Parental Involvement in Family Therapy for Adolescents who Sexually Offend

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Abstract

Adolescents commit between 30% and 50% of the sexual offenses against young children in the United States. Adolescents who complete specialized treatment for sexual offending, including family therapy, have lower rates of sexual recidivism. Despite the evidence that including families in adolescents’ treatment may contribute to lower sexual recidivism rates, there are few descriptions of family therapy with adolescents who sexually offend. In particular, there are no conceptualizations or models of family involvement derived from parents and adolescents’ perspectives on treatment. To address this need, this study examined adolescents' and their parents’ experiences of participation in family therapy when the adolescent son had been required to complete treatment for sexual offending. In addition, the study explored how parent and adolescent participation in family therapy was associated with adolescents’ progress in treatment for sexual offending. Using constructivist grounded theory methodology, a conceptualization of family therapy was developed through semi-structured interviews with ten adolescent boys who have sexually offended and their parents/caregivers. In addition, a focus group of seven family therapists who specialize in the treatment of adolescents who sexually offend reviewed the findings and offered input on refining the emerging clinical conceptualization. Findings suggest that youth have more successful outcomes when therapists foster hopefulness and use parents to help motivate youth and facilitate change. Positive outcomes of family therapy for youth included expressing himself more clearly, caring about people, thinking about his future and setting goals, having more confidence, following the rules,
progressing in treatment, being accountable for his behavior, becoming more honest, developing life skills, and understanding and expressing regret for sexually offending. Positive outcomes of family therapy for families included changes in household rules, family roles, setting boundaries, and having respectful communication. Implications for how to best include families in adolescents’ treatment of sexual offending are addressed.
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Chapter One: Introduction

Problem and Significance

Adolescent sexual offending is a significant problem in the United States. In 2011, there were 2,066 adolescents between the ages of 10 and 17 arrested for 14.1% of the forcible rapes and 9,402 adolescents arrested for 17.7% of the other sexual crimes (e.g., statutory rape) committed against men, women and children (Federal Bureau of Investigation, 2012a). In fact, adolescents are responsible for 30% to 50% of the sexual crimes committed against young children each year (Barbaree & Marshall, 2006).

Prevalence studies, in which the number of cases of sexual abuse are determined by retrospectively asking people whether they had been sexually abused, is one way of measuring childhood sexual abuse rates. In an international prevalence study, Krug, Dahlberg, Mercy, Zwi, and Loano (2002) found that 20% of adult females and between 5% and 10% of adult males stated that they had been sexually abused as a child. Given the high rate of sexual offenses that adolescents commit against children (i.e., 30% to 50%) it is likely that many of these offenses were committed by adolescents. In an incidence study, another way of measuring childhood sexual abuse rates, which examine the number of cases of sexual abuse that were investigated and substantiated, the U.S. Department of Health and Human Services (2012) reported that approximately 61,149 children (ages 17 and under) were sexually abused between October 2010-September 2011. Based on estimates of the incidence of sexual abuse perpetrated by adolescents, mentioned above, it can be assumed that, adolescents were responsible for approximately 18,345 to 30,575 of these children being sexually abused. Regardless of the way data are gathered, the actual rates of sexual crimes committed by adolescents may be greater because many sexual
crimes are not reported by the victim or are not substantiated (Finkelhor, 1994; Goldman & Padayachi, 2000; Wurtele, 2009). Thus, it appears that a large number of children are being sexually victimized; many of them by adolescents.

While both male and female adolescents commit sexual offenses, the majority of the adolescents referred and adjudicated for sexual offending are males. In 2011, there were 46 female adolescents between the ages of 10 and 17 arrested for .3% of the forcible rapes and 1,025 female adolescents arrested for 1.9% of the other sexual crimes (e.g., statutory rape) committed against men, women, and children (Federal Bureau of Investigation, 2012b). Because females represent such a small percentage of the adolescents who offend, researchers have typically focused on adolescent males (see, for example, Fortune & Lambie, 2006; Hendriks & Bijleveld, 2008; McGrath, Cumming, Burchard, Zeoli, & Ellerby, 2010). Given that the majority of the research literature is exclusive to males and that male adolescents commit the majority of sexual offenses, this study also focused on males who sexually offend.

Adolescents (youth ages 12-17) typically commit sexual offenses that fit into one of six categories: rape, incest abuse, child abuse, statutory rape, and non-contact sexual abuse (McGrath et al., 2010). The definitions of these offenses vary across states and governmental agencies. The Center for Sex Offender Management (1999) defines rape as the “forcible sexual penetration of a child or an adult (vaginal, oral, or anal) with a penis, finger, or object” (p. 18). In Oregon, which served as the location for this study, rape is defined as using force to have sexual intercourse with someone, having sex with someone under the age of 12, or having sex with one’s sibling or child under the age of 16 (Oregon State Legislature, 2009). Incest abuse is defined as having sexual relations with someone in one’s family, such as a sibling (Center for
Sex Offender Management, 1999; McGrath et al., 2010). Child abuse is committing a sexual crime, which may include rape, against a child outside of one’s family (McGrath et al., 2010), while statutory rape “refers to cooperative sex with a similar age peer who was under the age of consent” (McGrath et al., 2010, p. 27). Non-contact sexual abuse occurs when the perpetrator commits a sexual violation without touching the victim, such as in exhibitionism (i.e., exposing one’s genitals in order to be sexually aroused) and voyeurism (i.e., watching people, without their knowledge, dress or engage in sexual activities; McGrath et al., 2010).

Given the high rates of children who are sexually offended by adolescents, and the multiple types of sexual offenses adolescents are committing, it is clear that adolescent sexual offending is a significant problem. An additional way to understand the significance of adolescent sexual offending is to look at the repercussions for the victims, adolescents who sexually offend, and the community.

Consequences for victims. There are both short- and long-term negative consequences of sexual abuse for the victims. Children who are sexually abused are at an increased risk of experiencing negative behavioral and psychological difficulties during childhood (Paolucci, Genuis, & Violato, 2001; Putnam, 2003). More specifically, sexually abused children are more likely to participate in sexualized behaviors including putting objects into their vaginas or rectums, playing sexually with toys, having age inappropriate sexual knowledge, and seeking inappropriate sexual contact from peers and adults (Cavanagh-Johnson, 2009; Kendall-Tackett, Williams, & Finkelhor, 1993). Children who have been sexually abused may also experience psychological problems such as depression, anxiety, post-traumatic stress disorder (PTSD; Paolucci et al., 2001), excessive fear, nightmares, and behavioral withdrawal (Kendall-Tackett et
al., 1993). These children can also experience severe consequences of sexual abuse that manifest in adulthood. For instance, adults who were sexually abused as children show increased rates of PTSD, depression, and suicide (Paolucci et al., 2001). Additionally, abused adults may have problems with substance abuse, early onset sexual experiences and unprotected intercourse, and poor academic performance (Paolucci et al., 2001). Given that the consequences for victims of childhood sexual abuse are so severe, and can extend into adulthood, it becomes imperative to find ways to prevent child sexual abuse and sexual offense recidivism, including effective treatment of adolescents who sexually offend.

**Consequences for adolescents who sexually offend.** Along with the many negative consequences for victims of sexual abuse, there are also negative consequences for the adolescents who sexually offend. When adolescents commit sexual offenses, one immediate consequence is the potential separation from their families, particularly if the victim lives in the home or if the adolescent who offended is incarcerated. Adolescents who commit sexual crimes are also subject to public stigmatization. Moreover, adolescents who are adjudicated for a sexual offense are required to register as sex offenders and, in some states, this means being placed on public registries for life. In addition to being subject to community notification laws, these adolescents are required to disclose information about their crimes when applying for housing, jobs and school, which may result in further social exclusion and marginalization (Chaffin, 2008). This stigmatization may “diminish the prospects for healthy social anchors and can set a course for criminal behavior...” (Chaffin, 2008, p. 113).

Thus, when adolescents who sexually offend do not receive intervention, such as specialized treatment for their sexual offending behaviors, they may be at increased risk for
re cidivating and committing more sexual and nonsexual offenses. For instance, in a meta-
alysis, Worling and Curwen (2000) found that, when compared to adolescents who completed
a specialized treatment program for sexually offending \((n = 58)\), adolescents who did not receive
treatment \((n = 90)\) sexually reoffended 72% more times, committed 41% more violent nonsexual
offenses, and committed 59% more nonviolent offenses. In a more recent meta-analysis using
published and unpublished data, Reitzel and Carbonell (2006) compared recidivism (reoffending)
rates for adolescents who received treatment (e.g., cognitive-behavioral/relapse prevention,
classic cognitive behavioral, psychotherapeutic, psycho-socio-educational, psychoanalytic/
psychodynamic/ego psychology, humanistic, strictly behavioral, multisystemic therapy, and
treatment-as-usual or unspecified treatment) to those who received no treatment. The adolescents
who received treatment had a recidivism rate of 7.37% \((n = 1655)\). Statistically, the rate of
recidivism for adolescents receiving no treatment was significantly higher, at 18.93% \((n = 1331)\).

Because of the potentially serious consequences for adolescents who do not receive
treatment for their sexually deviant behaviors, it is crucial that researchers and practitioners focus
on identifying ways to help adolescents stop their sexual offending. Identifying treatment
approaches that can successfully reduce sexual and nonsexual recidivism will help these
adolescents participate more fully in society, thus preventing further negative consequences for
the adolescents who offend, the victims, and the larger community.

**Consequences for the community.** When adolescents sexually offend, it affects the
entire community. For example, the financial cost for supervising and treating one adolescent
who sexually offends ranges from $5,000 to $22,000 per year depending on the treatment
modality and whether the adolescent is in the community or incarcerated (Center for Sex
Offender Management, 2000). In addition to the financial burden on society, adolescents who sexually offend present a problem for community safety. As mentioned above, some adolescents, especially those who do not receive intervention, will continue to sexually offend and will commit other crimes as well (Worling & Curwen, 2000). However, by providing specialized treatment for sexual offending, practitioners can help these adolescents to stop sexually offending, thus decreasing sexual and nonsexual recidivism, increasing community safety, and saving communities money (Fortune & Lambie, 2006; Reitzel & Carbonell, 2006; Walker, McGovern, Poey, & Otis, 2004).

**Family Treatment for Adolescent Sexual Offending**

As indicated previously, specialized treatments for adolescent sexual offending are the key to limiting the negative consequences of sexual offending on the victims, the adolescents who sexually offend, and the larger community. Treatments for adolescents who sexually offend are based on a number of different theories and approaches including cognitive-behavioral therapy (CBT; Hammack, 2003) and family systems theory (Whitchurch & Constantine, 1993). Regardless of the theory or approach used, the primary goal of treatment is to eliminate the adolescents’ deviant sexual behaviors, thus decreasing sexual recidivism. McGrath and colleagues (2010) reported that most specialized treatment programs throughout the United States focus on the following specific treatment goals, which have also been identified as practice guidelines by the National Adolescent Perpetration Network (NAPN; 1993): taking responsibility for sexual offending behaviors, challenging attitudes that support sexual offending behavior, controlling sexual arousal, regulating emotions, teaching intimacy and relationship
skills, strengthening family support networks, increasing problem solving skills, self-monitoring, improving social skills, and developing victim awareness and empathy.

In addition to these common treatment goals, many theorists, treatment providers, and researchers have acknowledged the importance and effectiveness of including families when treating adolescents who sexually offend. Family systems theorists view families as being made up of interconnected and interdependent individuals (Whitchurch & Constantine, 1993). Thus, individuals are best understood, not in isolation, but within the larger systems of their family and community (Whitchurch & Constantine, 1993). Family systems theorists also believe that the behavior of each person in the family has an impact on all the other members of the family; human behavior is not a response to a linear cause and effect process (Becvar & Becvar, 2006).

From a family systems perspective, adolescents who sexually offend should be treated within the context of their families because the family system is the primary context or environment that most adolescents function in; thus, their family has a significant influence on their post-treatment functioning (Vizard, Monck, & Misch, 1995; Efta-Breitbach & Freeman, 2004). “Many youth will return to their families after treatment, making family involvement in treatment a priority for these programs” (McGrath et al., 2010, p. 97). By using family interventions, therapists can address family issues that may have contributed to the development or maintenance of adolescents’ sexual offending behavior, such as poor attachment, communication, supervision, and boundaries (Baker, Tabacoff, Tornusciolo, & Eisenstadt, 2003; Efta-Breitbach & Freeman, 2004; Marshall & Marshall, 2000; Wieckowski, Hartsoe, Mayer, & Shortz, 1998). In fact, in the 2009 national survey of specialized sexual offending treatment programs, McGrath and colleagues (2010) found that adolescents and families had completed a
median of 50 family therapy hours in community based programs \((n = 260)\) and a median of 11 family therapy hours in residential based programs \((n = 182)\).

As family systems theorists and treatment providers embrace these connections between the adolescent and his family and emphasize the importance of addressing systemic issues in the conceptualization and treatment of adolescent sexual offending, researchers have begun to examine the value and effectiveness of family therapy with this population (Worling & Curwen, 2000; Worling, Litteljohn, & Bookalam (2010); Zankman & Bonomo, 2004). Two qualitative researchers have interviewed adolescents about their experiences in the adolescents’ treatment for sexual offending. They found that family involvement was important to how the adolescents viewed treatment success (Franey, Viglione, Wayson, Clipson, & Brager, 2004) and their experiences in therapy and probation had a positive impact on the youths’ relationship with their parents (Thurston, 2005).

Another way researchers have demonstrated the importance of including families in adolescents’ treatment for sexual offending is through outcome studies. Specifically, researchers have justified using family therapy with adolescents who sexually offend based upon the successful outcomes of treating other delinquent youth with family interventions. In a report on youth violence (U.S. Public Health Service, 2001), the Surgeon General identified three effective treatments for juvenile delinquent behavior: Functional family therapy (Sexton & Alexander, 1999), multidimensional treatment foster care (Fisher & Chamberlain, 2000), and multisystemic therapy (Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 1998). Each of these treatments incorporates a strong family component as a part of the youths’ treatment for delinquent behavior and has demonstrated effectiveness. Because adolescents who sexually
offend are viewed as being similar, in terms of risk factors and family characteristics, to other youth with non-sexual offending delinquent behaviors (Ronis & Borduin, 2007; van Wijk et al., 2005), researchers and practitioners often suggest that family therapy may also be beneficial in the treatment for adolescents who sexually offend.

Researchers who study the outcomes of treatment for adolescent sexual offending have not examined specific family therapy techniques and interventions; however, several researchers have studied programs with strong family therapy components. Multisystemic therapy (MST; Henggeler et al., 1998) is an example of a treatment program that includes family therapy in conjunction with other theories, such as CBT. MST outcome studies with adolescents who have sexually offended have yielded positive results. In several studies, researchers found that adolescents who received multisystemic treatment for sexual offending had fewer arrests for sexual crimes than adolescents who received individualized treatment (cognitive behavioral group and individual treatment; Borduin, Henggeler, Blaske, & Stein, 1990; Borduin, Schaeffer, & Heiblum, 2009). MST researchers argued that the uniqueness of their treatment versus other treatments is that they intervene at multiple systemic levels in the adolescents’ natural environments (Borduin & Schaeffer, 2001). Therefore, MST may be more effective because they include parents in treatment and consider family interventions.

Worling and Curwen (2000) evaluated the SAFE-T treatment program, which uses family therapy to address the core treatment issues for adolescents who sexually offend. They found that the adolescents who had received treatment in the SAFE-T program had a 5% recidivism rate compared to the comparison group who had an 18% recidivism rate. Besides demonstrating that this treatment program is helpful in reducing adolescents’ sexual offense behaviors, Worling and
Curwen (2000) also supported the importance of including the family in treatment when they concluded that the “treatment of adolescent sexual offenders may be most successful when the family is included wherever possible” (p. 977). Furthermore, Worling and colleagues (2010) extended this follow-up study and found that youth who had participated in the SAFE-T program had a 9% recidivism rate compared to the comparison group who had an 21% recidivism rate at a 12 - 20 year follow-up ($M = 16.23$ years; $SD = 2.02$).

**Directions for further study.** Family systems theorists, treatment providers, and researchers have established that family therapy is effective in the treatment of adolescent sexual offending (see for example Baker et al., 2003; Efta-Breitbach & Freeman, 2004; McGrath et al., 2010; Tighe, Pistrang, Casdagli, Baruch, & Butler, 2012; Worling & Curwen, 2000; Worling et al., 2010). However, these theorists, treatment providers, and researchers have not adequately explained which specific family interventions or therapeutic strategies are most helpful for adolescents in completing sexual offending treatment. Furthermore, the information available on how to include families in the treatment for adolescent sexual offending are typically derived from theorists’ and researchers’ perspectives, and do not include the perspectives of the adolescents receiving the treatment or their parents. Asking parents and adolescents their perceptions of family therapy, specifically about what they find helpful and not helpful in treatment, may help researchers identify specific interventions that contribute to successful outcomes for youth and families (Tighe et al., 2012). This would provide a more full picture of how best to involve families in the adolescents’ treatment for sexual offending and provide guidelines for making treatment more effective. To address these needs and further the understanding of family treatment of adolescents who sexually offend, in the current study, I
developed a conceptual framework of family therapy in the treatment of adolescents who sexually offend based upon the adolescents’ and parents’ perspectives.

**Participants’ Perspectives**

Although there is evidence of the importance and benefits of involving families in the treatment of adolescents who sexually offend, none of the existing conceptualizations clearly explain how to include families based on the perspectives of the adolescents and parents receiving the treatment. There are several reasons that it is important to understand the perspectives of participants in developing a comprehensive conceptual framework of family inclusion in the treatment of adolescents who sexually offend. First, adolescents who sexually offend are a marginalized group (Chaffin, 2008). Therefore, in order to maintain a socially just perspective, it is important to generate a conceptual framework based upon client voice (Grover, 2004). Integrating adolescents and parents’ perspectives will help develop a conceptual framework that accurately reflects the concerns of clients rather than the concerns of clinicians, theorists, and researchers (Grover, 2004). Second, clients are experts in their own experiences (Charmaz, 2000). Thus, to fully understand how family involvement can best help clients progress in treatment, one needs to understand how clients experience this process. Third, understanding how clients understand their process of change may help researchers make recommendations that could improve their motivation to change and engagement in treatment, which may further affect treatment success (Miller & Rollnick, 2002). For these reasons, learning about clients’ perspectives may help in the development of a more comprehensive conceptual framework of family involvement in the treatment for adolescent sexual offending than is currently available.
Study Overview and Research Questions

Because adolescent sexual offending is such a significant problem for the victims (Paolucci et al., 2001; Putnam, 2003), the youth who sexually offend (Chaffin, 2008), and the larger community (Center for Sex Offender Management, 2000), it is crucial that researchers identify treatment interventions aimed at reducing recidivism. While specialized treatment for adolescent sexual offending appears to be helpful in reducing recidivism (Fortune & Lambie, 2006; Reitzel & Carbonell, 2006; Walker et al., 2004), adding family therapy to treatment seems especially promising (Borduin et al., 1990; Borduin & Schaeffer, 2001; Worling & Curwen, 2000; Worling et al., 2010). Theorists have shown the importance of addressing family issues (Baker et al., 2003; Efta-Breitbach & Freeman, 2004), treatment providers have begun to focus on these issues more often (McGrath et al., 2010), and researchers have suggested that treatment with family involvement is more effective (Tighe et al., 2012; Worling & Curwen, 2000; Worling et al., 2010). What is still not known about including families in the adolescents’ treatment for sexual offending is which specific family interventions help adolescents’ progress in treatment. One way of getting at this information, which is virtually missing in the literature on adolescents who sexually offend, is to ask the families who participate in this treatment about their perspectives. Researchers have not asked adolescents who sexually offend and their parents about their experiences in family therapy and how they think parental involvement has affected the youths’ progress in treatment. Parents and adolescents’ perspectives are needed to develop a conceptualization of family therapy for the adolescents’ treatment for sexual offending that is socially just (Chaffin, 2008) and accurately reflects their concerns (Grover, 2004).
For these reasons, the purpose of this study was to develop a conceptual framework of the parents’ participation in family therapy as a part of their adolescent sons’ treatment for sexual offending, and to make specific recommendations on how to include parents in the adolescents’ treatment for sexual offending, which may help treatment providers refine their treatment techniques. Using a constructivist grounded theory approach (Charmaz, 2000), I interviewed ten adolescent males and their parents\(^1\) about their experiences in family therapy as a part of their adolescent sons’ treatment for sexual offending. For the purposes of this project, I defined family therapy as the therapist meeting with the adolescent and one or more parents to address systemic issues, such as interactional patterns and family structure, that contribute to and or maintain the youths’ sexual offending behaviors. After these interviews, I took my findings to a focus group of seven family therapists who specialize in the treatment of adolescents who sexually offend and then incorporated their feedback into the conceptual framework.

The specific research questions guiding this study were: 1) What are adolescents and parents’ experiences of participation in family therapy when the adolescent son has been required to complete treatment for sexual offending? 2) How does parent and adolescent participation in family therapy relate to adolescents’ progress in treatment for sexual offending?

\(^1\)While both parents and caregivers, such as grandparents, were included in this study, I used the term parent to represent both.
Chapter Two: Literature Review

Adolescent sexual offending hurts the victims, the adolescents who sexually offend, and the larger community. Therefore, it is imperative that researchers focus on identifying treatment methods to help adolescents stop their sexual offending behavior. Recently, there has been growing evidence that interventions that include the family appear to be effective in helping adolescents reduce sexual recidivism (Borduin et al., 1990; Borduin & Schaeffer, 2001; Worling & Curwen, 2000; Worling et al., 2010). However, little is known about the specific types of interventions or the best ways to include families in order to help adolescents’ progress in treatment for sexual offending. Furthermore, researchers have not asked adolescents and parents about their experiences and perspectives of being involved in family therapy as a part of the adolescents’ treatment for sexual offending. Understanding the adolescents’ and parents’ perspectives would help researchers identify specific family interventions that help the youth progress in treatment. To address this need, the purpose of this study was to develop a conceptual framework of family therapy in adolescents’ treatment for sexual offending based on the adolescents’ and their parents’ perspectives.

Theoretical Framework & Sensitizing Concepts

Sensitizing concepts are the preconceptions and assumptions, such as theoretical perspectives on incorporating family therapy into the treatment of adolescents who sexually offend, that informed this research study (Charmaz, 2003). Sensitizing concepts alert the researcher to look for particular processes and possibilities in the data (Charmaz, 2006). As a grounded theory researcher, I identified five sensitizing concepts in order to develop an awareness of how they might inform my inquiry (Charmaz, 2003). In the following sections, I
explain the sensitizing concepts associated with this study and discuss how they informed my thinking about doing therapy with adolescents who sexually offend and the methods for this study. Specifically, the sensitizing concepts informing this investigation are family systems theory, which is the theoretical framework associated with this study, contraindications for family therapy, the process of change, adolescence, and issues involved in working with mandated clients.

**Family systems theory.** Psychiatrists originally believed that adolescent behavior could be explained as a linear process (i.e., cause and effect) and that pathology could be explained as a response to internal or external issues that caused one’s behavior (Becvar & Becvar, 2006; Keeney, 1983). During counseling sessions, psychiatrists focused on the psychodynamic and developmental qualities of individuals that caused them problems and thus, worked with the individual in the counseling setting (Becvar & Becvar, 2006; Keeney, 1983). In the 1950s, there was a shift in this thinking when psychiatrists Gregory Bateson and the Palo Alto group (Jay Haley, John Weakland, and Don Jackson) began to incorporate ideas from general systems theory (von Bertalanffy, 1968) into their work with families, which informed the development of family systems theory (Whitchurch & Constantine, 1993).

Developed by Ludwig von Bertalanffy, general systems theory is a theoretical framework that can be used to explain how a variety of complex systems behave (von Bertalanffy, 1968; Whitchurch & Constantine, 1993). In addition to concepts from general systems theory, major concepts from cybernetics (Wiener, 1961) were also incorporated into family systems theory. Cybernetics, which developed from general systems theory, is “a science of communication that is concerned with the transmission and control of information in the widest sense” (Whitchurch
Constantine, 1993, p. 332). There are a number of concepts, central to family systems theory, that explain how families interact and influence one another and, therefore, are particularly relevant to understanding adolescents who sexually offend and family therapy with this population. These include, holism, family interactional patterns, interdependence/mutual influence, hierarchy, rules, and boundaries.

**Holism.** One central concept of family systems theory is holism. Holism means, “a system must be understood as a whole and cannot be comprehended by examining its individual parts in isolation from each other” (Whitchurch & Constantine, 1993, p. 328). Thus, a family system is more than just its individual members, it is also the way the members are aligned and interact with one another (von Bertalanffy, 1968). As applied to psychotherapy, with the adoption of the idea of holism, therapists began to look away from the individual members of the system and, instead, began to look toward how family members created problems together through the way they interacted and their patterns of hierarchy (Becvar & Becvar, 2006).

As applied to the current study, holism suggests that adolescents who sexually offend must be viewed, understood, and treated within the context of their families. However, the concept of holism goes beyond simply involving families in the youths’ treatment. It implies that the family is part of the problem *and* the solution in adolescent sexual offending. For this reason, family therapists working with adolescents who sexually offend do not assess or treat the youth in isolation of their families. They assess the entire family, identifying family characteristics, such as poor communication, boundaries, and hierarchies that may contribute to the development or maintenance of the adolescents’ deviant sexual behaviors (Ronis & Borduin, 2007). In treatment, therapists informed by the concept of holism would focus interventions on changing
the entire family system through interrupting negative interactional sequences, helping the family adjust its hierarchy and boundaries, and learning communication and parenting skills, which changes the system so that it can support the youths’ new behaviors.

**Family interactional patterns.** According to family systems theory, families develop ways of communicating and interacting that repeat themselves through feedback loops. “A feedback loop is a closed ‘circuit,’ or path, along which information can be traced from one point in a system, through one or more other parts of the system or its environment, and back to the point of origin” (Whitchurch & Constantine, 1993; p. 334). Systems can have positive and negative feedback loops. Negative feedback loops work to maintain stability and reduce change. Therefore, when change occurs in the family, other family members will adjust to bring the family back to its original state. Positive feedback loops, however, allow for change in the family. If a family member changes and the others adjust to allow this change, positive feedback has occurred (Whitchurch & Constantine, 1993). These feedback loops create repeating interactional patterns in families.

In the context of psychotherapy, rather than looking for intrapsychic or personality problems within one person in the family, therapists look for repeating interactional patterns and feedback loops within the family. Family systems therapists assume that these interactional patterns contribute to patterns of health and or dysfunction within the overall family system (Watzlawick, Beavin, & Jackson, 1967). As such, therapists work to identify these family interaction patterns, which include, “family functioning, family communication and transactional patterns, family conflict, separateness and connectedness among members, cohesion, integration, and adaption to change” (Whitchurch & Constantine, 1993, p. 330). For example, adolescents
who sexually offend have frequently experienced or witnessed abuse within their own families (Burk & Burkhart, 2003). Therefore, therapists who work one-on-one with adolescents who sexually offend help the youth work through their personal experiences of abuse, but they risk returning these youth to an abusive environment. By including parents and other family members in the adolescents’ treatment for sexual offending, family therapists have more opportunity to identify and address family interaction patterns that maintain the sexual offending behavior, such as patterns of abuse. In the example of abuse, family therapists are able to help the family change their abusive patterns through teaching communication skills, correcting the hierarchy, and helping family members change their boundaries. Then when the adolescent returns to his family, the family has learned to support the youth and his new non-offending behaviors.

**Interdependence/mutual influence.** From a family systems theory perspective, individuals exist in the context of their relationships. They are influenced by and influence others in their family system (Becvar & Becvar, 2006; Whitchurch & Constantine, 1993). Thus, if something affects one member of the family system, all members are affected (Whitchurch & Constantine, 1993). When an adolescent commits a sexual offense, his behaviors affect his parents and siblings. For example, the parents may have to focus more on the adolescent who sexually offended, including supervising him or taking him to special counseling appointments, and may be unable to give as much attention to his siblings. Similarly, the siblings may act out behaviorally as a response to their concern for their brother or lack of attention from their parents. Likewise, when the siblings act out, they may be given more of the parents attention, which may make it difficult for parents to supervise and support the adolescent who sexually offended. Family therapists leverage this idea of interdependence and mutual influence to
identify how the adolescent’s behavior is affecting other family members, how the family members’ behavior is impacting the adolescent, and then intervene as needed.

**Hierarchy.** In family systems theory, hierarchy represents the arrangements of the subsystems within the family. All the individuals in a family make up the family system. However, some of the individuals within the family combine to make up specific subsystems within the family. For instance, siblings and parents form two different subsystems of the family system, the sibling and parental subsystems. The family system and its associated subsystems are also part of a larger systems, such as the community or peers, called suprasystems (Minuchin, 1974; Whitchurch & Constantine, 1993). The concept of hierarchies in family systems would suggest that some hierarchies are correct and lead to health in the family whereas some hierarchies are incorrect and cause dysfunction in the family. For example, the parental subsystem should have more hierarchy than the sibling subsystem (Minuchin, 1974). Family systems therapists pay attention to and view the individual within the context of all of these hierarchical systems. When therapists identify hierarchies within the family that are out of order, they work to adjust them.

In families where adolescents sexually offend, the hierarchy of the family, parents in charge of children, sometimes gets reversed and the children’s desires are elevated above the parents. When this occurs, the children are not supervised adequately by the parents and are allowed to make their own rules in the family (Wieckowski et al., 1998). In addition, suprasystems may be allowed to have more influence on the children than the parents. For example, adolescents who sexually offend may be encouraged by their peers (suprasystems) to view pornography. When combined with a lack of supervision by parents, this may contribute to
the development and maintenance of sexual offending behavior (DiGiorgio-Miller, 1998).

During family therapy meetings, therapists can assess for problems in the family hierarchy and intervene to correct the hierarchy. One way a therapist might do this is by helping the parents set rules and boundaries, which may help the adolescent to stop his deviant sexual behaviors.

Rules and boundaries. From a family systems perspective, families have rules that govern their behavior. These rules are generally not spoken or even understood by the family members. Rules express the family’s values and form boundaries that distinguish the family from other systems. These boundaries determine what information is allowed to leave and come into the system (Becvar & Becvar, 2006; Minuchin, 1974). Depending on the degree to which a family’s boundaries are permeable, they are considered an open (very permeable) or closed (impermeable) system. Along with looking at the boundaries between the family and the suprasystems within which they are embedded, family systems therapists are also interested in the boundaries between subsystems within the family (Minuchin, 1974; Whitchurch & Constantine, 1993). Family systems therapists assume that, in order to maintain health, the family needs to regulate how much information they allow between the subsystems that are on different hierarchical levels.

In family therapy with adolescents who sexually offend, therapists look for rules and boundaries that are too open or too closed so that they are having an impact on the adolescent’s behavior in a negative way. For example, therapists assess for boundaries that are too open, such as the parents allowing the youth to view pornography or inappropriate touching between the siblings (DiGiorgio-Miller, 1998). Likewise, therapists would look for boundaries that are too closed, such as parents being too rigid and not listening to their kids’ concerns about
inappropriate touch or communication. Therapists would talk about family boundaries and rules in family therapy and, in the case of boundaries that were too open, would help the parents set rules to limit what the children could see on the television and encourage better boundaries between the children to stop inappropriate touching. In the case where boundaries were too closed, therapists would help parents to listen to and appropriately address the kids’ concerns.

Summary. Therapists who work from a family systems perspective view adolescents who sexually offend as part of a larger system, namely their family system. They further conceptualize these families within the context of their larger systems, such as peers and the larger community. Additionally, family systems therapists see families as being made up of interconnected and interdependent individuals and believe that adolescents who sexually offend are best understood, not in isolation, but within the larger system of their family. Whereas individual psychology therapists focus on the problem of sexual offending resting within the individual, family systems therapists see sexual offending as an interaction between individuals and their greater systems (i.e., families and communities). Whether the sexual offending originates within or outside of the person, family systems therapists believe that problematic sexual behavior will be resolved or exacerbated within the interactions between other members of the system. Therefore, the focus of family systems interventions is on changing the structure (hierarchy, rules, and boundaries) and interactional patterns of the system to allow for behavior change within the adolescent who has sexually offended. Involving families in the treatment of adolescents who sexually offend can help therapists recognize certain systemic issues that maintain the adolescents’ deviant sexual behaviors and intervene in the family system in order to help the adolescent stop his sexual offending behaviors.
In addition to providing insight into how the family is relevant to the understanding of adolescent sexual offending, the concepts of family systems theory can also be applied to developing a conceptual framework of family therapy in adolescents’ treatment of sexual offending. That is, researching one part of the treatment constellation in isolation, such as the adolescents’ or the researchers’ perspectives, only provides part of the whole understanding of what is helpful for the adolescents’ treatment. Researchers need to consider how the interactional patterns of the parents and adolescents, including the rules, boundaries, and hierarchies within the family influence the youths’ treatment. In addition, researchers need to learn how the youths’ treatment impacts the family. Therefore, when asking parents and adolescents about their experiences in family therapy, researchers should ask questions that help adolescents and parents talk about how they affect one another and how the therapeutic interventions impacted their relationships. As a result of this type of systemic questioning, researchers may hear stories about specific interventions that helped change the interactions between the parents and the adolescents and how these interactions helped or hindered the youth in his treatment. Researchers can then integrate this data with current conceptualizations of family therapy to develop a more comprehensive conceptual framework of family therapy and make recommendations about how therapists can best involve parents in the adolescents’ treatment for sexual offending. Thus, to develop a more complete conceptualization of family therapy in the treatment for adolescents who sexually offend, this study integrated adolescent, parent, and therapist perspectives of how parental involvement in family therapy helps or hinders the adolescents’ progress in treatment.

**Contraindications for family therapy.** Family therapists attempt to include as many of the nuclear family and sometimes extended family members in family therapy as possible
However, from my clinical experience and personal communication with J. Teitelbaum (March 6, 2013), a family therapist who specializes in working with adolescents who sexually offend, I have noted that when working with adolescents who sexually offend, there are times when including family members may be contraindicated. If there is active abuse in the family, such as a parent physically or sexually abusing a child, the abusing member should not be included. This is because it is important that the family therapy sessions are a safe place for all members of the family. If the abusing member in the family is attending family therapy, the therapist will not be able to ensure the victim family members’ safety. In addition, if parents are denying or minimizing the abuse or aligning with the youth who offended against the child or sibling who was offended, then the therapist should limit these parents’ involvement. Similarly, if parents are triggered by the issues of the adolescent who had sexually offended, as is sometimes the case when parents have past issues of sexual abuse, then they should not be included (Teitelbaum, 2013).

Family therapists working with adolescents who sexually offend, should assess families for these relational dynamics, such as abuse within the family and parents’ denial, that would indicate that family therapy is contraindicated. In these cases, the therapist should work with these parents separately to help them recognize and stop minimizing the abuse and, if necessary, give them a referral for individual counseling to work through abuse issues and past traumas. Once the parents have worked through their individual issues and are ready to appropriately support all the children in the family, they can join family therapy.

In the context of the current research, this sensitizing concept was essential in informing the inclusion criteria for the participants. Specifically, I developed inclusion criteria that would
minimize the likelihood of interviewing adolescents and parents who should not be doing family therapy together. To participate, I required adolescents and parents to have done 10 sessions of family therapy. This was based upon my assumption and past experience (because this has not been discussed in the literature) that family therapists would not be doing family therapy in the above mentioned situations. In addition, I interviewed the adolescents separate from the parents. This allowed the adolescents and parents to speak freely without the threat of the parent or adolescent in the same room with a potentially unsupportive or abusing family member, which may have limited their responses.

**Process of change.** Prochaska, Norcross, and Diclemente (1995) developed the transtheoretical model of change to explain clients’ process of change. This model includes five stages of change. Prochaska and colleagues proposed that people change their behaviors, thoughts and feelings through a gradual process versus an instant decision to change (Prochaska & Norcross, 1999). In the first stage, precontemplation, clients have no intention of changing their behaviors and may be unaware that they have a problem. In the second stage, contemplation, people are aware they have a problem and are seriously considering taking action but have not made a commitment to change anything yet. In the third stage, preparation, people are intending to make changes but have been unsuccessful so far. The fourth stage, action, is where people actually make changes through modifying their behaviors, thoughts, and feelings to overcome their problems. The final stage, maintenance, is where clients work to maintain the changes they have made (Prochaska et al., 1995). At the heart of this model of change is the idea that many factors can influence the change process at any point among the five stages (Prochaska & Norcross, 1999).
This transtheoretical model of change has been applied to working with adolescents in treatment for a variety of mental health issues. Miller and Rollnick (2002) suggested that when people connect behavior change to something that is important to them, such as family, they experience greater behavior change. Related to this idea, several researchers have examined how the adolescent’s family impacts the adolescent’s motivation or desire to change. In a study of motivation to change with 310 minority adolescent males who were using drugs and/or alcohol, Austin, Hospital, Wagner, and Morris (2010) found that when adolescents perceived an increase in parental support, they had an increase in motivation for substance use change. Similarly, Zaitsoff and Taylor (2009) found that, for adolescents who were in treatment for eating disorders \((n = 54)\), reporting a good parental relationship was an important predictor of treatment motivation. In addition, in a sample of 140 shelter-recruited adolescents and their caregivers, Slesnick and colleagues (2009) found that, when adolescents perceived their family environments as being negative, they experienced more depressive symptoms, which increased their motivation to change. Taken together, these studies suggest that the quality of parent-adolescent relationships is related to adolescents’ motivation for change for a number of mental health issues and behavioral problems. Thus, when doing therapy with adolescents who sexually offend, it is crucial to consider their relationships with their parents and home environment. By including parents in family therapy, therapist can help increase positive interactions and improve relationship quality between the adolescents and parents, which may increase their motivation to change.

It is important to consider adolescents’ motivation to change and the process of change when creating a conceptual framework for parental participation in family therapy with the
adolescent as a part of his treatment for sexual offending. Of particular importance is the stage of change the adolescents and parents are in at the time of the interviews. According to the transtheoretical model of change (Prochaska et al., 1995), if the participants were in the first three stages, precontemplation, contemplation, or preparation, they likely would not have made substantial modifications to their behavior and would not be able to articulate the process of how they made progress in their treatment and what was helpful and not helpful in their treatment progress. To increase the possibility that participants were actively making changes, in the action or maintenance stages, I required that they had completed at least 10 family therapy sessions, which would have given them time in the program to start making changes individually and as a family.

Furthermore, the purpose of the current study was to develop a conceptualization of family therapy in the youths’ treatment for sexual offending and to explore how parent and adolescent participation in family therapy linked to adolescents’ progress in treatment. Understanding how clients perceive they make changes, particularly how parents may contribute to or hinder the adolescents progress in treatment, may help researchers make recommendations that could improve the adolescents’ motivation to change and engagement in treatment, which may affect treatment success (Miller & Rollnick, 2002). Thus, throughout the process of interviewing the adolescents and their parents and analyzing the data, I was listening for stories about how the adolescents and parents perceived the youth changing and how adolescent and parental involvement in family therapy linked to that process.

**Adolescence.** Boys are considered to be in the developmental stage of adolescence between the ages of 12-21 (Carter & McGoldrick, 2005). Erikson claimed that the primary goal
of adolescence is identity development (Erikson & Rapaport, 1968). During this stage, adolescents begin to move towards independence and seek emotional separation from their parents. They start questioning in order to develop their own opinions and values. As they establish their independence, they begin making decisions about who they want to be as adults. According to Piaget (Inhelder & Piaget, 1995), adolescents enter the formal operations stage of cognitive development. This means that they are more able to think conceptually, which allows them to think about their futures and imagine limitless possibilities for themselves (Crain, 2005).

In addition, adolescents are experiencing an ability to be more disciplined in physical and intellectual work (Carter & McGoldrick, 2005).

Adolescence is marked with rapid physical and sexual changes, which can cause uncertainty as they seek to develop their identities (Carter & McGoldrick, 2005). As youth are developing physically, they gain better coordination and physical skills. In addition, adolescents experience an increased awareness of sexuality. They may experiment with sexual relationships as they learn to handle their sexual impulses and seek to develop their sexual identities (Carter & McGoldrick, 2005).

In addition to developing their sexual identity, adolescents are exploring who they are emotionally and socially. They experience increased emotional competence and begin to understand their identity in relation to other people, i.e. their families and peers. As they are understanding themselves better, they seek to express who they are, who they want to be, in the midst of social pressure to conform to peers, parents, and societal views of themselves. They are learning to balance caring about themselves and others (Carter & McGoldrick, 2005).
Therapists who work with adolescents who sexually offend need to support specific adolescent developmental needs, namely youths’ search for identity and independence. There are several things therapists working with adolescents who sexually offend can do to accomplish this. First, it is important to normalize typical adolescent developmental issues. For example, many adolescents who sexually offend also struggle with social skills and thus experience social isolation (Hendricks & Bijleveld, 2008; Ronis & Borduin, 2007). It is important not to assume that lack of social skills are because of the youths’ sexual offending. Rather, therapists could talk with youth and their parents about how adolescence is a time when youth are struggling to find their place amongst their peers.

One developmental issue that is of particular importance to adolescents who sexually offend is sexuality. Not all of the adolescents’ sexual behaviors should be seen as deviant. Therapists should help adolescents learn about healthy sexuality and to recognize which of their sexual behaviors are typical. Furthermore, according to systems theory, parents may be the best people to help youth to learn about healthy sexuality. Therapists can support parents through giving them specific ideas of how to talk with their kids about sex and help parents learn how to monitor adolescents and differentiate healthy from deviant sexual behaviors.

While adolescents are seeking to become independent from their parents, they are also trying to learn who they are in the context of their families. Therapists can support the youths’ search for independence and identity development by helping parents and adolescents to have respectful conversations. Specifically, therapists can help adolescents to express their concerns, views, and values to their parents. In doing so, therapists can help parents listen to youth and validate their concerns and need for independence, which will help parents and adolescents to
develop healthy interactional patterns (Watzlawick et al., 1967; Whitchurch & Constantine, 

This sensitizing concept informed this research with adolescents and the development of 
the conceptual framework of family therapy. One of my initial goals in doing research with 
adolescents who sexually offend and their families, was to give voice to the adolescents by 
asking their perspectives and reporting their views. Thus, supporting their identity development. 
In addition, there were specific things I did to support the adolescents desire to share their views 
and opinions and gain independence from their parents. First, I interviewed adolescents 
separately from their parents. This allowed adolescents to share their perspectives without the 
risk of their parents dominating the conversation. I also asked the adolescents if they wanted to 
participate in the study. Furthermore, adolescent developmental perspective is important to keep 
in mind as therapists use this conceptual framework for family therapy with adolescents who 
sexually offend.

Mandated clients. Adolescents who sexually offend are mandated to specialized sexual 
offending treatment by a court order (Hunter & Lexier, 1998). As a part of this treatment, they 
are often required to do some family counseling (McGrath et al., 2010). While their parents are 
not court ordered to treatment, if they want their sons to succeed (which means following the 
rules of the treatment program), they must participate in counseling. In effect, this makes the 
parents mandated clients as well. There are some special issues to consider when doing 
counseling with and researching mandated clients.

As a part of sexual offending treatment, adolescents are required to disclose all of their 
deviant sexual behavior (Hammack, 2003; McGrath et al., 2010). This often means that
adolescents will need to disclose sexual offenses that have not yet been reported to the authorities. Disclosing these offenses is an important treatment issue because therapists will use the information to help the adolescent in treatment. However, it is also a legal issue because clinicians have no choice but to report new disclosures to authorities (Hunter & Lexier, 1998). Thus, adolescents may be hesitant to talk about their offenses, which can affect their treatment outcomes because adolescents are often required to disclose all of their offenses as part of treatment.

In addition to not wanting to disclose their sexual offenses, adolescents who sexually offend and their parents may not be forthcoming during the treatment process because they may be worried about consequences if the therapist learns about problems within the family. Therapists are required to give regular reports of the clients’ behavior and progress in treatment to their probation officers (Hunter & Lexier, 1998). For example, if an adolescent was left unsupervised during a home visit, even for a short amount of time, the therapist may be required to report this probation violation. His probation officer may give him consequences, such as a stay in detention, for this type of violation. In addition, if adolescents are not progressing in their treatment, their probation officers may give them more severe consequences, such as removing them from their homes or a residential treatment program and transferring them to a more secure setting, such as a locked facility. Being required to report probation violations can make it hard for the therapists to engage and build trust with parents and adolescents, which may further inhibit the process and outcomes of family therapy.

Therapists working with adolescents who sexually offend from a family systems perspective consider how individual issues, such as the youth talking about problems in the
family, affect the whole family as well as the youths’ treatment outcomes (Whitchurch & Constantine, 1993). Thus, a conceptual framework of involving parents in their sons’ treatment for sexual offending needs to account for special issues of mandated clients, such as the youth disclosing sexual abuse and discussing sensitive family issues.

Issues of working with mandated clients may also arise as part of doing research with adolescents who sexually offend and their parents. First, during interviews, adolescents and parents may not be open about their experiences with the researchers because they are connected, if only by the referral, to the juvenile department and treatment centers. On the other hand, they may be more honest because the researchers can assure confidentiality, with the exception of mandatory reporting laws. For this reason, in the present study, special care was taken to obtain informed consent from participants before beginning the interviews. During this process, I talked to the adolescents and parents separately about whether they wanted to participate. I discussed the purpose of the study and the limits of confidentiality. I explicitly told participants what I would be required to talk to their juvenile court counselors/DHS workers about, such as reporting abuse. In addition, I clearly told parents and adolescents that I was not going to ask them any information about the adolescents’ sexual abusing behaviors. Furthermore, I talked with the participants about how I would present the data and conceal identifying information. I told the adolescents and parents that their caseworkers and therapists would not know what they specifically told me except for cases of reporting previously undisclosed sexual abuse. Finally, I told the adolescents and parents that they did not have to participate and that participation would not affect the youths’ treatment.
Individual Characteristics of Adolescents Who Sexually Offend

Historically, clinicians applied adult sex offender treatment models, such as relapse prevention and cognitive behavioral therapy (CBT), to adolescents who had sexually offended (Letourneau & Miner, 2005; Rasmussen, 2013; Smith, Wampler, Jones, & Reifman, 2005). Given that sexual recidivism rates for adolescents who sexually offend are so low (Reitzel & Carbonell, 2006), there is a subgroup of adolescents who do not continue to sexually offend as adults. Thus, scholars tend to agree that adolescents who sexually offend and adults who sexually offend are different groups (Smith et al., 2005). For this reason, it is generally accepted that using treatment models designed for adults to treat adolescents who sexually offend is problematic because these models fail to address specific the developmental issues associated with adolescence (Rasmussen, 2013). In fact, Rasmussen asserted that using adult models with adolescents who sexually offend “subjects youth to interventions that are developmentally inappropriate, potentially harmful, and ultimately ineffective” (p. 122). Considering that adolescents who sexually offend are different from adults who sexually offend, clinicians and researchers need to focus on developing and researching treatment techniques that are effective with adolescents and address issues specific to adolescents.

To this end, researchers have attempted to identify specific characteristics that are unique to adolescents who sexually offend (Worling, 2001). However, in a study comparing adolescent sexual offenders (n = 46), adolescent nonsexual offenders (n = 46), and nondelinquent youths (n = 23), Ronis and Borduin (2007) concluded that individual characteristics of sexual offending juveniles are very similar to those of non-sexual offending delinquents. Similarly, Zakireh, Ronis, and Knight (2008) compared adolescents who had sexually offended (n = 50) with
adolescent delinquents who did not sexually offend \((n = 50)\) and confirmed that adolescents who sexually offend are a heterogeneous group with diverse individual and family characteristics. Because adolescents who sexually offend are different from adults who sexually offend and are more similar to nonsexual offending delinquents than they are different, treatment for adolescents who sexually offend should focus on individual characteristics of adolescents who sexually offend, such as academic problems and social characteristics.

**Academic characteristics.** In general, delinquent youth, whether they sexually offend or not, have academic difficulties. Specifically, adolescents who sexually offend have been found to have lower academic achievement and increased school truancy than their nondelinquent peers (Fehrenbach, Smith, Monastersky, & Deisher, 1986; Ford & Linney, 1995; Ronis & Borduin, 2007). In the previously mentioned study, Ronis and Borduin (2007) found that adolescents who sexually offended had lower grades than non-delinquent youth.

**Social characteristics.** Adolescents who have been adjudicated for sexual offending have been found to have more involvement with delinquent peers and to have problems with social skills and social isolation (Hendricks & Bijleveld, 2008; Ronis & Borduin, 2007). In a comparison study of sexually delinquent \((n = 78)\), non-sexually delinquent \((n = 156)\), and non-delinquent youth \((n = 80)\), Miner and Munns (2005) found that juveniles who had sexually offended were significantly more socially isolated than non-delinquent youth. They also scored higher on peer isolation than non-sexual delinquents. In the study mentioned previously, Ronis and Borduin (2007) also found that adolescents who sexually offend had fewer prosocial peers and more frequent association with delinquent peers than the nondelinquent youth.
Because adolescents who sexually offend typically struggle with academic success and social skills, these individual characteristics should be considered in their treatment. From a family systems perspective, adolescents’ parents may be in the best position to help youth navigate academic and social problems. For example, family therapists can help parents develop structure, including rules and consequences that will encourage youth to attend school, which can help their academic performance. In addition, therapists can help parents access community resources, such as a tutor to help the youth improve their grades. Also, family therapists can help parents teach youth social skills and give them opportunities to practice new social skills. Thus, individual characteristics should be considered and addressed in a comprehensive conceptual framework of family therapy in the youths’ treatment for adolescent sexual offending.

**Family Characteristics of Adolescents Who Sexually Offend**

In addition to examining their individual characteristics, researchers focused on adolescents who sexually offend have begun to examine how family characteristics may be associated with the adolescents’ sexual offending behaviors. Specifically, family characteristics, such as insecure attachment, abuse within the family, poor boundaries, inadequate supervision, and low family bonding have been found to contribute to the development and maintenance of adolescent sexual offending behavior (Burk & Burkhart, 2003; Daversa and Knight, 2007; DiGiorgio-Miller, 1998; Rasmussen, 2013; Ronis and Borduin, 2007). Because this research reveals that adolescents develop and maintain sexual offending behaviors within the context of their families, it becomes apparent that in order to successfully treat these adolescents, it is important to address their family characteristics and interactions through family therapy or other family-based interventions.
Insecure attachment to primary caregivers. Researchers have used attachment theory to explain adolescent sexual offending (Burk & Burkhart, 2003; Marshall, Hudson, and Hodkinson, 1993; Marshall & Marshall, 2000). Adolescents who sexually offend often come from chaotic families and experience a greater amount of sexual abuse than non-sexual offenders (Burk & Burkhart, 2003). As a result, these adolescents have often experienced disrupted relationships with their parents during childhood and, thus, have developed insecure attachments, conceptualized as an inability to connect and trust that their primary caregivers will be there for them (Marshall & Marshall, 2000). Marshall and colleagues (1993) argued that because these adolescents have experienced attachment disruptions, they have not developed a secure internal working model, an internal image of their caregiver that provides safety and skills for future relationships, and might struggle with and experience isolation and poor peer relationships. Adolescents who are isolated from their peers often experience a lack of intimacy and emotional loneliness (Marshall et al., 1993). They may be at risk for increased aggression and are at a disadvantage when they are confronted with normal adolescent decisions about sexuality (Marshall et al., 1993). In addition, they do not have the social skills that they need to be in sexual relationships with same aged peers (Marshall et al., 1993). Marshall and colleagues theorized that because forcing someone to have sex does not require social skills, adolescents who lack social skills and have disrupted attachments are particularly at risk for sexually offending.

Burk and Burkhart (2003) proposed that adolescents who sexually offend have a disorganized attachment; while under stress, they lack the ability to organize responses to obtain needed security. Thus, these adolescents are not able to comfort themselves when they
experience stress. In addition, they have not mastered a sense of self-control that securely
attached adolescents have mastered. Therefore, adolescents who sexually offend may look for an
external sense of control and coping strategies, which may explain why some adolescents choose
to sexually abuse others. Burk and Burkhart (2003) explained, “For some individuals, sexual
offending behavior is a part of larger interpersonal pattern aimed at avoiding a more disorganized

In sum, theorists and researchers have argued that the development of insecure
attachment with primary caregivers, often stemming from emotional, physical, and sexual abuse
in families, at least in part, explains why some adolescents sexually offend (Burk & Burkhart,
2003; Marshall et al., 1993; Marshall & Marshall, 2000). This conclusion highlights the family
systems concepts of holism and interdependence/mutual influence, which suggest that sexual
offending develops within a relational context, such as the family system (von Bertalanffy, 1968;
Whitchurch & Constantine, 1993). Thus, within the context of intervention, therapists often
consider how poor attachment between the adolescent and his parents influences the
adolescents’ deviant sexual behaviors. Family therapists can work with parents and youth to have
more positive connections and develop stronger bonds.

**History of abuse.** Adolescents who sexually offend experience higher rates of abuse
within their families than adolescents who do not sexually offend (Burk & Burkhart, 2003). In a
meta-analysis, Seto and Lalumière (2010) compared male adolescents who sexually offended \( n = 3,855 \) with adolescent delinquents who had not sexually offended \( n = 13,393 \). They found
that 46% of the adolescents who had sexually offended had experienced sexual abuse, compared
with 16% of the non-sexually offending delinquents. In a study of family violence and juvenile
sex offending, Caputo, Frick, and Brodsky (1999) found that male adolescents who had sexually abused \((n = 23)\) had witnessed more severe domestic violence than violent non-sexual offenders \((n = 17)\) and non-contact \((n = 29)\) offenders. Similarly, in a study comparing sex offending and conduct disordered youth, Tabacoff (2000) found that male adolescent sexual offenders \((n = 50)\) had witnessed more domestic violence, had fathers who perpetrated more domestic violence, and were more likely to have mothers who were victims of domestic violence than a group of non-sexually offending adolescents \((n = 46)\). Finally, in a study of 90 adolescent sexual offenders, Worling (1995) found that adolescents who had offended siblings reported more physical punishment from parents, increased feelings of being rejected by parents, more exposure to marital conflict, more negativity and arguing in the family, and less satisfaction with family relationships. Collectively, based on these studies, it is clear that adolescents who sexually offend are very likely to have experienced violence within their families.

There are a number of ways that being exposed to violence and abuse may contribute to the development of adolescent sexual offending. Over a period of five years, Daversa and Knight (2007) used the Multidimensional Assessment of Sex and Aggression (MASA; Knight & Cerce, 1999; Knight, Prentky, & Cerce, 1994) to collect data from 329 adolescent sexual offenders in impatient treatment facilities throughout four northeastern states. They found that adolescents who were emotionally or physically abused developed sexual offending behaviors through the following pathways: 1) experiencing psychopathy and sexual fantasy, which lead the adolescents to fantasize about child victims; 2) experiencing sexual inadequacy, sexual fantasy, and child fantasy, which lead to them to offending children, 3) experiencing sexual inadequacy, fantasizing about children, to sexually abusing children, and 4) directly abusing a child. The authors
concluded that early developmental and childhood maltreatment, such as experiencing family violence, disrupts secure attachment. Disrupted attachment, along with mediating personality characteristics such as impulsivity, contributed to the prediction of sexual crimes against young victims. In discussing these pathways, the authors made a special point of emphasizing that emotional abuse by parents had a key role in the development of psychopathology and sexual inadequacy among adolescents who sexually offend (Daversa & Knight, 2007).

Given the evidence that abusive or neglectful interactional patterns within families are connected to adolescents’ sexual offending, treatment providers should assess for and address abusive relationships in treatment (Daversa & Knight, 2007). Addressing abuse between parents, between the parents and adolescents, and between siblings may be best done within the context of family therapy (Whitchurch & Constantine, 1993). For example, family therapists can meet with the parents together without the children in order to address their interpersonal patterns of abuse. After the parents have been able to work through their issues and establish new patterns of interaction, family therapists can help strengthen parents’ connections with their youth and establish a new family rule that violence is not acceptable. One intervention that is particularly helpful in this regard is having parents apologize to youth for allowing violence in the home and talk to the youth about how violence is no longer acceptable, thus overtly changing the family rule (Madanes, 1990).

**Poor boundaries and chaotic family environments.** Families of adolescents who sexually offend often demonstrate poor boundaries, such as lack of privacy, open displays of sexualized behavior, sexualized talk, access to pornography, and inappropriate touching (DiGiorgio-Miller, 1998). In one study, Baker and colleagues (2003) compared 29 male
adolescents who had been adjudicated for sexual offending with 32 male adolescents with conduct disorder diagnoses. They found that the adolescents adjudicated for sexual offending had families that told more lies, perpetuated more family myths, exhibited more taboo behaviors, and exhibited more sexualized behaviors than families of adolescents with conduct disorders.

Similarly, Wieckowski and colleagues (1998) interviewed 30 adolescent males, ages 12 to 15, who had sexually offended. They found that 40% of the adolescents had lived in family environments with poor boundaries, lack of parental supervision, confusion about parental roles, and parents who set inconsistent rules and limits. In addition, 11% of the adolescents lived in “chaotic environments where primary caregivers were absent from the home for long periods of time without explanation, strangers arbitrarily came in and out of the home, caregivers frequently changed residences, or there was frequent police involvement within the family” (p. 299).

Based on these findings, it seems clear that a large number of adolescents who sexually offend come from families that demonstrate poor boundaries and chaotic family environments. This highlights how family systems concepts such as interactional patterns, hierarchy, rules and boundaries, explain the family-based nature of sexual offending. More specifically, a family environment where parents are not in charge (e.g., reversal of hierarchy) results in a lack of rules and inappropriate boundaries, which may encourage the adolescent to sexually offend (Minuchin, 1974; Whitchurch & Constantine, 1993). Given that poor boundaries are likely playing a role in maintaining the youths’ deviant sexual behaviors, addressing them in family therapy may help youth progress in treatment. For example, family therapists can teach parents skills to help parents provide more structure for their children, such as setting and enforcing rules.
Poor family bonding. Another family characteristic that may contribute to the development and maintenance of adolescent sexual offending behavior is poor family bonding. Ronis and Borduin (2007) compared male adolescents with sexual offenses \((n = 46)\) to male adolescents with non-sexual offenses \((n = 46)\) and male adolescents with no offense records \((n = 23)\). They asked the adolescents and their primary caregivers (primarily biological mothers; \(n = 111\)) to complete self-report instruments, behavior rating inventories, and a family interaction task. Family bonding was defined as cohesion and warmth (lower negative affect). Compared to the non-delinquent group, the adolescent offenders (both sexual and non-sexual offense groups) reported significantly lower levels of family cohesion and adaptability. In addition, the families of the adolescent offenders expressed more negative affect than the families of the non-delinquent adolescents. Ronis and Borduin stated that this finding is consistent with developmental theory that links adolescent delinquency to poor family bonding. However, more research is needed to identify how poor family bonding contributes to delinquent behavior, such as adolescent sexual offending.

Given that the rate of poor family bonding is higher in families with adolescents who sexually offend, including families in the adolescents treatment of sexual offending would allow therapists to address these issues by intervening in the family structure and hierarchy (Minuchin, 1974). For example, therapists could teach families communication skills and help them to practice those skills in family counseling sessions, which may help families feel more connected.

Summary. Published research indicates that adolescent sexual offending behavior develops within the family context through pathways of physical, sexual, and emotional abuse (Daversa & Knight, 2007; Knight & Sims-Knight, 2004), insecure attachments with primary
caregivers (Araji, 1997; Burk & Burkhart, 2003; Marshall et al., 1993), poor family boundaries, chaotic family structures (Baker et al., 2003), and poor family bonding (Ronis & Borduin, 2007). When viewed from the perspective of family systems theory, this research demonstrates that adolescents do not develop and maintain sexual offending behaviors in isolation. Rather, they develop these problematic sexual behaviors within the context of their families. Furthermore, the structure, hierarchy, and interactional patterns within the family often help maintain the youths’ sexual offending behaviors. Thus, including and addressing family issues must be part of the successful treatment for adolescent sexual offending.

While the existing literature points to the importance of the family in understanding the etiology of adolescent sexual offending, this research needs to be extended to identify specific interventions that would help change these family patterns and reduce the prevalence of adolescent sexual offending. Though addressing these family characteristics and interactions in family counseling, therapists can help families develop family interactional patterns, hierarchy, and structure that will support the adolescents changing their deviant sexual behaviors. Through this study, I sought to identify specific family therapy interventions that adolescents and parents found useful in helping to change these types of patterns within their families.

**Treatment of Adolescents Who Sexually Offend**

There are multiple approaches to treatment for adolescents who sexually offend, with two of the most popular approaches being cognitive behavioral therapy (CBT) and family therapy. As discussed previously, existing empirical evidence suggests that adolescents develop and maintain their sexual offending behaviors within the context of their families (Burk & Burkhart, 2003; Daversa and Knight, 2007; Ronis & Borduin, 2007). Thus, family therapy may be an important
part of the treatment for adolescents who sexually offend and, in some cases, may be more effective in treating adolescents who sexually offend than treatment approaches focused on the individual (Henggeler et al., 2009; Reitzel and Carbonell, 2006; Worling et al., 2010). In the following sections, I review cognitive-behavioral and family therapy treatments for adolescents who sexually offend, and treatment outcomes.

Cognitive-behavioral treatment. Treatment providers have primarily used cognitive-behavioral treatment (CBT), thus making it the standard of care for treating adolescents who sexually offend (McGrath et al., 2010). In a survey of treatment programs, McGrath and colleagues found that 64% of community programs \((n = 268)\) and 70% of residential \((n = 96)\) adolescent sexual offending treatment programs use a cognitive-behavioral treatment approach.

Cognitive-behavioral therapists focus on how the interaction of cognitions, emotions, and behavior influence adolescents’ sexual offending behaviors. Therapists using this approach believe that feelings and behavior are caused by internal thoughts rather than external influences. It is not people or situations that are problematic for clients; rather, the clients' interpretations or thoughts about those situations or people. Psychopathology is a result of incorrect perceptions of reality that then lead to “faulty” thinking that causes symptoms. The focus of therapy is helping clients change the way they think, and encouraging them to act differently based upon those thoughts. This change in thinking then resolves problematic feelings and behavior (Hammack, 2003; Kolko, Noel, Thomas, & Torres, 2004; National Association of Cognitive-Behavioral Therapy, 2008).

Cognitive-behavioral treatment for adolescents who sexually offend “should at least involve attempts to change internal processes – thoughts, beliefs, emotions, physiological arousal
alongside changing overt behavior, such as social skills or coping” (Kenworthy, Adams, Bilby, Brooks-Gordon, & Fenton, 2003, p. 3). Treatment goals of CBT programs for adolescents who sexually offend include changing problematic thinking patterns, becoming accountable for offending, developing social/relationship skills, developing healthy relationships, developing and demonstrating empathy towards the victim, controlling sexual arousal, preventing relapse, resolving personal victimization issues, managing emotions, developing support through skill building, managing emotions, and increasing self-esteem (Becker & Hunter, 1997; Fanniff & Becker, 2006; Hunter & Figueredo, 1999; Kolko et al., 2004; McGrath et al., 2010; Veneziano & Veneziano, 2002). Typically, parts of each of these goals are addressed in each session throughout treatment. Group treatment focusing on individual factors, such as sexual arousal and relapse prevention, have been the most common treatment modality used by cognitive-behavioral programs (McGrath et al., 2010). Family sessions are less common in CBT programs (McGrath et al., 2010). Several other researchers have also reported that most CBT programs primarily use individual or group therapy to focus on individual problems, such as problematic behaviors and thoughts (Becker & Hunter, 1997; Hunter & Figueredo, 1999; Veneziano & Veneziano, 2002).

While CBT therapists address some important issues, such as the adolescents’ problematic thinking, because of the individual and internal focus, the CBT approach neglects important family dynamics such as hierarchies, interactional processes, and household rules, family roles, and boundaries that contribute to the development and maintenance of the adolescents’ sexual offending behavior (Borduin & Schaeffer, 2001). Because adolescent sexual offending does not develop in isolation, but within the family context (Burk & Burkhart, 2003; Daversa & Knight, 2007; Ronis & Borduin, 2007), traditional treatment issues (e.g., being
accountable and developing healthy relationships) targeted by CBT therapists may be more successfully addressed within the family context.

**Family therapy.** In contrast to the individually-focused CBT approach, family systems therapists view adolescents’ sexual offending behavior within the context of their families. Family therapists consider how family characteristics (e.g., insecure attachment, abuse within the family, poor boundaries, inadequate supervision, and low family bonding) have contributed to the development and maintenance of the adolescents’ deviant sexual behaviors. Therapists using this perspective work with the family to change maladaptive relationship patterns to help adolescents stop their sexual offending behavior and prevent recidivism (McGrath et al., 2010). In the next section, I discuss multisystemic treatment, which is an approach with a strong family systems emphasis.

**Multisystemic treatment.** Multisystemic treatment for adolescents who sexually offend is a treatment program that combines cognitive-behavioral techniques with family interventions. Ronis and Borduin (2007) recommended, “treatments should be able to address multiple factors associated with adolescent sexual offending, including behavior problems, family relations, peer relations, and academic performance” (p. 161). Multisystemic therapy has its foundations in Bronfenbrenner’s (1979) social-ecological theory and uses aspects of strategic family therapy, structural family therapy, behavioral parent training, and cognitive-behavioral therapy (Borduin & Schaeffer, 2001). Multisystemic “interventions target identified adolescents and family problems within and between the multiple systems in which family members are embedded, and such interventions are delivered in the natural environment (home, school, neighborhood) to optimize ecological validity” (Borduin & Schaeffer, 2001, p. 32).
Multisystemic therapists address individual, family, and societal problems that have been associated with adolescent sexual offending (Borduin & Schaeffer, 2001). Then, therapists work with individual family members or conjointly with family members and other appropriate persons to develop a treatment plan that focuses on the safety of the victims, reducing the risk of sexual offending, and relapse prevention (Borduin & Schaeffer, 2001). At the individual level, multisystemic therapists address biological issues of all the individuals in the family such as ADHD or anxiety (Borduin & Schaeffer, 2001), which affects the entire family system. In addition, therapists work individually with the “youth or parent to modify the individual’s social perspective-taking skills, belief system, or attitudes that contribute to offending and sexual assault cycle” (Borduin & Schaeffer, 2001, p. 33). At the peer level, multisystemic therapists help adolescents learn social and problem-solving skills. They encourage adolescents to get involved with after school activities, athletics, or church adolescent groups to increase positive friendships, date, and decrease negative peer interactions.

At the family level, multisystemic therapists assess for barriers to effective parenting, such as abuse, parental psychopathology, parental drug and alcohol abuse, parental psychopathology, low social support, conflict in the marriage, and general stress. The therapist’s goal is to help parents remove these barriers through providing information about parenting, empowering parents, and promoting positive communication and affection between members in the family (Borduin & Schaeffer, 2001). For example, multisystemic therapists support and encourage parents to communicate with teachers and track their adolescents’ grades. In addition, therapists help parents to set consequences and limits for their adolescents (Borduin & Schaeffer, 2001). In cases where adolescents have offended people within the family (i.e. siblings), these
victims are given individual treatment to deal with the sexual assault. Even in this situation, the parent is involved in the interventions and, thus, is reinforced as an agent of change (Borduin & Schaeffer, 2001).

Multisystemic therapy is an example of treating adolescents who sexually offend in the context of their families to address family dynamics that contribute to the development and maintenance of the adolescents’ sexual offending behavior. Because of the special training that is required for therapists to use MST and the prohibitive cost associated with an MST treatment program, MST is not a solution for most therapists working with adolescents who sexually offend. Therefore, it is important to learn about the specific family therapy interventions that may make a difference for adolescents and parents in the youths’ treatment for sexual offending.

**Treatment Outcomes**

Researchers have demonstrated the importance of including families in adolescents’ treatment for sexual offending through outcome studies. Using sexual recidivism rates, re-offending, as an indicator of successful treatment outcomes, researchers have established that any specialized treatment for sexual offending is helpful (Reitzel & Carbonell, 2006). While I was not able to find any effectiveness studies that evaluated family therapy specifically, there are several studies on multisystemic therapy, a treatment model that uses family therapy interventions in addition to CBT (Borduin & Schaeffer, 2001). Based on these findings, it appears that treatment using family interventions might be particularly effective in treating adolescents who sexually offend.

For example, in a meta-analysis study, Reitzel and Carbonell (2006) evaluated the effectiveness of treatment as measured by recidivism. They compared recidivism rates for
adolescents who received treatment (cognitive-behavioral/relapse prevention, classic cognitive behavioral, psychotherapeutic, psycho-socio-educational, psychoanalytic/psychodynamic/ego psychology, humanistic, strictly behavioral, multisystemic therapy, and treatment-as-usual or unspecified treatment) to those who received no treatment. The adolescents who received treatment had a recidivism rate of 7.37% \( (n = 1655) \). In contrast, the rate of recidivism for adolescents receiving no treatment was 18.93% \( (n = 1331) \). In addition, the authors computed the effect size of treatment based upon type of treatment. They found that, while cognitive-behavioral treatment programs were more effective than many of the non-cognitive-behavioral treatments, multi-systemic therapy was the most effective. The researchers commented that multi-systemic therapy includes cognitive-behavioral therapy as a part of it and, thus, is generally included in the same category in effectiveness studies. However, the difference between the cognitive-behavioral programs and the multisystemic programs is that the multisystemic programs address problems within in the adolescents’ natural environments, including the family, while CBT programs only work with the adolescents individually. Thus, the findings from this study suggest that treatment for adolescent sexual offending that includes family therapy, such as multisystemic therapy, may be more effective than an individual CBT approach alone. However, more research is needed to discover how family involvement affects the adolescents’ treatment and what specific family interventions are most helpful in facilitating change.

In addition, there are several other studies that demonstrate the positive outcomes of MST for adolescents who sexually offend. These studies further highlight the benefit of including families in adolescents’ treatment for sexual offending. For instance, Borduin and
colleagues (1990) evaluated multisystemic treatment versus individual therapy (a combination of humanistic, psychodynamic, and behavioral approaches) by looking at adolescent recidivism rates in a randomized clinical trial. Adolescents and their families (N = 16) were randomly assigned to two treatment groups: home-based multisystemic treatment or outpatient individual therapy. At a 3-year follow-up, the MST group has significantly fewer arrests (12.5%) for sexual crimes than the individual group (75%). Similarly, Letourneau and colleagues (2009) randomly assigned participants and their families (N = 120) to two treatment groups: multisystemic treatment (MST) or treatment as usual (TAU; group treatment provided by the juvenile department, which addressed individual issues). The adolescents and caregivers were assessed at 3 points in time: 72 hours after recruitment into study (pretreatment; T1), 6 months postrecruitment (T2), and 12 months postrecruitment (T3). Compared to the TAU group, the MST adolescents had a significantly greater reduction in problem sexual behavior, significantly greater reductions in delinquent behavior, and a greater reduction in substance abuse over time. The MST group also had a greater reduction in mental health symptoms as assessed with the externalizing and internalizing scales of the parent-reported Child Behavior Checklist (CBCL; Achenbach, 1995). Lastly, the authors found that the “probability that an MST youth was in an out-of-home placement...during the past 30 days remained approximately 7% though 12 months postrecruitment” (p. 97) while the TAU group’s “probability of being placed increased from 8% to 17% during the course of the follow-up” (p. 97). Henggeler and colleagues (2009) did a mediational analysis on these outcomes to determine what mechanisms contributed to the favorable outcomes for the MST group. Caregiver discipline and concern about the youth’s deviant peers were found to be the key mediators of the reduction of sexual risk behaviors in the
adolescents.

Finally, Borduin and colleagues (2009) evaluated the effectiveness of MST with a pretest-posttest control group design. They randomly assigned adolescents and their families (N = 48) to two treatment conditions: multisystemic treatment (MST) or usual community services (UCS; cognitive-behavioral group and individual treatment). From pre-to post-treatment, the MST group reported decreases in their symptoms and behavior problems, decreases in their aggression, increases in their emotional bonding and social maturity towards peers, increases in their grades, and increases in their family cohesion and adaptability. The UCS group reported increases in their symptoms and behavior problems, increases in their aggression, decreases in their emotional bonding and social maturity towards peers, decreases in grades, and decreases in family cohesion and adaptability. The authors also examined arrest and incarceration measures at an 8.9 year follow-up and found that adolescents in the MST group had 83% fewer arrests for sexual crimes and 70% fewer arrests for other crimes than adolescents in the UCS group. In addition, MST group participants were in detention for 80% fewer days than participants in the UCS group.

Taken together, these studies suggest that multi-systemic therapy, which includes systemic interventions, such as family therapy, may be more effective than individual therapy for the treatment of adolescents who sexually offend (Borduin et al., 1990; Borduin et al., 2009; Letourneau et al., 2009). Furthermore, it appears that interventions with adolescents’ parents or caregivers may explain the reduction of sexual risk behaviors while using MST (Borduin & Schaeffer, 2001; Henggeler et al., 2009). While MST appears to be a promising therapy for adolescents who sexually offend, there are several limitations that need to be addressed. First,
MST researchers have not demonstrated what specific types of parent interventions are helpful in the adolescents’ treatment for sexual offending. Second, MST researchers do not address how adolescents and parents experience the process of family therapy and their perceptions about how family interventions affect adolescents’ treatment. Third, program cost is an important part in choosing a theory to use in treating adolescents who sexually offend. Using MST in the treatment for adolescents who sexually offend requires advanced training and is not cost effective. At this time, it is unknown whether family therapy interventions used outside of the MST model may yield the same results without the expensive training. Therefore, more research is needed to identify specific family therapy interventions that are helpful in the treatment for adolescents who sexually offend based on the perspectives of the adolescents and parents.

**Participants’ Perspectives**

As demonstrated by the previously mentioned research, specialized treatment for adolescents who sexually offend, especially those that include family interventions, appear to be effective in helping adolescents stop their sexual offending behaviors (Borduin et al., 1990; Borduin et al., 2009; Letourneau et al., 2009; Reitzel & Carbonell, 2006; Walker et al., 2004). However, few researchers have examined treatment outcomes for adolescents who sexually offend by asking adolescents and parents about their experiences in treatment. In two qualitative research studies, researchers interviewed adolescents about their experiences in treatment for sexual offending and concluded that involving parents in the treatment of adolescents who sexually offend is helpful. In the first study, Franey and colleagues (2004) interviewed seven male adolescents after they had graduated (an average of 36 months after graduation) from a treatment program for sexual offending and asked them what they believed helped them to
succeed in the program. When the interviewers asked the question, “to what do you attribute your success?” (p. 311), some of the answers given were, “They [family] were really there for you all the time; It was really good to have my family supporting me; and knowing they [family] care for you” (p. 312). The researchers grouped these answers into a category they labeled family support. Clearly, based on the findings from this study, family involvement is important to how the adolescents viewed treatment success. However, in this study the researchers did not specifically define what “family support” means. Nor did they obtain any specific information about how the families had supported the adolescents, how the treatment providers had encouraged this support, or how this support had specifically affected the adolescents’ treatment outcomes. Additionally, they did not ask about the parents’ perceptions of being involved in the adolescents’ treatment for sexual offending.

In the second qualitative study, Thurston (2005) examined adolescents’ perceptions of their family interactions in relation to their sexual offending. She interviewed 20 male adolescents in an outpatient program for the treatment of sexual offending. The adolescents reported that their experiences in therapy and probation had a positive impact on their relationship with their parents. Thurston described:

Participants stated that the therapeutic process [family counseling] and probation structure provided opportunities to improve family functioning, create healthier family interactions, and implement needed structure and supervision. Participants reported forming closer parent-child relationships, improved family communication and discussions about sexuality. Families also decreased their avoidance of problems and began coping with them as a family. (p. 140)
Again, it appears that the adolescents found their parents’ involvement in treatment helpful. However, Thurston did not ask the adolescents questions about what types of opportunities were created by the family therapists that helped parents influence these adolescents’ treatment. In addition, Thurston did not ask the parents their perspectives about being involved in their sons’ treatment for sexual offending. Taken together, these researchers accentuate the value of including parents in adolescents’ treatment for sexual offending from the adolescents’ perspectives. However, more research is needed to identify specific family interventions that are helpful from both the parents’ and adolescents’ perspectives.

There are several reasons why understanding and integrating clients’ perspectives is important to building a conceptual framework of family therapy in adolescents’ treatment for sexual offending. First, it is socially just to include clients’ perspectives in a conceptual framework of how to do treatment with them. Although adolescents in treatment for sexual offending are attempting to change their sexual offending behaviors, they are often mistreated by society and are a marginalized group (Chaffin, 2008). As such, their concerns and goals in treatment are commonly overlooked. My primary goal for this research was to make specific recommendations to therapists regarding how to involve families in therapy with adolescents who sexually offend. Those recommendations have the potential to affect how therapists do counseling with these individuals. Because these changes would directly affect clients, recommendations I make should accurately reflect their concerns (Grover, 2004). In fact, Grover argued that when doing research it is important to give “a voice to the vulnerable, rather than by creating images of those studied which are infused with the political and social agendas of the power elite” (p. 83). Therefore, asking clients about their perspectives is empowering and
elevates their voices. The goal of this research, however, is not to elevate the voices of the adolescents who committed sexual offenses over the voices of those who were offended. Rather, listening to the perspectives of adolescents who are in treatment for sexual offending and their parents, may help researchers learn about specific interventions that help adolescents stop their sexual offending behavior and reduce recidivism rates (Reitzel & Carbonell, 2006). Through sharing their perspectives and contributing to a conceptual framework of family therapy for the purpose of decreasing future sexual violence, adolescents who sexually offend have an opportunity help those they have hurt.

Learning about how clients understand the process of counseling and change is also appropriate because clients are the experts in their own experiences (Charmaz, 2000). Therapists and researchers should not expect to be able to fully understand how change happens without understanding the perspectives of their clients. Gabbard and Freedman (2006) recommended that clients’ voices be reflected in psychotherapy research. They argued that psychotherapy treatments described in research studies often do not accurately reflect what is happening in clinical practice. They suggested applying emerging research practices from the medical field that include patient voice:

Patients’ impressions of the effect of a new drug are often more illuminating than a change in rating scales. Patients can describe how the drug affected their thinking and mood more exquisitely than their answers to questions on research instruments can. (p. 182)

Gabbard and Freedman argued that listening to and including clients’ own words and accounts of what has happened contributes to the validity of scientific research. They concluded by saying,
“What is missing [in psychotherapy journals] is what we initially sought in our professional lives—our patients’s voices” (p. 183). For this reason, it is important to understand and integrate clients’ perspectives in building a conceptual framework of family involvement in adolescents’ treatment for sexual offending.

Furthermore, how clients experience their treatment may also affect their motivation to change and level of engagement in therapy, which may affect treatment success. Miller and Rollnick (2002) suggested, “behavior change seems to arise when the person connects it with something of intrinsic value, something important, something cherished” (p. 12). To know what is important and valuable to adolescents and their parents, in terms of treatment, we need to ask them. Integrating the issues that clients identify as important and valuable in a conceptual framework of family involvement may help treatment providers better engage clients in treatment and, therefore, may lead to more successful outcomes.

Currently, there is not a model of family inclusion in the adolescents’ treatment of sexual offending that is based upon the adolescents’ and parents’ perspectives. To fill this gap in the literature, I asked parents and adolescents about their experiences in family therapy and how these experiences related to the adolescents’ progress in treatment.

**The Present Study**

Researchers and theorists have demonstrated that adolescents develop and maintain their sexual offending behaviors within the context of the family (Daversa and Knight, 2007; Burk & Burkhart, 2003; Baker et al., 2003; Ronis & Borduin, 2007) and have suggested that adolescents should receive treatment for sexual offending within their family context (Baker et al., 2003; Efta-Breitbach & Freeman, 2004; McGrath et al., 2010; Tighe et al., 2012; Worling & Curwen,
2000; Worling et al., 2010). Furthermore, studies have demonstrated that adolescents who participate in specialized treatment for sexual offending, particularly programs that address systemic family issues have lower recidivism rates than those who do not (Borduin et al., 1990; Borduin & Schaeffer, 2001; Borduin et al., 2009).

Despite this evidence, researchers and theorists have not clearly identified how to involve families in the adolescents’ treatment for sexual offending. Specifically, there is little information about what family interventions are most helpful with these families. The information that is available, such as MST, requires specific training that is cost prohibitive and thus, is not accessible to most clinicians. Given the importance of treating the adolescents in the context of their families, and the potential effectiveness of doing so, a detailed conceptualization of family therapy in the treatment of adolescent sexual offending is needed. Furthermore, past research has not asked the adolescents and parents how they experience family interventions or how they perceive these family interventions as affecting the adolescents’ treatment. Parents and adolescents’ perspectives are needed to develop a more comprehensive model of family inclusion in the adolescents’ treatment for sexual offending that is socially just (Chaffin, 2008) and accurately reflects clients’ concerns (Grover, 2004; Gabbard & Freedman, 2006), which may improve clients’ motivation and engagement in treatment (Miller & Rollnick, 2002) and lead to better outcomes.

In this current study, I began to address these issues by asking parents and adolescents about their perspectives of being involved in family therapy as a part of the adolescents’ treatment for sexual offending. Using a constructivist grounded theory approach (Charmaz, 2006), I developed a conceptual framework of family therapy as a part of the adolescents’
treatment for sexual offending. The research questions guiding this study were: 1) What are adolescents and parents’ experiences of participation in family therapy when the adolescent son has been required to complete treatment for sexual offending? 2) How does parent and adolescent participation in family therapy relate to adolescents’ progress in treatment for sexual offending?
Chapter Three: Methods

Overview of the Research Design

The research study involved two phases. First, I interviewed adolescent males and at least one of their parents about their experiences attending family therapy sessions as a part of the adolescents’ treatment for sexual offending. Using a constructivist grounded theory perspective (Charmaz, 2006), I analyzed these interviews for the purposes of developing a conceptual framework of family involvement in treatment for adolescent sexual offending from the adolescents and parents’ perspectives. In the second phase of the study, I shared the emerging conceptual framework with a focus group of family therapists who specialize in the treatment of adolescents who sexually offend. During the focus group, the participant family therapists discussed how my emerging conceptual framework was consistent or inconsistent with what they have observed while doing family therapy with adolescents who sexually offend and their parents. In addition, focus group participants provided recommendations for refining the emerging conceptual framework. I incorporated the focus group data into my emerging conceptual framework. After revising the emerging conceptual framework based on the data obtained from the focus group participants, I returned to the parents and adolescents who participated in the interviews to do member checking (Creswell & Miller, 2000). For this portion of the study, I sent the parents and adolescents a summary of my results and asked them to complete a brief questionnaire about their responses to my results.

Constructivist Grounded Theory

A constructivist grounded theory (Charmaz, 2006) approach was selected for this study because the approach was consistent with my goals of developing a conceptual framework of
family involvement, inquiring about the process of family therapy, and honoring clients’
perspectives. Broadly, grounded theory researchers move beyond describing a phenomenon to
developing an explanation or theory of that phenomenon (Charmaz, 2006; LaRossa, 2005).
Charmaz (2006) defined grounded theory methods as “systematic, yet flexible guidelines for
collecting and analyzing qualitative data to construct theories ‘grounded’ in the data
themselves” (p. 2). Grounded theory researchers analyze rich descriptions of participants’
experiences to identify and conceptually link discrete categories to form “an abstract theoretical
understanding of the studied experience” (Charmaz, 2006; p. 4). Through listening to and
analyzing participants’ stories, I identified theoretical concepts and specific examples of how
parents and adolescents experience family therapy as a part of their treatment for sexual
offending.

Grounded theory methodology was also appropriate for the current study of family
therapy because family therapists ask questions that are process oriented. Echevarria-Doan and
Tubbs (2005) stated, “grounded theory, in particular, is applicable to questions therapists ask
about the process of therapy or about clients in therapy, because such questions usually refer to
meanings, perceptions, and understandings of clients” (p. 55). This is congruent with the research
questions for this study, as they are intended to elicit information about the process of therapy. I
sought to learn about adolescents and parents’ experiences of participation in family therapy
when the adolescent son was required to complete treatment for sexual offending. In addition, I
examined the ways parent and adolescent participation in family therapy related to adolescents’
progress in treatment for sexual offending.
Finally, the use of constructivist grounded theory allowed participants to speak for themselves through the telling of their stories of participating in family therapy (Charmaz, 2008a). Constructivist grounded theory “uses the research participants as a source of knowledge. After all, they are experts on the phenomenon being studied because they are experiencing it directly” (Auerbach & Silverstein, 2003, p. 7). Constructivist grounded theory acknowledges multiple realities and emphasizes that people construct their realities. Furthermore, this approach “recognizes the mutual creation of knowledge by the viewer and the viewed, and aims toward interpretive understanding of the subjects’ meaning” (Charmaz, 2000, p. 510). Using constructivist grounded theory methodology, I acknowledged that the participants are experts in their experiences and that I was not an objective observer discovering a right description of what I was observing. Rather, I attempted to describe how the participants’ perception of how their participation in family therapy related to the adolescents’ progress in treatment for sexual offending.

Phase One: Interviews with Adolescents and Parents

Participants. The participants included 10 male adolescents who were receiving treatment for sexual offending and their parents (9 mothers, 2 fathers, 1 partner, and 3 grandmothers). Most grounded theory experts are less concerned with sample sizes, which are generally fairly small (Creswell, 2002), and are more concerned with theoretical saturation (Charmaz, 2006, Strauss & Corbin, 1998). Theoretical saturation is reached when gathering data no longer adds theoretical insight to the existing categories and the emerging grounded theory (Charmaz, 2006). To assess theoretical saturation, as it relates to sampling, I transcribed and coded the interviews with the adolescents and parents throughout the interviewing process. This
allowed me to notice repeating patterns or ideas occurring; that is, when coding more data was not adding anything new to the theoretical categories (Charmaz, 2006; Strauss & Corbin, 1998). After interviewing seven adolescents and their parents, I determined that I was nearing theoretical saturation. I interviewed three more adolescents and their parents and confirmed that I had reached theoretical saturation.

**Adolescents.** Adolescent participants were required to meet a number of inclusion criteria. First, the adolescents needed to be between the ages of 12 and 17 (adolescents who were 18 were included in the study if they were still living with a parent/caregiver or were in a treatment program). Second, the adolescent participants must have committed at least one contact sexual offense against a child under 12 years of age. I did not include or exclude adolescents based upon the severity of their offenses. Finally, adolescent participants were required to be mandated to specialized treatment for sexual offending by the courts or the Department of Human Services (DHS). Their treatment for sexual offending could be based on any number of clinical approaches, but the adolescents must have participated in at least ten sessions of family therapy with at least one parent or caregiver who was willing to participate in the study (see below for inclusion criteria for parents).

For the purposes of this study, I defined family therapy as a therapist meeting conjointly with the adolescent and one or more parents to address systemic issues, such as interactional patterns and family structure, that contribute to and or maintain the youths’ sexual offending behaviors. In order for the adolescents to describe their experiences in family therapy and how they think participating in family therapy related to their progress in treatment, they needed to have had multiple experiences in family therapy sessions. Typically, adolescents in community
programs complete 50 hours of family therapy during their treatment, while adolescents in a residential program complete an average of 11 family therapy sessions (McGrath et al., 2010). Because I recruited from both outpatient and residential programs, I used just below the average for participants in residential programs, 10 sessions, as a minimum requirement for participation. In addition, I think that 10 sessions is a sufficient number for participants to have an understanding of what it is like to participate in family therapy.

**Parents.** I attempted to interview all of the adolescents’ parents who were involved in family therapy with the youth. However, due to scheduling conflicts, I accepted a minimum of one parent or caregiver. Given the diverse nature of the families of the adolescents, these parents could have been adoptive parents, stepparents, or grandparents. However, because the goal of the study was to examine how adolescents and their parents experience family therapy, if a caregiver was not a biological parent, s/he needed to be someone that the adolescents identified as a parental figure. In addition, the parents or parental figures had to have legal authority to give permission for the adolescents to participate in the study. In cases where adolescents were wards of the state, such as those adolescents in residential treatment, I asked the Oregon Youth Authority (OYA) probation officer or Department of Human Services (DHS) caseworker to give permission for the youth to participate, in addition to the parents.

**Recruitment.** I used selective sampling to recruit the adolescents and their parents based upon the specific inclusion and exclusion criteria as explained above and outlined in Appendix A. “Selective sampling is based on a pre-conceived set of criteria that originates from the researcher’s guiding assumptions and research questions” (Echevarria-Doan & Tubbs, 2005, p. 47). To obtain participants, I acquired lists of county/state workers (i.e., juvenile court
counselors/probation officers) and treatment providers from county juvenile departments throughout Oregon and the Oregon Youth Authority (OYA). Each of the programs/agencies I contacted required me to complete an approval process to recruit their clients as participants. I completed a research proposal application for OYA and one of the treatment programs. To protect confidentiality of the participants, I will not identify the specific agencies that participated in this study. Other treatment programs had more informal processes of giving approval for recruitment, such as talking to and getting approval from the agency directors. I obtained approval from OYA for youth in their custody to participate in my research, but I was not allowed to recruit participants through their probation workers (see Appendix B). Therefore, instead of recruiting participants through the OYA probation workers, I recruited participants involved with OYA through their treatment providers. After obtaining approval from the other treatment programs (see Appendix C), I emailed or called treatment providers to tell them about my study and asked them to assist with recruitment.

Specifically, I asked treatment providers to distribute a flier about the study to adolescents and parents who fit the inclusion criteria (see Appendix D). In recruiting their clients for participation in the study, I asked the therapists to emphasize that the youth and their parents were not required to participate and that participation in the study would not affect the adolescents’ standing in treatment. To limit the potential for coercion by the treatment providers and to protect participants’ confidentiality, I asked the treatment providers to have the parents contact me directly if they were interested in participating in the study. I heard back from several treatment providers that they had handed out the fliers and that there were several families interested in the study and that they would be contacting me. Despite this information from the
treatment providers, this recruitment method did not result in any emails or telephone calls from potential participants.

After realizing that participants were not contacting me directly after being given a flier by their treatment providers, I amended my first recruitment strategy. That is, I continued to have treatment providers talk to potential participants about my study and give them the flier. However, if the participant expressed interest in the study, the treatment provider asked them if they would like to contact me directly or if they would like the treatment provider to introduce them to me. Five parents said they would like to be introduced to me. In two of these cases, the treatment provider called the parent to make the introduction and then handed me the telephone to talk with the parents privately. In the other three cases, I went to the treatment program to meet the potential participants. After introducing me, the treatment provider left the room so that I could talk with the potential participants privately. I talked with the potential participants privately in order to limit the potential for coercion by the treatment providers and maintain their confidentiality. I told them that they were not required to participate and that their participation would not affect the youth’s treatment. In addition, I told them that I would not tell the treatment provider of their decision to participate or not, further protecting their confidentiality. All five of these sets of adolescent and parent chose to participate in the research study.

As an additional recruitment strategy, I visited four parent/multi-family support groups for adolescents who sexually offend to distribute my flier and talk with parents and adolescents about the study. During these group meetings, I introduced myself, explained the study, and talked about the limits of confidentiality. Group participants then had a chance to ask me questions and privately let me know if they were interested in participating. I originally had
seven sets of adolescents and parents tell me that they would like to participate in the study. They either scheduled an interview with me at the meeting or gave me their contact information and asked me to call later to schedule. Of the seven families who indicated an interest in participating, five participated in the study. Two families changed their minds and decided not to participate.

**Eligibility screening.** Regardless of how the potential participants were recruited, by phone or in person, I talked to the parents first and explained the purpose of the study and the limits of confidentiality. I told the parents that I would not share the information they and their sons disclose with anyone, including their sons’ treatment providers and county/state workers. I explained the exceptions to confidentiality by telling the parents, “If you or your son tell me about any abuse, such as abuse of a child, or that you plan to harm yourselves or someone else, I would need to tell the police about these things.” Furthermore, I explained how I planned to use the information after this study is over, in my dissertation paper, articles, trainings, and conference presentations. I told them, “there will be no information that would identify you, your son, or your family in any written documentation or presentation.” With verbal consent, I asked the parents the questions from the eligibility screening questionnaire (see Appendix E). If the parents met the eligibility requirements and agreed to participate, I asked their permission to talk with the adolescent. I documented that they gave me verbal permission to talk with the youth on the eligibility screening questionnaire.

My primary concern in interviewing both parents and adolescents was protecting the adolescents from being coerced into participating by their parents. In an effort to avoid this, I talked to the adolescents about participating in the study separately from their parents. When I
talked with the adolescents to screen for eligibility, I first obtained verbal assent from the adolescent, and then explained the purpose of the study and the limits of confidentiality. I told the youth that the information they and their parents told me would be kept confidential. I assured them that I would not tell their parents, treatment providers, and county/state workers anything they told me without their permission. Then I explained the limits to confidentiality by stating, “There are a few times when this would not be true. If you tell me about any abuse, such as abuse of a child, or that you plan to harm yourself or someone else, I would need to tell the police and your county/state workers about these things.” In addition, I talked to the youth about how I planned to share the results in my dissertation paper, articles, trainings, and conference presentations and assured them that I would not include any information that would identify them, their parents, or their family. I also specifically told the adolescents, “You do not have to participate in this study. If you decide that you do not want to be involved, I will not tell anyone about your choice.” If an adolescent had not been interested in participating, I would have interviewed the parent and not the youth. That way, the youth would not feel pressured to participate in order for his parents to be eligible for the research study. Then, I asked the youth questions from the eligibility screening questionnaire (see Appendix E) to be certain that they met the inclusion criteria. In each case, the adolescent decided to participate.

**Scheduling interviews.** If the parents and adolescents agreed to participate in the study and met the eligibility requirements, I scheduled separate interviews with them so that both groups would be able speak freely about their experiences in family therapy without being concerned with looking good or needing to answer in a specific way for the other group. The drawbacks of interviewing them separately were that I was not able to see as much family
process and was not able to ask follow-up questions during the interview. Nonetheless, I think it was more important to protect the adolescents from coercion and to get honest responses from both groups.

In all but one of the interviews, I scheduled the parent interview first so that I could obtain written permission from the parents for the youth to participate before meeting with the youth. I made one exception to this protocol due to the schedules and requests of a particular family; the youth wanted to do the interview before school started in the fall and the parents were not able to schedule before him. In this case, I had a brief meeting with the parent to obtain written permission for the adolescent to participate before meeting with the adolescent. I scheduled the interviews with parents directly and gave them a copy of the informed consent (see Appendix F) form to take with them so that they would have time to review it before the interview. I either scheduled the youth interview with the youth, his parents, or his treatment provider based upon his preference. I gave the youth a copy of the written assent (see Appendix G) form to take with them so that they would have time to review it before the interview.

Although I interviewed the parents separately from the adolescents, I wanted to analyze their data in a way that would allow me to compare, contrast, and combine their responses. Therefore, I attempted to schedule the parent and adolescent interviews within one week of each other so that I could analyze the two transcripts close together, but ultimately scheduled them when it was convenient for the adolescents and their parents. The average length between the parent and adolescent interviews was 11 days with the range being between 0 days and 20 days.

**Data collection procedures.** This research was conducted with the approval of the Virginia Tech Institutional Review Board (IRB), in compliance with all legal and ethical
requirements for research conducted with human subjects (see Appendix H). I collected data from parents and adolescents through in-depth interviews. In-depth interviews are a good way to gather rich data from participants about their experiences (Charmaz, 2006). As explained earlier, I met with the adolescents separately from their parents. If there was more than one parent/caregiver willing to participate, as was the case with six families, I interviewed them together. For example, in one case, there was a parent, a partner, and a grandparent of a youth who wanted to participate so I interviewed all three parental figures together. I met with participants in a location that was most convenient for them. I gave participants the option of meeting at my office, their homes, the youths’ residential programs, or the juvenile departments. I met with six of the parents in their homes and four of them at the youths’ treatment programs. I met with three of the youth in their homes and seven of them at their treatment programs.

**Interviews with parents.** When I met with the parents, before beginning the interviews, I gave them written information (see Appendix F) that explained the purpose of the study, how I planned to use the study results, and the protection/limits of confidentiality. I reviewed this consent information with them thoroughly and talked with them about issues of confidentiality, especially regarding issues of mandated reporting, recording, and publishing. Each person present was given an opportunity to ask questions about the study and to sign the informed consent form. I reviewed the parental permission form (Appendix I) with the parent(s) highlighting issues of confidentiality pertaining specifically to the adolescent, such as how I would need to report any abuse disclosed. I answered questions they had about the permission form and then had them sign the form if they agreed to allow the adolescent to participate. For the five youth who were wards of the state, I told the parents that I would also be obtaining
permission for the youth to participate from the youth’s OYA state probation officer or DHS caseworker before meeting with the youth.

Next, I asked the parents if I could gather some general information about the adolescent’s offenses from his OYA or DHS worker. I reviewed the demographic questionnaire (Appendix J) I wanted to give to the OYA/DHS worker with the parents and answered their questions about the type of data I wanted collect and how I planned to use the data. I also reviewed the release of information (Appendix K) with them and answered questions about the limits of confidentiality. If the parents agreed, I asked them to sign the release of information. In each case, the parents agreed to allow me to collect this information and signed the release. For the youth that were in OYA/DHS custody, I was not required to get the parents’ signatures because the state workers have the legal right to release the information. However, out of respect for the parents and youth, I obtained signatures on this release from all the parents, regardless of who had legal custody. Two of the families indicated that their sons do not have probation or DHS workers and asked me to obtain the information about the adolescents’ offenses from the youths’ therapists. I amended the release form accordingly and had them sign it.

After I obtained the appropriate consent from adults and permission to interview the adolescents, I gave each of the parents a $10 gift card to Target for participating in this study. I told the parents that if they chose not to complete the interview, they could still keep the gift card. Upon receipt of the gift card, each participant signed a receipt of compensation (see Appendix L). I then began the parent interview. I began by gathering demographic information from each participant, which is explained in more detail below (see Appendix M). While gathering this demographic information, I asked each of the parents if they would like to
participate in a member checking process and/or receive the results of this project. I explained to them that member checking is a way for me to show them my results and ask them if I am on the right track with my findings. I told them that if they agreed to participate in member checking, I would send them the results through email or mail, based upon their preference, and ask them to complete and return a brief questionnaire about their perspectives on the results (see Appendices N-P). Thirteen of the fifteen parents agreed to participate in the member checking process. I told the parents that they could receive a copy of the results even if they chose not to participate in the member checking. All of the parents chose to receive a copy of the results.

After gathering the demographic information and clarifying participants’ interest in participating in the member checking process, I used the interview protocol to conduct the interviews (see Appendix Q), which is described in more detail below. The parent interviews were audio-recorded and between approximately .75 and 1.75 hours in length, with the average interview lasting 1.25.

*Interviews with adolescents.* Before meeting with the adolescents, I obtained written permission for the youth to participate in this research study. As explained above, each of their parents reviewed and signed the parental permission form (Appendix I). Additionally, I contacted the OYA state probation officers or DHS caseworkers to obtain permission for the six youth who were wards of the state (Appendix I). Through an email to the OYA and DHS caseworkers, I explained the study, including limits of confidentiality, attached a copy of the IRB and OYA approval documentation, and asked the DHS and OYA caseworkers to sign and return the permission form. In addition, I told the DHS and OYA workers that I would be asking them to complete a demographic questionnaire about the adolescent after the interviews were complete.
Because the DHS and OYA workers had the legal authority to give me this information, I did not need to have them sign this release form. One of the DHS workers talked to me by phone to ask additional questions about the study and to ensure that I would not be asking the youth about his sexual offenses. The OYA and DHS workers, for the five adolescents who were wards of the state, signed and returned the permission form before I met with the youth.

One to two days before each of the scheduled interviews, I called the adolescents to ask them if they still wanted to be a part of the study. I reminded them that participation was voluntary, confirmed that they had had a chance to review the informed assent, and gave them a chance to ask me questions about the study. Each of the adolescents verbally confirmed that he still wanted to participate.

When I met with the adolescents, before beginning the interviews, I gave the adolescents another copy of the informed assent (see Appendix G), which explained the purpose of the study and how I planned to use the study results. I thoroughly reviewed information about protection/limits of confidentiality by talking with them about mandated reporting, recording, and publishing. Each adolescent was given an opportunity to ask questions and to sign the informed assent if they agreed to participate. As part of the consent process, I also went over the demographic questionnaire (see Appendix J) that I would be asking their county/state workers to complete. I explained why I was asking for this information and how I planned to use the data. I reviewed the release of information their parents had signed (see Appendix K), answered their questions about the release, especially pertaining to confidentiality, and asked them to sign the release as well. Each of the adolescents signed the assent and release.
After I obtained written assent from the adolescent (and parental and county/state permission for participation), I gave the youth a $10 gift card to Target for participating in this study. I told the youth that if they chose not to complete the interview, they could still keep the gift card. Upon receipt of the gift card, each participant signed a receipt of compensation (see Appendix L). Then I began the adolescent interview. I obtained demographic information using a questionnaire (see Appendix R), which is described in more detail below. While gathering this information, I asked the adolescents if they would like to receive a copy of the results of the study and if they would like to participate in the member checking process. Like their parents, I explained that member checking is an opportunity for them to let me know if I have accurately reflected their perspectives in my results. I explained that if they were interested, I would send them a copy of my results to review and ask them to complete and return a short questionnaire (see Appendices N-P). I told them that they could receive a copy of the results even if they did not want to be a part of the member checking. All of the adolescents said they would like a copy of the results and eight of the youth said they would like to participate in the member checking process.

Following the consent process and gathering demographic information, I conducted the interviews with the adolescents, using the interview protocol (see Appendix S). The interviews were audio-recorded and took about .75 hour to complete, and ranged in length from .5 to 1.5 hours.

Measures.

Demographic questionnaire. I asked each parent and adolescent to orally complete a demographic questionnaire, which was developed for the purposes of this study (see Appendix M.
Questions on the demographic questionnaire obtained information about each participant’s age, gender, family structure, and racial self-identification. The demographic questionnaire also included items about the amount and type of treatment that adolescent had received for sexual offending. Because I wanted to gather information focused on therapy, rather than the nature of the adolescents’ sexual offending, and wanted the participants to feel comfortable and share openly with me, I did not ask the parents and adolescents any information about the adolescents’ sexual offenses. Rather, after completing the interviews with the parents and adolescents, I requested general information regarding the adolescents’ sexual offenses (see Appendix J), such as the number of and types of offenses, from the adolescents’ county/state workers or therapists (for youth who were not on probation or in DHS custody).

**Interview protocol.** During the interviews, I asked open-ended questions to try to create a balance of gathering information about the participants’ stories and probing for process. I wanted my questions to both explore my research questions and fit the participants’ experiences (Charmaz, 2003). I used an interview protocol containing about thirteen open-ended questions with follow-up probes. The questions were designed to elicit information that would yield rich descriptions about the adolescents and parents’ experiences of family therapy and how they perceive this involvement as relating to the adolescents’ progress in treatment (Charmaz, 2003).

Sample questions for the parent interview include: How did you become involved in family therapy related to your son’s treatment for sexual offending? Tell me about a time in therapy when you left feeling hopeless or disappointed about how your son was doing in treatment. How do you think your involvement in family therapy sessions has affected your son? What was the most important lesson you learned through participating in family therapy
sessions? What recommendations do you have for family therapists who are working with families who are responding to an adolescent who has offended sexually? See Appendix Q for the full list of parent interview questions and follow-up probes.

The open-ended questions for the youth interviews were the same as those for the parents, but were worded appropriately for the youth. Follow-up probes were designed to elicit more detailed information about each of the questions. Example follow up probes used with the adolescents include: What helped you become involved? What did the therapist say or do that was helpful? How did this affect your relationship with your parents? How did this help or not help you in your treatment? See Appendix S for the full list of youth interview questions and follow-up probes. While eliciting information about the adolescents’ experiences in family therapy, I attempted to mirror the participants’ language, clarified how they defined terms, situations, and events. My goal was to understand the participant’s assumptions, implicit meanings, and tacit rules by asking clarifying questions (Charmaz, 2003).

I considered my first two interviews (one parent and one adolescent), as “pilot” interviews. After these initial interviews, I transcribed the audio recordings and began analyzing the data to evaluate if my interview questions worked at getting at the information I was seeking. I noticed that the two adolescents and parents who participated in my “pilot” interviews both talked quite a bit about the treatment program they were involved with rather than their actual family therapy sessions. To focus the discussion on family therapy versus treatment more generally, I added a question related to defining family therapy for subsequent interviews. Specifically, I asked, “Before we get started, will you please tell me what you think of when I say family therapy?” We discussed the definition of family therapy together and I told them that,
for the purposes of our interview, we would be focusing only on the family therapy sessions. Because I only made a minor change to interview questions, I decided to include these first two “pilot” interviews in my overall sample.

In addition, and consistent with recommendations from grounded theory experts, I was “seeking pertinent data to develop [my] emerging theory” by analyzing the data throughout the interviewing process (Charmaz, 2006, p. 96). While doing my data analysis during the interviewing process, I noted potential categories developing in the data (explained in detail in the data analysis section). As a result of noting these emerging categories, I asked an additional question in subsequent interviews to refine and elaborate on these emerging categories that would be the basis for my conceptual framework (Charmaz, 2003; 2006). Specifically, the fourth and the sixth parent I interviewed talked about how having the therapist addressing cultural and spiritual issues was important to them. Therefore, in later interviews, I added a question, “how did the therapist address cultural/spiritual issues that are important to you?”

Phase Two: Focus Group of Family Therapists

Participants. The focus group consisted of seven therapists who are considered specialists in the field of adolescent sexual offending treatment and family therapy. Focus groups are typically consist of between 6-12 people (Stewart & Shamdasani, 1990). Keeping the numbers small in a focus group allows each participant an opportunity to talk, which may contribute to more in-depth conversations and discussion between the participants (Piercy & Hertlein, 2005).

For the purposes of this study, a specialist in the treatment of adolescent sexual offending was defined by several criteria. First, the therapist had to hold a license recognized by the
Oregon Board of Licensed Professional Counselors and Therapists (OBLPCT) or the Oregon Board of Licensed Social Workers. Licensing organizations set strict standards of education and experience for licensees, which define expertise in this field. Second, the therapist was required to be either certified or eligible for certification as a sex offender therapist by the state of Oregon. This certification defines a therapist as an expert because most juvenile departments in Oregon and the Oregon Youth Authority require therapists that work with adolescents who sexually offend to either be eligible for or hold this special certification. In addition, specialized training and experience that would help define these therapists as experts in the treatment of sexual offending are already built into the requirements of this certification. Third, focus group participants were required to have specific training in family therapy and systemic issues, such as classes in family therapy and systems theory, workshops on family therapy, and supervised experience doing family therapy. Because I wanted these specialists to comment on my conceptual framework of including parents in family therapy, I wanted them to have specialized training in systemic issues. Fourth, the therapists had to have a minimum of 3 years experience doing family therapy with adolescents who sexually offend. This is because these therapists needed to be able to comment on my conceptual framework from their practice experiences.

**Recruitment.** I used selective sampling (Echevarria-Doan & Tubbs, 2005) to select the focus group participants based upon the specific inclusion criteria described above and outlined in Appendix A. Recruitment involved asking for the names of therapists who do family therapy with adolescents who sexually offend from juvenile departments in Oregon, the Oregon Youth Authority (OYA), and the Oregon Adolescent Sexual Offending Treatment Network (OASOTN) board. Once I received these names, I contacted the therapists by email, to screen for eligibility
and to ask them if they would be interested in participating in the focus group. When I contacted prospective focus group participants, I explained the purpose of the study, the reason I was contacting them, the eligibility requirements, the format of the focus group, and that the focus group would last for approximately two hours (see Appendix T). Most therapists replied to my email by telling me whether or not they were interested and how they did or did not meet the eligibility requirements. If they did not specify how they met the eligibility requirements, I contacted them by phone and completed the follow-up phone script for recruitment of therapists for focus group (see Appendix U).

After screening for eligibility, I sent the therapists who were eligible and had expressed interest in participating in the focus group an email requesting that they complete an on-line scheduler to tell me when they would be available to attend the focus group (see Appendix V). After seven therapists indicated that they could attend the focus group at the same time, I sent an email to schedule and confirm the date and time of the focus group (see Appendix W).

**Data collection procedures.** I collected data from therapists through a focus group. I used a focus group format because the “synergistic, snowballing effect of the group discussion often results in rich ideas” (Piercy & Hertlein, 2005, p. 86). I offered two options for how the participants could attend the focus group, in person or via Skype. I met with four of the focus group participants in my office, which was in a central location for those who attended in person. Three participants, who all lived over two hours from my office, chose to attend the focus group by Skype. Regardless of how therapists attended the focus group, in person or through Skype, they all appeared to be engaged in the focus group discussion.
After scheduling the focus group, I sent each therapist a copy of the informed consent (see Appendix X) that explained why I was conducting the focus group, how I planned to report the results, and the protection and limits of confidentiality. I asked the therapists who were attending the focus group through Skype to return their signed informed consent via mail or email before the group meeting. I had printed copies of the informed consent for the therapists attending in person to sign before the group started. Either way, I was available to both groups, in person and by Skype, to answer questions about the informed consent form and the study.

After obtaining informed consent from each of the focus group participants, I asked the participants to complete a demographic questionnaire. The therapists attending the group by Skype, mailed or emailed me their demographic questionnaire after the conclusion of the focus group. Then, using the interview protocol (see Appendix Y), which will be explained in detail below, I started the focus group. The focus group was audio-recorded and lasted 2 hours. To thank the focus group participants for their assistance, I offered compensation by giving each participant the chance to win a gift card. Each therapist was entered into a drawing for one $50 Amazon gift card. I randomly selected the winner at the conclusion of the focus group.

**Measures.**

**Demographic questionnaire.** At the beginning of the focus group, I asked each of the therapists to complete a one page demographic questionnaire that was developed for the purposes of this study (see Appendix Z). Questions on the demographic questionnaire gathered information about the therapists’ gender, type of treatment practiced, licensure, and experience doing therapy with adolescents who sexually offend and their families. The primary purpose of
obtaining this demographic information was for the purposes of describing my sample, but I also used it during data analysis as another data source (Charmaz, 2006).

**Interview protocol.** During the focus group, I shared a synthesis of the results from the analyzed adolescent-parent interviews with the participants. The handouts that were given to the focus group participants included a chart of 70 focused codes organized into 13 themes (see Appendix AA), a list of categories with focused codes (see Appendix AB) and a list of themes (see Appendix AC). In sharing this information, I did not release any identifying raw data to the therapists. After the participants had a chance to read through the handouts summarizing results of the interviews, I asked them to discuss the results. As they discussed the results, I guided their conversation by asking them a series of discussion questions. For example, I asked them the following questions: What are your thoughts and feelings about the themes or the categories that emerged from the study? How do my results compare with your experiences in doing family therapy with parents and adolescents for the treatment of sexual offending? Which of those categories are things you agree with and which ones do you disagree with? What are you seeing as you do work with these youth? A full list of the guiding focus group questions is included in Appendix Y.

**Reflexivity**

As a constructivist researcher, I acknowledge that I became part of the interview process, that I brought my interests and biases into the interviews, and that my participants co-constructed their stories together and with me (Charmaz, 2008b). Because I chose a topic that intersects with my professional life, prior to conducting the study and during data collection and analysis, it was important for me to acknowledge my biases and to examine how they might influence how I
conducted the interviews and analyzed the data (Charmaz, 2006; 2008b). To help me maintain awareness of my biases and influence, I maintained a reflexive stance throughout the research process through writing memos, which will be explained in more detail at the end of this section.

Charmaz (2006) defined reflexivity as the process of the researcher examining “her research experience, decisions, and interpretations in ways that bring the researcher into the process and allow the reader to assess how and to what extent the researcher’s interests, positions, and assumptions influenced inquiry” (p. 188). One way of assuming a reflexive stance is to explore my biases through sharing my personal narrative of how I became a therapist working with families of adolescents who sexually offend and how I decided to research parental involvement in family therapy for adolescents who sexually offend. After sharing my story, I will explicitly identify my biases, that I know of thus far, and talk about how they may have influenced my data collection, analysis, and results.

**Personal narrative.** Shortly after graduating from college, I accepted a job working as a recreation programmer for the park district. I planned recreation activities for kids and volunteered with troubled youth at a teen center. I was trying to decide what career path to follow and it was becoming more clear to me that, if I wanted to move forward professionally, I would need to go back to school. I was deciding between becoming a teacher or a counselor. To help me make this decision, I decided to volunteer full-time at a residential youth counseling program for six months before going back to school. While working at this counseling program, I began to wonder about how these youth would resolve their problems and get better without their families. As I talked with the youth, it seemed evident to me that their families had some responsibility for their difficulties, but were also important in their healing processes. This view
was further reinforced when I left the counseling program to work at a residential treatment center for adolescents. The staff, myself included, worked very effectively with the adolescents; however, just as they began to change their behaviors, they would have a home visit and come back a “mess.” It seemed to me that the parents of these adolescents could “undo” what we had worked for weeks on with the adolescents in a matter of a day. Through this experience, I became even more certain that families are important in the development and maintenance of adolescents’ problems. As a result of these experiences, I decided to pursue a master’s degree in marriage and family therapy (MFT).

At the start of my master’s program, I accepted a job as a supervisor/case manager of a residential treatment program for adolescent boys who had been adjudicated for sexual offending. I did not seek to work with youth who had sexually offended and was a little nervous about this at first because of my preconceived ideas that they may not be able to change. I quickly learned that these were not just young men who had done a terrible thing, they were also kind, generous, lovable and, for the most part, wanted to change. I began to respect how hard they worked to overcome their problems. I also worked with some incredible people at the treatment program who were committed to helping these youth make change. Nonetheless, some of the staff/clinicians were negative and not very hopeful that these youth could stop their sexual offending behaviors. For example, in meetings, I would hear stories of how these youth were not going to change and often heard the term “prognosis is poor” associated with certain youth. I quickly tired of this negative thinking. I believed that these youth could alter their behaviors, especially if their parents were involved in their treatment. The staff and clinicians I worked with seemed to have mixed feelings about involving the youths’ families. They regularly commented
that the youth who had involved families were doing better in treatment; I had noticed this as well. However, they also made comments about how some families were dysfunctional and refused to participate. At the time, I thought that we should address barriers to the parents’ participation and work harder to get them involved in the youths’ treatment. Therefore, I made a personal decision to involve families when I became a therapist and did treatment with these youth.

While my experience at the residential treatment program had taught me that involving families is the best way to work with adolescents who sexually offend, this became theoretically significant to me as well. During my master’s program in MFT, I learned about and embraced family systems theory. As a family systems therapist, I believe that while the family interactions do not always cause the adolescents’ offending behaviors, they have an influence and often allow those behaviors to continue. Therefore, I came to believe that therapists working with adolescents who sexually offend need to help their families change their interaction patterns and correct problems with hierarchies and boundaries in order to help the adolescents stop their deviant sexual behaviors.

After my masters program, I worked at a community mental health agency doing therapy with adolescents with many different problems. I worked hard to involve families, believing that that was the best way to help the youth. Seeing youth change so quickly with their parents’ help solidified my belief that family is the key to helping adolescents resolve their problems. After a few years, I again had the opportunity to work with adolescents who sexually offend. I took a job at a residential treatment program working full-time with these young men. This time, I was responsible for the individual and family therapy of these youth. I worked from a family systems
perspective and encouraged parents to attend family therapy sessions as often as possible. I began to notice that, sometimes, parental involvement in family therapy supported and encouraged adolescents in treatment. However, there were also times when family involvement sometimes discouraged the adolescents and took away from their progress in treatment. For example, one young man I worked with began to thrive when his parents became involved. As his parents encouraged him in family therapy sessions, he began to work harder on his treatment assignments. He started coming to family counseling with his homework done and expressed feeling excited at the possibility of seeing his siblings again. When these parents confronted and challenged this young man, he opened up and shared more of the details of his offenses. This helped him to be honest so that he could begin working towards clarification with his siblings and family reunification. On the other hand, I worked with a young man who seemed to do worse when his mother was involved. When his mom would confront him, he responded by communicating less and acting out behaviorally, which would delay his treatment progress. His mother was inconsistent in attending family therapy and never seemed to engage in the process.

As a result of these types of divergent experiences, I became intrigued with parent participation in the treatment of adolescents who sexually offend and looked to the literature for more information about how best to involve parents in their adolescents’ treatment. Although parental involvement is recommended for the treatment of adolescent sexual offending, I quickly discovered that there were few empirical studies or specific recommendations about how to include parents in adolescents’ treatment for sexual offending. I decided that I would like to do research that would examine family participation in the adolescents’ treatment for sexual offending so that I would have specific strategies for how to work with families and not just
vague recommendations to include the family.

**Reflection on biases.** Through writing this narrative, I identified several biases that I have about including parents in family therapy when the adolescent is required to complete treatment for sexual offending. As I present my biases, I will explain how I maintained an awareness of these biases and worked to address them throughout the process of conducting this study. First, while parents are not responsible for their sons’ sexual offending, I do believe that they have influenced the development and maintenance of the problem. Furthermore, it is my assumption that when parents actively participate in family therapy as a part of their sons’ treatment for sexual offending, the adolescents’ treatment will be more successful. In addition, I think that family treatment can help strengthen the connection between parents and adolescents, which may positively impact the adolescents’ progress in treatment and ultimately lead to more successful outcomes. Clearly, my bias is that parental involvement in the treatment of adolescent sexual offending is positive and helpful to adolescents’ success in treatment. As I collected and analyzed the data for this study, I attempted to take a more neutral stance around these issues. For example, I purposefully asked clients questions that elicited information about how parents’ involvement positively or negatively influenced the adolescents’ treatment.

Second, I believe that parents want to help their adolescents by being involved in their treatment but have barriers to being involved, such as living several hours from the residential treatment program or feeling blamed for their sons’ sexual offending behaviors. As a result, I have worked hard to engage families in the adolescents’ treatment processes. I also think that there are specific things that therapists could be doing that would help these families participate more actively in treatment and that most therapists do not do these things because of time
constraints and because it is more difficult. For example, one family I worked with refused to come to the residential treatment program for family therapy. I hypothesized that their primary barriers were feeling blamed and not cared for by me (the therapist). Thus, I drove two hours to meet them in their hometown. During the meeting, I talked to them about how important they are to their son and how I did not blame them for the youth’s behavior. After doing this, they started coming to family therapy, at the residential treatment program, on a regular basis. Because of this bias, in the context of the data analysis, I may have been too quick to identify themes of therapists not encouraging family participation and themes that tell therapists how to better involve families. Furthermore, because of my bias, I may have missed themes indicating that parents do not want to be involved. To address these issues, I wrote memos exploring my biases about the emerging themes, followed recommended protocol for data collection and analysis (Auerbach & Silverstein, 2003; Charmaz, 2006), and consulted with my research mentor for critical discussion about the developing themes.

Finally, I believe that most families encounter a lot of shame through the process of their sons’ adjudication. I think this is a major factor that inhibits many families from engaging in the their sons’ treatment. This bias may have caused me to ask probing questions to illicit these responses or to over identify these themes in my analysis. As I completed the data collection and analysis for this study, I made an effort to maintain an awareness of my biases and to manage the influence they had on the results of this study through writing memos.

Writing memos to address biases. I further acknowledged my biases and examined how they influenced my data collection and analyses through writing memos. Charmaz (2006) compared memo writing to having a conversation with oneself; it is a free flow of ideas on paper.
Before and after each interview, I recorded my observations, thoughts, and feelings about the interviews. I wrote memos to reflect on how my personal experiences and biases interacted with and influenced the interview process. I also wrote memos to examine my thoughts, feelings, and biases that emerged while transcribing the interviews and analyzing the transcriptions. In creating these memos, I looked for times when my biases seemed to be consistent with the results I was finding and then went back to the data to confirm that the results were coming from the participants’ voices and not my own. For example, I wrote the following memo about a potential bias that I observed while interviewing a parent:

As I was talking with this parent, I noticed her hesitation to say anything negative about the therapist she was talking about. Shoot, all the sudden I realized that she knew that I know this therapist. The therapist that had introduced us had told her that I am a therapist working in the field. I stopped the interview for a moment and talked with her about knowing some of these therapists but not having the same relationship with them or experiencing them in the same way that she does. I encouraged her to talk openly about the therapist. I told her that no one is perfect and we want to hear about her experiences, both positive and negative. After this, she seemed to talk more freely. In subsequent interviews, I need to talk about this at the beginning of the interview.

Through writing memos similar to this example, I tried to maintain an awareness of the biases that were emerging as I collected and analyzed the interview and focus group data. I will explore these biases more and how I believe they affected my data collection and the development of my conceptual framework in the discussion section.
Data Analysis

As previously stated, the data analyzed for this study consisted of 10 parent and 10 adolescent interviews, a focus group of 7 therapists, and 10 demographic questionnaires each from therapists, adolescents, and parents. I took notes during the interviews and the focus group and transcribed the focus group discussion and each of the parent and adolescent interviews. I transcribed the first three adult and adolescent interviews myself and then contracted with two transcription companies to help me transcribe the remaining interviews, including the focus group discussion. I obtained confidentiality agreements from the transcription companies (see Appendices AD-AE) prior to sending them any data. I transferred and kept the audiotapes and written transcriptions in a secure manner according to HIPPA regulations.

Consistent with constructivist grounded theory researchers, I analyzed my data throughout the research process rather than during an analysis stage after all the data were collected (Charmaz, 2006). I used the data from demographic questionnaires primarily to describe the personal characteristics of my sample. However, all data collected in grounded theory research should be treated analytically as another source of information (Charmaz, 2006). Therefore, whenever appropriate, I used this demographic information to help me develop theoretical concepts that helped me answer my research questions. For example, I considered the information about the number of family sessions when explaining how parental involvement impacted the youths’ progress in treatment, which I will explain further in the results section.

Throughout the data analysis process, I addressed sensitizing concepts, wrote memos, and referred to my conceptual framework and research questions. Data were coded in three phases: open coding, focused coding, and axial coding (Charmaz, 2003; 2006; Strauss, 1987; Strauss &
Corbin, 1998, LaRossa, 2005). These phases are not linear but cyclical in nature (Charmaz, 2006; LaRossa, 2005); thus, I moved back and forth between these phases as I coded the data. Throughout data analysis, my goal was to move from rich description of the participants’ experiences toward a higher level of abstraction in order to form a conceptual framework of family therapy as a part of the treatment of adolescent sexual offending (Charmaz, 2003; 2006).

**Examining sensitizing concepts.** While coding data, grounded theory researchers often identify sensitizing concepts, assumptions and theoretical perspectives that come from one’s discipline and inform their emerging theory (Charmaz, 2003). Charmaz (2003) stated, “constructivist grounded theory encourages researchers to be reflexive about the constructions—including preconceptions and assumptions—that inform their inquiry” (p. 319). To achieve this reflexivity, Charmaz (2003) suggested that the researcher ask the following questions about their sensitizing concepts while analyzing the data: “(a) What, if anything, does the concept illuminate about these data? (b) How, if at all, does the concept specifically apply here? (c) Where does the concept take the analysis?” (pp. 319-320).

With this in mind, as I analyzed my data during open, focused, and axial coding, I addressed these questions through writing memos (as described in more detail below). Explicitly identifying my sensitizing concepts of family systems theory, contraindications of family therapy, mandated clients, adolescence, and process of change (see chapter 2 for a description of these concepts) and answering Charmaz’ (2003) questions helped me to recognize to what extent these sensitizing concepts were influencing my interpretation of the data. That is, if the sensitizing concepts added to my emerging analysis, I used them for coding ideas (Charmaz, 2003). If not, I disregarded them. For example, one of my sensitizing concepts was family
systems theory (Whitchurch & Constantine, 1993). Through each level of analysis of the data, I looked for ways that my perspectives about this theory might enhance the codes I was developing. If I found aspects of this theory in the participants’ stories, I used family systems theory to inform the development of my conceptual framework of involving parents in family therapy when their adolescent sons are in treatment for sexual offending. If I did not find these concepts in the data, I disregarded this sensitizing concept while coding the data and developing my conceptual framework. I give a specific example of this process in the following section.

Writing analytic memos. In addition to using memos to explore biases, grounded theorists also use memos as a “framework for exploring, checking, and developing ideas” (Charmaz, 2008b, p. 166) while analyzing data. As Charmaz (2003; 2006) recommended, I wrote memos throughout the data analysis process. After each interview, I wrote memos identifying things I observed during the interview as well as my initial thoughts about key ideas that I became aware of during the interview. During data analysis, I also wrote memos as a way of “making comparisons between data and data, data and codes, codes of data and other codes, codes and category, and category and concept and for articulating conjectures about these comparisons” (Charmaz, 2006, pp. 72-73).

The following is an example of how I used memo writing during the process of data analysis. This is a memo I wrote after an interview with a parent:

I noticed that she had a lot to say about parenting and being empowered and that she really felt like the therapist had empowered her and done things to really support her parenting and she adjusted her parenting quite a bit with her kid.

This example memo demonstrates how I noticed a major idea (theme) in the parent’s interview.
Later, as I coded the other interviews, I was aware of my initial reflection that learning parenting skills and having the therapist support the parent being in charge may be a part of the parents’ experiences in family therapy. As a result, I noticed other parents talking about the same or similar ideas and wrote additional memos about this issue when I saw it emerge in the data. For example, while coding another parent interview, I wrote:

a) She’s talking about how the therapist helped her to learn to not take son’s responsibility away from him. Mom used to do that. She’s learning to take her part of the responsibility and give him his part. This sounds like the therapist is helping her with boundaries. This is a structural concept. b) Learning about hierarchy… how to be in charge and be mom… not a friend. Therapist is teaching mom these skills.

I referred to these and other analytic memos as I was developing codes at a higher level of abstraction. In doing this, I made an effort to maintain my awareness about how the sensitizing concepts associated with this study were contributing to analysis of the data. As the themes and the conceptual framework developed over the course of the data analysis, the sensitizing concept of systems theory most certainly influenced what I saw and gave importance to in the data and how I grouped the data into categories and themes.

**Stating the research concern and theoretical framework.** Before beginning the data analysis, as suggested by Auerbach and Silverstein (2003), I explicitly stated my research concern (question) and theoretical framework for this study. Auerbach and Silverstein suggested that this helps the beginning researcher stay focused on the topic and choose relevant text to code. To do this, I opened a separate document on my computer and wrote out my research concern. My research concern was that I wanted to learn about parents’ involvement in their
son’s treatment for sexual offending. I wanted to hear about the parents’ and adolescents’ experiences in family therapy. I was also curious about how the parents and adolescents thought the parents’ involvement in family therapy was either adding to or taking away from the youths’ treatment for sexual offending. To refamiliarize myself with the theoretical framework guiding the study, I then reread my section (see chapter 2) on sensitizing concepts, which included family systems theory, contraindications for family therapy, and mandated clients. After reading these sections, I wrote notes about them in the same document that I had written my research concern. I kept this document open and referred to it often throughout the coding process.

**Coding by family and role.** One of my goals in analyzing the data was to look at the parent and adolescent data together as a family. There are two things I did to keep track of and to be able to compare the adolescents with their parents. First, as explained earlier, I interviewed the adolescents as soon as possible after the parents so that I could begin analyzing their interviews close together. Second, as I began to combine the codes and develop themes, I labeled each open/focused code by who said the code. For example, if the code came from the first parent interview, I wrote $P1$ beside the code. If this parent’s youth also had the same code, I added the label, $Y1$. In that way, regardless of the order of the coding, I could quickly compare the youth with their parents. In addition, this also allowed me to easily be able to look at the data by roles, comparing parents with parents, and youth with youth, and all parents to all youth.

**Open coding.** During open coding, I began to categorize the data (Charmaz, 2006). Grounded theory researchers do not fit the data into predefined codes or categories; rather, they allow the codes to emerge from their interpretations of the data (Charmaz, 2000). Open coding is a process of breaking apart the data to examine each part (Charmaz, 2006; LaRossa, 2005). I did
this though analyzing each line of each transcribed interviews separately – line-by-line coding. As Charmaz (2006) explained, “Line-by-line coding frees you from becoming so immersed in your respondents’ worldviews that you accept them without question. Then you fail to look at your data critically and analytically” (p. 51).

To open code the transcripts, first, I read through the entire transcript. While doing so, I changed all of the names in the transcript to a generic title, such as parent, youth, therapist, and program to protect confidentiality of the participants. Then I copied the transcript into a new document and reformatted it into a table with three columns: transcript, code, and my thoughts. I read each line or segment of the transcript separately. In the code column, I wrote codes that represented the actions I saw in the data rather than the topics (Charmaz, 2006). For example, a participant stated, “But I do spoil him a little more than I should.” I wrote the code, “spoiling him more than I should” in the code column. Charmaz (2003) stated that identifying actions shows “what is happening, what people are doing. These codes move the researcher away from topics, and if they address structure, they reveal how it is constructed through action” (p. 321). Coding for actions also helps researchers make comparisons of the data, people, incidents, and categories (Charmaz, 2000). It helps researchers identify emerging links between the process and the data (Charmaz, 2008b). As I engaged in the open coding process, I asked myself the following questions recommended by Charmaz (2006):

• What process(es) is at issue here? How can I define it?

• How does this process develop?

• How does the research participant(s) act while involved in this process?

• What does the research participant(s) profess to think and feel while involved in this
process? What might his or her observed behavior indicate?

- When, why, and how does the process change?
- What are the consequences of the process? (p. 51)

As mentioned earlier, while open coding, I wrote memos to help me clarify my biases and record my initial thoughts about the data. I wrote brief memos directly in the *my thoughts* column of my coding document that described my initial reactions about how the data were connected and what I thought the participants were saying. For example, one participant stated, “She’s helped me to learn to not take on too much of what [son]’s supposed to be responsible for” (P3). In the *my thoughts* column, I wrote, “boundaries are a part of learning to take care of herself.” When I needed more space than a brief memo to process my thoughts, I wrote longer memos in a separate “memos” document and referenced them in the “my thoughts” column. For example, another participant said,

They were just amazing. If I hadn’t called them, they called me...They, [therapist] were really comforting, um, they’re not even my, my therapist, they don’t even have to take care of me...they checked up on me, they were very very concerned… At that point of time I knew that [son] was in really good hands, I knew that they weren’t here just to make him better just to get him back on the streets. They’re here and he’s going to stay here as long as he needs and he’s gonna get all the help he needs. (P2)

In response to this statement, I wrote the following memo:

This seems to be another theme arising… that the people in the program (therapists and staff) are there for mom. She’s saying more that they have to be there for her son but not for her, and yet they are. They care for her and go out of their way to help her. And this
helped her to realize that they are there for her son. Not just because it’s their job… they really care. And that he will be taken care of. This seems to be a repeating idea that I think may end up being a theme. It reminds me of theoretical concept of joining and unconditional positive regard. The therapists/staff are really connecting with mom, not just son, through including her, taking care of her, being there for her.

After finishing the open codes for the first parent and first youth interview, I discussed the open codes with my research mentor. She encouraged me to keep the codes concise and to include information about where the action was coming from in the code. For example, instead of writing “was more angry” as a code, she encouraged me to write, “youth was more angry.” I integrated her feedback into my coding and repeated this process of open coding for all of the parent and youth interviews. Then, I read through each interview a second time, carefully reading each line, to adjust and further refine the open codes.

**Focused coding.** The next step in the coding process was to sort and organize the most common and significant open codes into conceptual categories to represent recurrent themes seen in the data; a process known as selective or focused coding (Charmaz, 2003; 2006). Focused coding is more abstract and general than open coding and involves reviewing data across interviews. “Focused coding requires decisions about which initial codes make the most analytic sense to categorize your data incisively and completely” (Charmaz, 2006, pp. 57-58).

For my analysis, I copied the open codes from the first parent interview into a new document to make a list of all the repeating ideas or open codes (Auerbach & Silverstein, 2003). I then read through the list of open codes for that participant several times, combining the repeating ideas that were similar and beginning to organize them into conceptual categories. I
repeated this for each parent interview until I had 10 separate documents/lists of parent open/focused codes, one for each parent interview. Then, I combined the open codes from the first interview and the second interview into a master list of open/focused codes and continued to refine and organize the codes. One at a time, I combined the open codes from each parent open/focused codes list into the master list, while refining and organizing the codes each time. The result was a master list of all the parent open codes organized and grouped into focused codes.

As I organized the open codes into focused codes, I reread interviews, “comparing people’s experiences, actions, and interpretations” (Charmaz, 2006, p. 59) and referenced my memos in order to make decisions about which open codes fit together both within the same interview and across interviews. I grouped the open codes together and identified the focused code that fit with each group of open codes (Auerbach & Silverstein, 2003). For example, I grouped the open codes, showing an interest in me, therapist expressing concern for parent, feeling cared for by therapist, therapist wanting the best for the family, and therapist reaching out to parent under the focused code, parent feeling cared for by therapist.

At this point, I gave my codes to my research mentor for review. I further refined the focused codes by integrating her feedback for combining and organizing codes into the focused codes document. Once I had completed the focused coding of the parent interviews, I repeated this focused coding process for the youth interviews. Although I had already identified focused codes for the parents, I repeated this entire process for the youth interviews because I wanted to make sure that I did not force the youth codes into the parent codes. That said, most of the youth open codes were able to fit with the parent-focused codes. However, some new focused codes, specific to the youth, emerged. The result was a master list of open codes organized into focused
codes for parents and a separate list for youth. I then combined the parent and youth focused codes into one master document.

After developing my master list of combined youth and parent focused codes, I refined them by comparing the data to the codes. To do this, I carefully reread the transcripts and lists of focused codes to ensure that the codes actually represented what the participants were saying. As I was focused coding, I gained insight about the participants experiences, which sent me back to clarify earlier codes and interpretations. After I finished sorting and organizing the open codes into focused codes, I made a list of all the 73 focused codes. Auerbach and Silverstein (2003) recommend organizing and collapsing your codes until you end up with between 40 and 80.

Axial coding. While open coding is a way of breaking apart the data and analyzing each part of the data separately, axial coding is a structured process for putting the data back together (Charmaz, 2006). LaRossa (2005) stated that axial coding is about “developing hypotheses or propositions, which are statements about the relationship between or among variables [or codes/themes]” (p. 848). Thus, axial coding is the process of explaining how the codes and themes fit together. Charmaz (2006) proposed that axial coding, while providing a helpful framework, may limit researchers’ visions by encouraging them to “apply an analytic frame to the data…limit what and how researchers learn about their studied worlds and, thus, restricts the codes they construct” (p. 62). Charmaz (2006) suggested considering the relationships between categories (themes) and subcategories (focused codes) and reporting the links between them without using a prescriptive framework. I followed Charmaz’ recommendations while doing axial coding.

Before examining the relationships among the themes, I organized the focused codes into categories or themes (Auerbach and Silverstein’s, 2003). I started with the first focused code on
the list, therapist validating and accepting parent’s experiences, and moved it into the new
document to use as my starter code. Then I read through each code on the focused codes list until
I came to the next code that that seemed to be related to the starter focused code, therapist
encouraging parents. Both of these codes seemed to be about the therapist supporting the
parents. I moved it to the new document under that code. After reading through the entire list and
moving all of the codes related to the starter code I had my first theme. I repeated this process
until all the focused codes were grouped into themes. I continued reorganizing the focused codes
within the themes until they all seemed to fit together logically and conceptually. While doing
this, I named each of the themes. In the example given above, I added six more focused codes to
that theme: parent feeling cared for by therapist, parent liking and feeling connected with the
therapist, therapist being available to parents, therapist supporting and encouraging youth in his
treatment, youth having a good relationship with the therapist, and therapist going the extra mile
for youth and parents. I named this theme, therapist supporting and encouraging.

Next, I created a chart listing my themes, focused codes, and open codes. This visual
representation of my data helped me to see how my open codes, focused codes and themes fit
together. Throughout this axial coding process, I repeatedly went back to the data and my memos
to check my codes and to help me categorize the data and decide on the names of themes. Thus,
during this process I further reorganized and combined open codes, focused codes, and themes.
What resulted was a chart of 70 focused codes organized into 13 themes (see Appendix AA).
Then, I gave this chart and two additional handouts, a list of categories with focused codes (see
Appendix AB), and a list of themes (see Appendix AC), to the focus group of therapists. As
explained earlier, I asked the focus group participants to discuss the emerging conceptual
After having the audio from the focus group transcribed, I coded the focused group discussion. First, I read through the entire interview transcript and changed the names to common nouns, such as participant and program, to protect the confidentiality of the therapist participants. Next, I copied the transcript into a document and converted it to a table with three columns: transcript, code, and my thoughts. I read through the transcript line-by-line and wrote a code using action words in the “codes” column. As I coded the document, I went back to the parent and adolescent data, my focused and open codes, and the memos I had written to evaluate the therapists’ opinions about my codes.

After coding the focus group transcript, I integrated the information from the focus group into the parent and adolescent codes and further refined my focused codes and themes. I gave the updated themes, focused codes, and open codes chart my research mentor for review. She helped me clarify the meaning of some of the focused codes and themes and gave me feedback about codes that seemed to overlap conceptually. For example, one of the focused codes was labeled, feeling hopeful that everything was going to be all right. My research mentor commented/ questioned, “Will need to be specific about what “everything” means. Is it more about the hope for the youth’s future?” I went back to the data, looked at the open codes, that this focused code represented and then renamed the code, feeling hopeful the youth will successfully complete treatment. Following this review and discussion, I further organized and collapsed the codes. The result was 61 focused codes organized into 11 themes.

Next, I moved up a level of abstraction and developed theoretical concepts or statements about how the categories/themes linked together. To do this, I followed Auerbach and
Silverstein’s (2003) suggestion for organizing themes into theoretical concepts. First, I made a list of the 11 themes. After moving the first theme into a new document to use as the starter theme, I read through the list and moved connected themes under the starter theme. As I did this, I wrote a memo about how I thought the themes were linked and how I envisioned them relating to the sensitizing concepts for the study. In cases where a theme did not seem to fit into my sensitizing concepts, I thought about other information from the literature that might help to explain the theoretical concept that was emerging from the data. For example, my first theme listed was *youth and parents being hopeful about the future*, which I used as my starter theme. I read through the list until I came to the theme, *parents being committed to youth*. I moved that theme underneath the starter theme and wrote the following about how I thought they were linked; “this encourages hopefulness in youth.” As I read down the list of themes, I found two more themes that seemed to fit in this same group of themes, *therapist discouraging parent participation*, and *therapist supporting and encouraging youth and parents*. I repeated this process until each theme in the list was grouped to its related themes. I read through the lists I had created, reorganizing the themes and concepts until I felt that each theme was linked and represented the theoretical concept I was identifying. I then named the theoretical concept. In the above example, I thought about how the four themes I had grouped together all have to do with parents and adolescents having a sense of hope for the future. This reminded me of current family therapy literature, which highlights the importance of fostering hope in people to help facilitate change (Sprenkle, Davis, & Lebow, 2009). Thus, I named the theoretical code, *Fostering a Sense of Hopefulness*.

After grouping the themes into theoretical concepts, I gave a document that explained this
process and listed the concepts, themes, and memos about how I thought they were connected to my research mentor. She confirmed my process and gave me feedback about how I viewed the themes linking together and how I had named the conceptual categories. For example, she said, “I wonder if fostering hope is the backdrop by which parental involvement in treatment helps create positive outcomes. In other words, if hope is there it facilitates it…” I incorporated her feedback into my explanation of how the theoretical concepts linked. In addition, we discussed how some of the themes fit together and needed to be combined, while others needed to be divided into multiple themes. For example, therapist discouraging parent participation, seemed to be the converse of therapist supporting and encouraging; thus, I combined these two themes. With the help of my research mentor, I continued to organize the theoretical concepts, themes, and codes until we felt they accurately reflected the participants experiences and there was no conceptual overlap between the theoretical concepts and themes. The final conceptualization of family therapy consisted of eight themes organized into three interrelated theoretical concepts: Fostering a Sense of Hopefulness, Using Parents to Help Motivate Youth and Facilitate Changes in Youth and Family, and Outcomes: Changes in Individuals and the Family System (see Appendix AF). I explain these concepts and themes in detail in the results section.

**Trustworthiness**

To demonstrate the trustworthiness of my research, I used triangulation, member checking, an audit trail, and thick, rich description (Creswell & Miller, 2000). Anfara, Brown, and Mangione (2002) argued that while these strategies are good, most researchers do not go far enough in providing explicit evidence in how these strategies were achieved in a given study. Thus, I followed their recommendation and provide documentation tables (see Appendix AG)
explain how the research questions were related to interview questions, how triangulation was accomplished, and how the themes emerged from the data. The use of these documentation tables allows me to publicly disclose the methods and research processes I used in this study.

**Research questions in relation to interview questions.** To show how each of my interview questions were related to my research questions, I include a matrix in which I listed each research question and then put a code for the corresponding interview question in the next column (see Table AG1 in Appendix AG; Anfara et al., 2002). The use of this matrix demonstrates trustworthiness because it makes overt my decisions about how the interview questions were intended to obtain information specific to my research questions. The matrix also enhances the replicability of the study because it allows the reader to make judgments about how well the results may address the research questions (Anfara et al., 2002).

**Triangulation.** I collected multiple sources of data by interviewing adolescents, parents, and clinicians. While analyzing these interviews, I looked for a convergence of themes and categories across multiple perspectives, which is known as triangulation (Creswell & Miller, 2000). Finding the same themes across multiple sources of data enhances the likelihood that the theme or abstract categories I have chosen, in fact, represent what the participants are reporting. In addition, I compared the emerging themes and categories to the existing literature on adolescents who sexually offend, treatment for this population, and family systems theory. In order to be clear about how I triangulated the data from this study, I include a findings and data triangulation documentation table (see Table AG2 in Appendix AG), which demonstrates how I triangulated the data (i.e., interviews, observation, questionnaire, and literature) by being explicit about how each source of data was used to develop the codes, categories, and themes (Anfara et
**Member checking.** Member checking is the process of taking the results of a study back to the participants in order for them to confirm or disconfirm the accuracy of the information provided (Creswell & Miller, 2000). After collecting and analyzing the data, I returned to the 9 (of 10) adolescents and 13 (of 15) parents who had agreed to participate in member checking process. I sent these participants a summary report of my findings through email or mail (see Appendices N-P). This summary report included a general explanation of my theoretical concepts and conceptual framework. I asked the parents and adolescents to complete and return a questionnaire about their reflections on my findings (see Appendix P). The questions on the questionnaire included: What are your thoughts and feelings about the themes I came up with? Is there anything in the themes that you disagree with? Is there anything else you’d like to share with me? Any thoughts or feelings that have come up for you since our interviews? Do you have any further recommendations for therapists?

In conducting the member check, I was most interested in hearing if the findings made sense to the participants and if they considered the findings to be realistic and accurate (Creswell & Miller, 2000). After multiple follow-ups via email and phone, I received member checking information back from three of the parents and none of the adolescents. All three of these parents indicated that they agreed with the results. One mother stated, “Your findings are spot on. I would like therapists to know that their work with the youths and their families matter and makes a difference in our lives long after we are no longer in the treatment setting” (P5). The small number of questionnaires returned did not help much with trustworthiness, but they did indicate that my results fit for the participants in this study.
Audit trail. Another way of demonstrating the trustworthiness of a grounded theory study is by creating an audit trail (Creswell & Miller, 2000). An audit trail establishes the trustworthiness of a study because it allows other researchers to replicate a study and see exactly how the researcher made decisions about data collection and analysis. Throughout this research project, I kept clear documentation regarding how I collected the data and made decisions about developing my themes and theoretical concepts. More specifically, I kept a log outlining my data collection procedures. As described earlier, I also wrote memos while interviewing and during the data analysis process as a way of documenting my thinking and how I made decisions regarding the way I chose initial codes and grouped codes into focused codes and themes. Finally, I developed documentation tables (see Table AG3 in Appendix AG) to demonstrate the process of how I made decisions of developing themes from the initial codes (Anfara et al., 2002).

Thick, rich description. Finally, as I wrote about my findings, I established trustworthiness by including thick, rich description and providing as much detail about the participants’ experiences as possible. To accomplish this, I used quotes and the language of the participants in the write-up of the findings. This amount of detail allows helps “readers make decisions about the applicability of the findings to other settings or similar contexts” (Creswell & Miller, 2000, p. 129).
Chapter Four: Results

Based on the perceptions of the clients themselves, the purpose of this research was to develop a conceptual framework of family inclusion in the adolescent male’s treatment for sexual offending. Through semi-structured interviews, I listened to 10 adolescent boys and their parents talk about their experiences of participation in family therapy when the adolescent son had been required to complete treatment for sexual offending. In addition, I learned how the parents’ and adolescents’ participation in family therapy related to the adolescents’ progress in treatment for sexual offending. Using a constructivist grounded theory approach (Charmaz, 2006), I analyzed the interviews and then presented my findings to a focus group of family therapists who specialize in the treatment of adolescents who sexually offend. During the focus group discussion, the therapists talked about how the emerging conceptual framework was consistent and inconsistent with what they had observed in providing family therapy for adolescents who sexually offend. I integrated their recommendations into the emerging conceptual framework. I then went back to the participants to do member checking to verify that my results were consistent with their experiences.

Description of the Participants

Family participants.² Ten families made up of 10 adolescent boys and 15 parental figures (9 mothers, 2 fathers, 3 grandmothers, and a domestic partner) participated in this study. The parent interviews consisted of 6 interviews with mothers only, 1 interview with a couple (mother and father), 2 interviews with a mother and grandmother, and 1 interview with a father, his domestic partner, and grandmother.

²All percentages are rounded to the nearest whole number, therefore, totals may not equal 100%.
The adolescent boys were between the ages of 14 and 17, with the mean age being 16. Of the adolescent boys, five (50%) self-identified as being Caucasian, four (40%) as Caucasian-Hispanic, and one (10%) as Black-Hispanic. Each of the adolescent boys were in treatment for having committed at least one sexual offense against a minor. Five (50%) young men were living in a residential treatment program, three (30%) youth were living with family members and attending out-patient treatment programs, one (10%) youth was living in a proctor family attending a day treatment program, a foster home for youth in the juvenile justice system, and attending a day treatment program, and one (10%) youth had just moved home from a residential treatment program and was completing his treatment at this residential program as an out-patient client. The youth reported they had been in treatment for sexual offending between 11 and 36 months, with an average of 22 months in treatment. Additionally, they had participated in 13 to 50 family therapy sessions, with the average being 26 family therapy sessions. The adolescents had committed between 1 and 41 contact sexual offenses (Mo = 1 and 2; n = 7) and between 0 and 1 non-contact sexual offenses (Mo = 0; n = 7). The youth were between the ages of 7 and 14 (Mo = 13; n = 8) the first time and between 13 and 15 (Mo = 14; n = 8) the last time they sexually offended. The ages of the victims were between 2 and over 18. All of the youth sexually offended both males and females. See Table 1 for additional demographic information regarding the adolescent participants’ sexual offending behavior.
Table 1

Adolescent Sexual Offending Demographics

<table>
<thead>
<tr>
<th></th>
<th>Number of contact offenses (n = 7)</th>
<th>Number of non-contact offenses (n = 7)</th>
<th>Age at first offense (n = 8)</th>
<th>Age at last offense (n = 8)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mode</strong></td>
<td>1, 2</td>
<td>0</td>
<td>13</td>
<td>14</td>
</tr>
<tr>
<td><strong>S.D.</strong></td>
<td>14.65</td>
<td>0.53</td>
<td>2.19</td>
<td>0.756</td>
</tr>
<tr>
<td><strong>Range</strong></td>
<td>1 - 41</td>
<td>0 - 1</td>
<td>7 - 14</td>
<td>13 - 15</td>
</tr>
</tbody>
</table>

*a 2 questionnaires were not returned; 1 did not report total number of offenses

The parents were between the ages of 32 and 82, with the mean age being 45 (n = 13, as 2 parent participants declined to disclose their ages). Of the parents, twelve (80%) self-identified as being as Caucasian, one (7%) as Native American, one (7%) as Caucasian-Native American, and one (7%) as Hispanic-Black. Parents’ marital status consisted of seven married (46%), three divorced (20%), two domestic partnerships (13%), one single (7%), one widowed (7%), and one separated (7%). Parents reported their highest level of education: four had a 2-year associates degree (27%), three had a high school diploma or GED (20%), two had not completed high-school (13%), two had a vocational degree (13%), two had some college (13%), one had graduate degree (7%), and one was undisclosed (7%).

All of the families were from regions throughout Oregon. Five (50%) families lived in rural communities within an hour of Portland, four (40%) families lived in the Portland Metro area, and one (10%) family lived in Central Oregon. The number of children in each family (both in and out of the home) ranged from 1 to 5, with the average number of children per household being 3. One (10%) family reported their annual household income as being below $15,000, two (20%) were between $25,001 and $40,000, five (50%) were between $40,001 and $60,000, one (10%) was between $75,001 and $100,000 and one (10%) income was undisclosed. See Table 2.
for a summary of the demographic information for each of the families. However, to protect the
identities of the participants, some of the family demographic information presented is not
included in this table.

Table 2

*Family Demographic Information*

<table>
<thead>
<tr>
<th>Family</th>
<th>Parent/caregiver interviewed</th>
<th>Parent marital status</th>
<th>Combined annual household income</th>
<th>Parent education</th>
<th>Number of children&lt;sup&gt;a&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>mother</td>
<td>married</td>
<td>$25,001-40,000</td>
<td>less than high school</td>
<td>4</td>
</tr>
<tr>
<td>2</td>
<td>mother</td>
<td>divorced</td>
<td>$40,001-60,000</td>
<td>high school or GED</td>
<td>4</td>
</tr>
<tr>
<td>3</td>
<td>mother</td>
<td>divorced</td>
<td>&lt; $15,000</td>
<td>undisclosed</td>
<td>3</td>
</tr>
<tr>
<td>4</td>
<td>mother, father</td>
<td>married, married</td>
<td>$40,001-60,000</td>
<td>graduate 2-year associates</td>
<td>4</td>
</tr>
<tr>
<td>5</td>
<td>mother</td>
<td>married</td>
<td>$40,001-60,000</td>
<td>vocational</td>
<td>2</td>
</tr>
<tr>
<td>6</td>
<td>mother</td>
<td>married</td>
<td>$25,001-40,000</td>
<td>some college</td>
<td>5</td>
</tr>
<tr>
<td>7</td>
<td>mother</td>
<td>married</td>
<td>$75,001-100,000</td>
<td>high school or GED</td>
<td>3</td>
</tr>
<tr>
<td>8</td>
<td>mother, grandmother</td>
<td>single, divorced</td>
<td>$40,001-60,000</td>
<td>vocational 2-year associates</td>
<td>4</td>
</tr>
<tr>
<td>9</td>
<td>father, partner grandmother</td>
<td>domestic partner, domestic partner married</td>
<td>$40,001-60,000</td>
<td>some college high school or GED 2-year associates</td>
<td>1</td>
</tr>
<tr>
<td>10</td>
<td>mother, grandmother</td>
<td>separated, widowed</td>
<td>undisclosed</td>
<td>2-year associates less than high school</td>
<td>3</td>
</tr>
</tbody>
</table>

<sup>a</sup>Total number of children both in and out of the home. Some of the children were living in the home, some were older and living on their own, and some were in residential or foster homes.
**Focus group participants.** Seven family therapists who specialize in doing family therapy with adolescents who sexually offend participated in the focus group. Five (71%) participants were female and two (29%) were male. All of the therapists self-identified as being Caucasian. The therapists ranged in age from 33 to 68, with the mean age being 52. The therapists reported that they had been providing family therapy for adolescents who had sexually offended for between 5 and 30 years, with an average length of 16 years. Five (71%) of the therapists were licensed clinical social workers (LCSW), one (14%) was a licensed professional counselor (LPC), and the other therapist (14%) was a licensed clinical psychologist.

**Conceptual Framework of Family Therapy for Adolescents Who Sexually Offend**

In developing a conceptual framework of parents’ involvement in their son’s treatment for sexual offending, three overarching theoretical concepts emerged. These included (a) Fostering a Sense of Hopefulness, (b) Using Parents to Help Motivate Youth and Facilitate Changes in Youth and Family, and (c) Outcomes: Changes in Individuals and the Family System. For an outline of the theoretical concepts, themes, and focused codes along with the prevalence of parents and youth who talked about each code/theme, see Table 3. In the following sections, I will provide an overview of the overall framework and describe how the three theoretical concepts are linked to represent a conceptual framework of family therapy in the adolescents’ treatment for sexual offending (see Figure 1). Then, for each of these theoretical concepts, I will provide a description of the theoretical concept and the themes that make up the concepts, as well as an explanation of the relationships between the themes and the theoretical concept.
Table 3

Summary of Theoretical Concepts, Themes, Focused Codes

<table>
<thead>
<tr>
<th>Theme and Focused Code</th>
<th>Prevalence</th>
<th>Parents (n = 10)</th>
<th>Youth (n = 10)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Theoretical Concept: Fostering a Sense of Hopefulness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1 Therapist supporting and encouraging youth and parents</td>
<td>10</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Therapist validating parents’ and youths’ experiences</td>
<td>7</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Therapist praising youth and parents abilities and growth</td>
<td>7</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Therapist caring for youth and parents</td>
<td>5</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Therapist connecting with youth and parents</td>
<td>9</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Therapist encouraging youth and parents in treatment</td>
<td>8</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Therapist presenting things positively</td>
<td>6</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Therapist being available to youth and parents</td>
<td>6</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Therapist going the extra mile for youth and parents</td>
<td>6</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Therapist considering individual family needs</td>
<td>6</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>1.2 Parents being committed to youth</td>
<td>9</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Parents encouraging and supporting youth in his treatment</td>
<td>8</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Parents having and expressing unconditional love and commitment</td>
<td>9</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>1.3 Youth and parents recognizing changes</td>
<td>8</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>Youth and parents seeing the youth changing</td>
<td>8</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>2. Theoretical Concept: Using Parents to Help Motivate Youth and Facilitate Changes in Youth and Family</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.1 Therapist teaching skills and giving tools to youth and parents in family therapy</td>
<td>10</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Therapist teaching skills through modeling, giving feedback, and practicing</td>
<td>10</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Therapist teaching communication skills</td>
<td>7</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Therapist encouraging responsibility and honesty in youth</td>
<td>10</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>Youth and parents expressing their feelings</td>
<td>9</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Learning parenting skills</td>
<td>10</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>2.2 Partnering with parents in family therapy</td>
<td>10</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Finding strength in parents being a part of the family therapy</td>
<td>10</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Parents helping youth change</td>
<td>8</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Parents and family motivating youth</td>
<td>4</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>Parents/caregivers taking a break motivated youth to work harder</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Therapist partnering with parent to help youth</td>
<td>10</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Theme and Focused Code</td>
<td>Prevalence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------------------</td>
<td>------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Parents&lt;sup&gt;a&lt;/sup&gt;</td>
<td>Youth</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(n = 10)</td>
<td>(n = 10)</td>
<td></td>
</tr>
<tr>
<td>2.3 Strengthening family connections in family therapy</td>
<td>10</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Facilitating clarification and healing within the family</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Strengthening relationships/bonds</td>
<td>7</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>Improving the quality of youth and parent interactions</td>
<td>7</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Facilitating family reconnections</td>
<td>8</td>
<td>8</td>
<td></td>
</tr>
</tbody>
</table>

3. Theoretical Concept: Outcomes: Changes in Individuals and the Family System

3.1 Witnessing growth in youth

- Seeing him develop into a man | 10 |
- Parents noticing the changes in him | 5 |
- Expressing himself more clearly | 8 |
- Caring about people around him now | 10 |
- Thinking about his future and setting goals | 2 |
- Having more confidence in himself | 4 |
- Following the rules | 5 |
- Progressing in his treatment work | 3 |
- Being responsible for his behavior | 8 |
- Becoming more honest with himself | 3 |
- Developing life skills | 3 |
- Understanding and expressing regret for sexually offending | 6 |
- Recognizing he still has changes to make | 9 |

3.2 Having new family dynamics

- Changing family household rules | 10 |
- Changing family roles | 5 |
- Setting boundaries in and around family | 8 |
- Having respectful communication as a family | 5 |
- Family talking with each other more often | 4 |
- Resolving conflict in the family | 6 |

<sup>a</sup>Interviews containing more than one parent, were coded as one participant.
Overview. The first theoretical concept, *Fostering a Sense of Hopefulness*, captures how therapists help youth and parents develop and maintain hopefulness for their future; fostering a belief that they would complete treatment successfully and be able to be a family again. Through supporting and encouraging youth and parents, therapists helped youth and parents feel hopeful, which participants linked to successful outcomes for both the youth (i.e. caring about others, completing treatment assignments) and the family (i.e. changing family household rules, roles, and boundaries). Successful outcomes are the positive individual and family changes that
participants identified making as a result of being involved with family therapy. In addition, through supporting and encouraging the adolescents and their parents, therapists helped parents remain committed to the youth. Parents being committed to and supporting the youth in their treatment helped youth to feel hopeful about completing treatment and be able to make changes, such as changing their sexual offending behaviors and thinking more about and planning for the future. Furthermore, recognizing that the youth were making positive changes contributed to adolescents and parents feeling hopeful and further reinforced the parents’ commitment to youth.

The second theoretical concept, *Using Parents to Help Motivate Youth and Facilitate Changes in Youth and Family* depicts how, when parents and youth participate in family therapy, therapists can use parents to help the youth and family make changes that support the youths’ successful completion of treatment. Through modeling skills, giving feedback to youth and parents about skills, and practicing skills in family therapy sessions, therapists taught youth and parents skills in family therapy, which helped the youth and parents feel hopeful and helped them make individual and family changes. More specifically, therapists taught youth and parents how to communicate and express their feelings, especially around the youths’ sexual abusing behavior. Learning these skills helped strengthen the youth and family connections and facilitated individual and systemic change to help the youth complete treatment successfully. Additionally, youth and parents talked about how therapists taught the parents skills to improve their parenting. This helped change youth and parent interactions, which strengthened their emotional connections to one another and led to individual and family changes. For instance, using parenting skills helped parents hold youth accountable for their behavior and provide supervision for their sons, which supported the youths’ goals of not reoffending sexually.
Furthermore, therapists encouraged the youth to be responsible for their behaviors and to be honest, which helped youth make individual changes, such as understanding and expressing regret for sexually offending. This also helped parents improve their parenting skills as they learned to hold youth responsible. Finally, and in addition to learning skills and tools, parents and youth described being involved in family therapy allowed therapists to partner with parents to motivate and help the youth to complete treatment assignments, which participants viewed as contributing to successful outcomes for the youth and family.

The third theoretical concept, *Outcomes: Changes in Individuals and the Family System*, represents the youth and parents perceiving that they made positive individual and systemic changes through being involved in family therapy as a part of the youths’ treatment for sexual offending. Youth and parents identified a number of positive changes the youth had made in treatment for sexual offending such as expressing himself more clearly, caring about people around him, thinking about his future and setting goals, having more confidence in himself, following the rules, progressing in his treatment work, being responsible for his behavior, becoming more honest, developing life skills, and understanding and expressing regret for sexually offending. In addition, parents and youth identified changes they made as a family. Some of these changes, which were perceived as being positive, included changing household rules, including limiting the children’s use of media and having expectations of youth to help around the house, changing family roles, such as parents becoming more in charge, setting boundaries in and around the family, and having more respectful communication as a family. Youth and parents identified these outcomes as resulting directly from the other two theoretical
concepts, *Fostering a Sense of Hopefulness* and *Using Parents to Help Motivate Youth and Facilitate Changes in Youth and Family*.

**Fostering a sense of hopefulness.** The first theoretical concept, *Fostering a Sense of Hopefulness*, represents the process of youth and parents developing and maintaining hope for their future in the midst of a difficult time for them individually and as a family; the adolescent son being in treatment for sexual offending. Their hope centered around the belief that the youth would complete treatment successfully and they would be reunified as a family. Three themes emerged within this theoretical concept. In the first theme, *therapist supporting and encouraging youth and parents*, parents and adolescents described how the family therapist worked to develop a relationship with them and that they felt connected to and cared for by the therapist. Feeling supported and encouraged by therapists, in turn, helped foster a sense of hopefulness that the family could successfully make it through treatment. Therapists supporting and encouraging youth and parents linked to the next theme, *parents being committed to youth*. The parents and adolescents described the commitment parents showed to the youth by expressing their unconditional love and supporting and encouraging the youth in their treatment. This was important to the youth feeling hopeful about completing treatment and to being able to change their sexual offending behaviors. The final theme of this theoretical concept, *youth and parents recognizing changes*, is about the youth and parents recognizing that the youth were making changes, which helped them feel more hopeful that the youth would successfully complete treatment and that they would be reconnected as a family once again. In addition, when parents felt hopeful that the youth were changing, they felt more committed to the youth. As I describe these three themes in detail in the following sections, I will talk more about the relationships
between the themes and how they work together to foster a greater sense of hopefulness in youth and parents (see Figure 1).

**Therapist supporting and encouraging youth and parents.** This theme, *therapist supporting and encouraging youth and parents*, focuses on the ways in which therapists provide support and encouragement for the youth and their parents. Adolescents and parents experienced feeling supported and encouraged when therapists were validating, praising, caring, positive, available, and considering individual family needs. Through supporting and encouraging, therapists developed relationships with parents and youth, which helped give them confidence and assurance that they would be able to complete treatment and be a family again, which promoted a larger sense of hopefulness. Furthermore, the focus group participants identified the therapist developing a relationship with youth and parents as important in the youth and parents process of change.

**Validating.** One way that therapists supported and encouraged parents was through validating parents’ experiences. Parents reported that they appreciated therapists validating what they were going through because it helped them feel understood and accepted. One mother explained:

> It’s been a long process … the part that touched me so much was that they always called it for what it was. They were always right there validating how I was feeling. They never made me feel like I was stupid for not realizing this beforehand. (P7)

Several parents discussed feeling a great deal of responsibility and blame from themselves and society for their son sexually offending. In addition, some parents reported how they felt blamed by therapists, which interfered with therapeutic relationship and contributed to feelings of not
wanting to be involved in family therapy. The youth of these parents also talked about how when they saw the therapists blaming their parents, they did not want to be involved in treatment with those therapists. Conversely, parents felt encouraged and supported when therapists expressed understanding rather than blaming or judging them for the youths’ behavior. One parent explained how the therapist helped her realize that her son’s sexual offending was not her fault and that the therapist was not judging her,

It's [being involved in family therapy] not always comfortable because I think as a parent you're always kind of "Did I do something wrong? Am I not doing a good job? Am I a crappy parent?" The easiest thing to do is to take the blame for your kids, even though you try to remember that they make their own decisions a lot of the time no matter what you say. So it's uncomfortable in that sense, but it becomes comfortable when you realize that nobody's really judging you and they're encouraging you because it helps your kid to get through treatment if you're there and an active participant in it. (P5)

The therapists in the focus group talked about the importance of listening to, understanding, and accepting parents. One focus group participant explained how being a parent is difficult and that parents are doing the best job that they can. This focus group therapist went on to say that family therapists need to listen to parents and help them feel accepted and validated:

Having that parent have a chance to be able to talk to you about why this is so hard for them, so triggering for them, and just being really compassionate about that. All of a sudden they are like, “She gets it … is not going to make me feel horrible in front of my kid … To me, just aligning with the parent about what a struggle this is and, “I know how hard it is for you,” and that kind of stuff.
Feeling validated helped parents feel accepted by the therapists, which contributed to parents feeling connected with therapists and feeling hopeful about the youth being able to make changes. This, in turn, strengthened parents’ commitment to supporting the youth in their treatment.

Praising. In addition to the benefits associated with therapists’ validating behavior, several youth and parents also felt supported and encouraged when therapists noticed and praised them for how hard they were working in therapy. Hearing therapists acknowledge their efforts and accomplishments helped parents and youth to recognize their growth, which helped them to feel hopeful and believe that they would continue to change and complete treatment successfully. For example, as one father stated, “That he [the therapist] said that he’s already started to notice changes in me. I mean this is a guy who barely knew me. That must mean I’m doing something right” (P9). Another parent talked about feeling proud of herself when the therapist praised her for participating in family therapy and supporting her son,

The ones [therapists] here, they have been great, they praise me for being here, I’m being part of everything my son is doing. … They’re always telling me how great it is that I’m there for him. It feels really good. … It made me feel really proud. And you know, it’s not often a person gets to feel proud of themselves and knowing somebody says stuff like that, it helps. It makes you feel a lot better, especially in the midst of all this happening. (P1)

Likewise, when youth heard therapists praise them, they felt hopeful that they were changing, could continue changing, and would be successful at completing treatment. Even a simple, “Great job!” felt encouraging to youth (Y7). They particularly appreciated it when therapists
noticed and pointed out their achievements to their parents. One youth shared how good he felt when the therapist told him he was doing well in front of his family:

> It was like the best family counseling I could ever have … I saw the look on my mom and grandma’s face. It made me feel nice and welcome … By [therapist] saying, “… we’ve got our [higher level] guy now. He’s passed through the hardest [treatment] level they can ever pass.” He just kept cheering me on and everything. It was really nice. (Y10)

Youth and parents highlighted the importance of hearing therapists praise them. Hearing therapists commend them for their hard work, gave youth and parents support and encouragement to continue to make changes, and look toward their futures with a sense of hopefulness.

**Caring.** Additionally, parents and youth described feeling supported and encouraged when they felt cared for by therapists. Multiple participants gave examples of therapists showing an interest in them by asking them about their lives and checking up on them when they were struggling. Through reaching out to connect with them, therapists helped parents and adolescents feel cared for, supported, and more connected to the therapists. This, in turn, helped them to feel more positive and hopeful about the youth completing treatment. For example, a mother explained how the therapist caring for her family helped her have a good relationship with the therapist when she said:

> I've had a great relationship with [therapist]. … he's always thought about the family first, and what's best for [youth], but not just for [youth]; he thought about what's best for me and my husband too. (P6)
Conversely, a couple of parents expressed not feeling connected with or cared for by the therapist when they were not included in family therapy.

*Being positive.* Furthermore, most parents and a few youth appreciated when therapists were positive, ended sessions on a positive note, and showed how a positive could come out of a negative. Through this positivity, therapists encouraged youth and parents and gave them hope that things would get better – that the youth could be successful in treatment and that they would be able to be a family again. Even when they were talking about difficult subjects, such as the youths’ sexual abuse, therapists helped parents and youth to be positive and see hope for the future. One mother described how she felt discouraged when her son told her about his sexual offenses. She went on to explain that the therapist helped her to see his disclosure as being positive, “he [therapist] made a very dramatic … into a positive because he reminded me that even though it’s going to get harder, that disclosing is a very big step for [son] … (P2). A few youth also identified the positivity of the therapist as being supportive and encouraging, and ultimately fostering a sense of hope. For example, one youth described a typical family session in which he saw the therapist ending the session on a positive note, and how this encouraged him and his family to have hope for the future:

We’d walk in and be like, “Oh, we did this throughout the week.” [Therapist responded], “Good job!” “We also did this throughout the week.” Then she explains all the things we could’ve done differently … my mom and dad and I would talk and she’d sort of be there prompting us to different directions in the conversation. And then we’d work something out and … leave with high expectations. “We’re going to do this. We’re going to do good over the next week.” (Y7)
Conversely, some parents and youth said that hearing negative messages about the family and youth were discouraging. Rather, they preferred when therapists talked about and pointed out the positive in situations, which encouraged parents and youth to think more positively and be more hopeful about their futures. In addition, through seeing the therapists being positive, parents learned how to be positive themselves and support the youth in his treatment, which helped parents feel more committed to the youth.

*Being available.* Another way therapists developed relationships with adolescents and parents was through being available. Most parents and youth talked about how therapists being available and accessible to them helped them to feel supported, which contributed to them feeling hopeful. Parents described how therapists reached out to them to let them know they were available and how to reach them in between sessions by phone or email. Parents and youth talked about times when therapists adjusted their schedules to answer questions or spent time on the phone talking with them about unexpected stressful events or conflicts. In addition, parents felt that therapists were available to meet with and support them individually. One mother explained how she felt the therapist was available to support her:

> They’re there to help your child and they’re also there to help you to go over these bumps. And they’re there even if you want to call in the middle of the day and say hey, I just need someone to talk to. (P2)

Youth also noticed that therapists spent time alone with their parents and viewed this as the therapist supporting the parents. One youth stated, “There had been some times before or after family counselings where he just met with them; letting them know that the emotion is good and taking space is good” (Y8). Furthermore, therapists in the focus group indicated that it is
important for family therapists to meet with parents individually so that they can support the
parents.

Conversely, therapists not responding and not being available felt unsupportive to youth
and parents. Several parents and youth expressed feeling discouraged when therapists did not
return their phone calls, took another phone call during their family therapy sessions, frequently
cancelled, or did not show up for family therapy sessions. A mother explained how the therapist
being gone/not available slowed the treatment process down:

Every time there's a day off, we're sitting there going, "Really?" That's one more day
away from being done. … They can't control that and I understand that, too, but it's like
let's get on with it. One day away is one more day away. So the process is slow. There's a
lot of interruptions. (P5)

Her son also discussed this issue. He explained how the therapist missing appointments slows his
treatment progress down and holds him back from being reunited with his family:

To be honest, I’m kind of mad at him because he’s always gone. He skips out on me
sometimes. … If he’s not there then I can’t get stuff done. … it brings us all down
because it’s just a longer wait, because my whole family is waiting for me to get done.

The survivor that I hurt, she’s ready, and it’s kind of like having me being held back. (Y5)

Parents and youth discussed how family therapy was important to their progress and that it was
important the therapist be consistently available. When parents and youth felt that their therapists
where available to help them when needed, they were more hopeful and believed they would get
the help they needed to be successful in treatment.
Considering individual family needs. In addition to the therapist behaviors already mentioned, participants reported that therapists focused on what individual families needed, and were willing to accommodate special family needs. For example, participants shared stories of how therapists continued to meet with the family past the time when state funds ran out, served parents lunch after a long bus ride, or changed visiting times because of how far parents had to drive to pick up their youth from treatment programs. One mother talked about being amazed at how their family therapist seemed aware of what each family needed emotionally and how therapists responded to the families differently based upon their needs:

They [therapists] do it for every one [family] individual and it just amazes me that they keep them all straight. … this one needs a little more voice attention, which means, hey you’re doing a great job, did you need any help … where one needs more comfort. And everyone is different. I don’t know how they do it but they do. (P2)

Youth and parents expressed that the therapists responding to individual family needs, by making exceptions about program rules when needed, and connecting with them in the best way possible for each family, felt supportive, which helped them to feel more hopeful about the future. Therapists in the focus group confirmed this. As one focus group participant said, “we cannot assume family A equals family B equals family C.” Focus group therapists explained that therapists need to evaluate each family separately to identify their needs for treatment.

Parents being committed to youth. By supporting and encouraging parents through a number of different strategies (i.e., validating, praising, etc.), therapists fostered a sense of hope and helped parents be committed to their sons. This theme, parents being committed to youth, reflects how parents showed their commitment, or dedication, to the adolescents through
encouraging and supporting their sons in their treatment and by having and expressing unconditional love and commitment. When youth felt their parents were committed to them, were going to love and support them no matter what, the youth had hope that they could successfully complete treatment and that they would be reconnected as a family again. Furthermore, when parents saw youth progressing in treatment, they felt more hopeful, which also helped them to remain committed to their sons. The focus group therapists confirmed that in their practices, they have noticed that when parents feel more hopeful, they are more committed to the youth (see Figure 1).

**Encouraging and supporting.** Parents and youth expressed that part of the parents’ commitment to their sons, was to encourage and support the youth in their treatment, which helped youth feel more hopeful and confident about making changes in their lives. Youth explained that they experienced their parents commitment through feeling they have someone, their parents, there to support them and guide them in their daily tasks. For example, youth talked about parents helping them make decisions about how to interact with their peers, fill out job applications, and do their homework. When parents helped them from day to day, youth knew their parents were committed to being there and supporting them through their treatment. For instance, one youth described how he viewed his parents commitment as them being there to support him consistently, “they don’t just, they don’t give you the keys and say don’t crash. They sit in a car with you and they drive along. They help you out with your decisions” (Y2). Parents also recognized that their sons sought them out for support and felt it was important that they be available to help them. When the youth talked with their parents about successes and struggles they were having in treatment, it was helpful when parents listened, offered alternative
perspectives, and encouraged youth to seek support from their therapists and peers. Through being available to support and encourage youth in day to day activities, parents showed their commitment to youth in their treatment, which helped youth feel more hopeful about reconnecting with his family and completing treatment.

Another important way parents supported and encouraged youth was by giving them praise and positive feedback. This felt encouraging to youth and showed them that their parents were committed to them, which helped them to continue working in treatment and contributed to them feeling hopeful about completing treatment successfully. For example, one parent talked about how her son responds positively and is encouraged to work harder when she gives him praise, “It makes him do better … he thrives on praise” (P3). Alternatively, a youth shared how his parents praising him, “hearing from my family that I’m doing so well” (Y1) helped him feel more happy and hopeful. Thus, when youth saw that their parents were committed to being there for them, to encourage and support them, they felt more hopeful about being reunified with their families and successfully completing treatment.

Expressing unconditional love and commitment. Parents talked about being committed to and loving their sons unconditionally. They acknowledged feeling hurt and upset about what their sons had done – committing sexual offenses. In fact, they explained that they were disgusted by their sons’ sexual offending and were quite angry and struggled with feeling they did not like them very much at times. However, they said that no matter what their sons did, they loved them, were committed to them, and would be there for them. One mother summed up how many of the parents showed unconditional love and commitment to their sons:

No matter what he did, no matter how hurt I was, here I am. I know that’s what it is.
Because I’m so dedicated, because I choose to be here, every other week for family therapy, because one of those I love you, I may not like you today but I love you.

Because like he says, I’m the only one out of everybody that hasn’t just kinda [left]. (P3)

Youth also talked about how their parents were upset with them and struggled with liking them at times. Despite this perception, they said that they knew their parents loved them regardless. Youth recognized their parents’ love, commitment, and dedication to them and explained that it gave them hope. As one youth said:

Their involvement means … it shows me they still have hope. I betrayed their trust in one of the worst ways imaginable in a family and the fact that … they still care for me and are there for me every step of the way is a lot. (Y7)

Through encouraging and supporting youth in their treatment as well as expressing unconditional love and commitment, parents demonstrated their commitment to youth. When youth felt parents were committed to them, they felt more hopeful about being successful in treatment. Feeling hopeful, in turn, helped youth to engage in treatment and work towards completing assignments, which led to positive outcomes for youth, such as progressing in their treatment work. In addition, when parents saw youth working in treatment, they increased their commitment to youth.

Youth and parents recognizing changes. The final theme in the theoretical concept, Fostering a Sense of Hopefulness, is youth and parents recognizing changes. This theme describes how recognizing changes the youth were making gave adolescents and parents a sense of hopefulness about the youths’ futures. Parents and adolescents shared how having experiences in family therapy, such as the therapist supporting and encouraging, and seeing the youth work
and make changes helped them realize that treatment was working and that the youth were going to be able to successfully get through treatment. Parents talked about feeling hopeful that the youth were learning to understand themselves better, would not sexually offend again, and would have a positive future as an adult. Youth also recognized how seeing changes created a feeling of hope for their parents and themselves. A youth talked about his mom’s response to seeing he was making changes and progressing in treatment, “It made my mom more confident that I’m not the same person” (Y3). In addition, parents and youth explained that other family members (e.g., siblings and grandparents) became hopeful that the youth would complete treatment and return home. One parent explained:

His progress makes me hopeful that maybe, in a couple of years, maybe he’ll be able to go out and he’ll be a better person, be able to understand himself better. To where he’s not getting in trouble, that he won’t do it again. (P2)

Conversely, when the youth were not progressing in treatment, parents and youth felt discouraged and wondered if the youth would be able to complete treatment. One father described feeling worried when he did not see his son making changes:

For me, it was probably somewhere around the year mark, because most kids tend to be there a year, a year and a half at the most. [Youth] still was at the same spot he was when he started, pretty much, other than he was starting to talk more. And we had been bashing our heads against the wall trying to get across to him why he needed to change. We both just left going, “I don’t think he’s going to make it. He’s going to end up in prison labeled a sex offender for the rest of his life.” And we both were feeling pretty crappy that day. (P9)
This youth’s grandmother agreed, “Yeah, we both left that day feeling really crappy … saying that we don’t think he’s going to make it. We hadn’t given up on him, but we were pretty close to it” (P9).

Participants explained that therapists helped them recognize changes by talking about positive things the youth were doing in treatment, praising them for the changes they were making, and talking positively about the youths’ futures (see section on therapists encouraging and supporting). Focus group therapists confirmed that, in their counseling practices, they help instill hopefulness in youth and parents by helping them look towards the future and expect the youth to change. One focus group participant stated,

That’s where giving hope … is really important … Talking about what the reality of treatment is and what hope there is for the family. This is a kid, this isn’t a grownup, so what you see now is going to be different in five years.

As seen in Figure 1, when youth and parents recognized that youth were making changes, they felt more hopeful, which helped them to further engage in treatment and make additional changes, such as completing treatment work and communicating more as a family. Furthermore, feeling more hopeful about the changes youth were making, helped parents be more committed to youth.

Using parents to help motivate youth and facilitate changes in youth and family. The second theoretical concept in this conceptualization of family therapy is Using Parents to Help Motivate Youth and Facilitate Changes in Youth and Family. As seen in Figure 1, this concept depicts the process by which therapists utilize parents in family therapy to help youth and parents make individual and family changes – changes which also contributed to the youth and parents
feeling hopeful that the youth would successfully complete treatment. Three themes emerged within this theoretical concept. The first theme, *therapist teaching skills and giving tools to youth and parents in family therapy*, represents how therapists intervened and helped the youth and family system change. Specifically, therapists taught youth and parents communication skills, which helped them to communicate more respectfully and strengthened their connections as a family. Therapists also encouraged responsibility and honesty in youth, which helped youth take responsibility for their sexual offending behaviors. In the process of helping youth to become more honest and responsible, therapists encouraged parents to hold youth responsible, which helped strengthen their authority as parents. Additionally, therapists gave parents and adolescents tools to promote emotional expression, particularly around the sexual abuse, which helped strengthen youth and family connections and facilitated change in the youth (i.e. expressing himself more clearly and expressing regret for sexually offending) and the family (i.e. changes in family boundaries). Finally, therapists helped parents improve their parenting skills and change how they interacted with their sons, which strengthened family connections and facilitated changes in the family dynamics, such as parents having greater authority and supervising youth as a team. In addition, resulting changes in parenting helped youth make changes that helped them with their treatment, such as youth following the household and probation rules. The second theme, *partnering with parents in family therapy*, shows how therapists partnered with parents to help youth progress in treatment. For example, in family therapy, therapists had parents work with youth on the youths’ treatment assignments (e.g., writing apology letters), thus helping youth progress in treatment and make changes, such as understanding and expressing regret for sexual offending. In the third theme, *strengthening family connections in family*
Therapy, therapists helped parents and youth have new experiences of relating as a family and learn how to have healthy connections, which lead to the changes in family dynamics, such as better family communication.

**Therapist teaching skills and giving tools to youth and parents in family therapy.** The theme, *therapist teaching skills and giving tools to youth and parents in family therapy*, is about the process of therapists teaching parents and youth skills, such as communication, responsibility and honesty in youth, emotional expression, and parenting skills, which participants described as facilitating individual and family changes. Specifically, therapists taught skills that helped the youth make changes such as caring about people around him, following the rules, and understanding and expressing regret for sexually offending, all of which support the youth being safe and not sexually offending. Therapists also taught skills that helped families make systemic changes such as having new household rules, family roles, and setting boundaries in and around the family, and resolving conflict in the family. When combined with the youth’s individual changes, these changes in family structure helped to further support the youths’ goals of not sexually reoffending. Participants suggested that therapists taught these skills through modeling behaviors, giving feedback to adolescents and parents, and helping youth and parents practice skills in family therapy sessions.

**Modeling, feedback, and practicing skills.** Parents and youth discussed the process by which they learned new individual and family skills in family therapy. They talked about seeing therapists model skills, hearing the therapist give them direct feedback about their mastery of these skills, and practicing the new skills in therapy sessions through completing worksheets and role playing. Therapist participants said that modeling skills and giving parents and adolescents
clear and direct feedback is an important part of helping parents and youth learn new skills. One therapist stated, “once in a while you have to be stern … realistic.” Parents and youth said they benefited from therapists being direct and to the point in their skill training; they did not find “sugar coating” helpful when receiving feedback from the therapist. In addition, and in the spirit of the previous discussion about the value of therapists building hopefulness, participants said it was helpful when therapists identified their strengths before telling them that they needed to do something differently. Parents and youth talked about how after learning skills in family therapy, they started using them at home, which further contributed to the changes they made. For example, one mother talked about learning parenting skills through watching how the therapist worked with her son in family therapy and then taking those skills and successfully using them with the youth in treatment and her other children:

I would watch how [therapist] would talk to [youth], and I observed how youth would respond. So, I was watching some of his tools that he was using. So, I took them home. They were for free. I watched how he [therapist] would ask him [youth] a question and he'd [therapist] stop. And he'd let [youth] respond … And then I had been through so many therapy sessions that I knew how to do what he was doing. And I even tried it out with the younger kids to see if it worked. And it's very effective. (P6)

Through giving direct constructive feedback, modeling, and practicing skills in family therapy sessions, therapists helped parents and youth learn new skills. By teaching these skills in the context of family therapy sessions, versus to the youth individually, therapists used parents to help the youth and the family make change. Specifically, parents and adolescents took the new skills and used them outside of therapy, particularly at home with other family members. This
helped youth and parents to make changes in the ways they individually behaved, such as the youth sharing his feelings, and as a family, such as listening to each other and communicating more as a family.

*Teaching communication skills.* Of the many skills learned in the context of family therapy, youth and parents made special note of the value of learning communication skills during family therapy sessions. Therapists guided their conversations by asking them questions, helping them to listen to, paraphrase, validate each other, and helping them to recognize and respond to non-verbal communication. In addition, therapists facilitated conversations by keeping parents and youth focused and on topic or serving as a mediator. One mother explained how the therapist helped her family listen to each other better. She explained that the therapist guided communication during a family session with her son, husband, and herself by acting as a mediator:

[Therapist] acted as a mediator between us and that worked really well because we've got emotions flying. … When you have a mediator there, they can see it from all the different angles and they can draw you back [refocus] … Or if there's disrespect, she'd [therapist] call it out …[or ask] could you repeat … just so that I know what you just said.” (P7)

The youth in this family example also talked about how the therapist helped his family communicate better together. He explained that through directing their conversations and keeping them focused on the topic in family therapy, his family became more comfortable talking with each other and started to direct their own conversations:
we learned to start directing our conversations a lot better, and we didn’t need [therapist]
as much to be there guiding us through our conversations, keeping us on topic. We are a
lot more comfortable talking to each other now. (Y7)

In family therapy sessions, therapists used parents to help youth and parents change the ways
they communicated together. This helped them to understand each other better and feel closer as
a family. Furthermore, participants identified changes they made in their communication such as
talking more often and respectfully to each other. When youth and family saw that they were
changing and communicating better together, they felt more hopeful and were motivated to
continue making changes.

Encouraging responsibility and honesty in youth. Another skill that parents and youth
highlighted as important was therapists encouraging youth to take responsibility for themselves
by holding the youth responsible for their attitudes and behaviors. Youth and parents said that it
was helpful when therapists gave youth rules and had high expectations for youth. For example,
one mother stated that the therapist, “set the bar about what it means to be not just a man, but a
good man” (P6). In family therapy sessions, therapists expected youth to take responsibility and
be honest, which helped youth to make changes, such as following the rules. This also modeled
parenting skills for parents, which parents said helped them make changes in the family system,
such as the parents setting rules and boundaries for the adolescents at home and in other
contexts.

Therapists helped youth learn to take responsibility for their behaviors, particularly
sexual offending, through pointing out to youth how they would be better off if they made some
changes, which encouraged the youth decide to be responsible. Youth and parents also talked
about therapists helping youth learn how to make decisions about their behavior and then to take responsibility for their decisions. Parents and youth explained how the therapist helped youth to think about what would happen if he did not start taking responsibility for his sexual offending behaviors, such as going to a juvenile correction facility, and then let the youth make his own decision; be responsible. For example, a youth explained how the therapist helped him make decisions about his behavior by giving him choices, which helped the youth to feel responsible for those decisions:

[Therapist] kind of gave me choices, like you either go the bad way or go the good way. Really, treatment is a lot up to you [youth], you taking responsibility for the stuff you do. So it’s really up to the person to get stuff done. It’s not really up to the counselors … because the counselors can’t force you to care. They can only … lead you in that direction, but it’s really ultimately your choice to care, and ultimately your choice to get stuff done. (Y5)

Another way therapists helped youth to learn to be responsible for themselves is by encouraging them to be honest about their behaviors. Parents and youth talked about how therapists expected honesty, always seemed to know when the youth was being honest, and supported the youth in being honest. One mother explained how the therapist encouraged honesty through telling the youth how he could tell that the youth was not being honest, “[youth] you’re not being honest because you are stumbling over your words” (P8). Parents and youth said that it was helpful when therapists helped youth to open up and be honest without being afraid of consequences. One mother explained how the therapist encouraged her son to be honest about his behavior by assuring him there would not be further consequences for telling the truth,
“No matter what you say at this point, you know you’re not going to get in any more trouble. As long as you’re not hiding anything, we’re good. We’re here to help you” (P1). Her son also talked about how his therapist encouraged him to be honest and not worry about consequences or being judged for what he did:

   Even if I do wrong and then I tell them about it. Instead of you’re getting a consequence right now by being out of this program in two days. It’s more of thank you [youth] for at least letting us [therapists] know. … And it’s usually no consequence. … I won’t be judged as long as I come out and be honest … he [therapist] told me that no matter what I won’t be judged. (Y1)

Focus group participants also talked about how it is important for therapists to be upfront about consequences for youth talking about their offenses. They said that by talking about this at the beginning of treatment, youth will know what to expect and will be able to be more honest.

Through encouraging responsibility and honesty in youth, therapists helped youth make changes, such as being responsible for his behavior even when he was not at the treatment program.

Because therapists encouraged responsibility and honesty in youth during family therapy sessions, rather than only in individual sessions, therapists were able to model these skills to parents. Furthermore, parents reported that they took these skills and used them at home, which further supported the changes youth were making and helped them changed the family structure (i.e. parents being more charge).

Youth and parents expressing their feelings. In addition to the other skills therapists taught (i.e. communication, etc.) adolescents and parents reported that family therapists helped them explore and express their feelings, particularly around the adolescents’ sexual offending.
Furthermore, family therapists assisted in helping youth and their parents express difficult emotions, such as feelings of anger and wanting to avoid each other, which helped the participants talk through difficult issues that had contributed to them feeling disconnected as a family. Thus, by learning to express their feelings productively, the participants felt that they were able to strengthen their connections and feel closer as a family. According to participants, teaching youth and parents to talk about their feelings also facilitated positive outcomes in the youth and family, such as the youth expressing himself more clearly and the family having more respectful communication.

Within the larger context of expressing their feelings, family therapists helped youth and parents deal with feelings behind what had happened, namely the adolescents’ sexual offending. Parents talked about how family therapy had helped them learn to express their feelings of deep disappointment and sorrow related to the youths’ sexual offending. Parents said that they did not think something like this would ever happen to their family and went on to explain how family therapists asked them questions to help them express their feelings. For example, one parent related how the therapists’ non judgmental attitude and questions encouraged her expression of grief about her sons’ sexual offending:

[Therapist] would ask these real deep questions, and he never put me down. He wasn't judgmental. … There were places where I don't feel like I was allowed to really grieve and be angry and be sad and on the level that he knew I was on. And so, he would ask me these questions and it opened up the door for me to be free. (P6)

In family therapy, therapists also helped youth to open up and express their feelings about their sexual offending. Therapists facilitated this process by encouraging youth to express and process
emotions and by helping parents encourage youths’ emotional expression. Participants perceived that expressing their emotions contributed to youth making changes, such as expressing regret for sexually offending. For instance, one parent explained how her son expressing emotions in family therapy helped him to start taking responsibility for sexual offending:

We were talking about [youth]'s issues [sexual offending] and I seen my son cry. I seen that release come forth…. he was holding and holding and holding. … then he started talking about how he really felt. And he started taking responsibility. (P6)

Furthermore, parents and youth talked about how sexual offending or having a son who sexually offends is a shameful experience. They said that it was helpful to talk about these feelings during their family therapy sessions. By discussing the sexual offending in family therapy, therapists assisted youth and their parents in moving past feeling shameful for having sexually offended or having a son who sexually offended. In addition, parents learned to relate to their sons differently and how to help their sons express their feelings by watching how the therapists guided youth in processing their feelings. For example, one parent explained how watching the therapist helping her son talk about how he was feeling shame gave her insight on how to talk to him about his sexual offending without shaming him:

Going to [therapist], helped him … to be able to get past the shame of it. … In family counseling one of the things that [therapist] has really worked hard on, and I think has really helped [me] in watching her work with [youth] in our counseling sessions, is how to speak truth but not allow shame to be brought back into it. (P7)

Another aspect of expressing emotions around the youths’ sexual offending, was parents conveying feeling angry with youth about their sexual abusing behavior. Therapists helped the
parents manage these angry feelings and express them appropriately to their sons. For example, one mother talked about how in family therapy, she told her son she was angry at him, which strengthened their relationship and changed the way they communicate about their feelings:

It makes it [our relationship] much stronger because when he first went in there, I didn’t tell him I was angry at him. I just let it be. I never blew up at him. We acted as if nothing happened. I was pissed. And those feelings stayed locked up for a very long time and then one day I told him, “You know what … I just hate you” and “I’m very angry with you” … [now] we can talk about this for a minute and then let it go … because before we would just get angry with each other and stuff it. (P9)

When therapists encouraged emotional expression, parents and youth were able to share difficult feelings regarding the youths’ sexual offending, including feelings of shame, disconnectedness, and the parents’ anger with the youth. Through encouraging youth and parents to express feelings and facilitating communication around these feelings, therapists helped youth and parents relate to each other differently, which helped them feel more understood and connected as a family. Additionally, the participants perceived that expressing emotions around sexual offending contributed to successful outcomes, such as the youth expressing regret for sexual offending and the family communicating more respectfully. Furthermore, when parents and youth noticed changes in the youth and family, they felt more hopeful that the youth would complete treatment and they would be a family again.

Learning parenting skills. Through involving parents in family therapy, therapists taught parents skills to improve their parenting. Parents saw family therapy as a place for learning parenting skills and said they looked to their therapists for guidance related to parenting. One
mother and father explained how, in family therapy, they looked to the therapist to help them
know how to respond to their son in a way that would best help him successfully complete his
treatment for sexual offending:

[Youth] had to reveal … what he’d gone through …[youth] asked us if we wanted to just
read his little report or if we wanted him to read it … we looked to [therapist] for the
answer to that because we said, “What’s going to be best for [youth].” Is it going to be
helpful for him to go through this with us or would it be better for him [to read it to us].
(P4)

Furthermore, parents said they were serious about being better parents and described how
being involved in family therapy helped them to make personal changes, such as quitting
drinking or pursuing personal counseling, which helped them focus more on parenting their
children. One parent explained how the therapist helped him realize how his drinking was
affecting his son and encouraged him to stop drinking so that he could better help his son,

He [therapist] made me realize that unlike what I thought, “Yeah, [youth] can handle it,
he’s fine. He knows I drink and he has no problem with it.” He [therapist] showed me
that my over indulgence on the alcohol did have an impact on him [son] and it wasn’t a
good one (P9).

This father went on to describe how his relationship with his son changed when he stopped
drinking. He talked about feeling more connected with his son and being more available to listen
to and support his son. This helped him to feel like a better parent and become more hopeful
about making further changes as a family and his son successfully completing treatment.
In addition to helping them make parenting decisions and make personal changes, parents reported that their family therapists helped them learn to let youth take responsibility for themselves, set and enforce rules for youth, and become more in charge of youth. The focus group therapists explained how sometimes youth are parentified, put in the parent role, and how some parents prefer being friends with their kids. They said that family therapists need to help parents set rules and boundaries so that they can be in charge of their kids. Furthermore, focus group therapists talked about how when parents are more in charge of their kids, the whole family system changes. Like the other skills discussed in this theoretical concept, *Using Parents to Help Motivate Youth and Facilitate Change in Youth and Family*, therapists taught these parenting skills through modeling, talking directly to parents about these issues, and helping parents practice these skills in session. From the parents perspectives, improving parenting skills helped them relate to their children as parents rather than peers. Specifically, they described how they started setting limits and enforcing new household rules, which strengthened their power as parents and helped them to provide a structure for their kids that supported the youths’ new behaviors, such as following the rules.

One important skill parents reported learning from their family therapist was to let go and allow their son to be responsible for themselves, including their successes and their failures. This involved parents learning that it is up to the youth to use the skills parents have taught them. For example, one mother talked about realizing that she cannot make her son change and making the decision to allow him to be responsible:

You can only do so much for your child. No matter how much you’ve done, no matter
[what] you’ve given up, no matter what you’ve done to make that child perfect, it’s up to them what they do with what you’ve given them. … you can only take them so far to the water, you can’t make them drink it. (P2)

In addition, parents felt that their family therapists had taught them to not to be over involved in their sons’ lives, but to allow their sons to do things for themselves, such as searching for a job. For example, one mother talked about how her therapist taught her to let her son be his own person and not control everything he does. She went on to describe how her son expected her to take care of all the details when he told her that he needed to go to summer school. Instead, she explained that she would support him financially but that he needed to take responsibility and take care of the details of enrolling in summer school for himself:

He's [son] like, "I need to go to summer school." I'm like, "Okay, that's nice. I'll write the check." He's like, "What do you mean?" I'm like, "Get me the information. … You're gonna get it. You wanna go. You need to go. You need to make it up. You're the one that didn't do it right the first time. You need to bring me the stuff and then we'll get it taken care of." So I didn't go hunt that stuff down for him. (P5)

Through letting youth take responsibility for themselves, parents were of the opinion that they were helping their sons develop life skills that would help them set goals for their futures and be safe in the community.

In addition to helping parents let their sons be responsible for their actions, therapists helped parents improve their parenting skills by helping them provide greater structure for their sons. Some of these structuring skills, which were reported by both youth and parents, included supervising youth, setting rules, giving youth time to process their feelings, knowing how strict
or lenient to be, responding to youth instead of reacting, having expectations of their sons, and holding youth accountable for their behaviors. For example, one mother explained how the therapist helped her know how to provide structure for her son by giving him rules and consequences, “I couldn’t pinpoint how to go about building structure for him [son]. But [therapist] and [program] has totally showed me how the house is going to be ran” (P10). Another parent explained that the therapist had taught her and her husband to make decisions regarding discipline and to give the consequences together; “So having [dad] and I talk about it ahead up time, come up with a course of action very much was [therapist]-driven, very much was what she had been trying to get us to do all along” (P7).

Through helping parents provide structure for youth, parents perceived that therapists taught parents skills to help them become more in charge of their kids. In particular, parents talked about learning to be the youth’s parent and not his friend. Furthermore, parents felt that therapists had taught them about setting boundaries around what and how much information, such as parenting decisions or personal experiences, is appropriate to share with youth. For instance, one parent explained how, in family therapy, the therapist redirected her, in a non-shaming way, when she started sharing too much information with her son:

they [gave me] gentle reminders, OK, you know, he’s only 16, he doesn’t need to know about. … If I bring something up that she [therapist] kinda wonders, she’s like can we stay on the subject or can we redirect or not the [wagging finger]. Right. It’s just hey, we’re getting off the subject, let’s go back. (P3)

Through teaching parenting skills, such as letting youth take responsibility for themselves and parents being able to set and enforce rules for youth, participants felt that their family
therapists had helped their families develop new structure. Specifically, parents learned to be in charge of their kids rather than being their kids’ friends. In this way, therapists used parents’ in their sons’ treatment for sexual offending for the purpose of facilitating the outcome of having new family dynamics (i.e., changing household rules and boundaries). Furthermore, through providing structure, parents helped youth follow the rules and take responsibility for their actions, which supported healthy behaviors that maintained the youths’ commitment to not offend sexually.

**Partnering with Parents.** The second theme in the theoretical concept, *Using Parents to Help Motivate Youth an Facilitate Change in Youth and the Family*, is partnering with parents. This theme represents how therapists used parents in family therapy by partnering with them to help motivate the youth to complete treatment assignments. The therapists in the focus group emphasized their belief that parents help motivate the youth. One therapist explained, “For a lot of the kids, the only reason they are willing to change is for their family.” According to the youth and parents, by being involved in family therapy, parents were able to help youth complete his treatment assignments, which felt helpful and motivating to youth and contributed to the youth working harder and making progress in treatment. For example, a mother described how she helped her son recall information from his past and how that helped him complete his assignment of creating a timeline of his sexually offending behaviors:

I’m in a unique position where I hear from my daughter what happened and I hear from him [son in treatment] what happened. Sometimes those two things can be a little different. … They don’t really know exactly when things happened or how old they were … when things happened … I was able to help him put those together. So that was a very
helpful session with him. (P5)

This parent’s son also explained how his mom helping him complete his treatment assignment in family therapy made him feel they were working as a team:

   It’s really helpful having my mom there. If I forget something … have a timeline mixed up, she’ll put it there, and then [therapist] kind of works with us both at the same time … make us work together as a team, trying to figure … how we can help the person I hurt.

   (Y5)

By working as a team in family therapy parents helped youth complete treatment assignments, which helped the youth feel supported by the parent and motivated him to work harder.

Similarly, another parent talked about how being in family therapy allowed her to help her son write his clarification letter. She recalled that the therapist asked her to share some of her personal experience as a survivor to help her son think about how he had affected his sister, and move forward in treatment:

   I think we have a unique situation … I can talk to him from my daughter's perspective in some ways. … [therapist] bounced it off of me and asked me, “So as one who has been affected, if your brother wrote you this letter, what would you say?” And so I think that, because I've gone through very similar things, I think that I was able to answer in a way that [daughter] would have. (P7)

As these quotes illustrate, parents and youth talked about how the youth found it was helpful for their parents to be involved in family therapy. Conversely, some parents said that their initial therapists discouraged their involvement and did not include them in family therapy. These parents discussed how it was more helpful for their sons when they changed therapists and were
able to attend family therapy. Because parents were in the therapy sessions, therapists were able to use them to help their sons complete treatment assignments, which they may not have otherwise been able to complete. In this way, therapists used parents to help youth make progress in treatment and change their sexual offending behaviors.

**Strengthening family connections in family therapy.** In the final theme, *strengthening family connections in family therapy*, in the theoretical concept, *Using Parents to Help Motivate Youth and Facilitate Change in Youth and Family*, parents and youth described how their family therapists had helped them have new experiences of relating in family therapy. For example, therapists asked questions and directed conversations in family therapy to help parents and youth recognize how important they are to each other. One youth explained how the therapist asked him questions to help him to think about his parents’ importance in his life and his future:

> She’s like, “Your life’s going to suck if you don’t get along with your parents.” … And then I thought about it. … I can’t imagine life later … I’m going to be, like, going to my parents for help when I have kids, and if I don’t get along with them … I don’t think it would work out so well … I’m going to need my parents later in life so … [therapist] helped me come to the realization that I definitely need them. (Y7)

From the adolescents’ and parents’ perspectives, experiencing new ways of relating with each other in family therapy, helped them make changes in their family, such as the family talking with each other more often and resolving conflicts. Furthermore, participants perceived changes in families supported individual changes the youth made, such as expressing himself more clearly and being responsible for his behavior. Specifically, therapists helped families connect through facilitating clarification and healing within the family, improving the quality of youth
and parent interactions, and facilitating family reconnections (see Figure 1).

**Facilitating clarification and healing within the family.** Through teaching skills, such as expressing feelings about sexual offending, and facilitating conversations about the youths’ sexual offenses and family conflicts, in family therapy, therapists helped youth do clarification (admit what they did was wrong and their fault) with their siblings and parents, which facilitated healing in the family and strengthened their connections. For example, one youth explained that he had not seen his sister since he started treatment, and that he missed her and wanted to have a relationship with her again. He went on to say that after he did clarification with her, he would be able to spend time with her again. He described how the therapist had helped him with the clarification process:

I sent a letter to my sister’s [the survivor] therapist, and they said it was very, very nice, and I took a lot of responsibility. And then I went straight to the clarification letter, the letter that’s actually going to be to my sister, and I’m actually going to have the chance to read it to her in person. (Y5)

A parent described how clarification helped strengthen connections in their family when she said, “Because it [clarification] allowed family to spend time together, being able to have the clarification process happens so quickly [was helpful]” (P7). Similarly, another parent described how hearing her son apologize for sexually offending helped them connect:

[son] was kinda shying away and not connecting [with mom] … so [therapist] goes, just grab your mom’s hand. Hold her hand, look at her eyes, tell her how you really feel. And … [son] looked at me, held my hand and said hey, I’m really sorry for what happened [sexually offending]. I love you. (P2)
Through helping youth do clarification, in which he told what he did and admitted that it was his choice, with his siblings and parents, some youth and parents believed that their family therapists had helped strengthen their connections and feel hopeful about being reunified as a family.

*Improving the quality of youth and parent interactions.* In addition to facilitating healing via the process of reconciliation, parents and youth also described how their therapists had given them skills to help them improve their interactions, such as communicating respectfully, as a family. Parents and youth explained how they these new interactions felt positive and helped strengthen their relationships. Therapists helped parents and youth have these experiences in family therapy through directing communication and facilitating activities, such as role-plays. For example, one youth talked about feeling worried that his parents were going to leave him because of what he had done, sexually offending. He described how his parents reassured him that they love him and will be there for him only after the family therapist helped facilitate a conversation about the youths’ concerns:

> They [parents] were like, “If we would’ve left you, then we would’ve done it a long time ago, but we’re still here and we’re not going to give up on you.” Like I said, I think they really dug in on that one, and I think [therapist] kind of started that. He initiated that feeling of care and support, and just kind of initiated that so my parents could grab onto it and finish it up. (Y4)

*Facilitating family reconnections.* Another way that youth and parents recognized that therapists helped strengthen their family relationships was through facilitating reconnections with family. Youth and parents talked about how they experienced disconnections, such as family members being angry and not talking with them, amongst family members when the youth
sexually offended. Through encouraging multiple family members to be involved in family therapy, participants described how their family therapists had helped youth reconnect with family members, such as siblings and grandparents. For example, one youth talked about how before his brother started coming to family therapy, they had minimal interactions, in fact, he did not want to spend time with his brother. He went on to explain how he felt closer to his brother and wanted to spend more time with him after hearing his brother say positive things about him in family therapy:

My brother [name] … he always has the right words to say. … Hearing what my brother said about me and … I see my brother, both my brothers honestly, maturing more and more as they come here. So, I’d say that helps me want to be with my family. (Y1)

Through facilitating family reconnections, facilitating the clarification process, and improving the quality of family interactions, therapists helped youth and parents strengthen their connections in family therapy. This led to the youth and parents feeling more hopeful that they would be able to be a family again. Furthermore, reconnecting as a family helped change the family structure by helping the parents and youth communicate and express their feelings more as a family.

**Summary.** As presented from the perspective of youth and parent participants, the theoretical concept, *Using Parents to Help Motivate Youth and Facilitate Change in Youth and Family*, represents how family therapists used parents in family therapy to help the youth and family change. Therapists taught youth and parents skills by modeling the skills, giving youth and parents feedback about the skills, and practicing new skills during family therapy sessions. Specifically, therapists taught communication skills, facilitated emotional expression about the
youths’ sexual offending, encouraged responsible behavior and honesty in youth, and taught parenting techniques. Furthermore, therapists partnered with parents to help youth complete difficult treatment assignments, which felt helpful and motivating to youth. Through teaching these skills and partnering with parents to help youth complete treatment assignments, therapists help parents and youth strengthen their family connections.

As seen in Figure 1, this theoretical concept, Using Parents to Help Motivate Youth and Facilitate Change in Youth and Family, linked to the other two theoretical concepts. The first theoretical concept, Fostering a Sense of Hopefulness, represents how therapists help parents and youth to feel hopeful about the future. When youth and parents felt hopeful, they were willing to attend family therapy sessions, which facilitated therapists Using Parents to Help Motivate Youth and Facilitate Change in Youth and Family, which parents and youth perceived led to the third theoretical concept, Outcomes: Changes in Individuals and the Family System.

**Outcomes: Changes in individuals and the family system.** The third and final theoretical concept in this conceptual framework of family therapy as part of the treatment for adolescent sexual offending is Outcomes: Changes in Individuals and the Family System. This theoretical concept reflects the individual and family changes, or outcomes, that the youth and parents identified making through being involved in family therapy as a part of the youths’ treatment for sexual offending. Youth and parents identified these as lasting changes. Not only did they experience some of these changes in family therapy, but they also noticed them at home. Two themes emerged within this concept and reflect the specific changes that participants’ had experienced. The first theme, witnessing growth in youth, represents the individual outcomes of the youth in treatment, as identified by youth and parents. These changes included the youth
expressing himself more clearly, caring more about others, thinking about his future and setting
goals, having more confidence in himself, following household rules, progressing in his
treatment work, being responsible for his behavior, becoming more honest with himself,
developing life skills, and understanding and expressing regret for sexually offending. The
second theme, having new family dynamics, demonstrates the family outcomes, or the changes
youth and parents made as family. The family changes that youth and parents identified were
changing family household rules, roles, and boundaries, and communicating differently as a
family. These outcomes, for the youth and their families, are seen as the successful outcomes that
developed directly from the two other theoretical concepts, Fostering a Sense of Hopefulness and
Using Parents to Help Facilitate Change in Youth and Family (see Figure 1).

Witnessing growth in youth. In the theme, witnessing growth in youth, parents and youth
identified specific changes they saw youth make through being involved in family therapy as a
part of their treatment for sexual offending. Participants said that, while they saw the youth
making these changes at the treatment program they attended, they also noticed these changes
outside of the program, at home or on passes. Changes that participants identified in the youth
included the youth being able to share his feelings more clearly, showing that he cares for others,
setting goals for his future, appearing more confident, following household rules, completing his
treatment work, taking more responsibility for his behavior, being more honest about his sexual
offending and behaviors in general, developing life skills, and developing insight for and
expressing remorse for having sexually offended. While parents and youth identified all of these
areas of growth, they recognized that change is a process. As such, they also identified changes
the youth still needed to make, such as completing more of his treatment work, continuing to
make attitude and behavioral changes, using his time wisely, working on social skills, developing healthy relationships, and continuing to improve his communication.

_Expressing himself more clearly._ A key outcome for youth that participants identified was the youth expressing himself more clearly. Youth and parents saw this outcome through the youth being able to express his emotions more easily and by speaking up more often. For example, one parent explained how attending family therapy helped his son speak more often and more clearly:

I would have to say it was the first time that [youth] was able to articulate. He actually talked and spoke up. Normally, he would just mumble, you couldn’t hear what he was saying. … That was probably one of the most positive things that we could get out [of family therapy], because he started coming out of his shell a little. (P9)

_Caring about people._ In addition to being better at expressing themselves, another important outcome for youth that emerged in the study was the youth caring more about others. Parents and youth identified this as the youth showing greater concern for others, expressing empathy, having a more caring attitude, and being more patient. For example, one youth said the most important lesson he had learned in family therapy was, “It’s not all about you” (Y2).

Similarly, a father explained the changes that he witnessed in his son in terms of his awareness of others, which he attributed to their participation in family therapy, “He’s actually more caring about his family … Earlier when my mom cleaning … as soon as something fell, [youth] was out of the room coming out here, and I believe he asked if everything was okay” (P9). Parents also talked about the youth starting to show more empathy and having a more caring attitude towards others. As one parent stated, “He has gone from not caring about what somebody else feels or
thinks to processing and thinking what is that person going through, why are they feeling the way they [are]” (P7).

Thinking about his future and setting goals. Another way youth changed as result of treatment and family therapy was thinking more about their futures and setting goals. Some parents and youth talked about seeing this in how the youth started talking more about the future, setting new goals, and developing new interests such as going to community college or talking about career plans. For instance, one mother discussed how, as a result of their work in family therapy, the youth started finding things in his life that he enjoys and that he could continue to enjoy in the future, “He works out almost every day, plays basketball at the gym. . . . He found out he likes to work on cars. I think he's really just finding out who he is” (P5). One youth talked about how the family therapist helped him to set a goal to finish high school at the community college. He said, “I get go to this class at [community college] … which … is way down at the campus in Portland.” (Y3).

Having more confidence in himself. According to some of the parents and the youth, another key outcome of family therapy was that the youth were developing more confidence in themselves. Several parents discussed behaviors that they thought indicated that the youth had developed more confidence in himself, such as talking more positively about himself and his abilities. In addition, the youth themselves talked about gaining confidence. One youth explained, for example, how when he learned to care about someone else, he learned to care about himself and developed confidence in himself:

Well, it really shows, if you really want to care about the person you hurt, then you really learn to care about yourself, and that can really help you at the same time. Like for me . . .
when I hurt the person, I didn’t really care, but now … [after family therapy] … it makes me feel a lot better about myself, to make sure nothing like that will ever happen again, and that’s what they’re really focused on, to make sure you don’t do anything like that again, and you’re safe for the community. (Y5)

Following the rules. Beyond the outcomes already mentioned, following the rules was another important outcome for youth. In the interviews, some parents and youth talked about knowing the youth were doing well in treatment because they began following the rules of the treatment program and their probation, such as being supervised around children. Following program and probation rules is one way youth take responsibility for their sexual offending behaviors and demonstrate that they are serious about changing, not sexually offending, thus indicating progress. Parents and youth perceived this change as a result of therapists using parents to teach youth responsibility in family therapy sessions. In addition, youth started following rules that their parents set for them, as a result of learning parenting skills, at home or during visits. For example, one mother explained that when her son started following the rules in his residential treatment program, they recognized that he was starting to change:

I guess it goes back to the positive ones [family therapy sessions] during the summer. He went almost the whole summer without having a major rule violation, which is a big deal for him because he was given like two, three, four a month. … he actually moved up a color [treatment level] and we thought, “Oh he’s actually changing.” (P8)

Progressing in his treatment work. Another way that some youth and parents recognized the youth making progress in treatment, and a key outcome of participation in family therapy, was the youth progressing in his treatment work. Youth and parents discussed recognizing the
youths’ changes through seeing them progress in their treatment work, which was seen through the youth completing treatment assignments. For example, parents and youth talked about the youth completing treatment packets and working on clarification letters (apology letters to victims). For example, one youth talked about how attending family therapy with his parents, and knowing his family wanted him to successfully complete treatment and come home, motivated him to make changes, including working on and finishing treatment assignments:

the involvement with my family [in family therapy] and then hearing how many people [family] want me to come home. … I haven’t had restitution [particular consequence] for a good four months now. … I’ve been doing my work. Doing every assignment [therapist] gives me. (Y1)

*Being responsible for his behavior.* In regard to the youth and parents recognizing growth in the adolescents, they talked about how the youth started taking responsibility for their attitudes and behaviors. Taking responsibility means that the youth acknowledged that they have control over their actions and accept the resulting consequences, both positive and negative. For example, youth acknowledged responsibility for sexually offending by admitting what they had done, apologizing, completing treatment assignments to gain insight around why they sexually offended, and changing their behaviors, such as following rules to make sure that they would not reoffend. Additionally, youth demonstrated responsibility when they expressed that the results of treatment, successful or otherwise, were up to them. For example, one youth explained how through family therapy, the youth recognized that his actions affect others, primarily his family, and learned that he is responsible to work towards changing, which would show his family that he cared for them:
My mom and dad and [dad’s partner] are really affected by the decisions I make here because it’s all on me. If I want to be back out in the community, I have to make the effort to do that. If I want to come home, I have to make the effort to do that. But if I want to push them away it also takes effort to do that. … Every decision you make shows whether you care or don’t care [about your family]. And it takes effort to go in any position, whether to stay still, move forward, or step back [in regards to treatment progress]. (Y2)

In addition to learning about the importance of taking responsibility, parents and youth described how, as result of family therapy, youth started holding themselves responsible for their behavior. For example, when talking about a change she saw in her son, a parent said:

He's more responsible. He knows how to come to me and apologize, which was a biggie. And he'll catch himself when he's wrong, and hold himself accountable to me for his behavior … last week … he was mad about something and it came out on me. . . . So, he went upstairs and then he came back down and he said, "Mom, I was wrong. I could have said that better. I could have expressed this to you much better and I apologize, cause I don't want to hurt your feelings." (P6)

Youth and parents connected the youth learning to be more responsible to skills they had learned in family therapy. As discussed previously, therapists encouraged responsibility in youth for all of their behaviors, including but not limited to their sexual offending behaviors, during family therapy sessions. This included talking to the youth about their actions, setting rules and consequences, and encouraging them to take responsibility. Additionally, as parents learned
parenting skills through family therapy, they too held the youth more responsible for their behaviors through setting rules and giving youth consequences.

**Becoming more honest.** Apart from the outcomes already mentioned, some youth and parents identified youth becoming more honest as a key outcome from participating in family therapy. In particular, youth started telling the truth about his sexual offending behavior. This was seen by youth and parents as a result, at least in part, of therapists encouraging honesty in family therapy sessions. As discussed previously, therapists called youth out and held them responsible for being dishonest. In addition, therapists helped parents to recognize when youth were not telling the truth and taught parents to hold youth accountable for their dishonesty. For example, a mother talked about a time when her son started telling the truth in family therapy and how that helped her to recognize her son was changing:

. . . that's one of the best times that I had in family therapy, me and my husband were impressed and amazed, because [youth] had done a lot of lying, and I mean a lot of lying. And when you see your child, say, "You know what? I don't have to lie no more," it's a blessing. It's a blessing to see it. (P6)

**Developing life skills.** Beyond the other changes youth were making (e.g. following the rules, becoming more honest, etc.), some youth and parents talked about how they saw the youth developing life skills. This manifested itself as the youth keeping his room clean, doing his laundry, going to and showing improvement at school, being more social by spending time with peers, and showing leadership in his treatment program. As therapists taught and supported parenting skills in family therapy, parents were able to set structure that helped youth gain life skills. For example, parents set rules and consequences that encouraged youth to attend school.
A parent talked about how going to family therapy and having privileges taken away helped her son start attending school regularly and completing his homework:

He [youth] was struggling going to school. When he started treatment, even though a lot of his privileges were taken away, he felt better about going to school … And he wanted to be more involved with getting his homework done (P6)

Furthermore, when describing the changes he had noticed in himself as a result of family therapy, a youth talked about learning to keep his room clean, “I could not keep my room clean at all. It was messy. I had BBs all over the floor, clothes everywhere, toys everywhere. Now I keep my area nice, tight, clean” (Y10).

**Youth understanding and expressing regret for sexually offending.** A key outcome that arose from youth’s participation in family therapy was that the youth developed an understanding of and expressed regret for sexually offending. Expressing regret and developing and understanding of why he sexually offended, is seen as a key outcome and indicative in treatment progress because changing attitudes around sexual offending can help him to prevent reoffending. Youth and parents understood the youth was developing understanding and regret for sexual offending when they processed feelings about sexually offending on a deeper level, which helped them to develop understanding regarding their sexual abusing behaviors. In addition, youth and parents talked about the youth overtly expressing sorrow for having sexually offended. For example, one mother explained how, as a result of family therapy, her son explored what he had done to his sister at a deeper level:

It's like, "Well I touched my sister." That's not good enough. It's like what did you do, when did you do it, what were you thinking, how were you feeling, what maybe led up to
that. So he's [son] had to really dig deep into some stuff and has found out a lot about himself and about events in his life and how those contribute to his thinking errors. (P5)

In the interviews, a youth talked about how it was difficult for him to talk about having sexually abused. He described the process of working hard in family therapy to process and develop an understanding of his sexual offending behaviors:

At first just talking about sexual abuse . . . didn’t make me feel good. When I first came to [program] I had to really get used it. … It took like almost half a year to really adjust and to tell what you [youth] did . . . Like a lot of assignments…I would talk about how did I feel when I really actually [was] sexually abusing. … it was tough. It was tough.

(Y6)

Another youth talked about feeling relief after talking to his parents about his sexual offending. He said that they saw this as a turning point in his treatment, an accomplishment, when he was finally able to be honest about the details of his sexual offending behaviors. He stated:

To me, that went well. For them it sucked, I guarantee you, but to me it was just like, “Wow, this is awesome. I feel great. This is just awesome. It feels so good to be able to tell you guys, if you guys just understand and listen and just get it.” . . . I think for them, what was well was when I passed my full disclosure [polygraph] and they came and talked about it, and they were like, “You know what? This is what we’ve been looking for, is for you to finally be honest, for you finally to change.” (Y4)

**Having new family dynamics.** The second theme in the theoretical concept, *Outcomes: Changes in Individuals and the Family System*, is *having new family dynamics*. This theme represents family outcomes, or changes youth and parents recognized in the family, that resulted
from parents being involved in family therapy for their sons’ treatment for sexual offending.
Youth and parents perceived therapists helped them to feel more hopeful about their futures,
particularly about the youth successfully completing treatment and being reunified as a family,
and taught them skills, which helped them to make changes in the family. Specifically,
adolescents and parents identified changes in the household rules, family roles, boundaries, and
communication.

*Changing household rules.* Several youth and parents identified ways that their family
household rules had changed as a result of being involved in family therapy as a part of the
youths’ treatment for sexual offending. In particular, participants talked about how participating
in family therapy had helped parents to implement new house rules including regulating the
children’s use of media, establishing a curfew, and doing chores. For example, due to their
participation in family therapy, one mother talked about the most important change their family
made being establishing new rules about media in the house:

> The media in the house, TV and computers. … it was hard to be aware of what they were
looking at on the computer. … So there were some shows that I didn't watch until they
were in bed on purpose, but those were shows also that I would catch him peeking around
the corner at and I'd have to bust him and say, "Get back in your room. You're not
watching this." But that should have tipped me off because he was so insistent on
watching it that it should have tipped me off that maybe he was thinking about stuff he
shouldn't have been thinking about. That kind of stuff. So the media in our house, what
they're allowed to watch and stuff. (P5)
Similarly, one of the youth talked about how he started to do more to help out around the house as a result of his parents talking to him during family therapy sessions and setting new rules about keeping the house clean:

They’ve actually talked about some of their struggles with me and the things I need to do at [the] house…like they’re saying I didn’t clean up enough or they’ll ask me to clean up … So I do a lot more. (Y6)

Parents and youth said that they learned how to establishing new household rules in family therapy. As previously presented in the second theoretical concept, Using Parents to Help Motivate Youth and Facilitate Changes in Youth and Family, therapists taught parents skills, such as how to set rules for youth, to help them make changes in the family structure. As a result, parents established new household guidelines for their families, which helped parents establish they were in charge and thus, changing their roles in the family, another important family change.

Changing family roles. Through changing household rules, parents established their authority as parents, which reflect changes in family roles. In this theme, changing family roles are seen as changes in parental hierarchy, such as parents sharing in discipline of the youth and better monitoring. Parents and youth said that parents learned the importance of these behaviors in family therapy and then implemented them at home. Participants talked about how parents got back their authority and became in charge of their children and how their children were not allowed to take on parental responsibility. For example, a youth talked about how his mother’s role in the family changed as result of their participation in family therapy when he said, “She wants to be more of a mother to me. She’s not afraid of me. She’s more of a parent to my sister...
now” (Y3). Similarly, a mother talked about being more in charge of her son when she stated, “we [she and her husband] felt like we were getting back our authority” (P6).

A central part of parents being in charge and asserting their parental authority related to monitoring and disciplining the youth. In family therapy, parents learned skills which helped them to know how to monitor youth and give and follow through with consequences for youth. For example, a mother talked about how, as a result of their work with the family therapist, she and her husband began making decisions together regarding discipline for their son:

If we'd have a conflict with [youth] … my husband and I will talk about it separately before going to him [youth]...as a team. … He [youth] was speaking to [dad] very disrespectfully, it’d become a very integral part of how he responded to us. … my husband came to me and he's like, "You know, this is what he's doing and something needs to be done." And I'm like "Yes, okay. You're right". … we had decided on a course of action depending on how he [youth] reacted … He [youth] didn't end up getting the full punishment because he responded in a good way. (P7)

In addition to more effective discipline, increased monitoring was another component of parents’ increased authority in the family. Through learning parenting skills in family therapy, parents learned how to better supervise their sons. For example, a grandmother also reported a change in her role when she felt the authority to monitor what the youth was doing in her home:

Before, I would not have had any, I did not have any interaction with what [youth] got to do here. Of course, he wasn’t here all the time. If he played too long on the computer games, I didn’t like it but I didn’t say anything. If we watched too much television, I
didn’t like it, but I didn’t say anything. Because he wasn’t living here. He was going to be here for maybe a few hours. Now, I would not be that way. (P10)

Through participating in family therapy, youth and parents learned about family dynamics, including the roles different members of the family can and should play. This helped them change the way they interacted with each other and alter the roles of different family members. In addition to improving the relationships within the families, these role changes also helped support the youths’ successful outcomes, such as following the rules and accepting responsibility for their behaviors. When parents and youth saw the youth and family changing, they became more hopeful about the youth completing treatment and being able to be a family again, which helped parents remain committed to youth and youth to focus on completing treatment assignments.

*Setting boundaries in and around family.* In addition to the changes in household rules and family roles, several parents and a couple of youth identified setting boundaries in and around the family as an important family outcome of parents being involved in family therapy as a part of their sons’ treatment for sexual offending. During the interviews, both youth and their parents talked about learning about boundaries in family therapy. They learned when it was appropriate to keep secrets, both from immediate family members and from people outside the immediate family. They also learned how emotionally close they should be with different family members. For example, one mother talked about reading a book on boundaries that the therapist recommended, which “really helped to be able to see the difference on how to not get so involved with the emotions and everything that you are not able [change]. To actually focus on what needs to be done” (P7). Another mother discussed how she learned, in family therapy, to
create a boundary around her immediate family, by choosing not to talk to her extended family about her sons’ sexual offending, which she believed helped to protect her son:

I had to change my dialogue with my [extended] family. I had to do it for the protection of my son. … There's some things I say and there's some things I don't. … I just felt that to keep my family as healthy as possible, all the process we been through [the youths’ sexual offending], it just needed to stay with us. So, you become a protector of your family within your [extended] family. You recognize what's healthy, what’s not, because everybody in your family ain't healthy. . . . No, there's some things that you don't ever have to say, because they're not in the place. (P6)

This parent’s son also discussed how his family moved to a different neighborhood to create better boundaries around their family:

And we moved away from where we used to live and they used to sell a lot of crack and weed and whatever you wanted … but now we’re over here so I don’t know anybody so that’s even better. So we’ve changed a lot. (Y6)

Through attending family therapy, youth and parents said they learned to create boundaries in and around the family, which helped change other family dynamics, such as changing rules and roles and supported the changes the youth were making. For example, by setting a boundary of parents not talking to youth about adult issues, parents became more in charge of kids and more easily able to set rules and be in charge. This, in turn, helped the youth to be responsible for himself. Furthermore, adolescents and parents connected recognizing family changes, such as setting boundaries around their family, with feeling more hopeful that they would complete treatment and be able to be reunified as a family.
Having respectful communication as a family. Another important change that youth and parents identified was how they communicate together. They said that they were able to practice more respectful communication and conflict resolution in family therapy. Furthermore, they noticed that they started communicating with each other differently at home. Parents and youth said that they worked harder to see each others’ perspectives, resolved conflict, and spent time talking together as a family. For example, one parent talked about taking the tools they learned in family therapy and using them at home to help them communicate, “we would come home and we would have long family discussions; lots of them” (P6).

Though family therapy, youth and parents learned communication skills that helped them make other lasting changes in their family including changing family roles, rules, and boundaries. Furthermore, these family changes helped support the changes the youth made, such as sharing his feelings and following the rules. Furthermore, therapists helped parents and youth identify these changes to encourage them to continue making changes. Parents and youth identified noticing the changes they were making as a key to feeling more hopeful about being reconnected as a family and successfully completing treatment.

Summary of Findings

I examined parents and adolescents’ experiences of participation in family therapy when the adolescent son had been required to complete treatment for sexual offending. In addition, I looked at how the parents and adolescents’ participation in family therapy seemed to relate to adolescents’ progress in treatment for sexual offending. As a result of my grounded theory analysis, the following three overarching theoretical concepts emerged: (a) Fostering a Sense of Hopefulness, (b) Using Parents to Help Motivate Youth and Facilitate Changes in Youth and
Family, and (c) Outcomes: Changes in Individuals and the Family System. These theoretical concepts combine to offer a description of how participants viewed parent involvement in the youths’ treatment for sexual offending and how family therapy related to the youths’ progress in treatment and changes in the family (see Figure 1).

The first theoretical concept, *Fostering a Sense of Hopefulness*, represents how parents and youth develop and remain hopeful about their futures; hope that the youth will complete treatment for sexual offending successfully and hope that the family will be reunited. Parents and youth explained that they felt more hopeful when therapists supported and encouraged them. In addition, parents talked about how therapists’ support and encouragement helped them to be more committed to the youth, which also contributed to the youths’ feelings of hopefulness. Furthermore, parents and adolescents identified that when they were able to see the changes youth were making, they felt more hopeful about completing treatment, which also helped parents remain committed to their sons. *Fostering a Sense of Hopefulness* linked to changes in the youth and family directly and indirectly through the second theoretical concept, *Using Parents to Help Motivate Youth and Facilitate Changes in Youth and Family*. Specifically, when youth and parents experienced greater degrees of hopefulness, they either made changes on their own or were more willing to participate in family therapy, which allowed therapists to use parents in family therapy to teach skills to youth and parents, which helped youth and families change.

The second theoretical concept, *Using Parents to Help Motivate Youth and Facilitate Changes in Youth and Family*, demonstrates how the parents being involved in the youths’ treatment results in changes in the youth and family system. Because parents were involved in
their sons’ treatment, therapists were able to teach the youth and parents skills by modeling the skills, giving feedback when youth and parents used the skills, and practicing skills during sessions. In particular, therapists used these techniques to help youth and parents learn communication skills, express their feelings, learn parenting skills, and encourage responsibility and honest in youth, all of which helped strengthen family connections. Furthermore, therapists were able to use parents to help youth complete difficult treatment assignments, which felt helpful and motivating to youth. Using Parents to Help Motivate Youth and Facilitate Changes in Youth and Family linked to outcomes directly and through Fostering a Sense of Hopefulness.

More specifically, including parents in family therapy allowed therapists to partner with parents help youth complete treatment assignments and to teach youth and parents skills. Parents perceived learning these skills directly led to outcomes. For example, through learning parenting skills in family therapy, parents monitored and set consequences for youth, which helped the youth to follow rules and take responsibility for their actions. Furthermore, therapists including parents in family therapy felt hopeful to youth and parents, thus leading to changes through the theoretical concept, Fostering a Sense of Hopefulness.

The third theoretical concept, Outcomes: Changes in Individuals and the Family System, represents how parents and youth perceived the youth and family changed as a result of youth and parents being involved in family therapy as a part of the youths’ treatment for sexual offending. Changes the youth made consisted of youth being able to more clearly express himself, caring about people more, making plans and setting goals for his future, being more confident in himself, following the rules, completing his treatment assignments, being responsible for his behavior, being more honest, developing life skills, and understanding of and
expressing regret for having sexually offended. Family outcomes consisted of having new household rules, family roles and boundaries. In addition, youth and parents said they developed more frequent and respectful communication with each other. As seen in Figure 1, youth and parents identified these outcomes as being a result of three pathways: 1) Therapists helped foster a sense of hopefulness in youth and parents, which they perceived as leading to successful outcomes, 2) When youth and parents felt more hopeful, they were more willing to participate in family therapy, which allowed therapists to use parents in family therapy to help youth and families make changes, 3) Therapists used youth and parents in family therapy to teach skills and help youth complete treatment assignments, which led to successful outcomes, 4) Using parents in family therapy, helped youth and parents feel hopeful, which contributed to them changing.
Chapter Five: Discussion

Family involvement in the treatment of adolescents who sexually offend is an under-researched topic. Family systems theorists (Baker et al., 2003; Efta-Breitbach & Freeman, 2004), treatment providers (McGrath et al., 2010), and researchers (Tighe et al., 2012; Worling & Curwin, 2000) have indicated the importance of family influences on the development and maintenance of adolescent sexual offending and the overall effectiveness of treatment approaches that include family therapy (Borduin et al., 1990; Borduin & Schaeffer, 2001; Worling & Curwin, 2000). Given the importance and potential effectiveness of treating adolescents who sexually offend in the context of their families, a conceptual framework of how to include parents in family therapy as part of the treatment for adolescent sexually offending is needed. However, the precise nature of how to include parents in family therapy has either not been identified or is not well understood. Furthermore, researchers have not asked the adolescents and parents about their experiences in family therapy or about how they perceive their involvement as being related to the adolescents’ progress in treatment. Parents and adolescents’ perspectives are needed in order to develop a more thorough conceptualization of family therapy in the adolescents’ treatment for sexual offending that is socially just (Chaffin, 2008) and that accurately reflects clients’ interests (Grover, 2004; Gabbard & Freedman, 2006).

In this study I sought to answer the following research questions: 1) What are adolescents and parents’ experiences of participation in family therapy when the adolescent son has been required to complete treatment for sexual offending? 2) How does parent and adolescent participation in family therapy relate to adolescents’ progress in treatment for sexual offending? In order to answer these research questions, I interviewed 10 adolescent boys and their parents. I
analyzed the data gathered during interviews using a constructivist grounded theory methodology (Charmaz, 2006) to develop a conceptual framework of family therapy as part of the adolescents treatment for sexual offending. Then, a focus group of seven family therapists who specialize in the treatment of adolescents who sexually offend reviewed the findings and offered input on refining the emerging theoretical framework. I integrated the adolescents, parents, and therapists perspectives into the final conceptualization of family therapy for adolescents who sexually offend.

**Discussion of the Findings**

Three theoretical concepts, which included eight themes, emerged from my analysis of the data. The three theoretical concepts were: (a) Fostering a Sense of Hopefulness, (b) Using Parents to Help Motivate Youth and Facilitate Changes in Youth and Family, and (c) Outcomes: Changes in Individuals and the Family System. The first theoretical concept, *Fostering a Sense of Hopefulness* focuses on how therapists helped youth and their parents be hopeful about the youth completing treatment successfully and becoming a family again. Specifically, through encouraging and supporting, therapists developed a relationship with youth and parents to help inspire hope in them. Therapists also helped parents to stay committed to youth, which contributed the youth to feeling hopeful. Furthermore, when therapists helped participants identify changes youth were making, they felt more hopeful. As seen in Figure 2, parents and youth perceived two pathways in which fostering hopefulness contributed to their successful outcomes: 1) when parents and adolescents felt hopeful, they made individual and family changes; and 2) when youth and parents experienced greater degrees of hopefulness, they were
more willing to participate in family therapy, which allowed therapists to use parents in family therapy to teach skills to youth and parents, which helped youth and families change.

The second theoretical concept, *Using Parents to Help Motivate Youth and Facilitate Changes in Youth and Family*, shows how therapists taught youth and parents skills in family therapy, such as communication, expressing emotions, responsibility, and parenting skills. Furthermore, therapists partnered with parents in family therapy to motivate and help youth complete treatment assignments. From the perspectives of the participants, therapists using parents in family therapy led to youth and family outcomes by two pathways: 1) therapists teaching skills and partnering with parents helped youth and parents experience greater family connections, which contributed to their feeling hopeful, and led to successful individual and family outcomes; 2) Therapists partnering with parents and teaching skills contributed to the parents and youth having stronger relationships, which led to the youth and family changes.

The third theme, *Outcomes: Changes in Individuals and the Family System*, represents the changes that youth and parents perceived making, both individually and as a family. Positive outcomes of family therapy for youth included expressing himself more clearly, caring about people, thinking about his future and setting goals, having more confidence, following the rules, progressing in treatment, being accountable for his behavior, becoming more honest, developing life skills, and understanding and expressing regret for sexually offending. Positive outcomes of family therapy for families included changes in household rules, family roles, setting boundaries, and having respectful communication. As seen in Figure 2, and explained above, parents and adolescents perceived these changes stemmed from therapists *Fostering a Sense of Hopefulness* and *Using Parents to Help Motivate Youth and Facilitate Changes in Youth and Family.*
In presenting this framework, it is necessary to understand the context in which family therapy for adolescent sexual offending is occurring. As depicted in Figure 2, the framework identified in this study was occurring within a unique larger context. Adolescent and family contextual issues, such as multiple treatments, quality of the family environment, abuse within the family, barriers to treatment, and marginalization affect family therapy. Thus, understanding the framework presented in this study must occur with an understanding of context.

Figure 2. A Conceptual Framework of Family Therapy in the Youths’ Treatment for Sexual Offending in Context

Context. In presenting this framework, it is necessary to understand the context in which family therapy for adolescent sexual offending is occurring. As depicted in Figure 2, the framework identified in this study was occurring within a unique larger context. Adolescent and family contextual issues, such as multiple treatments, quality of the family environment, abuse within the family, barriers to treatment, and marginalization affect family therapy. Thus, understanding the framework presented in this study must occur with an understanding of context.
Most treatment programs for adolescents who sexually offend will include multiple treatment modalities, such as individual, group, family group, and family therapy. Having multiple treatment settings can either have a positive or negative effect on the work that is being done in family therapy. For example, if individual therapists are working with youth to be more independent and limit contact with their families, then family therapists may have a hard time helping youth and parents to feel more connected and strengthen their relationships. Thus, it is important for therapists from each of these treatment settings to collaborate and give consistent messages to youth and parents.

Another important contextual issue to consider with regard to understanding how youth and their parents experience family therapy for the treatment of adolescent sexual offending is the quality of the family environment. Different youth have varying levels of family support. For example, parents are often required to balance the time between their son who sexually offended and their other children and thus may not be able to attend family therapy sessions regularly. Additionally, some parents may not be willing to be involved in their sons’ treatment. In these cases, therapists can use the suggestions given in this theoretical framework to connect with parents and help them understand the importance of their involvement. If parents are still not able or willing to attend family therapy, therapists can seek other important people in the youths’ lives, such as grandparents or a foster parent to involve in family therapy.

Additionally, adolescents who sexually offend often come from family environments that consist of past physical, emotional, and sexual abuse (Burk & Burkhart, 2003; Seto & Lalumière, 2010). As discussed previously, when there is active abuse within the family, therapists should not include the abusive family member in family therapy. In addition, when parents have a
history of sexual abuse, they may not feel comfortable attending family therapy. When there is
either active abuse or history of sexual abuse, for the youth or parent, therapists may want to
work with the youth and parents individually. By working with parents individually, therapists
can help them work through their personal abuse, feelings about their sons’ abusing behaviors,
and any abusive behaviors they may have. After working on individual issues, parents and youth
could rejoin family therapy.

In addition to the other contextual variables mentioned, family therapists need to consider
that youth who have sexually offended and their families are a marginalized group (Chaffin,
2008). Thus, they may have stigmas, such as believing that they are sick and will never change,
that could interfere with their active engagement in family therapy. Therapists may have to work
harder to develop relationships with these youth and families before the adolescents and parents
are willing to participate in family therapy. Thus, therapists can use this conceptualization to
support and encourage youth and families, giving them hope that they will be a family again, and
helping them work through the shame they experienced as a result of the adolescent sexually
offending. Furthermore, it is possible that youth that feel stigmatized and are hesitant to engage
in family therapy did not choose to participate in this study, and thus are not represented in this
theoretical framework. Future research needs to be done to address wether this framework would
apply to a more representative sample of youth who sexually offend.

Finally, family therapists need to address other barriers to participation in family therapy,
such as the parents living a significant distance from the treatment program. For example,
parents may not have the money to buy gas to drive several hours or rent a hotel on a consistent
basis. Thus, therapists may need to be flexible to accommodate families who drive a great
distance. The youth and parents in this study reported that they appreciated therapists considering and accommodating each family’s specific needs. For example, one parent talked about how she took the bus several hours to get to the program because she did not have a car. Because she was not able to come that often, she appreciated that the therapist gave her extra time with her son when she could make it.

Taken together, these examples demonstrate how adolescent and family contextual issues, such as multiple treatments, quality of the family environment, abuse within the family, barriers to treatment, and marginalization affect family therapy. Therapists applying this theoretical framework need to consider the context in which family therapy for adolescent sexual offending is occurring.

**Fostering a sense of hopefulness.** The participants of this study shared how therapists developed a relationship with them and helped the parents remain committed to youth, both of which contributed to adolescents and parents feeling hopeful in family therapy. Additionally, youth and parents recognizing the changes youth were making helped them to feel more hopeful. They experienced feeling hopeful that the youth would change and would complete treatment successfully, as well as being hopeful that they would be able to reconnect as a family. These feelings of hope motivated youth and their parents to continue family therapy and to work towards making a variety of individual and family changes, such as the youth caring about people around him and the family changing their family structure, which were seen as successful outcomes in the study.

**Therapeutic Relationship.** One of the keys to parents and youth feeling hopeful was that therapists developed a relationship with them that felt supportive and encouraging. This finding
is consistent with the emphasis that has been placed on the importance of the therapeutic alliance, or the open, trusting, and collaborative relationship between therapists and clients in therapy (Bickman et al., 2012; Gaston, 1990; Rait, 2000; Shirk, Karver, & Brown, 2011; Sprenkle et al., 2009). This bond represents “the extent to which the client (especially) and therapist feel understood and emotionally connected” (Sprenkle et al., 2009, p. 42). Sprenkle and colleagues (2009) identified the therapeutic alliance as a significant common factor that is responsible for successful treatment outcomes in family therapy. Common factors are the “dimensions of the treatment setting that include client, therapist, relationship, expectancy, and treatment variables that are not specific to a particular model” (Sprenkle & Blow, 2004). Thus, the therapeutic alliance is an important factor in clients’ successful (or unsuccessful) engagement in and outcomes of treatment.

In addition to the common factors literature, family systems theorists also place a heavy emphasis on the importance of the therapeutic relationship when working with families (Satir & Baldwin, 1983). Many of the initial systems therapists paid close attention to their relationships with the family. For example, Satir and Baldwin (1983), who use a family systems lens, identified Making Contact, or establishing the therapeutic bond, as the first stage of therapy. Therapists make contact, or connect, through reaching out to each person in the family, making them feel like they are important, and creating a safe and non-judgmental relationship with them, so everyone can express their feelings. As Satir and Baldwin (1983) explained:

It is essential that every family member be engaged and validated . . . Another way to foster trust is to create a safe climate in which family members do not worry about the
consequences of revealing something about themselves or other family members. (pp. 210-211)

Consistent with systems theorists, participants in this study reported appreciating it when therapists took the first step towards developing a strong relationship with them. Both parents and youth described feeling connected with their therapists when they showed them that they cared about them as people and as a family. Participants explained that they knew their therapists cared about them when they showed an interest in them, asked about their lives, and got to know them. In addition, the families in this study felt that their therapists cared for them when they were available when parents and youth needed to talk through struggles or had questions. Furthermore, youth and parents expressed feeling accepted and understood when therapists validated rather than judged their experiences and recognized and gave them praise for their abilities and growth. Conversely, parents and youth discussed feeling disconnected and not cared for when therapists blamed and judged them.

According to participants, the value of the therapeutic alliance was also significant to the outcomes or success of therapy. That is, parents and youth described how therapists accepting them and caring about them helped them to better engage in treatment and feel more hopeful about completing treatment successfully and being a family. Likewise, when they experienced therapists as judging and not caring, they did not want to participate in treatment and felt hopeless; that they were not going to complete treatment successfully and would not be able to reconnect as a family. Clearly, having a positive relationship with therapists, felt valuable to participants because it gave them hope. And, when parents and youth had hope, they participated in treatment more actively, which contributed to successful outcomes for the youth (i.e.
completing treatment assignments) and the family (i.e. having more respectful communication as a family.

Other empirical studies have also supported the importance of the therapeutic alliance in therapy with adolescents who have sexually offended. For instance, in a qualitative study examining the process of change for 16 non-sexual offending adolescents, Tighe and colleagues (2012) asked families (19 mothers, one father, one couple, and 16 non-sexual offending youth) what was helpful and not helpful about treatment (MST) and what helped or hindered their change. They found that families placed high value on the therapeutic relationship, and believed that it helped them change. Like the families in the current study, the families in Tighe and colleagues’ study identified the therapist caring for them, being a source of encouragement and support, showing empathy, and understanding and not judging as key factors in the therapeutic relationship and as being central to helping them change.

In a meta-analysis of 49 empirical research studies, Karver, Handelsman, Fields, and Bickman (2006) calculated effect size to determine what degree therapeutic relationship variables were responsible for the outcome of treatment for youth. They found that the therapeutic alliance with the youth client was correlated ($r = 0.35$) with process variables such as parent-therapist relationship, therapist empathy, ratings of session impact, the inverse of child hostility toward treatment staff, and child participation in treatment. They concluded that this relationship was “highly generalizable, as it has been found across a wide variety of treatment settings (inpatient, outpatient, residential treatment centers, group homes, and in-home treatment) and treatment types (psychodynamic, behavioral, family systems, and treatment-as-usual in the community)” (p. 56). These studies, along with the current study and systems theory, suggest that
the therapeutic alliance, between the therapist and youth, as well as the therapist and parent, is a key factor in successful treatment outcome when working with adolescents who sexually offend.

In addition to supporting the idea that the therapeutic relationship contributes to successful outcomes for adolescents who sexually offend, the current study adds to the existing literature by suggesting that hope is a mechanism of change. Perhaps the therapeutic alliance leads to successful outcomes because positive relationships with therapists helps participants feel hopeful, which helps them to engage in treatment and continue working toward change. In addition, the current study supports the literature on therapeutic alliance by linking family outcomes, such as a change in the family structure (i.e., change in hierarchy, boundaries, rules, and roles), to the therapeutic relationship. For example, parents said that, when they felt validated and supported by the therapist, they were able to make personal changes, such as making changes in how they disciplined the youth. Changing the way they disciplined youth helped them be more in charge of their children (changing the hierarchy in their family) and helped them set rules for their kids. Moreover, parents talked about how the therapist supporting and encouraging them helped them to be more committed to the youth, which helped them to support and encourage the youth in their treatment. Through making personal changes and being committed to their sons, parents helped youth make a number of individual changes.

**Parents’ commitment.** Although the therapeutic relationship emerged as being a central factor in building hope among parents and youth, and helping them make individual- and family-level change, another key factor was parents maintaining a commitment to the youth. Parents demonstrated their commitment to their sons through encouraging and supporting the youth in their treatment. Parents demonstrated this encouragement and support through participating in
treatment with the youth, spending time talking to the youth about their treatment struggles and successes, giving them different perspectives, and telling them they can do it. In addition, parents overtly expressed their unconditional love to the youth. This was particularly important to the youth because they understood how deeply they had hurt their parents by sexually offending. While parents talked about feeling hurt and disappointed that their sons had sexually offended, they also affirmed their commitment to their sons by saying that no matter what, they would love and support them, which helped youth feel hopeful about reconnecting with their families and engaging in treatment.

The idea that the parents’ commitment makes a difference in helping their sons develop and maintain hopefulness is supported by systems theory, specifically the concepts of family interactional patterns (Watzlawick et al., 1967) and interdependence/mutual influence (Whitchurch & Constantine, 1993). Systems therapists look for interactional patterns that contribute to health and dysfunction within the family. It may be that repeated interactions involving parents expressing support, encouragement, love, and commitment is a healthy pattern in the family, which contributes to youth feeling hopeful and leads to successful outcomes. Furthermore, to increase hopefulness and successful outcomes for youth and families, therapists may be able to facilitate and encourage these patterns, which will be explained in the section on Using Parents to Help Motivate Youth and Facilitate Changes in Youth and Family.

From the perspective of the systems theory concept of interdependence/mutual influence, therapists view adolescents who sexually offend within the context of their relationships. Given that parents are part of the adolescents’ primary relationships, systems therapists would naturally look for the mutual influence between youth and parents. Specifically,
they would consider how the parents are influencing the youth and how the youth influence their parents (Whitchurch & Constantine, 1993). In the current study, parents and youth discussed how the parents’ commitment to youth, including parents showing the youth love and support, helped the youth to feel hopeful, which in turn, helped the youth to continue working in treatment. Likewise, parents talked about how they felt more hopeful and more able to support and encourage youth when they saw the youth working and making changes, such as completing assignments in treatment and following rules.

Though there is theoretical support for the finding that parental commitment was significant to creating hope and contributed to more positive outcomes for the youth and their parents, current research also reflects the importance of parental commitment to youth in therapy for sexually offending. In the study mentioned previously, Karver and colleagues (2006) calculated the effect size of the variables parent willingness to participate in treatment (found in 4 of the 49 studies) and parent participation in treatment (found in 8 of the 49 studies). They found that parent willingness to participate in treatment (average $r = .34$) and parent participation in treatment (average $r = .33$) were moderately and positively related to treatment outcomes. Participating in treatment or “being there” with youth was one of the key ways that parent and youth in the current study viewed parents’ commitment to youth. The research presented here along with the current research study and systems theory concepts, indicate that parents’ commitment to youth, including showing them unconditional love, support, and encouragement, facilitate hope in youth and parents, which lead to successful outcomes, such as the youth completing treatment assignments and the family feeling more connected.
Hopefulness. The therapeutic relationship and parents commitment to youth contributed to the youth and parents feeling hopeful, which led to successful outcomes. Thus, in the current study, hopefulness is seen as the primary factor that promoted change in youth and families. The families explained how therapists encouraged their feelings of hopefulness through developing a relationship with them, encouraging parents to remain supportive to youth, and talking to youth and parents about the change they were making and helping them think about their future. Through helping the family feel hopeful, therapists helped youth and parents engage in treatment and make individual and family changes, such as youth completing treatment assignments and families communicating more respectfully. Conversely, when therapists discouraged youth and parents from thinking they could change by constantly saying the youth was not doing well in treatment, giving messages that things will not change, and by judging and labeling them as not being able to change, youth and parents felt discouraged and hopeless and did not want to participate in family therapy or make changes.

The notion of hopefulness being a mechanism for change has been written about in the common factors literature. Lambert (1992) suggested that 15% of outcome variance for treatment success was due to expectancy factors, such as the client being hopeful and believing that treatment was working. While Lambert’s estimate was “just a ‘guesstimate’ on his part” (p. 53), expectancy variables have been widely accepted as common factors that contribute to successful outcome in therapy (Sprenkle et al., 2009). In fact, Sprenkle and colleagues reported that therapists regularly attempt to generate a sense of hopefulness and credibility with clients to facilitate change in therapy.
The importance of hope to therapy is supported by a number of systems theorists, but particularly Satir and Baldwin (1983), who stated that the first task in therapy “is to make them [clients] comfortable and create a feeling of hope” (p. 210). Additionally, many systems therapists use interventions, such as reframing, to help clients view problems and solutions as solvable, thus generating an expectation of change and hopefulness in clients (Minuchin, 1974). Much like these systems theorists, the parents and youth in this study described how their therapists fostered hopefulness, which helped the youth and parents believe the therapist was helpful and that treatment was working.

In addition to this theoretical support for the importance of hope to family therapy, empirical studies have also demonstrated that hope is key to the success of therapy. For instance, in the study discussed previously, Tighe and colleagues (2012) found similar results in that adolescent non-sexual offenders and their parents felt hopeful and motivated when they saw positive results early in therapy. The authors indicated that having a sense of hope helped the youth and parents overcome initial doubt and encouraged them to continue in treatment, which led to positive outcomes. Taken together, theory, past research and the current study demonstrate how fostering hopefulness in parents and adolescents as a part of the adolescents’ treatment for sexual offending helps adolescents and parents make important changes, such as changing the family structure and aiding youth in completing their treatment assignments, which contributes to the adolescents’ successful completion of treatment for sexual offending.

**Using parents to help motivate youth and facilitate changes in youth and family.**

When youth and parents felt hopeful about completing treatment successfully and being reunited as a family, they were more willing to engage in treatment through participating in family
therapy. Adolescents and parents participation in family therapy allowed for the second theoretical concept, *Using Parents to Help Motivate Youth and Facilitate Changes in Youth and Family*, identified in this conceptual framework of family therapy. This concept represents the particular interventions, identified by youth and parents, that therapists used to facilitate individual and family (systemic) change. Through modeling various behaviors, giving parents and youth feedback, and practicing skills in family therapy sessions, therapists helped parents and youth improve their parenting, communication, and emotional expression. In addition, therapists helped youth become more honest and responsible. Improving these skills helped youth and parents have new interactions with one another, which strengthened their family connections and facilitated individual and systemic change, including having more respectful communication and positively changing family household rules, roles, and boundaries. In addition to teaching needed skills, therapists also used parents presence and participation in treatment as means of motivating youth and helping them complete their treatment assignments. When youth were more motivated and active in treatment, this helped facilitate a variety of changes in the youth including being more responsible and understanding and expressing regret for sexually offending.

**Teaching skills.** Theoretically, teaching skills is an important part of changing the ways families relate to each other and often involves changing family interactional patterns and hierarchies (Minuchin, 1974). In fact, systems therapists commonly teach communication skills to disrupt negative interactional patterns and increase healthy interactions (Watzlawick et al., 1967). Likewise, teaching parenting skills helps parents to set rules and boundaries for children and can improve a problematic family hierarchy (Minuchin, 1974). Given that youth who
sexually offend experience specific family characteristics, such as poor family boundaries and chaotic family environments (Baker et al., 2003; Wieckowski et al., 1998), which contributes to the development and maintenance of the adolescents’ sexual offending, it is particularly important to change the ways these families relate and interact with each other. Parent and adolescent participants in this study confirmed that therapists teaching skills, particularly emotional expression and parenting skills, in family therapy as a part of the adolescents’ treatment for sexual offending, is important because it leads to successful outcomes.

Expressing feelings. Of the many skills that could be learned in family therapy, expressing feelings was especially important to the participants in the current study. The youth and their parents described how their family therapists had taught them about emotions and helped them to open up, process, and express their emotions, particularly their difficult feelings around the youths’ sexual offending. Participants believed that gaining skill and expressing their feelings helped facilitate change in the youth and family. In particular, being better at expressing feelings was linked to the youth expressing himself more clearly and the family changing the way they communicate, which also helped to strengthen the connections between family members.

Given that adolescents who sexually offend experience lower levels of family bonding, which has been measured in part by cohesion and negative affect, and that lower family bonding may contribute to the development and maintenance of sexual offending (Carpentier & Proulx, 2011; Ronis & Borduin, 2007), it is important to help parents and adolescents connect and strengthen bonds through positive emotional expression. Participants in the current study reported feeling more connected as a family when they were able to express themselves
emotionally. For example, youth and parents discussed how therapists facilitating the clarification process, in which youth express sorrow and grief for sexually offending to the people they hurt, often family members, facilitated healing in families.

Furthermore, Sprenkle and Blow (2004) identified emotional experiencing as a common factor that may be responsible for change in families. They explained that affective or emotional regulation “occurs when therapists facilitate clients regulating or experiencing emotions and making emotional connections with themselves, the therapist, and (most importantly) each other” (p. 123). Emotionally focused therapy (EFT) is a relational treatment based, at least in part, on family systems theory that has been used to treat adolescents in family therapy. Emotionally focused therapists believe that expressing emotions is the primary mechanism of change in families. Therefore, EFT therapists encourage youth and parents to express and discuss their feelings. EFT therapists believe that emotional expression helps family members understand each other, which will help change problematic interactional patterns in families (Johnson, Maddeaux, & Blouin, 1998; Johnson, Makinen, & Millikin, 2001). The current study supports these theories, common factors and EFT, by linking emotional expression in family therapy as part of the treatment for adolescents who sexually offend with successful youth and family outcomes, based on the perspectives of adolescent and parent participants. For instance, parents shared their experiences of being angry with their sons and described how therapists helped them to process and communicate their anger appropriately. In addition, adolescents talked about their experiences of hearing their parents express anger towards them. They discussed how this was helpful to them as it allowed them to work through relational issues, such as feeling hurt and betrayed. As they learned to talk about difficult feelings respectfully with
each other, through listening, and validating one another, they felt more understood and connected as a family.

*Parenting skills.* Teaching parenting skills is particularly important in families where adolescents sexually offend because their parents typically give them less supervision, are inconsistent in setting rules and limits, and have confused parental roles (Wieckowski et al., 1998). In addition, youth who sexually offend often exhibit sexualized behaviors, such as viewing pornography and sexual talk (Baker et al., 2003), which may result from poor parenting. The findings from the present study support the notion that addressing parenting, by teaching parenting skills, is a key way to help parents set boundaries, give rules, and hold youth accountable through giving appropriate consequences. When parents are able to do these things, youth may be more able to make changes and have successful outcomes. Additionally, the family roles change as parents become more in charge.

In the current study, parents shared their experiences of developing new parenting skills in family therapy. They explained how family therapy was a constant learning process, how their therapists gave them tools (e.g., setting rules and consequences) to use as parents, and how they looked to therapists to help guide them in their parental decision making (e.g., how much information about parent issues to share with youth). Through learning parenting skills, parents believed they were better able to set appropriate rules and boundaries for their children, which helped them regain their parental authority, thus improving the family hierarchy and their interactions with their sons. For example, one parent in this study mentioned that she and her husband learned to talk together in private to decide on consequences for their son before presenting the consequences together as a unified team. By suggesting that parents talk together
away from the kids and then speak to the kids together, the therapist strengthened the parental subsystem in the family, which showed the children that the parents are in charge, and improved the family hierarchy (Minuchin, 1974). From a family systems perspective, correcting family hierarchy is important to healthy outcomes. In addition to changing hierarchy, changing family boundaries, rules, and roles also contributed to youth successful outcomes, such as the youth following rules, being more responsible, and progressing in his treatment work. The participants in this study explained that, when parents started consistently setting rules and boundaries for their children, the youth began following the household rules (e.g., being home by curfew and helping out around the house).

The emphasis on the value of parenting skills in improving outcomes for both youth and his family is consistent with current research. Research on MST indicates that therapists have attributed successful outcomes, such as lower recidivism rates, to teaching parenting skills (Henggeler et al., 2009). Similarly, in the MST qualitative study explained previously, Tighe and colleagues (2012) found that teaching parenting skills led to change (i.e., reduced delinquent behavior) in a group of non-sexual offending youth. Similar to the current study, participants (parents and youth) in Tighe and colleagues’s study identified similar therapeutic processes that were found in the current study, such as therapists supporting and giving parents suggestions about how to set limits and give consequences in parenting. Furthermore, Tighe and colleagues attributed change in the family and adolescents to the parents learning and using new parenting skills. When considered together, the MST studies (Henggeler et al., 2009; Tighe et al., 2012) and the current study highlight teaching parenting skills as an important mechanism of change for adolescents who sexually offend. Through modeling behaviors, giving feedback to youth and
parents, and practicing skills in family therapy sessions, therapists taught parents more effective ways to provide structure for youth, which facilitated changes in the family system including clearer hierarchy and roles. This, in turn, allowed parents to create a family environment that prohibits sexual offending.

**Strengthening family connections.** Through teaching parents and youth skills, such as communication, parenting skills, and emotional expression, the therapists that were referenced in this study helped parents and youth have new experiences of relating to each other. Participants repeatedly described how learning and implementing new skills resulted in them feeling more cared for and connected to each other. For instance, youth and parents talked about how sharing feelings and communicating differently helped them to listen to, understand, and validate each other, which helped them feel more connected as a family. These stronger feelings of connection contributed to positive changes in the family, such as spending more time talking together, communicating more respectfully, and resolving conflict.

Increasing relationship connections, particularly between parents and adolescents, is important for adolescents who sexually offend because of the research (reviewed in chapter two) demonstrating poor attachment and family bonding in these families, which is thought to contribute to the development and maintenance of sexual offending (Burk & Burkhart, 2003; Rasmussen, 2013; Ronis and Borduin, 2007). As previously discussed, emotionally focused therapy (EFT) is an example of a systemic therapy that has been used to repair distressed attachment relationships in families (Johnson et al., 1998; Johnson et al., 2001). The primary goal of EFT is to change the “distressing cycles of interaction that create and maintain attachment insecurity in family members, particularly the adolescent” (Johnson et al., 1998, p.
Emotion is viewed, by EFT therapists, as defining the quality of the attachment between the youth and his parents. Thus, EFT therapists seek to help adolescents and parents express and change their emotional responses that contribute to the negative patterns of interaction between the parents and adolescents (Johnson et. al., 1998; Johnson et. al., 2001). In addition, EFT therapists seek to help parents and adolescents replace negative patterns of interaction with interactions that foster interactional patterns of caring and comfort, which helps promote secure attachment (Johnson et. al., 2001). This theory is consistent with the perceptions of parents and youth in the current study, who reported that communicating and expressing emotions helped promote positive interactions between youth and parents, which they contributed to changes in the family system.

**Partnering with parents.** While there are theorists and researchers who have advocated for involving parents in the youths’ treatment for sexual offending (see, for example, Worling et al. 2010), the idea that parents can be used purposefully in treatment to help youth be successful and motivated, through helping them complete treatment assignments, has not been explored. In the current study, it became clear that parents felt they were partnering with the therapists, in family therapy, to work together and help their sons change. Participants stated that having the parents be involved in family therapy helped the youth feel that they were not in this (treatment) alone. Youth expressed how knowing someone, especially family, was right there working with them and helping them with their treatment assignments motivated them to work harder to complete their treatment assignments.

Specifically, youth and parents talked about how parents helped them with specific treatment assignments that would have been more difficult for them to complete without their
parents being there. For example, youth and parents talked about how parents were able to help youth with their sexual offending timeline and clarification assignments, both of which are common elements of treatment for youth who sexually offend. The sexual offending timeline helps youth to recall their behaviors around sexually offending and to disclose all of their sexual offenses. Parents and youth talked about how parents were able to add specific dates and details to help the youth remember what happened. Clarification is the process of the youth taking full responsibility for what he did, sexually offending. Through this process, the youth who sexually offended “admits to the victim and pertinent family members to sexually abusing the victim, accurately describes the sexual abuse, takes responsibility for it, apologizes for it, and demonstrates empathy for the victim” (Harper, 2012, p. 47). By being part of family therapy, parents were able to help the youth with assignments associated with the clarification process by providing information about how the sexual offending affected their family, and in cases of sibling sexual abuse, the victim. Youth said that they read their clarification letters to parents and got feedback, which helped them make further changes on assignments.

Through directly helping youth complete assignments in family therapy, parents helped motivate youth to complete treatment work and make individual changes including becoming more honest, taking responsibility for themselves, and understanding and expressing regret for sexually offending. Clearly, therapists should be using parents as a resource in their sons’ treatment for sexual offending to motivate them and help them complete assignments that they may not otherwise be able to complete on their own.

In addition to helping youth feel motivated and complete assignments, having youth and parents work together on assignments would give therapists opportunities to assess for
potentially problematic and healthy family interactional patterns (Watzlawick et al., 1967). Once identified, therapists could intervene by using the assignments to help youth and parents practice new skills. This would give youth and parents opportunities to relate differently and understand each other, which participants in the current study identified helped them feel more connected.

As discussed in the previous section, helping parents and youth change the way they relate, interactional patterns, is viewed by systems theorists as a mechanism of change (Watzlawick et al., 1967). Theoretically, partnering with parents not only helps therapists motivate and help youth complete assignments, it has the potential to act as an intervention in family therapy to help families feel more connected, which contributes to families feeling more hopeful and family change.

**Outcomes: Changes in individuals and the family system.** In the final theoretical concept in this conceptual framework of family therapy, parents and youth shared their perspectives on how they changed, individually and as a family, as a result of being involved in family therapy as a part of the youths’ treatment for sexual offending. Both parents and youth attributed their changes to the therapist supporting and encouraging them, which helped them to feel positive about their futures, and have hope for completing treatment successfully and being a family again. They said that through therapists’ support, parents were able to remain committed to the youth, which helped the youth feel supported by their family and led to individual youth and family changes. In addition, when participants felt hopeful about their future, they were more engaged and willing to attend family therapy, which allowed therapists to use parents to facilitate changes in youth and families. Participants shared how therapists taught youth and parents skills, which helped strengthen family connections and led to individual and family
change. Youth and parents identified both individual and family outcomes resulting from their participation in family therapy, which will be explained below.

**Youth outcomes.** Youth and parents noticed the youth changing in treatment, and particularly as a result of family therapy. Parents explained that they observed the youth maturing before their eyes, which helped them to have hope that family therapy was helpful and that the youth would successfully complete treatment, which helped them be more committed to supporting and encouraging youth in their treatment. When youth experienced the parents’ support and noticed changes in themselves, they felt more committed to treatment and worked harder to make changes. One resulting change, from the youth and parents perspectives, was the youth showing more confidence in themselves and their abilities to complete treatment and be successful at school. In fact, youth and parents reported the youth made improvement in life skills, such as doing better academically. Youth and parents gave examples of how youth started thinking about their futures and setting goals, such as planning to attend a particular school, or looking for volunteer work.

Parents and youth talked about, as a result of therapists teaching youth and parents communication skills and facilitating emotional expression, and encouraging responsibility, youth started expressing themselves, particularly their feelings, more clearly, which helped parents better understand them. This helped change the way parents and youth communicated and interacted, which helped them feel more connected. Of particular importance is that youth expressed regret for sexually offending. Adolescents and parents saw this as evidence that youth were understanding their sexual offending behaviors, how they had hurt others, and making decisions to change. In addition to this change, the participants talked about how youth started
genuinely caring about people more, which was evidenced by the youth asking parents about how they were doing.

Through teaching parenting skills in family therapy and encouraging responsibility and honesty in youth, therapists helped parents have expectations for youth. This, in turn helped youth start following the rules, particularly rules that parents set for the household, which contributed to new interactional patterns between the youth and parents, such as the family talking with each other respectfully and resolving conflict. In general, parents and youth stated that youth were more responsible, honest, and worked hard to complete treatment assignments so that they could successfully complete treatment. In addition to these changes, parents and youth talked about how change is a process and that the youth still had changes they needed to make.

The youths’ individual changes, as identified by the parents and adolescents, are consistent with the key treatment goals that have been identified in the literature as practice guidelines for adolescents who sexually offend. These include taking responsibility for sexual offending behaviors, challenging attitudes that support sexual offending behavior, regulating emotions, teaching intimacy and relationship skills, strengthening family support networks, increasing problem solving skills, self-monitoring, improving social skills, and developing victim awareness and empathy (McGrath et al., 2010; National Adolescent Perpetration Network, 1993). The only treatment goal that youth and parents did not identify as a change the youth experienced was controlling sexual arousal. However, that may because the interviewer did not ask youth and parents any questions about their sexual offending behaviors.

Most outcome studies of the treatment of adolescents who sexually offend look at recidivism rates rather than identifying specific changes for the youth. However, previous
outcome studies of MST with this population have examined a few specific youth changes including fewer behavior problems, decreased criminal behaviors, improved academic performance, and improved peer relations (Borduin et al., 2009; Letourneau et al., 2009; Tighe et al., 2012). The current study extends MST studies by adding to the list of potential youth outcomes for future examination; outcomes which are consistent with existing practice guidelines (NAPN; 1993).

Consistent with the study described previously by Tighe and colleagues (2012), parents and youth in the current study attributed positive individual youth outcomes to the therapist developing a relationship with the parents and youth. However, the findings from the current study offer an explanation of how the relationship with the therapist might facilitate these outcomes, through fostering hopefulness and strategically involving parents in the youths’ treatment, which were explained in previous sections. Of particular interest in this study is that the youth and parents also attributed these changes to the parents being involved in family therapy. They talked about how parents were able to be supportive, encouraging, and motivating for youth, which contributed to youth feeling hopeful about successfully completing treatment. This helped them to remain committed to and work hard in treatment, which led to successful outcomes. Furthermore, parents and adolescents identified how therapists used the parents to motivate and facilitate changes in the youth, such as parents helping youth with treatment assignments in family therapy.

**Family outcomes.** Despite evidence that adolescent sexual offending develops in the family context (Ronis & Borduin, 2007; von Bertalanffy, 1968), current practice guidelines only identify one family treatment goal, strengthening family support networks (McGrath et al., 2010;
National Adolescent Perpetration Network, 1993). There have been few specific descriptions of what “strengthening family support networks” consists of when parents participate in family therapy (or treatment as usual, for that matter) as a part of their sons’ treatment for sexual offending. In their studies, Borduin and colleagues (2009), who are MST researchers, identified desired family changes as improved family relationships (i.e., increased cohesion and adaptability) and interactions (i.e., decreased conflict and increased supportiveness). Similarly, the youth in Thurston’s (2005) study reported experiencing improved functioning in their family, more positive interactions with family members, and more supervision and structure. They also reported experiencing improved communication and feeling closer to their parents. In addition, they stated that their families had started talking about and resolving conflicts as a response to treatment. In the previously discussed MST study, Tighe and colleagues (2012) found that parents experienced increased confidence and skills and improved relationships with their child.

The findings from this study are consistent with the outcomes previously identified, support family systems theory concepts, and add more specific descriptions of the changes that families made when parents participated in family therapy as part of their sons’ treatment for sexual offending. Specifically, parents and youth discussed how they established new rules and roles in their family. This reflects the family systems goals of correcting hierarchy in families (Minuchin, 1974). For example, parents talked about how therapists taught parenting skills to help parents establish rules for youth to follow at home, such as doing chores. The adoption of these rules changed the family roles such that parents became more in charge (correcting the family hierarchy), and helped youth make individual changes, such as following the rules and
being more responsible, which helped parents and youth feel hopeful that the youth was changing.

In addition, youth and parents reported changed family boundaries, which is consistent with the family systems goals of creating boundaries to distinguish the family system from other systems (Minuchin, 1974). Specifically, one parent talked about learning when to talk to members outside their family about the sexual offending. Through teaching youth and parents about when and how much information to share, the family therapist helped this mother create a boundary between the family system and the suprasystems (Minuchin, 1974), in this case, the extended family.

Another important family change was having more frequent and respectful communication as a family. This is consistent with family systems goals of supporting healthy and changing problematic interactional patterns within the family (Watzlawick et al., 1967; Whitchurch & Constantine, 1993). Through teaching youth and parents to communicate, work through conflict, and share their feelings, therapists helped parents and youth increase healthy relational patterns and strengthen their relationships, which supported the changes the family had made as well as the youths’ new behaviors (individual outcomes), such as being honest and being responsible so that he will not sexually reoffend. Likewise, recognizing the changes youth and family were making and experiencing improved relationships contributed to the adolescents and parents feeling hopeful that the youth would successfully complete treatment and they would reconnect as a family.
Limitations

While the current conceptual framework of family therapy has great potential to provide practitioners, who work with adolescents who sexually offend, insight about how family therapy can help, the study is not without limitations. First, it is possible that participants who self-selected for a study on family therapy already had a strong positive response to family therapy. Because of this, youth and parent participants may have given a more positive assessment of family therapy. Including more families in the study who have had negative reactions to family therapy, or who have not found it helpful, may have contributed a more critical lens. Specifically, including these families may have provided more feedback about what is not helpful or what does not work in family therapy. Nonetheless, the families in this study still gave critical feedback about family therapy, which was integrated into the current conceptual framework of family therapy.

Another limitation regarding the participants was that I was not able to ask about a number of contextual factors that would have helped me to describe the sample in more detail. I tried to get as much information as possible and screened out active abuse, but I did not ask the youth or parents any information about their backgrounds of abuse, treatment, and other marginalization. Not having this information limits my understanding of the families and who this conceptual framework is applicable to; however, gathering this information would have been too burdensome and potentially harmful for the participants.

When I recruited participants for this study, some of the participants learned that I have a personal relationship with their therapist. For example, before speaking at one of the parenting groups, the therapist greeted me with a big hug and introduced me as someone who used to work
at the program. Another therapist, before introducing me to a family, introduced me as a previous professor and told the family I encouraged him/her to work in this field. Knowing that I had a personal relationship with their therapist, and a personal investment in the research I was doing, may have discouraged participants from telling me about ways their therapist or treatment was not helpful. To address this issue, I told youth and parents that while I know some of their therapists, I have a peer/colleague relationship with them, which is different than a therapist-client relationship. I further explained that I was interested in hearing their perspectives, both positive and negative about their experiences in family therapy. I assured them that therapists are interested in hearing what they can do to make a difference and help youth and parents, which includes hearing what they need to do differently. In addition, I explained how the results would be reported and assured them that their responses would remain confidential and that therapists would not know specifically what they said. This seemed to help parents and youth open up and tell me about both positive and negative aspects of their experiences.

Another limitation for this study is the lack of information about the therapists of the youth in the study. I did not collect any data regarding the amount of experience the therapists had, the theories of family therapy they used, or what their goals or expectations of treatment were. By not talking with the youth’s therapists, I was not able to develop a comprehensive picture of the youth’s treatment and may be missing important elements of their family therapy experiences. Gathering this information would have helped me make decisions about what was helping these youth and parents. However, I did not interview the youth’s therapists to protect the youth’s confidentiality. Perhaps future studies could include detailed information about therapists and family therapy offered.
An additional limitation for this research was relying on participants to describe a process, how their experiences in treatment relate to the youths progress in treatment, that they had not completed. Because none of the youth interviewed had completed treatment, they may not have been able to accurately reflect how their experiences relate to the changes they were making. To lessen the chance of this, I required that all youth and parents had attended at least 10 family therapy sessions. Knowing that most programs did not do family therapy ever week, I assumed that this would mean participants would have completed between 6 - 10 months of treatment. However, the participants in the current study had been in treatment for sexual offending for an average of 22 months (between 11 and 36 months). Therefore, the chances of youth and parents being able to describe the process was strengthened.

Furthermore, in this study, I asked participants to describe their outcomes and to give a value, positive or negative, to those outcomes. The clients’ recognition of how they were doing in treatment may differ greatly from the therapists’ perspectives. Without the therapists’ voice it is impossible to whether the youth and family outcomes were consistent with the therapists’ goals and intentions.

The final two limitations are regarding the focus group. First, there may have been a social desirability bias with the focus group. Because the therapists in the focus group all do family therapy with adolescents who sexually offend, it is possible that they answered questions and gave me feedback about the conceptualization that would make them look more favorable by the other members of the focus group. They may have agreed with parts of the framework that made family therapists look good. To reduce this possibility, I did not change any of the results that adolescents and parents reported based upon the responses of the focus group. For example,
the therapists in the focus group were initially defensive when they saw that parents and adolescents were frustrated by therapists not being available. They talked about their large caseloads and that they could not be available all of the time. Regardless of the therapists’ responses, I included the youth and parents perspectives that therapists not being available slows the process down for them in the theoretical conceptualization.

Additionally, there was a bias of the researcher in the focus group. I had arranged for another researcher to conduct the focus group, however, she was unable to do it at the last minute so I facilitated the group. I am well acquainted with three out of the seven therapists that participated in the focus group. It is possible that they were less critical of my theoretical conceptualization than they would have been if we did not have a personal relationship. In addition, all of the therapists in the focus group knew that I had conducted the research and that I am a therapist who works with adolescents who sexually offend. This may also have discouraged them from being completely honest about the limitations and problems they saw with the findings. To mitigate this, I told the therapists that the theoretical framework that I was presenting them was in process and that I wanted their feedback to help me refine the emerging framework. All of the therapists in the group appeared to be comfortable giving me constructive comments about the emerging framework.

**Implications and Recommendations for Research and Clinical Practice**

The findings of this study suggest that adolescents who have sexually offended may greatly benefit from their parents participating in family therapy as a part of the adolescents’ treatment for sexual offending. Specifically, based on the conceptualization of family therapy identified in this study, therapists can assist these families by fostering a sense of hopefulness
and using parents to help motivate youth in their treatment for sexual offending. Based on the findings from this study, if therapists are able to accomplish these things, it may lead to more successful outcomes for youth and families. Clearly, the findings of this study have a number of important implications for research and clinical practice.

**Implications and recommendations for research.** While these findings extend current research by providing a more detailed conceptual framework of family involvement in adolescents’ treatment for sexual offending, future research is needed to continue to refine this framework. The findings from this study furthered the understanding of the importance of the therapeutic alliance in helping youth and families change. Specifically, parents and youth talked about how therapists initiating a relationship, caring, supporting and encouraging, and validating them contributed to youth and parents feeling more hopeful about their futures, which helped the youth work harder in treatment and helped the parents remain committed to supporting youth. Future research could extend this work by obtaining more specific information about each variable, either through qualitative descriptions from participants or quantitative surveys, and how they connect to outcomes. For example, a mixed methods study, in which the researcher would gathers qualitative descriptions for each variable and then surveys a larger sample to find out quantitative data on the variables and connect them to outcomes. Furthermore, more information is needed about how this connection fosters hopefulness and leads to change. In the previous example, the survey could contain questions representing the concept of hopefulness. Statistical analysis could be used to demonstrate how participants view the therapeutic alliance relates to hopefulness.
Similar to learning more about therapeutic alliance, more research is needed about the parents’ commitment to youth helped the youth progress in treatment. Because there is little information about this concept in the literature, a qualitative research study specifically about parents’ commitment and how it is helpful and not helpful to youth would help to establish more specific details about this theme. For example, researchers could ask parents and adolescents about each of the key variables: parents showing unconditional love to youth, parents supporting youth, and parents encouraging youth. Researchers should seek descriptions of these variables and then test whether these variables make a difference in youth and parent outcomes.

Another important finding of this study is the idea that therapists can purposefully use parents to help youth progress in treatment through teaching skills, strengthening connections, and having parents help youth with their treatment assignments. To further the understanding of parents’ roles in family therapy, using each of the specific variables identified in the current study, researchers could survey therapists to learn how therapists use parents in treatment. Of particular interest is the idea of parents helping youth with treatment assignments. Because there were not many specific treatment assignments identified in the current study, researchers could include a qualitative component in this survey so that therapists could write in the types of treatment assignments they use parents to help youth complete. In addition, a qualitative option would allow therapists to include interventions using parents that have not yet been identified. Furthermore, it would be helpful for researchers to test whether or not these interventions lead to youth and family outcomes.

Finally, the findings from this study have demonstrated how asking adolescents and parents about their experiences in family therapy provides valuable information about the
process of change. More qualitative studies focused on gathering detailed descriptions of each part of this change process are needed (Tighe et al., 2012). In these studies, researchers could ask participants specific questions about how the specific interventions and outcomes that were identified in this study are connected. For example, researchers could ask questions about how therapists using parents to help youth complete treatment assignments link with youth and family outcomes, such as youth taking responsibility or families communicating more.

In conjunction with obtaining data from parents and adolescents, future research should include data obtained from probation officers, DHS workers, and therapists. In addition, researchers could follow youth over time to see if their perspectives change about the process of therapy or if they maintain changes. Both of these suggestions for further research would provide a more complete understanding of the participants’ experiences in family therapy and how they are linked to individual and family outcomes.

**Implications and recommendations for clinical practice.** The conceptual framework of family therapy in the adolescents’ treatment for sexual offending identified in this study has significant implications for clinical practice. Specifically, when including family therapy in youths’ treatment for sexual offending, therapists should help youth and parents develop a sense of hopefulness. In addition, therapists can strategically use parents to help motivate the youth, through teaching youth and parents skills, such as communication, emotional expression, responsibility, honesty, and parenting skills. In addition, therapists can use parents to help youth complete difficult treatment assignments and help parents and youth strengthen their relationships. Furthermore, therapists can use the outcomes identified in this study to guide their treatment goals.
Fostering a sense of hopefulness. Youth and parents described how feeling hopeful that youth would successfully complete treatment and they would be reconnected as a family, helped them make individual and systemic changes. Based on the findings from this study, there are several ways that therapists can help youth and parents feel more hopeful:

• Initiate and develop a relationship with youth. Show youth that you care about them and that you want them to be successful. Encourage them by telling them when they are doing well and how you see them changing. This will help youth feel more positive and hopeful about being able to complete treatment successfully.

• Initiate and develop a relationship with the parents or parental figures. Help parents feel accepted by validating their experiences and not blaming them for their sons’ sexual offending. Show an interest in parents by asking them questions about what else is going on in their lives (i.e., their jobs, hobbies, other family members).

• Give praise. Tell youth and parents when you see them working hard. Identify what they are doing and the specific changes you see them making. This will help them to recognize their growth, which will help them be hopeful that they can be successful and make changes individually and as a family. Particularly, praising youth in front of their parents helps parents to recognize how their involvement is making a difference and helps them to continue supporting their sons.

• Be positive. While it is important that you help youth and parents identify changes they need to make, present constructive feedback in a positive way. For example, give a negative in between two positives. Also, help parents and youth see how something that feels negative to them, such as the youth talking about sexual offenses, is also positive
in that he is making progress in treatment. Furthermore, ending sessions on a positive
will help youth and parents leave the session feeling hopeful that they responded
appropriately to whatever was discussed in the session.

• Be available. Let parents and youth know when (days and times) and how (phone,
email, etc.) they can reach you in between sessions. In addition, be present and
available to parents and youth during sessions. By focusing on them, and not taking
phone calls during session, you will show them you care about them and are committed
to helping them in their treatment, which helps foster hopefulness.

• Help parents support and encourage youth in their treatment. Let parents know that you
are glad that they are involved and that they are important in their sons’ treatment. Give
parents ideas of how they can support and encourage their sons (e.g., being available to
talk with them about their feelings around issues that come up in therapy, bringing them
to appointments on time, and by participating in family therapy). If you work in a
residential program, give parents opportunities to talk to and visit their sons.

• Help parents express their love and commitment for their sons. In family therapy,
facilitate conversations that help parents tell their sons that they are there to support
them and that they love them.

Using parents to help motivate youth and facilitate changes in youth and family.

Therapists have a great resource in parents. The results of this study suggest that therapists can
use parents in a variety of ways to help motivate youth in their treatment. The findings from this
study point to a number of specific ideas for using parents in youths’ treatment for sexual
offending:
• Model behaviors that you want to see in the parents and youth. For example, parents are watching you interact with their sons. Model how you would like parents to talk to their sons and hold them responsible for their behaviors.

• Give direct feedback. Tell parents and youth what you think and give them clear direct feedback about changes that they can make.

• Practice skills in family therapy sessions. You can practice skills through facilitating conversation and doing role-plays. Through practicing new skills in session, parents and youth will have an easier time doing the new behaviors outside of session.

• Help facilitate youth and parents express their emotions. Teach them about emotions, particularly how to identify them and help them express constructively. Particularly, help them talk about feelings around the youths’ sexual offending. This includes helping parents identify and appropriately express anger with their sons.

• Teach parenting skills. Parents look to you for support and guidance in parenting. Help parents to know how strict or lenient to be, how to create rules, and how to follow through on consequences. Discuss different parenting scenarios with them and help them to think of new options of ways they can respond. Help couples to co-parent by deciding on rules and consequences a team.

• Help parents and youth talk together during family therapy sessions. Teach them communication skills and help them practice these skills with each other. Help them to talk through difficult issues of conflicts while listening and validating each others’ perspectives. Helping them communicate respectfully in family therapy sessions will help youth and parents be able to talk more frequently and respectfully outside of
sessions.

• Teach youth through holding them responsible for their behavior. Communicate clear expectations for youth and hold them responsible when they are not meeting your expectations. Parents really appreciate it when therapists call youth on their “stuff.” This helps the youth take responsibility and models for parents how to hold youth responsible outside of therapy sessions.

• Strengthen family connections in family therapy. Help parents and youth have new experiences of positively relating to one another. Help youth to apologize to parents for sexually offending. Having the family back together is important to youth and parents. Help them to do this process as quickly as possible by starting the clarification process as soon as the survivor is ready.

• Use parents to help youth complete treatment assignments. Have youth and parents work on assignments together. For example, parents can help youth understand their history by helping them remember and identify what was happening in the family at different times. Parents can also help youth work towards clarification with survivors. Specifically, you could have youth read parents clarification letters. After hearing the letter, parents could give the youth feedback, which will help parents hold him responsible for sexually offending and help the youth be more thoughtful in writing the letter to how the survivor might be feeling.

**Outcomes.** The youth and parents in this study identified several changes the youth and family made as a result of the parents being involved in family therapy when their son was in treatment for sexual offending.
• Use these outcomes as a starting point for identifying treatment goals for youth and families. A couple of the participants expressed how they wished they had a road map for where they were headed in treatment. Therapists could use the outcomes from this study, combined with the common outcomes in your treatment programs, to design a brochure for parents and youth that would give them an idea of the types of things they will be learning through family therapy.

• Start tracking outcomes in your programs. Regularly meet with clients when they are close to completing treatment and ask them about how they perceived they changed from participating in family therapy. Combining the list you develop with the outcomes identified by the participants in this study would help you develop a more comprehensive list of outcomes to be used in your treatment programs.

Conclusion

By asking adolescent and parent participants about their experiences in family therapy, I developed a conceptual framework of family therapy in the treatment of adolescents who sexually offend. This framework demonstrates the importance of involving parents in their sons’ treatment for sexual offending. It shows how therapists can help youth reach their goals of not sexually reoffending by supporting and encouraging youth and parents, which helps the youth remain hopeful and work harder in therapy. Furthermore, through supporting and encouraging these families, therapists also help parents remain committed to supporting their sons in treatment for sexual offending. Parental support is a key factor in youths’ hopefulness and contributes to the youth making significant changes, including among other things, completing treatment assignments. Furthermore, by including parents in family therapy, therapists are able to
utilize parents as a resource to help youth successfully complete treatment. Through modeling specific skills, providing direct feedback to youth and parents, and practicing skills in family therapy, therapists can teach parents and youth skills, such as emotional expression and parenting skills, which can help strengthen family relationships and lead to change in the youth and families. Additionally, parents are in a unique position to motivate and help youth complete treatment assignments. Therefore, therapists can have parents work with youth on assignments, such as clarification and timelines. Through fostering hopefulness and using parents to help youth in treatment, therapists can help youth and families make substantive changes, such as positively changing the family structure that may have contributed to the development and maintenance of the abuse and the youth understanding and showing regret for sexual offending.
References


Appendix A

Inclusion and Exclusion Criteria

Adolescents will:

1. be between the ages of 12-17 (may be 18 if living with parent/caregiver or in a treatment program).
2. have committed at least one contact sexual offense against a child (under 12 years-old).
3. have been mandated to specialized treatment for sexual offending by the courts or the Department of Human Services (DHS).
4. not be included or excluded based upon the severity of his offense(s).
5. have participated in at least ten sessions of family therapy with at least one parent or caregiver who is willing to participate in the study (see below for inclusion criteria for parents).

The parents or caregivers will:

1. be biological parents, adoptive parents, stepparents, or grandparents. If a caregiver is not a biological parent, s/he needs to be someone that the adolescents identifies as a parental figure.
2. have legal authority to give permission for the adolescents to participate in the study. In cases where the adolescent is a ward of the state, such as those adolescents in residential treatment, the probation/parole officer will be asked to give permission to participate, along with the parents.

The family therapists will:

1. hold a license recognized by the Oregon Board of Licensed Professional Counselors and Therapists or the Board of Licensed Social Workers.
2. either be certified or eligible for certification as a sex offender therapist by the state of Oregon.
3. have specific training in family therapy and systemic issues, such as classes in family therapy and systems theory, workshops on family therapy, and supervised experience doing family therapy.
4. have a minimum of 3 years experience doing family therapy with adolescents who sexually offend.
Appendix B

Oregon Youth Authority Approval Letter

January 27, 2012

To: Vanilea Kraus

RE: Research Proposal Decision for project titled "Parental Involvement in Family Therapy for Adolescents who Sexually Offend"

Dear Ms. Kraus,

Thank you for submitting your proposal to conduct research with Oregon Youth Authority. We appreciate your interest in working with our agency.

The Research Committee’s top priority is to select external research projects that best match the goals and resources of Oregon Youth Authority while meeting the needs of researchers, youth, staff, and the state of Oregon. After reviewing your research proposal, the Research Committee has decided that we are willing to approve consenting for youth that are in our custody that may be included in your study, but we do not approve of OYA staff actively recruiting participants.

After much discussion, we feel the risk of coercion is too great for OYA Juvenile Parole and Probation Officers to recruit for the study. We feel youth and families may interpret participation as a requirement of their supervision.

As a reminder, by signing the proposal application, you agreed to:

- Report any changes in the proposed study and any unanticipated problems involving human participants to the OYA Research Committee.
- Provide a copy of the final research report.
- Be responsible for upholding the ethical standards of this research and for protecting the rights and welfare of human participants.

Please notify Shannon Myrick (shannon.myrick@oya.state.or.us or 503-373-7367) when your project has been completed or if you have any questions. We look forward to working with you.

Sincerely,

Shannon Myrick, PhD
Chair, Oregon Youth Authority Research Committee
Appendix C

Agency Approval Letter

March 29, 2012

Vanieca Kraus, LMFT
Ph.D. Candidate, Virginia Tech

Re: Research Project: Parental Involvement in Family Therapy for Adolescents who Sexually Offend

Hi Vanieca,

I am writing to inform you that your proposal has been reviewed and accepted by the [redacted] Child and Family research review committee. We did not identify any concerns as you have depicted your project in our application. I presume that you will be working with [redacted] and [redacted] in regards to implementing it; both programs are under the supervision of [redacted], who has approved your project as part of the committee review. The committee believes that you have thought through the possible issues very well, and are excited to be able to participate in research that seems very likely to add significantly to both knowledge and practice.

Going forward, I will need an update from you at the end of three months, or sooner if issues emerge, to meet our institutional requirements. Generally it is a simple update regarding how the implementation is going. I will also need to know if any concerns arise that might compromise participant’s rights. And finally, I will need a copy of any reports that result from the investigation.

All the best to you; don’t hesitate to contact me if I can be of any help. The best way to reach me is my cell at [redacted].

[Signature]

Pa.D.
Chief Psychologist
Director of Training
Appendix D

Flier about Research Study

PARENTS INVOLVEMENT IN FAMILY THERAPY

Adolescents and parents are invited to participate in a research study!

Purpose: I am interested in understanding the treatment experiences of parents/caregivers and their adolescent sons when the son is in treatment for sexual offending.

Who: Young men (ages 12-18) who are in counseling for sexual offending and their parents/caregivers.

What: The interviews will last about 2 hours each.

When: A convenient time for you!

Where: A location of your choosing. Options include my office, the juvenile department, or your home.

Why: To help counselors understand how to best help adolescents and their families.

Payment: Each adolescent and parent will get a $10 gift card to Target. You may also receive a copy of the findings if you wish.

Note: This interview will be confidential! Your participation is NOT required and does NOT take the place of any probationary or treatment expectations.

For more information or to volunteer, please contact me:

Vanessa Kraus, LMFT
Ph.D. Candidate, Virginia Tech
research@vanieca.com
(303) 766-6547
Appendix E

Parent and Adolescent Eligibility Phone Screening and Interview Scheduling Scripts

Parents

Parent name: ___________________________ Phone number: ______________________

Introduction & purpose: “My name is Vanieca Kraus. I’m a doctoral student at Virginia Tech and I’m conducting a research study for my dissertation. I’m interested in understanding your experiences in family therapy with your adolescent son as a part of his treatment for sexual offending. My hope is that this study will improve treatment for adolescents who have sexually offended.”

“I would like to tell you more about participating in this study, confidentiality, and ask you some eligibility questions. Would that be OK?” □ yes □ no

If no, “Thank you for your time. I hope you have a nice day.” [end phone conversation]

If yes… Participation: “Your participation would mean that I would interview you (with your partner) face-to-face, for about 1 ½ to 2 hours. Then I would do a separate face-to-face interview with your son for about 1 ½ to 2 hours. During the interviews, I will first ask some general questions about you and your family, for example, how many kids you have, your ethnicity, etc. (demographics). Then I will ask a series of questions about your involvement in your son’s treatment for sexual offending. Specifically I would like to know about your participation in family therapy. I will audio-record and transcribe the interviews to make sure I get them right. You do not need to answer any questions that you do not want to and you can end the interview at any time. I will not ask you or your son any questions about your son’s offenses. However, I will ask you if you will sign a release for me to ask his county/state worker to fill out a questionnaire telling me general information about his treatment and offenses. I will go over this questionnaire with you when we meet. You do not have to agree to this in order to participate.”

“Do you have any questions so far about this study or your participation?” □ yes □ no

“Do you have any questions about your son’s participation?” □ yes □ no

Questions/Answers:
Confidentiality: “I want you to know that your participation in this study is completely voluntary. It has nothing to do with your son’s treatment and will not impact your son’s treatment. The information that you disclose will not be provided to or shared with his therapist. Also, the information you and your son give me will be kept confidential. I will not share what you tell me with your son or anyone else. In addition, I will not share the information your son gives me with you or anyone else. For example, I will not talk with your son’s treatment providers, county and state workers, or his peers about anything you or your son tell me without your permission. There are a couple of exceptions to this. If you or your son tell me about any abuse, such as abuse of a child, or that you plan to harm yourselves or someone else, I would need to tell the police about these things. After this study is over, I plan to share the results in my dissertation paper, articles, trainings, and conference presentations. There will be no information that would identify you, your son, or your family in any written documentation or presentation.”

“How do you have any questions about confidentiality?”

Questions/Answers:

Compensation: “As a thank you for participating in this interview, I will give you and your son each a $10 Target gift card. If you start the interviews and chose not to finish them, you will still receive the gift card.”

Verbal Consent to Participate? (The parents will be sent a copy of the informed assent and permission forms to review before the interviews. In addition, these informed consent and permission forms will be reviewed and signed at the interviews) “You and your son’s consent are completely voluntary. This study has nothing to do with your son’s treatment. It is not an expectation of his treatment or probation requirements. You are not required to participate and your participation will not take the place of any requirements that your son has for probation or treatment.”

“Would you like to participate in this study?”

If no, “I can understand that. Thank you for letting me talk with you about this. I hope you have a nice day.” [end phone conversation]

If yes, “Do you give permission for your son to participate in this study if he is interested?”
If no, “I can understand that. Thank you for letting me talk with you about this. I hope you have a nice day.” [end phone conversation]

“Are you the adolescent’s parent or caregiver?” ☐ yes ☐ no

“Do you have the legal authority to give consent for this adolescent to participate in this study?” ☐ yes ☐ no

If not, “Who is the adolescents’ juvenile court counselor/OYA worker that I should seek consent from?” _________________________________

Eligibility:
“Would it be OK for me to ask you a few questions to help me determine your eligibility to participate in this study?” ☐ yes ☐ no

If no, “I can understand that. Thank you for letting me talk with you about this. I hope you have a nice day.” [end phone conversation]

“Has your son committed at least one contact sexual offense against a child (under 12 years-old)?” ☐ yes ☐ no

“How many family sessions have you participated in with your son?” ______ sessions

“Before we schedule a meeting, I need to talk with your son about this study and to ask him few questions to help me determine eligibility to participate. May I talk with your son about this?” ☐ yes ☐ no

If son is not present and/or not available to talk to me at that time: “May I have your son’s contact information please? [Record in spaces below]. Thank you for talking with me about this today. I’ll contact your son and then contact you again to talk about whether or not you were chosen for the study. And, if appropriate, to schedule the interviews. Thank you for your time and interest.”

If the son is present, complete the adolescent screening.

Adolescent

Name: ______________________________ Phone number: ______________________________

Introduction & purpose: “My name is Vanieca Kraus. I’m a doctoral student at Virginia Tech and I’m conducting a research study for my dissertation. I’m interested in understanding your
experiences in family therapy with your parents as a part of your treatment for sexual offending. My hope is that this study will improve treatment for adolescents who sexually offend.”

“I have already talked with your parents and they said it would be OK if I talk with you about this study. But you do not have to talk with me if you do not want to. I would like to tell you more about participating in this study, confidentiality, and ask you some eligibility questions. Would that be OK?” ☐ yes ☐ no

If no, “Thank you for your time. [end phone conversation… see eligibility response below]”

If yes… Participation: “Your participation would mean that I would interview you face-to-face, for about 1½ - 2 hours. I will also do a separate face-to-face interview with your parents. During the interview, I will first ask some general questions, for example, your ethnicity and how long you have been in therapy (demographics). Then I will ask a series of questions about your involvement in family therapy as a part of your treatment for sexual offending. I will not ask you any specific information about your offenses. I will get general information about your offenses from your county/state worker if you and your parents say that is OK. You do not need to answer any questions that you do not want to and you can end the interview at any time. I will audio-record and transcribe the interview to make sure I get it right.”

“Do you have any questions so far about this study or your participation?” ☐ yes ☐ no

“Do you have any questions about your parents’ participation?” ☐ yes ☐ no

Questions/Answers:

Confidentiality: “I want you to know that your participation in this study is completely voluntary. It has nothing to do with your treatment. The information that you disclose will not be provided to or shared with your therapist. Also, the information you and your parent(s) give me will be kept confidential. I will not share what you tell me with your parents or anyone else. In addition, I will not share the information your parent(s) give me with you or anyone else. For example, I will not talk with your treatment providers, county and state workers, or your peers about anything you or your parents tell me without your permission. There are a few times when this would not be true. If you tell me about any abuse, such as abuse of a child, or that you plan to harm yourself or someone else, I would need to tell the police and your county/state workers about these things. After this study is over, I plan to share the results in my dissertation paper,
articles, trainings, and conference presentations. There will be no information that would identify you, your parents, or your family in any written documentation or presentation.”

“Do you have any questions about confidentiality?” □ yes □ no

Questions/Answers:

Compensation: “As a thank you for participating in this interview, I will give you and your parents each a $10 Target gift card. If you start the interviews and chose not to finish them, you will still get the gift card.”

Verbal Assent to Participate? (The adolescent will be sent a copy of the informed assent form before the interview. In addition, this informed assent form will be reviewed and signed at the interview) “You have a choice whether or not you are a part of this study. This study has nothing to do with your treatment and will not replace any of your treatment or probation requirements. You do not have to participate in this study. Nobody can make you participate if you chose not to. You should not be forced to participate by your parents. If you decide that you do not want to be involved, I will not tell anyone about your choice, not even your parents.”

“Would you like to participate in this study?” □ yes □ no

If no, “I can understand that. Thank you for letting me talk with you about this. [end phone conversation… see eligibility response below]”

“May I ask you a few questions to help determine your eligibility to participate in this study?” □ yes □ no

If no, “I can understand that. Thank you for letting me talk with you about this. [end phone conversation… see eligibility response below]”

“How old are you?” _____ (must be between the ages of 12-17 or 18 if living at home or a treatment program)

“Have you committed at least one contact sexual offense against a child (under 12 years-old)” □ yes □ no
“How long have you been in treatment for sexual offending?” ______

“How many family sessions have you participated in with your parents?” ______

Eligibility Responses:

If not eligible because the adolescent does not want to participate: “Thank you for spending time talking with me today. I will briefly contact your parent(s) to tell him/her that you both have not been chosen for this study. I will not tell anyone about your choice not to participate. I wish you the best.”

If not eligible for other reasons: “Thank you for spending time talking with me today. I’m sorry but you are not eligible to participate in this study. I will briefly contact your parent(s) to tell him/her that you both have not been chosen for this study. I wish you the best.”

If eligible: “Thank you for your interest in participating in this study. I will contact your parents to schedule an interview. I’ll look forward to talking with you again soon.”

Scheduling with Parents

“Hi. This is Vanieca Kraus. I talked with you on [date] about your participation in a research study.

If not eligible because the adolescent does not want to participate: “I appreciate your interest in this study but you have not been chosen to participate. I really appreciate you taking the time to talk with me and learn more about what I am doing. I wish you and your son the best.”

If eligible: “I’ve talked with your son and am calling today to schedule your interviews. I would first like to meet with you (and your partner). When would be a good day and time for you?”

Date: _____________________ Time: ___________________

“I would prefer to meet with you at my office, which is located at 2225 NE Martin Luther King Blvd., Portland. This is the location that I can best offer you confidentiality. However, we could also meet at the juvenile department. If we meet there, you and your son may run into people you know (for example, his juvenile court counselor, other youth in his program, and his treatment provider). Where would you like to meet?”

Location: ________________________________________________

“Thank you. I’d also like to schedule a separate interview with your son. When would be a good day/time/location for that interview?”
“Thank you. Would you like me to send you a confirmation email?”  □ yes  □ no

Email: ______________________________

“Great. I will also be sending you and your son a copy of the informed consent, assent and permission forms. Please feel free to contact me about any questions you have about these forms. We will also review these forms together before the start of the interviews. In addition, I’ll call you a few days before your appointment to confirm. I’m looking forward to talking with you more about your experiences in family therapy with your son as a part of his treatment for sexual offending.”
Appendix F

Informed Consent Form for Parents

VIRGINIA POLYTECHNIC INSTITUTE AND STATE UNIVERSITY
Informed Consent for Participants in Research Projects Involving Human Subjects

Parent Consent Form

**Title of Project:** Parental Involvement in Family Therapy for Adolescents Who Sexually Offend

**Investigators:** Vanieca I. Kraus, M.A., LMFT; Megan Dolbin-MacNab, Ph.D., LMFT

**I. Purpose of this Research:** The purpose of this research study is to learn about how parents and their adolescent sons experience family therapy as a part of the son’s treatment for sexual offending. This study involves approximately 10 adolescents and their parents.

This study has nothing to do with your son’s treatment or probation. It is **not** part of his treatment or probation requirements. You do not have to be in the study. Being in the study will not take the place of any requirement of his probation or treatment.

**II. Procedures:** You can ask questions about this study. If you want to be in the study, we will schedule an interview with you. You will meet with the researcher in person for the interview. Before you start the interview, you will be given two copies of this form. You will sign both copies. One copy will be for the researcher and one will be for you to keep.

The interview will be in a place that you chose. This could be at the researcher’s office, the juvenile department, or another private location. One researcher will come to the place that you choose. The researcher will ask you some questions. Some of the questions will be about general information about you and your family, such as your ethnicity. The rest of the questions will be about your experiences in family therapy as a part of your son’s treatment for sex offending. It should take you about 1½ to 2 hours to finish the interview. The interview will be audio-recorded.

The researcher will interview your son at a separate time from you. Your son will be asked similar questions. The interview with your son should take about 1½ to 2 hours.

At a later date, you will be asked to look at the results of the study. If you want to help with this part of the study, the researcher will email or mail you a short survey. You will answer questions about whether or not the results seem right to you. This survey should take you about 30 minutes to complete.
III. Risks: The risks of being in this study are very small. However, you might have some uncomfortable feelings such as sadness or anger. You do not have to answer any questions that make you feel uncomfortable. You can stop at any time. If you would like to talk about your feelings, the researcher will give you the name of a trained professional. You are responsible for paying any costs that go with seeing a professional.

The researcher will not ask you any questions about your son’s sexual offenses. We will get general information about this from his county or state worker after obtaining a release from you. We encourage you to not to give us this information directly. However, if you tell us about any abuse of a child or threats of harm to self or others, we have to report it to his juvenile court counselor or OYA worker. Additional reports of abuse may affect your son’s treatment or probation requirements.

IV. Benefits: We cannot promise that you will benefit from being in this study. But you might learn more about yourself and your family. The information you share may be used to improve counseling for other families. As a result, you might feel a sense of personal pride from knowing that you are helping other families who have a son in counseling for sex offenses.

V. Extent of Anonymity and Confidentiality: Your participation in this study is confidential. This means that no one, except the researchers, will see or hear your answers to the questions. The researchers may include quotes from your interview in the results of the study. If this happens, the researcher will change these quotes enough so that no one can identify you by reading the quote. What you say will never be linked to your name.

The interview will be audio-recorded and then transcribed. These audio-recordings and all information collected during this study will be stored on a password protected computer or in a locked file cabinet in a locked office. Only members of the research team will be able to open the file cabinet. These audio-recordings will be destroyed after they have been transcribed. The researcher may hire someone to help with the transcription. This person will sign a confidentiality agreement and will not have access to any of your personal information. When the study is over, the questionnaires and other forms will be destroyed. A database containing only your answers and the transcripts will be kept for future use. These will not include any information that could identify you. Only the research team can use this database.

It is possible that the Institutional Review Board (IRB) may view this study’s collected data for auditing purposes. The IRB is responsible for the oversight of the protection of human subjects involved in research.

We will protect your confidentiality unless we learn about child abuse or elder abuse. Abuse can be physical or sexual abuse. This information must be given to the appropriate government authorities. For example, if you tell us that a child was touched in a sexual way, we will need to tell his juvenile court counselor/OYA worker or the police. Also, if we think you are a threat to
yourself or someone else, we must tell the authorities. These are the only times when your confidentiality would not be protected.

**VI. Compensation:** We cannot fully repay you for your time and effort. To say thank you for helping with this study, you will receive one $10 Target gift card. Your son will also receive a $10 Target gift card. If you chose to stop the interview for any reason, you will still receive the gift card. We will have you sign a form saying that we gave you the gift card. If you are interested, we will mail you a written summary of the findings of the research.

**VII. Freedom to Withdraw:** You do not have to be a part of this study. Once you start answering questions, you can stop at any time. You may also choose to not answer certain questions. If you stop, there is no penalty and nothing bad will happen. You will still get the $10 Target gift card if you decide to stop being in the study.

**VIII. Subject’s Responsibilities:** You voluntarily agree to participate in this study. You have the following responsibilities: 1) to be in an interview that lasts for 1½ to 2 hours, 2) to answer questions if you feel comfortable.

**IX. Subject’s Permission:** I have read the Informed Consent form and conditions of this project. I have had all my questions answered. I hereby acknowledge the above and give my voluntary consent:

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<th>Participant signature</th>
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**Contact Information of Investigators:**

Vanieca I. Kraus, Investigator  
Doctoral Candidate Department of Human Development  
Virginia Polytechnic Institute & State University  
2225 NE Martin Luther King Blvd., Suite #203  
Portland, OR 97212

Megan Dolbin-MacNab, Investigator  
Associate Professor Department of Human Development  
Virginia Polytechnic Institute & State University  
Blacksburg, VA 24061
If I should have any questions about the protection of human research participants regarding this study, I may contact:

David M. Moore                   Telephone: 540-231-4991
Chair, Virginia Tech Institutional Review Board       E-mail: moored@vt.edu
Office of Research Compliance
1880 Pratt Drive, Suite 2006 (0497)
Blacksburg, VA 24061
Appendix G

Adolescent Assent Form

VIRGINIA POLYTECHNIC INSTITUTE AND STATE UNIVERSITY
Assent for Participants in Research Projects Involving Human Subjects

Adolescent Assent Form

Title of Project: Parental Involvement in Family Therapy for Adolescents who Sexually Offend

Investigators: Vanieca I. Kraus, M.A.; Megan Dolbin-MacNab, Ph.D.

What this study is about: You are being invited to participate in a research study involving approximately ten adolescent males who are in treatment for sexual offending and their parents. The purpose of this research study is to learn about how parents and their teen sons experience family therapy.

This study has nothing to do with your treatment or probation. It is not part of your treatment or probation requirements. You are not required to be in this study. Being in this study will not take the place of any requirement of your probation or treatment.

Why I qualify for this study:
1. You are a male between the ages of 12-17 (may be 18 if living with parent/caregiver or in a treatment program).
2. You have committed at least one contact sexual offense against a child (under 12 years old).
3. You have been mandated to specialized treatment for sexual offending by the courts or DHS.
4. You have participated in at least 10 sessions of family therapy with at least one parent or caregiver who is willing to participate in this study.

Participation in this study is voluntary: Your participation in this study is your choice. You may choose not to answer any question and may stop being in the study at any time. You will be treated the same whether or not you agree to join the study. You may quit this study at any time without any problems for you.

Procedures: You can ask questions about this study. If you want to be in the study, we will schedule an interview with you. You will meet with one of the researchers in person for the interview. Before you start the interview, you will be given two copies of this form. You will sign both copies. One copy will be for the researchers and one will be for you to keep.
The interview will be in a place that you chose. This could be at the researcher’s office, the juvenile department, or another private location. One researcher will come to the place that you choose. The researcher will ask you a series of questions. Some of the questions will be about general information about you and your family, such as your ethnicity. The rest of the questions will be about your experiences in family therapy as a part of your treatment for sexual offending. It should take you about 1½ to 2 hours to finish the interview. The interview will be audio-recorded.

The researcher will interview your parents or caregivers at a separate time from you. They will be asked similar questions and their interview should take about 1½ to 2 hours.

At a later date, you will be given the chance to look at the results of the study. If you want to help with this part, we will email or mail you a short survey. This survey will ask about whether or not the results seem right to you. This survey should take you about 30 minutes to complete.

**Potential risks:** The risks of being in this study are very small. However, you might have some uncomfortable feelings such as sadness or anger. You do not have to answer any questions that make you feel uncomfortable. You can stop at any time. If you would like to talk about your feelings, the researcher will give you the name of a trained professional. You are responsible for paying any costs associated with seeing a professional.

We will not be asking you any questions about your sexual offenses. We will get general information about this from your county or state worker if you and your parents say it is OK. We encourage you to not to tell us about this directly. However, if you tell us about any abuse of a child, we have to report it to your juvenile court counselor or OYA worker. Additional reports of abuse may affect your treatment or probation requirements.

**Potential benefits:** We cannot promise that you will benefit from being in this study. But you might learn more about yourself and your family. The information you share may be used to improve counseling for other families. As a result, you might feel a sense of personal pride from knowing that you are helping other families who have a son in counseling for sex offenses.

**My information will be kept anonymous and confidential:** Your participation in this study is confidential. This means that no one, except the researchers, will see or hear your answers to the questions. The researchers may include quotes from your interview in the results of the study. If needed, the researcher will change these quotes enough so that no one can tell who you are by reading the quote. What you say will never be linked to your name.

The interview will be audio-recorded and then transcribed. These audio-recordings and all information collected during this study will be stored on a password protected computer or in a locked file cabinet in a locked office. Only members of the research team will be able to open the file cabinet. These audio-recordings will be destroyed after they have been transcribed. The researcher may hire someone to help with the transcription. This person will sign a
confidentiality agreement and will not have access to any of your personal information. When the study is over, the questionnaires and other forms will be destroyed. A database containing only your answers and the transcripts will be kept for future use. These will not include any information that could identify you. Only the research team can use this database.

It is possible that the Institutional Review Board (IRB) may view this study’s collected data for auditing purposes. The IRB is responsible for the oversight of the protection of human subjects involved in research.

We will protect your confidentiality unless we learn about child abuse or elder abuse. Abuse can be physical or sexual abuse. This information must be given to the appropriate government authorities, such as the police or your juvenile court counselor. For example, if you tell us that a child was touched in a sexual way, we will need to tell your juvenile court counselor/state OYA worker and police. Also, if we think you are a threat to yourself or someone else, we must tell the authorities. These are the only times when your confidentiality would not be protected.

I will be given compensation: We cannot fully repay you for your time and effort. To say thank you for helping with this study, you will receive one $10 Target gift card. Your parents will also receive a $10 Target gift card. If you chose to stop the interview for any reason, you will still receive the gift card. We will have you sign a form saying that we gave you the gift card. If you want, we will mail you a written summary of the findings of the research.

My responsibilities: I voluntarily agree to participate in this study. I have the following responsibilities: 1) to be in an interview that lasts for 1½ to 2 hours, 2) to answer questions if you feel comfortable.

Freedom to Withdraw: You do not have to be a part of this study. Once you start answering questions, you can stop at any time. You may also choose to not answer certain questions. If you stop, there is no penalty and nothing bad will happen. I will not tell any one of your choice not to finish the study, including your parents. You will still get the $10 Target gift card if you decide to stop being in the study.

I agree to participate: I have read the Assent Form and I have had all my questions answered. I hereby acknowledge the above and voluntary agree to participate in this study:

Participant signature __________________________ Date __________________________

Participant name __________________________ Date __________________________
Contact Information of Investigators:

Vanieca I. Kraus, Investigator
Doctoral Candidate Department of Human Development
Virginia Polytechnic Institute & State University
2225 NE Martin Luther King Blvd., Suite #203
Portland, OR 97212

Megan Dolbin-MacNab, Investigator
Associate Professor Department of Human Development
Virginia Polytechnic Institute & State University
Blacksburg, VA 24061

If I should have any questions about the protection of human research participants regarding this study, I may contact:

David M. Moore
Chair, Virginia Tech Institutional Review Board
Office of Research Compliance
1880 Pratt Drive, Suite 2006 (0497)
Blacksburg, VA 24061

Telephone: 540-231-4991
E-mail: moored@vt.edu
Appendix H

IRB Approval Letter

MEMORANDUM
DATE: July 24, 2012
TO: Vaniece I. Elizabeth Kraus, Megan Leigh Dobin-MacNab, Joyce A. Arditi, Christine Kaastie, Fred Percy
FROM: Virginia Tech Institutional Review Board (FWA0000572 expires May 31, 2014)
PROTOCOL TITLE: Parental Involvement in Family Therapy for Adolescents who Sexually Offend
IRB NUMBER: 11-063

Effective July 23, 2012, the Virginia Tech Institution Review Board (IRB), at a convened meeting, approved the Continuing Review request for the above-mentioned research protocol.

This approval provides permission to begin the human subject activities outlined in the IRB-approved protocol and supporting documents.

Plans to deviate from the approved protocol and/or supporting documents must be submitted to the IRB as an amendment request and approved by the IRB prior to the implementation of any changes, regardless of how minor, except where necessary to eliminate apparent immediate hazards to the subjects. Report within 5 business days to the IRB any injuries or other unanticipated or adverse events involving risks of harms to human research subjects or others.

All investigators listed above are required to comply with the researcher requirements outlined at:

http://www.irb.vt.edu/pages/responsibilities.htm

(Please review responsibilities before the commencement of your research.)

PROTOCOL INFORMATION:
Approved As: Full Review
Protocol Approval Date: July 23, 2012
Protocol Expiration Date: July 22, 2013
Continuing Review Due Date*: June 24, 2013

*Note a Continuing Review application is due to the IRB office if human subject activities covered under this protocol, including data analysis, are to continue beyond the Protocol Expiration Date.

FEDERALLY FUNDED RESEARCH REQUIREMENTS:
Per federal regulations, 45 CFR 46.105(f), the IRB is required to compare all federally funded grant proposals/work statements to the IRB protocol(s) which cover the human research activities included in the proposal/work statement before funds are released. Note that this requirement does not apply to Exempt and Interim IRB protocols, or grants for which VT is not the primary awardee.

The table on the following page indicates whether grant proposals are related to this IRB protocol, and which of the listed proposals, if any, have been compared to this IRB protocol, if required.
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* Date this proposal number was compared, assessed as not requiring comparison, or comparison information was revised.

If this IRB protocol is to cover any other grant proposals, please contact the IRB office (irbadmin@vt.edu) immediately.
Appendix I

Parental Permission Form

VIRGINIA POLYTECHNIC INSTITUTE AND STATE UNIVERSITY
Permission Form for Research Projects Involving Human Subjects

Parent/Guardian Permission Form

Title of Project: Parental Involvement in Family Therapy for Adolescents who Sexually Offend

Investigators: Vanieca I. Kraus, M.A.; Megan Dolbin-MacNab, Ph.D.

I. Purpose of this Research: The purpose of this research study is to learn about how parents and their adolescent sons experience family therapy as a part of the son’s treatment for sexual offending. This study involves approximately 10 adolescents and their parents.

This study has nothing to do with your son’s treatment or probation. It is not part of his treatment or probation requirements. Your son does not have to be in the study. Being in the study will not take the place of any requirement of his probation or treatment.

II. Procedures: You can ask questions about this study. If you agree that your son may participate, we will schedule an interview with him. He will meet with one of the researchers in person for the interview. Before we meet with him, you will be given two copies of this form. You will sign both copies. One copy will be for the researchers and one will be for you to keep. Your child will be given two copies of the assent form. He will have a chance to ask questions about the study. He will sign both copies of the assent form. One copy will be for the researchers and one will be for him to keep.

The interview will be in a place that you chose. This could be at the researcher’s office, the juvenile department, or another private location. One researcher will come to the place that you choose. The researcher will ask your son some questions. Some of the questions will be about general information about him and your family, such as his ethnicity. The rest of the questions will be about his experiences in family therapy as a part of his treatment for sex offending. It should take him about 1½ to 2 hours to finish the interview. The interview will be audio-recorded.

At a later date, your son will be given the chance to look at the results of the study. If he wants to help with this part, we will mail or email him a short survey. He will answer questions about whether or not the results seem right to him. This survey should take him about 30 minutes to complete.
III. Risks: The risks of being in this study are very small. However, your son might have some uncomfortable feelings such as sadness or anger. He does not have to answer any questions that make him feel uncomfortable. He can stop at any time. If he would like to talk about his feelings, the researcher will give him the name of a trained professional. You are responsible for paying any costs that go with him seeing a professional.

The researcher will not ask your son any questions about his sexual offenses. We will get general information about this from his county or state worker after obtaining a release from you. We encourage him to not to give us this information directly. However, if he tells us about any abuse of a child or threats of harm to self or others, we have to report it to his juvenile court counselor or OYA worker. Additional reports of abuse may affect your son’s treatment or probation requirements.

IV. Benefits: We cannot promise that your son will benefit from being in this study. But he might learn more about himself and his family. The information he shares may be used to improve counseling for other families. As a result, he might feel a sense of personal pride from knowing that he is helping other families who have a son in counseling for sex offenses.

V. Extent of Anonymity and Confidentiality: Your son’s participation in this study is confidential. This means that no one, except the researchers, will see or hear his answers to the questions. The researchers may include quotes from your son’s interview in the results of the study. If this happens, the researcher will change these quotes enough so that no one can identify him by reading the quote. What he says will never be linked to his name.

The interview will be audio-recorded and then transcribed. These audio-recordings and all information collected during this study will be stored on a password protected computer or in a locked file cabinet in a locked office. Only members of the research team will be able to open the file cabinet. These audio-recordings will be destroyed after they have been transcribed. The researcher may hire someone to help with the transcription. This person will sign a confidentiality agreement and will not have access to any of your son’s personal information. When the study is over, the questionnaires and other forms will be destroyed. A database containing only your son’s answers and the transcripts will be kept for future use. These will not include any information that could identify him. Only the research team can use this database.

It is possible that the Institutional Review Board (IRB) may view this study’s collected data for auditing purposes. The IRB is responsible for the oversight of the protection of human subjects involved in research.

We will protect your son’s confidentiality unless we learn about child abuse or elder abuse. Abuse can be physical or sexual abuse. This information must be given to the appropriate government authorities. For example, if your son tell us that a child was touched in a sexual way, we will need to tell county/state worker and the police. Also, if we think he is a threat to himself
or someone else, we must tell the authorities. These are the only times when your son’s confidentiality would not be protected.

**VI. Compensation:** We cannot fully repay your son for his time and effort. To say thank you for helping with this study, he will receive one $10 Target gift card. If he chooses to stop the interview for any reason, he will still receive the gift card. We will have him sign a form saying that we gave him the gift card. If he is interested, we will mail him a written summary of the findings of the research.

**VII. Freedom to Withdraw:** Your son does not have to be a part of this study. Once he starts answering questions, he can stop at any time. He may also choose to not answer certain questions. If he stops, there is no penalty and nothing bad will happen. He will still get the $10 Target gift card if he decides to stop being in the study.

**VIII. Subject’s Responsibilities:** You voluntarily agree to allow your son to participate in this study. Your son has the following responsibilities: 1) to be in an interview that lasts for 1½ to 2 hours, 2) to answer questions if he feels comfortable.

**IX. Subject’s Permission:** I have read the Informed Consent form and conditions of this project. I have had all my questions answered. I hereby acknowledge the above and give my voluntary consent for my son to participate:

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<th>Parent/guardian signature</th>
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**Contact Information of Investigators:**

Vanieca I. Kraus, Investigator  
Doctoral Candidate Department of Human Development  
Virginia Polytechnic Institute & State University  
2225 NE Martin Luther King Blvd., Suite #203  
Portland, OR 97212  
Telephone: 503-766-6547  
Email: research@vanieca.com

Megan Dolbin-MacNab, Investigator  
Associate Professor Department of Human Development  
Virginia Polytechnic Institute & State University  
Blacksburg, VA 24061  
Telephone: 540-231-6807  
Email: mdolbinm@vt.edu
If I should have any questions about the protection of human research participants regarding this study, I may contact:

David M. Moore
Chair, Virginia Tech Institutional Review Board
Office of Research Compliance
1880 Pratt Drive, Suite 2006 (0497)
Blacksburg, VA 24061

Telephone: 540-231-4991
E-mail: moored@vt.edu
Appendix J

Demographic Questionnaire to be Completed by Worker

Your Name: _________________________   Date: ____________________

Title: ______________________________ County/State office: ___________________

Adolescent’s Name: _______________________________  Age: ______

I agree to not disclose that the adolescent and parents participated in this study to the adolescent’s treatment provider: ______ (initial)

Please answer the following general questions about the adolescent’s sexual offenses.

Approximately how many people did this adolescent sexually offend?
  Contact (hands-on) offenses: _____  Non-contact (hands-off) offenses: _____

For each type of offense, please indicate the ages of victims: (please check all that apply)

- Contact Offense:
  - under 2
  - between 3-5
  - between 6-8
  - between 9-12
  - between 13-15
  - between 16-17
  - 18 and older

- Non-contact Offense:
  - under 2
  - between 3-5
  - between 6-8
  - between 9-12
  - between 13-15
  - between 16-17
  - 18 and older

For each type of offense, please indicate the gender of victims: (please check all that apply)

- Contact Offense:
  - male
  - female

- Non-contact Offense:
  - male
  - female

What types of relationships did the adolescent have with the people he sexually offended (please check all that apply):

- Family member living in the same household
- Family member living in a different household
- Neighbor
- Someone the adolescent knew but not a family member or a neighbor
- Someone the adolescent did not know (i.e., a stranger)

How old was the adolescent at the time of his first contact offense? _______ age
How old was the adolescent at the time of his last contact offense? _______ age

To date, how many family therapy sessions has the adolescent and parents participated in? For the purposes of this study, family therapy is being defined as one or more parents/caregivers meeting with the adolescent and his therapist. Typically, the purpose of family therapy is to help the adolescent in his treatment, change interactional patterns and family structure, and/or strengthen parent-adolescent relationships.

_____ # of family therapy sessions

Has this adolescent passed a full-disclosure polygraph?
☐ yes; date polygraph was passed: __________
☐ no
Appendix K

Authorization to Use and Disclose Confidential Health Information

Adolescent’s Name: ______________________________ Age: _____________

I authorize the principal investigator, Vanieca Kraus, to receive the following information from his county juvenile department or the Oregon Youth Authority.

Person: ______________________________ Agency: ______________________________

Address: ______________________________________________________________________

City: ____________ State: _____________ Zip: _____________

This information will be used in the research project, Parental Involvement in Family Therapy for Adolescents who Sexually Offend. It is my understanding that this information will be used for describing general statistics only. My son’s name and other identifying information will be kept confidential and will not be released or published.

The information to be disclosed includes: number of contact and non-contact sexual offenses, type of sexual offenses committed, age of victims, relationship with victims, adolescent’s age at offense, and number of family therapy sessions the adolescent has participated in. _____ (initial)

I understand that my records are protected under the federal and state laws. They cannot be disclosed without my written consent.

I also understand that I may revoke this consent in writing at any time I choose. I further understand that the information may have already been used in the study and I cannot take that back.

_____________________________    ____________________________
Parent/Guardian Signature        Date

_____________________________    ____________________________
Parent/Guardian Signature        Date

_____________________________
Adolescent Signature

Date
Appendix L

Receipt of Compensation

Name: ____________________________

Thank you for volunteering for this research study. We cannot fully repay you for your time and effort but to say thank you for helping with this study, you are receiving one $10 gift card for ______________________. By signing below, you are agreeing that you received your $10 gift card.

_______________________________________ ______________________
Participant Signature Date
Appendix M

Demographic Questionnaire for Parents/Caregivers

All of the following questions will be asked orally during the interview and recorded by interviewer.

Parent/Caregiver Information

Parent/Caregiver 1: Name: _____________________________________________
Age: _____    Gender: ____________   Racial Identification: _____________________
Phone: ________________________   May I leave a message?   ☐ yes   ☐ no

Parent/Caregiver 2: Name: _____________________________________________
Age: _____    Gender: ____________   Racial Identification: _____________________
Phone: ________________________   May I leave a message?   ☐ yes   ☐ no

Marital Status: (please check all that apply)

Parent/Caregiver 1   Parent/Caregiver 2
☐ Single               ☐ Single
☐ Dating               ☐ Dating
☐ Domestic partnership ☐ Domestic partnership
☐ Married              ☐ Married
☐ Separated            ☐ Separated
☐ Divorced             ☐ Divorced
☐ Widowed              ☐ Widowed

What is the highest level of education you have obtained?

Parent/Caregiver 1   Parent/Caregiver 2
☐ Less than high school    ☐ Less than high school
☐ High school or GED       ☐ High school or GED
☐ Some College            ☐ Some College
☐ Two-year College Degree (Associates)   ☐ Two-year College Degree (Associates)
☐ Four-year College Degree (BA, BS)       ☐ Four-year College Degree (BA, BS)
☐ Graduate Degree (Masters, Ph.D.)        ☐ Graduate Degree (Masters, Ph.D.)
☐ Professional Degree (MD, JD)            ☐ Professional Degree (MD, JD)
What is your combined annual household income after taxes?

- [ ] Up to $25,000
- [ ] $25,001-$40,000
- [ ] $40,001-$60,000
- [ ] $60,001-$75,000
- [ ] $75,001-$100,000
- [ ] $100,001 or more

Family Information

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<th>Children (initials only)</th>
<th>Age</th>
<th>Gender</th>
<th>Relationship to parent/caregiver (biological, step, adopted)</th>
<th>Living in home?</th>
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Family tree (genogram):
Family Therapy Information

How long has your son been in treatment for sexual offending? ______________ months

Approximately how many family therapy sessions have you attended as a part of your son’s treatment for sexual offending? ___________ sessions

Results/Member Checking

Would you like to receive the results of this project?  □ yes  □ no

How would you like to receive the results?  □ mail  □ email

Preferred address/email: ____________________________________________________

Would you like to participate in member checking?  □ yes  □ no

Preferred address/email: ____________________________________________________
Appendix N

Summary Report for Member Checking

Major ideas from the study:

1. **Fostering a Sense of Hopefulness**: It is important for therapists to help youth and parents feel hopeful about their futures.

   Therapists can help youth and parents feel hopeful by:
   - Supporting and encouraging youth and parents.
   - Supporting parents being involved.

2. **Using Parents to Help Motivate Youth and Facilitate Changes in Youth and Family**: Parents motivate the youth to do their treatment work. This helps youth and families be successful.

   Therapists can help parents be involved by:
   - Teaching youth and parents skills and giving them tools in family therapy.
   - Teaching skills to help youth and parents share their feelings with each other.
   - Teaching skills to support their parenting.
   - Helping to strengthen family connections.

3. **Changes in the youth and family**: Youth and parents made individual and family changes through being involved in family therapy.

   Examples of changes youth made:
   - developing into a man
   - sharing his feelings
   - communicating better
   - caring about people
   - thinking about his future and setting goals
   - being more confident
   - following the rules
   - making progress in his treatment work
• being responsible and accountable for his behavior
• becoming more honest with himself
• learning life skills
• understanding and saying he regrets sexually offending

Examples of changes families made:
• changes in family rules and roles
• setting boundaries
• communicating with each other more respectfully
• talking with each other more often
• being able to resolve conflict

Picture of Results:
Appendix O

Email/Letter for Member Checking

Dear [participant’s name],

Thank you for being a part of this research study exploring family therapy when the adolescent son is completing treatment for sexual offending. I am excited about the results and would like to share them with you. I have attached a summary report of my findings, which includes the major ideas that came out of all the interviews that I did for this study. Under each idea, you will find examples of what the people who were in the study told me. I used what they told me to develop these main ideas. I changed some of the details so that nobody will be able to tell who said these statements. These are the ideas I will use when writing about my results and findings in my paper.

I am also writing to ask you about your opinion of my results. It is important to me that these ideas seem right to you. Not all of these ideas came directly from information you gave me, some of them came from other people I interviewed. However, I hope that you will see how what you shared with me fits in with these ideas. Will you please help me make sure that my results are right? I attached a short questionnaire for you to complete. You can fill it out and mail it to me, send it back to me as an email attachment, or type the information directly into your reply to this email. Please return your responses no later than two weeks from today, [date]. If I do not hear back from you in 7 to 10 days, I will send you a reminder email or give you a call.

I very much appreciate your help with this project. Please feel free to contact me with any questions you may have.

My best,

Vanieca Kraus
503-766-6547
research@vanieca.com
2225 NE Martin Luther King Blvd., Suite #203
Portland, OR 97212
Appendix P

Member Checking Questionnaire

After reading over the ideas, please answer the following questions:

1. Is there anything in the ideas that you agree with? If so, what do you agree with and why?

2. Is there anything in the ideas that you disagree with? If so, what do you disagree with and why?

3. Is there anything else about your involvement in family therapy as a part of the adolescents treatment for sex offending that you would like to share with me?

4. What else would you like family therapists who are working with families when the adolescent sexually offended to know?
Appendix Q

Guiding Questions for Interviews with Parents

I’m going to ask you questions about your involvement in your son’s treatment for sexual offending. Specifically I would like to know about your participation in family therapy. You don’t need to answer any questions that you don’t want to and you can end this interview at any time.

1. How did you become involved in family therapy related to your son’s treatment for sexual offending?

Possible follow-up probes:

- What helped you to become involved?
- What got in the way of your involvement?
- What did the therapist say or do to encourage your involvement?
  - How did this affect you? Your son? Other members in your family?
- What did the therapist say or do that discouraged your involvement?
  - How did this affect you? Your son? Other members in your family?
- What did the therapist say or do to help you feel comfortable about being involved?
  - How did this affect you? Your son? Other members in your family?
- What did the therapist say or do that made you feel uncomfortable about being involved?
  - How did this affect you? Your son? Other members in your family?

Thank you. May I ask you questions about your relationship with the family therapist?
2. What was your relationship with the family therapist like?

Possible follow-up probes:

• Tell me about an interaction that you had with the family therapist that felt positive to you? What did the therapist say? Do?
  • How did this affect you? For example, was it helpful? If so, how?
  • How did it affect your son? His treatment?
  • How did it affect other members in your family?
• Tell me about an interaction that you had with the family therapist that was not helpful to you? What did the therapist say? Do?
  • How did this affect you? For example, was it helpful? If so, how?
  • How did it affect your son? His treatment?
  • How did it affect other members in your family?
• What did the therapist say or do to help you feel important or valuable in your son’s treatment?
  • How did this affect you? For example, was it helpful? If so, how?
  • How did it affect your son? His treatment?
  • How did it affect other members in your family?
• What did the therapist say or do that made you feel insignificant or not important in your son’s treatment?
  • How did this affect you? For example, was it helpful? If so, how?
  • How did it affect your son? His treatment?
• How did it affect other members in your family?

Thank you. May I ask you questions about the family therapy sessions?

3. Tell me about a family therapy session that went well.

   **Possible follow-up probes:**
   
   • What did the therapist say or do that was helpful?
   
   • How did this affect your relationship with your son? Your family?
   
   • How did this help or not help your son in his treatment?

4. Tell me about a family therapy session that did not go well.

   **Possible follow-up probes:**
   
   • What did the therapist say or do that was not helpful?
   
   • How did this affect your relationship with your son? Your family?
   
   • How did this help or not help your son in his treatment?

5. Tell me about something that happened in family therapy that caused you to leave feeling positive and ready to make changes?

   **Possible follow-up probes:**
   
   • What was going on for you that made you feel positive?
   
   • What did the therapist say or do?
   
   • How did this affect you? Your son? Your family?
   
   • What changes did you make as a response to this?
• How did these changes affect your son? His treatment progress? Your family?

6. Tell me about a time in therapy when you left feeling hopeful or excited about the changes that your son was making?

Possible follow-up probes:

• What do/did you attribute this hopefulness or excitement to?

• What did the therapist say or do to encourage you feeling hopeful or excited?

• How did this affect you? Your son? Your family?

• What changes did you make as a response to this?

  • How did these changes affect your treatment progress? Your family?

7. Tell me about a time in therapy when you left feeling hopeless or disappointed about how your son was doing in treatment?

Possible follow-up probes:

• What do/did you attribute this hopelessness or disappointment to?

• What did the therapist say or do to encourage you feeling hopeless or disappointment?

• How did this affect you? Your son? Your family?

• How did this affect your son’s treatment progress?

Thank you. May I ask you some questions about how your involvement in the treatment affected your son?
8. How do you think your involvement in family therapy sessions has affected your son?

**Possible follow-up probes:**

- Do you think you were able to help him?
  - Tell me about something that you learned in family therapy that helped you to help your son in his treatment?
  - How did the therapist help with this? What did he say? Do?
- How did being involved in family therapy affect your relationship with your son?
  - How did this change affect the rest of your family?
  - How did this change affect your son’s treatment?
- How did this affect the rest of your family?

Thank you. May I ask you some questions about the changes that your son and your family have made?

9. Tell me about the progress or changes that your son has made since starting family therapy.

**Possible follow-up probes:**

- What do you attribute this progress/changes to?
- What did your son do to make this change?
- What did the therapist say or do that encouraged or discouraged this progress/change in your son?
- What did you do to help your son with these changes?
10. Tell me about the progress or changes that your son needs to continue to make in treatment.

Possible follow-up probes:

- What do you think will help him progress or make these changes?
- What could your son do to help himself make these changes?
- What could the therapist say or do to encourage this progress/change in your son?
- What could the therapist say or do to discourage this progress/change in your son?
- What could you do to help your son make these changes?
  - How could the family therapist help with this? What could the therapist say or do that would not be helpful with this?
  - How will your son’s progress/changes in these areas affect you? Your family?

11. What was the most important lesson you learned through participating in family therapy sessions?

Possible follow-up probes:

- How was the therapist involved in you learning this lesson? What did she/he say or do?
- How did that lesson affect you?
- How did that lesson affect your son’s treatment?
How did that affect your relationship with your son? Your family?

12. What was the most important change your family made as a result of you being involved in family therapy?

**Possible follow-up probes:**

- What did your therapist say or do to help your family make this change?
- How did this affect your son’s treatment?
- How did it affect you? Your son? Your family?

Thank you. May I ask you one last question about what you think is important?

13. What recommendations do you have for family therapists who are working with families who are responding to an adolescent who has offended sexually?
Appendix R

Demographic Questionnaire for Adolescents

All of the following questions will be asked orally during the interview and recorded by interviewer.

Adolescent Information

Name: _____________________________________________ Age: _____

Racial Identification: _____________________ Grade: _____

Phone: ________________________          May I leave a message? □ yes □ no

How long have you been in treatment for sexual offending? ___________ months

Have you passed a full-disclosure polygraph? □ yes □ no

Approximately how many family therapy sessions have you attended while in treatment for sexual offending? ___________ sessions

Results/Member Checking

Would you like to receive the results of this project? □ yes □ no

How would you like to receive the results? □ mail □ email

Preferred address/email: ____________________________________________________

Would you like to participate in member checking? □ yes □ no

Preferred address/email: ____________________________________________________
Appendix S

Guiding Questions for Interviews with Adolescents

I’m going to ask you questions about your parents involvement in your treatment for sexual offending. Specifically I would like to know about your participation with them in family therapy. You don’t need to answer any questions that you don’t want to and you can end this interview at any time.

1. How did you become involved in family therapy related to your treatment for sexual offending?

   Possible follow-up probes:

   • What helped you to become involved?
   • What got in the way of your involvement?
   • What did the therapist say or do to encourage your involvement?
     • How did this affect you? Your parents? Other members in your family?
   • What did the therapist say or do that discouraged your involvement?
     • How did this affect you? Your parents? Other members in your family?
   • What did the therapist say or do to help you feel comfortable about being involved?
     • How did this affect you? Your parents? Other members in your family?
   • What did the therapist say or do that made you feel uncomfortable about being involved?
     • How did this affect you? Your parents? Other members in your family?

Thank you. May I ask you questions about your relationship with the family therapist?
2. What was your relationship with the family therapist like?

   Possible follow-up probes:

   • Tell me about an interaction that you had with the family therapist that felt positive to you? What did the therapist say? Do?
     • How did this affect you? For example, was it helpful? If so, how?
     • How did it affect your treatment?
     • How did it affect your parents? Other members in your family?
   
   • Tell me about an interaction that you had with the family therapist that was not helpful to you? What did the therapist say? Do?
     • How did this affect you? For example, was it helpful? If so, how?
     • How did it affect your treatment?
     • How did it affect your parents? Other members in your family?
   
   • What did the therapist say or do to help you feel important or valuable in your treatment?
     • How did this affect you? For example, was it helpful? If so, how?
     • How did it affect your treatment?
     • How did it affect your parents? Other members in your family?
   
   • What did the therapist say or do that made you feel insignificant or not important in your treatment?
     • How did this affect you? For example, was it helpful? If so, how?
     • How did it affect your treatment?
     • How did it affect your parents? Other members in your family?
Thank you. May I ask you questions about the family therapy sessions?

3. Tell me about a family therapy session that went well.

Possible follow-up probes:

- What did the therapist say or do that was helpful?
- How did this affect your relationship with your parents? Your family?
- How did this help or not help you in your treatment?

4. Tell me about a family therapy session that did not go well.

Possible follow-up probes:

- What did the therapist say or do that was not helpful?
- How did this affect your relationship with your parents? Your family?
- How did this help or not help you in your treatment?

5. Tell me about something that happened in family therapy that caused you to leave feeling positive and ready to make changes?

Possible follow-up probes:

- What was going on for you that made you feel positive?
- What did the therapist say or do?
- How did this affect you? Your parents? Your family?
- What changes did you make as a response to this?
  - How did these changes affect your treatment progress? Your family?
6. Tell me about a time in therapy when you left feeling hopeful or excited about the changes that you are making?

Possible follow-up probes:

- What do/did you attribute this hopefulness or excitement to?
- What did the therapist say or do to encourage you feeling hopeful or excited?
- How did this affect you? Your parents? Your family?
- What changes did you make as a response to this?
  - How did these changes affect your treatment progress? Your family?

7. Tell me about a time in therapy when you left feeling hopeless or disappointed about how you were doing in treatment?

Possible follow-up probes:

- What do/did you attribute this hopelessness or disappointment to?
- What did the therapist say or do to encourage you feeling hopeless or disappointed?
- How did this affect you? Your parents? Your family?
- How did this affect your treatment progress?

Thank you. May I ask you some questions about how your parents involvement in treatment affected you?
8. How do you think your parents’ involvement in family therapy sessions has affected you?

Possible follow-up probes:

- Do you think they have been able to help you?
  - Tell me about something that your parents learned in family therapy that helped you in your treatment?
  - How did the therapist help with this? What did he say? Do?
- How did your parents being involved affect your relationship with them?
  - How did this change affect the rest of your family?
  - How did this changes affect your treatment?
- How did this affect the rest of your family?

Thank you. May I ask you some questions about the changes that you and your family have made?

9. Tell me about the progress or changes you have made since starting family therapy?

Possible follow-up probes:

- What do you attribute this progress/changes to?
- What did you do to make this change?
- What did the therapist say or do that encouraged or discouraged your progress/change?
- What did your parents do to help you with this change?
  - How did the family therapist help with this? How was the family therapist not helpful with this?
10. Tell me about the progress or changes that you need to continue to make in treatment.

Possible follow-up probes:

- What do you think will help you progress or make these changes?
- What could you do to help yourself make these changes?
- What could the therapist say or do to encourage this progress/change?
- What could the therapist say or do to discourage this progress/change?
- What could your parents do to help you make these changes?
  - How could the family therapist help with this? What could the therapist say or do that would not be helpful with this?
  - How will your progress/changes in these areas affect you? Your family?

11. What was the most important lesson you learned through participating in family therapy sessions?

Possible follow-up probes:

- How was the therapist involved in you learning this lesson? What did she/he say or do?
- How did that lesson affect you?
- How did that lesson affect your treatment?
- How did that affect your relationship with your parents? Family?
12. What was the most important change your family made as a result of you being involved in family therapy?

Possible follow-up probes:

• What did the therapist say or do to help your family make this change?

• How did this affect your treatment?

• How did it affect you? Your parents? Your family?

Thank you. May I ask you one last question about what you think is important?

13. What recommendations do you have for family therapists who are working with families who are responding to an adolescent who has offended sexually?
Dear [therapist's name],

Hello, my name is Vanieca Kraus. I'm a doctoral student at Virginia Tech in the Marriage & Family Therapy Ph.D. program. I would like to tell you about my dissertation research study and ask for your help. I am looking at the experiences adolescent males and parents have in family therapy as a part of the adolescents' treatment for sexual offending. Specifically, I am interested in learning how the parents' or caregivers’ participation in their sons' treatment affects the adolescents’ motivation and progress in treatment. To learn more about this, I have interviewed [#] adolescent males and their parents. I have analyzed their interviews and developed a model of parental involvement based upon the adolescents and parents’ perspectives. The next step in my study is to conduct a focus group. That is, I plan to do a group interview with a sample of family therapists who specialize in working with adolescents who sexually offend to learn about their opinions.

I am contacting you because you have been identified by [name] as someone who might be interested in participating. To participate in the focus group, you must

1. hold a license recognized by the Oregon Board of Licensed Professional Counselors and Therapists or the Board of Licensed Social Workers.
2. either be certified or eligible for certification as a sex offender therapist by the state of Oregon.
3. have specific training in family therapy and systemic issues, such as classes in family therapy and systems theory, workshops on family therapy, and supervised experience doing family therapy.
4. have a minimum of 3 years experience doing family therapy with adolescents who sexually offend.

If you meet these criteria, would you consider participating in this focus group? The focus group will be held in person or through Skype, whichever is most convenient for the therapists attending. During the focus group, you will have an opportunity to share your perspective on how parents and caregivers influence the adolescents’ motivation and progress in treatment. In addition, I would like to hear your response to my findings. If we meet in person, I will provide
snacks or a light meal (depending on the time of day). You will also be entered into a drawing to win a $50 Amazon gift card. The group will be about 2 hours long and will be scheduled at a convenient time.

Please respond to this email to let me know whether or not you are interested in participating in this focus group. I’ll call you in the next few days to follow up on this email [or other kind of contact].

If you have any questions about this study please contact me through email at research@vanieca.com or by phone at (503) 766-6547. You may also contact my research advisor and co-investigator, Dr. Dolbin-MacNab by email at mdolbinm@vt.edu or by phone at (540) 231-6807. If you have any questions about the protection of human research participants regarding this study, you may contact David Moore, Chair of the Virginia Tech Institutional Review Board by email at moored@vt.edu or by phone at (540) 231-4991. In addition, I have attached a copy of the Virginia Tech Institutional Review Board approval letter for your review.

Thank you,

Vanieca Kraus, LMFT
(503) 766-6547
research@vanieca.com
Appendix U

Follow-up Phone Script for Therapists

(Contact with Potential Therapist Participants)

“Hello, this is Vanieca Kraus. I am calling to follow up about the email I sent you regarding my research study. Did you receive my email?” ☐ yes ☐ no

If no, explain the study using the email script above.

If yes, “Do you have any questions about the study?” ☐ yes ☐ no

Are you interested in participating?” ☐ yes ☐ no

If no, “Do you know of other therapists who meet the criteria and may be interested in participating?” Get referral information. “Thank you so much for your time. I wish you the best.”

If yes, “Great. May I ask you a few questions to make sure you meet the eligibility requirements?” ☐ yes ☐ no

What state are you licensed in and what is your license #: ______________________

Are you either certified or eligible for certification as a sex offender therapist by the state of Oregon? ☐ yes ☐ no [might need to review certification requirements with therapist]

“Do you have specific training in family therapy and systemic issues, such as classes in family therapy and systems theory, workshops on family therapy, and supervised experience doing family therapy?” ☐ yes ☐ no

Have you been doing family therapy with adolescents who sexually offend for at least 3 years? ☐ yes ☐ no

If therapist meets eligibility requirements, “Great. I’d like to have you participate. I’ll send you an email with a link to a Doodle, which I’ll use to help me schedule. [might need to explain what a Doodle is]. Then I’ll send you an email confirming the time and location of the focus group. Thanks so much for your help. I’m looking forward to hearing your perspectives on this issue.”

If therapist does not meet eligibility requirements, “I appreciate your interest in this study but you do not meet eligibility requirements. I really appreciate you taking the time to talk with me and learn more about what I am doing. Would you like to receive a copy of my results after the study is over?” ☐ yes ☐ no

“Thank you for your time. I wish you the best.”
Appendix V

Email to Schedule Focus Group

(Contact with Potential Therapist Participants)

I will cut and paste this into an email or letter or use this as a script if I talk with the person on
the phone or in person. I will personalize this information if it is someone I know or have a
connection to.

Dear [therapist's name],

Thank you for agreeing to participate in this focus group on family therapy for adolescents who
sexually offend. I’m looking forward to hearing your perspectives on how parents influence the
adolescents’ motivation and progress in treatment and your response to my findings.

To schedule this focus group, I will be using an online scheduler, Doodle, to obtain availability
information from therapists who would like to participate. To indicate your availability, please
follow this link [insert link here] and complete the doodle by [date]. Please mark all the times
that you could be available for this focus group. I will choose the time that will allow the most
number of therapists to participate. On [date] I will send you an email confirming the time and
location of the focus group.

Thank you,

Vanieca Kraus, LMFT
(503) 766-6547
research@vanieca.com
Appendix W

Email to Confirm Focus Group

Hi [therapist],

I enjoyed talking with you for a few minutes. Here's the information about the focus group:

**Date:** Saturday, November 3, 2012

**Time:** 11:00 a.m

**Location:** 2225 NE Martin Luther King Blvd. #203, Portland, OR 97212

Please note, my office is located on the west side of MLK between Sacramento and Thompson. It's above the restaurant OX. Don't hesitate to call if you have any trouble finding it.

**Length:** Approximately 2 hours

**Snacks** I will have a light lunch for us

I’m really looking forward to meeting you. I’m excited to hear about your experiences working with families of adolescents who sexually offend. I’m especially interested in hearing about how you have think the parents/caregivers’ participation in family therapy affects the adolescents treatment for sexual offending. In addition, I will ask you to comment on the results of my study.

I've attached the informed consent for you to review. I will have a copy with me for you to sign before the focus group. Please don't hesitate to contact me if you have any questions.

See you soon,

\[Signature\]

Vanieca Kraus, LMFT
Ph.D. Candidate, Virginia Tech
research@vanieca.com
(503) 766-6547
Appendix X

Informed Consent for Therapists

VIRGINIA POLYTECHNIC INSTITUTE AND STATE UNIVERSITY
Informed Consent for Participants in Research Projects Involving Human Subjects

Therapist Consent

Title of Project: Parental Involvement in Family Therapy for Adolescents who Sexually Offend

Investigators: Vanieca I. Kraus, M.A.; Megan Dolbin-MacNab, Ph.D.

I. Purpose of this Research: You are being invited to voluntarily participate in a focus group as a part of a research study exploring how parents’ involvement in family therapy affects their sons’ treatment for sexual offending and what this type of treatment looks like. During the initial stages of this project, the researcher interviewed approximately ten adolescent males who are in family therapy as a part of their treatment for sexual offending and their parents. The purpose of this focus group is for clinicians, who are considered experts in the field, to discuss their own ideas about family therapy with this population and to review and discuss the findings of this research study.

II. Procedures: You can ask questions about this study. If you agree to be in the study, we will schedule a focus group with approximately 6 to 8 professionals who specialized in doing family therapy with adolescents who sexually offend and the researcher. The group may be held at a juvenile department, the researcher’s office, or a public location that is centrally located for all the therapists involved. Before you start the focus group, you will be given two copies of this form. You will sign both copies. One copy will be for the researcher and one will be for you to keep. In addition, you will be given a demographic questionnaire to complete. During the focus group, you will be asked to respond to and discuss a series of questions about your experiences in working with adolescents who sexually offend and their parents in family therapy. In addition, you will be asked to review and comment on the results of the interviews with the adolescents and their parents. The focus group will last approximately 2 hours and will be audio-recorded.

III. Risks: My participation in this research carries no unanticipated risks or benefits beyond what can be expected from normal daily conversation about my professional role as a family therapist for adolescents who sexually offend. My participation is strictly voluntary. I may choose not to answer any question and may terminate my participation at any time.

IV. Benefits: No promise or guarantee of benefits have been made to encourage you to participate. We cannot promise that you will benefit from being in this study. However, you may find yourself experiencing positive feelings from having the opportunity to share your thoughts.
and experiences regarding family therapy for adolescents who sexually offend. You may also feel positive knowing that you have contributed to the common good by advancing research.

V. Extent of Anonymity and Confidentiality: Your participation in this study is confidential. This means that no one, except the researchers, and the other participants in the focus group, will see or hear your answers to the questions. The researchers may include quotes from your interview in the results of the study. If needed, the researcher will change these quotes enough so that no one can identify you by reading the quote. What you say will never be linked to your identity.

The focus group will be audio-recorded and then transcribed. These recordings and all information collected during this study will be stored on a secure computer or in a locked file cabinet in a locked office. Only members of the research team will be able to open the file cabinet. These audio-recordings will be destroyed after they have been transcribed. The researcher may hire someone to help with the transcription. This person will sign a confidentiality agreement and will not have access to any of your personal information. When the study is over, the questionnaires and other forms will be destroyed. A database containing only your answers and the transcripts will be kept for future use. Only the research team can use this database.

It is possible that the Institutional Review Board (IRB) may view this study’s collected data for auditing purposes. The IRB is responsible for the oversight of the protection of human subjects involved in research.

We are mandatory reporters. If an instance of child or elder abuse is revealed to us, or we are told of a person’s intention to cause harm to self or others, we are required by law to report this to the proper authorities. These are the only times when your confidentiality would not be protected.

VI. Compensation: We cannot fully repay you for your time and effort. To say thank you for helping with this study, we will provide a snack or a light meal at the focus group. In addition, you will be entered into a drawing with the other participating therapists to win a $50 Amazon gift card. You must be present at the end of the focus group to be eligible for the drawing. The odds of you winning this gift card are approximately 1:8. If you win the drawing, you will receive the gift card before leaving the focus group. We will have you sign a form confirming your receipt of the gift card.

VII. Freedom to Withdraw: You are free to withdraw from the focus group at any time without penalty. You may also choose to not answer certain questions.

VIII. Subject’s Responsibilities: You voluntarily agree to participate in this study. You have the following responsibilities: 1) to attend a 2 hour focus group, 2) to complete a demographic questionnaire, 3) to answer questions if you feel comfortable, and 4) to respectfully listen when other therapists are speaking.
IX. Subject’s Permission: I have read the Informed Consent form and conditions of this project. I have had all my questions answered. I hereby acknowledge the above and give my voluntary consent:

__________________________________________  _____________________________  __________
Participant signature          Participant name          Date

Contact Information of Investigators:

Vanieca I. Kraus, Investigator
Doctoral Candidate Department of Human Development
Virginia Polytechnic Institute & State University
2225 NE Martin Luther King Blvd., Suite #203
Portland, OR 97212

Telephone: 503-766-6547
Email: research@vanieca.com

Megan Dolbin-MacNab, Investigator
Associate Professor Department of Human Development
Virginia Polytechnic Institute & State University
Blacksburg, VA 24061

Telephone: 540-231-6807
Email: mdolbinm@vt.edu

If I should have any questions about the protection of human research participants regarding this study, I may contact:

David M. Moore
Chair, Virginia Tech Institutional Review Board
Office of Research Compliance
1880 Pratt Drive, Suite 2006 (0497)
Blacksburg, VA 24061

Telephone: 540-231-4991
E-mail: moored@vt.edu
Appendix Y

Guiding Questions for Focus Group with Therapists

Ground rules: (Review at start of group)

1. Confidentiality
2. Listen to and respect the opinions of others.
3. The facilitator will keep the discussion moving so that we can get through the questions and respect your time.

Therapists’ responses to study findings:

“Please take a few moments to read over the results of this study. After you finish, I will facilitate a discussion about your reaction to these results.”

1. What are your thoughts and feelings about the themes or theoretical model that emerged from the study?

2. How do my results compare with your experiences in doing family therapy with parents and adolescents for the treatment of sexual offending?
   
   • Which themes do you agree with? Why?
   
   • Which themes do you disagree with? Why?

3. How do you these themes fit with what you see in your treatment with adolescents who sexually offend?

4. What in these results surprises you?
   
   • Which themes are listed here that surprise you?
   
   • What is not there that you thought would be?

5. Is there anything else you’d like me to know or consider?
Appendix Z

Demographic Questionnaire for Therapists

Name: ________________________________  Age: _______  Gender: ________

Racial Identification: ____________________

Phone: ________________________________  May I leave a message?  □ yes  □ no

Email: ________________________________

Please explain your education, training, and experiences below:

Degree(s): ______________________________________________________

License(s): ____________________________________________________________________

Are you certified or eligible for certification as a sex offender therapist in Oregon? ____yes/no check box?_______

List any special training in family therapy and systemic issues: ___________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Approximately how many years have you provided family therapy for adolescents who sexually offend? _____ years

Information about Family Therapy Sessions:

What is your theoretical orientation when doing family therapy with adolescents who sexually offend? ___________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
What are your broad treatment goals for families of adolescents who sexually offend?
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
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______________________________________________________________________________
______________________________________________________________________________

Please describe typical interventions you use for family therapy with adolescents who sexually offend:  _______________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Is there anything else you would like me to know about your work with adolescents who sexually offend and their families? _________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
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### being hopeful about the future

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>feeling hopeful that everything is</td>
<td>It’s going to be a long road but we’re going to be OK. Family noticing the changes he’s making. Therapist giving hope things can change. Parents hopeful about handling things in the future. Hopeful about youth’s future. Seeing changes brings hope that he might come home a better person. Hearing positive things and seeing youth work is helpful.</td>
</tr>
<tr>
<td>going to be all right</td>
<td></td>
</tr>
<tr>
<td>believing that treatment/therapist is</td>
<td>Family evaluation [therapy] is helpful. Therapist does a real good job. Believing he’s in a good place and it’s gonna work. Therapist being qualified.</td>
</tr>
<tr>
<td>helpful</td>
<td></td>
</tr>
<tr>
<td>hearing therapist talk about youth’s</td>
<td>Hearing therapist praise youth to parent. Having therapist say what he’s doing, what they see he is doing well.</td>
</tr>
<tr>
<td>accomplishments</td>
<td></td>
</tr>
</tbody>
</table>

### changing the family

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>changing family dynamics</td>
<td>Having new family dynamics. Learning about family roles and dynamics (peacemaker, etc.). Recognizing family dynamics to understand youth. Learning not to tiptoe around his father. Pushing daughter to raise her kids differently.</td>
</tr>
<tr>
<td>setting boundaries in and around family</td>
<td>Learning about boundaries. Knowing when to keep secrets. Creating a boundary around immediate family. Therapist limiting contact helped family change. Grandma feeling she has a say now.</td>
</tr>
<tr>
<td>changing the family structure</td>
<td>Implementing new house rules. Knowing things will have to change. Tried to take what we’ve learned and bring it home and use it here. Mom wanting to be more of a mother to me.</td>
</tr>
</tbody>
</table>
## changing the family

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>developing respectful communication as a family</td>
<td>Family members listening to see each other’s perspectives. Parents talking respectfully to youth. Learning to validate each other.</td>
</tr>
<tr>
<td>family talking with each other more often</td>
<td>Improving communication in the family. Youth talking and sharing more about himself with parents. Having more family discussions.</td>
</tr>
<tr>
<td>communicating well as a family affects youth’s treatment</td>
<td>Hasn’t had to keep stuff bottled up inside. Being able to communicate what he needs from us. Being able to focus more on my treatment and what I needed to do instead of worrying about family stuff.</td>
</tr>
<tr>
<td>resolving conflict in the family</td>
<td>Having the opportunity to talk it out.</td>
</tr>
</tbody>
</table>

## expressing feelings

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>processing feelings and behaviors -- gaining understanding around sexual offending</td>
<td>Understanding hard things are helpful. Therapist helping youth dig deeper. Therapist bringing out youth’s offenses. Talking about sexual abuse to his family. Youth being able to deal with the feelings behind what happened. Parent dealing with painful feelings around son’s sexual offending. Youth seeing parents deal with painful feelings around his sexual offending.</td>
</tr>
<tr>
<td>parents feeling safe and learning to express feelings helped</td>
<td>Parent opening up. Being able to share my feelings with the therapist. Therapist helping parent open up. Something about the therapist that helped parent open up. Therapist reins me back in when emotions are high.</td>
</tr>
<tr>
<td>youth learning how to express feelings</td>
<td>Youth expressing hard feelings. Parents encouraging emotional expression. Youth expressing emotions helped family mend. Connecting feelings with thinking and behaving. Therapist helping youth open up and process feelings. Therapist pressuring youth to open up was not helpful.</td>
</tr>
</tbody>
</table>
### It’s Up to Me - Youth Being Responsible for Changing

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>attributing changes to youth</td>
<td>He’s gotten himself to where he is now. It comes down to him really wanting to come home. It’s mainly just up to me.</td>
</tr>
<tr>
<td>youth choosing to take responsibility and be accountable for his behaviors</td>
<td>Choosing to be responsible/accountable. Doing it for the person he hurt. Holding himself accountable for his behavior. Becoming more honest with himself. Being committed to treatment.</td>
</tr>
<tr>
<td>therapist encouraging youth to be responsible for himself</td>
<td>Setting the bar about what it means to be a good man. Therapist pointing out youth would be better off with these changes. Therapist gave him the mindset of needing to hold himself. Accountable and responsible for his behavior. Telling youth he needs to do good here in honor of person they hurt. Therapist helping youth learn how to make decisions and own his decision.</td>
</tr>
<tr>
<td>therapist making sure he’s holding up his end</td>
<td>Therapist holding him accountable. Not calling him out on it was not helpful. Therapist holding him accountable very firmly and directly.</td>
</tr>
<tr>
<td>encouraging honesty</td>
<td>Therapist helping youth tell the truth. Parents encouraging honesty.</td>
</tr>
</tbody>
</table>

### Learning Parenting Skills

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>parents learning to allow youth to take responsibility for himself</td>
<td>Learning it’s up to the child what they do with what you’ve given them. Therapist said to let his successes be his successes and let his failures be his failures. Learning not to take on son’s part of accountability. Parents learning to let go and let him do it himself.</td>
</tr>
<tr>
<td>parents learning to hold youth accountable</td>
<td>Calling him on something. Learning to have expectations. Learning to question him. Helping him open eyes and understand what he’s done. Learning to draw the line in the sand. Therapist thinking we let youth off the hook. Therapist helping parents hold youth accountable.</td>
</tr>
</tbody>
</table>
### learning parenting skills

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>parents seeing family therapy as a place for learning</td>
<td>Constant learning process for youth and for us. He’s learning here.</td>
</tr>
<tr>
<td>parents looking to therapist for guidance in parenting</td>
<td>Looking to therapist for guidance in parenting. Therapist helping parent make a decision.</td>
</tr>
<tr>
<td>parents learning to set and enforce rules for youth</td>
<td>Learning how to supervise youth. Learning to anticipate youth’s behaviors. Learning to set rules for youth. Learning to give youth time to process. Learning about how strict or lenient to be. Learning to give consequences. Learning to respond instead of reacting. Learning to make decisions together.</td>
</tr>
<tr>
<td>parents learning to be in charge</td>
<td>Parents getting back their authority. Learning to be his parent and not his friend. Learning what and how much to share. Needing to make an impact on son.</td>
</tr>
<tr>
<td>being serious about being a better parent</td>
<td>Making changes to be a better parent. Seeking personal growth. Becoming a better person for kid. Practicing self-care. Learning to take breaks.</td>
</tr>
</tbody>
</table>

### parents being committed to youth

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>parents encouraging and supporting youth</td>
<td>Youth seeking parents out for support. Parents encouraging son to seek support. Supporting son. Parents encouraging confidence. Parents praising youth.</td>
</tr>
<tr>
<td>parents having and expressing unconditional love and commitment</td>
<td>No matter what he did, how hurt I was, here I am. Being dedicated. Not liking him but loving him. Parent expressing love and commitment.</td>
</tr>
<tr>
<td>parents/caregivers helping youth in treatment</td>
<td>Code</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>caregivers taking a break</td>
<td></td>
</tr>
<tr>
<td>motivated youth to work harder</td>
<td></td>
</tr>
<tr>
<td>finding strength in parents being a part of the family therapy</td>
<td></td>
</tr>
<tr>
<td>finding strength in parents being a part of the family therapy</td>
<td></td>
</tr>
<tr>
<td>therapists partnering with parent to help youth</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>strengthening family connections</th>
<th>Code</th>
<th>Descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>facilitating clarification and healing within the family</td>
<td></td>
<td>Helping clarification and healing to happen. Hearing son apologize. Forgiving.</td>
</tr>
<tr>
<td>strengthening relationships/bonds</td>
<td></td>
<td>Helping youth and family to know they’re important to each other. Attending therapy strengthened caregiver-youth relationships. Strengthening caregivers’ relationships.</td>
</tr>
<tr>
<td>improving the quality of the interactions</td>
<td></td>
<td>Having some better interactions because of these therapies. Trusting each other. Spending time together building connections.</td>
</tr>
<tr>
<td>facilitating reconnections</td>
<td></td>
<td>Bringing family back together. Including other family members.</td>
</tr>
</tbody>
</table>
## strengthening family connections

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>becoming a big brother</td>
<td>Learning how to be a big brother. Youth wanting to help his sister. Using the tools therapist gave him with sister. Therapist has worked with him to see the perspective from his sister’s eyes. Helping him recognize sister has a different healing process. Parents encouraging youth to be an example to sisters. Therapist talking with him about what to expect with his sister. Helping him discern when to leave and stay with sister.</td>
</tr>
</tbody>
</table>

helping family feel more connected through changing communication

## therapist discouraging parent participation

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>therapist not responding and not being available is not helpful</td>
<td>Therapist not calling back. Therapist being gone slows the process down. Therapist not showing up is not helpful. Therapist being late. Sessions being interrupted by phone calls is not helpful. Not having a relationship with therapist when not included.</td>
</tr>
<tr>
<td>therapist judging and labeling is discouraging</td>
<td>Being negative, putting him down discourages changes. Hearing that the youth won’t change or the family won’t be back together is discouraging. Labeling youth as sick and deceitful felt upsetting and discouraging. Feeling blamed and judged as a parent. Feeling judged and labeled discouraged participation in family therapy. More helpful when therapist is not judging. Considering the whole picture is helpful.</td>
</tr>
<tr>
<td>therapist discouraging parents’ involvement was not helpful</td>
<td>Discouraging parents involvement. Not being included.</td>
</tr>
<tr>
<td>Code</td>
<td>Descriptions</td>
</tr>
<tr>
<td>------</td>
<td>--------------</td>
</tr>
<tr>
<td>therapist validating and accepting parent’s experiences</td>
<td>The therapist validating what I was going through.</td>
</tr>
<tr>
<td>therapist encouraging parents</td>
<td>Feeling encouraged by the therapist. The therapist praising my abilities and growth.</td>
</tr>
<tr>
<td>parent feeling cared for by therapist</td>
<td>Having the therapist show an interest in me. Expressing concern for me. Feeling cared for by the therapist. Therapist wanting the best for my family. Reaching out to me.</td>
</tr>
<tr>
<td>parent liking and feeling connected with the therapist</td>
<td>Therapist qualities that helped parents trust and feel connected with the therapist. Having a great relationship with the therapist.</td>
</tr>
<tr>
<td>therapist being available to parents</td>
<td>The therapist being available and accessible to me. Being able to check in with the therapist individually.</td>
</tr>
<tr>
<td>therapist supporting and encouraging youth in his treatment</td>
<td>The therapist praising youth. Therapist being encouraging and supportive. Being available. Has been a good influence and helpful to youth.</td>
</tr>
<tr>
<td>youth having a good relationship with the therapist</td>
<td>Therapist and youth having a good relationship. Feeling accepted by therapist. Therapist showing an interest in me. Feeling cared for by therapist. Therapist qualities that helped youth connect with therapist.</td>
</tr>
<tr>
<td>therapist going the extra mile for youth and parents</td>
<td>Being there to support when they don’t have to be. Being more than a job for the therapist. Focusing on what individual families need. Willing to accommodate special needs families have. Knowing everyone’s a little different.</td>
</tr>
<tr>
<td>Code</td>
<td>Descriptions</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>parents seeing family therapy as a place for learning</td>
<td>Constant learning process for youth and for us. He’s learning here. Getting tools in counseling.</td>
</tr>
<tr>
<td>therapist teaching skills through modeling, giving feedback, and practicing</td>
<td>Practicing skills in counseling. Therapist modeling. Giving both positive and constructive feedback. Experiencing therapist as direct.</td>
</tr>
<tr>
<td>therapist presenting things positively</td>
<td>Being always positive. Always ending on a positive. Having a positive come out of a negative.</td>
</tr>
<tr>
<td>therapist facilitating communication process</td>
<td>Therapist facilitating communication process. Guiding us through our conversations. Having a third person in the party. Therapist telling us to communicate. Therapist telling us to keep trying when we failed. Being helped by therapist by censoring situations. Getting out of the way and letting family talk. Therapist asking questions to help us talk. Therapist clarifying what would be shared in family therapy… confidentiality helped him to open up and feel comfortable.</td>
</tr>
<tr>
<td>parents and youth learning communication skills</td>
<td>Parent learning to communicate with son. Learning to listen for what’s underneath. Youth learning how to negotiate instead of demanding. Good we’re all learning to communicate together.</td>
</tr>
<tr>
<td>Code</td>
<td>Descriptions</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>witnessing growth</td>
<td>Seeing him develop into a man. Seeing a difference in him. Noticing changes youth as made. Youth a completely different person.</td>
</tr>
<tr>
<td>expressing himself more clearly</td>
<td>Being able to express his emotions easier. Youth being able to talk and speak up more. Being assertive.</td>
</tr>
<tr>
<td>caring about people around him now</td>
<td>Starting to genuinely care about how other people feel. Has empathy. More caring about his family. Having a more caring attitude. Being more patient with people in general. Learning it’s not all about you.</td>
</tr>
<tr>
<td>thinking about his future and setting goals</td>
<td>Having goals for himself that he didn’t used to have. Finding things in his life that he likes to do. Moving in. Getting to go to this class at community college. Reaching my goal.</td>
</tr>
<tr>
<td>having more confidence in himself</td>
<td>Started showing confidence in himself. Changing his outside as he changed his inside. Knowing himself more. Overall demeanor is better. Feeling a lot better about myself. Helping me gain confidence in myself.</td>
</tr>
<tr>
<td>following the rules</td>
<td>Following the rules. Getting passes was hopeful, it showed that he’s progressing. Therapist advocating for me to take son to [city]. Giving up addictions. Having more control over his behaviors.</td>
</tr>
<tr>
<td>progressing in his treatment work</td>
<td>Being honest. Doing better in treatment.</td>
</tr>
<tr>
<td>learning life skills</td>
<td>Learning responsibility of keeping house. Goes to school. Youth showing leadership with his peers. Being more social.</td>
</tr>
<tr>
<td>youth understanding and expressing regret for his actions</td>
<td>Youth internalizing. Starting to show more emotion towards what he has done. Feeling better to think he maybe understands and does more thinking. Not doing it again.</td>
</tr>
</tbody>
</table>
### witnessing growth

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>recognizing he still has changes to make</td>
<td>Treatment work. Attitude and behavioral changes. Seeing change as a process. Something about how he uses his time. Learning assertiveness. Working on having healthy relationships. Follow all the rules. Continue to talk and work hard and get his feelings out. Needing to learn to trust. Son trying to earn back trust. Not trying to be perfect. Working on social skills. Continuing to improve family communication.</td>
</tr>
</tbody>
</table>

### youth behavior affecting other people

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>being angry and wanting to avoid each other as a result of family therapy sessions</td>
<td>Parent being hard and angry in beginning. Being more vigilant makes relationship worse. Hearing negative things about son (possibly a pedophile) starting to push her away from son. Wanting to avoid him. Leaving sessions not wanting to talk to one another. Wanting to distance themselves.</td>
</tr>
<tr>
<td>caregiver taking a break from the relationship</td>
<td>Parent choosing to take time away from son. Grandma quit seeing him. Therapist encouraging caregiver to take a break. Good to take a break from it emotionally. Youth worrying parents would leave him.</td>
</tr>
<tr>
<td>parents feeling torn between family members</td>
<td></td>
</tr>
<tr>
<td>youth’s behavior affecting the whole family</td>
<td>Youth’s behavior affects the whole family. Affecting other kids. Treatment affects the whole family.</td>
</tr>
<tr>
<td>caregivers expressing feelings of anger towards son</td>
<td>Feeling angry at son. Helping parent manage anger. Expressing feelings with son.</td>
</tr>
</tbody>
</table>
### youth behavior affecting other people

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>youth not progressing in treatment is discouraging</td>
<td>Not progressing in treatment. Not taking responsibility/being accountable. Youth breaking rules. Youth not being ready to talk or open up. Every time he screws up. Left thinking he [youth] wasn’t going to make it. Feeling I [dad] failed him as a parent. Youth blaming the victim.</td>
</tr>
</tbody>
</table>
Appendix AB

Focus Group Handout: List of Categories with Codes

being hopeful about the future
feeling hopeful that everything is going to be all right
believing that treatment/therapist is helpful
hearing therapist talk about youth’s accomplishments

changing the family
changing family dynamics
setting boundaries in and around family
changing the family structure
developing respectful communication as a family
family talking with each other more often
communicating well as a family affects youth’s treatment
resolving conflict in the family

expressing feelings
processing feelings and behaviors -- gaining understanding around sexual offending
parents feeling safe and learning to express feelings helped
youth learning how to express feelings

it’s up to me - youth being responsible for changing
attributing changes to youth
youth choosing to take responsibility and be accountable for his behaviors
therapist encouraging youth to be responsible for himself
therapist making sure he’s holding up his end (therapist holding youth accountable)
encouraging honesty

learning parenting skills
parents learning to allow youth to take responsibility for himself
parents learning to hold youth accountable
parents seeing family therapy as a place for learning
parents looking to therapist for guidance in parenting
parents learning to set and enforce rules for youth
parents learning to be in charge
being serious about being a better parent

parents being committed to youth
parents encouraging and supporting youth
parents having and expressing unconditional love and commitment
parents/caregivers helping youth in treatment
caregivers taking a break motivated youth to work harder
finding strength in parents being a part of the family therapy
parents helping youth change
parents and family motivating youth
therapist partnering with parent to help youth

strengthening family connections
facilitating clarification and healing within the family
strengthening relationships/bonds
improving the quality of the interactions
facilitating reconnections
becoming a big brother
helping family feel more connected through changing communication
Appendix AC

Focus Group Handout: List of Themes

being hopeful about the future
changes in the family
expressing feelings
learning parenting skills
parents/caregivers helping youth in treatment
parents being committed to youth
strengthening family connections
therapist discouraging parent participation
therapist supporting and encouraging
therapist teaching skills and giving tools
witnessing growth
Appendix AD

Confidentiality Agreement with Transcription Company #1

I ("Client") agree to pay Outsuits, Inc. d/b/a Verbal Ink ("Verbal Ink") for any and all transcription work or other services performed by Verbal Ink ("the Work") on or by my company’s behalf on audio material submitted by me ("Source Material"). Client has reviewed and agrees to the rates on Verbal Ink’s website for its services and agrees to pay for all work performed by Verbal Ink promptly and in full.

Client is fully aware and agrees that it is responsible for an accurate and truthful description of the audio contained on its Source Material. Regardless of Client’s description of the Source Material, in the event its description is inaccurate, the appropriate classification below will apply for all purposes hereunder, including rates. If Verbal Ink determines that its classification of any Source Material is different than the Client’s, it will notify the Client before proceeding with the Work. Client agrees that any work performed over five minutes on an individual file will be charged and paid for by Client. Any samples up to five minutes will not be charged to Client.

Client agrees and understands that pricing is based on the number of speakers in an audio file or source. Client also agrees and understands that audio variables might increase the price. Client also agrees and understands that the level of turnaround time may or may not impact the cost. Verbal Ink guarantees a 98% accuracy rate or higher for good audio. This is any Source Material that is clearly recorded in a controlled environment (preferably professionally) with one person either talking or interviewing one subject with minimal background noise interference and no media noise or defects. The format must be recorded digitally on standard audio cassette, VHS, or DVD. Client understands that poor duplication procedures can lead to degradation of the original Source Material and could result in a higher price, depending on the degree of degradation. While Verbal Ink does its best to get the most accurate transcript possible regardless of the quality of audio, Client should be aware that any audio that does not meet the previous criteria may impact the quality of the transcript and cause it to drop below the 98% accuracy rate. If for some reason, the client is not satisfied with the transcript and thinks it falls below the 98% accuracy rate and it was good audio, Client has one full month to notify Verbal Ink so that it can examine the discrepancy.

The burden of proof rests with Client and Client realizes and accepts that no transcript is ever "perfect." Judgment calls have to be made on pronunciation, spellings, grammar, etc. Furthermore, often the spoken word consists of run-on sentences and other grammatical or incorrect language. Verbal Ink does not correct grammar or proofread material — it only transcribes what is on the Source Materials. If its accuracy rate is indeed below 98%, Verbal Ink will correct the mistakes free of charge.

All Source Materials are subject to Verbal Ink’s acceptance, which it may exercise in its sole and absolute discretion. Verbal Ink has the right to reject, in its sole and absolute discretion, any Source Material for any reason whatsoever, including without limitation that it is considered to be of such poor quality that: 1. transcription is not possible or 2. the project is beyond Verbal Ink’s resources, if the audio quality of any Source Material appears to be different than the quality represented by Client, Verbal Ink will contact Client and discuss this discrepancy and a possible increased rate. If the parties are unable to agree on the appropriate rate, Verbal Ink may decline to work on the project and, in such case, all Source Materials will be returned and no Work will be performed by Verbal Ink.

If the source audio appears to have a large number of inaudible or questionable words, Verbal Ink will contact the client with a 5 minute sample. All work will stop for that particular file until the client has notified Verbal Ink if he/she would like to proceed with the file. If the client would prefer to not proceed, Verbal Ink will not charge the client for the first 5 minutes of the sample transcript. Any audio that is completed that is over 5 minutes of audio on a file will be charged to the client.

While Verbal Ink strongly requires that its clients not submit any original or master Source Materials ("Masters"), in the event that Client elects to submit Masters or its original audio Source Material, Client shall do so solely at its own risk. Client hereby agrees to indemnify and hold Verbal Ink harmless from any expenses, claims, losses, costs, actions or damages, including reasonable attorneys’ fees, ("Claims") arising out of or related to damage to or loss of any Source Materials whether Masters or duplicates, including without limitation data and media. While Verbal Ink ditzes all audio it receives, it can make no guarantees that the Source Material will be received or returned free from damage during the shipping process. Under any circumstances, Client hereby acknowledges that any Source Materials submitted to Verbal Ink have no commercial value whatsoever. Client agrees to not hold Verbal Ink liable for any loss or damages to or destruction of any Source Materials, including those that may occur in shipping or transmission electronically.

Client agrees to pay all shipping costs for submission and return of Source Materials. Verbal Ink offers Client different shipping options, but when one is not selected, Verbal Ink will send Source Materials back to Client in the most cost-effective way possible (which will likely be the slowest way possible).

Client acknowledges that Verbal Ink bills audio minutes of recorded audio and not on page count, number of characters, or work hours. Any additional seconds that do not make up a full sixty (60) seconds are billed as a minute. Client agrees to pay the rates prevailing at the time the Work is requested as set forth in the Rates section of Verbal Ink’s website. Payment is due upon delivery of the Work to Client. All clients whether paying by check or credit card must have a valid credit card or file with Verbal Ink. Payment is due within 30 days. For clients who are paying by check and have not paid within 30 days, Verbal Ink reserves the right to charge the credit card on file for the total amount due. Agreement to these Terms of Service hereby authorizes Verbal Ink to charge the credit card on file. Client further agrees that Verbal Ink may hold any Source Materials until it receives payment in full from Client for any Work related to such Source Materials.

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Client shall not upload, load, post, publish, transmit, reproduce or distribute in any way, information or other material which is protected by a copyright or other proprietary right, or derivative works with respect thereto, without obtaining permission of the copyright owner or the right
holder or violate any individual's organization's right of privacy, right of publicity or other rights. The Work and any work product of the Work shall be used solely for lawful purposes only. Client agrees that it will not use the Work or any work product of the Work in any way that is, or is reasonably likely to be, harmful either to Verbal Ink’s customers, or operations or its reputation.

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Client hereby indemnifies and holds Verbal Ink and its employees, officers, directors, and agents harmless from and against any and all Claims or threat of Claims and damages against Verbal Ink and/or its employees, officers, directors, and agents arising out of or related to Client’s Source Materials and any use of the Work based thereon.

Verbal Ink shall not be held liable for any indirect, incidental, special or consequential damages, or loss of profits, revenue, data or use, by the Client or any third party, whether in an action in contract or tort or strict liability or other legal theory, even if Verbal Ink has been advised of the possibility of such damages. If Client is dissatisfied with the Work, Client’s sole and exclusive option is to have Verbal Ink correct mistakes in the Work. Verbal Ink's sole liability for any claim or loss, damage or expense from any cause whatsoever arising out of or related to this Agreement, the Work or any Source Materials, shall in no event exceed sums actually paid to Verbal Ink by Client. Verbal Ink shall not be liable for any failure or delay in performing its obligations hereunder, if such failure or delay is due to circumstances beyond its reasonable control, including, without limitation, acts of any governmental body, war, insurrection, sabotage, embargo, fire, flood, strike or labor disturbance, interruption of or delay in transportation, or inability to obtain raw materials, supplies or power used in, or the equipment needed for the provision of the Work.

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Appendix AE

Confidentiality Agreement with Transcription Company #2

FOXTRANScribe CONFIDENTIALITY AGREEMENT

FoxTranscribe (the "Receiving Party") understands that the other party (the "Disclosing Party") has disclosed or may disclose information relating to the Disclosing Party's business or personal affairs, which to the extent previously, presently or subsequently disclosed to the Receiving Party is hereinafter referred to as "Proprietary Information" of the Disclosing Party. Notwithstanding the foregoing, nothing will be considered "Proprietary Information" of the Disclosing Party unless either (1) it is or was disclosed in tangible form and is conspicuously marked "Confidential", "Proprietary" or the like, (2) it is or was disclosed in non-tangible form and identified as confidential at the time of disclosure, or (3) the nature of the information and the manner of disclosure are such that a reasonable person would understand it to be confidential.

In consideration of the parties' discussions and any access of the Receiving Party to Proprietary Information of the Disclosing Party, the Receiving Party hereby agrees as follows:

1. The Receiving Party agrees (i) to hold the Disclosing Party's Proprietary Information in confidence and to take reasonable precautions to protect such Proprietary Information (including, without limitation, all precautions the Receiving Party employs with respect to its own confidential materials), (ii) not to divulge any such Proprietary Information or any information derived therefrom to any third person, (iii) not to make any use whatsoever at any time of such Proprietary Information except to evaluate internally its relationship with the Disclosing Party, (iv) not to copy or reverse engineer any such Proprietary Information and (v) not to export or reexport (within the meaning of U.S. or other export control laws or regulations) any such Proprietary Information or product thereof. Without granting any right or license, the Disclosing Party agrees that the foregoing shall not apply with respect to any information after five years following the disclosure thereof or any information that the Receiving Party can document (i) is or becomes (through no improper action or omission by the Receiving Party or any affiliate, agent, consultant or employee of the Receiving Party) generally available to the public, or (ii) was in its possession or known by it without restriction prior to receipt from the Disclosing Party, or (iii) was rightfully disclosed to it by a third party without restriction, or (iv) was independently developed without use of any Proprietary Information of the Disclosing Party by employees of the Receiving Party who have had no access to any such Proprietary Information. The Receiving Party may make disclosures required by law or court order provided the Receiving Party uses diligent reasonable efforts to limit disclosure and to obtain confidential treatment or a protective order and allows the Disclosing Party to participate in the proceeding.

2. Immediately upon a request by the Disclosing Party at any time, the Receiving Party will turn over to the Disclosing Party all Proprietary Information of the Disclosing Party and all documents or media containing any such Proprietary Information and any and all copies or extracts thereof. The Receiving Party understands that nothing herein (i) requires the disclosure of any Proprietary Information of the Disclosing Party or (ii) requires the Disclosing Party to proceed with any transaction or relationship.

3. This Agreement applies only to disclosures made before the first anniversary of this Agreement. The Receiving Party acknowledges and agrees that due to the
unique nature of the Disclosing Party’s Proprietary Information, there can be no adequate remedy at law for any breach of its obligations hereunder, which breach may result in irreparable harm to the Disclosing Party, and therefore, that upon any such breach or any threat thereof, the Disclosing Party shall be entitled to appropriate equitable relief, without the requirement of posting a bond, in addition to whatever remedies it might have at law. In the event that any of the provisions of this Agreement shall be held by a court or other tribunal of competent jurisdiction to be illegal, invalid or unenforceable, such provisions shall be limited or eliminated to the minimum extent necessary so that this Agreement shall otherwise remain in full force and effect. This Agreement shall be governed by the laws of the State of California without regard to the conflicts of law provisions thereof. This Agreement supersedes all prior discussions and writings and constitutes the entire agreement between the parties with respect to the subject matter herof. The prevailing party in any action to enforce this Agreement shall be entitled to costs and attorneys’ fees. No waiver or modification of this Agreement will be binding upon a party unless made in writing and signed by a duly authorized representative of such party and no failure or delay in enforcing any right will be deemed a waiver.

Aug 31, 2012

By: [Signature]
Name: DAVID ABRAMETO
Title: CFO

By:
Name:
Title:
Appendix AF

Theoretical Concepts, Themes, Focused Codes, & Open Codes

**Theoretical Concept 1: Fostering a Sense of Hopefulness**

<table>
<thead>
<tr>
<th>Focused Code</th>
<th>Open Code</th>
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</thead>
</table>
| therapist validating parents’ and youths’ experiences | therapist always validating what I was going through \( (P1, P3, P5, P6, P7, Y5, Y10) \)  
  \* converse: feeling blamed and judged as a parent \( (P1, P5, P8, Y1) \)  
  \* converse: parents feeling judged and labeled discouraged participation in family therapy \( (P1, Y1) \)  
  \* converse: more helpful when therapist is not judging \( (P3, P5, P6, P8, Y1, Y3) \)  
  \* converse: considering the whole picture of what’s going on with youth is more helpful than labeling and judging \( (P1, P2, P5, Y2) \) |
| therapist praising youth and parents abilities and growth | therapist praising parents’ abilities and growth \( (P1, P5, P7, P9) \)  
  \* therapist praising youth \( (P3, P4, P5, P6, P7, Y1, Y2, Y7, Y9, Y10) \) |
| therapist caring for youth and parents | showing an interest in me \( (P3, Y7) \)  
  \* feeling cared for by therapist \( (P2, P3, P7, Y2, Y3, Y5) \)  
  \* therapist wanting the best for the family \( (P6, P7) \)  
  \* therapist reaching out to parent and expressing concern \( (P2, P3) \) |
| therapist connecting with youth and parents | therapist qualities that helped parents trust and feel connected with the therapist \( (P4, P5, P6, P7, P8, P9, P10) \)  
  \* parents having a good relationship with therapist \( (P3, P9) \)  
  \* therapist and youth having a good relationship \( (P6, P10, Y2, Y3, Y4, Y5, Y6, Y7, Y8, Y9, Y10) \)  
  \* therapist qualities that helped youth connect with therapist \( (P2, P6, P8, Y1, Y3, Y4, Y5, Y6, Y8, Y9) \)  
  \* converse: not having a relationship with therapist when not included \( (P2, P8) \) |
| therapist encouraging youth and parents in treatment | feeling encouraged by therapist \( (P3, P5, P7, P8) \)  
  \* therapist being encouraging and supportive \( (P3, P4, P6, P7, Y1, Y2, Y3, Y4, Y5, Y6, Y7, Y8, Y9, Y10) \)  
  \* therapist giving hope things can change \( (P1, P2, P3, P5, P7, P8, Y3, Y4, Y5, Y6, Y7, Y8, Y10) \) |
## Theme 1: Therapist supporting and encouraging youth and parents

<table>
<thead>
<tr>
<th>Focused Code</th>
<th>Open Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>therapist presenting things positively</td>
<td>• being always positive ((P2, P4, P8, Y1))</td>
</tr>
<tr>
<td></td>
<td>• always ending on a positive ((P6, P8, Y7, Y8))</td>
</tr>
<tr>
<td></td>
<td>• having a positive come out of a negative ((P2, P3, P8, P9))</td>
</tr>
<tr>
<td>• converse: hearing negative messages about the</td>
<td>• converse: therapist not responding and not being available felt</td>
</tr>
<tr>
<td>family and youth is discouraging ((P1, P2, Y1, Y8))</td>
<td>discouraging to youth and parents ((P2, P5, P8, Y2, Y5, Y8))</td>
</tr>
<tr>
<td>therapist being available to youth and parents</td>
<td>• being available to youth ((P4, P8, Y8, Y9))</td>
</tr>
<tr>
<td>• therapist being available and accessible to the</td>
<td>• therapist being available and accessible to parent ((P2, P3, P4, P7)</td>
</tr>
<tr>
<td>parent</td>
<td>• parent checking in with therapist individually ((P2, P4, P5, P7, P8, Y2, Y3, Y6, Y8))</td>
</tr>
<tr>
<td>• converse: therapist not responding and not</td>
<td>• reverse: therapist not responding and not being available felt</td>
</tr>
<tr>
<td>being available felt discouraging to youth and</td>
<td>feeling discouraging to youth and parents ((P2, P5, P8, Y2, Y3))</td>
</tr>
<tr>
<td>parents</td>
<td>• reverse: therapist not responding and not being available felt</td>
</tr>
<tr>
<td>• being there to support when they don’t have to</td>
<td>feeling discouraging to youth and parents ((P2, P5, P8, Y2, Y3))</td>
</tr>
<tr>
<td>be</td>
<td>• being more than a job for the therapist ((P2, P4, P6, Y3, Y6))</td>
</tr>
<tr>
<td>therapists considering individual family needs</td>
<td>• focusing on what individual families need ((P2, P4, P6, P7, Y7))</td>
</tr>
<tr>
<td>• willing to accommodate special needs families</td>
<td>• knowing everyone’s a little different ((P2, P3, P5, P7))</td>
</tr>
<tr>
<td>have</td>
<td>• knowing everyone’s a little different ((P2, P3, P5, P7))</td>
</tr>
<tr>
<td>• knowing everyone’s a little different ((P2, P3, P5, P7))</td>
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</table>

## Theme 2: Parents being committed to youth

<table>
<thead>
<tr>
<th>Focused Code</th>
<th>Open Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>parents encouraging and supporting youth in his</td>
<td>• youth seeking parents out for support ((P3, P4, P5))</td>
</tr>
<tr>
<td>treatment</td>
<td>• supporting and encouraging son ((P1, P2, P3, P5, P6, P9, P10, Y1, Y2, Y4, Y5, Y6, Y8, Y9))</td>
</tr>
<tr>
<td>• parents praising youth ((P1, P3, Y1, Y4, Y9)</td>
<td>• parents praising youth ((P1, P3, Y1, Y4, Y9))</td>
</tr>
<tr>
<td>parents having and expressing unconditional love</td>
<td>• no matter what he did, how hurt I was, here I am ((P1, P2, P3, P4, Y2, Y4, Y5, Y7, Y10))</td>
</tr>
<tr>
<td>and commitment</td>
<td>• being dedicated ((P2, P3, P8, P9, Y3, Y4))</td>
</tr>
<tr>
<td>• not liking him but loving him ((P2, P3, P5, P10, Y3, Y5, Y6))</td>
<td>• not liking him but loving him ((P2, P3, P5, P10, Y3, Y5, Y6))</td>
</tr>
<tr>
<td>• parents expressing love and commitment ((P2, P3, P4, P5, P6, P8, P10, Y2, Y3))</td>
<td>• parents expressing love and commitment ((P2, P3, P4, P5, P6, P8, P10, Y2, Y3))</td>
</tr>
</tbody>
</table>
### Theme 3: Youth and parents recognizing changes

<table>
<thead>
<tr>
<th>Focused Code</th>
<th>Open Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>youth and parents seeing the youth changing</td>
<td>changes showing parents that he might come home a better person <em>(P1, P2, P3, P4, P5, P6, P8, Y1, Y3, Y8)</em></td>
</tr>
<tr>
<td></td>
<td>being hopeful about youth’s future <em>(P1, P2, P3, P4, P5, Y10)</em></td>
</tr>
<tr>
<td></td>
<td><em>converse:</em> youth not progressing in treatment is discouraging <em>(P1, P3, P4, P5, P6, P9, Y2, Y3, Y5, Y6)</em></td>
</tr>
<tr>
<td></td>
<td>hearing about and seeing youth work is helpful <em>(P3, P4, P5, P6, Y1, Y9, Y10)</em></td>
</tr>
</tbody>
</table>

### Theoretical Concept 2: Using Parents to Help Motivate Youth and Facilitate Changes in Youth and Family

#### Theme 1: Therapist teaching skills and giving tools to youth and parents in family therapy

<table>
<thead>
<tr>
<th>Focused Code</th>
<th>Open Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>therapist teaching skills through modeling, giving feedback, and practicing</td>
<td>practicing skills in counseling <em>(P2, P7, Y1, Y2)</em></td>
</tr>
<tr>
<td></td>
<td>therapist modeling <em>(P4, P6, P7, P8, Y1, Y3)</em></td>
</tr>
<tr>
<td></td>
<td>giving both positive and constructive feedback <em>(P1, P2, P3, P5, P7, P9, P10, Y1, Y2, Y4, Y5, Y7, Y9)</em></td>
</tr>
<tr>
<td></td>
<td>experiencing therapist as being direct while giving feedback <em>(P3, P4, P5, P6, P7, P9, Y10, Y2, Y7)</em></td>
</tr>
<tr>
<td>therapist teaching communication skills</td>
<td>therapist facilitating communication process <em>(P3, P4, P6, P7, P8, Y2, Y3, Y4, Y5, Y7, Y8, Y9)</em></td>
</tr>
<tr>
<td></td>
<td>parents and youth learning communication skills <em>(P1, P2, P3, P4, P6, P7, Y2, Y4, Y7, Y8)</em></td>
</tr>
<tr>
<td>therapist encouraging responsibility and honesty in youth</td>
<td>therapist teaching youth responsibility <em>(P1, P4, P5, P6, P9, Y2, Y3, Y4, Y5, Y6, Y8, Y10)</em></td>
</tr>
<tr>
<td></td>
<td>therapist teaching youth through holding him accountable <em>(P1, P2, P3, P4, P5, P6, P7, P8, P10, Y2, Y3, Y5, Y6, Y7, Y8)</em></td>
</tr>
<tr>
<td></td>
<td>encouraging honesty <em>(P1, P6, P8, Y1, Y2, Y3, Y6)</em></td>
</tr>
<tr>
<td>Theme 1: Therapist teaching skills and giving tools to youth and parents in family therapy</td>
<td></td>
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</tr>
<tr>
<td><strong>Focused Code</strong></td>
<td><strong>Open Code</strong></td>
</tr>
<tr>
<td>youth and parents</td>
<td>• parents and youth processing feelings around sexual offending (P1, P2, P3, P4, P5, P6, P7, P8, P9, P10, Y2, Y3, Y4, Y6, Y8, Y10)</td>
</tr>
<tr>
<td>expressing their feelings</td>
<td>• parents learning to express feelings (P1, P2, P3, P4, P5, P6, P7, P8, P9, P10, Y10)</td>
</tr>
<tr>
<td></td>
<td>• youth learning to express feelings (P1, P2, P3, P4, P5, P6, P7, P8, P9, P10, Y2, Y3, Y4, Y6, Y8, Y10)</td>
</tr>
<tr>
<td></td>
<td>• parents expressing feelings of anger towards son (P2, P3, P8, Y8)</td>
</tr>
<tr>
<td></td>
<td>• being angry and wanting to avoid each other as a result of family therapy sessions (P2, P3, P9, Y8)</td>
</tr>
<tr>
<td>learning parenting skills</td>
<td>• parents seeing family therapy as a place for learning (P2, P4, P5, P6, P7, P10)</td>
</tr>
<tr>
<td></td>
<td>• parents looking to therapist for guidance in parenting (P1, P2, P4, P6, P7, Y6)</td>
</tr>
<tr>
<td></td>
<td>• parents learning to let youth to take responsibility for himself (P2, P3, P5, P6, P7, Y2)</td>
</tr>
<tr>
<td></td>
<td>• parents learning to set and enforce rules for youth (P1, P2, P3, P5, P6, P7, P8, P10, Y2, Y3, Y4, Y5, Y6, Y8)</td>
</tr>
<tr>
<td></td>
<td>• parents learning to be in charge (P1, P3, P4, P7, P8, P10, Y2)</td>
</tr>
<tr>
<td></td>
<td>• being serious about being a better parent (P1, P3, P4, P7, P8, P9, Y3)</td>
</tr>
</tbody>
</table>

| Theme 2: Partnering with parents in family therapy |
|---------------------------------|-----------------|
| **Focused Code**               | **Open Code**   |
| finding strength in parents    | • youth wanting parents to be involved (Y2, Y3, Y4, Y5, Y8) |
| being a part of the family     | • parent being involved in treatment is positive (P1, P2, P5, P8, P9, P10, Y1, Y7, Y8) |
| therapy                        | • youth having someone there for him helps (P1, P2, P4, P5, P6, P7, Y4, Y6, Y9, Y10) |
|                                 | • choosing to become involved (P1, P2, P3, P8, P10, Y1, Y3, Y4, Y8) |
|                                 | • making it a priority (P3, P5, P6, P9, P10) |
| parents helping youth change   | • helping youth change (P1, P5, P8, Y1, Y2, Y4, Y6, Y7, Y8) |
|                                 | • parents helping with treatment work (P1, P2, P5, P6, P7, P8, P10, Y1, Y2, Y5) |
|                                 | • holding him accountable to do treatment work (P3, P5, P7, Y2) |
|                                 | • helping him open eyes and understand what he’s done (P2, P3, Y7, Y8) |
### Theme 2: Partnering with parents in family therapy

<table>
<thead>
<tr>
<th>Focused Code</th>
<th>Open Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>parents and family motivating youth</td>
<td>• parents/family are a motivation <em>(P1, P2, P7, P9, Y1, Y2, Y3, Y4, Y5, Y6, Y7, Y8)</em></td>
</tr>
</tbody>
</table>
| parents/caregivers taking a break motivated youth to work harder | • parent/caregiver choosing to take time away from youth *(P2, P8, Y8)*  
• taking a break was motivating for youth *(P2, P8, Y2, Y4, Y8)* |
| therapist partnering with parent to help youth | • being used as a resource *(P7, P8, P10)*  
• therapist and parent working as a team *(P2, P10)*  
• therapist encouraging and supporting parent involvement *(P1, P2, P3, P4, P5, P6, P7, P8, P9, P10, Y1, Y2, Y3, Y4, Y5, Y8, Y9)*  
• hearing what’s going on with son is helpful *(P2, P3, P5, P8, Y3, Y4)*  
• converse: discouraging parents involvement *(P1, P2, P5)*  
• converse: not being included *(P2)* |

### Theme 3: Strengthening family connections in family therapy

<table>
<thead>
<tr>
<th>Focused Code</th>
<th>Open Code</th>
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</thead>
</table>
| facilitating clarification and healing within the family | • helping clarification and healing to happen *(P5, P7, Y2, Y3, Y5)*  
• hearing son apologize *(P2, Y3)*  
• forgiving *(P2, Y4, Y5)* |
| strengthening relationships/bonds | • helping youth and family to know they’re important to each other *(P10, Y2, Y4, Y5, Y7)*  
• attending therapy strengthened caregiver-youth relationships *(P4, P7, P8, P9, P10, Y2, Y4, Y5, Y6, Y7, Y8, Y9, Y10)*  
• helping family feel more connected through communicating *(P1, P4, P6, P7, Y4, Y7)* |
| improving the quality of youth and parent interactions | • having some better interactions because of these therapies *(P2, P3, P4, P7, P8, P9, P10, Y1, Y4, Y5)*  
• trusting each other *(Y3, Y4, Y7)* |
| facilitating family reconnections | • bringing family back together *(P7, P8, Y1, Y2, Y4, Y6, Y7)*  
• including other family members *(P4, P5, P7, Y8)*  
• becoming a supportive brother *(P7, Y5)*  
• spending time together building connections *(P2, P3, P5, P6, P10, Y2, Y3, Y4, Y8)* |
### Theoretical Concept 3: Outcomes: Changes in Individuals and the Family System

<table>
<thead>
<tr>
<th><strong>Focused Code</strong></th>
<th><strong>Open Code</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>seeing him develop into a man</td>
<td>(P1, P3, P5, P6, P8, Y1, Y7, Y8, Y9)</td>
</tr>
<tr>
<td>parents noticing the changes in him</td>
<td>(P1, P2, P3, P4, P7, P8, P9, P10)</td>
</tr>
<tr>
<td>expressing himself more clearly</td>
<td>(P4, P6, P8, P9)</td>
</tr>
<tr>
<td></td>
<td>(P1, P4, P6, P7, P8, P9, Y2, Y4, Y7, Y8, Y9)</td>
</tr>
<tr>
<td></td>
<td>(P4, P6, P7, Y2, Y7)</td>
</tr>
<tr>
<td>caring about people around him now</td>
<td>(P5, P7, P8, P9, Y1, Y2, Y4, Y5)</td>
</tr>
<tr>
<td></td>
<td>(P3, P4, P5, P7, P8, P9, Y2, Y3, Y4)</td>
</tr>
<tr>
<td></td>
<td>(P2, P3, P4, P6, P7, P10, Y1)</td>
</tr>
<tr>
<td></td>
<td>(P1, P2, P4, P5, P7, P8, Y2, Y5, Y8)</td>
</tr>
<tr>
<td>thinking about his future and setting goals</td>
<td>(P5, P7, P3, Y7)</td>
</tr>
<tr>
<td></td>
<td>(P5)</td>
</tr>
<tr>
<td>having more confidence in himself</td>
<td>(P2, P5, P9)</td>
</tr>
<tr>
<td></td>
<td>(P5, P6)</td>
</tr>
<tr>
<td></td>
<td>(Y5, Y10)</td>
</tr>
<tr>
<td>following the rules</td>
<td>(P8, P9, P10, Y1, Y6)</td>
</tr>
<tr>
<td></td>
<td>(P3, Y3, Y8)</td>
</tr>
<tr>
<td></td>
<td>(P5, Y6)</td>
</tr>
<tr>
<td>progressing in his treatment work</td>
<td>(P5, P6, P8, Y1, Y3, Y5, Y8)</td>
</tr>
<tr>
<td></td>
<td>(P5, P6, P8, Y2)</td>
</tr>
<tr>
<td>being responsible for his behavior</td>
<td>(P1, P2, P3, P5, P6, P8, P9, Y1, Y2, Y3, Y4, Y5, Y6, Y7, Y9, Y10)</td>
</tr>
<tr>
<td></td>
<td>(P1, P5, Y2, Y5)</td>
</tr>
<tr>
<td></td>
<td>(P2, P3, P4, P6, P8, Y1, Y2, Y3, Y5, Y6, Y8)</td>
</tr>
</tbody>
</table>
### Theme 1: Witnessing growth in him

<table>
<thead>
<tr>
<th><strong>Focused Code</strong></th>
<th><strong>Open Code</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>becoming more honest with himself</td>
<td>becoming more honest with himself ( (P2, P6, P8, Y1, Y2, Y3, Y6) )</td>
</tr>
</tbody>
</table>
| developing life skills | learning responsibility of keeping house -R \( (P2, Y6, Y10) \) 
| | goes to school \( (P5) \) 
| | youth showing leadership with his peers \( (P4, Y6) \) 
| | being more social \( (Y7, Y8, Y9) \) |
| youth understanding and expressing regret for sexually offending | youth internalizing \( (P7, P8, P10, Y2, Y5, Y8) \) 
| | digging deeper to understand what happened \( (P5, P7, P8, Y2, Y5, Y7, Y8) \) 
| | talking about sexual abuse to his family \( (P4, P5, P9, P10, Y2, Y3, Y4, Y6, Y8, Y10) \) 
| | youth seeing parents deal with painful feelings around his sexual offending \( (Y2, Y6, Y8, Y10) \) |
| recognizing he still has changes to make | seeing change as a process \( (P2, P3, P4, P6, P7, P8, P9) \) 
| | treatment work \( (P1, P5, Y6, Y8, Y9) \) 
| | attitude and behavioral changes \( (P1, P2, P3, P4, P6, P7, P8, Y1, Y2, Y3, Y4, Y7, Y8, Y10) \) 
| | using time wisely \( (P5, P6, Y5) \) 
| | working on social skills and healthy relationships \( (P5, P7, Y9) \) 
| | improving communication \( (P5, P9, Y4, Y7) \) |

### Theme 2: Having new family dynamics

<table>
<thead>
<tr>
<th><strong>Focused Code</strong></th>
<th><strong>Open Code</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>changing family household rules</td>
<td>implementing new house rules ( (P1, P4, P5, P7, P10, Y1, Y4, Y6) )</td>
</tr>
</tbody>
</table>
| changing family roles | parents getting back their authority \( (P6, P7, P8, P10, Y3) \) 
| | changing family roles \( (P1, P3, P4, P7, P9, P10, Y1, Y3, Y7, Y8, Y10) \) |
| setting boundaries in and around family | learning about and creating a boundary around immediate family \( (P1, P3, P6, P7, P10, Y4, Y6) \) |
| having respectful communication as a family | family members listening to see each other’s perspectives \( (P2, P4, P6, Y7, Y2, Y5, Y6, Y7, Y10) \) 
| | parents talking respectfully to youth \( (P6) \) |
### Theme 2: Having new family dynamics

<table>
<thead>
<tr>
<th>Focused Code</th>
<th>Open Code</th>
</tr>
</thead>
</table>
| family talking with each other more often | • improving communication in the family  
                                   |   (P2, P4, P5, P7, P8, Y2, Y4, Y7)  |
|                              | • having more family discussions                              | (P4, P6, Y4, Y7) |
| resolving conflict in the family | • having the opportunity to talk it out  
                                   |   (P2, P3, P4, P5, P7, P8, Y7, Y8)  |
Appendix AG

Documentation Tables

Table AG1

*Research Questions in Relation to Interview Questions*

<table>
<thead>
<tr>
<th>Research question</th>
<th>Interview question</th>
<th>Adolescents</th>
<th>Parents</th>
<th>Family Therapists</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) What are adolescents and parents’ experiences of participation in family therapy when the adolescent son has been required to complete treatment for sexual offending?</td>
<td>1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12</td>
<td>1, 2, 3, 4, 5, 6, 7, 8, 11, 12</td>
<td>1, 2, 3</td>
<td></td>
</tr>
<tr>
<td>2) In what ways does parent and adolescent participation in family therapy link to adolescents’ progress in treatment for sexual offending?</td>
<td>2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12</td>
<td>2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12</td>
<td>1, 2, 3</td>
<td></td>
</tr>
</tbody>
</table>

Table AG2

*Matrix of Findings and Sources of Data Triangulation*

<table>
<thead>
<tr>
<th>Major finding</th>
<th>Source of data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapist supporting and encouraging youth and parents</td>
<td>YI</td>
</tr>
<tr>
<td>Parents being committed to youth</td>
<td>X</td>
</tr>
<tr>
<td>Youth and parents being hopeful about the future</td>
<td>X</td>
</tr>
<tr>
<td>Therapist teaching skills and giving tools to youth and parents in family therapy</td>
<td>X</td>
</tr>
<tr>
<td>Youth and parents expressing their feelings</td>
<td>X</td>
</tr>
<tr>
<td>Learning parenting skills</td>
<td>X</td>
</tr>
<tr>
<td>Strengthening family connections in family therapy</td>
<td>X</td>
</tr>
<tr>
<td>Parents being involved in the youth’s treatment is motivating</td>
<td>X</td>
</tr>
<tr>
<td>Witnessing growth in youth</td>
<td>X</td>
</tr>
<tr>
<td>Having new family dynamics</td>
<td>X</td>
</tr>
</tbody>
</table>

*Note.* YI = Youth Interview, PI = Parent Interview, FG = Focus Group, Q = Questionnaire, L = Literature. Adapted from “Qualitative research on stage: Making the research more public,” by V. A. Anfara, K. M. Brown, and T. L. Mangione, 2002, *Educational Researcher, 31*, p. 34. Copyright 2002 by the American Educational Research Association.
Table AG3

*Code Mapping: Three Iterations of Analysis (to be read from the bottom up)*

<table>
<thead>
<tr>
<th>RQ #1: What are adolescents and parents’ experiences of participation in family therapy when the adolescent son has been required to complete treatment for sexual offending?</th>
<th>RQ #2: How does parent and adolescent participation in family therapy relate to adolescents’ progress in treatment for sexual offending?</th>
</tr>
</thead>
</table>

(THIRD ITERATION: THEORETICAL CODES)

Fostering a Sense of Hopefulness

(SECOND ITERATION: THEMES)

1. Therapist supporting and encouraging youth
2. Therapists considering individual family needs
3. Youth and parents recognizing changes and parents
4. Youth and parents seeing the youth changing

(FIRST ITERATION: FOCUSED CODES)

1. therapist validating parents experiences
2. therapists considering individual family needs
3. therapist presenting things positively
4. therapist being available to youth and parents

DATA

DATA

DATA
(THIRD ITERATION: THEORETICAL CODES)

Using Parents to Help Motivate Youth and Facilitate Changes in Youth and Family

(SECOND ITERATION: FOCUSED CODES)

1. Therapist teaching skills and giving tools to youth and parents in family therapy
2. Partnering with parents in family therapy
3. Strengthening family connections in family therapy

(FIRST ITERATION: INITIAL CODES)

1. therapist teaching skills through modeling, giving feedback, and practicing
2. therapist teaching communication skills
3. therapist encouraging responsibility and honesty in youth
4. youth and parents expressing their feelings
5. learning parenting skills
6. finding strength in parents being a part of the family therapy
7. parents helping youth change
8. parents and family motivating youth
9. parents/caregivers taking a break motivated youth to work harder
10. therapist partnering with parent to help youth

11. facilitating clarification and healing within the family
12. strengthening relationships/bonds
13. improving the quality of youth and parent interactions
14. facilitating family reconnections
(THIRD ITERATION: THEORETICAL CODES)

Outcomes: Changes in Individuals and the Family System

(SECOND ITERATION: FOCUSED CODES)

1. Witnessing growth in him
2. Having new family dynamics

(FIRST ITERATION: INITIAL CODES)

1. seeing him develop into a man
2. changing family household rules
1. parents noticing the changes in him
2. changing family roles
1. expressing himself more clearly
2. setting boundaries in and around family
1. caring about people around him now
2. having respectful communication as a family
1. thinking about his future and setting goals
2. family talking with each other more often
1. having more confidence in himself
2. resolving conflict in the family
1. following the rules
1. progressing in his treatment work
1. being responsible for his behavior
1. becoming more honest with himself
1. developing life skills
1. understanding and expressing regret for sexually offending
1. recognizing he still has changes to make

DATA

DATA