existing theories, but the process is an inductive one where themes are drawn out from the data (Padgett, 2008). The coding process is one that uses both axial (where data is separated into categories and sub-categories) and selective phases (when the data is selected and refined into single core categories and into relationships with other categories). In this way, this coding process slowly leads the researcher to develop an overall conceptual framework (Padgett, 2008).

**Qualitative analyses.** Two-research assistants were hired to help transcribe the interviews, and the data were judiciously transcribed with the oversight of the researcher. The data were then entered in the qualitative data analysis software, ATLAS.Ti 7 (ATLAS.TI, 2012, Berlin, Germany, www.atlasti.com). A research assistant was hired for the purpose of aiding in the coding process alongside the researcher. Having an additional onlooker observe the data helped establish observer triangulation and inter-subjective agreement among emerging themes (Padgett, 2008). A coding template, or codebook that compiles a list of the codes, their descriptions, and contexts for their use (Saldana, 2009) was developed in conjunction with the research assistant. In establishing
this template, the two researchers coded the first five transcripts simultaneously to ensure inter-rater agreement, and approximately 80% of the codes were agreed upon. The coders reconvened and discussed ways to improve their consistency. After coding the next five transcripts, the coders were able to agree on approximately 95% of the codes. This coding template was used to guide the remainder of the analyses.

Prior to developing the coding template, a coding schema, or an analytical approach to coding (Saldana, 2009) was developed to assign meaning to the data and to accurately capture the discourse in the interviews (Saldana, 2009). This coding schema included open cycle coding, first cycle coding (structural and values coding), and second cycle coding (focused coding). Open cycle coding (the process of initially labeling the data) was used as a preliminary coding scheme in which the data were approached with a blank slate (Padgett, 2008). The first cycle of coding and the second cycle of coding have addressed the research questions by applying different techniques to extract information from the data, but the two coding cycles ultimately lead to consensus among the findings (Saldana, 2009). The first and second cycle coding structures were formed based on the nature of the qualitative interview questions within the semi-structured interview guide.

Not all of the original questions asked to the participants were used in the analyses. For the purposes of focusing on families and families in treatment, only questions pertaining to family were analyzed. Structural coding, a type of “content based coding” that relates to a specific research question used to frame the interview (Saldana, 2009, p. 67), was used as a first cycle coding mechanism to analyze responses to the following interview questions, “How would you generally describe families of sexually
abusive youth?” “What does family therapy look like when it’s adapted for families of sexually abusive youth?” “What are the barriers and challenges associated with getting families to engage in family services?” and “How can family services for families of sexually abusive youth be improved?” Structural coding was appropriate for these questions as the interview guide was framed in a way that the researcher could easily index and access the relevant data. In analyzing responses to the interview question, “What are the costs and benefits of incorporating families into services?” values coding was used as a first cycle coding technique. Values coding reflects participant values, beliefs, and attitudes that represent their different perspectives and worldviews (Saldana, 2009). Values coding was particularly useful in answering this question because it is framed in such a way that elicits participants’ opinions and how they value or place importance on families (Saldana, 2009).

Focused coding, which involves searching for the most significant or most frequently used initial codes to establish more “salient categories” (Saldana, 2009, p. 24), was used as the second cycle of coding. Focused coding was used to analyze all semi-structured interview questions because it has been argued to be especially advantageous for drawing out themes in studies that employ a Grounded Theory approach (Saldana, 2009). It was in the second cycle of coding that patterns began to emerge and categories and themes were eventually developed.

Using a grounded theory approach through inductive coding and memo writing (Padgett, 2008), the data were analyzed through a constant comparison technique. Constant comparison is a type of analyses that continuously compares different elements
of the interviews to gain understanding of the findings as a whole (Boeije, 2002). This technique was used to compare the data of one treatment provider throughout the duration of an interview, compare the data of one treatment provider throughout interviews and member checks, and compare different providers in different interviews (Boeije, 2002). Using multiple observers further supported the findings that emerged.

To ensure qualitative rigor, this study incorporated multiple coders, triangulation of data (focus groups, interviews, and written memos), member checks, peer debriefing, and a well-organized audit trail (Padgett & Henwood, 2012). After coding was completed, a member of the CSOMB reviewed the transcripts and the themes and categories were agreed upon.

**Quantitative.** Quantitative data analysis software, PASW 18 (PASW Statistics, Inc, 2009, Chicago, IL, www.spss.com) and SPSS (SPSS, Inc., 2012, Chicago, IL, www.spss.com), was used to organize and clean the data, run descriptive statistics, test bivariate relationships, handle missing data, and estimate logistic regression models. Prior to running any analyses, the variables were transformed, and the data set was cleaned. Descriptive data were run on the variables of interest to ascertain the missing data distribution, look for patterns, check for assumptions, ensure all data is coded appropriately, and summarize the frequencies and percentages for the variables. As previously reported, chi-square and t-tests were conducted to determine differences between fiscal year groups. Chi-square tests and t-tests were also conducted to determine bivariate relationships, and the use of each test was contingent upon a particular variable’s level of measurement. Furthermore, tests of assumptions were conducted for
the purposes of ensuring that parametric tests produce accurate results (Erceg-Hurn & Mirosevich, 2008).

**Bivariate relationships.** Chi-square and t-tests were conducted to determine bivariate relationships between the sample characteristics, covariates, and independent variables of interest and the dependent variables. Only those variables that were statistically significantly related to the outcomes at the bivariate level were included in the final logistic regression models. The variables were modeled this way because of the small sample size and the risk of reducing power by modeling all covariates in one multivariate model (Meyers, Gamst, & Guarino, 2006). The first tests were conducted to examine how the independent variables, including *age, gender, ethnicity, jurisdiction, type of sentence, mental health diagnosis, prior adjudications, risk level, placement, and change in placement* were associated with *involvement in family therapy*. The second set of tests were conducted to examine how the same independent variables, along with *family service involvement* were associated with *treatment completion* and *recidivism*.

**Tests of assumptions.** Prior to running any final models, assumptions for logistic regression analyses were tested. The first assumption of logistic regression models is that the dependent variables should be binary (Meyers, Gamst, & Guarino, 2006). The outcomes of this dissertation are dichotomous and therefore met this assumption. Another assumption of logistic regression models is that only meaningful variables should be included in the models (Meyers, Gamst, & Guarino, 2006). This assumption has been met as the meaningful variables were tested at the bivariate level to determine their fit for the logistic regression models. Finally, there should be an absence of multi-colinearity
between the independent variables (Meyers, Gamst, & Guarino 2006). This assumption was tested by running correlations on the independent variables, and the results demonstrated that the independent variables of interest were independent from each other with the exception of placement and change in placement which were moderately negatively correlated \((r=-.74, p<.001)\). Because the variables were significantly associated with involvement in family therapy at the bivariate level, they will be included in the models. However, because of the multi-collinearity, inserting the variables together into the logistic regression models may misrepresent the data by inflating the standard errors and masking true significance (Bobko, 2001), so the variables were included in two separate models. After the assumptions of the logistic regression models were tested and met, the next step was to run the models.

**Logistic regression models.** Logistic regression models were chosen as the most appropriate statistical method of predicting dichotomous outcomes. Quantitative data were used to answer two specific research questions. To answer these questions, three total logistic regression models were run. The first two models answered the first research question, “What prohibits family involvement in treatment?” This research question was posed with the intention of being answered through qualitative means. Knowing that there was available quantitative data related to youths’ living situation that could partially answer this question (i.e. whether youth living in an in home placement and those with more placement changes are more or less likely to be involved), the researcher decided to test this relationship quantitatively and enrich the response through the qualitative findings. Therefore, two logistic regression models were conducted to answer this
research question. According to the bivariate results (only those significant variables related at the bivariate level were included in the multivariate model), the three variables that were statistically significantly related to involvement in family therapy were age, placement, and change in placement. As previously mentioned, the models were estimated separately to account for the effects multi-collinearity could have on the findings. The first model regressed involvement in family therapy on age and placement. The second model regressed involvement in family therapy on age and change in placement. Family therapy was used as the dependent variable as it is the type of family service that is implemented most frequently and consistently throughout treatment (CSOMB, 2011).

The third model answered the fourth research question: “Are family services associated with positive outcomes?” This research question was posed with the understanding that primarily quantitative data could answer it. So, of the four research questions, this one places prominence on the quantitative strand to answer it. However, qualitative data were also used to enhance the answer this particular question. Based on the bivariate results, only significant predictors including family service involvement, placement, risk level, mental health diagnosis, and prior adjudications were included in the final model that tested the outcome of treatment completion. The bivariate results revealed that only one variable, placement, was associated with the second outcome, recidivism. As a result, these variables were not tested in a multivariate model.
Chapter Four: Results

Chapter four reports the results of this study. The chapter begins by reviewing the research questions and is then organized by using the research aims as overarching headings and the research questions as sub-headings. Within each sub-heading, there will be a detailed description of findings resulting from the specific method used to answer the question. For those questions that required multiple methodological strands, quantitative findings will be explained first followed by qualitative findings. Under the research questions subheadings answered with quantitative methods are thorough explanations of the results complete with tables illustrating bivariate relationships and logistic regression models. The qualitative findings will first detail the theme, provide an explanation and context of the theme, list the categories one by one that fall under the theme, incorporate the explanation and context of each category, support the category with quotes from the data, list the applicable sub-categories one by one that fall under the category, incorporate the explanation and context of each sub-category, and support the sub-categories with quotes from the data. Each research question sub-heading will have a figure that displays the hierarchy of qualitative findings and a table complete with the themes, categories, sub-categories, and qualitative quotes.

Research questions

One overarching research aim was, “Understanding the process of family-inclusive treatment” and three subsequent research questions were formulated to address
this aim. Research question 1: “What prohibits family involvement in treatment?”

Research question 2: “How do providers engage families in treatment?”  Research question 3: “What does family treatment entail and what factors are responsible for helping families progress through treatment?” The second overarching research aim was “Understanding how families contribute to positive outcomes”, and the fourth research question, “Are family services associated with positive outcomes?” addresses this aim.

Understanding the process of family-inclusive treatment

First research question

**What prohibits family involvement?** This question was answered through quantitative and qualitative inquiry into circumstances, situations, and contexts that were associated with families’ unwillingness or inability to be involved in treatment. The available quantitative data related to youths’ living situation was tested, as it was conjectured that this particular variable was related to level of involvement. Because of the limitations of this quantitative data to thoroughly answer this question, qualitative data were used to comprehensively address this question.

**What prohibits family involvement: Quantitative findings.** The quantitative data included information pertaining to a youths’ living situation that was hypothesized to be associated with the degree to which they are involved in family services, particularly family therapy. *Family therapy* was used as the dependent variable as it is the type of family service that is implemented most frequently and consistently throughout treatment (CSOMB, 2011). The independent variables of interest were the living situation variables including *jurisdiction, in-home placement, and change in placement* and the covariates
included gender, ethnicity, type of sentence, mental health diagnosis, prior adjudications, age, and risk level. The quantitative findings are organized by first describing significant bivariate relationships. Again, only those significant bivariate relationships were included in the final logistic regression models. Then, the results of the final models are explained in detail.

**Bivariate relationships.** Chi-square and t-tests were run to determine associations between the independent variables of interest and family therapy. The results revealed that older youth are less involved in family therapy than younger youth, \(t(83) = -2.0, p < .05\). Youth living in an in home placement were less involved in family therapy than those in an out of home placement, \(t(83) = -2.8, p < .01\). Finally, youth who changed placements more frequently during treatment were more involved in family therapy than those that didn’t change placements, \(t(83) = 3.1, p < .01\). The sample characteristics and bivariate relationships table are provided in Table 4.1.

Table 4.1 Sample characteristics and bivariate relationships: Family therapy

<table>
<thead>
<tr>
<th>Total Sample</th>
<th>Family Therapy ((N = 85))</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
</tr>
<tr>
<td>Type of Sentence</td>
<td></td>
</tr>
<tr>
<td>Probation</td>
<td>66</td>
</tr>
<tr>
<td>Other</td>
<td>18</td>
</tr>
<tr>
<td>Age</td>
<td>14.5</td>
</tr>
<tr>
<td>Gender</td>
<td>.05</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>.83</td>
</tr>
<tr>
<td>Jurisdiction</td>
<td>1.2</td>
</tr>
<tr>
<td>Mental Health Diagnosis</td>
<td>.51</td>
</tr>
<tr>
<td>Prior Adjudications</td>
<td>.25</td>
</tr>
<tr>
<td>Risk Level</td>
<td>3.2</td>
</tr>
<tr>
<td>Placement (In home)</td>
<td>.53</td>
</tr>
<tr>
<td>Change in Placement</td>
<td>.56</td>
</tr>
</tbody>
</table>

*\(p < .05\), **\(p < .01\), ***\(p < .001\)
Logistic regression models. Because of the moderate negative statistically significant correlation between the two independent variables of interest; placement and change of placement \((r(85)=-.74, p<.001)\), and the impact that multi-colinearity has in inflating the standard errors and subsequently masking true significance (Bobko, 2001), it was vital to test these variables independent of one another. The first logistic regression model regressed involvement in family therapy on age and placement. The second logistic regression model regressed family therapy on age and change in placement.

Model 1: Predicting family therapy. The Hosmer and Lemeshow test was used to interpret the overall fit of the model, and the results from this test revealed that there is a good model fit, \((\chi^2(2, N=85)=2.8, p>.05)\). The value of the pseudo R-square or the Cox & Snell suggests that 11% of the variance is explained by this model. The results of the final model revealed that youth living in an in home placement are 70% less likely to be involved in family therapy \((OR=.30, p<.01)\). Age did not remain a statistically significant predictor in this model. The results from the first model are provided in Table 4.2.

Table 4.2 Model 1: Predicting family therapy

<table>
<thead>
<tr>
<th>Involvement in Family Therapy</th>
<th>OR</th>
<th>(B)</th>
<th>SE</th>
<th>CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Placement (In home)</td>
<td>.30**</td>
<td>-1.2</td>
<td>.51</td>
<td>.07-.65</td>
</tr>
<tr>
<td>Age</td>
<td>.8</td>
<td>-.21</td>
<td>.12</td>
<td>.60-1.0</td>
</tr>
</tbody>
</table>

\*\(*p<.05, **p<.01, ***p<.001*

Model 2: Predicting family therapy. The Hosmer and Lemeshow test was used to interpret the overall fit of the model, and the results from this test revealed that there is a
good model fit, \( \chi^2(2, N = 85) = 10.37, p > .05 \). The value of the pseudo R-square or the Cox & Snell suggests that 15.3% of the variance is explained by this model. The results of the final model revealed that youth who changed placements were 4.9 times more likely to be involved in family therapy than those that did not change placements (OR=4.9, \( p < .01 \)). Age did not remain a statistically significant predictor in this model.

The results from the second model are provided in Table 4.3.

**Table 4.3 Model 2: Predicting family therapy**

<table>
<thead>
<tr>
<th></th>
<th>Involvement in Family Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>OR</td>
</tr>
<tr>
<td>Change in Placement</td>
<td>4.9**</td>
</tr>
<tr>
<td>Age</td>
<td>.79</td>
</tr>
</tbody>
</table>

*p < .05, **p < .01, ***p < .001

**What prohibits family involvement: Qualitative findings.**

The qualitative interviews revealed themes pertaining to *stress, families’ level of preparedness,* and *subjective barriers.* The categories present under the theme of *stress* included *new rules and demands* and *family system changes.* The categories that emerged under the theme of *families’ level of preparedness* included *external support* and *internal processes.* The category *external support* contained the following sub-categories: *distrust of the system* and *societal judgment.* The category *internal support* contained the following sub-categories: *grief process* and *fear and vulnerability.* The categories that emerged under the theme of *subjective barriers* included *resources* and *living situation.* To easily illustrate these findings, the themes, categories, and subcategories are displayed in displayed in Figure 4.1.
Figure 4.1 What prohibits family involvement: Qualitative themes, categories, and subcategories.

**Theme: Stress.** Treatment providers reported that there were various factors that resulted in families’ reluctance to be involved in treatment. Many of these reasons were directly attributed to the overwhelming feeling of stress that is coupled with the sexual offense. Stress was defined as a feeling of strain that decreases families’ interests, desires, or opportunities to actively be involved in treatment. The degree of stress can be so powerful that it may quite literally incapacitate or paralyze families in becoming involved. A high level of stress may be a new and unfamiliar hurdle, which families struggle to navigate around. Providers reported that families recognize they may not have the skills or capacities to cope with or confront the stress, which may result in a decreased motivation or opportunity seeking services.

Stress was underscored as an experience associated with attempts to cope with the sexual crime and it was also an experience associated with the consequences or sanctions placed on the family. Treatment providers noted the all-encompassing strain and the accompanying consequence that this event has in the lives of the families. Families feel more stress because of new rules and demands placed upon them and the family system.
changes that are commonly seen in families coping with a sexual crime. The stress experience therefore results in families’ inability to become involved in services.

*Category: New rules and demands.* New rules and demands placed on the family is one explanation that exemplifies just how deeply families experience stress and the resulting difficulties in becoming involved in services. Because public safety is a primary goal of the justice system, increased security measures are taken when a youth commits a sexual crime. There are amplified regulations, rules, and protocols (adhering to safety plans, no victim contact, restrictions related to community interactions) that youth are required to undergo, and by default, families are often mandated to assume similar responsibilities. Families are the main system involved in youths’ lives, and because youth are often times living with and dependent upon their families, they are the system that is most aptly suited for ensuring the safety and security of their children.

Because families are required to undertake this new responsibility, they feel an insurmountable amount of stress and pressure, and this impacts their participation in treatment. Treatment providers noted how deeply families might experience this stress and the following quote validates the family experience by explaining how families are grappling with incorporating the new rules while balancing the existing demands of life.

> You know, we’re living our lives happily before, now all these people are in our lives…they really have all these things and now the system is involved with, and yea licensing requirements upon them and no necessarily to parent right, and you have to parent in this particular way, it’s like you have to do certain things. You might have to watch this kid, you might have to drive this kid to a meeting, and it’s like that kind of thing. This is costly, it’s going to cost money, so and then invariably the other kids’ needs come into effect and having to balance the other children does put pressure on the families no doubt. (William, 59)
It is evident that families are responsible for the welfare and well being of their children, but the providers noted that the system, maybe unintentionally, places additional demands on the families to ensure that they are incorporating the most appropriate strategies to supervise. The families feel these rules can in some ways punish them rather than serving their intended purpose as a consequence for the youth. One treatment provider expressed this phenomenon very poignantly when she discussed not only the extent to which families are expected to implement the rules, but also how they perceive this as a punishment for a crime they didn’t actively commit. From this quote, it is clear that families feel it is an unremitting stress and an unfair consequence.

Then they have rules put on them. You need to take the informed supervision in order to supervise, you know, your kids need to be safety planned, so every time you do something or now you can’t travel out of state because you need a probation voucher. I think they get all of these specific rules placed on them too and that’s a complaint I’ve heard. We weren’t the ones who did this. You know, look what’s changed for us. (Pamela, 39)

Because of the increased pressure placed on them to follow the rules, families are put in a position where they have to make decisions and prioritize their schedules based on what they have been told are important meetings or appointments. Some families may not know how to prioritize their schedules, which can add to the existing stress that families feel, but ultimately illuminates factors impeding involvement. One treatment provider explained how the rules and demands can be an exceptionally intrusive process on families, and how families struggle to find a balance in their lives.

The process is so invasive. And so, that is really hard and I think part of the difficulty for families is that because everybody acts with them as though everything is of equal importance, they don’t know how to prioritize so it becomes difficult to deal with. (John, 35)
The new rules and demands are circumstances that contribute to the stress experienced by families because they require additional time and energy. The rules and demands therefore intensify the stress and consequently lead to hesitancy towards involvement in services.

*Category: Family system changes.* There are a variety of different changes the family undergoes that can amplify stress and impact involvement in services. Family system changes occur typically when the family is required to alter a part of their existing system, such as family dynamics, relationships, communication patterns, and day-to-day activities as a result of either existing stress or additional regulations and requirements. The existing stress could lead to family system changes as families begin to recognize differences, grow apart, or become angry, frustrated, or distrust one another. For example, one treatment provider said, “sometimes we’ll see where mom or dad blame the other parent for what happened” (Jeff, 36). Furthermore, family system changes can occur when depending on the type of crime, and sometimes in the case of incest, the justice system places additional restrictions on families, like mandating separation of family members. One treatment provider explained this further when she said,

Families doing things like saying dad will go with the son and live with the grandmother while mom stays with the female victim in the home and they’re just working so hard to try and follow the rules. (Patty, 56)

The concept of family system changes was noted several times throughout the interviews, where one treatment provider outlined an example and suggested that these changes may occur within the immediate family and with extended family members.

You know, I’ve definitely seen families be completely broken, you know, unable to be put back together; umm because, for example, I can think of a family where
he offended on his niece and nephew, the parents really supported him through his
treatment and so the parents of the victim completely kind of didn’t want anything
to do with their parents anymore, so that family was completely split up because
the parents supported the offender through treatment. (Jessica, 37)

Regardless of the reason behind the family system changes, many families will
inevitably face them and learn to adapt, relate, and function in a new or different system
than the one they’ve become accustomed to. One therapist noted how many families
focus on adapting to their lives after these changes, and how much of their energy is
wasted on futile efforts to contest the changes.

Everything changes. So the roles are going to change, um, I think it just depends
on the family. But one of the things that can happen with it is it can almost be an
unintended paradox. I’ve found that sometimes when you do what’s logical and
makes sense, the family then organizes itself around fighting that thing and that
becomes their focus instead of what is it about the family that we need to work
on. (Patty, 56)

Family system changes are an ongoing struggle for many families and contribute to the
stress experience. Because the family system changes are overwhelming, the stress is
exacerbated, which impacts treatment involvement because many families lack time,
energy, and motivation to seek services.

**Theme: Families’ level of preparedness.** Providers noted that families feel
inadequately prepared to handle the fallout that invariably follows from the sexual crime,
and this prohibits service involvement. The sexual offense can leave families feeling lost
and confused. Certainly, there is an absence of knowledge and understanding as to where
to go, whom to depend on, and the steps to take to improve situations. The level of
preparedness is the degree to which families are equipped with the tools to cope with a
problem of this magnitude and subsequently be involved in treatment. The level of
preparedness can be understood in the context of shock, in that early signs went undetected. For some families, youth never exhibited symptoms that would suggest they would commit a sexual crime. One treatment provider explained the sense of feeling alarmed and the ensuing confused sentiment,

It usually comes out of the blue for them, they’re like ‘I never saw this coming, I can’t believe this happened, what can we do to get through this because I don’t know what to do, I’m at a loss’. (Deborah, 28)

There are two distinct factors contributing to unprepared feelings: deficient external supports and maladaptive internal processes. Lacking external supports and enduring conflicting internal processes are avenues through which inadequate feelings can be perpetuated. Without fail, these challenges impact families’ ability and willingness to fully participate in treatment.

*Category: External support.* Families that have an absence of supports in their external world may feel less prepared to cope with the sex offense. Having a large support system can be beneficial for any one grappling with difficulties. So, when a youth commits a sexual crime and the resulting difficulties arise, families can lose those supports or feel distrust towards them. People that would ideally provide encouragement and reinforcement during difficult times, such as a close personal connection to the family are no longer a lasting or encouraging presence in the lives of these families. Furthermore, supports that exist to provide provisions and assistance, but ultimately hold decision-making powers are doubted and questioned. With a deficient support system, families feel even more isolated. One treatment provider expressed the lack of external supports accurately when he said, “What they are experiencing really is that they don’t
have control over these other people (friends and family) and these other people are a part of their lives now (the system), and that’s, they don’t like that” (William, 59).

*Sub-category: Distrust of the system.* Families learn very quickly that they are unable to lean on the system that has been instituted to keep them safe. Families perceive the justice system negatively, and lack trust that the system will carry out its intended role. “The system is always looked at as the enemy and the bad guy, and they’re going to make their life worse because this family is trying to get their son home” (Andrea, 40).

Consequently, families avoid the system. One treatment provider expressed how families frequently draw parallels between the system and family therapy, which impacts their desire to be involved in services. She explained,

> They feel like the system is out to get them, and so family therapy, to them, is just one big part of the system, it’s something they think is going to be reporting back, or judging them, or not giving them a chance to speak. (Terri, 50)

Another provider explained this phenomenon in more detail, as she described how the family does not typically receive services until after they have gone through the system, leaving them feeling jaded. So, it is evident that families fail to actively seek services because they lack trust in the system and in family services.

> I think by the time we wanted to get them engaged, you know they were in residential treatment, they have a very distrust of the system. I think a lot of times they don’t trust the system, you know like, they feel like the system is out to get them. And so, family therapy to them is just one big part of the system, you know, it’s something they think is going to be reporting back, or judging them, or you know, not giving them a chance to speak. (Jessica, 37)

*Sub-category: Societal judgment.* Adverse societal judgment is another factor that prohibits involvement in services. They cannot depend on their support systems because of the stigma that is so frequently associated with sexual offending behavior. Sexual
behavior in and of itself is incredibly taboo in American culture, so when sexual offending and youth are coupled together, deep-rooted anger and aversion can be a standard response. Providers suggested that many families feel embarrassment and therefore avoid disclosing the event. One treatment provider explained that this is a shaming experience for families. He described this emotion very clearly when he said, “Because sexual offending is the most shameful thing in the world. It’s the most shameful impacting behavior or phenomenon as a family” (Larry, 56). Another quote validates this finding, where a treatment provider explained that families might feel that their child will be perceived as an atrocious person, so they don’t disclose the offense to others. The provider noted, “I think that’s huge, I think that there’s a bully for a myth in our culture that kids who commit sexual offenses are like those perverts you see on TV and stuff” (Arlene, 55).

Families that do disclose the offense can experience negative responses as a result. They may be judged and ostracized by their support systems if they confide in someone they trust. Families may also feel that they are being excluded or banished from their communities. Some families experience profound levels of marginalization upon reporting the offense, “There is this really strong feeling of feeling judged and ostracized and that you can’t really share what happened and they can’t even tell the people closest to them what happened for fear of being judged and giving up their children’s privacy” (Carol, 32).

Clearly, youth are not the only individuals experiencing backlash from disclosing the crime. Families have legitimate fears that in addition to their child being judged, they
too will be arbitrated for this crime. Although parents and siblings may not have directly committed the offending behavior, the families are undergoing a similar experience. One treatment provider explained that sometimes youth are unaware of the impact that this can have on the family system and the parents.

And again, the kids forget when they are going through their stuff, they register for some, they’re having to do treatment, feeling labeled, blah blah blah, but the kids forget. You’ve got parents who are right there with you. You know for some, lost their families themselves, who are shunned by the community, or can’t or have to be untruthful to families and friends as to where the kid is. (Pamela, 39)

Societal judgment and feelings of marginalization contribute to reluctance to be involved in services. Because families feel profound stigma from the communities and those closest to them, they fear the additional judgment if they seek services. Families may be deterred from treatment because they fear potential judgment from service providers or further societal arbitration related to seeking therapeutic resolution. Either way, societal judgment penetrates family systems and hinders their involvement.

*Category: Internal processes.* Like external supports, families may have internal processes that make it challenging to feel prepared to cope and subsequently prohibit involvement. Families have competing thoughts and are inundated with a host of new feelings, reactions, and responses to the offending behavior. The feeling of ambiguity and indifference is very common, where they are recurrently grappling with managing these emotions and may not necessarily know what to think, how to feel, or what to say or do to feel better. Families unaffectedly begin to question how this could happen and have to struggle with the idea that their child did this, “It’s hard for families to wrap their brains around their kids having done something so horrible” (Sarah, 42).
Although families continue to battle these emotions internally, the feelings can ebb and flow. The families may experience different emotions during different stages. One treatment provider elaborated on these varying emotions and how family members undergo these changes.

There is a continuum of processes families go through. You know, what he did was horrible, I can’t believe he did this, you know and boy he really needs treatment to um, really supporting the kid’s denial and resistance to treatment. (Tom, 59)

While the internal processes evolve and change, they are an enduring challenge for families and may be a reason families do not become involved in services. The process of attempting to reconcile or internally process the behavior impacts family’s motivation for or willingness to seek services.

*Sub-category: Grief process.* The grief process is an example treatment providers gave as an analogy to understanding how these internal processes are experienced by families. The way families grapple with the sexual offense is similar to how some individuals cope with death. There are many different internal emotions that are coupled with this experience, and sometimes the manner in which families progress through it is healthy and other times it is maladaptive. So, as families process internally, they endure stages that mirror the experience of grieving. The stages are characterized by a fluctuation of mindsets, feelings, cognitions, and reactions.

You’re almost dealing with the stages of grief where you have some denial initially, and some minimization, and then you kind of go into an anger place, and then hopefully at the end, you’re coming to a place of more acceptance. (Damien, 42)
Because families are experiencing a “grief” process, they may be tentative to seek treatment because they believe it will amplify feelings of hurt and pain. The feelings, as one treatment provider explained, are dynamic and evolving where families typically experience innumerable emotions.

Well first you’ve got the dynamic is so dynamic. I mean you’ve got these parents that feel guilty for not protecting a member of their family or you’ve got a mother or a father feeling guilty for not protecting, so you’ve got all that and then you’ve got this anger towards yourself and the perpetrator, whoever. The dynamics are just amazing. It’s very much like a death. I’ve always found that. (Laurie, 65)

Sub-category: Fear and vulnerability. Another emerging finding related to internal processes was the fears and vulnerabilities of families. The act of sexual offending, especially when committed by a family member, can breed insecurities. With these families, fear and vulnerability go hand in hand. “I think fear, hurt, you know, vulnerability, they’ve got something to hide. Anytime we’re vulnerable it means something is going to come out that we don’t like coming out… insecurities” (Larry, 56).

Families feel vulnerable and fearful because they want to mask an uncomfortable, shaming, or painful experience. One treatment provider explained the genuine vulnerabilities of families in a profound way when she expressed a family member’s fear of others seeing her mistakes. “But they’re like, I don’t want people to see my imperfections, I don’t want people to see, one woman put it, “I don’t want someone to see the hold in my shoe” (Deborah, 28). These fears are predominantly played out in the service setting. Part of the internal process is that families struggle with others knowing they will be judged or perceived in a negative way, and are subsequently fearful of treatment. Parents and families are continuously fighting the internal urge to avoid
treatment because they don’t want their mistakes to be on display. “Who wants to sit in a room opposite a professional and look at the things you have done and feel like utter failures, and who wants to sit with that” (Gayle, 45)?

Fear and vulnerability is caused by the “unknown”, so in the case of these families, fear is a function of not knowing the future outcome. Families may feel hesitation to be involved in services if they are unsure of the future. Some fears are related to the potential for family secrets to be exposed in treatment. “I think they’re scared. They’re worried about what’s going to happen. They’re worried about what secrets or that family secrets may come out” (Arlene, 55). Secrets are prevalent in all families, but are particularly relevant in families of sexually abusive youth. This is not necessarily because families of sexually abusive youth have more secrets; but because the offense is often a secretive action, these family secrets receive more attention. The fear surrounding the exposure of secrets can be due to unhealthy or unaccepted family dynamics. “The kids themselves create huge secrets in order to get their victims not to tell. And I think that in some families that we have seen, the thinking is, what happens in the family stays in the family” (Pamela, 39). Other times, the secrets are kept as a way to avoid more system involvement. “Secrets, they keep a lot of secrets. Young kids are taught to keep secrets, even with like, don't tell you saw your brother, you’re not supposed to have contact” (Andrea, 40).

Although the supports given to families decrease substantially and they experience stigma at the hands of their community, friends, and peers, there is a continuous fear related to further marginalization. Families are careful and selective with
whom they share the offense with, and fear the fallout that would ensue if they were to reveal it to individuals or institutions that would take action against the family.

They’re fearful of other people finding out what’s going on in my family, not wanting to be associated with. I did work with one family in an adoptive case, the father was a teacher and so he was very fearful of the school finding out that his son had committed a sex offense and the kind of stigma that would go along with that. (Jeff, 36)

Service involvement would make families more vulnerable to people knowing the crime, so consequently, they are apprehensive to becoming involved. Families are already distrustful of the system, so if they “let them in”, they believe service providers will abuse their power. The providers noted that families fear that they will not get a chance to speak, or that trusting the system will lead to permanent family separation. Families may also base their fears off of their previous experience, where the justice system has failed them in the past and therefore it will happen again. One treatment provider explained this in more detail.

And the fear is that if they get, if they are exposed, or they are vulnerable, they expect that people in authority will hurt them because that’s what their life experience is. They have a little bit of hope that we won’t, but expect we will, so they are terrified of what we are going to do with them and they are afraid of what they will have to face and deal with. (Patty, 56)

**Theme: Subjective Barriers.** There are many subjective barriers that vary by family and stand in the way of treatment participation. Subjective barriers are different for every family, whereby some families have unique circumstances that position them at a disadvantage to obtain services. These circumstances are considered to be outside the control of families and can be related to location, economic disparities, or time
constraints. Two categories are considered to be subjective barriers: Resources and living situation.

**Category: Resources.** Many families of sexually abusive youth lack the necessary resources to become engaged in treatment. It may be profoundly challenging for them to attend meetings, go to appointments, talk on the phone, or acquire transportation if they lack the resources to support these endeavors. Some parents may lack childcare, access to a car, or struggle with costly treatment. “Lack of money, time, ability to change, lack of support, lack of resources. So they don’t see themselves as a resource either” (Laurie, 65). Another deficient resource for many families is time. Parents have to work full time jobs or have extenuating circumstances, and many times, they are unable to take time off to attend treatment meetings or therapy that are typically scheduled Monday through Friday during typical work hours. “Time demands where some families, they are over, they are maxed out, or they have extra jobs or because they are caring for other relatives” (Tom, 59).

**Category: Living situation.** As tested quantitatively, the families’ living situation relates to their ability or willingness to be involved in treatment. Although the quantitative data failed to identify jurisdiction as an important finding, providers noted that families who live in rural areas are be less apt to be involved, where it is substantially more difficult to attend weekly meetings or therapy appointments. It is challenging for families to find transportation and time if they live a great distance from the host agency. One provider talked about her agency location being a barrier for many families.

It’s usually the distance and often times it’s car problems. It could be a lack of money for gas, or we don’t have a vehicle to get here. Even families that live in
[city where agency is located] have difficulty getting here. But even, you know distances that are relatively short, distances are really difficult for families it seems. (Sarah, 42)

Other times, families may be physically separated from one another, making it difficult to maintain communication and connection among the youth and his or her family. Contrary to what the quantitative findings revealed, providers noted that families with youth living outside of the home might be less involved than those living in the home because it would be easier to withdraw and avoid contact.

It is that kind of out of sight out of mind philosophy. So, I think that a lot of families when things get tough, it is easier to back away than if the kid was still at home. I think anytime they are out of the home where you create that distance, you a low for the families to kind of check out a little bit more. (Jeff, 36)

When youth are living outside of the home, it is also very difficult for parents to assert themselves and feel heard. “When kids are in an out of home placement, you have a lot of professionals, and I think it can be hard for the parents to work around and feel they have a voice” (Cherri, 33). Parents that are able to fight through this and “find their voice” find it exhausting at times to maintain a high level of involvement. “Yeah I do think there is a dynamic, uh a difference, that requires so much energy from the family system when an offender is placed outside the home. It requires the best of their energy” (Damien, 42).

What prohibits family involvement: Summary of qualitative findings.

Overall, the qualitative findings related to the first research question revealed that this is a substantial transition for families to undergo. They are stressed from the new rules and demands and resulting family system changes. They are also unprepared to cope with the offense because they lack external supports and they having conflicting internal processes. Finally, there are subjective barriers such as resources and living
situation that prohibit their engagement in treatment. A summary of the qualitative findings related to the first research question is provided in Table 4.4. Definitions of each theme are given, and quotes are pulled to put the categories and sub-categories into context.

Table 4.4 What prohibits family involvement: Summary of qualitative findings

| Theme: Stress | Definition: A feeling of strain that decreases families’ interests, desires, or opportunities to actively be involved in treatment. |
| Category: New Rules and Demands | “The process is so invasive. And so, that is really hard and I think part of the difficulty for families is that because everybody acts with them as though everything is of equal importance, they don’t know how to prioritize so it becomes difficult to deal with” (John, 35). |
| Category: Family System Changes | “Everything changes. So the roles are going to change, um, I think it just depends on the family” (Patty, 56). |

| Theme: Level of Preparedness | Definition: The degree to which families feel equipped with the tools to cope with the sexual offense and subsequently engage in treatment. |
| Category: External Support | “What they are experiencing really is that they don’t have control over these other people and these other people are a part of their lives now, and that’s, they don’t like that” (William, 59). |
| Sub-Category: Distrust of the System | “They feel like the system is out to get them, and so family therapy to them is just one big part of the system, it’s something they think is going to be reporting back, or judging them, or not giving them a chance to speak” (Terri, 50). |
| Sub-Category: Societal Judgment | “There is this really strong feeling of feeling judged and ostracized and that you can’t really share what happened and they can’t even tell the people closest to them what happened for fear of being judged and giving up their children’s privacy” (Carol, 32). |
| Category: Internal Processes | “It’s hard for families to wrap their brains around their kids having done something so horrible” (Sarah, 42). |
| Sub-Category: Grief Process | “You’re almost dealing with the stages of grief where you have some denial initially, some minimization, and then you kind of go into an anger place, and then hopefully at the end, you’re coming to a place of acceptance” (Damien, 42). |
Sub-Category: Fear and Vulnerability
“But they’re like, I don’t want people to see my imperfections, I don’t want people to see, one woman put it, ‘I don’t want someone to see the hole in my shoe’” (Deborah, 28).

Theme: Subjective Barriers
Definition: Circumstances that are considered to be outside the control of families and can be related to location, economic disparities, or time constraints

Category: Resources
“Lack of money, time, ability or willingness to change, lack of support, lack of resources. So they don’t see themselves as a resource either” (Laurie, 65).

Category: Living Situation
“When kids are in an out of home placement, you have a lot of professionals, and I think it can be hard for the parents to work around and feel they have a voice” (Cherri, 33).

Second research question

How do providers engage families in treatment? Qualitative inquiry was used to understand strategies used by treatment providers to engage families. The qualitative interviews revealed two themes: building rapport and strengths-based family approach. The categories that emerged under the theme of building rapport included feeling safe, trust and connection, and empathy. The categories that emerged under the theme of strengths-based family approach included valuing families and families as a change agent. To easily illustrate these findings, the themes and categories are displayed in Figure 4.2.

Figure 4.2. How do providers engage families in treatment: Qualitative themes and categories
**Theme: Building rapport.** One theme that emerged from the qualitative data was that providers are proactive in building rapport with families to get them engaged. Building rapport is part of the process by which providers create bonds with the families. Before treatment even begins, providers seek to diminish feelings of distrust, marginalization, or fear by establishing a relationship with families. This rapport building process works to dispel some pre-conceived notions about treatment that can normally prohibit family involvement. One provider explained how she builds rapport, dispels myths, and goes above and beyond to engage families.

I’m in a therapeutic role, so they have somebody to vent to about their frustrations, about the system, and that sort of thing, and I’m not part of that, I’m not part of social services, and I’m not part of the courts. And so, the reason we go to court with the family, the reason we go to school meetings with the family and all of those things are to build engagement. (Deborah, 28)

Providers consistently discussed the importance of building rapport. There are specific techniques treatment providers use to build relationships with families in the beginning of treatment. Providers talked about using themselves as a resource, using effective communication, and being consistently present in the families’ lives.

I try to convey to them either implicitly or explicitly uh my role that is here to help, I’m here to advocate when I can, with the caveats that this won’t always be a pretty process and all that stuff, but I try to communicate with them very clearly that I’ve been placed in their family system as a resource…and sometimes I just say those things over and over again. (Damien, 42)

Providers have to work at building rapport with clients, because it is a difficult process. Building the relationship with families takes a vast amount of energy from therapists, and they may cross “acceptable” boundaries to do so. One therapist explained that although it
may be a boundary issue, being proactive and going above and beyond is how
connections are formed with families.

And that we’ve got to figure out what’s going to work for them. Um, I’m there
when I say I’m going to be there. Sometimes I spend extra time, which some
people may say is a boundary problem, but there are certain stages of treatment
where I think you have to make decisions. Is this about giving them too much and
not having the boundaries or demonstrating compassion? (Patty, 56)

In order to build a rapport with families and engage them in treatment, providers portray
an array of therapeutic emotions. Therapists build a relationship with families by making
them feel welcomed through feelings of safety, establishing trust and connection, and
having empathy.

*Category: Feeling safe.* In building the therapeutic rapport with the families,
providers want to ensure families feel safe as it is one of the first steps in making others
feel comfortable and welcomed. One provider explained how helping families feel safe is
incredibly important in this work because of the difficulties that they’ve already
encountered. Families have experienced negative reactions through this experience, and
because of their associated fears, they ought to feel protected in the therapeutic setting.
One provider explained how helping families feel safe might ease their fears. “Basically
to just create a new place where they can, you know just be themselves, be open or be
feel safe to address this stuff, because this is the hardest stuff to go through” (Larry, 56).

Treatment providers also expressed how establishing a safe space for families can help
them open up and talk about their experiences, fears, and stress. Ultimately, this should
be a space for open expression of thoughts and ideas without fear of being judged again,
and doing this allows families to feel comfortable engaging in treatment.
You know, promoting open communication and promoting the kinds of interactions where families can feel safe, feel safe to really be honest and talk without fearing they are going to be judged or punished is really crucial to helping them have an environment that is going to support their treatment. (Terri, 50)

Category: Trust and connection. Another way to build the therapeutic relationship with families is through trust and connection. Because they are feeling stressed, unprepared, and extant barriers still exist, they need to feel like they can trust their provider and this process. It is essential for families to feel a sense of belonging and put their faith and trust in their provider. Building this connection is vital, because otherwise, families may not engage in treatment. “If they don’t see you as someone they can talk to, they’re not going to tell you stuff” (William, 59). Also, because families are so guarded, connecting with individual family members in addition to the entire family system is important. One therapist talked about how he builds a relationship with the youth, and because the mother sees that relationship, she is more willing to trust him and be engaged in treatment. “Also when I can really make the relationship with the client on an individual basis. You know if mamma bear sees that I’m going to be good and I’m going to treat the kid well, then she likes me” (Tom, 59).

Providers referred to self-disclosure as a way to earn the trust of some families. Self-disclosure can be another way providers cross boundaries and go above and beyond to get them engaged. “I tend to do a lot more self-disclosure than other therapists would. Because the information that we ask is so personal and so in depth that to just sit there and share nothing, it just interferes with the therapeutic alliance” (Jeff, 36). Other times, providers talked more about connecting with the family through their communication patterns. “And I use language that conveys that we're all human and we're all in this
together and this is not a we or them…especially with parents” (Patty, 56). The same provider emphasized the need to establish trust by being genuine with her actions. “I show an interest, I convey a sense of hope. I behave myself in a trustworthy way; I return phone calls right away. I demonstrate care and concern for them” (Patty, 56).

*Category: Empathy.* To build the therapeutic relationship and to get families engaged in treatment, providers evoke empathy for the families and really try to put themselves in the families’ shoes. One provider spoke of being able to do this with the families he works with. “I try to empathize with the family about the difficulty of the experience” (Damien, 42). Another provider supported this sentiment by working to acknowledge the difficulties these families face in this situation. “You know, it’s just acknowledging their feelings and where they are coming from” (Jessica, 37).

Having empathy for the families means that providers are able to acknowledge where they are coming from and try to understand their situation. It also means that providers stick with the families through the difficult times. “You have to be supportive, you have to listen to everything, you have to give them a little bit of ‘I understand’ you know that kind of thing. You just have to hang in there with them” (William, 59).

Providers also work hard to listen to what their families are telling them to gain understanding and build empathy. “You really have to have a great ability to judge what the family needs and most of them come into my office in the first session and for two hours I listen” (Laurie, 65).

*Theme: Strengths-based family approach.* Treatment providers consistently talked about how they view families as a strength in the treatment process, and that they
take a strengths-based approach in treatment by incorporating families. A strengths-based family approach is a method by which families are considered to be one of the most important protective factors in the lives of youth that can foster change. “So, we are very much a strengths-based county who really looks at empowering families. Not over-serving, not over giving or under-giving” (Arlene, 55). So, families are viewed predominately as a resource in the treatment process. The treatment providers aim to use the strengths of the family to engage the family and facilitate adaptive changes in both the youth and family. “Engaging families is one of our principles. One of the first things I do in my initial paper work is to find the strengths and needs of the family to build off of those strengths” (Deborah, 28). There are two distinct explanations behind providers’ use of a strengths-based family approach; they value families enough to incorporate them into treatment and they ultimately see families as an agent of change.

*Category: Valuing families.* Providers use a strengths-based family approach in engaging families because they value them and perceive them to be one of the most important systems that influence youth. They understand that youth derive from part of a larger system that shapes their actions, beliefs, and points of view. One provider discussed the extent to which families can impact the lives of youth. “The family is the primary system, so that’s who we get the biggest messages from typically who we get our main messages from, and I think a lot of times, that’s who kids want to be accepted by” (Cherri, 33). Overall, providers agreed that families have many strengths and that family can be a large resource for youth. “Because he or she is not alone in this and these are my people, this is my family that’s going to help me through it” (Sarah, 42).
Category: Seeing families as a change agent. Although providers agreed that families are, by in large, the most important system, they fail to make an impact if they are not involved in treatment. So, providers pointed out the need to not only consider families to be a protective factor for youth, but to value them enough to incorporate them into treatment, draw on their strengths while they are in treatment, and promote their abilities to make lasting changes in their lives. “I found that including families into treatment is very powerful. I found that it created a support system that would outlive me, which is the original thought, but it was much more than that” (John, 35). So, it is really that providers proactively seek out families to be an agent of change and empower them towards sustaining these changes. They talked about the ability of the family to create a new and healthy way of living. “But to know that if parents really support their kids pro-socially, that going forward, that it creates a better dynamic for the kid” (Pamela, 39).

Providers additionally discussed how families are a change agent because they can recognize their role in contributing to the behavior and safeguard against future offending, subsequently making improvements for the family system. “You can look at yourself and say, what contributed to this, and what kind of changes do I need to make in my parenting. If they can hold onto that, I think they get better” (Joan, 41). Seeing families as a change agent in this way can empower them to integrate these changes independent of providers.

How do providers engage families in treatment: Summary of qualitative findings. The qualitative findings related to the second research question revealed that treatment providers make a concerted effort to help families feel comfortable with
engagement. They build rapport through giving families a safe place to share experiences, helping families feel trust and connection, and providing understanding and empathy.

Treatment providers are also proactively engaging families by using a strengths-based family approach to treatment. They are not only valuing families by perceiving them as a vital system influencing youth, but they draw on their strengths and perceive them as an agent of change in treatment. A summary of the qualitative findings related to the second research question is provided in Table 4.5. Definitions of each theme are given, and quotes are pulled to put the categories and sub-categories into context.

Table 4.5 How do providers engage families in treatment: Summary of qualitative findings

<table>
<thead>
<tr>
<th>Theme: Building Rapport</th>
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<tbody>
<tr>
<td>Definition: Building rapport is part of the process by which providers create bonds with the families.</td>
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<td>“Also, a big emphasis is um, really trying to um, connect with them or so build rapport with the family. And that’s usually where I will get people from other treatment programs or other agencies is because the um true provider is not making the connection with the parents or the kid is dropped off” (Tom, 59).</td>
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<tr>
<th>Category: Feeling Safe</th>
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<tr>
<td>“Basically to just create a new place where they can, you know just be themselves, be open or be feel safe to address this stuff, because this is the hardest stuff to go through” (Larry, 56).</td>
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<th>Category: Trust and Connection</th>
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<th>Category: Empathy</th>
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<td>“You have to be supportive, you have to listen to everything, you have to give them a little bit of ‘I understand’ you know that kind of thing. You just have to hang in there with them” (William, 59).</td>
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<table>
<thead>
<tr>
<th>Theme: Strengths-Based Family Approach</th>
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<tr>
<td>Definition: Method by which families are considered to be one of the most important protective factors in the lives of youth that can foster change</td>
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<tr>
<td>“Engaging families is one of our principles. One of the first things I do in my initial paper work is to find the strengths and needs of the family to build off of those strengths” (Deborah, 28).</td>
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<th>Category: Valuing Families</th>
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| “The family is the primary system, so that’s who we get the biggest messages from
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<th>Category: Seeing Families as a Change Agent</th>
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<td>“I found that including families into treatment is very powerful. I found that it created a support system that would outlive me, which is the original thought, but it was much more than that.” (John, 35)</td>
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**Third research question**

**What does family treatment entail and what factors are responsible for helping families’ progress through treatment?** The qualitative interviews revealed three overarching themes: *sex offender specific treatment*, *therapeutic relationship* and *treatment components*. The categories present under the theme of *sex offender specific treatment* included *engaging families as partners in sex offender specific treatment*. The categories that emerged under the theme of *the therapeutic relationship* included a *relationship is important and ongoing*. The categories that emerged under the theme of *treatment components* was *restructure families*, and *unite families*. The sub-categories that emerged under the category of *restructure families* included *communication skills* and *problem solving*. The sub-category that emerged under the category of *unite families* was *working through the pain*. To illustrate these findings, the themes, categories, and subcategories are displayed in Figure 4.3

Figure 4.3 What does family treatment entail, and what factors are responsible for helping families progress through treatment: Qualitative themes, categories, and subcategories
Theme: Sex offender specific treatment. Treatment providers revealed that sex offender specific treatment is overwhelmingly applied in treatment. Sex offender specific treatment involves using different elements such as learning about boundaries, the offense cycle (learning about personal triggers, high risk situations, and thinking errors that precipitate the offending behavior while developing exit strategies to avoid a relapse), safety planning, victim clarification work (when the victims and offender work through harm), and traditional sexual education to help inform, recognize, and change inappropriate sexual behavior patterns. Sex offender specific treatment focuses on youth beginning to diagnose their problems and learn techniques to avert future deviant behavior. Families can also be an integral part of this process, and treatment providers talked about their ability to engage families as partners in sex offender treatment.

Category: Engaging families as partners in sex offender treatment. Part of involving families in treatment requires that they be integrated into the sex offender specific treatment. Treatment providers suggested that families are fundamental to learning about the offense and the circumstances that lead up to the offense. One
treatment provider explained that families are a valuable resource as youth are going through this aspect of treatment.

Then going into you know, here are some things we worked on in treatment last week and I will ask the kid to recite some of those things. What did you learn about those things that will trigger you to offend? What did you learn about that- what are the thinking errors- what are those things? Can you explain that to your mom? That’s like again, a lot of work with that fellow will need to be shared with the parents because they want to know these things. So, in my work with the guy when he gest one of these things like a timeline, like what was the first sexual awareness you can recall and really mapping that all and revisiting that and adding, well then I usually have them, you know present that to the parents umm so each step along the way, the thinking as they learn all this stuff, how they justified it to being okay, sort of details of the offense; where, how many times, when, and how did you keep them quiet; all those sorts of things that parents are dying to know- that all gets shared. (Larry, 55)

Treatment providers discussed how bringing families into sex offender specific treatment involves teaching families about youths’ personalized offense cycle.

We do a lot of explaining to the family ‘you know here’s my red flags, my triggers, my cycle’, you know all of those big assignments we do in individual treatment I have to take into family therapy to go over and explain. (Cheri, 33)

When parents are able to understand their child’s cycle of behavior, they are more prepared to recognize warning signs and prevent future offending. “Educating them on the cycle, triggers, and getting information from them about their own relations or what they see happening when the child is acting out or what’s going on” (Terri, 50). The providers provide parents with the necessary tools to understand youths’ behavior. When they bring families into sex offender specific treatment, they are truly able to keep communities and families safe. However, there are many complexities associated with this type of treatment, and many families may be confused by it. Knowing this, providers take the time to educate families about the nuances of sex offender specific treatment.
And then bringing them into family therapy to like resolve the distortions that are going on with the kid. A lot of times we are going over what the kids are working on in treatment, reinforcing what they learned in informed supervision to understand triggers, cycles, and that kind of stuff. It’s such a different treatment than traditional therapy for them to really understand the components of it for them to feel savvy in questioning their thinking errors, and understanding behaviors, what does it look like as far as where they are at in their cycle. I always tell parents that knowledge is power. Once they know it, once they can confront on it, they feel more confident, and they can hold their kids more accountable. (Pamela, 39)

Another benefit of involving families into sex offender specific treatment is that youth are ultimately able to share, out loud with the people closest to them, the damage that they have caused, not only to the victim, but also the family system. This acknowledgement is the often first step youth take in building empathy.

So, most of our families have started kind of the educational piece of informed supervision. So, I’m doing the very initial nuts and bolts of informed supervision…umm and then take family therapy a little bit further…so then the youth is talking about their cycle and how it relates to him. You know, and specific pieces of what they learned in informed supervision and how it relates specifically to him and the offense. We are looking at him and the impact of his behavior on the family, and accountability and being able to be accountable to the family. (Jessica, 37)

An added component to sex offender specific treatment is safety planning and sex education. Engaging the families as partners is a learning experience for families in many ways. One treatment provider acknowledged the uncomfortable feelings associated with talking about sex with family members, but he explained how in one situation, forcing families to do this in treatment was beneficial. “This was his favorite relative, this is who he confided in and all those things, and so us doing sex-ed together and then some boundary stuff to follow was great” (John, 35). This component is also helpful for families to learn new ways to maintain safety and security in their homes and living
environments. “We do work around safety planning. Not just in terms of a written safety plan, but really talking about the structure of the house. Making sure there are rules in terms of who can be in who’s bedroom” (Jeff, 36). Another provider expanded on this as she explained that families are educated on ways to change things in the house, and particularly if it is an incest case, the siblings are involved in this process.

We are going to work on things like clarification, and education, where the siblings are going to be more involved and we are going to be working more on the safety rules and how to changing things in the house. (Carol, 32)

Sex offender specific treatment, as described by one treatment provider, is only one aspect of family-inclusive treatment. Engaging families as partners in sex offender specific treatment typically occurs at the beginning stages of treatment, where families are learning these skills early on. Doing treatment in this way allows for ample time to focus on working through family dynamics. “That’s not a lot of the treatment, that is pretty much the early part of the treatment. That’s the learning kinds of things that you teach them. If that’s what your goal is for treatment, that would be easily accomplished” (William, 59).

**Theme: Therapeutic relationship.** Another core piece of family treatment is using the therapeutic relationship. The therapeutic relationship helps providers draw on existing connections to continue working with families. The therapeutic relationship was stressed as the mechanism that allowed treatment to progress successfully. It is how providers are able to address the difficulties of treatment and work to overcome the sexual offense. The treatment providers explained how important it is to not only build
the relationship and establish rapport, but to continue to use that relationship throughout the course of treatment.

*Category: Relationship is important and ongoing.* Treatment providers explained how the therapeutic relationship was used throughout treatment. As previous findings reported, the providers noted the importance of establishing initial rapport with families. This rapport evolves into a therapeutic relationship and is considered to be a valued asset in ongoing treatment. Having a strong relationship allowed providers to constantly check in with families and parents. Using the relationship in this way allows providers to work with individual family members and consider their distinctive experiences through the process. “I throw the kid out of the session to ask the parents, ‘how is this going for you?’ Some parents, ‘no one ever asked me that.’ Or no one’s ever asked dad, they may have asked mom, but not dad” (Tom, 59).

The relationship was described time and time again as the part of the treatment process that allowed providers to be an unremitting resource for families from the beginning of treatment to the end. “Having them see you as a support and like you’re an ally with them helping them to support that process” (Pamela, 39). Another provider expanded on this idea and talked about how a better relationship through treatment with the families will lead to better outcomes for youth. “You have to have a relationship with them, to be successful with the kid, the more relationship you can have with the parents, or with the family, the more successful the kid will be in therapy” (William, 59).

Overall, providers agreed that the therapeutic relationship is the piece of treatment that ultimately helps families and youth heal. The relationship is an opportunity for
providers to “get through to” families. The relationship is used to break down the walls inducing resistance and fear. One provider referred to the relationship as the most important aspect of treatment, as it sets the groundwork for progress to occur.

The therapeutic relationship is THE KEY (said with emphasis). Yeah, you know, there’s all kinds of data out there about technique and evidenced-based and all of that stuff, and I still have not been able to find a way around these for me personally. But when I’ve got a good therapeutic alliance with a family, good work gets done. (Damien, 42)

The same provider expounded on this idea by suggesting that families make strides in treatment because of the therapeutic relationship. A good relationship allows families, youth, and providers to feel comfortable arguing and having conflict in treatment. “Some of the kids who I had the best outcomes with are also the kiddos who have the most conflict in treatment with me. We were able to work through that, build trust, and come out on the other end” (Damien, 42). Another provider confirmed this sentiment, and talked about her experience with one family where conflict was prominent. She explained that because of the relationship, they were able to disagree, but because of the disagreement, the youth and family healed.

Um she would get so mad. She’s really strong spirited and she would like spit in my face (laughter) and she’d yell at me, and she’d go ‘you don’t match’ (laughter). You know and she’d be really really angry, and um she speaks now about her experiences and she says it was the relationship, even she, but, the thing is, she’d get really mad at me because I reminded her and her mother of how their relationship should be. (Patty, 56)

The therapeutic relationship was expressed as an exceptionally important relationship to families of sexually abusive youth. The providers explained how this relationship might serve a different function than therapeutic relationships in other contexts. Because of the profound stress and stigma associated with the sexual offense
and the fear that is so frequently coupled with seeking services, the fallout is often more extreme than other types of offenses, the therapeutic relationship with families of sexually abusive youth is particularly significant to not only getting families involved in services, but in advancing them through treatment.

I think every therapeutic relationship is important, but especially here, because it’s such a tough subject, it’s such a taboo subject. I mean our country just isn’t as progressive when it comes to looking at this issue in another way. (Deborah, 28)

Providers also explained how the therapeutic relationship is something that youth and families remember in this work. The therapeutic relationship was talked about as the most influential piece of family treatment.

Sex offender treatment definitely helps, but when you talk to guys who have done well in their life, five to ten years after treatment, and you ask them what was the one thing that stands out in the work that you did that made all the difference, you know what they say? The relationship…now that’s at the core of it. (Larry, 55)

**Theme: Treatment components.** Another theme that emerged was the specific components embedded in family treatment. Although the providers emphasized the importance of the therapeutic relationship, they also discussed certain components that are used in treatment. The therapeutic relationship and the treatment components were viewed as reciprocal provisions of treatment, whereby one is contingent upon the other for ethical service delivery. The treatment components are approaches and techniques regularly used with families to achieve certain goals. Although the treatment components have unique goals they aim to accomplish (i.e. to restructure families, providers instill problem solving and communication techniques), the overall objective in integrating these components is to develop skills and competencies so families are able to function independently of treatment.
Category: Restructure families. One basic treatment goal is to improve family structure and establish new boundaries, rules, and individual responsibilities. Providers talked about familiar family patterns that contributed to the acting out behavior and explained the importance of re-visiting those patterns, diagnosing the problem, and making improvements. To restructure families, providers use their skills to teach families unique ways of operating. Sometimes this requires family members to re-learn their roles and other times this required families to incorporate new rules. One treatment provider specifically explained how she helps families restructure.

The work is around learning roles, responsibilities. I think that’s probably the strong approach than others; I think it’s more structural. That’s where things kind of get lose, so and like with some enmeshed kids, with their moms, and the lack of structure in the home, poor rules, kids are running the show, they are in charge. (Arlene, 42)

Another provider agreed that part of restructuring families means formulating new rules and consistency within the household. He noted the importance of teaching parents ways to make improvements. “You know, I think this last session I did with dad, just talking about simple things about the kids putting their clothes on before they leave the bathroom after showering.” (Carol, 32).

Restructuring also includes establishing a hierarchy in the family. It is important for parents to be the leaders and the decision makers in the household. So, part of restructuring was for providers to allocate tools for parents to “take back control” and set regulations for their children. One provider explained how incorporating structure involves helping parents “re-invent the wheel” with improved parenting techniques. “There’s a lot of parenting and coaching and training that goes on in terms of how to
appropriately set limits with your kids, here’s how to be aware of what’s going on in their life and the decisions they’re making” (Jeff, 36).

*Sub-Category: Communication Skills.* Families may have established poor methods of communicating, so providers acknowledged that this was a critical piece in helping them improve their structure. Providers talked about the widespread disagreements and arguments among families of sexually abusive youth, but suggested that these were really errors in perceiving the messages they receive.

To make sure they are not misunderstanding and to help people, because a lot of times when either the kid or parents really believe that they are sending one message, they are sending a completely different message. (Cherri, 33)

Another provider supported the notion that disagreements are common among families of sexually abusive youth and explained how families learn new methods of expressing feelings and emotions.

I want dad to be able to confront him on it, and it wasn’t really that he was yelling at him, it was more like, you know, he was confronting him on it, but I wanted to try to make it into you don’t always want to focus on the negative. (Sarah, 42)

Interactions between family members are important if they want to re-establish the family structure. Treatment providers discussed how families’ methods of discourse could have changed since the offense because the sex offense elicits a variety of emotions. One treatment provider explained how family dialogue may have changed, and how she uses interventions that are focused around improving communication.

Start with communication. Because whether their communication is good or not— it has probably broken down as a result of the offense. I do a listener intervention with a kid first and then help him teach his family how it works. That usually brings up some issues. It’s not unusual that kids will bring up things that will be bugging them in the family. Once parents get a sense the kid will appropriately
respond, those issues will be tackled more easily. Communication is key. (Gayle, 45)

Moreover, because secrets are common in families of sexually abusive youth, communication skills can help families work through those secrets and become honest with one another. Communication can help families openly discuss hurtful family secrets and work towards healthy family operations. One treatment provider talked about using communication techniques to help families battle secrets. “You know try to promote open communication and decrease the secrecy that a lot of times you see” (Terri, 50).

One specific communication intervention employed by providers is role-playing and reframing. In this intervention, families practice current methods of communication, address problems within these patterns, and incorporate new ways to talk and listen. Providers referred to the importance of practicing communication with families to help re-structure them.

You know, how to respectfully talk to each other and listen and not feel like you have to be defensive. And you have to sort of model for them, help reframe so they know how to say it. I spend more time with clients teaching them how to say it. We will like practice. (Patty, 56)

Sub-Category: Problem solving. Problem solving is another component of treatment that helps restructure families. The qualitative findings already revealed the notion that family systems undergo insurmountable stress. Providers noted that families under great stress might have developed ineffective problem solving patterns. Because of this, providers improve the family structure by assisting them in formulating new solutions to their problems. One provider specifically acknowledged the importance of problem solving. “Problem solving, how they problem solve is a good thing. How they
share, how resources get allocated within the family, the emotional resources” (William, 59).

Part of instituting new ways of problem solving is helping families explore the root of the problem. Because minor family disagreements can escalate and eventually turn into a significant family concerns, understanding the reason behind the problem can help families address the true area of concern. Treatment providers explained that part of their job is to help families identify the real source of the problem and contemplate effective solutions.

Getting them to do this antecedent behavior consequential type of stuff. What was happening before this fight that may have occurred during this week, or this explosion that may have occurred during this week? The family will come in wanting to focus on this explosion and I will try to get them to, let’s take a look at some of the things that set the stage for this. Uh, it’s not just about the blow up. Maybe it is sometimes, but more often than not, we can look back and say I saw, I see now there were these off ramps for this family to kind of divert and use some of these skills. (Damien, 42)

Similar to improving communication skills, treatment providers talked about interventions they use to help families work on refining their problem solving skills. One general intervention noted by treatment providers was role-playing. Providers encourage families to practice how disagreements occur within the family and then consider alternative ways to handle similar situations. This type of intervention approach can be a valuable resource for families.

Let’s role play so yesterday you guys had a fight over not being able to use the car, not being able to eat what you wanted over dinner, so let’s role play. Maybe mom, what could you have done differently and kid, what have you done differently so that the situation didn’t escalate. (Deborah, 28)
Category: Uniting families. Another goal is to unite families because many families of sexually abusive youth are physically and emotionally disjointed. Part of the treatment process involves helping families re-establish bonds and repair their relationships. “I said the healthy relationship piece, let’s talk about relationships within your family and ways that maybe you think, what you want to improve within your family” (Deborah, 28). Uniting families includes reconciling the different emotions and feelings within the family system so every member feels validated and understood. The goal of uniting families is to form a cohesive unit. The providers help families open up, feel vulnerable, and expose themselves. One treatment provider explained how part of this process involves helping families connect.

It is also about parents being able to express their feelings to the kids in a safe and healthy way. About how their behaviors have impacted them. Being able to hear it in a safe way, you know, I can’t believe you did this. I’m mad at you, but it doesn’t mean I don’t love you. So, a lot of it has to do with what they are working on in treatment, but then also connecting with their feelings and how does this impact the family and being able to even understand some of the changes that have gone on and what it’s going to look like for the future, if and when the kids come home. (Pamela, 39)

When uniting families, treatment providers talked about the process of going in-depth and addressing underlying concerns and problems. This involves bringing to light latent feelings, circumstances, or situations that may have been emotionally damaging for the family. Helping families unite requires providers to get detailed information from the families and explore the deep meaning behind their troubles.

When you have the foundation you can start chipping away and going deeper with what it mean to different people in the family when certain thing happen. Maybe it was they had a grandparent die and no one ever talked about it. You know, and then kids can begin to talk how abandoned they felt. Or how everybody walks on...
Uniting families is part of the treatment process that allows families to both function as a system but express their individual needs. Treatment providers explained a distinct method by which they unite families: Working through the pain.

*Sub-Category: Working through the pain.* One specific component used to unify families is helping them work through the pain. Families are in profound emotional turmoil, and working through these feelings is a crucial piece of treatment. Working through the pain means that families accept that this process is painful and that there are many hurtful emotions, but that it is important to find ways to overcome this pain. One treatment provider explained that working through the pain sometimes requires them to confront and challenge families. “Kind of trying to repair harm, there. In one specific case, in therapy what I ended up doing and confronting and really pushing with the family in her unwillingness to kind of deal with what was going on” (Jeff, 36). Another provider talked about using a similar approach that was reality focused and challenged families to consider the situation truly from an authentic standpoint. “Because they come from a bad background, or whatever, but I find that the reality, that look, this is the way it is, and this is how it is going to be, and you have to point out things they haven’t heard” (Andrea, 40).

As the findings have previously revealed, many emotions are coupled with this experience. Working through the pain can powerful experience for many families as it affords the opportunity to not only express their emotions openly, but also acknowledge the hurt. Working through the pain means addressing feelings of anger and frustration in
treatment. Some families blame each other for the family system fallout, and providers talked about the process of unifying families through allowing each member to share their anger and feel heard.

A lot of work with that system, okay, was her rage at this stepchild for abusing her kids. I mean that was a lot of the work that had to be done with that kid and as long as she was so angry with him and demonstrating how angry she was at that kid, what that did was drove a wedge between her and her husband because he always had to take his son’s side and it destabilized the environment for everybody. So, some of the work that had to be done in that case was dealing with how enraged this woman was for having this stepson, that she really didn’t like that much, and then he did this you know, she was really mad. (William, 59)

Working through the pain additionally means that therapists are helping families address other emotions related to the offense, such as denial and guilt. Treatment providers explained that part of the treatment process includes helping families perceive the situation differently to overcome painful and often times paralyzing emotions. “I think the challenge is helping parents pass that level of denial because this is their child, and there is a level of guilt because they want to look out for themselves. I think that is a very big challenge” (Carol, 32)

Another major aspect of working through the pain is exposing family fears. As previous findings revealed, families have many fears related to being judged, secrets being divulged, or additional system sanctions. These fears carry over into treatment, and part of the job of providers is to not only alleviate the fears, but to uncover them.

Um, I just, I think that parents have to, you know, are forced by the nature of this treatment to look at their own mistakes, they’re own history. It’s painful, you know, they have to look at their own shit sometimes. Excuse me! (Arlene, 55)

Exposing fears is component of treatment that helps families recognize their vulnerabilities. “A lot of my work is to help these families tolerate the pain and suffering
and feeling vulnerable, and the willingness to be vulnerable altogether is part of the healing process” (Larry, 56). Fears can control the lives of some families, but the family system has to be willing to process them and openly discuss them. Exposing family fears fosters honesty and openness in treatment.

Being straightforward and working through the pain is incredibly valuable in treatment. Openly discussing family secrets, awkward situations, or painful mistakes can be undeniably uncomfortable for both families and treatment providers. However, it is through this exposure that progress is made. One treatment provider gave an example of a situation where he required the family to disclose their secrets, and although he admitted it was an uncomfortable revelation, the family and youth grew from this experience.

Boy, what an uncomfortable thing to be exposed in a family. And especially the kid, I’m talking to him about his sexual history, every sexual behavior he’s had…and uh when you have crimes that, you know. I’m working with a family also right now where the mom was kind of the target of some of this behavior from a voyeuristic standpoint. So, you sit in a room with mom, dad, and 17-year-old son and we’re talking about the time when 17-year-old son videotaped mom in the shower and masturbated. I mean, who’s uncomfortable…everyone. They are fearful of that kind of information, but it needs to come out. (Damien, 42)

Overall, helping unite families requires that treatment consider both the family system and the members there within. Accordingly, treatment providers work on understanding how the offense influenced the system, how it continues to separate family members, and ways to ameliorate the pain. Treatment also involves understanding what factors contribute to the pain and how it is manifested. Treatment providers explained that these aspects of treatment help families heal.

We are really looking at the kind of impact of this behavior on the family, so what does this mean about the family and how is this impacting the family. We are
What does family treatment entail, and what factors are responsible for helping families progress through treatment: Summary of qualitative findings. The qualitative findings related to the third research question revealed that treatment providers employ two distinct approaches when helping families progress through treatment: sex offender specific treatment, the therapeutic relationship, and treatment components. Treatment providers bring families into sex offender specific treatment to join youth in helping them recognize triggers, high-risk situations, and develop exit strategies. Providers also use the therapeutic relationship throughout the course of treatment because they perceive it to be an impactful approach in relating to families. There were also specific components employed by providers to restructure and unite families, including improving their problem solving, communication skills, and working through the pain. A summary of the qualitative findings related to the third research question is provided in Table 4.6. Definitions of each theme are given, and quotes are pulled to put the categories and sub-categories into context.

<table>
<thead>
<tr>
<th>Theme: Sex Offender Specific Treatment</th>
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<tr>
<td>Definition: Involves using different elements such as learning about boundaries, the offense cycle (learning about personal triggers, high risk situations, and thinking errors that precipitate the offending behavior while developing exit strategies to avoid a relapse), safety planning, victim clarification work (when the victims and offender work through harm), and traditional sexual education to help inform, recognize, and change inappropriate sexual behavior patterns.</td>
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<tr>
<th>Category: Engaging Families as Partners in Sex Offender Specific Treatment</th>
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<tr>
<td>“And then bringing them into family therapy to like resolve the distortions that are going on with the kid. A lot of times we are going over what the kids are working on in treatment, reinforcing what they learned in informed supervision to understand</td>
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triggers, cycles, and that kind of stuff. It’s such a different treatment that than traditional therapy for them to really understand the components of it for them to feel savvy in questioning their thinking errors, and understanding behaviors, what does it look like as far as where they are in their cycle. I always tell parents that knowledge is power. Once they know it, once they can confront on it, they feel more confident, and they can hold their kids more accountable” (Pamela, 39).

### Theme: Therapeutic Relationship
Definition: A method by which providers were able to draw on their existing connection with families to help heal families.

#### Category: Relationship is Important and Ongoing
“Sex offender treatment definitely helps, but when you talk to guys who have done well in their life, five to ten years after treatment, and you ask them what was the one thing that stands out in the work that you did that made all the difference, you know what they say? The relationship…now that’s at the core of it” (Larry, 56).

### Theme: Treatment Components
Definition: The treatment components are approaches and techniques regularly used with families to achieve certain goals.

#### Category: Restructure Families
“There’s a lot of parenting and coaching and training that goes on in terms of how to appropriately set limits with your kids, here’s how to be aware of what’s going on in their life and the decisions they’re making” (Jeff, 36).

##### Sub-Category: Communication Skills
“You know, how to respectfully talk to each other and listen and not feel like you have to be defensive. And you have to sort of model for them, help reframe so they know how to say it. I spend more time with clients teaching them how to say it. We will like practice” (Patty, 56).

##### Sub-Category: Problem Solving
“Problem solving, how they problem solve is a good thing. How they share, how resources get allocated within the family, the emotional resources” (William, 59).

#### Category: Unite Families
“It is also about parents being able to express their feelings to the kids in a safe and healthy way. About how their behaviors have impacted them. Being able to hear it in a safe way, you know, I can’t believe you did this. I’m mad at you, but it doesn’t mean I don’t love you. So, a lot of it has to do with what they are working on in treatment, but then also connecting with their feelings and how does this impact the family and being able to even understand some of the changes that have gone on and what it’s going to look like for the future, if and when the kids come home” (Pamela, 39).

##### Sub-Category: Working Through the Pain
“Kind of trying to repair harm, there. In one specific case, in therapy what I ended up doing and confronting and really pushing with the family in her unwillingness to kind of deal with what was going on” (Jeff, 36).
Understanding how families contribute to positive outcomes

Fourth research question

Are family services associated with positive outcomes? The final research question was answered through quantitative and qualitative inquiry into whether youth had successful outcomes as a result of family service involvement. This research question with posed with the understanding that it could be answered primarily through quantitative methods. However, qualitative data additionally answered this question by comprehensively asking providers about non-traditional outcomes for both families and youth. The quantitative and qualitative results will be explored further.

Are family services associated with positive outcomes: Quantitative findings.

The fourth research question was primarily answered through quantitative methods. The independent variable of interest was family service involvement and the covariates included gender, ethnicity, jurisdiction, type of sentence, mental health diagnosis, prior adjudications, age, in-home placement, and change in placement, and risk level. The dependent variables were treatment completion and recidivism. The quantitative findings are organized by first describing the results of the bivariate relationships that are significant. Again, only those significant bivariate relationships were included in the final models. The results of the final logistic model testing treatment completion are explained in detail.

Bivariate relationships. Chi-square and t-test were run to determine associations between the independent variables of interest and treatment completion and recidivism. In predicting treatment completion, the results revealed that youth with a mental health
disorder, \( t(83) = -2.3, p < .05 \) and those with a prior adjudication, \( t(83) = -2.8, p < .01 \) successfully completed treatment less than those without a mental health disorder and a prior adjudication. Youth living in an in home placement successfully completed treatment more than those youth living an out of home placement, \( t(83) = 2.7, p < .01 \).

Youth with a higher risk level successfully completed treatment less than those at lower risk, \( t(83) = -2.1, p < .05 \). Youth with more family service involvement successfully completed treatment more than those without family service involvement, \( t(83) = 5.1, p < .001 \). In predicting recidivism, the results revealed that youth living in an in home placement recidivated less than those youth living an out of home placement, \( t(82) = -2.6, p < .05 \). Because only one variable was significantly related to recidivism at the bivariate level, the recidivism outcome was not tested in a multivariate model. The sample characteristics and bivariate relationships table are provided in Table 4.7.

Table 4.7 Bivariate relationships: Treatment completion and recidivism

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<th>Recidivism ((N=84))</th>
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<td></td>
<td>Frequency</td>
<td>%</td>
<td>Frequency % ( \chi^2 )</td>
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<td>Type of Sentence</td>
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<td>Ethnicity</td>
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<td>.36</td>
<td>.87</td>
</tr>
<tr>
<td>Jurisdiction</td>
<td>1.2</td>
<td>.45</td>
<td>1.3</td>
</tr>
<tr>
<td>Mental Health</td>
<td>.51</td>
<td>.50</td>
<td>.42</td>
</tr>
<tr>
<td>Prior Adjudication</td>
<td>.25</td>
<td>.42</td>
<td>.16</td>
</tr>
<tr>
<td>Family</td>
<td>2.4</td>
<td>1.2</td>
<td>3.0</td>
</tr>
</tbody>
</table>
Logistic regression model. The logistic regression model regressed treatment completion on mental health diagnosis, prior adjudication, risk level, in-home placement, and family service involvement. The Hosmer and Lemeshow test was used to interpret the overall fit of the model, and the results from this test revealed that there is a good model fit, ($\chi^2 (5, N = 85) = 3.6, p > .05$). The value of the pseudo R-square or the Cox & Snell suggests that 31% of the variance is explained by this model. The results of the final model revealed that youth with greater family service involvement were more likely to successfully complete treatment, and for each single point increase in the family service involvement scale, there is a 3.1 times greater likelihood of successfully completing treatment (OR = 3.1, $p < .001$). Youth in an in-home placement are 3.8 times more likely to successfully complete treatment than youth in an out of home placement (OR = 3.8, $p < .05$). Mental health diagnosis, prior adjudication, and risk level were not statistically significant predictors in this model. The results from the logistic regression model are provided in Table 4.8.

Table 4.8 Logistic Regression Model: Treatment Completion

<table>
<thead>
<tr>
<th></th>
<th>Treatment Completion</th>
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<tbody>
<tr>
<td></td>
<td>OR</td>
</tr>
<tr>
<td>Mental Health Diagnosis</td>
<td>.38</td>
</tr>
<tr>
<td>Prior Adjudication</td>
<td>.32</td>
</tr>
<tr>
<td>Risk Level</td>
<td>1.4</td>
</tr>
<tr>
<td>Placement (in home)</td>
<td>3.8*</td>
</tr>
<tr>
<td>--------------------</td>
<td>------</td>
</tr>
<tr>
<td>Family Service Involvement</td>
<td>3.1***</td>
</tr>
</tbody>
</table>

*p<.05, **p<.01, ***p<.001

Are family services associated with positive outcomes: Qualitative findings.

The qualitative findings that emerged from the fourth research question supported and expanded on the quantitative findings. The qualitative interviews revealed one theme pertaining to healthy adjustment. The categories present under the theme of healthy adjustment included family functioning and family relations. To easily illustrate these findings, the themes, categories, and subcategories are displayed in Figure 4.4.

Figure 4.4 Is family-inclusive treatment for sexually abusive youth linked to successful treatment completion and low recidivism rates: Qualitative themes, categories, and subcategories

**Theme: Healthy adjustment.** The quantitative results clearly demonstrated that family services are associated with treatment success for youth. Qualitative results supported these findings but added to them in a profound way. Together youth and families demonstrate successful outcomes from services, but outcomes are not limited to treatment completion and recidivism. The inclusion of family services leads families and youth to healthy adjustment post treatment. Families and youth alike were effectively able to incorporate positive changes into their lives. Treatment providers explained how

160
family services produce noteworthy changes in youth and families. “It helps everybody heal. It helps everybody get to where you want them to be, which is leading some type of healthy productive life and it helps everybody” (Laurie, 65).

Healthy adjustment was also referred to as a positive outcome that leads to noticeable transformations in youth and family lifestyles. Some providers explained this as new strategies retained to avoid relapse.

This is a kid who did good work, this is a kid who, he’s not going to hurt his sister anymore. A) His sister isn’t going to let it happen, she’s gotten what she needs, B) the parents are on top of this situation now, and c) this kid clearly at the very least doesn’t want to go through this again. (Damien, 42)

Whereas other providers clarified that healthy adjustment can be the physical changes youth undergo. One treatment provider explained that youths’ physical appearance and behaviors are starkly different after family treatment.

I tell ya, we always and I did this a few times, when they first come out, I take a picture of them. And when they are done, I take a picture of them, and compare the two. They’re like, ‘holy shit, that’s what I looked like?’ They physically look different totally in a big way. They’re bright, alert and tuned in, and they look you in the eye, and they carry themselves better, they’re doing better in school, they have a healthy relationship, they have a job. (Larry, 56)

Even still, other providers described healthy adjustment as improvements in their lifestyle as evident through better decision-making skills, self-esteem and self-efficacy, and improved social capacity.

Most of our kids remain in school, most of our kids return home if they are in an out of home placement, Most of our kids are by self report, feeling much better about themselves, their self-esteem has increased, their sense of ‘I feel like a normal kid’ is increased. Their social skills, assertiveness skills. (Arlene, 55)

Healthy adjustment is a result of families and youth recognition of the patterns that have contributed to unhealthy sexual behavior. Although difficult, families emerge
with a better understanding of their former dysfunctional lifestyle and how to integrate positive coping skills, begin to work as a unit, improve their communication, develop efficient problem solving strategies, and express their feelings openly.

When they start recognizing unhealthy patterns that they’ve gone through. When they can be more honest about their shortcomings of the family in general. Like abuse of alcohol, um…things like that. When kids can just, I think probably the most success is when parents can say, ‘he’s just talking to me like he’s never talked before, he’s just sharing things he’s never shared before. He’s not having anger outbursts anymore; he just sits down and talks to me, you know more one on one time. (Joan, 41)

*Category: Family functioning.* One distinct way families and youth adjust in a healthy way is by learning to function together. Family operations are drastically enhanced after they go through family treatment. “So, generally, the engaged parents, the overall family functioning improves significantly” (Jeff, 36). Overall, the family structure changes. Old family operations are abandoned and families strengthen their system. “You know, they’ve done some of their own work and they’ve gone to therapy and have really been able to change their family structure” (Carol, 32).

Family functioning improves because of deepened unity among members. Families are able to work and unite together to solve problems. Functioning as a unified system is when open communication is accepted and embraced. “You know, when you see them functioning as a unit again. Just communication, accepting what it is, not being angry, not going around angry or scared or just being able to live life” (Laurie, 65). This response is validated by others, as an additional provider explained how families, especially parents become allies rather than enemies as a result of family treatment. “I
see parents become more aligned, work more as a team, collaborate with their strengths as parents so they are not in conflict and so they can conjoin” (Patty, 56).

Improved family functioning is further evident through strengthened parent proficiencies. Parents progress in their parenting abilities, as they are able to appropriately set limits for their children. In addition, youth are more responsive to these rules and limits. Setting boundaries allows the youth to recognize that they are consistently being held accountable.

You know, he had kind of been involved with gang stuff, but had the mother that you know, felt they got to a good place where he was more respectful of her setting limits, and uh, you know holding him accountable and enforcing the rules, and that was better for both of them. (Terri, 50)

Category: Family relations. Family relations also improve as a result of family treatment. Restored family relations means that family members have repaired long-standing maladaptive dynamics to relate to each other more progressively. “Helping them find a way to think about those situations in their minds, that they can be comfortable with, not have it be a constant struggle, being able, being mature enough” (Terri, 50). Family relationships are improved because families were able to work through the pain and express their emotions. Families who convey their feelings, whether it’s anger, frustration, disappointment, guilt, or shame, ultimately strengthen their relationships.

We definitely see you know, we see families where parents have been so angry that maybe they don’t want to deal with the kids. But, we have been able to work with them to a point where they are able to have a healthy relationship and they are able to be a really good support in their kids’ lives. (Carol, 32)
As previous findings suggested, expressing one’s feelings is extraordinarily challenging for many families. So, providers deemed it successful for them to reach this point.

Realizing that this is a kid who has been severely traumatized and he’s actually starting to talk about his feelings now and open up, so seeing a lot of that come together, yeah he’s able to express to his grandparents that he’s angry, that’s the first time I’ve seen him do that, so that’s huge. (Sarah, 42)

It is clear that emotions manifested in family treatment lead families and youth to have improved relationships. Parents and youth are able to return to a state of feeling accepted, loved, and cherished by their family members.

And it made it a lot easier for her son to understand when she was able to tell him that if a family session and it made, you know, he felt a lot better because he didn’t feel like, he just had his mommy again. She was able to understand why she was mad at him about the sex offense. (Cheri, 33)

Family members who work diligently through treatment feel a sense of closeness and compatibility with one another. There is an appropriate level of attachment dependency, and concern between family members. With the assistance of treatment providers, families translate treatment into action. Independently, families are able to restore their relationships and integrate learned concepts in their lives.

And the family kind of comes together and you can translate and say, ‘okay, you guys as a family are able to work together to accomplish something.’ And they start to feel empowered and very close to each other and then it’s easier to then take that dynamic and say “what other tasks do you as a family need to work together to try and complete?” (Jeff, 36)

Are family services associated with positive outcomes: Summary of qualitative findings. The qualitative findings related to the fourth research question revealed that clinicians perceive a variety of outcomes resulting from family services. Families and youth alike benefit from such approaches, and overall, they adapt in a
healthy manner. Healthy adjustment is manifested in two forms: family functioning and family relations. Family functioning and family relationships are strengthened when families are engaged in services. A summary of the qualitative findings related to the fourth research question is provided in Table 4.9. A Definition of the theme is given, and quotes are pulled to put the categories into context.

Table 4.9 Are family services associated with positive outcomes: Summary of qualitative findings

<table>
<thead>
<tr>
<th>Theme: Healthy Adjustment</th>
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<tbody>
<tr>
<td>Definition: Families and youth alike undergo noticeable transformations in lifestyle choices, improved self-efficacy, self-esteem, and social capacity and are able to integrate these changes in their lives.</td>
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</table>

<table>
<thead>
<tr>
<th>Category: Family Functioning</th>
</tr>
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<tbody>
<tr>
<td>“You know, they’ve done some of their own work and they’ve gone to therapy and have really been able to change their family structure” (Laurie, 65).</td>
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</table>

<table>
<thead>
<tr>
<th>Category: Family Relations</th>
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<tbody>
<tr>
<td>“And it made it a lot easier for her son to understand when she was able to tell him that if a family session and it made, you know, he felt a lot better because he didn’t feel like, he just had his mommy again. She was able to understand why she was mad at him about the sex offense” (Cherri, 33).</td>
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Chapter Five: Discussion

Aiming to deeply synthesize the process and experiences of families in treatment, this study contributes knowledge in understanding a profoundly vulnerable population. This dissertation challenges existing notions of families and endorses a new perspective by which families are perceived as a predominant system that fosters change. This dissertation proposes a conceptual model from which the remainder of the chapter will be organized. The conceptual model emerged from the findings as a mechanism for understanding the progression of treatment. This chapter will also examine why the study findings are relevant, put them into context, explore their meaning, and propose implications. Furthermore, this chapter will cover study limitations before describing overall implications for programs, aftercare efforts, and policy initiatives.

Conceptual model

A conceptual model emerged from the findings and represents the process by which families move and progress through treatment. The model, labeled the conceptual model of family-inclusive treatment for sexually abusive youth explains how families begin in a state of crisis. Families are overwhelmed with stress from the new rules and family system changes, they feel inadequately prepared, and they experience subjective barriers; a particularly important barrier was their living situation. All of these experiences lead to a state of crisis and consequently they are unable or unwilling to engage in treatment. The first stage in the conceptual model is similar to components of
Family Stress Theory. The pieces of Family Stress Theory that explore the accumulation of stress, poor resources, and adverse perception and meaning as critical variables that lead families into crisis and maladaptation (Hill, 1958; McCubin & Paterson, 1983) resemble the initial stage of this conceptual model. These stages align similarly as they both denote interactions leading a family into crises. However, it is the intention of the model of family-inclusive treatment for sexually abusive youth to adapt this model to extent beyond merely conceptualizing the crisis to propose intervention tactics useful in eliciting positive outcomes.

Unlike the Family Stress Theory, the conceptual model of family-inclusive treatment for sexually abuse not only suggests the need to intervene when families are in a crisis, but also provides ample strategies for doing so. It is through this model that families are seen as a vital resource, having the power to avert an otherwise inevitable undesirable outcome, as Family Stress Theory would suggest. Accordingly, families are given ways to mitigate the crisis through involvement in services. Providers work unremittingly to engage families by employing a strengths-based approach and by perceiving families as a resource, with capacities and abilities to determine their own outcome. But more notably, and as a theme embedded throughout this model, having a relationship with the families is paramount; the therapeutic relationship is perceived as a change mechanism. The relationship allows providers the opportunity to apply family specific treatment components, which are used to restructure and re-unite families. Ultimately, these services lead to treatment success for youth and healthy adaption for
families. The conceptual model of family inclusive treatment for sexually abusive youth is illustrated in Figure 5.1.

Figure 5.1. Conceptual model of family-inclusive treatment for sexually abusive youth

This conceptual model adds to the field in many ways. First, it suggests ways that providers can get families involved in services. Although there has been increasing support for getting families involved in services (Ryan, 2010c), many providers and service agencies continue to struggle with effective means for doing so (OJJDP, 2012b). Under the amended Juvenile Justice and Delinquency Prevention Act of 1974, funding has been streamlined so that services for system-involved youth are family-inclusive (OJJDP, 2012b). However, many programs around the country, including programs in Colorado struggle to acquire treatment buy-in because some of the difficulties that arise in engaging families are attributed to staff resistance and risk-oriented perceptions of families (OJJDP, 2012b). This model, distinguishing families as having many strengths and highlighting the therapeutic alliance, is one that can be applied to a variety of different programs and treatment contexts.
Second, this model endorses current techniques being used by providers. Although the field has begun to emphasize certain elements of family therapy such as how disparate dynamics effect treatment (Thomas, 2010), ultimate goals of treatment (Rich & Longo, 2003), or logistical challenges in providing treatment (Rich & Longo, 2003), there is limited information on the components of family treatment and how therapeutic relationship dynamics drive ongoing participation. This model serves as a guide for knowing components of family therapy and more generally, a framework for understanding how family services are carried out. Furthermore, it equally emphasizes components of treatment as well as the importance of therapeutic connection.

Finally, this model is one of the first of its kind to clearly illuminate how the family treatment process can lead to positive outcomes. Aside from outcome studies that show effectiveness of large-scale system interventions that include families such as MST (Letourneau & Henggeler et al., 2009), little has been done to demonstrate the effects of incorporating families into treatment. The usefulness of family services that are frequently applied in many different service settings (i.e. family reunification, informed supervision, family therapy, multi-family group therapy, and multi-disciplinary team involvement) has not been well documented. This model demonstrates that when families are considered as an asset and incorporated into treatment, youth and families have positive outcomes.

The following discussion will be organized according to the chronological stages of the conceptual model that emerged directly out of the research questions posed in this dissertation. First, the family crisis will be contextualized and explored – appraising
factors that contribute to crisis while highlighting implications. Next, engagement in
treatment will be understood, particularly from a strengths-based, action oriented, and
therapeutic relationship perspective with subsequent implications for these findings.
Then, the therapeutic relationship and treatment components will be put into context,
where factors influencing these findings will be expanded upon. Finally, the outcomes
associated with the family treatment will be explored and understood with applicable
implications for the findings.

**Discussion of findings from first research question: Experiencing the crisis**

Every family experiences their crisis differently and there are varying degrees of
stress, internal processes, external supports, and barriers that prohibit their involvement in
treatment. However, the differences in the ways in which families experience the crisis
does not discount the fact that the crisis is real. Families invariably undergo the crisis and
it is a significant experience for them. Like the conceptual model represents, it is as if
families have all of these “bubbles” in the air and they are attempting to grapple with
each one. Experiencing a crisis like this changes the family system and comes with new
feelings, emotions, expectations, roles, and fears. In many ways, the crisis can effectively
be considered a “learning experience” for many families. They begin to question their
family system and the members in it. They also begin to understand more about their
external world, reactions from others, and resources available.

Many situations can evoke a crisis situation for families, and a sexual offense is
not necessarily a unique circumstance in that way. However, exclusive to the experience
of a sexual offense crisis are two extraordinary circumstances: 1) The family is now
influenced by an outside judicial system with decision-making powers. 2) The family is under extreme scrutiny and judgment by society. These two situations can partially explain why families of sexually abusive youth have an atypical and exceptionally difficult time navigating through the crisis. This distinctive experience makes it particularly challenging on families of sexually abusive youth. The findings from this dissertation suggest that families of sexually abusive youth undergo this crisis and fail to be involved in treatment because they are stressed from system requirements and family discord, they experience societal stigma, they lack appropriate coping and regulation skills, and there are barriers that stand in their way. Overall, the family crisis has not been well documented in the literature. Families have been rarely studied in relation to their reactions, feelings, or experiences as a result of their youth perpetrating a sexual crime.

**Stress: System requirements.** There is great stress that goes along with new system requirements. The findings from this dissertation revealed that system requirements leave families inundated with new and unfamiliar demands and pressure. The stress resulting from system involvement, although a prevailing experience for many families, has received little attention by field research. This dissertation is one of the first studies to highlight the stress that families feel when working in conjunction with the system. So, although the field has acknowledged the punitive responses to youth such as mandated registration and community notification, tracking and supervision, or associated stigma (Letourneau & Miner, 2005; Lobanov-Rostovsky, 2010), they have yet to explore the lasting effects they have on families.
These results suggest that the justice system is a powerhouse that ultimately determines the fate of youth (Lobanov-Rostovsky, 2010). Stress may be exacerbated because families fear the fallout if they fail to conform to the commands of the system or because families feel as if they lack a voice in determining the outcome or the fate of their child. Either way, this experience can leave families feeling powerless and helpless. Literature has suggested that families often feel powerless when the sex offense is disclosed (Ryan, 2010c). This may be due to the fact that many families are unaware of the legal ramifications or the laws pertaining to the sexual crime (Ryan, 2010e). Furthermore, the families are uncertain what the future holds as they may question whether the youth will be reunited with the family (if he or she is living outside of the home) or rehabilitated (Ryan, 2010e). Ultimately, these factors may contribute to the reasons families are not fully engaged in services; as a result of system involvement, families feel helpless, lack system knowledge, and are fearful of the future.

Additionally, the findings from this dissertation suggest that families of sexually abusive youth are undergoing family system changes. Again, very little research and literature has been documented to address the stress that is associated with family discord and physical separation. Some professionals have briefly noted the negative impact that the sexual offense can have on the relationships in the family system, including the potential for relationships to be damaged or broken (Prescott & Levenson, 2007). Other professionals have supported these findings with anecdotal claims that families of sexually abusive youth experienced separation and discord (Thomas, 2004). However,
many of these arguments pertaining to the impact on the family system are not supported with evidence.

Therefore, this dissertation substantially contributes to the extant literature and research by suggesting that families of sexually abusive youth may separate as a result of new requirements and experience an increase in conflicts among members. Knowing how deeply families experience these forms of stress leads to a greater understanding of their hesitancy to be involved in treatment. For example, it can be anticipated that some families fear the long-term family system changes, including the dread that youth will permanently live apart from the family or that parents, siblings, other system dyads, or external family members may never resolve conflicts.

**Societal Stigma.** The findings from this dissertation suggest that families undergo widespread societal judgment that literally paralyzes their willpower and motivation to be engaged in treatment. This particular finding adds to the literature by suggesting that it may not only be youth that undergo societal repercussions, but that families similarly experience these effects. To a large extent, society influences us in our every day choices and decisions (Siegfriedt, 2011). Societal responses to sexual crimes are argued to be severe and harsh (Letourneau & Miner, 2005; Trivits & Reppucci, 2002; Quinn, Forsyth, & Mullen-Quinn, 2004), particularly because of the perceived dangerousness and future risk associated with the criminal behavior (Zimring, 2004). So, as the findings from this dissertation reveal, when society shuns youth for a sexual crime, families also receive backlash. This anger directed towards families has not received wide attention in the field, primarily because research has yet to explore the overall effects of the sexual crime
on families. Even so, it can be conjectured that families who feel ostracized from society may not wish to seek services for a variety of reasons. Families may feel that seeking services only exacerbates the societal retribution. It may be that families experience further ostracism from society as a result of seeking services. Consequently, these extreme reactions deter many families from engaging in treatment.

**Subjective barriers.** It is no surprise that the findings from this dissertation revealed that families are frustrated by the various subjective barriers that stand in their way of engagement. The literature has acknowledged that barriers such as financial constraints, time, travel, work schedules, and living situation exist, and there is a great sense of stress and anxiety related to them (Ryan, 2010f). For example, the literature has supported the findings that finances hinder families’ ability to engage in services (Ryan, 2010e). In addition to individual and group treatment, family services are often times an added expense, and many families are unable to afford it (Ryan, 2010e). Furthermore, the literature has recognized just how logistically and pragmatically challenging it is to carry out aspects of treatment if families are overwhelmed with these barriers (Thomas, 2010). The findings from this dissertation supported existing literature in revealing that subjective barriers interfere with families’ ability to seek services.

**Living situation.** The youths’ living situation was one finding that was disclosed as a predominant qualitative and quantitative theme. Qualitative findings from this dissertation suggest that an out of home placement is a large barrier in treatment engagement. Literature has considered the difficulty in engaging in treatment if youth live in an out of home placement largely due to the fact that many families are physically
separated and distanced from their youth (Hunter et al., 2004). Families of youth in an out of home placement may be less motivated, contacted less frequently, or considered less often in service delivery (Thomas, 2010). Because of this, there has been a recent push in the field to move away from residential treatment facilities or out of home placements and distribute services through community-based programs (CSOMB, 2011; Burton & Smith-Darden, 2001; Hunter et al., 2004; McGrath).

In contrast to what the qualitative findings suggest and the literature states, the quantitative findings from this dissertation revealed that youth living in an in-home placement were less likely to be involved in family therapy. This finding could be attributed to the fact that family services may not be considered to be important if the family is intact. In fact research has shown that some youth who live in the home display less problem behaviors than those living outside of the home (Dishion, McCord & Poulin, 1999; Poulin, Dishion & Burraston, 2001). So, because services target youths’ individual needs (Leversee, 2010), family services may not be warranted for youth not displaying problem behaviors. Because family treatment is at the formative stages of development in the field (Duane & Morrison, 2004), and knowing when, how often, and in what contexts to deliver treatment has yet to be determined, family services may be occurring less often for those living in the home.

This study also adds to existing research by revealing that a change in placement is associated with more involvement in family therapy. This finding suggests that youth who move more frequently may be regarded to be more in need of services. Research has shown how more moves between homes or placements leads to more instability and
externalizing behavior problems among general delinquent youth (Herz, Ryan, & Bilchik, 2010), which may partially explain why these youth necessitate more services. Overall, though, this finding runs counter to what research has documented, not only in the general child welfare literature (Redding, Fried, & Britner, 2000), but also in the juvenile sex offending literature. One study specifically revealed that sexually abusive youth receiving traditional treatments in a variety of different settings have more placement changes (compared to youth receiving multi-systemic treatment in the home), which ultimately leads to difficulty progressing youth through treatment (Letourneau & Henggeler et al., 2009). So, in fact, youth may be less involved in services the more they change placements, and further research is needed to accurately investigate this association.

Furthermore, although qualitative findings revealed that youth who live in a rural area or further away from the treatment setting are less likely to be involved in family treatment, quantitative findings did not support this claim. This may be because there were relatively little rural areas surveyed in this study, or because of there was not enough power to demonstrate an effect for those rural areas that were surveyed. Although providers indicated the struggles of rural families and how undoubtedly these families have challenges in service engagement, it needs to be followed up with additional quantitative inquiry with larger rural sample sizes.

**Experiencing the crisis: Implications.** There are a variety of implications inherent in the first stage of the conceptual model. One major implication is that there needs to be crisis prevention initiatives for families of sexually abusive youth. To some
degree, families will experience stress during this process. However, if resources in the form of energy, funding streams, and justice system re-organization can be re-allocated so families do not necessarily undergo a crisis, it can serve two purposes: 1) it can “mandate” them to engage in services before fear sets in; effectively linking more families with services and 2) prepare families for treatment during offense disclosure thereby leading to earlier engagement and expedited services. System changes ought to reflect initial support and resources so that treatment begins before crisis state.

The profound stigma felt by families can be decreased though a concerted effort to educate the public about sexually abusive youth. For many reasons, stigma exists because the public is unaware of the actual risk posed to society by sexually abusive youth and fails to consider the developmental or contextual differences between youth and adults (Caldwell, 2007; Chaffin, 2008; Letourneau & Miner, 2005; Lobanov-Rostovsky, 2010). Educating communities on the facts related to low recidivism rates and amenability to treatment can help to reduce inaccurate portrayals. Furthermore, educating the public on the families, particularly understanding family typologies and ways to compartmentalize families according to shared characteristics and dynamics can help to contextualize the criminal behavior and lower stigma.

Recognizing there are ongoing barriers specific to families that prohibit their involvement, it is suggested that family treatment should be mandated for all youth and treatment funds should be re-allocated to pay for all engaged families. Because even with some policies streamlining funding for family services (OJJDP, 2012b), families continue to struggle affording high priced treatment (Duane & Morrison, 2004). Helping families
acquire necessary resources may particularly important for youth and families, as they will be ultimately reunited into a family system that by all accounts of the literature somehow contributed to the offending behavior. Understanding that treatment is taken from a risk, need, and responsivity framework, and knowing the need for family treatment among all sexually abusive youth, family service efforts should occur across a continuum for youth in various settings, including both residential and community or outpatient.

**Discussion of findings from second research question: Engagement in treatment**

The second stage of the *conceptual model of family-inclusive treatment for sexually abusive youth* clarifies how families become engaged in treatment after they have undergone a crisis. The findings from this dissertation suggest that providers expend a great amount of energy and time procuring family involvement. Their efforts are used to build the therapeutic relationship and consider families as an asset in the treatment process. Although treatment providers are part of a larger team, they are often the ones carrying the heaviest burden (Duane & Morrison, 2004). They are responsible for instituting appropriate therapeutic approaches while ensuring youth success. It has been well document that treatment providers are expected to go above and beyond for their clients, particularly when it pertains to assimilating a new or unfamiliar treatment paradigm (Duane & Morrison, 2004; Thomas, 2004; Thomas, 2010). So, when family services are being considered as an option in treatment, it is often the responsibility of the providers to get families engaged (Thomas, 2004). Although this can be time consuming
and challenging, the providers enthusiastically reach out to families because they recognize it as the most ethical approach to service delivery (Thomas, 2004).

**Building a therapeutic relationship.** A noteworthy finding revealed in the second stage of the conceptual model is that providers build a therapeutic connection with families. The providers expressed just how meaningful the relationships are for families to become fully engaged in services. Establishing the therapeutic relationship for the purpose of engagement in treatment is not necessarily a new phenomenon in the general treatment literature. In fact, many researchers have argued that in order to get youth engaged in treatment, providers must establish a relationship with them (Karver et al., 2008; Shirk & Karver, 2003). This concept has also received some attention in the sex-offending field, particularly concerning individual work with juveniles (Lambie & McCarthy, 2004; Powell, 2010; Smallbone et al., 2009). However, the importance of creating a therapeutic relationship has been rarely been studied in the context of families of sexually abusive youth. This may be because family treatment is not always mandated (Duane & Morrison, 2004), because families have traditionally been perceived as a risk (Bremmer, 1998), or because little is known about how this can be achieved.

The field has a limited understanding on how the therapeutic relationship can be established with families, particularly resistive families or those undergoing a crisis. The findings from this dissertation suggest that empathy, trust and connection, and feeling safe are all ways providers establish this connection with families. Research indicates that these are the mechanisms needed to establish a relationship with a system (such as the family) to ultimately get them engaged in treatment (Flaskas, 1997). Knowing this, these
approaches should be uniformly considered in building the therapeutic relationship with families of sexually abusive youth, predominantly because of the stigma and immense emotional turmoil experienced by them. Building an alliance allows families to feel comfortable with the notion of treatment and ultimately facilitates their initial steps into the process. The therapeutic relationship is truly the component that flips the conceptual model from a risk model to a strengths-based model. Building an honest and sincere relationship with families is the first step towards recognizing their strengths.

**Strengths perspective.** The field literature has succinctly identified the plethora of risk factors of families of sexually abusive youth. However, many studies have yet to determine family strengths or protective factors. There are discrepancies between what the research reports and what the findings in this dissertation signify; providers do not perceive families as a risk the way many field professionals do. This may be attributed to a shift in awareness after the risk assessment is conducted and before treatment begins (Thomas, 2004), because overall, providers value families. Ingrained in their work is the sense that families can overcome troubled times (Thomas, 2004).

Just as there are risks inherent in families, there are also protective factors within families and the field has yet to fully investigate them. Some literature has argued that there are certain protective factors including the presence of the family itself (Ryan, 2010c; Thomas, 2010) and optimism, hopefulness, and support (Houtzager et al., 2004; Johnson & Endler, 2002; Smith et al., 1989) that may buffer against risk and benefit sexually abusive youth. The insufficient attention to protective factors may be because for so long, research on sexually abusive youth has sought to understand the etiology or
causal relationships (Bremer, 1998). It may also be because the act of sexual offending is such an atrocious crime that we are unintentionally looking for someone or something to “blame” (Bremer, 1998). Either way, providers are taking a step in the right direction when they perceive the inherent strengths within families.

**Engagement in treatment: Implications.** There are many implications associated with these findings. Treatment providers require support from supervisors, agencies, and the multi-disciplinary team in making strides to get families engaged. Treatment providers currently have many demands placed on them, and it may ease their workload if they were to receive help in these efforts. Engaging families should not merely be a one-person task. Rather, all individuals, including all multi-disciplinary team members with vested interest in the youth and their families should take an active role in this process. Even with the efforts of treatment providers some families may avoid seeking services. This problem may be resolved through mandated family treatment. Full family engagement for all youth adjudicated of a sexual crime should be an objective for all agencies or organizations, and this can be achieved through requiring family participation.

Treatment centers and providers should also consider the impact that the therapeutic relationship and perceiving families’ strengths could have on their engagement levels. Bringing awareness to the factors that can enhance engagement among families of sexually abusive youth can be a benefit for many organizations. Families will be more apt to be involved if current risk perspectives are challenged, revised, and improved. Operating from a risk framework may help to identify the
problem, but it does not provide a viable solution for eradicating the problem. It is proposed that the “risk, need, and, responsivity” (Andrews, Bonta, & Hoge, 1990; Bumby & Talbot, 2007) framework be adapted to be inclusive of principles that enhance strengths, and therefore be renamed the “risk, protection, need, and responsivity” framework. In this way, the treatment engagement steps outlined in this dissertation can be manualized, where providers can be trained and these steps tested and validated so there is a standardized approach to engaging families. Treatment providers can then follow and use these standardized steps to better engage families.

**Discussion of findings from third research question: Family treatment**

When families of sexually abusive youth are engaged, providers continue to work diligently to deliver services and foster change. The third stage of the conceptual model of family-inclusive treatment for sexually abusive youth represents the methods providers utilize to maintain family interest and involvement through the course of treatment. This stage exemplifies the aspects, details, and idiosyncrasies of family treatment for sexually abusive youth. The results revealed that the providers use therapeutic components to enhance family skills in their service delivery efforts. The third stage of this conceptual model is important because distinctions of family treatment for sexually abusive youth have rarely been made. These findings are a framework for better understanding the ways in which family services are conducted, and it is the hope that these findings inform all practices for families of sexually abusive youth.

**Families and sex offender specific treatment.** One predominant piece of family treatment was when families were incorporated into sex offender specific treatment. This
element of treatment is not for youth alone; rather, families are a crucial factor that can add to understanding and integrating topics specific to the sexual offense. Incorporating families in sex offender specific treatment is advantageous because it is a method by which families begin to acknowledging the role, whether unintentional or intentional, they played in contributing to the offense (Thomas, 2010). They also begin to comprehend the additional environmental, situational, or internal factors that supported the offending behavior (Ryan, 2010c; Thomas, 2010). Recognizing the factors that contributed to or reinforced the crime helps families learn how to prevent the behavior from reoccurring by adapting new strategies or tactics to intervene during a problem situation (Zankman & Bonomo, 2004). Families can interrupt the offense cycle at its beginning just by knowing youths’ triggers or high risk situations (Zankman & Bonomo, 2004). Families can also be a support system for youth, as they can depend on them or lean on them during troubled times (Zankman & Bonomo, 2004). Furthermore, because many youth will be reunited with families, or among those that continue to live in the home, and because the family system is the most instrumental in influencing change (Bronfenbrenner, 1989), the family takes on a supervisory role (Ryan, 2010c). Ultimately, they are the ones responsible for sustaining the changes made in treatment, and therefore, knowing the nuances of the youths’ offense(s) is critical to effective supervision and long-term change.

**The therapeutic relationship is ongoing.** The findings from the third stage of the conceptual model stressed that useful family treatment occurred when there was a strong therapeutic alliance with the family, and that the family treatment components employed by providers necessitated the alliance. As the second stage of the conceptual model
represents, the therapeutic relationship is important in getting families engaged in treatment. However, it is also an element that perpetuates and reinforces the advancement of treatment and is fundamental to implement treatment components. The therapeutic alliance may be important in treatment because it promotes empathy and understanding. Receiving empathetic care in the therapeutic context may help youth and families develop and understanding of how to incorporate empathetic components into their own lives (Knight & Prentky, 1993). The therapeutic relationship also signifies the value of human relationships. It is a central to the human condition to establish connections and form trusting relationships, and so, it is when these relationships are nurtured that change begins to take place (Thomas, 2004).

Although the therapeutic relationship is an essential concept, it has been relatively understudied in the context of treatment for families of sexually abusive youth. This could be attributed to stigma and stereotypes so closely associated with the sexual offense (Quinn, Forsyth, & Mullen-Quinn, 2004; Sahlstrom & Jeglic, 2008), particularly among providers (Fortney & Baker, 2009; Nelson, Herlihy, & Oescher, 2002; Nelson, 2007). Treatment providers may have their own biases, points of view, or subjective feelings towards working with sexually abusive youth and their families (Nelson, 2007), and these perceptions may influence their ability to establish empathy and trust in the form of a therapeutic bond (Ertl & McNamara, 1997). However, ethical providers are acutely aware of these biases (Ertl & McNamara, 1997; Powell, 2010), and will take applicable steps to ensure appropriate treatment. Therefore, the therapeutic relationship may more accurately
be understudied not because providers are failing to establish those bonds, but because the effectiveness of such approaches continues to be contested among professionals.

The value of the therapeutic relationship in treatment with youth and families has lead professionals to question critical mechanisms of change. What treatment factors are ultimately responsible for change and could the therapeutic relationship play a role in prompting change? The therapeutic relationship has been studied as a factor leading to change among specific samples of youth. For example, research has demonstrated the impact of therapeutic relationship on youth treatment outcomes (Shirk & Karver, 2003) and has also pointed to the significance of both the relationship and treatment components, such as CBT (Karver et al., 2008). Still, others argue that the therapeutic relationship is a mute concern when employing evidenced based practices, where research has failed to demonstrate the influence of the therapeutic relationship among families (Hogue et al., 2006).

Despite the perplexing professional stance on mechanisms of change, equal importance should be placed on evidenced based practices and the therapeutic relationship; one cannot occur without the other (Rubin & Bellamy, 2012). The sexual offending field has limited knowledge on family specific evidenced based practices (outside of multisystemic therapy), and has yet to reveal the therapeutic relationship as a mechanism of change. Therefore, the field is still at the formative stage of conceptualizing the way these two constructs interact. This dissertation is the first step in clarifying this interface as it clearly reveals the importance of using the therapeutic
relationship with families who have been stigmatized and marginalized to build on their strengths and enhance their progression through treatment.

**Treatment components.** In a similar vein, there are components specific to family-inclusive treatment for sexually abusive youth that were perceived as especially useful by providers. Little is currently known about what works and what does not work in the field. Specifically in the state of Colorado, the standards for treatment recommend the inclusion of families (CSOMB, 2011), but the types of family work outlined in the standards and employed nationwide (Thomas, 2004; Worley et al., 2011) (i.e. family reunification, multi-disciplinary team involvement, family therapy, multi-family group therapy, and informed supervision) have not yet been supported by evidence. Furthermore, because there are so many different approaches to family services, research is lacking in understanding what specific approaches are being used with families of sexually abusive youth (Thomas, 2004, 2010; Worley et al., 2011). This study adds to existing literature on how family treatment is being carried out, the distinct components of treatment, and the multitude of ways families can be involved in services.

The purpose of family treatment is not to exclusively treat the sexual offending behavior; rather treatment should consider ways that families can reconcile their differences and operate as a unified system (Etgar & Shulstain-Elrom, 2009; Thomas, 2010). The findings from this dissertation revealed that providers employ specific intervention components to restructure and unite families. Similar techniques such as problem solving and communication skills are used more generally with families of high-risk youth, particularly in structural family therapy (Minuchin, 1981) or brief strategic
family therapy (Szapocznik & Williams, 2000), and have been shown to be effective in reducing problem behaviors (Santisteban et al., 1996). These intervention methods have historically been shown to be important in the family relations literature where youth and families who have received problem solving and communication interventions had reduced parent and youth conflict (Robin, 1981). They have also been argued to be essential for refining overall family interactions and functioning (Sillars, Canary, & Tafoya, 2004). These constructs may be especially salient for families of sexually abusive youth as there is often a breakdown in communication patterns and methods of problem solving among families, and when these barriers are addressed in family treatment, it has been argued that family functioning is likely to improve (Worley et al., 2011).

Moreover, the findings also point to the importance of uniting families by working through the pain. Literature on families of sexually abusive youth has begun to acknowledge that this is a core component of the treatment process (Etgar & Shulstain-Elrom, 2009). Working through the pain is how families begin to establish empathy for each other, relinquish control, and confront their deep-rooted issues (Etgar & Shulstain-Elrom, 2009). This is a large piece of the recourse that families ought to experience in order to rectify the harm (Etgar & Shulstain-Elrom, 2009).

**Family treatment: Implications.** There are many implications associated with the third stage of the conceptual model. The therapeutic relationship could be a significant concept when referring to the “risk, need, and responsivity” framework. Responding appropriately often means responding with sensitivity, connectedness, and empathy (Lambie & McCarthy, 2004). If families can be connected with services and if
services are carried out with regard for the therapeutic alliance, treatment may have a strong effect on their outcomes. Treatment providers can be trained on ways to augment the therapeutic relationship in their particular settings. Providers should also be trained in ways to recognize biases or personal stigma to avoid tarnishing the therapeutic relationship.

There are differing perceptions on whether evidenced-base practices or therapeutic relationships ultimately lead to change. Findings from this dissertation support the need to expand evidenced based practices related to family services in the field. The field would greatly benefit from understanding how family treatment components like communication, problem solving, and working through the pain can be quantitatively linked to outcomes. There is a similar call for investigating the relative influence of the therapeutic relationship on outcomes. Despite the need for further research in this area, this study is a starting point for understanding how both component based approaches and the therapeutic relationship are uniformly valued. These findings can inform the development of family-based approaches that can be tested, validated, and disseminated. It is the goal that treatment programs and providers across the country can execute this model across various service sectors.

**Discussion of findings from fourth research question: Family treatment outcomes**

The final stage of the conceptual model of family-inclusive treatment for sexually abusive youth represents the outcomes associated with family services. This dissertation is a method by which families in the treatment process are understood, and the final stage in this model validates the significance of family involvement in the treatment of sexually
abusive youth. The findings from this stage revealed that family oriented services are helpful for youth and families alike. This study makes a significant contribution to the field as it discovers differential forms of family service involvement (i.e. family therapy, multi-family group, multi-disciplinary team involvement, informed supervision, and family reunification) and links them with youth and family outcomes. Very few studies have explored these types of family services, and even fewer have thoroughly investigated the impact those services on treatment success and recidivism.

**Successful treatment completion.** The findings revealed that the more families are involved in services, the greater the likelihood of treatment success. Evaluating the effect of family treatment has many benefits. It may be that family services are a useful form of treatment because youth are able to work through their pain, anger, and other dynamics from having families present (Bremmer, 2001; Thomas, 2010). Youth can rely on the family system as a formative support during the process, and recognizing the stability and dependability of that support, youth may be more apt to open up, explore deep feelings, and alter maladaptive behavior patterns (Bremer, 2001).

It can be argued that youth may fair better when families are involved in treatment more often. Youth may have greater success the more their families are involved and the more support the families offer during treatment. Among general delinquent youth, research has shown that the presence of the family can be powerful and impactful (Latimer, 2001). Research has also demonstrated that there are certain factors, such as the frequency and quality of treatment implementation that are associated with greater success (Lipsey, 2009). Therefore, supplementary research is needed in this area to study
how the frequency, quality of treatment, and gradation of family engagement can be
associated with better outcomes for youth.

There is now some evidence demonstrating that family services are useful for
youth. This may be especially poignant among those youth that are being reunited with
their families or living in an out of home placement. Because it is argued that those youth
living out of the home receive family services less frequently (Dishion, McCord &
Poulin, 1999; Poulin, Dischion & BurraStage, 2001) and because of the great need to
ensure safety and security while reunifying youth with families (Ryan, 2010e), the effect
of family services may be stronger for those youth.

**Recidivism.** Family service involvement was not statistically significantly
associated with recidivism. The fact that family services was not associated with
recidivism suggest that although the direction of the relationship was what would be
expected (family service involvement was associated with less recidivism), the effects
from family services may not be strong enough to impact youth in the long run. This may
be attributed to restricted or absent aftercare efforts that are imparted to sustain the effects
of treatment (Hunter et al., 2004; Thomas, 2004).

In fact, because of the low recidivism rate, not many variables of interest were
associated with recidivism. Although risk level is argued to be associated with recidivism
(Worling & Langstrom, 2003, 2004; Worling, 2004), this study failed to find an
association between the two variables. This finding suggests that the various different
risk assessment tools used to ascertain risk level in the file review have limitations. The
specific assessment tools used to determine respective risk levels were not indicated in
the files, and although many of these actuarial risk assessment tools are frequently
utilized in the field, their predictive utility is questionable, particularly pertaining to
future offending (Hempel et al., 2013). Improving the validity of current risk assessment
tools is needed to predict long-term recidivism (Hempel et al., 2013).

The results revealed that youth who were living in an in-home placement were
less likely to recidivate. This development may be associated with the fact that youth who
are living in the home and receiving treatment in conjunction with immediate familial or
social supports are less likely than those living out of home to demonstrate behavior
problems (Chamberlain et al., 2006; Handwerk et al., 1998). Inversely, it may be because
youth living in an often times unstable out of home placement experience iatrogenic
effects and adopt analogous behavior patterns of their peers, and consequently develop
long-term difficulties (Dishion, McCord & Poulin, 1999; Handwerk et al., 1998; Poulin,
Dishion & Burraston, 2001; Zima et al., 2000).

**Positive family outcomes.** The fourth stage of the conceptual model further
revealed the providers believe family treatment to result in in positive family outcomes.
Overall, providers indicated that families experience healthy adjustment in the form of
improved family functioning and relationships. The findings suggest the value in
evaluating not only youth outcomes, but also family outcomes. Because family treatment
considers the family from a systemic perspective (Thomas, 2010), it is necessary to
consider how families acclimate post treatment. Treatment can be the platform through
which families are empowered. As findings previously demonstrated, families are united
and restructured through treatment, and it may be that families truly learn to integrate
those effects, independent of providers or the treatment team upon completion of treatment (Thomas, 2004; 2010). So, as a result of family services, families effectively adapt. Learning to work together, face fears, improve deficiencies, and evaluate their family system is how families overcome the crisis. From treatment, the family system is greatly enriched, and learns to consider themselves and the youth as imperfect but worthy of rehabilitation (Thomas, 2010).

**Family services outcomes: Implications.** There are many implications associated with the fourth stage of the conceptual model. First and foremost, service agencies and providers can actively begin to consider the crucial role that families play in the treatment process. Providers can use these findings as preliminary evidence that the various forms of family services can be useful for youth and families. Furthermore, service programs and agencies can modify current services that lack family involvement to include families. Because these findings suggest that at least one form of family involvement is helpful, programs can begin to take a uniform approach to including families in one or more ways.

Aftercare initiatives should also consider the ability of families to influence youth in the long-term. With scant energy being paid to aftercare initiatives for sexually abusive youth (Hunter et al., 2004; Thomas, 2004), resources should be allocated to coordinate services for families. In this way, services can be continuous and unremitting. If family services gradually fade, treatment is reinforced, and follow-up efforts are provided, families may feel more empowered to preserve, assimilate, and indoctrinate the concepts of treatment into their lives. Because aftercare services have been shown to be effective
in reducing recidivism for general offenders (Chrissy et al., 2013), they may be the key to establishing an effect of family treatment on long term behaviors like recidivism for sexually abusive youth.

Finally, when family services are delivered, family-oriented outcomes should be operationalized. Because families equally benefit from treatment, these outcomes should be measured in a systematic manner. Beyond understanding these outcomes from the perspectives of treatment providers, research needs to test the effects of family service involvement on family wellbeing and functioning. A first step in this process will be operationalizing family outcome variables that should be considered in future studies that seek to demarcate the effects of family treatment.

**Study limitations**

**Qualitative limitations.** Although these findings reveal the process of family treatment and report the benefits of it, this dissertation has many limitations that should be addressed. Qualitatively, the findings are not generalizable to all treatment providers or even all treatment providers in the state of Colorado. These findings were amassed from a relatively small sample of providers who voluntarily submitted to partaking in this study, and therefore it cannot be assumed that these providers’ modes of treatment are congruent with those of all treatment providers. Additionally, this study does not account for the innumerable perspectives of providers who did not participate. It could be that those who chose not to participate do not or cannot for whatever reason employ family services, and because of this, they were not interviewed. The opinions of those providers could be a valued perspective, as it may provider further insight into the reasons family
services are not used more frequently. Some other limitations related to the researchers’ inability to conduct member checks with every participant interviewed. Member checks were only conducted among those individuals who were willing to submit to a follow-up interview.

Because the survey focused so deeply on the experiences of the families, it may have been beneficial to additionally survey families of sexually abusive youth. Particularly in the foremost part of this study, families could most accurately report their experiences while in a crisis, their experience with the justice system, their relative degree of marginalization, their resources, and overall feelings or emotions. So, considering the family perspectives would have an added benefit to this study. However, this study was conducted by in large to understand how treatment is carried out with families, so the most appropriate population to target would be treatment providers. Future research should be conducted to examine how family perspectives may differ or coincide with the perceptions of treatment providers.

Finally, the qualitative portion of this dissertation has limitations in regards to social desirability bias. The researcher association with the Colorado Sex Offender Management Board could have influenced the response received from providers. Where some providers see the CSOMB as an accommodating, supportive, or advantageous organization, others perceive it as autocratic, overbearing, and forceful, making mandatory treatment decisions on their behalf. The divergent opinions of the board could have lead to the willingness or reluctance to be involved in the survey.
**Quantitative limitations.** The quantitative data also had limitations. The small sample size although consistent with other samples of sexually abusive youth limits the power afforded to this study and restricts the ability to conduct advanced statistical analyses. It is possible that certain variables may have been significant but not had the power to detect. Because of the small sample size, these findings should be met with caution and should not be generalized to all families of sexually abusive youth nor all youth and families in Colorado. Because the data were collected at different time points and only in three jurisdictions, the findings can generalize only to those youth surveyed during the time points that they were taken. Furthermore, it is important to acknowledge that there are limitations in joining the two fiscal year samples for the analyses. There was a large span of time separating the two groups and various policy changes or the implementation of the standards for treatment could attribute to differences not captured between the two groups. There were also limitations in regards to the multiple recorders that collected the data. Although the study was designed to control for the different ways researchers would collect data, there could have been discrepancies in the way constructs were defined and how they were reported.

The quantitative data were derived from file reviews, and this has many limitations associated with it. Because file review data requires one to retract only the data that is available in the files, information was denoted as missing because the provider did not document it, because the pages were missing, or because the researcher did not have access to it. The multiple imputation method, although recognized as the most appropriate form of handling missing data, still has its limitations. It attempts to
accurately impute missing values, and in the end, is purely an estimation of the values. Furthermore, the file review data warrants reduced variability, as it was primarily dichotomous data that was collected. The missing data imputation on the dichotomous data leads to a transformation in the variable level of measurement interpreted.

**Overall Implications and Future Research Recommendations.**

Overall, the *conceptual model of family-inclusive treatment for sexually abusive youth* aims to advance treatment and intervention initiatives and inform policies and legal sanctions for sexually abusive youth and their families. Although the findings from this dissertation are informative, they leave the field with many unanswered questions. The final section of the discussion section will explore overall implications, specifically related to service delivery and policy and make recommendations for future research.

**Treatment and intervention implications.** Social workers working in the field of sexually abusive youth can benefit from this conceptual model. Sexually abusive youth and their families are a particularly vulnerable population that have been marginalized and stigmatized. This strengths-based model of service delivery assists social workers in providing a voice to sexually abusive youth and their families who commonly face discrimination and oppression. They can draw on family strengths to help them overcome the crisis and resulting feelings of marginalization.

The conceptual model suggests that the progression of steps to engage families and work with them requires diligence from both treatment providers and families. In order to successfully work through this model, the families, providers, and agencies or organizations need to be aware of the potential challenges and benefits. This model
outlines a process for understanding family stress, engaging families in services, and using the therapeutic relationship and components during treatment. Because this model distinguishes and cultivates the strengths of families while appropriating both alliance and component based approaches, it is positioned as a novel and instructive framework for service delivery.

**Policy implications.** The conceptual model has several implications that seek to inform social justice initiatives. One goal is to illuminate the stresses of sexually abusive youth and their families to dismantle any existing biases and beliefs and restore an impartial attitude towards them. This dissertation implies an ongoing need to not only resist false ideologies regarding sexually abusive youth and families, but to institute systemic changes in policy.

Inherent in current policies such as registration and community notification and supervision and management is the idea that sexually abusive youth are chronic, dangerous, and life-threatening offenders (Caldwell, 2007; Chaffin, 2008; Letourneau & Miner, 2005; Lobanov-Rostovsky, 2010). With the enactment of sex offending legislation in the 1990’s, there was a punitive shift in the manner in which retribution for juveniles was carried out (Hunter & Lexier, 1998). Although general youth delinquents are perceived to be amenable to treatment and respected in regards to confidentiality, legislation has set a different precedent for sexually abusive youth (Trivits & Reppucci, 2002). There has also been an increase in longer sentences, out of home placements (residential facilities) (Letourneau & Miner, 2005), and civil commitment (at risk
criminals required to remain incarcerated as a function of a risk assessment) (Letourneau, 2006).

The punitive nature of legislation has repercussions for the psychological and emotional outcomes for youth (Lobanov-Rostovsky, 2010; Dicataldo, 2009; Trivits & Reppucci, 2002; Levenson & Cotter, 2005; Letourneau, 2006), and findings from this dissertation clearly demonstrate that families feel overwhelmed from system demands and are frequently ostracized from their communities. Punitive policies not only impact youth, they also negatively impact families. For example, literature has suggested that as a result of mandatory registration and community notification sanctions, communities mistakenly associate families and parents with the sexual offending behavior (Prescott & Levenson, 2007) and may unintentionally exacerbate youth and family risk (Leversee & Pearson, 2001). Knowing this, it is increasingly important to reevaluate, redefine, and modify current policies to take a more rehabilitative response by eliminating registration and community notification for offenses committed by juveniles. Policy should shift to considering contextual and developmental circumstances, and ultimately these shifts can change misrepresentations and stigma to reduce family stress and lessen the crisis experience.

**Recommendations for future study.** Now that the components and the process of treatment are better understood and there is evidence to support the usefulness of family treatment, the *model of family-inclusive treatment for sexually abusive youth* should be rigorously tested. Overall, future research steps can detail a manual for how to pragmatically move families through the treatment process, test that manual, and then
disseminate effective methods to the provider community. There are specific stages of this model that can be manualized in such a way, including the strengths-based approach to family inclusion. By in large, the fact that providers talked about families’ strengths, value families, and work to engage them in treatment was an indicator that they were using a strengths-based approach. However, further research can use standardized scales, such as the protective factors scale (Bremer, 2001) to identify family protective factors and systematically test how they are heightened in treatment.

Moreover, the effects of the therapeutic relationship can be tested in a standardized manner and compared with the effects of the treatment components to determine the usefulness of either approach. Additional studies should be done to further evaluate the value in family treatment, like the ones examined in this study. Although the field is increasingly acknowledging the importance of family treatment, and has found evidenced-based practices like MST to be particularly effective, more research is needed in this area. If the field seeks to advance treatments, provide ethically sound services, reduce punitive responses, and operate from a strengths perspective, this study requires further replication and the effectiveness of family work should continue to be explored.
References


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Appendix A: Quantitative Data Collection Form

Juvenile Standards Evaluation - DATA COLLECTION FORM

Judicial District File Review: 1st 13th 21st
File Review: Probation DYC (Detention Commitment) DHS
DCJ ID Number: __________ ML Number: __________ Trails Number: __________

Is Human Services assigned to this case as well? 0. NO 1. YES

Name: ____________________________________________________________

AKA: _____________________________________________________________

Social Security Number: ____________________________________________

FBI Number: ______________________________________________________

SID Number: ______________________________________________________

Date of Birth: _______ / _______ / _______

Gender: 0. Male 1. Female

Ethnicity: 1. Anglo/White
2. African American
3. Hispanic
4. Native American
5. Asian
6. Other

Primary/Most serious Sex Offense Case Number: __________ County: __________

Any change of venue or case numbers? 0. NO 1. YES
If yes, new case number1: __________ County: __________
If yes, new case number2: __________ County: __________

Supervised Jurisdiction1: __________ County1: __________
Supervised Jurisdiction2: __________ County2: __________
Supervised Jurisdiction3: __________ County3: __________

Concurrent Number of...
Charges: __________________________________________________________

Sexual Offense Charges: ___________________________________________
Non-violent, non-sexual charges: ___________________________________
Violent, non-sexual charges: _______________________________________
Failure to Register charges: _______________________________________
Felony: _________________________________________________
MI: Misdemeanor: ____________________________________________

1
1) Primary/Most Serious Charged/Filed Offense: ____________________________

2) Primary/Most Serious Plead/Adjudication Offense: ____________________________

3) Date of Adjudication: ______/_____/_______

4) Date of Sentence: ______/_____/_______

5) Sentence:  
1. Probation  
2. Probation/Detention  
3. DYC (Commitment)  
4. Other: ____________________________

6) Was the juvenile under criminal justice supervision at time of this offense?  
0. No 1. Yes 9. Do Not Know

7) Has the juvenile had any prior adjudications?  
1. No  
2. Yes (circle all that apply)  
   I. Misdemeanor  
   II. Felony  
   III. Municipal Level  
   IV. Petty  
   V. Non-violent Sexual Offense  
   VI. Violent Sexual Offense  
   VII. Non-violent, non-sexual  
   VIII. Violent, non-sexual  
   IX. Do Not Know  
3. Do Not Know

8) Has the juvenile had any prior deferred sentences/judgments?  
0. No 1. Yes 9. Do Not Know

9) At the time of the offense (or arrest), which best described the juvenile’s living situation?  
1. Living with immediate family  
2. Living with legal guardians and/or foster family  
3. Living in a residential facility  
4. Other: ____________________________
9. Do Not Know

10) At the time of offense, was the juvenile attending school?  
1. No  
2. Yes  
3. What grade?  
4. What School District (write name of school if don’t know what district)?
9. Do Not Know
11) At the time of offense, was the juvenile active in any extra-curricular activities?
   0. No
   1. Yes
   9. Do Not Know

12) Did the juvenile fail either 1st or 2nd grade?
   0. No
   1. Yes
   9. Do Not Know

13) Did the juvenile have an Individualized Education Plan at the time of offense/arrest?
   0. No
   1. Yes
   9. Do Not Know

14) Did the juvenile change schools while under supervision?
   0. No
   1. Yes
   Date changed school1: __/__/__
   Reason for changing school1: ____________________________________________
   Date changed school2: __/__/__
   Reason for changing school2: ____________________________________________
   Date changed school3: __/__/__
   Reason for changing school3: ____________________________________________
   9. Do Not Know

15) Did the juvenile get expelled from school or drop-out of school while under supervision?
   0. No
   1. Yes
   Explain why: __________________________________________________________
   9. Do Not Know

16) Did the juvenile graduate high school or obtain a GED while under supervision?
   0. No
   1. Yes
   a) HS Diploma
   b) GED
   c) Do Not Know
   9. Do Not Know
17) At the time of offense, was the juvenile employed?
0. No
1. Yes
   I. Full-time
   II. Part-time
   III. Summer job
   IV. Do not know
   9. Do Not Know

18) When NOT a student, was the juvenile employed while under supervision?
0. No
1. Off and on
2. Summer job
3. Yes, all of the time:
   I. Full-time
   II. Part-time
   III. Do not know
9. Do Not Know
10. N/A - Juvenile was always attending school
11. N/A - Juvenile was too young to be employed

19) At the time of offense (or within 6 months prior to the offense), did the juvenile have a mental health diagnosis?
0. No
1. Yes:
9. Do Not Know

20) At the time of offense (or within 6 months prior to the offense), did the juvenile have any other medical diagnosis?
0. No
1. Yes:
9. Do Not Know

21) At the time of offense (or within 6 months prior to the offense), was the juvenile prescribed any psychotropic medications?
0. No
1. Yes (Name and reason):
9. Do Not Know
22) Date of Pre-Trial Evaluation or first Offense-Specific Evaluation: ______/_____/_____

23) Date of Pre-Sentence and Post-Adjudication Evaluation: ______/_____/_____

24) Risk Level per offense-specific evaluation (evaluation most recent prior to sentence):
   1. Low
   2. Low-Moderate
   3. Moderate
   4. Moderate-High
   5. High
   6. Other, ______________________________
   9. Do Not Know

25) Placement recommendation per evaluation:
   1. Out-patient
   2. DHS out-of-home placement/foster care
   3. DYC correctional placement
   4. Other, ______________________________
   9. Do Not Know

26) Actual placement:
   1. Out-patient
   2. DHS out-of-home placement/foster care
   3. DYC correctional placement
   4. Other, ______________________________
   9. Do Not Know

27) Reason for placement (if different than recommendation): ______________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
28) Who was involved in the MDT? Circle all that apply:
1. Treatment Provider
2. Supervising Officer/agent
3. Polygraph examiner
4. Victim Representative
5. DHS caseworker
6. Caregiver in any out-of-home placement
7. Family member
8. GAL
9. Other, ___________

29) Was there documentation of the MDT meeting regularly (a minimum of quarterly)?
   0. No
   1. Yes

30) Has the supervising officer noted any concerns with supervision that resulted in a recommendation for change in supervision level or placement level?
   0. No   1. Yes
   Please explain: ________________________________

31) Status at termination of supervision?
   0. Positive completion of supervision
   1. Neutral completion of supervision
   2. Negative discharge/termination of supervision
   31a) If supervision was revoked, reason for revocation: ________________________________

32) What was the criminal justice supervision end-date? __________/__________

Treatment Information
33) Modalities used (circle all that apply):
   1. Group Therapy, # of sessions (if known) __________
   2. Individual Therapy, # of sessions (if known) __________
   3. Family Therapy, # of sessions (if known) __________
   4. Multi-Family Groups, # of sessions (if known) __________
   5. Other, __________

34) Did the juvenile’s family participate in family therapy?
   0. No
   1. Yes, consistently, during the entire case
   2. Yes, off and on
   9. Do not know

35) Did the juvenile’s family complete informed Supervision therapy or training?
   0. No
   1. Yes
   9. Do not know
36) Did the juvenile participate in victim clarification procedures?
   0. No
   1. Yes
   9. Do not know

   If NO, please explain: ______________________________

37) Did the juvenile participate in family reunification procedures?
   0. No
   1. Yes
   9. Do not know

   If NO, please explain: ______________________________

38) Were there any changes in treatment agencies?
   0. No
   1. Yes

   Date of change 1: __/__/____
   Reason for change 1: ______________________________

   Date of change 2: __/__/____
   Reason for change 2: ______________________________

   Date of change 3: __/__/____
   Reason for change 3: ______________________________

39) Were there recommendations for changes in level of treatment?
   0. No
   1. Yes

   39a) Were the recommendations followed through...
       1. All recommendations were followed through
       2. Some of the recommendations were followed through
       3. None of the recommendations were followed through

   If answered some or none (2 or 3), explain why:
   __________________________________________________________________
   __________________________________________________________________
   __________________________________________________________________

40) Has the treatment provider noted any concerns in treatment that would affect their placement or supervision level?
   0. No
   1. Yes

   Please explain: ________________________________________________
   ________________________________________________
   ________________________________________________
   ________________________________________________
41) Did the juvenile get moved to a different placement or living situation/arrangement?
   0. No
   1. Yes
      Type 1:
      Date of placement 1: __/__/____
      Reason for placement 1: ________________________________
      Date placement 1 ended: __/__/____
      Reason placement 1 ended: ________________________________

      Type 2:
      Date of placement 2: __/__/____
      Reason for placement 2: ________________________________
      Date placement 2 ended: __/__/____
      Reason placement 2 ended: ________________________________

      Type 3:
      Date of placement 3: __/__/____
      Reason for placement 3: ________________________________
      Date placement 3 ended: __/__/____
      Reason placement 3 ended: ________________________________

42) Status at final treatment completion:
   0. Positive completion of treatment
   1. Neutral completion of treatment
   2. Negative discharge/termination of treatment

43) What was the final treatment discharge date? __/__/____
Appendix B: Qualitative Informed Guide

Qualitative Interview Guide

Background Information
  Name:
  Age:
  Ethnicity:
  Highest Level of Education:
  Agency Affiliation:
  Length of time at agency:
  Length of time working with juvenile sex offenders:
  Degrees earned:

1. What is your professional experience in treating sexually abusive youth?
   a. What sparked your interest in working with youth sex offenders?
   b. What do you enjoy about working with this population?
   c. Can you describe a typical session with one of your clients?

2. What is your general treatment philosophy?
   a. What treatment approach do you align yourself with?
   b. Can you explain how you came to use this approach?
   c. Can you explain why you do or do not apply this approach with complete fidelity?

3. How would you generally describe families of sexually abusive youth?
   a. In thinking about families of juvenile sex offenders, how do families typically react when their child commits a sexual offense?
   b. Can you provide examples of specific cases?

4. What factors distinguish families of juvenile sex offenders from families of generally delinquent youth?
   a. Can you describe some of the typical family dynamics you have seen?
   b. How do these dynamics change if the victim was someone in the home?
   c. How do these dynamics change if the juvenile offender is in the home during treatment versus in an out of home placement?
   d. Can you explain why family dynamics can be considered a risk factor?

5. What are the costs and benefits of incorporating families into services?
   a. Why do you or why don’t you think incorporating families into treatment is important?
   b. Can you describe a case where including family treatment was helpful?
   c. Can you describe a case where including family treatment was not helpful?
6. What are the barriers and challenges associated with getting families to engage in family services?
   a. Barriers clinicians face
      i. What makes it difficult to work with families?
      ii. How do you overcome these challenges?
   b. Barriers families face
      i. Can you explain how family dynamics affect family participation in treatment?
      ii. Can you talk about some of the fears that families have in becoming engaged in treatment?
      iii. How often do you see families reluctant to engage in therapy because of fear?
      iv. How do families overcome these challenges?
      v. To what extent do you think emotional reactions to offenses play a role in deterring family involvement in treatment?
      vi. Can you talk about some of the emotional reactions that families have?
      vii. How do families overcome these challenges?
      viii. What are some of the tangible challenges that families face in attending treatment?
      ix. How often do you see families reluctant to engage in therapy because of tangible barriers?
      x. How do families overcome these challenges?

7. What does family therapy look like when it’s adapted for families of sexually abusive youth?
   a. What is the general flow of a typical family session?
   b. Can you explain why you would or would not treat the family as a unified system in therapy?
   c. What principles or components do you use most frequently when you work with families?
   d. What are some successful outcomes you’ve seen as a result of applying these principles or components?
   e. How frequently do you see families in therapy and what dictates this?
   f. Can you explain how family therapy with juvenile sex offenders may look different than it does with other populations?

8. How can family services for sexually abusive youth be improved?
   a. If you could change one thing about your work with the families of juvenile sex offenders, what would it be and why?
   b. To what extent are these changes possible? Why or why not?
   c. In your ideal world, what should family therapy look like in your work with juvenile sex offenders?