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Challenges in Researching the Relationship Between Delinquency and Family Dynamics in Juvenile Sex Offenders

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ABSTRACT

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Recently developed treatment approaches on juvenile sex offenders include the offenders and their families. These approaches have some empirical support; however, little research attempts to link family dynamics and child abuse with juvenile re-offending. This study attempted to examine the family dynamics from the juveniles' perspective. The Family Assessment Measure (FAM-III), Parental Bonding Instrument (PBI), Self Reported Delinquency measure (SRD), and Childhood Trauma Questionnaire - Short Form (CTQ-SF) were used to assess family dynamics, parenting style, delinquency and childhood maltreatment, respectively. Problems with recruitment resulted in too few participants (N=6) to conduct meaningful statistical analyses. Participant responses suggested elevated impression management scale scores and likely underreporting of sexual and non-sexual delinquency. The challenges inherent in research on this population were explored in lieu of reporting statistical analyses that are likely to be misleading.

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Ryan (1997) defined sexual abuse as any sexual interaction with people of any age that is perpetrated against the person's will, without their consent, or in an aggressive, manipulative, exploitative, or threatening manner. About 15% of adults report childhood sexual abuse (Finkelhor, 1994). This rate likely underestimates the actual rate of childhood sexual abuse because only 39% of victims report sexual assaults (OJJDP, 2007). Childhood sexual abuse causes long term damage to many victims by increasing their risk of suffering from depression, borderline personality disorder, somatization disorder, substance abuse disorder, posttraumatic stress disorder, dissociative identity disorder and bulimia nervosa (Putnam, 2003). Juveniles are responsible for a significant amount of this damage because they commit roughly 35% of child sexual abuse (Davis & Leitenberg, 1987). Further, 50% of adult sex offenders report committing their first offense as a juvenile (Becker & Abel, 1985). Despite juvenile sex offenders committing about one-third of the childhood sexual abuse, most research focuses on adult sex offenders (Becker, 2004). Because treating juvenile sex offenders could help reduce the number of sexual assaults before the behaviors become entrenched in adulthood (Barbaree & Marshall, 2006), more research on juvenile sex offenders could help reduce the number of sexual abuse victims. Although most sexual abuse research focuses on adult offenders, researchers have searched for differences between juvenile sex offenders and general juvenile delinquents.

Investigations have revealed few robust differences between juvenile sex offenders and general juvenile delinquents. Only higher levels of social isolation and problems with peers differentiate juvenile sex offenders from general juvenile delinquents (Katz, 1990; van Outsem, Beckett, Bullens, Vermeiren, van Horn, & Doreleijers, 2006). Researchers,

however, have failed to find robust differences in impulsivity, academic difficulties, antisociality, general personality, cognitive abilities, family characteristics, delinquent behavior and abuse history when comparing juvenile sex offenders to general juvenile delinquents (Righthand & Welch, 2001). The two groups appear more alike than different. This suggests that juvenile sex offenders may not attain maximum benefit from treatments focusing solely on their sexual offense.

Research supports the notion that juvenile sexual offending reflects a pattern of general delinquent behavior more than it reflects a pattern of lifelong sexual offending (Letourneau & Miner, 2005). Juvenile sex offenders are much more likely to reoffend non-sexually than sexually. Only 5% of adjudicated juvenile sex offenders reoffend sexually in adulthood, yet 61% reoffend non-sexually (Nisbet, Wilson, & Smallbone, 2004). This 5% sexual re-offense rate seems counterintuitive when considering that 50% of adult sex offenders reported that they began offending in adolescence. The 5% refers to official court records in which the cases were adjudicated as sexual offenses. The 50% refers to retrospective self report of offending in adolescence by adult sex offenders. The difference between the 2 rates likely results from methodological differences (i.e., official records vs. self-report). Researchers have struggled to determine the true prevalence rate of sexual offending and their estimates often seem contradictory. In addition to struggling to determine the prevalence of sexual offending, researchers have also struggled to find efficacious treatments for juvenile sex offenders.

The ability of cognitive-behavioral sexual offense focused treatments to reduce sexual recidivism is questionable because many program descriptions exist, yet there are few randomized controlled trials of these programs (Efta-Breitbach & Freeman, 2004). The

most prevalent form of treatment for juvenile sex offenders stresses intraindividual factors like cognitive distortions, empathy, anger and deviant sexual arousal using cognitive-behavioral interventions. However, the only randomized controlled trial of juvenile sex offender treatment supported multisystemic therapy over individual cognitive-behavioral therapy (McGrath et al., 2003). Perhaps intraindividual focused cognitive-behavioral treatments possess equivocal support because the sexual offense related components often targeted in cognitive-behavioral treatments (i.e. victim empathy, deviant sexual interests, victim empathy and denial) have a questionable influence on sexual reoffending. In fact, only one of this treatment's targets, deviant sexual interests, has an empirically supported relationship with sexual reoffending (MCann & Lussier, 2008; Seto & Lalumière, 2009). Besides having unclear effectiveness, this type of treatment also ignores much of the theory behind juvenile sexual offending.

Treatments focusing on intraindividual factors ignore the primary cause of sexual offending, according to several theories: family dysfunction that limits the psychological health of the juvenile (Finkelhor, 1984; Marshall, & Barbaree, 1990; Hall & Hirschman, 1992; Lane, 1997; Ward & Siegert, 2002). Despite the theorized importance of the family, and the effectiveness of treatments addressing family factors, there has been a paucity of research investigating the families of juvenile sex offenders. The existing research suggests these families have the following characteristics: weak mother-child bonds, inadequate parental monitoring, a lack of positive parental reinforcement, inadequate economic resources, a sexualized environment, and an increased risk of physical and sexual abuse (Blaske, Borduin, Hennggeler, & Mann, 1989; Ford & Linney,

1995; Gray, Busconi, Houchens, & Pithers, 1997; Pithers & Gray, 1998). These characteristics give little information about the details of the family dysfunction, the family members' interactions with each other. Further, the influence of these characteristics on assessment and treatment remains unclear. Additional investigation of juvenile sex offenders' experience of family interactions and family dysfunction could inform assessment and treatment. The proposed research explores juvenile sex offenders attribution of family blame (i.e., internalized vs. externalized or self vs. family) with delinquency, maltreatment history, parental care and parental control.

The findings of this study can potentially make treatment more effective. For example, the findings of this study could suggest that juvenile sex offenders internalizing family problems have been overcontrolled by their caretakers and could benefit from treatment reducing parental control. The findings of this study could also suggest that juvenile sex offenders externalizing family problems have experienced an inadequate level of affection and could benefit from treatment that increases caretaker affection.

This study could also suggest dynamic risk factors that if investigated further could make risk assessment more accurate. For example, when compared to family problem internalizers, juvenile sex offenders externalizing family problems could have a higher risk of reoffending nonsexually, but a lower risk of reoffending sexually. On the other hand, juvenile sex offenders internalizing family problems may have a lower risk of reoffending nonsexually, but a higher risk of reoffending sexually.

The ensuing literature review discusses the following areas of juvenile sex offender research: theory, risk factors for reoffending, assessment measures, and treatments.

Because males represent roughly 95% of juvenile sex offenders (Camp & Thyer, 1993), this review focuses on research with male juvenile sex offenders.

Chapter 1

Literature Review

Theories of sexual offending explain the development and maintenance of sexually abusive behaviors. In many theories, family experiences have a primary role; unfortunately, the theories lack comprehensive empirical support. This section discusses the role of the family in the following theories/models: Finkelhor's 4 factors and 4 preconditions model, Barbaree, Marshall and McCormick's integrated theory, Ward and Siegert's pathways theory, Lane's sexual abuse cycle, and Ward and Beech's integrated theory of sexual offending.

Finkelhor's 4 Factors and 4 Preconditions

Finkelhor (1984) provided a model of sexual offending with 4 factors and 4 preconditions. The 4 factors explain the development of a sex offender and the 4 preconditions explain sexual abuse using offender, victim, and family variables. The 4 factors are emotional congruence, sexual arousal to children, blockage, and disinhibition.

The emotional congruence factor investigates the emotional gratification the offender obtained from sexually abusing their victim. Finkelhor (1984) gave 4 explanations of the gratification: emotional immaturity, poor social skills, past traumatic experiences, and a need to feel powerful or dominant. The offender's emotional maturity level may be similar to a child's level; as a result, the offender feels emotional congruence because they are relating to someone on the same developmental level. An offender with poor social skills may find it easier and less threatening to form a relationship with a child than

with an adult. Repeated failures and embarrassments when attempting to form relationships with adults may make an offender avoid relationships with adults and seek relationships with children. Finkelhor (1984) suggested offenders who experienced a trauma, such as sexual abuse may try to overcome their trauma by identifying with their abuser and abuse a child themselves. The last explanation Finkelhor (1984) gives concerns domination. Sexual offenders may want to feel dominant and powerful because their experiences have made them feel weak and powerless. Committing sexual abuse can gratify the offender by giving him a chance to feel powerful and dominant. In addition to emotional congruence, sexual arousal to children contributes to the development and maintenance of sexual offending.

Finkelhor's (1984) next factor, sexual arousal to children, investigates the offender's ability to find children sexually arousing. He offers several explanations: prior experiences, misinterpretation, and biological factors. Finkelhor (1984) gives several examples of prior experiences influencing sexual arousal. Sexually abused offenders may find children sexually arousing because when they were sexually abused, they found the experience emotionally disturbing, yet physically gratifying. An offender could also normalize sexual abuse because they experienced it frequently in their family. Misinterpretation can contribute to sexual arousal to children because an offender may misinterpret emotional arousal to children as a sexual arousal. Biological abnormalities caused by genes or experience can contribute to an offender's sexual arousal to children through a predisposition for preferring children.

Finkelhor's (1984) next factor, blockage, explores the offender's failure to meet their emotional and sexual needs through adult relationships. Finkelhor (1984) suggests that

offenders can experience developmental or situational blockage. Offenders' experiencing developmental blockage may have found their initial romantic or sexual experiences emotionally painful; as a result, they may have given up on these relationships and failed to mature emotionally. For example, an offender's first girlfriend may have cheated on him and ridiculed him. As a result, he gives up on romantic relationships. Offender's experiencing situational blocks may have lacked acceptable sexual access to other adults; as a result, they may seek sexual relationships with children to cope. An example of an offender experiencing a situational block would be a sexually frustrated married man that wants the community to believe he is faithful to his wife; instead of getting a divorce or finding a mistress, he sexually abuses his child.

Finkelhor's (1984) final factor, disinhibition, investigates the lowering or elimination of natural inhibitions against sexual abuse. Finkelhor (1984) names some factors that could overcome normal inhibitions against sexual abuse or explain the absence of these inhibitions in an offender: impulse control problems, senility, substance abuse, psychosis, situational factors, weakened family bonds, and social approval of excessive patriarchal or parental authority. Impulse control problems, senility, substance abuse, and psychosis can directly reduce an offender's inhibitions against committing sexual abuse. Situational factors include experiences causing severe personal distress for the offender, like loss of employment, divorce, or death of a loved one. Situational factors can overcome an offender's inhibitions against sexual abuse. Weakened family bonds can overcome an offender's inhibitions as well. Having a stepchild or being separated from a child for an extended amount of time are situations that can weaken family bonds. The offender may feel emotionally detached from the child and this detachment overcomes his inhibitions

against sexual abuse. Social approval of excessive patriarchal or parental authority can overcome an offender's inhibitions by allowing an offender to see himself as the king of his family. As a result, he may feel entitled to do anything he wants to his family, including sexually abusing his child. Finkelhor (1984) considers the 4 factors as *contributors* to the development of a sex offender; however, he considers his 4 preconditions *necessary* for an offender to commit an act of sexual abuse.

Finkelhor's (1984) 4 preconditions explain sexual abuse using offender, victim, and family variables. According to Finkelhor, the offender must 1) possess the motivation to sexually abuse, and 2) overcome internal inhibitions, 3) external inhibitions, and 4) the child's resistance. The offender's motivation to abuse comes from the first 3 factors in Finkelhor's (1984) 4 factor model: emotional congruence, sexual arousal to children, or blockage. It's important to note that each factor is a potential contributor to an offender's motivation, but no single factor is necessary for the sexual abuse to occur. For example, an offender may sexually abuse a child because feeling powerful and dominant sexually arouses him, but children by themselves do not arouse him. In addition to having motivation to sexually abuse, an offender must overcome his internal inhibitions.

The 2nd precondition, overcoming internal inhibitions against committing sexual abuse, is identical to the disinhibition factor. The offender must overcome any internal factors preventing the abuse (i.e. shame or guilt). Substance abuse, environmental stressors, impulse control problems, and weak family bonds can overcome the internal inhibitions against sexually abusing a child.

The 3rd precondition, overcoming external inhibitions, refers to the offender overcoming inhibitions besides his own internal inhibitions and the child's resistance.

External inhibitors include adult supervision or the presence of the child's peers, which do not allow the offender access to the victim. Offenders can overcome these inhibitors by grooming, lingering where children play, or babysitting.

The 4th precondition, overcoming the child's resistance, refers to the offender's ability to overcome direct and indirect resistance from the child. A child can resist sexual abuse directly by escaping or saying "no". A child can resist indirectly by appearing likely to resist or disclose the abuse. For example, secure, emotionally healthy children resist indirectly because they seem likely to have a strong support system and the psychological health necessary to resist or disclose the abuse. Insecure, socially isolated children fail to resist indirectly because they seem unlikely to have a strong support system. Offenders may overcome the child's resistance by grooming the child and then using emotional threats, physical threats or force.

Family factors seem relevant to several parts of Finkelhor's (1984) 4 factors, which describe the development of a sex offender. A healthy family environment can help overcome factors like, emotional immaturity, poor social skills, sexual abuse experiences, and developmental blockage, which may contribute to sexual offending. According to Finkelhor's (1984) model, the family environment could reduce the juvenile's chance of reoffending.

Quadripartite Model

Hall and Hirschman's quadripartite model (1991; 1992; Hall, 1996) explains sexually abusive behaviors using 4 components. The first 3 components physiological sexual arousal, cognitive distortions, and negative affective states, are state and situation

dependent. The 4th component, personality problems, is an enduring trait and early life experiences play a crucial role in the development of these problems.

The 1st component, physiological sexual arousal provides motivation for the sexual abuse, whether the arousal is deviant or normative. Offenders with child victims may have deviant sexual arousal patterns, but those with adult victims may have normative sexual arousal patterns. The 2nd component, cognitive distortions, contributes to sexually abusive behaviors by justifying the sexually abusive behavior. The 3rd component, negative affective states, like anger, hostility, and depression, contribute to sexually abusive behaviors when they overcome emotional inhibitors of sexual abuse, like guilt and anxiety (Hall and Hirschman, 1991, 1992; Hall, 1996).

The quadripartite model views physiological arousal, cognitive distortions, and negative affective states as situational motivators that alone probably cannot account for sexually abusive behaviors. The 4th component, personality problems, like antisociality and selfishness, are enduring factors that can contribute to sexually abusive behaviors. The model views early life experiences, like physical abuse, parental divorce, and poor socialization experiences, important in the development of personality problems (Hall and Hirschman, 1991, 1992; Hall, 1996).

Although the quadripartite model considers each of its 4 components as influencing almost any sexually abusive behavior, the relative levels of influence vary. The model divides offenders into 4 subtypes based on the primary motivating component. The 4 subtypes consist of offenders primarily motivated by: physiological sexual arousal, cognitive distortions, negative affective state, or personality problems.

Family factors seem relevant to 2 components of the quadripartite model, negative affective states and personality problems. A juvenile's family environment influences how he copes with negative affective states and attempts to overcome the early life experiences implicated in the development of personality problems (i.e. physical abuse, parental divorce, and poor socialization experiences). In this model, the family environment could influence the juvenile's chance of reoffending.

The Sexual Abuse Cycle

Lane's (1997) sexual abuse cycle rests on the assumption that nonsexual needs and triggers contribute to the offender's sexually abusive behaviors. The offender progresses through the cycle until he obtains relief from the psychologically stressful trigger. The cycle consists of precipitating, compensatory and integration phases. In the precipitating phase, the juvenile experiences stressors that make him feel helpless and powerless. The juvenile responds to these feelings using avoidance or repression and adopts negative core beliefs about himself. For example, a juvenile that tries unsuccessfully to stop his father from beating his mother feels powerless in his attempt to protect his mother. The juvenile could adopt the negative core belief that he is useless because he cannot protect his mother. As a result, the juvenile may exhibit avoidance of the domestic violence by staying out late, daydreaming, or sleeping excessively. The juvenile may apply these avoidance behaviors to any situation where he feels helpless or powerless.

If the precipitating phase fails to provide enough relief to the juvenile, he proceeds to the compensatory phase. In the compensatory phase, the juvenile responds to feelings of helplessness and powerlessness using externalizing coping strategies. These strategies include fantasy, defiance, and aggression. For example, the juvenile may refuse to

comply with authority, start fights, or have fantasies of being powerful. The fantasies of power could include sexually abusive acts, which can lead to a sexual offense. If the juvenile decides to commit a sexual offense, he uses cognitive distortions to justify the behavior, then chooses a victim, and a strategy to avoid getting caught (Lane, 1997). After committing the offense, the juvenile enters the integration phase.

In the integration phase, the juvenile attempts to cope with the anxiety and negative self-image resulting from his sexually abusive act through more cognitive distortions. Because these distortions fail to eliminate the juvenile's anxiety and negative self-image, he becomes more likely to respond to feelings of powerlessness by sexually reoffending. Although Lane (1997) does not believe family problems cause juvenile sexual offenses, she believes attachment issues, parenting style, family dysfunction, family violence, maltreatment, and several other family factors influence the juvenile's responses to stressful stimuli, committing a sexual offense is just one of the possible responses.

Barbaree, Marshall, and McCormick's Integrated Theory

Barbaree, Marshall, and McCormick's (1998) integrated theory considers problematic parent-child bonding the cause of sexually abusive behaviors. Their theory focuses on abusive family experiences, which they believe cause interpersonal skills deficits. These deficits can contribute to the development of sexually abusive behaviors. Barbaree, Marshall, and McCormick (1998) suggest that abusive families force children to use maladaptive interpersonal strategies because the family fails to respond appropriately to the child's adaptive behaviors. Children from these families fail to form secure attachments to their caregivers; as a result, they use disorganized, disruptive, or coercive strategies to meet their emotional needs in relationships. Repeated failures by children to

develop lasting relationships can reduce their self-esteem and empathy and increase antisociality (Barbaree et al., 1998). These children also fail to develop intimate relationships outside their family. For example, when an alcoholic father comes home from the bar, his child may ask him to spend more time at home. Instead of spending more time with the child, the father yells at the child out of anger. The child may begin to hide the father's keys or get in trouble at school in a maladaptive attempt to force the father to spend more time with him. When the child becomes an adolescent, he may use maladaptive strategies to get sexual satisfaction. The strategies could involve manipulating, coercing, or forcing peers or younger children into sexual acts. Next, the child may develop deviant sexual interest by fantasizing about and masturbating to thoughts of the coercive or forceful sexual experience. Lastly, the adolescent develops cognitive distortions supporting their sexually abusive behaviors and they may later reoffend (Barbaree et al., 1998).

Barbaree, Marshall, and McCormick's (1998) integrated theory attributes the development of juvenile sexual offending to a family factor, problematic parent-child bonding. The theory considers the family's response to the child's bonding attempts crucial in creating the conditions within the child that make a sexual offense more likely. Changing the family's response to the juvenile's bonding attempts could reduce his chance of reoffending.

Pathways Theory

Ward and Siegert (2002) proposed the pathways model of sexually abusive behavior. The model describes 5 primary pathways leading to sexual offending: intimacy and social skills deficits, deviant sexual scripts, emotional dysregulation, antisocial cognitions, and

multiple dysfunctional mechanisms. Although Ward and Siegert's (2002) model identifies a primary pathway for each offender, they believe the other pathways contribute to the sexually abusive behavior as well, but to a lesser extent. The intimacy and social skills deficits pathway begins with the child experiencing maltreatment, which gives the child a maladaptive approach to developing relationships. As a result, the child struggles to form strong relationships, and then becomes isolated and lonely. The juvenile uses his victim as a stand-in for a similar aged partner and sexually abuses the victim. Afterwards, the offender uses cognitive distortions to justify the sexually abusive behavior. Offenders on this pathway do not have a primary attraction to children.

Offenders on the deviant sexual scripts pathway confuse signs of interpersonal closeness with signs of sexual desire. For example, an offender may believe a child's hug is a sign of sexual desire and the offender may see his sexual abuse of the child as a sign of interpersonal closeness. According to Ward and Siegert (2002), these offenders' abusive behaviors result from their attempt to meet their emotional and sexual needs instead of a primary attraction to children. Offenders on this pathway also develop cognitive distortions supporting their behaviors.

Offenders on the emotional dysregulation pathway failed to learn to adaptively cope with their negative emotions. When strong emotions overcome offenders on this pathway, they use sexual relationships to soothe themselves. Their choice of sexual partner is indiscriminate; they will use children if adults are unavailable. Offenders on the emotional dysregulation pathway show normal sexual behaviors until they experience strong negative emotions and do not have access to adult sexual relationships.

The antisocial cognitions pathway does not involve a deviant sexual interest; instead it involves a lack of concern for the rights of others. Offenders on this pathway may participate in various antisocial activities including violence, and substance abuse. These offenders have a history of violating the right of others. Sexually abusive behavior represents one of their many antisocial activities, but probably does not indicate a primary sexual interest in children.

Offenders on the multiple dysfunctional mechanisms pathway are pure pedophiles, meaning they have a primary attraction to children. They also have characteristics of the offenders on all other pathways. They are likely to begin sexually abusing children early, and may have had fantasies about the abuse before doing it. Offenders on this pathway use strong cognitive distortions. These distortions are so strong that the offender maintains high self-esteem even after committing their offense.

Although the pathways model fails to implicate family factors in the development of juvenile sexual offending, family factors seem important in the intimacy and social skills and emotional dysregulation pathways. A juvenile's family can help him learn to overcome intimacy and social skills deficits and adaptively cope with emotional dysregulation. Theoretically, the family's help in these areas could reduce the juvenile's chance of reoffending.

Integrated Theory of Sexual Offending

Ward and Beech (2006) developed a model of sexual abuse integrating genetic, neuropsychological, social, and ecological factors called the integrated theory of sexual offending (ITSO). According to this theory, neuropsychological, genetic, ecological, and social factors can affect the following psychological systems: motivational/emotional,

perception and memory, and action selection and control. Genetic dispositions can contribute to dysfunction in these systems on a neurochemical level. Social factors, such as social isolation, family problems and emotional abuse can also contribute to dysfunction in these systems. According to Ward and Beech (2006), dysfunction in any of these psychological systems can increase the likelihood of sexually abusive behaviors. Dysfunction in the motivation/emotion system can lower the threshold for sexually aggressive behaviors. Dysfunction in the perception and memory system can lead to cognitive distortions supportive of offending. Dysfunction in the action selection and control can contribute to impulsivity, and to poor problem solving skills, which can increase the risk of a sexual offense. Ecological and social systems can contribute to any of the above dysfunctions and increase the risk of a juvenile sexually offending. Because family represents a significant piece of a juvenile's ecological and social systems, addressing family factors may play an important role in reducing a juvenile's chance of reoffending.

Research on risk factors for juvenile sexual re-offense is contradictory and unreplicated findings complicate interpretation of existing research; however, this section reviews the empirical support for sexual re-offense risk factors and discusses the relevance of these factors to assessment and treatment of juvenile sex offenders. It divides sexual re-offense risk factors into 2 categories: offense characteristics and offender characteristics.

Offense Characteristics

Stranger victim. Juveniles with at least 1 stranger victim have an increased risk for sexual reoffending. Some believe this increased risk exists because having a stranger as a

victim suggests impulsive or indiscriminate selection of victims (Smith & Monastersky, 1986; Långström, 2002; Heilbrun, Lee, & Cottle, 2005; McCann & Lussier, 2008).

Multiple victims. The effect of the number of victims on sexual re-offense risk is unclear. Rasmussen (1999) failed to find a relationship between the number of male victims and sexual re-offense risk; however, 2 later studies found a significant relationship between these variables (Långström & Grann, 2000; Worling, 2001).

Male victim. Research on the sexual re-offense risk with juvenile males who sexually abuse other males has mixed findings. Rasmussen (1999) and Worling and Curwen (2000) failed to find a significant relationship between a juvenile's number of male victims and sexual re-offense risk, however, Långström and Grann (2000) and Smith and Monastersky (1986) found a significant relationship between these variables. Surprisingly, the significant increase found in Långström and Grann (2000) became nonsignificant over the follow-up period (Långström, 2002). Individually, the studies assessing the influence of a male victim conflict, but according to a meta-analysis, they support the risk factor's relationship with risk (McCann & Lussier, 2008).

Child victim. The effect of having a child victim on sexual re-offense risk is unknown. Kahn and Chambers (1991) and Sipe, Jensen, and Everett (1998) found support for the risk factor, however, 5 other studies failed to find support for the risk factor (Hagan & Cho, 1996; Långström, 2002; Rasmussen, 1999; Smith & Monastersky, 1986; Worling & Curwen, 2000).

Threats. Excluding death threats, using threats during the sexual offense increases sexual re-offense risk. Using death threats failed to increase risk for sexual re-offense (Långström, 2002); however, using verbal threats or weapons during the sexual offense

increased the juvenile's sexual re-offense risk (Kahn & Chambers, 1991; McCann & Lussier, 2008). The use of verbal threats or weapons as a risk factor shows promise, but researchers have not replicated this finding.

Offender Characteristics

Deviant sexual interest. Empirical evidence supports juvenile sexual interest in younger children and sexual violence as risk factors for sexual re-offense. Worling and Curwen (2000) found that deviant sexual fantasies increased re-offense risk. Kenny, Keogh, and Seidler (2001) replicated this finding using a sample of 70 sex offenders 13-21 years old. Further, meta-analytic findings suggest that deviant sexual interests play a role in juvenile sexual offending (MCann & Lussier, 2008; Seto & Lalumière, 2009).

Sexual recidivism. Sexually recidivist juveniles have an increased risk for further sexual offending. Schram, Malloy, and Rowe (1992) noted an increased sexual re-offense risk for juveniles with prior sex-related convictions. Juveniles with multiple sex-related convictions also showed an increased risk for sexually reoffending (Långström, 2002).

Blaming the victim. Some juveniles blame their victim for the offense. Researchers have conceptualized blaming the victim in different ways. Examples of blaming the victim include believing their victim wanted the offender to abuse them or believing their offense did not harm their victim. Juveniles who blamed their victim had a higher risk for sexually reoffending (Kahn & Chambers, 1991). Unfortunately, Kahn and Chambers' (1991) study remains the lone investigation on this risk factor.

Social isolation. Social isolation increases a juvenile sexual offender's risk for sexual re-offense. Juveniles with limited extrafamilial contact have an increased risk for

reoffending sexually, as do juveniles with inadequate social skills (Seto & Lalumière, 2009), and the resulting poor peer relationships (Kenny et al., 2001).

Parental rejection. A single study has explored the quality of the relationship between the juvenile sex offenders and their parents. Worling and Curwen (2000) found an increased risk for sexual re-offense in juveniles reporting parental rejection. This promising factor could benefit from further exploration.

Personality. Research shows juvenile sex offenders represent a heterogeneous group with different personality types (Smith, Monastersky, & Deisher, 1987). Smith et al. (1987) identified 4 MMPI personality profile subgroups among juvenile sex offenders: Impulsive/Acting-Out, Social Introversion/Depression, Repression/Denial and Hypermasculine Identification. These profiles parallel the 4 profiles identified by Worling's (2001) study of juvenile sex offenders: Antisocial/Impulsive, Unusual/Isolated, Overcontrolled/Reserved and Confident/Aggressive. None of the personality profiles showed an increased risk of sexual re-offense but the profiles may aid treatment planning (Worling, 2001). Antisociality, although predictive of nonsexual recidivism, has little support as a risk factor for sexual recidivism (Gretton, McBride, Hare, O'Shaughnessy, & Kumka, 2001; Seto & Lalumière, 2009; Curwen, 2000; Långström & Grann, 2000). McCann and Lussier's (2008) meta-analysis found a relationship between antisociality and sexual recidivism, despite these findings, by uniquely defining antisociality. Their meta-analysis defined antisociality as any of the following: prior nonsexual offenses, a high number of previous convictions, use of threats or weapons, psychopathy, antisocial personality disorder, aggressive behavior, lack of discipline, and drug use (McCann & Lussier, 2008). The relationship between this unique definition of antisociality and sexual

reoffending had a small effect size (.10), which suggests a weak relationship (McCann & Lussier, 2008). Antisocial personality features, like many other sexual re-offense risk factors lack strong empirical support. The small number of studies on risk factors limits empirical support for sexual re-offense risk, however, a meta-analysis revealed the strength of some risk factors. McCann and Lussier's (2008) meta-analysis showed a meaningful relationship between many risk factors and sexual re-offense as the following factors had a medium effect size: child victim, multiple victims, threats, deviant sexual interest and sexual recidivism. Having a stranger victim showed a large effect size. The majority of empirically supported risk factors are static. The paucity of dynamic risk factors for reoffending suggests 2 possibilities: 1) re-offense risk is static and unchangeable or 2) researchers have not yet discovered the dynamic risk factors.

Re-offense Risk Assessment

Juvenile sex offender assessments strive to provide an estimate of re-offense risk and guide treatment decisions (Rich, 2003). Contradictory findings make it difficult to determine the rate of juvenile sexual recidivism. The rate varies across studies, ranging from 0% to 79% and samples sizes ranging from 16 to 350 (Becker, Kaplan, Cunningham-Rathner & Kavoussi, 1986; Brannon & Troyer, 1991; Brannon & Troyer, 1995; Bremer, 1992; Bremer, 1992; Hagan, Gust-Brey, Cho & Dow, 2001; Kahn & Lafond, 1988; Kahn & Chambers, 1991; Långström & Grann, 2000; Långström, 2002; Nisbet, Wilson, & Smallbone, 2004; Prentky, Harris, Frizzell, &Righthand, 2000; Rasmussen, 1999; Rubenstein, Yeager, Goodstein, & Lewis, 1993; Sipe, Jensen, & Everett, 1998; Smith & Monastersky, 1986; Gretton et al., 2001). Combining the participants from these studies (N = 2,439) produces a more reliable estimate of the

overall sexual re-offense rate: roughly 14% with no significant difference between the types of records used to assess re-offense (Worling & Långström, 2006). Fortunately, few (5%) juvenile sex offenders reoffend sexually in adulthood; however, nonsexual recidivism (61%) occurs often (Nisbet, Wilson, & Smallbone, 2004). Although research on risk factors for juvenile sexual re-offense is in its infancy (McCann & Lussier, 2008); researchers have designed assessment measures for juvenile sex offenders.

These assessments fall into 2 categories: actuarial and clinical. Actuarial assessments use statistically based algorithms and risk factors to assign re-offense risk (Beech, Fisher, & Thornton, 2003; Rich, 2003). Many actuarial assessments focus on static historical factors, like the age of the victim. As a result, actuarial assessments provide risk estimates insensitive to changes within the individual or the environment. Because actuarial measures for juvenile sexual re-offense need more validation, many clinicians use adult actuarial measures to assess juvenile sex offenders (Witt, Bosley, & Hiscox, 2002).

Clinical assessment provides another choice for clinicians assessing juvenile sex offenders. Clinical assessments use formal testing, interviews and case records to assess risk (Hanson, 1998). Clinical assessments fall into 2 categories: unstructured and structured. Unstructured clinical assessment has the following features: clinician defined constructs, clinician selected data sources, flexible administration, clinical interviews, use of data lacking validity and reliability, and intuitive assessment of risk (Witt et al. 2002). Empirically guided structured clinical assessments rely on risk factors and re-offense base rates to guide clinicians' assessments of risk (Hanson, 1998). In addition to risk assessment measures, clinicians can use sexual interest measures to assess a juvenile's

level of deviant sexual arousal. All existing juvenile sex offender risk assessments and sexual interest measures have little validation.

This section will review the following risk assessment and sexual interest measures: the Juvenile Sex Offender Risk Assessment Protocol-II (J-SOAP-II), the Estimated Risk for Adolescent Sex Offender Recidivism (ERASOR), Penile Plethysmography (PPG), the Adolescent Sexual Interest Cardsort (ASIC), the Abel Assessment for Sexual Interest (AASI), and the Screening Scale for Pedophilic Interests (SSPI).

Juvenile Sex Offender Risk Assessment Protocol - II. The Juvenile Sex Offender Risk Assessment Protocol –II (J-SOAP-II; Prentky & Righthand, 2003) is an empirically guided structured interview that assesses re-offense risk in juveniles aged 12-18 years. It consists of 23-items; clinicians assign each item a score between 0 and 2. Generally, 0 marks the absence of an item, 1 marks the partial or suspected presence of an item and 2 marks the presence of an item. The J-SOAP-II assigns a total score and 4 subscale scores: Impulsive/Antisocial Behavior, Sexual Drive/Preoccupation, Intervention, and Community Stability. Clinicians calculate the Total score and the subscale scores by summing the relevant items. The J-SOAP-II uses static factors for Scales 1 and 2 and dynamic factors for Scales 3 and 4. The authors suggest having 2 clinicians independently give the measure, discuss any scoring differences and agree on a final score. The authors also urge clinicians to use other methods of risk assessment in addition to the J-SOAP-II. Existing research provides limited support for the validity of the J-SOAP-II. The validation sample consisted of 96 juveniles followed for 1-year. The J-SOAP-II showed good internal consistency and item reliability (Prentky & Righthand,

2003; Righthand et al., 2005). Sexually reoffending juveniles scored an average of 7 points higher than the juveniles that did not sexually reoffend, but only 3 juveniles sexually reoffended (Prentky et al., 2000). The low-level of sexual re-offense inhibited interpretation of the measures predictive validity.

The J-SOAP-II has good concurrent validity, but questionable predictive validity. The J-SOAP-II's strong correlation (.91) with the Total score on the Youth level of Service/Case Management Inventory, which measures general delinquency risk (Hoge & Andrews, 1994; Prentky et al., 2000), supports its concurrent validity. Righthand et al. (2005) provided added support for the J-SOAP-II's concurrent validity by showing that juveniles placed in residential treatment score higher than those in the community. Researchers examining the J-SOAP-II's predictive validity have produced mixed results. Prentky (2006) assessed re-offense risk using the measure in a sample of 797 juveniles followed over 7-years. Total scores and sexual recidivism had a strong association (Cohen's d = 1.24 – 1.30). A study using a sample of 60 mostly urban Latino and African-American juveniles found the J-SOAP-II total scores predicted sexual recidivism and showed sensitivity to treatment (Martinez, Flores, & Rosenfeld, 2007). Prentky (2006) and Martinez et al.'s (2007) findings supported the J-SOAP-II's predictive validity; however, other investigations failed to replicate those findings (Elkovitch, Viljoen, Scalora, & Ullman, 2008; Viljoen et al., 2008). Viljoen et al. (2008) and Elkovitch et al. (2008) failed to find a relationship between J-SOAP-II scores and sexual recidivism risk. Overall, the J-SOAP-II holds promise as risk measure, but could benefit from further research to strengthen its predictive validity.

Estimate of Risk of Adolescent Sexual Offense Recidivism. Worling and Curwen (2000) designed the Estimate of Risk of Adolescent Sexual Offense Recidivism (ERASOR) to help clinicians assess short-term sexual re-offense risk in juveniles aged 12-18. The ERASOR consists of 25 total items (16 dynamic factors and 9 static factors) and 5 categories: (1) Sexual Interests, Attitudes, and Behaviors, (2) Historical Sexual Assaults, (3) Psychosocial Functioning, (4) Family/Environment Functioning, and (5) Treatment (Worling & Curwen, 2000). Clinicians rate each item as (1) Present, (2) Possibly Present, (3) Partially Present, (4) Not Present, or (5) Unknown Presence. After completing each item, clinicians assign an overall risk estimate of low, moderate, or high. The assignment relies on the clinician's judgment, instead of an exact scoring procedure.

Worling (2004) evaluated the psychometric properties of the ERASOR using a sample of 136 juveniles; the ERASOR has acceptable interrater agreement (for individual items and the overall risk estimate), internal consistency, discriminant validity, and shows sensitivity to treatment effects. The ERASOR may benefit from further research on its items because 4 items failed to correlate with the overall risk estimate: (1) ever sexually assaulted same victim 2 or more times, (2) threat of, or use of, violence/weapons during sexual offense, (3) ever sexually assaulted a child, and (4) environment supporting opportunities to reoffend sexually. Worling's (2004) findings support the discriminant validity of the ERASOR by showing that sexual reoffenders had significantly higher Total scores than those detected for the first time (Worling, 2004). Juveniles assessed at intake had higher Total scores and higher risk estimates than juveniles completing treatment (Worling, 2004). This finding suggests the ERASOR is sensitive to treatment effects. Overall, the ERASOR has acceptable concurrent validity, internal consistency,

interrater agreement, and sensitivity to treatment effects; however, it lacks support for its predictive validity, which limits its utility as a risk assessment measure.

Penile plethysmography. Penile plethysmography or PPG measures changes in penile volume; a larger PPG response to deviant sexual stimuli than nondeviant sexual stimuli suggests a deviant sexual interest (Gretton et al., 2001). Several studies showed PPG responses could discriminate convicted juvenile sex offenders from nonoffenders (Becker, Kaplan, & Tenke, 1992; Hunter, Goodwin & Becker, 1994; Kaeming, Koselka, Becker & Kaplan, 1995; Seto, Lalumière & Blanchard, 2000; Seto, Murphy, Page & Ennis, 2003); however, only 1 study examined the predictive validity of PPG responses (Gretton et al., 2001). Gretton et al. (2001) compared PPG responses in 220 male sex offenders (12-18 years old) measured before treatment, with sexual offenses committed after treatment completion. Gretton et al. (2001) followed the offenders for a mean of 55 months after treatment discharge to record recidivism. Their findings failed to display a statistically significant relationship between deviant sexual arousal measured by PPG and sexual reoffending (Gretton et al., 2001). Although the PPG has significant discriminant validity, it does not have utility as a risk assessment tool because it lacks predictive validity. Future research and refinement of PPG may improve its predictive validity and clinical utility.

Adolescent Sexual Interest Cardsort. Hunter, Becker, and Kaplan (1995) designed the Adolescent Sexual Interest Cardsort to measure sexual interest in 17 categories: (1) Aggressive Sex with Adult Female, (2) Violence Only with Adult Female, (3) Aggressive Sex with Same-Age Female, (4) Consensual Sex with Same-Age Female, (5) Aggressive Sex with Young Female, (6) Nonaggressive Sex with Young Female, (7) Violence Only

with Young Female, (8) Aggressive Sex with Same-Age Male, (9) Consensual Sex with Same-Age Male, (10) Aggressive Sex with Young Male, (11) Nonaggressive Sex with Young Female Incest, (12) Aggressive Sex with Young Female Incest, (13) Aggressive Sex with Young Male Incest, (14) Frottage, (15) Voyeurism, (16) Exhibitionism and (17) Filler Items. Juveniles rate 64 sexual vignettes on a 5 point arousal scale (higher scores suggest greater arousal) and clinicians assess deviant sexual interest based on the responses (Hunter, Becker, & Kaplan, 1995). In the validation sample, the authors suspected self-report bias because only 1 deviant sexual interest category had group mean scores suggesting arousal and juveniles can easily deny or minimize their reports of sexual interest (Hunter, Becker, & Kaplan, 1995). Although susceptible to self-report bias, in one case, the ASIC showed sensitivity to treatment effects (Hunter, Ram, & Ryback, 2008). Overall, the ASIC has acceptable test-retest reliability, sensitivity to treatment and internal consistency, however, its concurrent validity and susceptibility to self-report bias limits its utility as a risk assessment measure (Hunter et al., 1995).

Abel Assessment for Sexual Interest. The Abel Assessment for Sexual Interest has clients complete a questionnaire about sexual thoughts, fantasies, and behaviors. Next, the client reports their arousal to slides of males and females from different age categories. The AASI assesses sexual interest using covertly measured viewing time of the different slides (Abel, Jordan, Rouleau, Emerick, Barboza-Whitehead, & Osborn, 2004). Smith & Fischer (1999) found that the AASI had inadequate test-retest reliability and discriminant validity. They questioned the discriminant validity of the AASI because it failed to distinguish between juvenile offenders with prepubescent victims and nonoffenders.

Abel (2000) responded to Smith and Fischer's (1999) findings by arguing that they failed to use the AASI for its intended purpose and they failed to use an adequate control group. According to Abel (2000), Smith and Fischer (1999) failed to use the AASI to detect subjects with sustained sexual interest in children (i.e. pedophiles), which is its intended purpose (Abel, 2000). He argued that many juvenile sex offenders are not pedophiles. They may sexually abuse children for various reasons besides sustained sexual interest in children, including availability, sexual experimentation, brain injury, and impulsivity (Abel, 2000). He also argued that Smith and Fischer (1999) used an inadequate control group. Their nonoffending control group's sexual history may have compromised their findings because nearly half of juvenile males never accused of child molestation reported sexually touching a much younger child. As a result, Smith and Fischer's (1999) nonoffending control group may have contained undetected offenders (Abel, 2000). In addition to writing a rebuttal to Smith and Fischer's (1999) study, Abel also published research on the AASI.

Abel et al. (2004) corrected many of the flaws in the Smith and Fischer (1999) study and found support for the discriminant validity of the AASI. With a sample of 1,704 juveniles, the AASI results detected admitted offenders and significantly correlated with the number of victims and frequency of sexually abusive acts (Abel et al., 2004); however, no published research has examined the AASI's ability to detect juveniles with sustained sexual interest in children.

Screening Scale for Pedophilic Interests. The Screening Scale for Pedophilic Interests (SSPI) screens for pedophilic sexual interest using 4 items scored as follows: male victim (yes = 2), multiple victims (yes = 1), any victim under age 12 (yes = 1) and,

any unrelated victim (yes = 1); all "no" answers receive a score of 0 (Seto & Lalumiére, 2001). Seto et al. (2003) found that among juvenile sex offenders, 40% with a score of 5 (the maximum score) reported pedophilic sexual arousal and 15% with a score of 1 reported pedophilic sexual arousal. The SSPI's categorization rate makes it reasonable for clinicians to use it as a screening measure or when they lack the resources for a more valid measure.

Clinicians assessing juvenile re-offense risk and sexual interest have the choice of using measures either lacking empirical support or possessing limited empirical support, however, the J-SOAP-II and the ERASOR show some promise as risk assessment measures. Research on the relationship between family factors and re-offense risk may produce more accurate measures and refine existing ones. Assessment measures of juvenile re-offense risk and sexual interest lack strong empirical support, much like the existing treatment models.

Treatment Models

Clinicians often use cognitive-behavioral treatment models based on Lane's (1997) sexual abuse cycle to treat juvenile sex offenders (Efta-Breitbach & Freeman, 2004). Most treatments address most or all of the following: denial, accountability, victim empathy, the offender's sexual abuse cycle, the offender's victimization, sex education, deviant sexual arousal, cognitive distortions supportive of sexually abusive behavior, social skills, and anger management (Borduin & Schaeffer, 2001). This treatment approach helps offenders discover their specific sexual abuse cycle and their cognitive, emotional, and situational triggers for sexually offending. They also learn adaptive ways to cope with their triggers and strategies to alter their deviant sexual arousal patterns.

This treatment approach focuses on intraindividual cognitive-behavioral factors and considers all other factors to be nonessential to treatment (Ward, Mann, & Gannon, 2007). This treatment approach often fails to address family factors in treatment. Further, only one factor addressed by this treatment approach, deviant sexual interests, has an empirically supported relationship with re-offense risk.

The Good Lives Model - Comprehensive. The Good Lives Model – Comprehensive (GLM-C) assumes that juveniles commit sexual offenses because they lack the capability to use socially acceptable strategies to attain the primary human goods needed for a good life (Ward, Mann, & Gannon, 2007; Ward & Gannon, 2006). "Primary human goods are states of affairs, states of mind, personal characteristics, activities, or experiences that are sought for their own sake and are likely to increase psychological well-being if achieved" (Ward & Gannon, 2006, p. 79). Examples of primary goods include friendship, community, inner peace, happiness, knowledge, and excellence in work and play. The GLM-C views a sexual offense as a socially unacceptable attempt to attain primary human goods. The GLM-C treatment model aspires to help the offender develop a healthy identity that provides meaning and fulfillment by developing the skills needed in his environment to attain primary goods. This treatment model takes into account an offender's strengths, preferences, and resources (Ward & Gannon, 2006). Ward, Mann, and Gannon (2007) view the GLM-C as a positive treatment because it holistically manages problems instead of trying to remove risk factors.

Family factors appear important in some of this model's treatment principles. The first 2 treatment principles of the GLM-C note that many sex offenders lacked the opportunity and support required to attain a Good Life because of adverse developmental

experiences. As a result, they lack the skills necessary to attain a fulfilling life (Ward, Mann, & Gannon, 2007). If the families of sex offenders contributed to the adverse developmental experiences, then family factors play an important role in the development of juvenile sexual offending and may influence a juvenile's re-offense risk.

Multisystemic therapy. Multisystemic Therapy (MST) addresses the family, peer, school, neighborhood, and intraindividual factors associated with juvenile sexual offending using home interventions based on social-ecological theory (Borduin & Schaeffer, 2001). MST addresses family factors by removing barriers to effective parenting, enhancing parenting knowledge, promoting communication and affection within the family, and when necessary, treating family members victimized by the offender. MST addresses peer factors by increasing the juvenile's social and problem solving skills, decreasing affiliation with delinquent peers, and increasing affiliation with prosocial peers. MST addresses school and neighborhood factors by increasing communication and support from teachers and other members of the community (i.e. teachers, religious leaders, and coaches). Lastly, MST addresses intraindividual factors, if necessary, using interventions that alter the juvenile's attitudes and social perspective-taking skills (Borduin & Schaeffer, 2001). MST therapists maintain small caseloads (4 to 8 families) because of the intensity of the intervention.

Treatment Effectiveness

Although researchers have developed many treatments for juvenile sex offenders; they have produced equivocal empirical support for their treatments. As a result, clinicians lack evidence-based treatment guidelines for this population (Burton, Smith-Darden, & Frankel, 2006). Intraindividual cognitive-behavioral approaches have almost

no empirical support; multisystemic treatments and treatments with a strong family component have limited empirical support; and GLM-C lacks outcome research. This section reviews research on the effectiveness of different treatments for juvenile sex offenders.

Several studies have investigated the effectiveness of juvenile sex offender treatments that use an intraindividual cognitive-behavioral approach (e.g. Labs, Shields, & Schondel, 1993; Guarino-Ghezzi & Kimball, 1998; Edwards, Beech, Bishopp, Erickson, Friendship, & Charlesworth, 2005). Lab, Shields, and Schondel (1993) compared sex specific treatment to non-sex specific treatment (N = 155). They failed to find a statistically significant reduction in sexual and nonsexual recidivism rates in the sex specific treatment group. Guarino-Ghezzi and Kimball (1998) conducted a similar study (N = 58) and also failed to report a statistically significant difference in sexual or nonsexual recidivism. Edwards et al. (2005) compared treatment completers to dropouts. They found that treatment completers had significantly lower total recidivism and violent recidivism rates than dropouts, but the treatment completers' reductions in sexual recidivism rates were not significant.

Only multisystemic therapy has randomized controlled trials supporting its effectiveness with juvenile sex offenders. Juveniles receiving MST spent less time in out-of-home placements, had lower sexual and nonsexual recidivism rates, and spent less time in jail compared to juveniles receiving treatment as usual (intraindividual cognitive-behavioral interventions) in the initial and follow-up studies (Borduin, Henggeler, Blaske, & Stein, 1990; Borduin, Schaeffer, & Heiblum, 2009). Unfortunately, these trials had small sample sizes (N = 16 and N = 48), which limits the support of MST.

Treatments with a significant family component also have some support for their effectiveness. Worling and Curwen's (2000) treatment incorporated a strong family component as well as intraindividual cognitive-behavioral interventions. They compared treatment completers with a control group comprised mostly of juveniles that refused treatment or dropped-out. At an average follow-up of 6 years after treatment, they found significantly lower rates of sexual reoffending (5% vs. 17%), violent nonsexual reoffending (18% vs. 32%), and nonviolent reoffending (20% vs. 50%) in the treatment completers group. This study's lack of random assignment may have compromised its findings. Seabloom, Seabloom, Seabloom, Barron, and Hendrickson (2003) conducted a study of a juvenile sex offender program with a strong family component. The study compared treatment completers to dropouts. Treatment completers had lower sexual re-offense rates (0% vs. 8-10%) and nonsexual re-offense rates (8% vs. 18-22%) than dropouts at a mean follow-up of 18 years (Seabloom et al., 2003).

In addition to quantitative empirical support for addressing family factors in treatment, qualitative research has supported the importance of family factors in treatment. Franey, Viglione, Wayson, and Brager (2004) conducted a qualitative study on adults that completed juvenile sex offender treatment and did not reoffend. Many of the participants reported that although they had completed treatment, they still struggled with the possibility of sexually reoffending. The participants (n = 7; ages 18 – 23) completed treatment at least 1 year before the study and the mean time since treatment completion was 36 months. The researchers conducted file reviews, open-ended demographic interviews, and in-depth interviews that addressed several areas. Every participant reported current family difficulties and many reported fear about raising their own

children (i.e. “What if I have a kid and my wife won’t let me hold him because of the past?”). The authors noted that the participants faced social challenges, like family discord, which could have contributed to their sexual offense, but many specialized treatment programs, fail to address these challenges. Many participants believed that their treatment would have been more helpful if treatment addressed issues like family discord (Franey et al., 2004).

Research on the effectiveness of juvenile sex offender treatment suggests that treatments addressing family factors may be more effective than treatments addressing only intraindividual cognitive-behavioral factors. Unfortunately, the studies on the effectiveness of juvenile sex offender treatments provide only limited support because of their small sample sizes and methodological problems.

Families of Juvenile Sex Offenders

Researchers studying juvenile sex offenders’ families have investigated the families using different methods, different samples, and different variables; however, none of the studies have explored the relationship between family factors and future sexual or nonsexual reoffending. This section reviews the research on juvenile sex offenders’ families. It divides the research into 4 categories: descriptive, victim type comparisons, abuse history comparisons, and offense type comparisons.

Descriptive studies. Several researchers have studied the families of juvenile sex offenders without comparing them to a control group. The lack of a control group makes it difficult to determine if families of juvenile sex offenders differ from normative families; however, the findings can provide useful information regarding the offenders’

families. This section reviews the studies that investigated the families of juvenile sex offenders and lacked a control/comparison group.

Becker, Cunningham-Rathner, and Kaplan (1986) reported family related demographic information from a sample of 67 juvenile sex offenders, 94% of the sample either admitted to a sexual crime or the court found them guilty of a sexual crime. The mean age of the sample was 15.47 years with a range of 13 – 19 years of age. The participants were African-American (63%), Hispanic (25%), or White (12%). The residence of the juvenile sex offenders at the time of the evaluation varied: 35.8% lived with their mother only, 32.4% lived with both parents, 11.9% lived in a group home, 4.5% lived with a legal guardian only, 4.5% lived with their grandmother only, 3% were in homes for runaways, 1.5% lived with their father only, 1.5% lived with foster parents, 1.5% lived in a detention center, 1.5% lived alone, and 1.5% lived with a sibling. The authors collected family psychiatric history from the juveniles. They found that 4.5 % of the juvenile sex offenders had a family member that was hospitalized because of psychiatric illness. This study provided preliminary information about the demographics of families of juvenile sex offenders.

Kaplan, Becker, and Cunningham-Rathner (1988) used structured interviews to assess the parents of juvenile incest perpetrators (n = 27; mean age = 43) receiving outpatient treatment. Most interviews were conducted with mothers; only 1 interview was conducted with a father. The authors assessed the parents' abuse history and admission/denial of the offense. Many of the parents experienced abuse: 27% reported physical abuse and 30% reported sexual abuse.

The authors also assessed admission/denial of the offense in the parents and in the children. The authors considered a juvenile or adult in denial if they blamed the victim, denied that force was used (if reports indicated the use of force), blamed pornography, or claimed the sex was consensual. In 45% of cases the parent, the child, or both denied the offense.

Ryan, Miyoshi, Metzner, Krugman, and Fryer (1998) described family factors in a nationally recruited sample of juvenile sex offenders (n = 1,616; modal age = 14). Males comprised the majority of the sample (97.4%). The participants came from 30 states and a diverse array of cities and towns. The authors used 4 structured questionnaires that collected factual information and clinical impressions. Most of the offenders lived in a parent's home at the time of their offense (84.9%); others lived in a relative's home (6.3%), or with an unrelated caregiver (8.8%).

Many of the offenders experienced abuse: 41.8% reported physical abuse, 39.1% reported sexual abuse, and 25.9% reported neglect. The authors also asked about significant family events. They found that 63.4% of offenders witnessed family violence, 57% experienced the loss of a parental figure, and 42% of offenders' parents left them home alone or placed them in charge of their younger siblings before they reached 10 years of age.

Manocha and Mezey (1998) described the family characteristics of 51 juvenile sex offenders (mean age = 15.4) using file review. The sample was 90.2% White and 96.1% male. Most of the sample, 72.5%, lived with at least 1 biological parent, 31.4% of the sample lived with both parents, 9.8% lived in foster care, 5.9% lived with a relative, 5.9% lived in a residential home, and 3.9% lived in a boarding school.

The authors investigated the offenders' family dynamics and family history. They found that 37.3% of families experienced marital violence, 23.5% of juveniles experienced regular violence, 27.5% of parents had criminal backgrounds, 23.5% of juveniles experienced physical abuse, 13.7% experienced emotional abuse, 11.8% experienced neglect, 29.4% experienced sexual abuse, 11.8% of juveniles had a sexually abusive sibling, 9.8% had a sex offender in their extended family that they were in frequent contact with, and 29.4% of parents were rejecting, uncaring, unloving, or disinterested.

Victim type comparisons. Researchers comparing juvenile sex offenders' families by offender victim type have used varying methodologies and samples, and have produced varying results. These variations, although minor, can limit comparisons between studies and obscure interpretation of findings. Although the studies and the results vary, this area of research as a whole supports the notion of pathology within families of juvenile sex offenders. This section reviews research comparing juvenile sex offenders by victim type.

Hsu and Starzynski (1990) compared adolescent rapists (n = 15; mean age = 16.3) to child sexual assaulters (n = 17; mean age = 14.7). The authors defined adolescent rapists and child sexual assaulters by the age of their victim. Adolescent rapists' victims were at least 12 years of age; and child sexual assaulters' victims were under 12 years of age. The adolescent rapist group was 73% African-American and 27% White. The child sexual assaulter group was 47% African-American and 53% White.

The authors reported that the groups did not significantly differ on family history; however, they failed to mention the family history variables they investigated. There

were no significant differences between the groups on family history; as a result, the authors reported some information on the entire sample. Only 1 (3%) of the juvenile sex offenders lived with both parents, 50% of the offenders' parents abused alcohol, 25% of offenders had immediate family with a criminal history, and 18% of offenders were neglected or abused.

Ford and Linney (1995) compared juvenile rapists (n = 14; mean age = 15.8), juvenile child molesters (n = 21; mean age = 15.2), juvenile violent nonsexual offenders (n = 26; mean age = 14.9), and status offenders (n = 21; mean age = 14.9) from residential treatment facilities. The researchers used structured interviews and file review to assess the offenders' families. The clinicians also elicited the juvenile's 3 earliest memories. The researchers found 2 significant differences among the groups: 1) the child molesters were significantly more likely to witness parental violence than the other groups and 2) the child molesters and violent nonsexual offenders were more likely to be victims of parental violence than rapists and status offenders. The authors' failed to find significant differences among the groups regarding marital status, family criminal history, and the number of juveniles living with both parents.

The authors did not statistically analyze the juveniles' earliest memories; however they noted that rapists and child molesters 3 earliest memories were more likely than the violent nonsexual and status offenders to contain abuse and abandonment. The authors believed that each group had interpersonal deficiencies, which may have been influenced by early memories of violence, cruelty, and abandonment (Ford & Linney, 1995).

Kaplan, Becker, and Martinez (1990) compared mothers of incest perpetrators (n = 48) and mothers of non-incest sexual perpetrators (n = 82). The juveniles in this study

had been formally charged, but their cases had not been adjudicated. The researchers conducted structured clinical interviews with the mothers. The authors found that the mothers of incest perpetrators reported higher rates of experiencing physical abuse and sexual abuse than mothers of non-incest sexual perpetrators and they were more likely to report that their son was physically abused. The mothers of incest perpetrators were also more likely to report that their child committed the offense and needed treatment. The authors failed to find significant differences between groups regarding the mothers' reports of psychiatric hospitalizations of their immediate family members.

The authors' use of juveniles formally charged with a sexual offense but not yet adjudicated meant that some of the juveniles included in the study may not have committed a sexual offense. On the other hand, the authors' inclusion of juveniles before adjudication allowed them to include offenders whose cases were later plea bargained down to a nonsexual offense.

Awad and Saunders (1991) compared juvenile sexual assaulters (n = 49), juvenile child molesters (n = 45), and general juvenile delinquents (n = 24) matched for age and socioeconomic status. The juveniles either admitted to their offense or the court found them guilty. The clinicians completed a 401-item questionnaire after conducting unstructured interviews with the juvenile, the parents, and the family. The authors found several significant findings: 1) juvenile child molesters and sexual assaulters had more children in their families than general delinquents and 2) juvenile child molesters were more likely to have experienced sexual abuse than the sexual assaulter and delinquent groups. There were no significant differences among groups regarding rates of parental psychiatric disturbances, juveniles experiencing physical abuse, and parental separation.

Graves, Openshaw, Ascione, and Ericksen (1996) conducted a meta-analysis on the demographic and parental characteristics of juvenile sex offenders. To meet the authors' inclusion criteria, a study must have used a sample of juvenile or adult sex offenders. Studies using a juvenile sample had to give descriptive information on 1 or more relevant variables. Studies using adult sex offenders met inclusion criteria if the adults reported on their experiences as a child or adolescent. The authors excluded any studies conducted before 1981 or studies using secondary analyses on data unless they considered it a "landmark" study.

The authors reported the following findings on juvenile sex offender families: 1) sexual assaulters were more likely to come from single parent families than pedophiles and mixed offenders 2) sexual assaulters were more likely to live in single parent homes than in foster homes 3) the pedophiles were more likely to live with foster families than the sexual assaulters and mixed offenders 4) pedophiles' mothers were more likely to have been physically abused than mothers or sexual assaulters or mixed offenders, and 5) pedophiles' mothers were more likely to have been physically abused than mothers of sexual assaulters or mixed offenders.

In addition to reporting statistically significant findings, the authors reported their findings on the entire sample of juvenile sex offenders: 1) most offenders came from families with pathological levels of cohesion and adaptability 2) 55% of offenders' fathers abused alcohol and 62% abused drugs, and 3) 36% of offenders' mothers abused alcohol and 43% abused drugs.

The authors used their findings to give descriptions of "typical" offenders. The "typical" juvenile sex offender was a White Protestant from a low socioeconomic status

family with a neglectful, substance abusing father, a physically abusive mother, and pathological levels of family adaptability and cohesion. The "typical" juvenile pedophile was a White juvenile with low to middle socioeconomic status, a 6th grade education, a substance abusing father, and lived in a foster home. The "typical" juvenile sexual assaulter was a White juvenile with low to middle socioeconomic status, an alcohol abusing father, and came from a single-parent family with pathological levels of adaptability and cohesion. The "typical" mixed offender was a White Protestant with low socioeconomic status, a 7th – 12th grade education, a substance abusing, neglectful mother, and came from a family with pathological levels of adaptability and cohesion. The authors noted several limitations of their study: 1) upper class families were underrepresented 2) small sample sizes, and 3) many instruments used by the studies lacked standardization (Graves, Openshaw, Ascione, & Ericksen, 1996).

Using semistructured interviews and file review, Richardson, Kelley, Bhate, and Graham (1997) compared juvenile incest offenders (n = 20; mean age = 15.55), juvenile child molesters (n = 31; mean age = 15.03), juveniles with peer or adult victims (n = 24; mean age = 14.91), and juveniles with multiple types of victims (n = 22; mean age = 14.56). The authors reported several statistically significant findings: 1) mixed offenders were more likely to have experienced sexual abuse than the incest, child molester, and peer/adult victim groups 2) the child molester and mixed offender groups were more likely to be at risk for neglect and abuse than the incest and peer/adult victim groups, and 3) offenders that experienced abuse began sexually abusing at a younger age than offenders that did not experience sexual abuse.

The authors failed to find statistically significant differences among the groups regarding intrafamilial violence and the mean number of victims. Unfortunately, the mean number of victims per group member was a poor measure of central tendency in this study because of outliers. The mean number of victims for all offender groups was 4.8, but the median was 2 and the mode was 1. This may have prevented the mean number of victims between groups from reaching statistical significance. Further, interpretation of the mean differences becomes difficult because it is a poor representation of the typical offender.

Ronis and Borduin (2007) compared juvenile sex offenders with a peer/adult victim (n = 23), juvenile sex offenders with a child victim (n = 23), violent nonsexual offenders (n = 23), nonviolent nonsexual offenders (n = 23), and nondeliquent controls (n = 23) matched on age, socioeconomic status, and race. The researchers gave the mother-son dyads the Family Adaptability and Cohesion Evaluation Scales - III (FACES-III; Olson, Portner, & Lavee, 1985) and watched the dyad come to an agreement on their responses on the Unrevealed Differences Questionnaire – Revised (URD-D; Borduin, et al., 1989)

The FACES-III gives scores for 2 scales: Adaptability and Cohesion. Family adaptability refers to the family's flexibility. This measure classifies families as Very Flexible, Flexible, Structured, or Rigid. Family cohesion refers to the family's level of connectedness. It classifies families as Very Cohesive, Cohesive, Somewhat Cohesive, or Disengaged.

The authors conducted a principle components factor analysis on the observational data, which revealed 2 factors in the dyadic interactions: Negative Affect and Facilitative Information Exchange. Negative Affect referred to emotionally negative family

interactions. Facilitative Information Exchange referred to the active exchange of information that facilitates communication within the family.

The authors found the following significant differences: 1) juvenile offenders had lower adaptability and cohesion than the nondelinquent group and 2) juvenile offenders showed more Negative Affect than the nondelinquent group. The authors failed to find statistically significant differences in the following areas: 1) Facilitative Information Exchange between any groups, and 2) Family adaptability and Cohesion among the groups of offenders.

Comparisons by offender sexual abuse history. Although some studies have reported findings on the sexual abuse history of the juvenile sex offenders, only 2 studies have used it as the primary independent variable. Both studies conceptualized sexual abuse as a dichotomous variable: present or absent. Hummel, Thömke, Oldenbürger, and Specht (2000) compared juvenile child molesters with a history of sexual abuse (n = 16), to those without a history of sexual abuse (n = 20). The juveniles had been charged, but had not been adjudicated. The researchers used semistructured interviews and file reviews to assess the juveniles. The authors considered a finding statistically significant if it had a large effect size. The groups did not differ significantly with regard to family conflict and family violence; however, offenders with a history of sexual abuse were significantly more likely to have lost a parent than offenders without a history of sexual abuse.

Symboluk, Cummings, and Leschied (2001) studied the families of juvenile sex offenders with a history of sexual abuse (n = 20), juvenile sex offenders without a history of sexual abuse (n = 19), and general juvenile delinquents without a history of sexual

abuse (n = 15) using the FACES-II and demographic information. The authors determined juvenile sexual abuse history by using reports from the juvenile, caregivers, and the police. They gave the FACES-II to the parents and read the measure to the juveniles. The authors failed to find significant differences among groups on the FACES-II cohesion and adaptability scales, however, a significantly lower percentage of juvenile sex offenders with a history of sexual abuse lived with their families. About 35% of sexually abused juvenile sex offenders lived with their families, whereas 67% of juvenile delinquents and 63% of juvenile sex offenders without a history of sexual abuse lived with their families.

This study may have failed to accurately assess the families of juvenile sex offenders because many offenders lived outside of the home at the time of the assessment. Almost half of the subjects lived in a foster home, group home, or detention center. Further, many juveniles reported difficulty with remembering how their families interacted. This difficulty may have influenced their responses on the FACES-II and resulted in nonsignificant findings on the Cohesion and Adaptability scales (Symboluk, Cummings, & Leschied, 2001).

Comparisons by type of offense. Researchers comparing juvenile sex offenders' families by type of offense have used many different methodologies and have produced different results. These variations, although minor, can limit comparisons between studies and obscure interpretation of findings. Although the studies and the results vary, they tend to find that juvenile sex offenders' families have acceptable levels of adaptability, but poor levels of cohesion. This section reviews research comparing juvenile sex offenders by offense type.

Awad, Saunders, and Levene (1984) used clinician's reports to compare the families of juvenile sex offenders (n = 24) with general juvenile delinquents (n = 24) matched on age, sex and socioeconomic status. The clinicians in the study completed a 300-item questionnaire after conducting unstructured interviews with the juvenile, the parents, and the family. The authors reported their findings but failed to consistently specify statistically significant and nonsignificant findings. The researchers found that juvenile sex offenders and general juvenile delinquents experienced similar rates of maternal rejection (36% vs. 36%), paternal rejection (63% vs. 50%), detachment from mother (26% vs. 27%), detachment from father (50% vs. 48%), lax mother (59% vs. 64%), lax father (47% vs. 28%), and sexual deviance within the family (38% vs. 43%).

Juvenile sex offenders seemed to have higher rates of long-term separation from their mothers (55% vs. 33%) and fathers (79% vs. 58%). Awad, Saunders, and Levene (1984) concluded that juvenile sex offender and general juvenile delinquents' families were similar. The results of this study may not be valid because the clinician completed questionnaire was not validated; however, the clinicians in this study conducted at least 2 interviews with each juvenile, 2 interviews with the parents, and an interview with the family, which gave the clinicians more time to build rapport and obtain multiple family perspectives. This gave them more information to use in their assessment than pencil and paper based assessments.

Fagan and Wexler (1988) assessed violent recidivist juvenile sex offenders' families (n = 34) and violent recidivist general juvenile offenders' families (n = 208). The researchers conducted interviews and reviewed court records. The violent recidivist juvenile sex offenders reported significantly more severe forms of child abuse, higher

rates of experiencing sexual abuse, higher rates of parental incarceration, and more participation in school and work related social activities.

The authors failed to find significant differences between the groups with regard to the family and peer's participation in social activities. Fagan and Wexler (1988) believe their findings suggest that violent recidivist juvenile sex offenders differ from violent recidivist general juvenile offenders. Therefore, explanations of violent nonsexual delinquency do not apply to violent sexual offenders.

Awad and Saunders (1989) used clinician, school and agency reports to compare the families of juvenile child molesters (n = 29) with general juvenile delinquents matched on age and socioeconomic status. The clinicians in the study completed a 401-item multiple choice questionnaire after conducting unstructured interviews with the juvenile, the parents, and the family. Although Awad and Saunders (1989) failed to report all of the factors they investigated, they did report their findings on the families of juvenile child molesters with a history of antisocial behaviors. These juveniles were more likely to experience abuse, neglect, and separation from their parents than general juvenile delinquents.

Blaske, Borduin, Henggeler, and Mann (1989) compared the juvenile sex offenders, juvenile assaultive offenders (n = 15), juvenile nonviolent offenders (n = 15), and nondelinquent juveniles (n = 15) matched on juvenile age, race, social class, family size, age of first arrest, number of arrests, mother age, and length of father absence. The researchers gave the mother-son dyads the FACES-II and watched the dyad come to an agreement on their responses on the Unrevealed Differences Questionnaire – Revised (URD-D; Borduin, et al., 1989).

The authors conducted a principle components factor analysis on the observational data, which revealed 2 factors in the dyadic interactions: Positive Communication and Conflict-Hostility. Positive Communication is the active exchange of information that supports and facilitates communication within the family. Conflict-Hostility refers to the emotionally negative family interactions resulting from conflicting ideas and interests. The authors found the following statistically significant differences between groups: 1) juvenile sex offenders had higher adaptability and cohesion than assaultive offenders, 2) juvenile sex offenders and nondelinquents had higher adaptability scores than assaultive offenders and nonviolent offenders, and 3) nondelinquent mother-son dyads had higher rates of positive communication than the juvenile sex offender, assaultive offender and nonviolent offender dyads. The authors failed to find statistically significant differences among the groups on their Conflict-Hostility scores, and between juvenile sex offenders and nondelinquents' cohesion and adaptability scores.

Bischof, Stith, and Wilson (1992) used the FACES-III (Olson, Portner, & Lavee, 1985) to explore the family adaptability and cohesion of juvenile sex offenders (n = 37; mean age = 15.39), violent delinquents (n = 24; mean age = 16.16), nonviolent delinquents (n = 40; mean age = 16.34), and normative families. The authors used the FACES-III normative data for the normative family sample. The violent delinquent and nonviolent delinquent groups consisted of primarily inpatient offenders, however, the juvenile sex offender group consisted of both inpatient and outpatient offenders. The researchers asked the offenders to complete the FACES-III based on their view of their family at the time of their offense. The authors failed to find a significant difference among the groups' levels of adaptability. In fact, each delinquent group's mean scores on

adaptability fell outside the clinical range; however, the groups differed significantly on their levels of cohesion. All 3 delinquent groups' mean scores indicated disengaged families and their scores differed significantly from the FACES-III normative sample. Surprisingly, the juvenile sex offenders had significantly higher levels of cohesion than the other delinquent groups. The authors did not consider this finding clinically significant because all delinquent groups' mean scores fell into the clinical range. Further, the dominance of inpatient offenders in the violent and nonviolent delinquent groups may have influenced the level of cohesion relative to the juvenile sex offender sample, which contained nearly equal numbers of inpatient and outpatient offenders.

Bischof, Stith, and Whitney (1995) conducted a study that used the same sample as Bischof, Stith, and Wilson (1992). Both studies compared juvenile sex offenders, violent offenders, nonviolent offenders, and a normative sample. The studies differed only on the measure used to assess the families; Bischof, Stith, and Wilson (1992) used the FACES-III, whereas Bischof, Stith, and Wilson (1992) used the Family Environment Scale (FES; Moos & Moos, 1986).

The FES has 10 subscales: Cohesion, Expressiveness, Conflict, Independence, Achievement Orientation, Intellectual-Cultural Orientation, Active-Recreational Orientation, Moral-Religious Emphasis, Organization, and Control. Cohesion refers to the level of commitment, support, and help family members give to one another. Expressiveness is the amount of openness and direct expression of feelings in the family. Conflict refers to the amount of anger, aggression, and conflict openly expressed by family members. Independence is the level of self-sufficiency and assertiveness displayed by family members. Achievement Orientation refers to the family's level of

competitiveness or focus on achievement. Intellectual-Cultural Orientation is the family's interest in political, social, intellectual, and cultural activities. Active-Recreational Orientation refers to the participation in social and recreational activities by the family. Moral-Religious Emphasis refers to how much emphasis the family places on ethics and religion. Organization is the level of structure and organization in the family's activities and duties. Control refers to the how much the family uses rules and procedures.

Bischof, Stith, and Whitney (1995) failed to find significant differences among the delinquent groups; however, the delinquent groups had lower Cohesion, Expressiveness, and Independence than the FES normative sample. Similar to Bischof, Stith, and Wilson (1992), Bishof, Stith, and Whitney's (1995) findings suggest that delinquent families possess less Cohesion than a normative sample. Their study builds upon the previous study by finding that juvenile offenders' families display less Expressiveness and Independence than a normative sample.

Duane, Carr, Cherry, MacGrath, and O'Shea (2003) used the Family Assessment Device (FAD; Epstein, Baldwin, & Bishop, 1983) to compare families of child sexual abuse perpetrators (n = 22; 15 mothers, 15 fathers) with normative families (n = 19; 13 mothers, 6 fathers) and clinical families (n = 10; 9 mother, 1 father). The clinical control group adolescents were receiving mental health services, but did not have a history of sexually abusive behavior. The FAD has 7 scales: Problem-Solving, Roles, Affective Responsiveness, Affective Involvement, Behavior Control, and General Functioning. Problem-Solving refers to the family's ability to solve problems and maintain effective family functioning. Communication is the level of clarity and openness in the family's communications. Roles refers to family members' performance of behaviors that help the

family accomplish the everyday tasks of existence. Affective Responsiveness refers to the family's willingness to reveal their feelings. Affective Involvement is the family's willingness to help each other. Behavior Control refers to how much family norms and rules influence family members' behavior. The General Functioning scale measures the overall health of the family.

The child sexual abuse perpetrators' families mean scores fell in the clinical range for every FAD scale except the Behavior Control scale, which was about $1/6^{th}$ of a standard deviation from the clinical range. The child sexual abuse perpetrator and clinical control families mean scores were significantly higher than the normative control families on every FAD scale except Communication and Problem-Solving. The child sexual abuse perpetrator scores were significantly higher than the normative controls on the Problem-Solving scale. Communication scores showed no significant differences between groups. Child sexual abuse perpetrator families and clinical control families showed no significant differences on any scale. In fact, the mean scores on all subscales for these groups were very similar; however, the groups had significantly different sexual abuse histories. The child sexual abuse perpetrators and their parents were more likely to have experienced child abuse than the clinical and normative groups. The findings from this study suggest that child sexual abuse perpetrator families have more dysfunction than normative families, however, the authors of this study failed to find significant differences in several areas: family history of mental health problems, amount of harsh physical punishment, child neglect, and family violence.

Because social desirability bias may affect responses on self-report measures, the authors included a measure of social desirability. A correlation above .3 between any

dependent variable and social desirability scores would suggest a social desirability bias on that variable. The authors failed to find a correlation above .3 between any dependent measure and social desirability. In fact, the correlations were nonsignificant for every dependent measure (Duane, Carr, Cherry, MacGrath, & O'Shea, 2003).

Smith, Wampler, Jones, and Reifman (2005) compared the families of low, medium, and high risk offenders using the FACES-III. The authors determined risk level by the number of risk factors present. They used the following risk factors: violent or predatory offense (including grooming), court record of prior offense(s), self or family sexual abuse (offender sexually abused or offender's victim was a family member), self or family substance abuse, behavior problems or antisocial behavior, and unstable home life (i.e. single parent home, caregiver changes, and foster home placement). The authors considered a juvenile low risk if they had 0 – 2 risk factors, medium risk if they had 3 risk factors, or high risk if they had 4 – 6 risk factors. The offenders in the low-risk group had more family cohesion than offenders in the high-risk group. The authors failed to find a significant relationship between risk level and family adaptability. The findings from this study suggest that family cohesion may influence a juvenile's risk of sexually reoffending; however, the authors' assessment of risk was not based on an empirically validated measure, which limits the validity of their findings.

Present Study

This study originally intended to investigate the relationship between the delinquency and family history of juvenile sex offenders. However, it was very difficult to access participants due to Institutional Review Board (IRB) requirements related to obtaining consent for participation. Thus few participants were actually recruited. Consequently,

low power prevented me from making meaningful inferences based on the available data. Therefore, this study explores the participants' responses including whether their answers appear to be valid. I also review the complexities of obtaining consent from juvenile sex offenders given current IRB regulations.

Hypotheses

At the outset of this study I had several hypotheses about the relationship between delinquency and the family history of juvenile sex offenders. However, because the data do not allow meaningful evaluation of these hypotheses, they will not be presented here.

Chapter 2

Method

Participants

This study included 6 juveniles referred for sex offender treatment to Kim Molnar's office. They ranged from 12 – 15 years of age. Four were Caucasian, one was Hispanic, and one was African-American. All of these juveniles had either admitted to or had been found guilty of a sexual offense. During data collection, all participants were on probation for their sexual offense and were in the 10^{th} – 20^{th} week of a treatment program that typically lasts 24 weeks. Participants were given no incentives for participation.

Measures

Information Sheet. The information sheet requests the following information from the participant: age, race, parents' age and marital status, which parent(s) the child lived with before justice system involvement and the relative proportion of time spent under each parent's care.

Family Assessment Measure - III. The Family Assessment Measure – III (Skinner, Steinhauer, and Santa-Barbara, 1983) assesses family functioning using 3 forms: general, dyadic relationships, and self-rating. The general form (50 items) assesses overall family health. The dyadic relationship form (42 items) assesses the participant's relationships with other family members. The self-rating form (42 items) assesses the participant's functioning within the family.

Each form contains the following scales: task accomplishment, role performance, communication, affective expression, involvement, control, and values and norms. The general form has 2 additional scales: social desirability and defensiveness. The task accomplishment scale measures achievement of various developmental tasks. Task accomplishment is the overarching goal for the family. The role performance scale assesses the effectiveness of the family's assignment of roles within the family. The communication scale measures the degree and clarity of communication among family members. The affective expression scale assesses the quality, degree, and appropriateness of affective communications. The involvement scale measures the degree and quality of family members' interest in one another. The control scale assesses how family members influence and manage each other. The values and norms scale measures the influence of culture, norms and family background on the participant. The social desirability scale assesses the participant's degree of bias towards socially appropriate responses. The denial scale measures the participant's tendency to deny symptoms and respond defensively. All scales are given t-scores which have a mean of 50 and a standard deviation of 10 (Skinner, Steinhauer, Santa-Barbara, 1983).

Skinner (1987) demonstrated the discriminant validity of the FAM-III by using it to differentiate clinical families from non-clinical families. The FAM-III has demonstrated sensitivity to treatment effects in several studies (Steinhauer, 1984; Grizenko & Sayegh, 1990; Shekter-Wolfson & Woodside, 1990). Further, the FAM-III's scales possess good internal consistency. Its scales have the following reliability coefficients: general scale (α = .93), dyadic relationships scale (α = .95), and self-rating scale (α = .89) (Skinner, Steinhauer, & Santa-Barbara, 1983). This study used the FAM-III because of its strong reliability and validity; however, only the general and self-rating forms were given.

This study excluded the dyadic relationships form because attempts to use this form could have caused harm to the participant and would have been very difficult to interpret. The dyadic relationships forms require specification of the 2 family members. This would have been a problem if the researcher chose the family members or the juvenile chose the family members. The participant's victim could have been a family member and contacting them would have been inappropriate. Further, some parents and juveniles may not have disclosed the sexual abuse to all immediate family members. Attempting to enlist the immediate family members could have harmed a participant's victim or compromised the participant's privacy. For example, if this study assessed father-child dyads, a juvenile living with his mother may not have disclosed his offense to his estranged father. Attempting to contact the father, could have jeopardized the juvenile's confidentiality because the skeptical father could have probed and attempted to uncover the purpose of the research.

Using the dyadic relationships form would have also made interpretation difficult if the juvenile specified the other member of the dyad or used their primary caretaker. The

families of juvenile sex offenders are often not intact and the primary caretaker may have changed multiple times. It would have been very difficult to interpret and compare the results if the dyads varied significantly among the juveniles (i.e., juvenile-mother vs. juvenile-father vs. juvenile-uncle vs. juvenile-brother).

Parental Bonding Instrument. The Parental Bonding Instrument (PBI; Parker, Tupling, & Brown, 1979) assesses parental care and control using 25-items and 2 forms. The mother form (25-items) assesses the participant's perception of maternal care and control, whereas, the father form (25-items) assesses the participant's perception of paternal care and control. Care refers to the amount of warmth and affection the participant received from the identified parent. Low scores on the Care scale suggest that the parent was rejecting, cold, or indifferent to the participant. High scores on the Care scale suggest that the parent was affectionate, empathic and warm. Care scale scores range from 0-36. Control refers to the level of autonomy the parent allowed the child. Control scale scores range from 0-39. Low scores on the Control scale suggest that the parent allowed the child to be independent. High scores on the Control scale suggest intrusive and overbearing parenting. Care scores below 24 are classified as low for fathers and those above are high. For mothers the cutoff score is 27. Control scores have a high/low cutoff of 13.5 for mothers and 12.5 for fathers (Parker, Tupling, & Brown, 1979). Although the PBI's creators intended for the instrument to assess subjects over the age of 16; the measure remains appropriate for the proposed study because it has been used successfully in several juvenile delinquent samples (Howard, 1981; Rey & Plapp, 1990; Mak, 1990).

The PBI possesses strong validity and reliability. Several studies have demonstrated the discriminant validity of the PBI by showing significant correlations between PBI scores and blind assessors' ratings of parental care and control (Parker, Tupling, & Brown, 1979; Parker, 1981; Parker & Lipscomb, 1981; Parker, 1983). The PBI's scales possess good internal consistency. Its scales have the following reliability coefficients: care scale (α = .88 - .92) and control scale (α = .74 - .88) (Parker, Tupling, & Brown, 1979; Zenmore & Rinholme, 1989). The PBI possesses acceptable test-retest reliability even at 20-year intervals (Wilhelm, Niven, Parker, & Hadzi-Pavlovic, 2005).

Childhood Trauma Questionnaire – Short Form. The Childhood Trauma Questionnaire – Short Form (CTQ-SF-SF; Bernstein et al., 2003) measures physical abuse, emotional abuse, sexual abuse, physical neglect, and emotional neglect in people over 12 years of age. The 28-item self-report measure is composed of 5-point Likert-type items and includes a false-negative scale. The measure gives percentiles scores for each subtype of maltreatment and categorizes each maltreatment subtype as severe, moderate, low, or none. Bernstein et al. (2003) derived the CTQ-SF-SF from the original 70-item CTQ-SF (Bernstein & Fink, 1998), which possesses strong internal consistency (α = .95) and good test-retest reliability (r = .79 - .86). Research has demonstrated the discriminant validity of the original CTQ-SF by showing that clinical samples have higher scores than nonclinical samples (Bernstein & Fink, 1998). The CTQ-SF evidenced an equivalent factor structure across several samples: adolescent psychiatric inpatients, adult substance abusers, and a normative community sample (Bernstein et al., 2003). This finding supports the reliability of the measure. Researchers have demonstrated the discriminant

validity of the measure by showing that CTQ-SF scores correlate significantly with therapists' ratings of maltreatment.

Self Report Delinquency Scale. The Self Report Delinquency Scale (SRD; Elliot, Huiziga, & Ageton, 1985) consists of 24-items and measures the frequency with which the participant committed a range of delinquent acts in the last year. The SRD has 2 scales: index offenses and general delinquency. In addition, researchers can measure the frequency of delinquency by summing the participant's responses. The index offenses scale measures the mean frequency of serious delinquent acts. The general delinquency scale measures the mean frequency of delinquent acts (Elliott, Huiziga, & Ageton, 1985). The SRD possesses adequate validity and reliability. Farrington, Loeber, Stouthamer-Loeber, Kammen, and Schmidt (1996) demonstrated the predictive and concurrent validity of the SRD by showing that SRD scores had significant correlations with court records of delinquency before and after SRD completion. The SRD also has adequate 1-month test-retest reliability (Huizinga & Elliott, 1986) and good internal consistency (α = .92) (Elliott, Huizinga, & Ageton, 1985). This study will use a questionnaire version of the SRD to ensure confidentiality. Questionnaires evaluating delinquency produce similar results to interviews. Some researchers found that self-administered questionnaires produce similar results to interviews (Krohn, Waldo, & Chiricos, 1974; Hindelang, Hirschi, & Weis, 1981). Other researchers have found that self-administered questionnaires produce a higher frequency of responses relative to interviews, however, the effect size is small (Turner, Lessler, & Devore, 1992; Aquilino, 1994). It seems unlikely that using questionnaires instead of interviews significantly influenced the reports of delinquency.

Procedure

The proposed procedure included recruiting juvenile sex offenders from inpatient facilities (Desert Willow Treatment Center, Briarwood Group Home, and Eagle Quest of Nevada) and outpatient facilities (Family and Child Treatment and Kim Molnar's office).On the initial IRB application, a waiver of informed consent was requested for the inpatient juveniles because obtaining parental consent was unlikely. Tracy Kingera, the head of the juvenile sex offender unit for Juvenile Justice Services in Clark County, stated that it would be extremely difficult to get consent from the parents of the inpatients for three reasons. First, the parents' visits to the inpatient facilities were rare and sporadic because many of the parents seemed to have given-up on their children. According to her, this happened because the inpatient juveniles broke the law repeatedly and this frustrated the parents so much that they often felt relieved to have their child taken out of the home. Second, many of the visitors were not parents. She said that grandmothers and siblings were the only visitors for some of the juveniles. Third, I would have to get each parent to make two visits. On the first visit the staff would have to obtain permission for me to contact the parent about the study. This safeguard was in place in case one of the parents knew the researcher or someone affiliated with the research. This safeguard allowed the parents to control the researchers' access to them, but it also meant that the researchers could not be present if even one parent who had declined to be contacted was present during the visitation period. On the second visit, an attempt to obtain consent from the parents would have been made. According to Miss Kingera, the study's dependence on not just a first visit, but a second visit as well made it very unlikely that parental consent would be obtained for more than a few juveniles over the course of several months of

recruitment. Because it was anticipated that the majority of the sample would come from inpatient participants, the waiver of informed consent was crucial because it would have allowed the difficulties in obtaining parental consent to be averted.

The IRB asked for revisions while reviewing the request for a waiver of informed consent. Initially, they asked for a court order giving the researchers consent to conduct the study with the inpatients because they were under county custody. After the judge granted this order, the IRB requested an order in which the judge appointed himself the guardian of the inpatients and consented all of them into the study. The IRB was given this order, but after seeking legal counsel they decided that the judge's blanket consent was insufficient. Next, they requested a court order in which the judge appointed the inpatients' caseworkers as their guardians. This would allow the caseworkers to consent the inpatients into the study. The judge decided against granting the final requested court order because it required giving the caseworkers too much power and responsibility. As a result, the IRB denied the request for a waiver of informed consent. At this point, the IRB approval process had taken roughly 16 months. The IRB was willing to approve the protocols for the outpatient participants. Thus, the inpatient participants from Desert Willow Treatment Center, Briarwood Group Home, and Eagle Quest of Nevada were excluded from the study and IRB approval was obtained only for the outpatient participants.

While the IRB review process was unfolding, Family and Child Treatment ended their juvenile sex offender treatment program, which left only Kim Molnar's office as an option for data collection. Recruitment and data collection took place in her office. The juveniles signed the assent forms and their parents gave written consent. The participants

understood that they needed to leave their names off of the questionnaires to ensure confidentiality. The juveniles completed the information sheet, the FAM-III general and self-rating scale forms, the maternal and paternal PBI forms, the CTQ-SF, and the SRD. Juveniles with insufficient knowledge about their father left the paternal PBI form blank. Each participant took roughly 50 - 60 minutes to complete the forms. Participant data did not include any personally identifying information. At the request of the IRB, I completed the consenting procedures and Ms. Molnar completed data collection in order to prevent me from being forced to make a mandated report of child abuse if a participant verbally disclosed abuse while asking a question about the CTQ-SF. Each participant completed the questionnaires in Ms. Molnar's office, put them into unsealed envelopes, and gave them to Ms. Molnar. She was the only person present in the office. The participants' parents were not present and neither were the other participants. She promised the participants that she would not read their packets. After she had collected multiple packets, she shuffled the envelopes after each participant handed-in the completed questionnaires. This shuffling was done in an attempt to enhance confidentiality. Ms. Molnar did not review the participants' data.

Chapter 3

Results

The original intention of this study was to look for links between juvenile sex offenders' family and delinquency history. However, only six participants were recruited for the study, leading to insufficient statistical power to make reliable statistical inferences. Thus, I abandoned the intended analyses and instead present descriptive statistics for all measures completed, compare participants' scores to normative samples

when available and examine the evidence addressing the reliability of the participants' answers to key questionnaires.

Table 1 shows the following demographic characteristics of the participants, including age, mother's age, father's age, and the percentage of time participants spent under each parent's care. The participants spent substantially more time under maternal than paternal care. Of this study's six participants, four were White, one was Hispanic/Latino, and one was African-American.

Table 1

Demographics

Variable	Mean	SD
Participant's Age	13.83	0.98
Mother's Age	38.5	5.79
Father's Age	38	4.69
% Time Mom	78.33	20.41
% Time Dad	21.67	20.41

Table 2 displays the score categories for the Childhood Trauma Questionnaire – Short Form (CTQ-SF) scales with the exception of the minimization/denial scale. On this scale, minimization or denial is suspected when "very often true" is endorsed for one of the critical items. Table 3 shows CTQ-SF mean scores, standard deviation, and alpha values for the current study as well as for a normative sample of college students (Bernstein et al., 2003). Comparison of the participants' scores with those from a normative sample of college students (Bernstein et. al., 2003) indicate that the scores of these participants were highly similar to those of the normative sample of college students with the exception of the physical abuse and neglect alphas; however, the physical neglect alpha increases to an

acceptable level (.83) with the deletion of a single item ("When I was growing up I didn't have enough to eat"). The low sexual abuse alpha could not be attributed to a single item. Although the sexual abuse alpha is low, it does not seem low enough to suggest random responding. It was likely low because this scale asks questions that are particularly uncomfortable for perpetrators of sexual abuse. The scores on the CTQ-SF indicate that few of these subjects reported abuse or neglect; all of the means were in the "none" or "low" range with a few individual scores falling in the "moderate" or "severe" ranges.

Table 2

CTQ-SF Score Categories

	Categorization			
Scale	None	Low	Moderate	Severe
Emotional Abuse	5-8	9-12	13-15	>15
Physical Abuse	5-7	8-9	10-12	>12
Sexual Abuse	5	6-7	8-12	>12
Emotional Neglect	5-9	10-14	15-17	>17
Physical Neglect	5-7	8-9	10-12	>12

Table 3

Childhood Trauma Questionnaire

Study Participants				Normative Sample		
Scale	Mean	SD	Alpha	Mean	SD	Alpha
Emotional Abuse	8.67	4.80	0.85	8.50	4.00	0.89
Physical Abuse	6.00	1.27	0.37	6.90	3.10	0.78
Sexual Abuse	5.33	0.82	0.63	5.20	1.00	0.72
Emotional Neglect	9.83	4.49	0.84	9.70	4.30	0.92
Physical Neglect	6.67	1.97	0.02	6.80	2.20	0.60

Table 4 presents information from the Parental Bonding Instrument (PBI). The PBI categorizes scores as high if they fall above the validation sample mean and low if they are below it. Care scores at or above 24 are classified as high for fathers and those below are low. For mothers the cutoff score is 27 with scores equaling this exact value being classified as high. Control scores have a high/low cutoff of 13.5 for mothers and 12.5 for fathers (Parker, Tupling, & Brown, 1979). The maternal care and control and paternal control mean scores displayed in Table 4 fall into the high category; whereas, the paternal care mean score fell into the low category. Each PBI scale mean obtained in this study falls within one standard deviation of the respective value from the validation sample. Although the paternal control alpha is low; it does not seem to result from random responding.

Table 4

Parental Bonding Instrument

Scale	Mean	SD	Alpha
Maternal Care	28.68	6.89	0.92
Maternal Control	20.50	7.87	0.82
Paternal Care	19.00	7.26	0.80
Paternal Control	16.25	5.25	0.52

Tables 5 and 6 show the FAM-III General and Self means, standard deviations, and alphas obtained in this study. These scores were all within one-half of a standard deviation of the normative sample T-scores of 50. Some of the FAM-III scales have alpha values that fall below the generally accepted cutoff of 0.7 (Nunnally, 1978) and the values obtained in the validation sample; in fact the role performance – general scale had a negative value. This occurred because some items from this scale were given identical

values by every participant, which resulted in zero variance for those items and contributed to the resulting negative average covariance among scale items; however, the identical values actually represent a high level of reliability. This negative alpha is a statistical anomaly. All of the remaining low alpha values increased substantially, generally to acceptable levels with the deletion of a single item from each of these scales: the minimization/denial alpha increased to .78, the family affective expression alpha increased to .89, and the task accomplishment alpha increased to .57. Following is a list of the questions that would lead to significant increases in alpha if they were deleted: "When I was growing up there was nothing I wanted to change about my family." (minimization/denial), "When someone in our family is upset, we don't know if they are angry, sad, scared, or what." (family affective expression), and "When problems come up in my family, I let other people solve them." (task accomplishment-self). Although the task accomplishment-self scale does not increase above the cutoff value of .7; it exceeds the alpha of .4 obtained in the FAM-III validation study.

Table 5

FAM-III General Scores

Scale	mean T-score	SD.	Alpha	Normative Sample Alpha
Task Accomplishment	50.67	9.85	0.54	0.60
Role Performance	51.67	6.98	-0.49	0.64
Communication	52	10.2	0.77	0.70
Affective Expression	51.33	11.78	0.58	0.71
Involvement	52.67	12.04	0.87	0.75
Control	52	12.39	0.79	0.63
Values & Norms	49.33	10.33	0.86	0.62
Overall	51.33	9.46	0.70	0.94
Social Desirability	46.67	8.45	0.83	0.87
Defensiveness	53.67	15.46	0.88	0.70

Table 6

FAM-III Self

Scale	mean T-score	SD.	Alpha	Normative Sample Alpha
Task Accomplishment	47.33	9.85	0.29	0.40
Role Performance	53.67	13.17	0.56	0.27
Communication	48.33	13.17	0.77	0.58
Affective Expression	52.67	16.08	0.74	0.55
Involvement	51	9.86	0.08	0.44
Control	46	13.86	0.35	0.39
Values & Norms	44.67	6.02	0.43	0.46

This study found an average of 0.33 delinquent acts reported on the SRD with only one participant reporting any delinquent act besides his sexual offense.

Table 7

Invalid Profiles

Scale	n
CTQ-SF Minimization/Denial	2
FAM-III Defensiveness	1
FAM-III Social Desirability	0
Total	2*

*One participant had an invalid profile for two scales.

Table 7 shows that a total of two participants evidenced invalid profiles on at least one measure. The participants' responses seemed to indicate that they minimized or denied some offenses and incidents. For example, two of the six participants had elevations on at least 1 scale that measured minimization, denial, or defensiveness. This was one sign that the participants were engaging in impression management. Another sign was that four of the six participants failed to report their sexual offense on the Self-Report Delinquency Scale (SRD). This could result from denial or an intentional attempt

at deception; both are forms of impression management. Another possibility is that their sexual offenses occurred more than a year ago. This seems unlikely to be the case for all participants because treatment typically lasts 6 months or less and they were all in the middle stage of their treatment.

The final indication of impression management was their likely underreporting of delinquent offenses on the SRD. The average number of delinquent offenses reported by adolescents in a community sample is 45 (Huizinga & Elliot, 1986). The community average may seem high, but on this scale delinquency includes less serious offenses like loitering, disorderly conduct, breaking curfew, and smoking cigarettes. This study found an average of 0.33 acts reported with only one participant reporting any delinquent act besides his sexual offense. Being on probation may have reduced the participants' likelihood of committing delinquent acts; however, reducing the rate by a factor of 100 seems likely to have resulted more from reporting bias than from probation. Following are the items from the SRD scale for which all participants gave a response of zero or never:

How many times in the last year have you…?

Purposely damaged or destroyed property that did not belong to you

Stolen or tried to steal a motor vehicle such as a car or motorcycle

Stolen or tried to steal something worth more than $50

Purposely set fire to a building, a car, or other property or tried to do so

Carried a hidden weapon other than a plain pocket knife

Stolen or tried to steal things worth $5 or less

Attacked someone with the idea of seriously hurting or killing that person

Used checks illegally or used phony money to pay for something

Sold marijuana or hashish (“pot”, “grass, “hash”, “weed”)

Hitchhiked where it was illegal to do so

Hit or threatened to hit someone

Sold drugs any illegal drugs or prescription drugs

Tried to cheat someone by selling them something that was worthless or was not what you said it was

Taken a vehicle for a ride or drive without the owner’s permission

Bought or given liquor to a minor

Used force to get money or things from people

Avoided paying for such things as movies, bus rides, or food

Been drunk in a public place

Stolen or tried to steal things worth between $5 and $50

Broken or tried to break into a building or vehicle to steal something or just to look around

Begged for money or things from strangers

Used or tried to use credit cards without the owner’s permission

Used alcoholic beverages, beer, wine, hard liquor

Used tobacco (cigarettes, cigars, hookah)

Used any illegal or prescription drugs

Skipped school

Chapter 4

Discussion

Although this study began as an attempt to investigate juvenile sex offenders' family and delinquency history, ultimately it was determined that the data were not able to shed light on that original question. IRB mandated protocol changes, in addition to participant defensiveness, combined to undermine the initial goal of the study. The IRB required the participants' therapist to collect the data which affected recruitment and seemed to bias responses. In many cases the therapeutic alliance would limit response bias; however, in this study the therapist reported to the participants' probation officers because the court mandated treatment. This reporting may have contributed to the participants' defensiveness because the participants feared that any disclosures they made in treatment would be shared with their probation officer and could result in negative consequences.

Requirements for participant consent mandated by the IRB also limited the ability to recruit participants. The requirements made collecting data from the majority of the initially targeted population impossible. Thus the size of the available sample was severely reduced.

Due to the small sample size, a case-study approach was initially employed. But after reviewing the responses, several factors suggested systematic impression management by the participants; therefore, the data could not be meaningfully analyzed and the case-study approach was abandoned. Inspection of the participant's responses revealed elevated impression management scale scores and likely underreporting of sexual and non-sexual delinquency. The participants' seemed to underreport known

sexual offenses and their reported frequency of total delinquent acts in the past year was roughly 100 times lower than the rate found in a community sample of adolescents (Huizinga & Elliott, 1986). The possibility of random responding by the participants seemed unlikely given that the scale alpha and alpha-if-item deleted values generally suggested consistent responding. This left impression management as the most plausible explanation for the severe underreporting of delinquent acts, especially sexual offenses.

The participants may have viewed giving honest responses on the questionnaires as a risk. For example, they could have been subjected to punishment and embarrassment if the participants' parents, probation officers, or therapist discovered their answers. Because the embarrassment associated with the commission of a sexual offense is much more powerful than for a nonsexual offense, confidentiality weighed heavily for the juveniles. During the consenting procedure I explained the procedures in place to keep their disclosures confidential. In addition, the participants' therapist, Ms. Molnar, collected their questionnaires and promised not to read the responses; however, our assurances may not have alleviated the participants' doubt. Because the court mandated the participants into treatment and required Ms. Molnar to report to their probation officers, any participant who reported committing a delinquent act would risk further punishment from the judicial system if their probation officers learned of the offense. The punishments could include an extension of their probation, time in juvenile detention, or lifelong registration as a sex offender. The participants' parents could punish them as well. Any underreporting of delinquency seems understandable given the potential consequences.

Disclosing abuse posed a risk as well because the participants' parents could get upset about the juveniles disclosing family problems to someone outside of the family or the probation officer could mandate family therapy. Another risk is that the participants could have been separated from their parents and placed in foster care if their therapist or probation officer learned of the abuse. The participants clearly had much to lose by giving unguarded responses; however, punishment and embarrassment are not the only potential outcomes.

The participants may have engaged in impression management because they were in denial. Disclosing abuse, family problems, or the commission of delinquent acts on the questionnaires is a form of acknowledgement. To make this disclosure would mean acknowledging the occurrence of the events. It is plausible that at least some of the juveniles were in denial. This possibility is supported by the focus on denial of sexual offenses and victimization in empirically supported juvenile sex offender treatment programs (Borduin & Schaeffer, 2001).

Although the participants' defensive responses undermined the ability to use their data to answer my original research question, I avoid labeling the juveniles' responses as dishonest or deceptive. I prefer guarded or defensive because their responses made their dilemma clear. For future studies, I would suggest three significant changes to the original methodology. First, I would omit the demographic questionnaire because the responses could possibly be linked to an individual (i.e., if there was only one Hispanic participant). Second, I would collect the data in groups instead of from individuals, which would enhance confidentiality. Last, I would have their therapist collect the data after they completed treatment and probation with the hope that this would alleviate some of

their defensiveness. The participants might worry less about additional punishment from their probation officer and treatment should have reduced any potential denial regarding their sexual offense(s), their own experiences of abuse, and any other delinquent offenses they may have committed. These methodological changes might reduce, but probably would not eliminate, denial and defensiveness. Defensiveness is always likely to be a factor in this type of research because methodological changes may never be enough to encourage all of the participants to completely let down their guard against the possibility of a breach in confidentiality and the potential consequences.

All of the studies I found researching juvenile sex offenders' families lacked embedded impression management scales. At best, these studies employed a file review to substantiate the participants reports of sexual abuse victimization (Kaplan, Becker, & Cunningham-Rathner, 1988; Ryan, Miyoshi, Metzner, Krugman, & Fryer, 1998; Manocha & Mezey, 1998; Ford & Linney, 1995; Kaplan, Becker, & Martinez, 1990; Awad & Saunders 1991; Richardson, Kelley, Bhate, & Graham, 1997; Ronis & Borduin, 2007; Hummel, Thömke, Oldenbürger, & Specht, 2000; Symboluk, Cummings, & Leschied, 2001; Awad, Saunders, & Levene, 1984; Fagan & Wexler, 1988; Awad & Saunders, 1989; Blaske, Borduin, Henggeler, & Mann, 1989; Bischof, Stith, & Wilson, 1992; Bischof, Stith, & Whitney, 1995; Duane, Carr, Cherry, MacGrath, & O'Shea, 2003; Smith, Wampler, Jones, & Reifman, 2005). The full impact of impression management on juvenile sex offender research is unknown because, to the best of my knowledge, it has not been investigated extensively; however the results of this study and the finding that more disclosures of abuse are made in the latter stages of treatment and in residential treatment settings suggest that further investigation could be helpful (Worling,

1995; Hummel, Thömke, Oldenbörger, & Specht, 2000). Perhaps a qualitative approach to collecting data could help reduce the inherent defensiveness among juvenile sex offenders. . Further, the development of more sophisticated subscales that detect and statistically compensate for impression management could enhance future research.

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Educational History

1. Marquette University
Major: Computer Science and Psychology
Dates Attended: 09/1999-03/2001

2. University of Nevada – Las Vegas
Major: Psychology
Dates Attended: 09/2001-06/2002

3. Saint Louis University
Major: Psychology
Dates Attended: 08/2002-08/2005
Degree: B.A.

4. University of Nevada – Las Vegas
Program: Clinical Psychology – Doctoral Program
Dates Attended: 09/2006-Present

Professional Positions

1. Part-Time Practicum Therapist, Family & Child Treatment, 2008-present
Duties: Conduct group, family, and individual therapy with maltreated adults, adolescents, and children; perform therapeutic assessments on maltreated adults; conduct group and individual therapy with juvenile and adult sex offenders, perform re-offense risk assessments on adult sex offenders.
Supervisor: John Matthias, Ph.D., Clinical Director

2. Practicum Therapist, Center for Individual, Child, and Family Counseling, 2007-2008

Duties: Conduct individual therapy with adults referred for long-term treatment; perform assessments on adults and children for learning disabilities and personality disorders.
Supervisors: Michelle Carro, Ph.D., Assessment Clinic Director; Marta Meana, Ph.D., Therapy Supervisor

3. Part-Time Instructor/Graduate Assistant, University of Nevada – Las Vegas, Nevada. 2007-2009; 2009-2011
Duties: Teach 2 section of General Psychology, Proctor and grade exams, Tutor students

4. Enlistment Coordinator, AchievementCenter, Las Vegas, Nevada. 2006-2007 Graduate Assistantship Position
Duties: Develop and Maintain Enlistment and Retention procedure Manual; Act as a Liaison Between the Therapists, the Department of Child and Family Services, and the Client; Develop and Maintain Presentations to the Department of Child and Family Services and other Organizations about our Family Behavior Therapy Program; Schedule Therapists; Assign Child Management Specialist to Families in Need

5. Aide, Child Center of Our Lady, Saint Louis, Missouri. 2004 Summer Part-Time Volunteer Position
Duties: Assist staff with students, Mentor and tutor severely traumatized children.
Supervisor: Jim Bausch, Executive Director

6. Research Assistant, University of Nevada – Las Vegas. Spring 2002 Part-Time Volunteer Position
Duties: Assisted with Sport Psychology Research; Catalogued Research Database in AchievementCenter
Supervisor: Yanni Dickens M.A.

7. Teaching Assistant, University of Nevada – Las Vegas. Spring 2002 Part-Time Volunteer Position
Duties: Teach one class; Organize PowerPoint presentations for professor; handle grade spreadsheets; Find examples of cognitive psychology in the media; Conduct independent study on deception and detecting deception.
Supervisor: Dr. Karen Kemtes

Publications

Kearney, C.A., Turner, D., &Gauger, M. (2010).School refusal behavior. In I. Weiner & E. Craighead (Eds.), *Corsini's encyclopedia of psychology* (4th ed.) (pp. 1517-1519). New York: Wiley.

Awards

Edward D. Lovinger Psychology Scholarship – 2007

Poster Presentations

Turner, D.K., Rodgers, M., Terauds, S., Reis, J. (May 2005). Addressing developmental and adjustment needs of siblings of the autistic. Presented to the Saint Louis University Psychology Department.Received First Place Undergraduate Presentation Award.

Professional References
Available Upon Request