ADOLESCENT MALE SEXUAL OFFENDERS' PERCEPTIONS OF THEIR FAMILY CHARACTERISTICS

by

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Thesis submitted to the Faculty of the

Virginia Polytechnic Institute and State University

in partial fulfillment of the requirements for the degree of

MASTER OF SCIENCE

in

Family and Child Development

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May 22, 1991

Blacksburg, Virginia

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(ABSTRACT)

Literature on families of adolescent sexual offenders is sparse. Adolescents' perception of family structure, family adaptability and cohesion, parent-child communication, and family communication about sexuality are considered in an effort to identify family characteristics that distinguish families of adolescent sex offenders (n=39) from violent juvenile delinquents (n=25), non-violent juvenile delinquents (n=41), and from non-problem families (normative data). Families of sex offenders are characterized by greater family cohesion, poorer communication with fathers than with mothers, a higher value on family sex communication, and a change in living arrangement when compared to other delinquents' families. Several variables differentiate between families of delinquents in this study and non-problem families. In general, there are some differences between families of adolescent sex offenders and other delinquents, but more dramatic differences emerge between non-problem families and all delinquent samples. Implications for practice are offered.

ACKNOWLEDGEMENTS

As I embarked on this thesis, I wanted it to be a capstone that adequately represented the excellent training and education I received in the Marriage and Family Therapy Program at Virginia Tech. Gaining "expert" status in this area was also a goal. With the collaboration of faculty and colleagues, I have fulfilled those aims.

Committee member Stephan Wilson provided valuable guidance in research methodology and professional writing and imbued my confidence with his encouraging comments. Linda Little assisted with comments on earlier drafts, and more significantly provides solid leadership to a thriving program.

Stephanie Barasch helped with computer systems and by her friendly interest in my progress. Arlene Tave also gave me enthusiastic assistance on computer programs. John Sayers artfully produced the research questionnaire.

I am grateful to the many professionals and adolescents who took their time to assist me in this study.

Finally, and most importantly, Sandi Stith, my advisor, was a gem. Always available, I am thankful for her prompt reviews of drafts, her confidence in me, for the gentle nudges when I got discouraged, and for the abiding collegial nature of her interactions with me and others.

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Until recently, adolescent sexual offenders (ASOs) received little attention in the professional literature. In the last decade several states, primarily in the north and northwest, commissioned studies regarding the incidence of sexual offenses by adolescents (Davis & Leitenberg, 1987). In addition, the National Adolescent Perpetrator Network (1988) was formed and completed a preliminary report on juvenile sexual offending. Much of the existing research has been concerned with individual characteristics of offenders and offenses, but little is known about the family environment of these offenders. It is also unclear how, if at all, these offenders and their families differ from other juvenile delinquents who have committed either violent or non-violent offenses or from normal adolescents since few studies compare these groups or include a normal (i.e., representative sample of non-offenders) control.

Clinicians working with ASOs suggest that the sexual knowledge of these youths is lacking (O'Brien, 1985), but virtually no studies have addressed how these offenders gain information about sexuality or how much they have discussed sexuality with their parents. This study was designed to fill some of these gaps in the literature on male ASOs and their families. Male ASOs were compared with male juvenile

delinquents who had committed violent or non-violent non-sexual offenses. Several variables were considered, most notably, family structure, family adaptability and cohesion, parent-adolescent communication, and communication about sexuality with parents.

Families of these offenders are frequently involved in treatment, and findings from this study are likely to enhance services to these families. ASOs and other juvenile delinquents are frequently placed together in treatment facilities, while experts advocate offense-specific treatment for ASOs (Knopp, 1985). Professionals in the ASO field claim that ASOs are indeed unique and distinct from other delinquents and non-offending adolescents (Knopp, 1985; O'Brien, 1985). Results may help clarify whether, and in what ways, ASOs and their families differ from other juvenile delinquents. Findings may also promote continued development of theories on the etiology of sexual offenses by adolescents, and help foster early identification of at-risk families.

Literature Review and Hypotheses

An ASO is defined as a "youth from puberty to the legal age of majority who commits any sexual act with a person of any age, against the victim's will, without consent, or in an aggressive, exploitative or threatening

manner" (Ryan, 1986, p. 126). Sexual offenses by adolescents range from non-contact offenses such as exhibitionism or voyeurism, through contact offenses such as fondling that often involve deception or coercion, to completed penetration as in the case of violent rape done with the use of a deadly weapon. When younger children are victims, an age difference of five years between the adolescent and victim, or the presence of any form of coercion or intimidation are generally thought to constitute a sexual offense (Groth & Loredo, 1981).

The decade of the 1980's saw a burgeoning of the literature on ASOs. Previously, sexual offenses by adolescents were not taken very seriously, often explained as normal experimentation or developmental curiosity. A "boys will be boys" attitude prevailed (Knopp, 1985).

Studies now indicate that incidents of sexual offenses by adolescents are more numerous than has often been thought. Ageton (1983), in a general population study found that approximately 3-4% of adolescents aged 15-21 had committed a sexual offense, resulting in an estimated 500,000 offenses by adolescents each year. Crime reports and surveys of sexual abuse have determined that adolescents are responsible for approximately 20% of rapes and from 30% to 50% of cases of child sexual abuse (Davis & Leitenberg,

1987; Deisher, Wenet, Paperny, Clark & Fehrenbach, 1982; Groth & Loredo, 1981). These figures may be underestimates, due to the high number of incidents which go unreported. In addition, only a small number of complaints ever result in an arrest (Groth & Loredo, 1981). Studies of adult sexual offenders (Abel, Mittleman & Becker, 1984; Becker & Abel, 1985) have revealed that about 50% of adult offenders report that their first sexual offense occurred as an adolescent, and often offenses escalated in frequency and severity over time. These alarming findings have led to increased efforts in the identification and treatment of ASOs and to the recognition of this group of offenders as a distinct juvenile justice problem and clinical population.

Much of the literature on ASOs has been descriptive in nature, delineating characteristics of offenders, their offenses and their victims. Summarizing findings from a review of the literature, Davis and Leitenberg (1987) concluded the following: (a) virtually all identified ASOs are male; (i.e., females account for less than 5% of cases); (b) median age is generally between 14 and 15; (c) black male adolescents are overrepresented, relative to their numbers in the general population; (d) behavioral and school disturbances are common, but no more so than in other non-sexual juvenile delinquents; (e) social isolation and poor

social skills are typical; (f) ASOs claim to have had more sexual experiences, including consenting ones, than do comparison groups of adolescents, contrary to the notion that sexual offenses stem from a lack of sexual experience; (g) ASOs more frequently have a history of being physically or sexually abused than do other groups of male adolescents; and (h) recidivism and treatment outcome statistics are encouraging, with recidivism rates of 10% or lower being typical.

In nearly two-thirds of these offenses, younger children are the victims, the vast majority being acquaintances or relatives of the offender. There are generally more female (68% to 80% across several studies) than male victims, but the proportion of female victims is less in cases when a child is the victim. The proportion of female victims is higher (87%-91%) in contact offenses when the victim is peer-age or older, and much higher (95%) in cases of non-contact offenses (Fehrenbach, Smith, Monastersky & Deisher, 1986; Groth, 1977; Van Ness, 1984). Offenses usually occur indoors, frequently take place during babysitting, and intoxication at the time of offense is uncommon. ASOs (n=67) in one study were also characterized by prior delinquent behavior and prior sexual offenses (Becker, Cunningham-Rathner & Kaplan, 1986), confirming

(Becker, Cunningham-Rathner & Kaplan, 1986), confirming clinical impressions about the occurrence of prior offenses.

Aside from these descriptive studies, many of which are limited by small sample size and geographical bias, research on ASOs is sparse. Studies including normal control groups are essentially non-existent (Davis & Leitenberg, 1987). Clinical impressions abound, but little scientific research has been conducted to confirm or disclaim these impressions. This is especially true of research on family dynamics of these adolescents, though there is conjecture on how the family influences the commission of an offense. Reviewing the literature, Monastersky and Smith (1985) conclude that studies are virtually unanimous in identifying the family as a crucial influence in the development or elicitation of the offending behavior, but it is not clear how this occurs. The present study considered several family and parent-child communication variables in an effort to increase understanding about how, if at all, families of ASOs differ from families of violent and non-violent juvenile delinquents. Findings may also further advance understanding about familial influence on the occurrence of sexual offenses by adolescents.

Family Structure

Geismar and Wood (1986) report family structural variables as a major category of family variables in the research on family influence upon juvenile delinquency. Family structural variables include items such as family intactness, family size, birth order, and sibling configuration. A review of the literature concludes there is a consistent positive association between broken homes and general delinquency (Wells & Rankin, 1985), though this relation is rather modest. Some claim that other factors such as race or socioeconomic status serve as overarching influences that effect both family intactness and delinquency (Farnworth, 1984). In a matched study (n=24) of ASOs and non-sexual offending juvenile delinquents (Awad, Saunders & Levene, 1985), there was no difference in terms of family intactness. However, using an incarcerated sample comparing violent delinquents (n=208) and ASOs (n=34), Fagan and Wexler (1988) found that ASOs more often lived with both natural parents and in general more closely resembled normal adolescents on several variables. On-the-other-hand, Smith and Monastersky (1987) found that only 23% of the outpatient-treated ASOs (n=163) in their study lived with both natural parents when the offense took place.

Based on clinical experience, Lankester and Meyer (1988) identified five types of ASO families, the only known typology of families of ASOs. Of these, three were related to family structure: (a) single-parent (mother) family with sexual role confusion; (b) remarried single parent; and (c) blended family with two-tier sibling system. These types, though, have not been held up to scientific validation.

Other family structural variables associated with delinquency are birth order and sibling configuration. In a study (LeFlore, 1988) comparing chronic delinquents and non-delinquents, delinquents had larger sibling subsystems and more often were middle children. In a comparison of ASOs and a like number of other delinquents matched on age and socio-economic status (Awad et al., 1985), there was no difference between the two groups regarding birth order, but ASOs more often came from large families (i.e. three or more children). One descriptive analysis of ASOs (n=30) found that these boys were the oldest male sibling in 46% of the cases, the only child in 13%, and the second male in 11% of the cases (Pierce & Pierce, 1987). No other information was reported on sibling configuration, and it should be noted that nearly half of the subjects resided in a foster home at the time of the offense. More boys in the sibling subsystem appears to favor the development of antisocial behavior in

boys and the presence of more sisters seems to suppress potential for antisocial behavior (Jones, Offord & Abrams, 1988).

Based on the preceding review of the literature, the following hypotheses regarding family structure were proposed:

(a) ASOs will report living with both natural parents more often than either violent or non-violent juvenile delinquents;

(b) There will be no difference in birth order between ASOs and other delinquents;

(c) Sibling gender configuration will be characterized by more boys for ASOs and other delinquents;

(d) ASOs will report living with families larger than those of both violent and non-violent delinquents.

Family Adaptability and Cohesion

Family adaptability and cohesion are frequently examined when evaluating the family system. Family adaptability has to do with the extent to which the family system is flexible and able to change and is defined as the ability of a family system to change its power structure, role relationships, and relationship rules in response to situational and developmental stress (Olson, Portner & Lavee, 1985). Cohesion assesses the degree to which family

members are separated from or connected to their family and is defined as the emotional bonding that family members have toward one another (Olson et al., 1985).

Several studies have appeared addressing adaptability and cohesion of families of troubled adolescents. Adolescent substance abusers and their families were found to be far more disengaged than non-problem families, while on measures of adaptability, substance-abusing adolescents see their families as slightly more rigid than non-problem families (Volk, Edwards, Lewis & Sprenkle, 1989). Conversely, mothers of substance abusers see their families as slightly more chaotic than non-problem families. In a study of juvenile delinquents and their families (McGaha & Fournier, 1988) which assessed both the adolescents' and parents' perceptions, the study sample was found to be significantly less cohesive and much more rigid than the national norms. Family adaptability and cohesion were also related to the type of offense. Extreme families, who scored in the extreme range on both measures, tended to commit more violent crimes or status offenses, while balanced (moderate on both measures) and midrange (moderate in only one measure) families were more likely to commit property crimes (see Figure 1, p. 11).

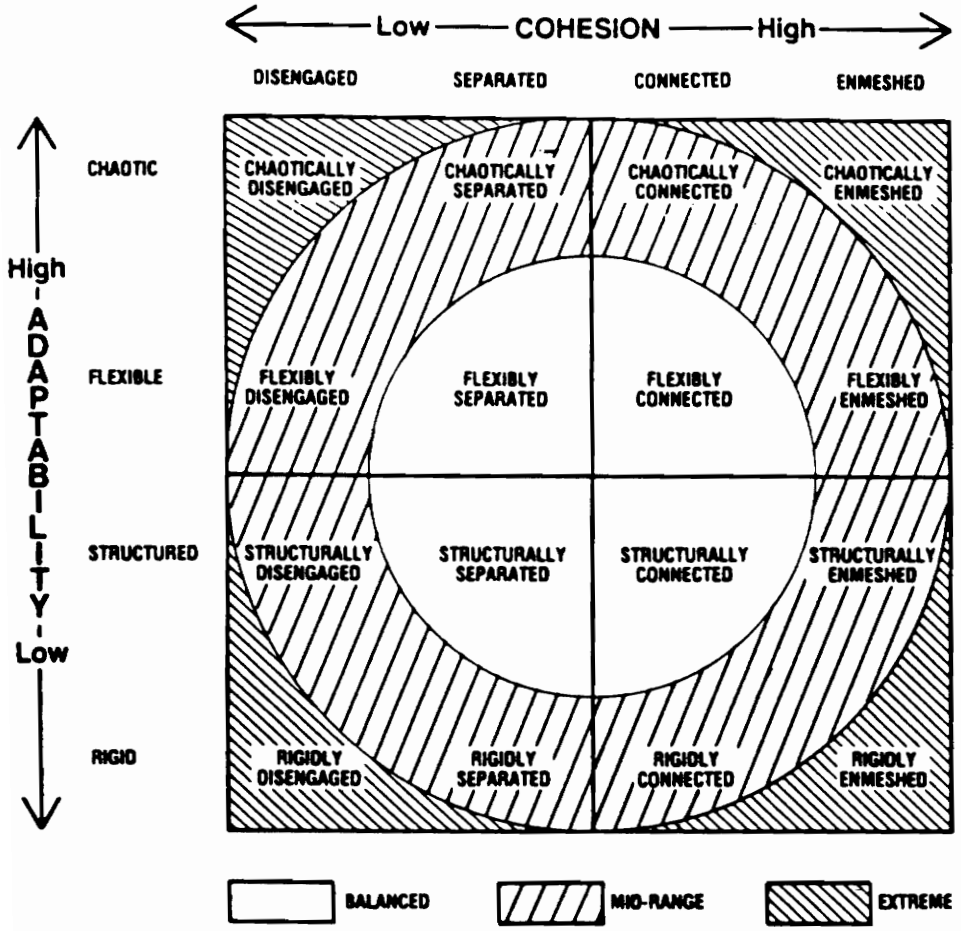


Figure 1: Circumplex Model, Sixteen Family Types.

Knopp (1982), reporting on limited clinical impressions of an unspecified number of families in one ASO program, found ASO families reflect two types of family systems. Either the families are very rigid and enmeshed, with strict rules and a perfectionist bent to parental expectations, or they are very chaotic with a great deal of role confusion. In a review of another ASO program serving very violent and dangerous ASOs in a long-term locked facility, Knopp reports that staff used the word "chaotic" when describing the families of the majority of the ASOs there. In these families it was not uncommon for one of the parents to have demonstrated deviant behavior very similar to the child's.

Three studies have addressed adaptability and cohesion of ASO families more formally. Considering ASOs (n=51) who had committed offenses of various patterns and levels of severity, Bera (1985) found no significant difference between the family systems of ASOs and non-problem adolescent families. ASOs had balanced, midrange and extreme scores very similar to the normal population of adolescents. Further, no differences were found in the family systems of "mild" (i.e., few and less violent offenses) versus "severe" (i.e., many and more violent) ASOs. Yet, when comparing ASOs classified by several factors associated with a seven-type classification system,

some significant differences emerged, leading Bera to conclude that simple dichotomies were not adequate in distinguishing the family systems of the heterogeneous population of ASOs.

While Bera used only the ASO's perception of his family system, Smith and Monastersky (1987) gathered perspectives from ASOs (n=66) and their mothers (n=71) and fathers (n=51). Their sample included ASOs treated in an outpatient program, a majority of whom had committed less aggressive offenses. They found that the ASO families were more likely than the general population to be characterized as rigid in response to changes (i.e., low adaptability) and emotionally disengaged (i.e., low cohesiveness). In their study, degree of violence of the offense was related to the family system; the more rigid and disengaged the family (according to the parents' perceptions) the more violent the offense. These findings are consistent with McGaha and Fournier's (1988) findings about general juvenile delinquents. Smith and Monastersky noted a difference between ASOs' and juvenile delinquents' perceptions of their families, though. The ASOs' perceptions of their families were generally similar to their parents' perception, while studies of juvenile delinquents have revealed that the delinquents frequently view their family as more harsh and unresponsive than do

other family members.

Finally, a small study (Sefarbi, 1990) evaluated adaptability and cohesion for ASOs who denied their offense (n=5) and those who admitted to their offense (n=5). The "deniers" tended to be in enmeshed family organizations, while "admitters" were in disengaged family systems. Deniers' families were also characterized by overwhelmed mothers who relied on the parentified ASO child for physical and emotional support. A history of abandonment, first by fathers, and later by mothers for crucial periods, distinguished the families of admitters.

Moos and Moos (1986) define cohesion slightly differently as the degree of commitment, help, and support family members provide one another. Lower scores on this measure of cohesion for families of delinquents were found when these families were compared to national norms. Further, delinquents perceived their family relationships as less cohesive when compared to the perceptions of a matched group of non-delinquents (LeFlore, 1988). No studies have considered cohesion, as defined by Moos and Moos (1986), of families of ASOs, but parents from families with a history of physical or sexual abuse, common experiences in the history of many ASOs, also tend to report less cohesion (in Moos & Moos, 1986). However, in a study of father-child

incest families (Saunders, McClure & Murphy, 1987) using this definition of cohesion, scores for the study sample were somewhat lower, but not significantly different from national norms.

Based on the above review of the literature, the following hypotheses regarding adaptability and cohesion were proposed:

(a) Due to the lack of detailed information about the offenses committed by subjects in this study, and given the fact that ASOs have not been directly compared to juvenile delinquents in a study of these variables, a directional hypothesis is not warranted. Therefore, it is proposed that ASO families will differ from violent and non-violent juvenile delinquents and from non-problem adolescents on measures of adaptability and cohesion;

(b) Using the Circumplex model, ASOs will perceive their families as being classified as extreme, midrange and balanced types in different proportions than will violent and non-violent juvenile delinquents and non-offending adolescents.

Parent-Child Communication

Communication between adolescents and parents seems to be a reliable indicator of the quality of the relationship. Galvin and Brommel (1986) define communication as a

symbolic, transactional process in which participants both affect and are affected by the interaction. Communication affects the way family members relate, and family relationships affect the communication that occurs. Satir (1972) claimed that good family communication is the largest single factor determining the kinds of relationships we have with others. The significance of effective communication between family members has been recognized by therapists, researchers and family life educators. Olson (1976) cited the important diagnostic function of communication and the need to focus upon family communication patterns as indicators of the quality of relationships. This strong association between communication and the quality of a relationship is the basis upon which communication will be examined in this study. That is, communication is seen as an indicator of the relationship between an adolescent and his mother and/or father.

The association between parent-child communication and general juvenile delinquency has been examined. Several reviews of the literature (McGaha & Fournier, 1988; Thornburg, 1986; Tolan, Cromwell & Brasswell, 1986) report relationships between aspects of family communication and juvenile delinquency. In communication with their children, parents of delinquents had difficulty in establishing

consistent rules and expectations, were less likely to praise children or show interest in their activities, often disagreed, and gave conflicting directives to children. Family communications were often defensive, lacking focus, or dominated by one family member. Communication was further characterized by difficulty resolving conflicts, an unwillingness to compromise, and a greater proportion of communication was misperceived.

Parent-child communication has not been considered for ASOs, but the father appears to play a significant role in the etiology of adolescent sexual offenses. A generally poor relationship between father and son, if there is a relationship at all, is a common thread among ASOs (O'Brien, 1985). From on-site interviews at treatment programs across the country, Knopp (1982, 1985) reported that none of the offenders claimed to have a warm, close, nurturing relationship with his father. Instead, fathers seem to be either abusive or physically or emotionally absent from these young people. In a comparison of ASOs and a matched group of non-sexual offending delinquents (Awad et al., 1985), fathers of ASOs were found to be more rejecting and were nearly twice as lax in providing parental control as fathers of the general delinquents. Mothers of the two groups of boys scored very similarly across measures of

parent-child interaction. O'Brien (1985) postulates that a poor father-son relationship may have a profound impact on sexuality, sex roles, parenting, and attitudes toward women. He suggests examining father-son relationships among other juvenile delinquents and among non-offending teens to determine whether these initial indications are indeed unique to ASOs.

The ASO tends to identify with his overprotective and dominant mother (Shoor, Speed & Bartelt, 1966). In the Awad et al. study (1985), mothers were less rejecting and less detached but more lax in controls than were fathers of both ASOs and other juvenile delinquents. Some clinical impressions suggest that ASOs are overly close to and protected by their mothers (Knopp, 1982). Other clinical impressions of ASO families claim that a detached or hostile relationship between mother and son is frequently apparent (Eddy, 1990).

Based on this review of the literature, the following hypotheses regarding parent-child communication were proposed:

(a) ASOs will score qualitatively lower on communication with their fathers than will other delinquents and normal adolescents on open communication (positive aspects of family communication), on problems in communication

(negative aspects of family communication), and on overall quality of communication;

(b) ASOs will report qualitatively better communication with their mothers than with their fathers on all three of the above communication measures.

Parent-Child Communication about Sexuality

Peers have remained the major source of information about sexuality for adolescents over several eras (Walters & Walters, 1983). Yet, adolescents report in several studies a preference for parents as the primary source of sexual information (Handelsman, Cabral & Weisfeld, 1987). Alexander (1984) found that parents wanted to be the primary sex educators and wanted schools to supplement their efforts. Explanations for the lack of sexual education from parents include parents' overestimating the quality of knowledge held by their children, lack of parental knowledge about sexual matters, inability to comfortably approach children about sexuality, and reciprocal misperceptions that parents and children have about each others' attitudes and behaviors regarding sexuality (Walters & Walters, 1983).

There appears to be a relationship between parent-child communication about sexuality and responsible sexual behavior. Adolescents who talk with their parents about sex begin having sexual intercourse later than those who do not

discuss sex with parents; this is especially true for girls (Walters & Walters, 1983). There is conflicting evidence for boys, as it appears that any communication about sexuality increases sexual activity. Generally, though, more discussion about birth control leads to more use of birth control, and more knowledge about sexuality leads to more responsibility. In another study, the presence of open parent-child communication did not seem to influence sexual activity, but did influence contraceptive use (Handelsman et al., 1987). In a study that assessed adolescents' sexual self-disclosure to parents (Papini, Farmer, Clark & Snell, 1988), it was found that disclosure was strongly associated with adolescent perception of the openness and adaptiveness of the family context and that teens generally disclosed more to the same-sex parent.

ASOs' sexual knowledge and the inherent impact of this knowledge on offenses is an area in need of much more research (Freeman-Longo, 1985; O'Brien, 1985). O'Brien claims that sexual myths and misinformation abound in this population. As early as 1943, Doshay suggested that sexual education classes be emphasized in the treatment of ASOs. Another early study (Shoor et al., 1966) noted the lack of suitable sex education, particularly by ASOs' parents. Of the 27 parents surveyed in a study of adolescent incest

perpetrators (Kaplan, Becker & Cunningham-Rathner, 1988), 62% provided no sex education to their sons.

Smith and Monastersky (1987) hypothesize that denial of sexual tensions in the family is the major factor that distinguishes ASOs from general juvenile delinquents. They observed a marked lack of knowledge in the family about normal adolescent sexual behavior. Parent-child interactions implicitly demanded that the adolescent act either as if he were a much younger child with no sexual interests, or as if he were a spouse with obligations to meet the needs of parents. Sefarbi (1990) supports this claim, noting that families of ASOs either exhibited a lack of clarity and mixed messages about deviant and non-deviant sexuality, or they simply avoided discussion of sexuality, even when overall family communication was quite open.

In an extensive review of the literature on ASOs (Davis & Leitenberg, 1987) no studies of sexual knowledge or education could be located. One uncontrolled study (Becker et al., 1986) addressed male ASOs' (n=67) primary sources of information about sexuality. Sex education in schools ranked highest (25%), followed by personal experience (19%), friends (18%), media (13%), siblings (12%), parents (6%), observation of others (1.5%) and other (4.5%). One small study (n=17) also evaluated the effect of a psycho-

educational ASO group treatment program on sexual knowledge, and reported sexual knowledge before and after participation in the group for small sample and control groups (Hains, Herrman, Baker & Graber, 1986). It is not known, however, how these limited findings about sources of sexual information or sexual knowledge for ASOs compare to sexual sources or knowledge for juvenile delinquents or normal adolescents, since these comparison groups were not included.

O'Brien (1985) recommends that the influence of sexual education and attitudes on the occurrence of victimizing behavior be studied, and that normal adolescent control groups be included in such studies. Considering ASOs' frequent social isolation from peers, lack of open communication with parents, and poor relationships with fathers, one could surmise that the quality of sexual knowledge and information for ASOs is quite low.

Based on the preceding literature, the following hypothesis regarding parent-child communication about sexuality was proposed:

(a) ASOs will score lower than other juvenile delinquents and normal youth on measures of communication with parents about sexuality.

In summary, research on ASOs has been largely limited to descriptive studies and geographically-limited state surveys. These findings have been helpful in calling attention to the extent and seriousness of sexual offenses by adolescents. However, little scientific investigation has been conducted to determine how ASOs and their families compare to other juvenile delinquents or normal adolescents and their families, although experts advocate for offense-specific treatment for ASOs due to their supposed unique characteristics. Few studies have even considered family variables, though the family is thought to be influential in the etiology of these offenses. This study examined adolescents' perception of their family structure, family adaptability and cohesion, parent-adolescent communication with each parent, and parent-child communication about sexuality. Based on the preceding literature reviews on these areas, several hypotheses have been proposed. In general, these hypotheses suggest that ASOs will differ from violent and non-violent juvenile delinquents and from non-problem adolescents, thus supporting recognition of ASOs as a distinct juvenile justice problem and clinical treatment population.

Methods

Subjects

Questionnaires were distributed to 109 adolescent males in various outpatient and residential programs; 105 questionnaires were returned (96.3%). Participants were adolescent males, aged 12-18, who were grouped as follows: a) adolescent sexual offenders (n=39) who self-reported having committed child sexual molestation or who were involved in treatment programs designated for identified ASOs; b) non-sexual offending juvenile delinquents (n=25) who self-reported committing violent offenses (i.e., homicide, manslaughter, forcible rape, robbery, aggravated assault); and c) non-sexual offending juvenile delinquents (n=41) who self-reported committing non-violent offenses, such as property offenses, non-violent crimes against persons, status offenses or substance abuse violations. Individuals in the latter two groups were involved in group homes, treatment programs or correctional facilities. All but one of the participants in the latter two groups were in residential programs, while the ASO group was more evenly divided between outpatients (n=21) and residents (n=18). A normal control group was not included in this study, but each of the instruments included in the study has been normed to the general population and these norms were

compared to scores by the groups in this study. Participants were not paid, but were encouraged to participate in the research as a way to help other young people and society in general. Programs/facilities participating in the research were offered copies of the results.

Measures

Family Structure. Four family structural variables were assessed in this current study: a) adolescents' living arrangement at the time of offense and during most of their lives; b) birth order; c) sibling gender configuration; and d) family size. Participants were presented with an array of choices of living arrangements and were asked to specify where they lived both at the time of their offense and during most of their lives. Responses were classified as either living with both natural parents or living with other than both natural parents. Subjects were also asked to designate ages and gender of siblings and step-siblings. Using this information along with the adolescent's reported age, birth order (i.e., oldest, middle, or youngest) and sibling gender configuration (i.e., predominance of either males or females in the sibling subsystem) were determined. Family size was computed by summing the number of siblings and step-siblings reported.

Family Adaptability and Cohesion. Family Adaptability and Cohesion Evaluation Scales (FACES-III) (Olson, et al., 1985). FACES-III is a 20-item scale that is a revised version of earlier self-report tests designed to assess perceptions of the family system. Subjects respond to each question with one of five Likert-type answers from "almost never" to "almost always." Family cohesion assesses the degree to which family members are separated from or connected to their family. Family adaptability has to do with the extent to which the family system is flexible and able to change. Scores on cohesion and adaptability can be plotted onto the Circumplex Model (Olson, 1986) to indicate the type of family system among 16 possible types. On the model, families can be classified as "balanced" (moderate in both dimensions), "midrange" (moderate in only one dimension) or "extreme" (extreme on both dimensions, indicating the greatest pathology) (see Figure 1, p. 10). Reported test-retest reliability is .83 for the cohesion subscale and .80 for adaptability. Internal consistency reliability for the cohesion subscale is .77 and .62 for adaptability. The authors also report very good content and face validity (Olson, 1986). Norms exist for adults across the life cycle and for non-problem adolescent families. The perceived form, covering perceptions of current family

perceived form, covering perceptions of current family functioning, was used.

Family Environment Scale (FES) Form-R, Cohesion subscale (Moos & Moos, 1986). The FES is a true-false self-report instrument designed to measure the social-environmental attributes of various kinds of families. The Cohesion subscale contains nine items designed to assess the degree of commitment, help, and support family members provide to one another. Test-retest reliability is high (.86) for this subscale, and the authors claim a satisfactory level of internal consistency reliability. This subscale was tested along with other FES subscales for reliability (Roosa & Beals, 1990), and it was found that measures of internal consistency for some types of families were considerably lower than reported by Moos. They also found that a great deal of variability in the internal consistency measures existed between various types of stressed families, calling into question the ability to compare adequately across types of families using this subscale. The alpha reliability coefficient for internal consistency was calculated for each group in this current study. Alphas for the FES Cohesion subscale were .79, .84 and .83 for ASOs, violent delinquents and non-violent delinquents, respectively. The FES has been used

extensively with many types of families and in several studies comparing distressed and normal families. Form-R, for reality, measures respondents' perception of their nuclear family environment.

Parent-Adolescent Communication. Parent-Adolescent Communication Scale (PAC) (Barnes & Olson, 1982). The PAC is a 20-item scale to which subjects respond with one of five Likert-type answers from "strongly disagree" to "strongly agree". It is designed to measure both positive and negative aspects of family communication. The scale has two subscales. Open Family Communication addresses positive aspects of family communication and has an internal consistency reliability coefficient of .87. Problems in Family Communication covers more negative aspects with an internal consistency reliability of .78. The total scale has an internal consistency reliability of .88. Separate forms exist for parents and adolescents; the adolescent form allows for separate answers about communication with each parent. Overall scores range from 20 to 100; the higher the score, the more positive the communication. Norms exist for adolescents aged 16-20, slightly older than the sample in this study, but in the absence of norms for younger aged adolescents, were used here. Separate scores were tallied for communication with mothers and fathers in this study.

Parent-Child Sexual Communication. Family Sex Communication Quotient scale (FSCQ) (Warren & Neer, 1986). The FSCQ was designed as a diagnostic measure of family orientation toward sexual communication, with a focus on communication between parents and children. The instrument consists of 18 Likert-like items anchored from "strongly agree" to "strongly disagree." Three dimensions, each consisting of six items, are included: communication comfort, communication information, and value of communication. The communication comfort dimension measures the perceived degree of openness with which sex is discussed in the family (e.g., "I feel free to ask my parents questions about sex."). The information dimension measures perception of the amount of sexual information learned and shared during family discussions (e.g., "My parents have given me very little information about sex."). The value dimension measures the perceived overall importance of the family role in sexual learning (e.g., "The home should be a primary place for learning about sex."). All items yield significant correlations with the summed FSCQ score, and dimension-to-total correlations provided strong evidence (.82-.93) for the internal consistency of the FSCQ with all three dimensions. Reliability and validity studies are limited, but after comparing the instrument with similar

self-report information, the authors conclude the FSCQ is a highly reliable instrument to measure orientation to family sex communication.

Subjects in this study were asked how often (rarely/never to very often) they talked with each of their parents or step-parents about human sexuality. They were also asked to rate their comfortability about talking with each parent about sexuality (e.g., "I feel comfortable talking with my mother about sexuality.") on a five-choice Likert scale from strongly disagree to strongly agree.

Delinquency and Sexual Offense Self-Report. Subjects were provided a list of several categories of delinquent acts and sexual offenses, and were asked to indicate whether they had committed an offense from each category and whether they had been held by the police or convicted for any offense from a particular category. The seven categories included: violent offenses against persons; property offenses; nonviolent offenses against persons; general sex offenses; child molestation; offenses against public order and drug abuse violations; and status offenses.

Demographic Variables. The following demographic factors were included: age and race of participants; family income; and parental employment status, occupation, and educational level. These were assessed by using standard

fact sheet items.

Procedure

A paper-and-pencil self-report survey was administered to adolescent participants by a research investigator or treatment professional. Programs/facilities participating in the study signed a statement of participation, indicating their understanding of the purpose and procedures of the study. Parents/guardians/custodians gave their written permission and informed consent for the youth in their charge to participate in the study. Questionnaires were coded to match the youth with appropriate parental permission forms. Youth were given information about the study and the use of the results prior to completion of the questionnaire, and were asked not to write their name on the questionnaire. Completion of the survey was understood to imply participants' informed consent.

Participants were asked to report their perception of their family and environmental conditions at the time of their offense or when their treatment began. Confidentiality was protected, as respondents placed their survey in an envelope and sealed it upon completion. When treatment professionals administered the survey, all surveys were placed in a sealed envelope and sent to the researcher. Research investigators administering the survey placed all

surveys in a common envelope and transported the surveys to the research site.

Results

Instrument Validation

Table 1 (p. 33) presents the alpha reliability coefficients for subscales of each of the instruments used in this study (i.e., Family Adaptability and Cohesion Evaluation Scales, Cohesion subscale of the Family Environment Scale, Parent-Adolescent Communication Scale and the Family Sex Communication Quotient). As can be seen, the alpha coefficient was at least .74 for all subscales, with the exception of the adaptability subscale of the FACES-III, which was .64, an acceptable level. The reported internal consistency for this subscale is normally .62; it will be retained here in the interest of continuity and theoretical consistency with previous research. Thus, the instruments were shown to be internally consistent with this sample.

Demographic Factors

Analyses of Variance (ANOVAs) were executed among the three groups on demographic factors. There was a significant difference in age among the three groups ($F = 6.41$, $df = 2$, $p = .002$); mean age for the ASO group was 15.39, whereas mean age for violent and non-violent juvenile delinquents was 16.16 and 16.34, respectively. Results from

Table 1: Means, Ranges, Standard Deviations and Reliability Coefficients for Instruments in Study.

Instrument	Mean	Range	SD	N	Alpha
Family Adaptability and Cohesion Evaluation Scales-III:					
Adaptability	23.66	10-41	6.14	101	.64[1]
Cohesion	26.87	10-44	8.70	101	.86
Family Environment Scale:					
Cohesion	4.41	0-9	2.88	97	.82
Parent-Adolescent Communication Scale:					
Open Communication:					
Mother	32.30	14-50	9.38	98	.91
Father	28.56	10-50	10.44	86	.94
Problems in Communication:					
Mother	28.44	16-48	7.26	98	.78
Father	27.80	16-46	7.13	86	.77
Total Communication:					
Mother	60.73	35-98	15.29	98	.91
Father	56.36	26-96	16.32	86	.92
Family Sex Communication Quotient:					
Comfort	16.56	6-30	5.48	98	.87
Information	16.28	6-30	4.39	98	.74
Value	18.06	6-30	4.80	98	.79
Total	50.90	19-86	12.49	98	.90

[1]Though internal consistency reliability coefficient is marginal, it is consistent with large representative samples and the scale is being retained in this study in the interest of continuity and theoretical consistency with previous research.

a chi-square analysis demonstrated that there were no significant differences in race among the three groups (73% white, 16% black, 3% latino, 3% asian, 5% other for entire sample) (See Table 2, p. 35).

Participants came predominantly from the Washington, D.C. metropolitan area. Level of family income differed significantly between the three groups ($F = 4.44$, $df = 2$, $p = .01$). Mean family income was $38,400, $41,000 and $52,000 for ASOs, violent juvenile delinquents and non-violent delinquents, respectively (see Table 10, Appendix J). The majority of fathers (74%) and mothers (71%) were employed full-time, with no significant differences between groups. Mothers most frequently worked in service occupations (33%) or in technical or clerical work (32%). Fathers worked primarily in service or military occupations (26%) and in administration, engineering or scientific endeavors (19%). There were no significant differences between the groups for parents' occupation (see Table 11, Appendix J).

In addition, there were no statistically significant differences between the groups in education level of either mothers (Chi-sq. = 14.4, $df = 8$, $p = .07$) or fathers (Chi-sq. = 8.2, $df = 8$, $p = .41$). Though not statistically significant, an apparently higher proportion of mothers of both violent and non-violent delinquents pursued education

Table 2: Demographic Characteristics of Sample: Age, Race, Income.

Variable	ASO n=39	VJD n=25	NVJD n=41	Total n=105
Juvenile:				
Age:				
Mean	15.39	16.16	16.34	15.94
Race:				
White	69.2%	72.0%	78.0%	73.3%
Black	20.5%	16.0%	12.2%	16.2%
Latino	7.7%	-	-	2.9%
Asian	-	-	7.3%	2.9%
Other	2.6%	12.0%	2.4%	4.8%
				(χ^2 = 14.4)
Family Income:				
Mean:	$38,400	$41,000	$52,000	$44,900

Chi-square is not significant.
ASO = Adolescent Sex Offender
VJD = Violent Juvenile Delinquent
NVJD = Non-violent Juvenile Delinquent
Note: Percentages do not total 100% due to missing values.

beyond high school. Only 37% of ASOs' mothers continued education beyond high school, whereas nearly 70% of mothers of violent and non-violent delinquents furthered their education beyond high school. Fathers of non-violent delinquents were twice as likely as fathers of ASOs to have attained a college degree and almost five times as likely to have completed a graduate degree. See Table 3 (p. 37) for details of parental demographic characteristics.

In summary, ASOs were slightly younger than both violent and non-violent delinquents, but there were no significant differences in race, parental employment, parents' occupation, or in the educational level of mothers or fathers. Non-violent delinquents in this study tended to come from families with higher incomes.

Family Structure

It was hypothesized that ASOs would report living with both natural parents more often than either violent or non-violent delinquents at the time of offense and during most of their lives. A chi-square statistic was computed. This hypothesis was not supported. At the time of offense, 21.1% of ASOs lived with both natural parents, compared to 41.7% of violent delinquents and 36.6% of non-violent delinquents. During most of their lives, 38.5% of ASOs lived with both natural parents, while 54.2% of violent and 51.2% of non-

Table 3: Demographic Characteristics of Sample: Parents' Employment Status and Educational Level.

Variable	ASO n=39	VJD n=25	NVJD n=41	Total n=105
Employment Status:				
Mother:				
Full-time	66.7%	64.0%	78.0%	70.5%
Part-time	5.1%	16.0%	7.3%	8.6%
Unemployed	20.5%	8.0%	7.3%	12.4%
Retired/ Disabled	5.1%	-.-	4.9%	3.8% (χ^2=12.5)
Father:				
Full-time	71.8%	84.0%	70.7%	74.3%
Part-time	2.6%	-.-	4.9%	2.9%
Unemployed	7.7%	4.0%	4.9%	5.7%
Retired/ Disabled	7.7%	-.-	7.3%	5.7% (χ^2=4.1)
Highest Educational Level:				
Mother:				
H.S./GED	62.9%	30.3%	30.8%	42.3%
Vo-Tech/ Some College	20.0%	26.1%	41.0%	39.9%
College Deg.	8.6%	30.4%	12.8%	15.5%
College+	8.6%	13.0%	15.5%	12.4% (χ^2=14.4)
Father:				
H.S./GED	45.1%	36.4%	25.0%	34.9%
Vo-Tech/ Some College	19.1%	31.8%	30.5%	28.1%
College Deg.	12.9%	18.2%	13.9%	18.0%
College+	6.5%	4.5%	-.-	3.4%
Grad Deg.	6.5%	9.1%	27.7%	15.8% (χ^2=8.2)

None were significant.

Note: a) Some percentages do not equal 100% due to missing values.

b) Unemployed is understood to mean not employed outside the home.

violent delinquents did so. There were no statistically significant differences among the groups regarding living arrangement at the time of offense or most of the adolescent's life (see Table 4, p. 39).

A chi-square analysis resulted in no significant differences in birth order between the three study groups, as was hypothesized. ASOs were the oldest or only child in 63.2% of the cases, the middle child in 21.1%, and the youngest in 15.8%. Violent delinquents were oldest children 32% of the time, middle children 32%, and youngest children 36% of the time. For non-violent delinquents, the percentages were 51.2%, 24.4%, and 24.4%, respectively (see Table 4, p. 39 & Fig. 2, p. 40).

It was expected that the sibling subsystem for all three groups would be characterized by more boys than girls. Utilizing a chi-square analysis, this hypothesis was not supported. There were more male siblings and step-siblings in 38.5% of ASOs' families, 36% of violent delinquents' families, and in 46.3% of non-violent delinquents' families (see Table 4 & Fig. 3, p. 41). There were no significant differences in sibling gender configuration for the three study groups.

ASOs' families were predicted to be larger than families of either violent or non-violent delinquents. An

Table 4: Percentages of Offenders for Living Arrangement, Birth Order, and Sibling Gender Configuration.

Variable	ASO n=39	VJD n=25	NVJD n=41	Chi-square
Living Arrangement:				
Time of Offense:				
Both Natural Parents	21.1%	41.7%	36.6%	
Other	78.9%	58.3%	63.4%	3.52
Most of Life:				
Both Natural Parents	38.5%	54.2%	51.2%	
Other	61.5%	45.8%	48.8%	1.93
Change in Living Arrangement:				
Chi-square	4.89*	1.52	3.51	
Birth Order:				
Oldest	63.2%	32.0%	51.2%	
Middle	21.1%	32.0%	24.4%	
Youngest	15.8%	36.0%	24.4%	6.17
Sibling Gender Configuration:				
More Boys	38.5%	36.0%	46.3%	
More Girls	33.3%	24.0%	34.1%	
Boys=Girls	28.2%	40.0%	19.5%	3.44

*p < .05.
ASO=Adolescent Sex Offender; VJD=Violent Juvenile Delinquent; NVJD=Non-violent Juvenile Delinquent.
Note: Change in living arrangement was calculated by using living arrangement most of life as the expected proportions and comparing these to proportions for living arrangement at time of offense.

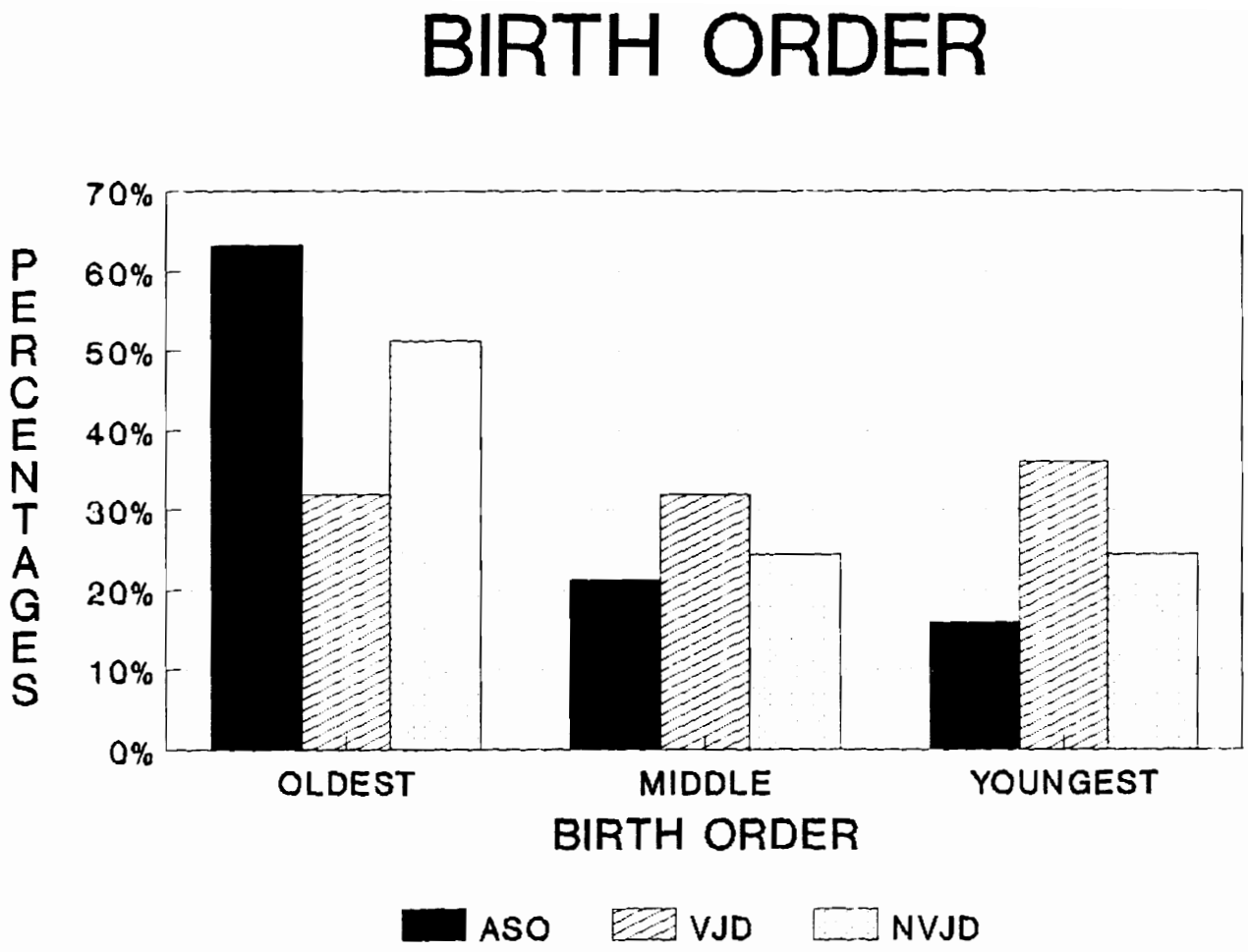


Figure 2: BIRTH ORDER PERCENTAGES

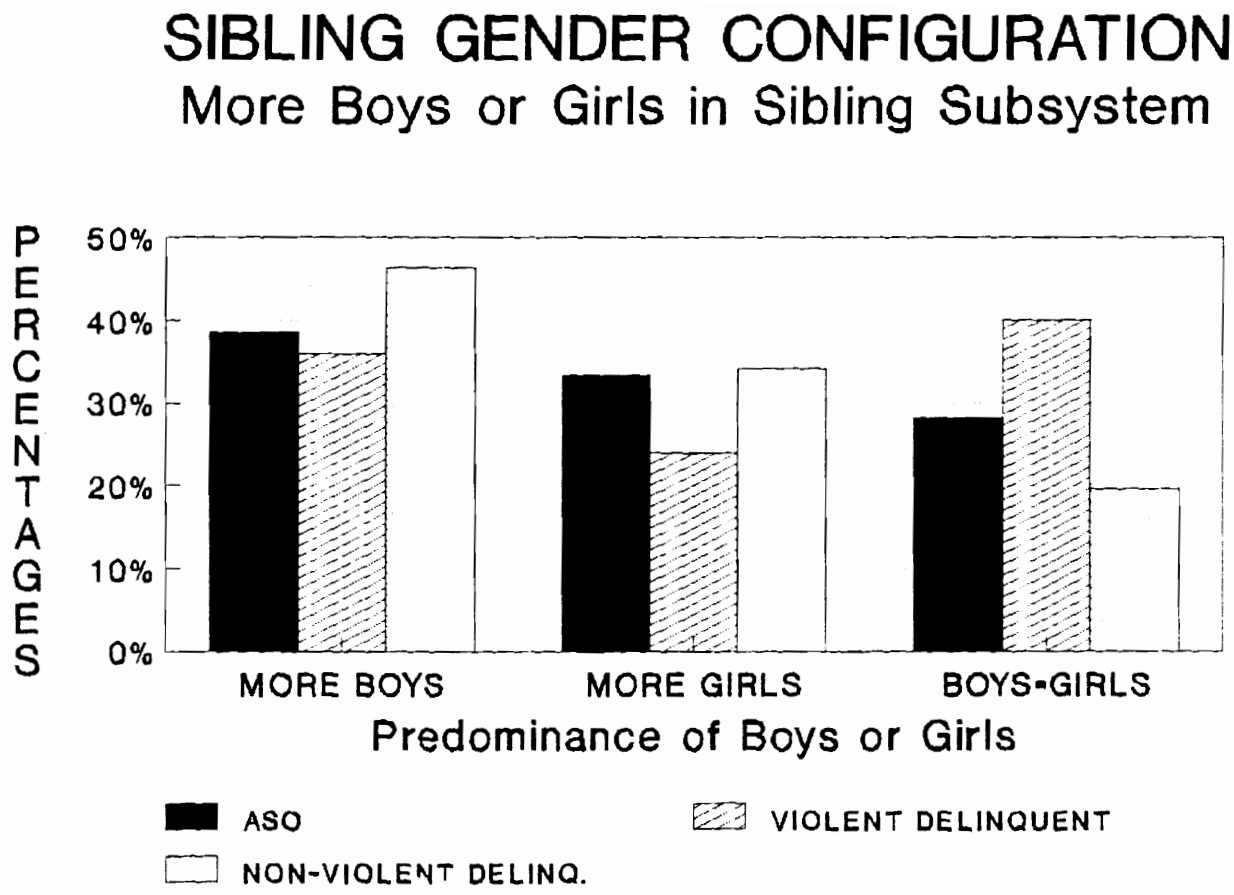


Figure 3: SIBLING GENDER CONFIGURATION

(Note: Siblings = Sibs + Step-sibs)

ANOVA was performed, resulting in no significant differences in family size among the three groups (see Table 5, p. 43). Means (i.e., total number of siblings and step-siblings) for ASOs, violent delinquents, and non-violent delinquents were 2.87, 2.52, and 2.39, respectively.

Adaptability and Cohesion

ANOVAs were performed for measures of adaptability and cohesion (see Table 5, p. 43). It was hypothesized that ASOs would differ from violent and non-violent juvenile delinquents and from non-problem adolescents on measures of family adaptability and cohesion. The hypothesis was not supported for adaptability, as measured by FACES-III (i.e., the ability of a family system to change its power structure, role relationships and relationship rules in response to situational and developmental stress), but it was supported ($F = 87.76$, $df = 3$, $p < .001$) for cohesion, as defined for FACES-III (i.e., the emotional bonding that family members have toward one another). ASOs perceived their families as having higher levels of emotional bonding among family members ($M = 30.08$) than did either violent ($M = 24.96$) or non-violent ($M = 25.05$) delinquents. Non-problem families ($M = 37.10$) were perceived as being significantly more cohesive than ASOs, violent delinquents, and non-violent juvenile delinquents.

Table 5: ANOVAs for Study Samples and Normed Scores for Family Size, Adaptability and Cohesion and Parent-Child Communication.

Variable	ASO	VJD	NVJD	Norms	F-ratio
	Mean	Mean	Mean	Mean	F
Family Size	(n=39) 2.87	(n=25) 2.52	(n=41) 2.39	NA	.56
FACES-III:	(n=37)	(n=24)	(n=40)	(n=1315)	
Adaptability	23.76	24.54	23.05	24.30	.44
Cohesion	30.08	24.96	25.05	37.10	87.76**
FES:	(n=35)	(n=24)	(n=38)	(n=446)	
Cohesion	4.94	3.67	4.39	6.09	16.18*
PAC:					
Open Communication:	(n=36[a]) (n=32[b])	(n=22[a]) (n=21[b])	(n=40[a]) (n=33[b])	(n=417)	
Mother	33.69	31.18	31.65	NA	.65
Father	28.97	29.86	27.33	NA	.41
Problems in Communication:					
Mother	27.44	28.82	29.13	NA	.54
Father	26.31	29.62	28.09	NA	1.42
Total Score:					
Mother	61.14	60.00	60.78	66.56	5.52**
Father	55.28	59.48	55.42	63.74	8.38**

*p < .05; **p < .001.
[a] for Mother PAC scores; [b] for Father PAC scores.
Note: Norms for FACES-III are for parents & adolescents combined.

The FACES-III manual (Olson et al., 1985) provides cutoff scores for levels of adaptability and cohesion. Chaotic families (very high adaptability) are characterized as possessing unclear leadership, very lenient discipline, endless negotiation and poor problem-solving skills, and dramatic rule and role shifts. Rigid families (very low adaptability) are characterized by authoritarian leadership, limited negotiation and poor problem solving, and many strict rules. See Table 6 (p. 45) for the full range of levels for both adaptability and cohesion. Disengaged families (very low cohesion) are typified by low emotional bonding, closed internal boundaries, rigid generational boundaries, and a general sense of separateness. In contrast, enmeshed families (very high cohesion) are characterized by high emotional bonding, high dependence among family members, closed external and open internal boundaries, parent-child coalitions and a general sense of oneness. Scores at either extreme are considered to be indicative of unhealthy family functioning.

The mean scores for adaptability (i.e., ASO = 23.76, violent = 24.54, nonviolent = 23.05) all fall within the structured level (see Table 6, p. 45), considered moderate (toward the rigid level), and within the range for healthy family functioning. See Figure 4 (p. 46) for a portrayal of

Table 6: Percentages of Offenders and Normed Scores for the Sixteen Family Types of the Circumplex Model.

Low----------COHESION----------High

FAMILY TYPE	DISENGAGED n	%	SEPARATED n	%	CONNECTED n	%	ENMESHED n	%
CHAOTIC	A-4	10.8%	A-2	5.4%	A--	---	A-1	2.7%
	V-2	8.3%	V-1	4.2%	V--	---	V--	---
	N-3	7.5%	N-1	2.5%	N-1	2.5%	N--	---
	Norm	3.0%	Norm	3.3%	Norm	4.8%	Norm	2.7%
FLEXIBLE	A-3	8.1%	A-2	5.4%	A-4	10.8%	A--	---
	V-8	33.3%	V--	---	V-2	8.3%	V--	---
	N-10	25.0%	N--	---	N-1	2.5%	N--	---
	Norm	5.1%	Norm	9.9%	Norm	12.6%	Norm	5.3%
STRUC-TURED	A-6	16.2%	A-4	10.8%	A-2	5.4%	A--	---
	V-3	12.5%	V-3	12.5%	V--	---	V--	---
	N-8	20.0%	N-3	7.5%	N-2	5.0%	N--	---
	Norm	3.8%	Norm	11.3%	Norm	14.7%	Norm	4.9%
RIGID	A-7	18.9%	A-1	2.7%	A-1	2.7%	A--	---
	V-5	20.8%	V--	---	V--	---	V--	---
	N-11	27.5%	N--	---	N--	---	N--	---
	Norm	3.8%	Norm	6.0%	Norm	4.3%	Norm	1.8%

High | ADAPTABILITY | Low

A = Adolescent Sex Offender (n=37).
V = Violent Juvenile Delinquent (n=24).
N = Non-violent Juvenile Delinquent (n=40).
Note: Norm indicates results from non-problem families (n= 1,315); norm scores are combination of adolescent and parent scores, while other scores are only adolescent scores.
χ^2 = 213.06, $p < .0001$. (Some cells have frequencies less than five, making the chi-square statistic questionable.)

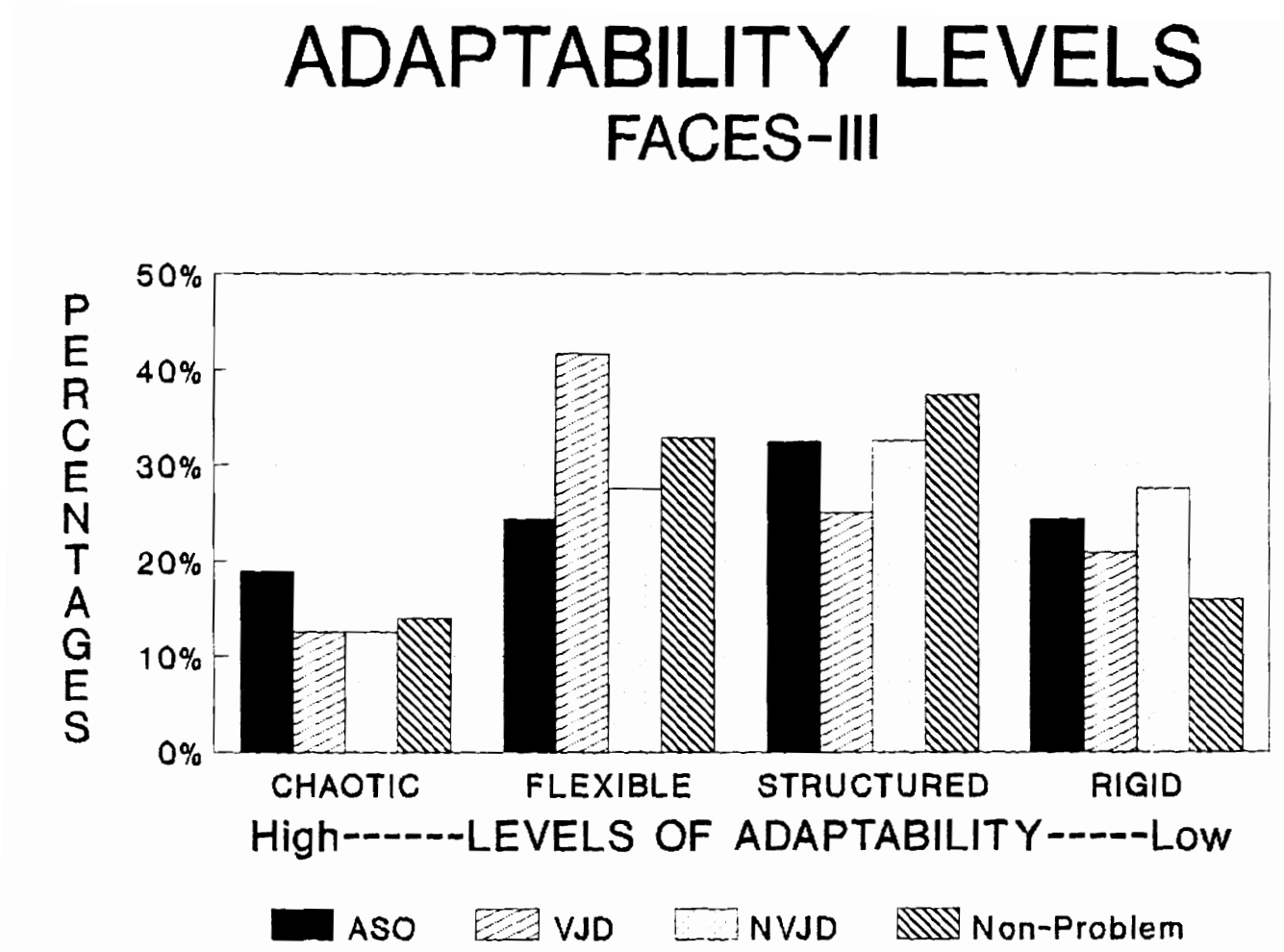


Figure 4: FACES-III ADAPTABILITY LEVELS

the distributions among the various levels of adaptability. While the mean scores of the four groups differed significantly on levels of cohesion (see above), all the scores fall within the disengaged level, indicating that adolescents in all three groups perceived their families as having low emotional bonding, closed internal boundaries, rigid generational boundaries and a general sense of separateness. The ASOs see their families as more cohesive, but still as disengaged, the extreme low level of cohesion. Figure 5 (p. 48) shows the percentages of study samples and non-problem adolescents for the levels of cohesion.

Cohesion and adaptability types represent the two dimensions of the Circumplex Model. Using the cutoff points provided in the FACES-III manual (Olson et al., 1985), 16 family types are created. Table 6 (p. 45) provides a matrix of the 16 types with percentages listed for each of the groups in this study and for non-problem adolescent families. It should be noted that scores for this current study represent the adolescent's perception of his family, whereas the non-problem family norms are a combination of parents' and adolescent's perceptions. This will be discussed later. The percentages of family types for the samples in this current study differed significantly from

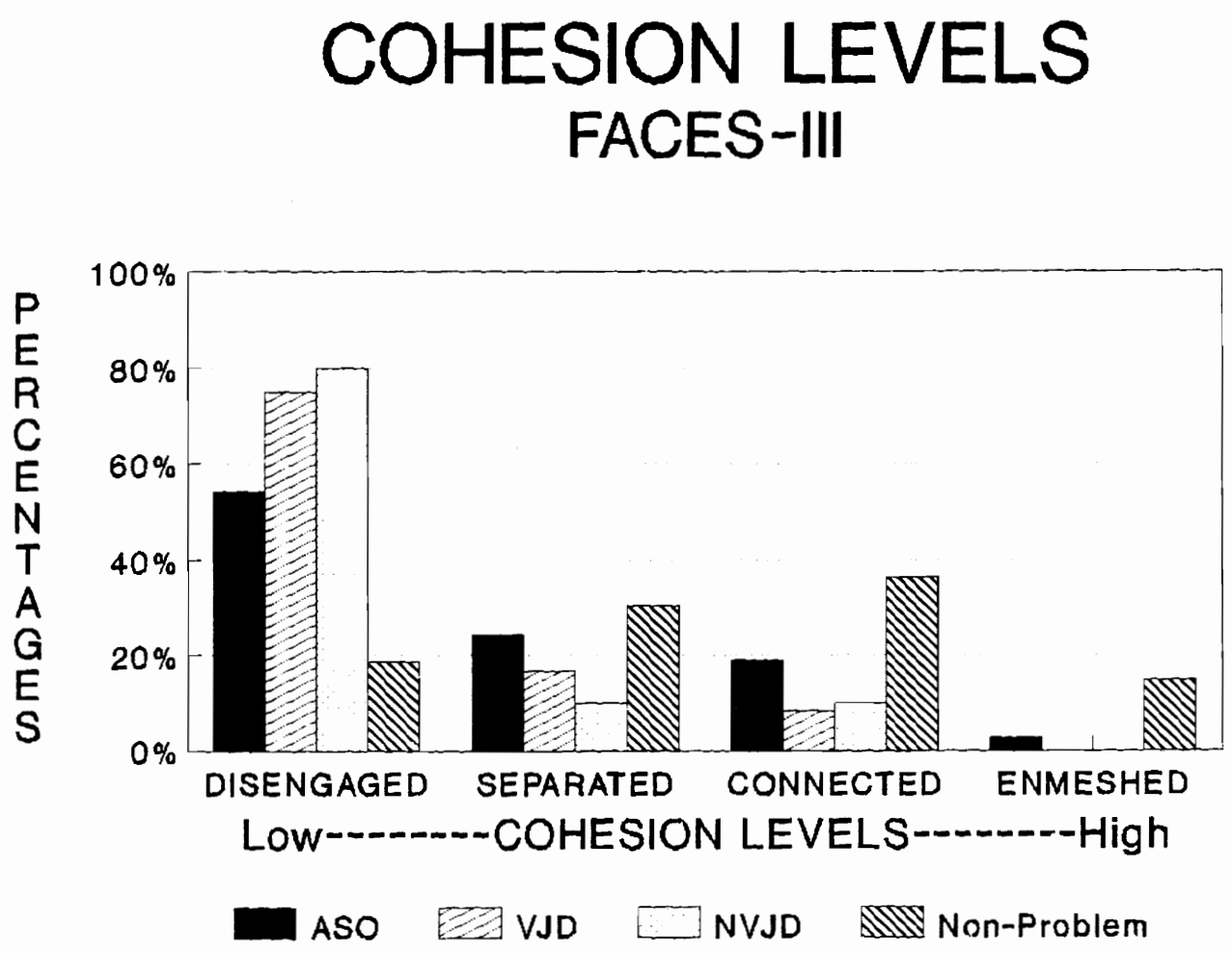


Figure 5: FACES-III COHESION LEVELS

the percentages of the 16 family types for non-problem families (Chi-sq. = 213.06, df = 3, $p < .0001$).

The 16 family types of the Circumplex Model are collapsed into three general types: balanced, midrange and extreme (Olson et al., 1985). Balanced families are those whose scores for both adaptability and cohesion fall with the moderate ranges. Scores extreme on one dimension and moderate on the other are considered midrange. Extreme families score in the extreme ranges on both dimensions, and are depicted in the four corners of Table 6; these are considered to have the greatest pathology. Both balanced and midrange types indicate less family dysfunction than extreme types.

Based on scores for family adaptability and cohesion, it was anticipated that ASOs would classify their families as balanced, midrange and extreme in different proportions than violent delinquents, non-violent delinquents, or normal adolescents would classify their families. The observed frequencies for each family type for each of the groups in this study were compared to expected frequencies based on those observed in the non-problem families using the SPSSX CHISQUARE procedure and EXPECTED subcommand (SPSS Inc., 1988). Thus, for example, the expected proportions for balanced, midrange and extreme types are .485, .402 and

.113, respectively. Those observed for ASOs (.324, .351, and .324) differ significantly (Chi-sq. = 16.8, df = 2, $p < .001$) from expected proportions based on the non-problem sample data (see Table 7, p. 51 & Fig. 6, p. 52). Additionally, for both violent delinquents (Chi-sq. = 11.1, df = 2, $p = .004$) and non-violent delinquents (Chi-sq. = 30.1, df = 2, $p < .001$), the observed proportions for balance, midrange and extreme family types differed significantly from expected proportions.

To assess if there was a difference between study groups in proportions of balanced, midrange and extreme types (see percentages on Table 7, p. 51), a chi-square statistic was computed (Chi-sq. = 3.4, df = 4, $p = .41$), and no significant differences were found. Thus, for percentages of balanced, midrange and extreme family types, ASOs differed from non-problem families, but did not differ significantly from violent or non-violent juvenile delinquents.

Cohesion was also considered using Moos' (1986) definition: the degree of commitment, help, and support family members provide one another. It was proposed that ASOs would differ from violent delinquents, non-violent delinquents and from non-problem adolescents using this definition of cohesion. This hypothesis was supported for

Table 7: FACES-III Family Types (as percentages) for Study Families with Offenders and Non-Problem Families.

Family Type	ASO n=37	VJD n=24	NVJD n=40	NORMAL n=1,315
Balanced, Midrange and Extreme Types:				
Balanced	32.4%	20.8%	15.0%	48.5%
Midrange	35.1%	50.0%	50.0%	40.2%
Extreme	32.4% (χ^2 = 16.8*)	29.2% (χ^2 = 11.1**)	35.0% (χ^2 = 30.1*)	11.3%
Cohesion:				
Disengaged	54.1%	75.0%	80.0%	18.6%
Separated	24.3%	16.7%	10.0%	30.3%
Connected	18.9%	8.3%	10.0%	36.4%
Enmeshed	2.7 (χ^2 = 32.2*)	-- (χ^2 = 51.2*)	-- (χ^2 = 100.1*)	14.7%
Adaptability:				
Chaotic	18.9%	12.5%	12.5%	13.9%
Flexible	24.3%	41.7%	27.5%	32.9%
Structured	32.4%	25.0%	32.5%	37.3%
Rigid	24.3% (χ^2 = 3.4)	20.8% (χ^2 = 1.9)	27.5% (χ^2 = 4.0)	15.9%

Note: Univariate chi-square tests were used to compare the frequencies observed for each family type from the study sample groups with expected frequencies based on the non-problem sample and are reported in parentheses.
*$p < .001$; **$p < .005$.
ASO = Adolescent Sex Offender, VJD = Violent Juvenile Delinquent, NVJD = Non-violent Juvenile Delinquent.

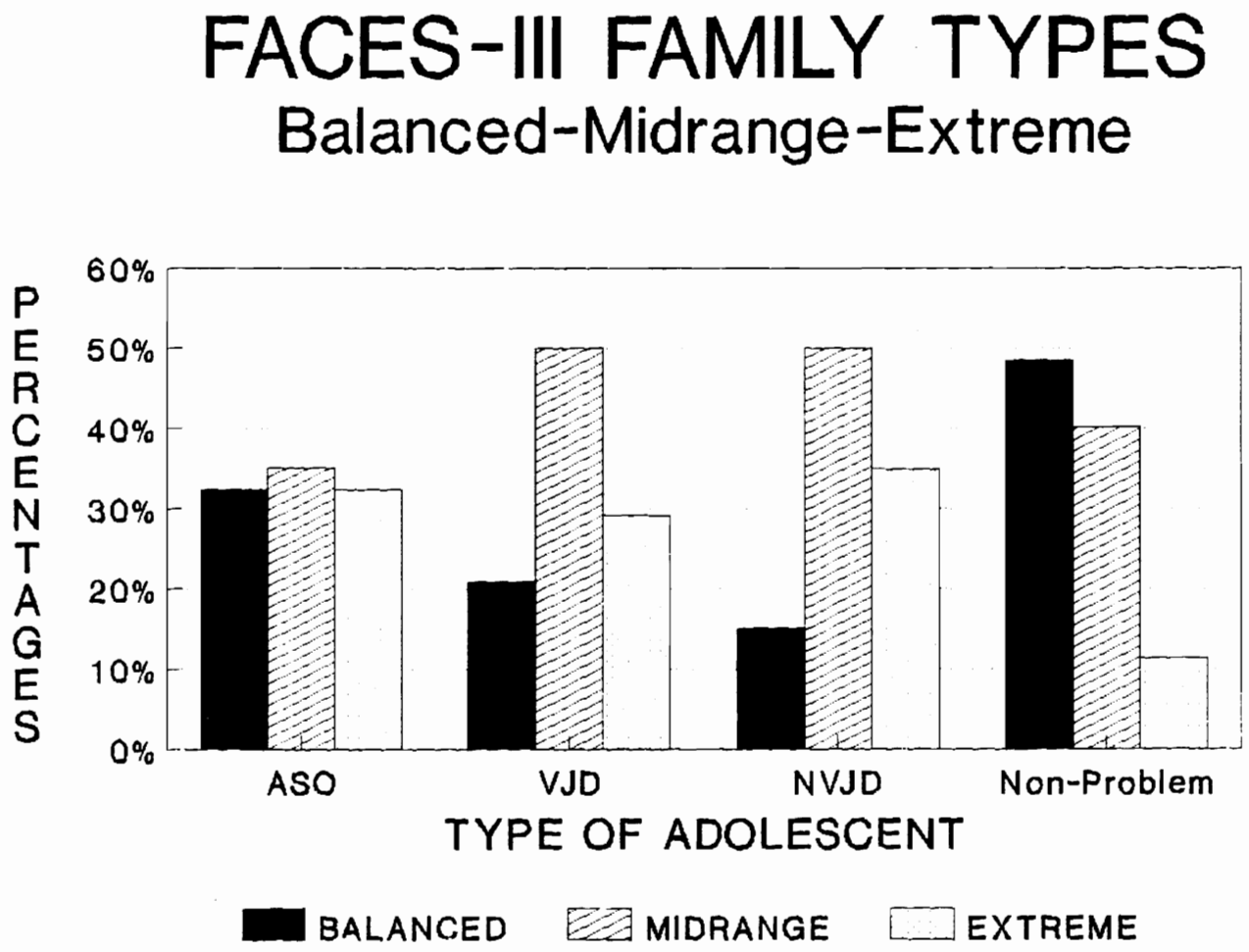


Figure 6:BALANCED-MIDRANGE-EXTREME TYPES

violent delinquents and normal adolescents. There was a significant difference ($F = 16.18$, $df = 3$, $p < .0001$) between ASOs ($M = 4.94$) and violent delinquents ($M = 3.67$); ASOs view their families as having a higher degree of commitment, help and support for one another than do violent delinquents. In addition, all three study groups scored significantly lower on this measure of cohesion than non-problem adolescents ($F = 16.18$, $df = 3$, $p < .01$). Therefore, while ASOs perceive their families as more helpful and supportive when compared to violent delinquents, ASOs view their families as less helpful and supportive compared to adolescents from non-problem families (see Table 5, p. 43 & Fig. 7, p. 54).

Parent-Child Communication

Assessing adolescent delinquents' communication with their fathers, it was predicted that ASOs would score qualitatively lower than violent and non-violent delinquents and non-problem adolescents on all measures of father-adolescent communication. Three aspects of communication were assessed: open communication (positive aspects), problems in communication (negative aspects), and overall quality of communication. Normative data was available only for overall quality of communication. ANOVAs were executed. ASOs and non-violent delinquents scored significantly lower

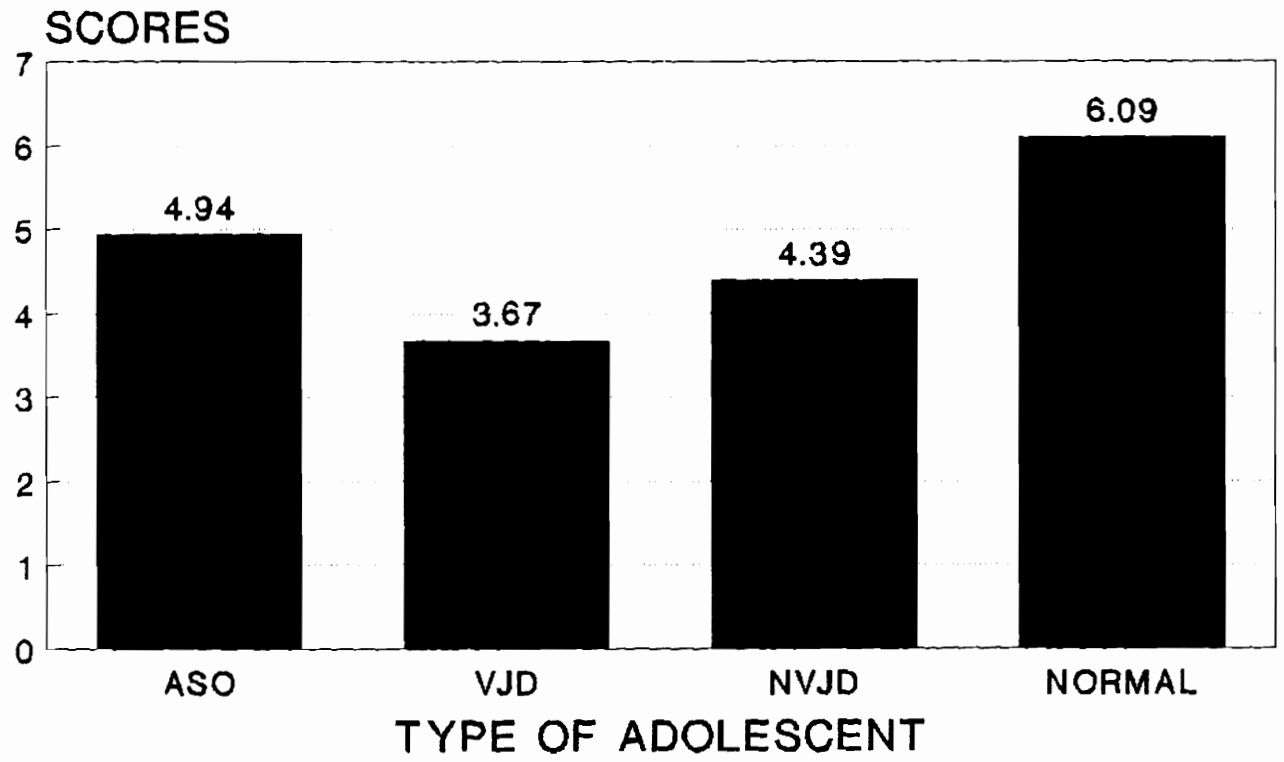


Figure 7: FES COHESION SCORES

($F = 16.18$, $p < .05$)

than non-offending adolescents on overall father-adolescent communication ($F = 8.38$, $df = 4$, $p < .01$). All three study sample groups also scored lower on overall communication with mothers when compared to non-problem adolescents ($F = 5.52$, $df = 3$, $p = .001$). No other differences between groups were found for measures of father-child communication (see Table 5, p. 43).

It was hypothesized that ASOs would report qualitatively better communication with their mothers than with their fathers on all three of the above aspects of communication. Utilizing paired t-tests, ASOs were found to score higher on measures of open communication ($t = 2.90$, $df = 31$, $p = .007$) and overall communication ($t = 2.18$, $df = 31$, $p = .04$) with their mothers than with their fathers, but there was no significant difference between ASOs' problems in communication with mothers and fathers (see Table 8, p. 56). In contrast, violent delinquents did not differ on any measures of communication between their mothers and fathers, and non-violent delinquents differed significantly only on the measure of open communication ($t = 2.24$, $df = 32$, $p = .03$) with their mothers and fathers (see Tables 12 & 13 in Appendix J). See also Figure 8 (p. 57) for the t-Test comparisons of overall communication with mothers and fathers for the offender groups and for non-problem youths.

Table 8: Paired t-Tests Comparing Adolescent Sex Offenders' Communication with Mothers and Fathers.

Type of Communication	Mean	t-Value
Open Communication Mother.....	33.84	2.90**
Open Communication Father.....	28.97	
Problems in Communication Mother...	27.47	.78
Problems in Communication Father...	26.31	
Overall Communication Mother.....	61.31	2.18*
Overall Communication Father.....	55.28	

n = 32
*p < .05; **p < .01.

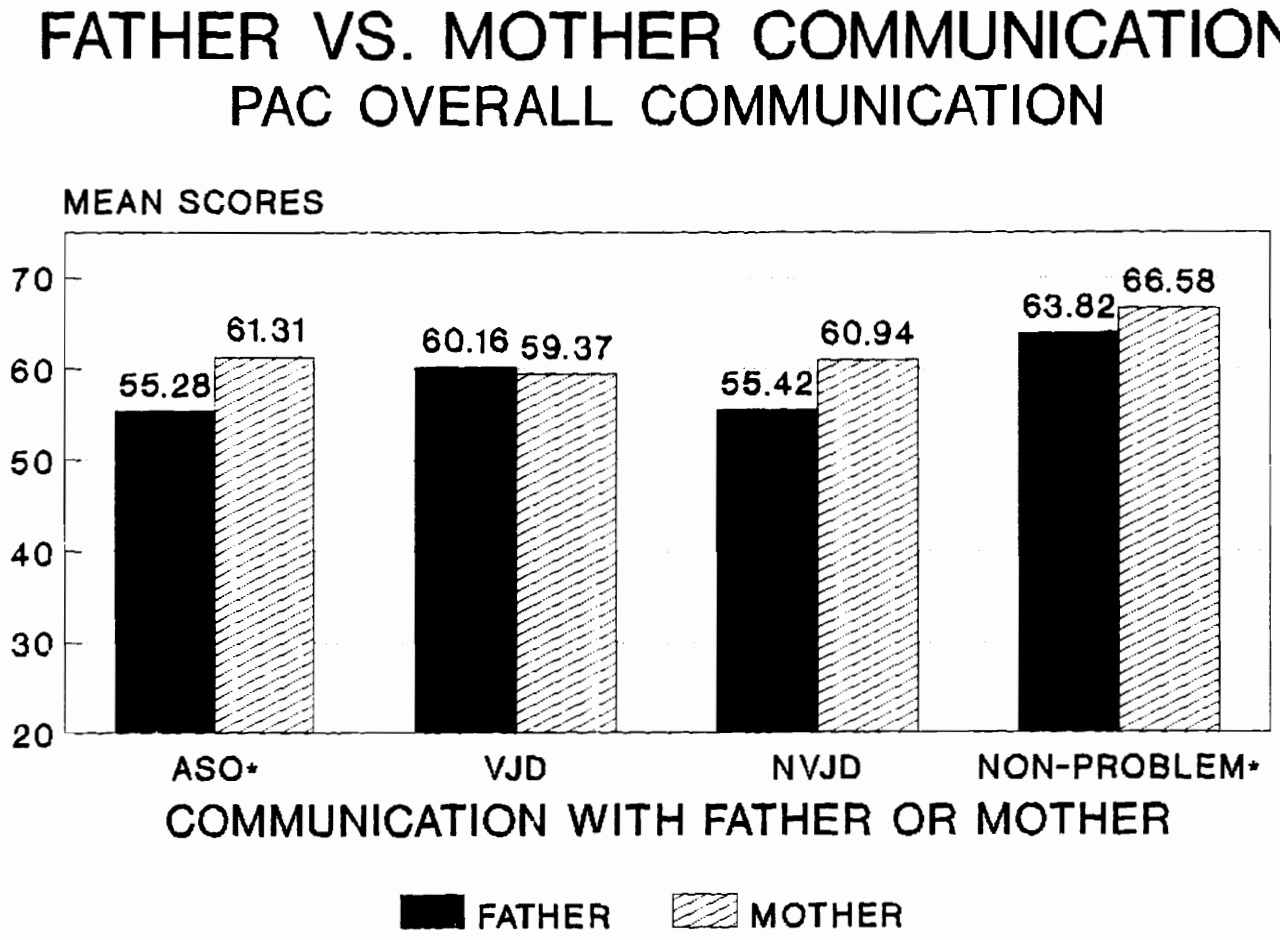


Figure 8: FATHER vs MOTHER COMMUNICATION

(*p < .05)

Parent-Child Communication about Sexuality

Given the nature of their offense, it was thought that ASOs would score lower than juvenile delinquents and normal adolescents on measures of communication with parents about sexuality. Using an ANOVA, ASOs were found to value the role of the family in sex education more highly than did non-violent juvenile delinquents ($F = 6.15$, $df = 2$, $p = .003$), but did not differ from violent delinquents. There were no significant differences regarding adolescents' comfort about sexual communication with parents or regarding the amount of information about sexuality obtained from parents (see Table 9, p. 59).

Normed data was available only for overall parent-child communication about sexuality. Using an ANOVA, significant differences between groups were found ($F = 3.41$, $df = 3$, $p = .02$). Surprisingly, ASOs, along with normal adolescents, scored higher than non-violent delinquents on overall communication about sexuality. Mean scores for ASOs (54.74) and normal adolescents (54.08) were very similar.

Participants were also asked to rate (from 1 to 5) their comfortability with and frequency of communication with each parent about sexual matters. The hypothesis that ASOs would report lower comfortability with and less frequency of communication about sexuality with parents was

Table 9: ANOVAs for Parent-Child Communication about Sexuality.

Variable	ASO	VJD	NVJD	Norms	F-ratio
Family Sex Communication Quotient:					
n	35	25	38	187	
Comfort	17.46	17.32	15.24	NA	1.85
Information	17.23	16.68	15.13	NA	2.28
Value	20.06	17.92	16.32	NA	6.15*
Total Score	54.74	51.92	46.68	54.08	3.41*
Frequency Sex Communication with Mother/Step-Mother:					
Mother:					
n	34	23	37	NA	
	2.44	2.13	1.95	NA	1.60
Step-Mother:					
n	12	6	7	NA	
	1.92	1.83	1.29	NA	.81
Frequency Sex Communication with Father/Step-Father:					
Father:					
n	32	21	32	NA	
	2.13	2.33	1.81	NA	1.26
Step-Father:					
n	11	5	11	NA	
	1.64	1.20	1.89	NA	.54
Comfortable Talking about Sex with Mother:					
n	35	25	38	NA	
	2.74	2.68	2.53	NA	.29
Comfortable Talking about Sex with Father:					
n	34	23	37	NA	
	2.59	2.91	2.59	NA	.57

Note: a) Frequency of sex communication was rated on a 1-5 scale, from "rarely/never" to "very often."
b) Comfortability talking about sexuality with parents was rated on a 1-5 scale from "strongly disagree" to "strongly agree."
*$p < .05$.

not supported. There were no significant differences between the groups on these measures. See Table 9 (p. 59) for a complete reporting of these results.

Discussion

Adolescent sexual offenders' perceptions of their families were compared with the perceptions of violent juvenile delinquents and non-violent juvenile delinquents. This data was compared with normative data for non-problem adolescents and their families when it was available. Variables considered included family structure, family adaptability and cohesion, parent-child communication with each parent and parent-child communication about sexuality. Hypotheses generally suggested that ASOs would differ from violent and non-violent delinquents and from non-problem adolescents, thus supporting recognition of ASOs as a distinct juvenile justice problem and clinical treatment population.

Family Structure

Family structural variables assessed in this study were: a) adolescents' living arrangement at the time of offense and during most of their lives; b) birth order; c) sibling gender configuration; and d) family size. None of these variables were significant in distinguishing the three groups of offenders.

ASOs were found to be no more likely to live with both natural parents than other delinquents. This is consistent with a matched-sample study of ASOs and other juvenile delinquents (Awad, et al., 1985) that found no difference in family intactness. The percentage of ASOs in this current study who lived with both natural parents at the time of offense (21%) was very similar to the percentage (23%) of outpatient ASOs who lived with both natural parents at the time of offense found by Smith and Monastersky (1987). Conversely, Fagan and Wexler (1988), in a sample of incarcerated violent offenders, found that ASOs more often lived with both natural parents. The ASOs in this current study were from both outpatient and residential programs. It may be important in future studies to control for outpatient or residential status when assessing family structure of ASOs and other delinquents.

Though there were no significant differences between groups for living arrangement at either the time of offense or during most of life, there was a significant change in living arrangement from most of the adolescent's life to the time of offense for ASOs. Using the CHISQUARE and EXPECTED subcommand mentioned above (SPSS, Inc., 1988), the adolescents' living arrangement most of their lives was used as the expected proportions (see Table 4, p. 39). These

expected proportions were compared with proportions of adolescents living with both natural parents and proportions living with other than both natural parents at the time of offense. ASOs were the only study group that evidenced a significant change (Chi-sq. = 4.9, df = 1, p = .03) in living arrangement from most of life to the time of offense (see Table 4); significantly fewer ASOs lived with both natural parents at the time of offense.

The meaning behind a change in living arrangement is unclear. One explanation is that such a change in residence could have resulted from prior unreported offenses that were dealt with internally by families' expelling the adolescent from the home. Subsequent offenses in other settings, perhaps, led to reporting and identification of the offender. Another explanation for the change in living arrangement may be that the family underwent some dramatic change, such as divorce of parents or the death of a parent. This suggests support of the broken home theory of delinquency (Wells & Rankin, 1985) for ASOs. Future studies could address the sequence of events that transpired to lead to a change in living arrangement to clarify whether a change in living arrangement preceded or followed the sexual offense.

This finding also seems to provide empirical support for some of the ASO family types proposed by Lankester and Meyer (1988). Based on clinical experience, they suggested that a change in the family structure and associated change in the adolescent's role in the family were influential in the etiology of some sexual offenses by adolescents. For example, the oldest male child may take on a peer-like role in the single mother family. The mother may look to her son for support and nurturance, and sometimes may covertly, or even overtly, rely on the adolescent for physical or sexual satisfaction. This role confusion and elevated status, they hypothesize, can result in the adolescent's sexually offending a younger sibling or other child.

Other types of ASO families associated with a change in family structure are: a) the remarried single parent family in which the parentified adolescent loses status as a new adult male becomes part of the family; and b) the blended family with a two-tier sibling subsystem in which the adolescent also loses status, and in addition, lives with younger step-siblings who, not being blood relatives, may be more vulnerable to sexual abuse by the adolescent. In both these types of families, Lankester and Meyer (1988) theorize, the sexual offense is a manifestation of the

adolescent's sexual role confusion and attempt to regain lost status in the family.

Overall for ASOs, the evidence of change in living arrangement from most of their lives to the time of offense may be a significant factor in the etiology of sexual offenses. This is consistent with traditional theories of juvenile delinquency (i.e., broken homes) and supports clinical experience with ASOs. It is not clear, though, exactly what happens in this process of adjusting to family structural change. Further, it would be helpful to identify differentiating factors between families in which a sexual offense occurs and those families who make the transition without significant incident. Qualitative studies may prove helpful in gaining a clearer understanding of the dynamics associated with a change in family structure and the impact of this change on the etiology of sexual offenses by adolescents.

This study found no difference in birth order between ASOs and other delinquents, thus supporting a similar finding (Awad et al., 1985) of no difference in birth order between matched samples of ASOs and other juvenile delinquents. While there was no statistically significant difference in birth order in this study, observed percentages should be noted. ASOs were the oldest children

in almost two-thirds of the cases, whereas about 1/2 of non-violent delinquents and only 1/3 of violent delinquents were oldest children. In the ASO family types mentioned above, Lankester and Meyer (1988) observed that the offender is often the oldest child, or at least the oldest male child. The high percentage of ASOs who were oldest children in this current study can be deemed as additional support for these etiological theories related to change in family structure.

No significant differences were identified in sibling gender configuration or family size. Families of ASOs were no more likely than families of other delinquents to be characterized by more boys in the sibling subsystem. The lack of a significant difference in family size in this current study is contradictory to Awad et al.'s (1985) finding that ASOs more often came from large families.

In general, family structure itself does not seem to be a significant differentiating factor for ASOs when compared with other delinquents. What may be more significant is a change in family structure or intactness and the processes associated with such changes. While a change in family structure may be related to sexual offending for some adolescents, other families of ASOs have remained intact, therefore other dynamics must also be at work.

Family Adaptability and Cohesion

Family adaptability did not distinguish among delinquents in this study, nor did it differentiate sample groups from non-problem adolescent families. There were significant differences in family cohesion (FACES-III), with ASOs perceiving their families as more cohesive compared to other delinquents, but less cohesive in contrast to non-problem adolescents. A second measure of family cohesion (FES) showed similar results. ASOs scored higher than violent delinquents on this measure of cohesion, and all delinquent groups in this study scored lower than non-problem adolescents.

There were no significant differences between the groups in this study or between the study samples and non-problem adolescent families in family adaptability (i.e., the ability of the family system to change its power structure, role relationships, and relationship rules in response to situational and developmental stress) (Olson et al., 1985). Mean scores for adaptability for all the samples in this study were in the moderate range, toward the rigid (i.e., low adaptability) level. This confirms findings by Bera (1985) that outpatient ASOs were very similar to non-problem adolescents in their perception of family adaptability. Yet, it is inconsistent with results

of an analysis of outpatient ASOs (Smith & Monastersky, 1987) which found that ASO families were more likely than the general population to be characterized as rigid in response to changes.

The proportions of ASOs' perceptions of their families among the various levels of adaptability (see Table 7, p. 51) are distributed similarly to those of non-problem adolescent families. This may be seen as support of previous claims that ASO families are a heterogeneous group, similar in some ways to non-problem families (Fagan & Wexler, 1988; Knopp, 1985; O'Brien, 1985).

ASOs perceived their families as more cohesive, that is, viewed their family members as more bonded emotionally to each other (Olson et al., 1985), than did violent or non-violent delinquents in this study. While mean scores for family cohesion were significantly different, all fell within the lowest level for cohesion (i.e., disengaged), which questions whether this statistical difference is actually meaningful. ASOs perceive their families as significantly less cohesive than do non-problem adolescent families. These findings support those found by Smith and Monastersky (1987), that ASOs' families are more likely than non-problem families to be emotionally disengaged. The preponderance of low family cohesiveness for ASO families in

this study conflicts with clinical impressions (Knopp, 1982) that many families of ASOs are enmeshed. Only one ASO in this study viewed his family as being enmeshed.

The lack of enmeshed ASO families could be attributed to two factors. One, only the adolescent's perception of his family was assessed in this study. Adolescents tend to view their family with greater negativism and tend to perceive their families as more disengaged (Olson et al., 1983). Normative data for the perceptions of adaptability and cohesion (FACES-III) for adolescents only is not available. Normed scores represent combined adolescents' and parents' perceptions. This may account for the preponderance of low family cohesion scores in the study sample. Interestingly, though, Smith and Monastersky (1987) surveyed both adolescents and parents using FACES-III and found that ASOs and their parents perceived their families very similarly. Similarity between adolescent and parent scores was significantly higher for ASO families than it was for families of non-sexual offending delinquents. Therefore, for ASO families, the adolescent's perception alone may be an accurate representation of the entire family's perception.

The second factor that could account for the discrepancy between clinical impressions and family members'

experience of their family is the vantage point, either from inside the family or as an outsider looking in (Olson, 1977). Clinical impressions are outsiders' perspectives; clinicians see many ASO families as enmeshed, with diffuse internal boundaries, and closed external boundaries (Knopp, 1982). These families rely on their family almost exclusively for support and are socially isolated. Family members, though, perceive their family from the inside, resulting in a different view. Hence, they see their family and the relationships therein as less cohesive and more separate. This explanation was also proposed to account for a similar discrepancy between the clinical literature (i.e., clinicians viewing families as enmeshed and overinvolved) and family perceptions (i.e., family members viewing themselves as disengaged) for adolescent substance abuse families (Volk et al., 1989).

Scores for family adaptability and cohesion were used to classify families as balanced, midrange and extreme family types (see Figure 1, p. 11) using cutoff points for FACES-III. Balanced families score in the moderate levels for both adaptability and cohesion. Midrange families score in the moderate level on one dimension. Families scoring in the extreme level on both dimensions are considered extreme, indicative of unhealthy family functioning. The proportions

of balanced, midrange and extreme family types for all three study groups differed significantly from those of non-problem families. There were no significant differences between ASOs, violent delinquents and non-violent delinquents. ASOs' perceptions of their families led to an even distribution of balanced, midrange and extreme families; each type of family accounted for approximately 1/3 of the ASO families in this sample. About 20% of violent delinquent families and only 15% of non-violent delinquent families were classified as balanced.

While the differences between the three groups of offenders was not statistically significant, there appears to be a more even distribution of ASO families classified among the three family types. This provides support for claims that ASOs and their families are not a homogeneous group (Bera, 1985; O'Brien, 1985), and that some types of ASO families are similar to non-problem families (Bera, 1985; Fagan & Wexler, 1988). The evidence of an even distribution among balanced, midrange and extreme family types challenges Knopp's (1982) assertion that families of ASOs are one of two extreme types, either very rigid and enmeshed or chaotic with much role confusion.

Parent-Child Communication

Parent-adolescent communication was assessed for communication with both mothers and fathers. Parent-adolescent communication had not been considered in previous studies about ASOs. Three aspects of communication were evaluated: open communication (positive aspects); problems in communication (negative aspects); and overall quality of communication. ASOs and non-violent delinquents scored significantly lower than non-problem adolescents on overall father-adolescent communication. All three groups scored lower on overall communication with mothers when compared to non-offending adolescents. Thus, there was little difference in parent-child communication between the three study groups, but all three groups scored lower than non-problem adolescents on the aspects of parent-child communication for which normed scores were available.

Clinical impressions suggest that ASOs generally have poor or non-existent relationships with their fathers, and tend to identify more with their mothers. Communication with mothers and with fathers was compared for ASOs. ASOs were found to score higher on measures of open communication and overall communication with their mothers than with their fathers, thus supporting clinical impressions. It should be noted, though, that non-problem adolescents also report a

greater degree of openness and higher overall quality of communication with their mothers (Barnes & Olson, 1985; Olson et al., 1983). Therefore, the difference between communication with mothers and fathers for ASOs is not necessarily specific to that population, but rather may be indicative of normal differences between adolescents' perception of communication with mothers and fathers. Other clinical impressions (Eddy, 1990) have suggested that ASOs have poor relationships with both mothers and fathers. Since ASOs scored significantly lower than non-problem adolescents on overall communication with both mothers and fathers, this finding may be viewed as empirical support for these (Eddy, 1990) impressions.

Parent-Child Communication about Sexuality

It was thought that ASOs would report significantly less communication about sexuality with parents than would other delinquents. Surprisingly, ASOs were found to value the importance of the role of the family in sexual learning more highly than did non-violent delinquents. Due to the higher score on this subscale, ASOs also scored higher than non-violent delinquents on the total score for family sex communication. There were no significant differences between groups in adolescents' ratings of the frequency of sex communication with mothers or fathers, or in ratings

about the comfortability of discussing sexuality with parents.

The finding that ASOs value the family's role in sex education more highly and the lack of expected differences in parent-child sex communication are likely to have been an effect of treatment. Participants in this study were all involved in treatment programs, and most of the ASOs were being treated in programs specifically designed for this population. The amount of time that the adolescent had been involved in treatment was not assessed, but it is known that many had been involved in treatment for several months, with one ASO having been in a secure setting for violent offenders for over four years. Sex education and family discussions about sexuality are included in many ASO treatment programs.

The aspect of family sex communication on which ASOs scored more highly is the value they place on the role of the family in sex education. This unexpected finding could also be due to the adolescents' recognition that they received an inadequate amount of information about sexuality from parents and that they desired much more. ASOs may be more aware of the need for parent-child sex communication, and their valuing more highly the role of the family may be an expression of a desire for more communication about

sexuality with parents.

Future studies should address how much information about sexuality is learned from parents and from other sources in different areas of sexuality for ASOs and other adolescents. This would help clarify the significance of the quantity and quality of family sex education in the etiology of sexual offenses by adolescents. There may be a considerable amount of overt and covert communication about sexuality in families of ASOs, yet this communication may be inappropriate and of a poor quality. It is recommended that evaluations of parent-child sex communication be conducted during initial assessment or treatment, so results are not biased by the effect of treatment.

Limitations

Participants in this study were voluntary and self-selected, and therefore are not necessarily representative of the delinquent populations included here. Parental/guardian permission first had to be obtained, and then adolescents decided if they would participate after learning what would be required. Participants came from programs/facilities that agreed to cooperate with the study. Non-sexual offending delinquents came primarily from four residential programs, and all but one was involved in a residential program. ASOs were closely divided between

outpatients and residents. Placement in residential care often comes only after other less restrictive alternatives have been exhausted, and frequently family dysfunction is a criterion for placement out of the home. Future studies should either include offenders from various levels of outpatient and residential treatment, or should control for placement setting.

Information in this study was obtained by adolescent retrospective self-report. Participants were asked to report on conditions at the time of their offense. In some cases, a long period of time had passed since the offense, inviting the possibility of treatment effect and inaccurate recall of prior family conditions. For a more accurate and complete perspective of family characteristics, information ideally should be obtained early in the assessment or screening process and should include the perceptions of several family members. It is recommended that family instruments be included in routine assessment, as families are frequently involved in treatment. A more comprehensive understanding of the family context would prove valuable in treatment planning and intervention design.

Detailed information about offenses and offense history was not obtained in this study. Future studies should attempt to differentiate family characteristics among

various types of ASOs. Indeed, Bera (1985) found little difference between families of ASOs and non-problem adolescent families in general, but significant differences emerged between various types of ASOs, classified according to offenses and offense patterns.

Following the classification system suggested by the Office of Juvenile Justice and Delinquency Prevention, forcible rape was classified in this study as a violent offense. Respondents indicated only whether they committed an offense from among various types of violent offenses. Therefore, it is not known which specific offense(s) was actually committed. Participants could have committed a forcible rape and have been classified as a violent delinquent instead of a sexual offender in this study. Therefore, there may be some overlap between the violent delinquent and sex offender classification. It is recommended that forcible rape be considered as a violent sexual offense and not simply a violent offense in future studies and in juvenile justice classifications.

A limitation mentioned above was the lack of normative data for the adolescent's perception for FACES-III. Comparisons of adolescents' perceptions for samples in this study and combined adolescent and parent scores for non-problem families may be questionable. Admittedly, it is

preferred to gather information from several family members when assessing family variables, yet this is not always possible, and was beyond the scope of this study. The reporting of separate family member's perceptions for normative data is suggested so accurate comparisons can be made when access is limited to individual family members.

Implications for Practice

The review and findings of this study have a number of implications for intervention with families of ASOs. ASOs' families are similar in many ways to families of violent and non-violent juvenile delinquents. All three offender groups differed more from non-problem adolescent families than they differed from each other. Even when there was a significant difference in mean scores for family cohesion (FACES-III), the means all fell within the same disengaged level of cohesion. Treatment approaches and family interventions proven effective with general juvenile delinquents are likely to be helpful with ASOs, too. Clinical literature and experience with general juvenile delinquents are more advanced and lessons learned with juvenile delinquents should be transferable to ASOs and their families.

While similar to delinquents' families in some ways, ASOs' families more closely approximated non-problem families in several areas. These areas included measures of

family cohesion, communication with mothers, differences between communication with mothers and fathers, value placed on family communication about sexuality and overall parent-child sex communication. These findings support some previous literature (Fagan & Wexler, 1988) that ASOs and their families are more similar to non-problem adolescents and their families than are other delinquents. This would indicate that families of ASOs have competencies that would be helpful for the clinician to notice, call attention to, and enhance in treatment.

Findings in this study support theories about the impact of a change in family structure and intactness as influential in the etiology of adolescent sexual offenses suggest that the change from one family structure to another is a potentially vulnerable time. Clinicians could devise interventions that would help single parents, often mothers, gain support and nurturance from other adults outside the family, so they will not depend on children for their needs. At the same time, fathers should be actively engaged in treatment, as a poor father-son relationship is common in families of ASOs. When fathers are unavailable or their whereabouts are unknown, also common, it is suggested that some other responsible adult male, such as an uncle or grandfather, be involved in treatment to help provide the

adolescent with a responsible male role model. Interventions could also be designed to help maintain the appropriate status of the oldest male sibling, especially in family transitional stages, and to aid parents in clarifying their children's roles.

Knowledge and theories about step-families and blended families, and the stages of their development may prove useful in understanding the dynamics involved in these significant family transitions. Prevention and educational programs aimed at divorced or remarried families could help to normalize typical family struggles and assist families through difficult transitional stages without experiencing serious negative incident.

The finding that most ASOs view their families as disengaged and few perceive their families as enmeshed can be beneficial to clinicians. Understanding the adolescent's perspective can be helpful in joining and creating strategies that fit with the adolescent's world view. Utilization of interventions designed to enhance emotional support and bonding among family members would seem appropriate for most ASO families.

While the adolescent views his family as disengaged from an insider perspective, the clinician can maintain an outsider perspective that may be helpful in hypothesizing

about the family system. The systemic belief that delinquent behavior may serve some positive function in the family system could be applied here. ASOs, who view their families as disengaged, may be attempting through their behavior to unite family members around some common cause. Another systemic hypothesis is that the ASO's offense is a misplaced attempt at "closeness" with other family members from whom he feels disengaged. Further, the offense could be seen as an effort to seek help for other unacknowledged problems that may be occurring in the family.

Support for the belief that ASOs and their families are a heterogeneous group was found in this study in the quite even distribution of balanced, midrange and extreme family types. This suggests that there are family strengths to be tapped and enhanced; some of these families are doing things well. Further, these findings challenge the assumption that all ASO families are alike, suggesting the clinician should keep an open mind in order to discover the uniqueness and nuances inherent in individual ASO families.

A final implication for practice is associated with the low parent-adolescent communication scores for ASOs when compared to non-problem families. This suggests that focusing on family relationships to improve communication may prove useful. Rather than attempt to treat the

adolescent individually, clinicians should direct efforts toward changing the ways ASOs and their parents relate to and communicate with one another. This may not be easy, as often poor communication patterns are exacerbated by the offense, the stigma attached to sexual offenses, and by involvement with an adversarial legal system.

Summary

Literature on the families of adolescent sexual offenders (ASOs) is sparse. Family structure, family adaptability and cohesion, parent-child communication, and family communication about sexuality were considered in an effort to identify family characteristics that distinguish families of ASOs from other non-sexual offending delinquents and from non-problem families. Family cohesion, comparison of communication with fathers and mothers, family sex communication, and a change in living arrangement distinguished ASOs from other delinquents. Several variables were significant in differentiating between families of offenders in this study and non-problem families. In addition, in several areas, ASOs' perceptions of their families more closely approximated non-problem families than did the family perceptions of other juvenile delinquents. Implications of the findings for clinical practice are discussed.

References

Abel, G., Mittleman, M., & Becker, J. (1984). Sexual offenders: Results of assessment and recommendations for treatment. Unpublished manuscript, available from NY State Psychiatric Institute, Sexual Behavior Clinic.

Ageton, S. S. (1983). Sexual assault among adolescents. Lexington, MA: Heath.

Alexander, S. J. (1984). Improving sex education programs for young adolescents: Parents' views. Family Relations, 33, 251-257.

Awad, G. A., Saunders, E., & Levene, J. (1985). A clinical study of male adolescent sexual offenders. International Journal of Offender Therapy and Comparative Criminology, 28, 105-115.

Barnes, H. L., & Olson, D. H. (1982). Parent-Adolescent Communication Scale. St. Paul, MN: Family Social Science, University of MN.

Becker, J. V., & Abel, G. G. (1985). Methodological and ethical issues in evaluating and treating adolescent sex offenders. In E. M. Otey & G. D. Ryan (Eds.), Adolescent sex offenders: Issues in research and treatment (pp. 109-129). Rockville, MD: USDHHS.

Becker, J. V., Cunningham-Rathner, J., & Kaplan, M. S. (1986). Adolescent sexual offenders: Demographics, criminal and sexual histories and recommendations for reducing future offenses. Journal of Interpersonal Violence, 1, 431-445.

Bera, W. H. (1985). A preliminary investigation of a typology of adolescent sex offenders and their family systems. Unpublished master's thesis, University of Minnesota.

Davis, G. E., & Leitenberg, H. (1987). Adolescent sex offenders. Psychological Bulletin, 101, 417-427.

Deisher, R. W., Wenet, G. A., Paperny, D. M., Clark, T. F., & Fehrenbach, P. A. (1982). Adolescent sexual offense behavior: The role of the physician. Journal of Adolescent Health Care, 2, 279-286.

Doshay, L. J. (1943). The boy sex offender and his later career. Montclair, NJ: Peterson Smith.

Eddy, D. (1990, March). Strategic therapy with juvenile sex offenders. Presentation at the Thirteenth Annual Family Therapy Network Symposium, Washington, DC.

Fagan, J., & Wexler, S. (1988). Explanations of sexual assault among violent delinquents. Journal of Adolescent Research, 3, 363-385.

Farnworth, M. (1984). Family structure, family attributes and delinquency in a sample of low-income, minority males and females. Journal of Youth and Adolescence, 13, 349-364.

Fehrenbach, P. A., Smith, W., Monastersky, C., & Deisher, R. W. (1986). Adolescent sexual offenders: Offender and offense characteristics. American Journal of Orthopsychiatry, 56, 225-233.

Freeman-Longo, R. E. (1985). The adolescent sexual offender: Background and research perspectives. In E. M. Otey & G. D. Ryan (Eds.), Adolescent sex offenders: Issues in research and treatment (pp. 130-146). Rockville, MD: USDHHS.

Galvin, K. M., & Brommel, B. J. (1986). Family communication: Cohesion and change (2nd ed.). Glenview, IL: Scott, Foreman.

Geismar, L. L., & Wood, K. M. (1986). Family and delinquency: Resocializing the young offender. New York: Human Sciences Press.

Groth, A. N. (1977). The adolescent sexual offender and his prey. International Journal of Offender Therapy and Comparative Criminology, 21, 249-254.

Groth, A. N., & Loredo, C. M. (1981). Juvenile sexual offenders: Guidelines for assessment. International Journal of Offender Therapy and Comparative Criminology, 25, 31-39.

Hains, A. A., Herrman, L. P., Baker, K. L., & Graber, S. (1986). The development of a psycho-educational group program for adolescent sex offenders. Journal of Offender Counseling, Services & Rehabilitation, 11, 63-76.

Handelsman, C. D., Cabral, R. J., & Weisfeld, G. E. (1987). Sources of sexual information and adolescent sexual knowledge and behavior. Journal of Adolescent Research, 2, 455-463.

Jones, M. B., Offord, D. R., & Abrams, N. (1980). Brothers, sisters and antisocial behavior. British Journal of Psychiatry, 136, 139-145.

Kaplan, M. S., Becker, J. V., & Cunningham-Rathner, J. (1988). Characteristics of parents of adolescent incest perpetrators: Preliminary findings. Journal of Family Violence, 3, 183-191.

Knopp, F. H. (1982). Remedial intervention in adolescent sex offenses: Nine program descriptions. Orwell, VT: Safer Society Press.

Knopp, F. H. (1985). Recent developments in the treatment of adolescent sex offenders. In E. M. Otey & G. D. Ryan (Eds.), Adolescent sex offenders: Issues in research and treatment (pp. 1-27). Rockville, MD: USDHHS.

Lankester, D., & Meyer, B. (1988). Sex gone wrong: Adolescent sex offenders and their families. Family Therapy Networker, 12, 43-45, 86-90.

LeFlore, L. (1988). Delinquent youths and family. Adolescence, 23, 629-642.

McGaha, J. E., & Fournier, D. G. (1988). Juvenile justice and the family: A systems approach to family assessment. Marriage and Family Review, 12, 155-172.

Monastersky, C., & Smith, W. (1985). Juvenile sexual offenders: A family systems paradigm. In E. M. Otey & G. D. Ryan (Eds.), Adolescent sex offenders: Issues in research and treatment (pp. 164-175). Rockville, MD: USDHHS.

Moos, R. H., & Moos, B. S. (1986). Family Environment Scale Manual (2nd ed.). Palo Alto, CA: Consulting Psychologists Press.

National Adolescent Perpetrator Network (1988). Preliminary report from the national task force on juvenile sexual offending, 1988. Juvenile and Family Court Journal, 39, 5-67.

O'Brien, M. (1985). Adolescent sexual offenders: An outpatient program's perspective on research directions. In E. M. Otey & G. D. Ryan (Eds.), Adolescent sex offenders: Issues in research and treatment (pp. 147-163). Rockville, MD: USDHHS.

Olson, D. H. (1976). Treating relationships. Lake Mills: Graphic Publishing.

Olson, D. H. (1977). Insiders' and outsiders' views of relationships: Research studies. In G. Levinger & H. L. Rausch (Eds.), Close relationships: Perspectives on the meaning of intimacy (pp. 115-136). Amherst, MA: University of Massachusetts Press.

Olson, D. H. (1986). Circumplex model VII: Validation studies and FACES III. Family Process, 25, 337-351.

Olson, D. H., McCubbin, H. I., Barnes, H. L., Larsen, A. S., Muxen, M. J., & Wilson, M. A. (1983). Families: What makes them work. Beverly Hills, CA: Sage Publications.

Olson, D. H., Portner, J., & Lavee, Y. (1985). FACES-III. St. Paul, MN: Family Social Science, University of MN.

Papini, D. R., Farmer, F. L., Clark, S. M., & Snell, W. E. (1988). An evaluation of adolescent patterns of sexual self-disclosure to parents and friends. Journal of Adolescent Research, 3, 387-401.

Pierce, L. H., & Pierce, R. L. (1987). Incestuous victimization by juvenile sex offenders. Journal of Family Violence, 2, 351-364.

Roosa, M. W. & Beals, J. (1990). Measurement issues in family assessment: The case of the family environment scale. Family Process, 29, 191-198.

Ryan, G. (1986). Annotated bibliography: Adolescent perpetrators of sexual molestation of children. Child Abuse and Neglect, 10, 125-131.

Satir, V. (1972). Peoplemaking. Palo Alto, CA: Science and Behavior Books.

Saunders, B. E., McClure, S. M., & Murphy, S. M. (1987, July). Structure, function, and symptoms in father-child sexual abuse families: A multilevel-multirespondent empirical assessment. Presented at the Family Violence Research Conference, Durham, NH.

Sefarbi, R. (1990). Admitters and deniers among adolescent sex offenders and their families: A preliminary study. American Journal of Orthopsychiatry, 60, 460-465.

Shoor, M., Speed, M. H., & Bartelt, C. (1966). Syndrome of the adolescent child molester. American Journal of Psychiatry, 122, 783-789.

Smith, W. R. & Monastersky, C. (1987). Strategies for studying the role of the family in the commission of sexual offenses by adolescents. Unpublished manuscript.

Smith, W. R., Monastersky, C., & Deisher, R. M. (1987). MMPI-based personality types among juvenile sexual offenders. Journal of Clinical Psychology, 43, 422-430.

SPSS, Inc. (1988). SPSS-X users guide (3rd ed.). Chicago, IL.

Thornburg, H. (1986). Adolescent delinquency and families. In G. K. Leigh & G. W. Peterson (Eds.), Adolescents in families (pp. 358-380). Cincinnati, OH: South-Western Publishing.

Tolan, P. H., Cromwell, R. E., & Brasswell, M. (1986). Family therapy with delinquents: A critical review of the literature. Family Process, 25, 619-650.

Van Ness, S. R. (1984). Rape as instrumental violence: A study of youth offenders. Journal of Offender Counseling, Services and Rehabilitation, 9, 161-170.

Volk, R. J., Edwards, D. W., Lewis, R. A., & Sprenkle, D. H. (1989). Family systems of adolescent substance abusers. Family Relations, 38, 266-272.

Walters, J., & Walters, L. H. (1983). The role of the family in sex education. Journal of Research and Development in Education, 16, 8-15.

Warren, C., & Neer, M. (1986). Family sex communication orientation. Journal of Applied Communication Research, 14, 86-107.

Wells, L. E., & Rankin, J. H. (1985). Broken homes and juvenile delinquency: An empirical review. Criminal Justice Abstracts, 17, 249-272.

Appendix A:

Extended Literature Review:

Family Environment and

History of Being Sexually Abused

Family Environment

Overall, family interactional style and the home environment are more direct indicators of the family's role in delinquency than are family structural variables (Geismar & Wood, 1986; LeFlore, 1988). Controlled studies of ASOs and their families are very limited to non-existent (Davis & Leitenberg, 1987). Clinical impressions abound, but little scientific research has been conducted to confirm or disclaim these impressions. This is especially true of research on the family environments of these adolescents, though there is conjecture on how family environment influences the commission of an offense (Davis & Leitenberg, 1987).

A few studies have addressed the question of whether these sexual offenders and their families differ from other juvenile delinquents who have committed non-sexual offenses, but these studies also are lacking in controls and generally fail to consider family dynamics. An early study (McCord, McCord & Verden, 1962) comparing sexually deviant adolescents (defined more by manner and sexual attitudes than by actual commission of an offense) and a normal control group found some significant differences in family environment. Families of sexually deviant adolescents were

characterized by having authoritarian and sexually repressed mothers who do not discuss sex, intense parental conflict, and harsh, physically punitive fathers.

Later uncontrolled research supported some of these findings. The evidence of unstable family backgrounds and a history of family violence or being physically abused and neglected are thought to be contributing factors in the etiology of sexual offenses by adolescents (Fehrenbach, Smith, Monastersky & Deisher, 1986).

Direct investigations of family environment or the characteristics of parents of ASOs have been very limited. One study (Kaplan, Becker, & Cunningham-Rathner, 1988) surveyed 27 parents of adolescent incest perpetrators and found these parents under-reported physical and sexual abuse of their sons, had a high incidence of being sexually abused themselves and a high rate of denial of their sons' offenses. These parents generally failed to educate their children about sex. The authors conclude this is but a first step in evaluating the family environment of ASOs and suggest that other family variables be examined in future research.

A few controlled studies have contrasted ASOs and non-sexual-offending juvenile delinquents, yet these did not include a normal sample. Forty-one percent of ASOs reported

a history of exposure to intrafamily violence or neglect, compared to only 15% of a matched group of juvenile delinquents (Van Ness, 1984). Lewis, Shankok and Pincus (1981) combined ASOs and violent, non-sexual offenders and compared them to non-violent, non-sexual juvenile delinquents. They found that ASOs and violent delinquents had been physically abused nearly three times as often as the comparison group and had observed family violence almost four times as often. They failed to compare ASOs and violent delinquents.

These two groups were compared, however, by Fagan and Wexler (1988) in a sample of chronic violent offenders of which ASOs comprised 14.1%. Through official records and face-to-face interviews it was found that ASOs: had fewer nonviolent offenses, but more often had been incarcerated; had lower self-reports of delinquency, fewer drug and alcohol problems and less often were gang members; had less justice system involvement by family members and friends; showed higher family incidence of spousal violence, child abuse and child molestation; were more sexually and socially isolated; held stronger beliefs in the law and external authorities, but had fewer internal behavior controls; and achieved higher success in school and at work. In general, the ASOs comprised a "hidden" population more closely

resembling normal populations than traditional delinquents on a variety of social factors and attitudinal variables.

LeFlore (1988) studied the perceived family environment of delinquents and non-delinquents and found non-delinquents to score most significantly higher in personal growth. The non-delinquent family environment also could be distinguished by a more positive perception of the family's moral-religious emphasis, and more achievement and active-recreational orientations. The delinquents perceived their family relationships as less cohesive and less expressive.

These studies are admittedly limited, but do suggest that ASOs differ from other juvenile delinquents. These youths, though, are often adjudicated in similar manners and frequently are placed together in treatment facilities where ASOs usually do not receive any offense-specific treatment (Davidson, 1987; Knopp, 1985b).

History of Being Sexually Abused

A history of being sexually abused has also been purported to be a major factor in the etiology of sexual offenses. It is clear, though, that not all ASOs report being sexually or physically abused, as estimates range from 17.9% (Becker, Cunningham-Rathner & Kaplan, 1986) to 47% (Longo, 1982) for sexual abuse and from 16.4% (Becker et al., 1986) to 25.8% (Seeherman & Brooks, 1987) for physical

maltreatment. Experts generally believe these figures are underestimates. O'Brien (1985) reports that the majority of the offenders treated at their nationally known facility have not been victimized, so other factors must be at work.

References

Becker, J. V., Cunningham-Rathner, J., & Kaplan, M. S. (1986). Adolescent sexual offenders: Demographics, criminal and sexual histories and recommendations for reducing future offenses. Journal of Interpersonal Violence, 1, 431-445.

Davidson, H. A. (1987). Improving the legal response to juvenile sex offenders. Children's Legal Rights Journal, 8, 15-20.

Davis, G. E., & Leitenberg, H. (1987). Adolescent sex offenders. Psychological Bulletin, 101, 417-427.

Fagan, J., & Wexler, S. (1988). Explanations of sexual assault among violent delinquents. Journal of Adolescent Research, 3, 363-385.

Fehrenbach, P. A., Smith, W., Monastersky, C., & Deisher, R. W. (1986). Adolescent sexual offenders: Offender and offense characteristics. American Journal of Orthopsychiatry, 56, 225-233.

Geismar, L. L., & Wood, K. M. (1986). Family and delinquency: Resocializing the young offender. New York: Human Sciences Press.

Lewis, D. O., Shankok, S., & Pincus, J. H. (1979). Juvenile male sexual assaulters. American Journal of Psychiatry, 136, 1194-1196.

Longo, R. E. (1982). Sexual learning and experience among adolescent sexual offenders. International Journal of Offender Therapy and Comparative Criminology, 26, 235-241.

Kaplan, M. S., Becker, J. V., & Cunningham-Rathner, J. (1988). Characteristics of parents of adolescent incest perpetrators: Preliminary findings. Journal of Family Violence, 3, 183-191.

Knopp, F. H. (1985). Recent developments in the treatment of adolescent sex offenders. In E. M. Otey & G. D. Ryan (Eds.), Adolescent sex offenders: Issues in research and treatment (pp. 1-27). Rockville, MD: USDHHS.

LeFlore, L. (1988). Delinquent youths and family. Adolescence, 23, 629-642.

McCord, W., McCord, J., & Verden, P. (1962). Family relationships and sexual deviance in lower-class adolescents. International Journal of Social Psychiatry, 8, 165-179.

Monastersky, C., & Smith, W. (1985). Juvenile sexual offenders: A family systems paradigm. In E. M. Otey & G. D. Ryan (Eds.), Adolescent sex offenders: Issues in research and treatment (pp. 164-175). Rockville, MD: USDHHS.

O'Brien, M. (1985). Adolescent sexual offenders: An outpatient program's perspective on research directions. In E. M. Otey & G. D. Ryan (Eds.), Adolescent sex offenders: Issues in research and treatment (pp. 147-163). Rockville, MD: USDHHS.

Seeherman, A. M. & Brooks, L. (1987). The juvenile sex offender in Massachusetts. Middlesex County, Cambridge, Mass: Office of the District Attorney.

Van Ness, S. R. (1984). Rape as instrumental violence: A study of youth offenders. Journal of Offender Counseling, Services and Rehabilitation, 9, 161-170.

Appendix B: Extended Literature Review:

Adolescent Sex Offenders:

Assessment and Treatment

This review will address the assessment and treatment of adolescent sexual offenders. Initial assessment issues will be raised, particularly those criteria that distinguish normal experimentation from sexual assault. Assessing the risk to the community and deciding whether residential placement is called for will also be addressed.

After an overview of treatment programs, theories and goals, various treatment modalities will be explored, with particular emphasis on group and family therapy. Community outpatient and residential treatment will be discussed, and models of various methods of treatment will be mentioned throughout. A discussion of treatment effectiveness and future considerations will conclude the review. The preponderance of adolescent sexual offenders are male and in this paper will be referred to with masculine pronouns, not discounting the occurrence of sexual abuse by female adolescents.

Assessment

Groth and Loredo (1981) remind us that the adolescent sex offender does not self-refer, fearing the adverse legal and social consequences. Families of these youths also generally do not seek help on their own, and often minimize or deny the abusive behavior. Referrals are usually the result of victim reports, police investigations, witnesses

or discovery by other persons. Typically, the juvenile offender comes to the attention of the clinician only after first coming to the attention of someone else.

There appears to be a reluctance to regard this behavior as serious or significant. The behavior is too often dismissed as merely sexual curiosity or experimentation and due to the normal aggressiveness of a sexually maturing adolescent (Groth & Loredo, 1981). The initial assessment must distinguish whether the behavior reflects relatively normal exploration or if it represents the early stages of an emerging sexual deviance syndrome or sexual maladjustment (O'Brien, 1985).

Knopp (1982) cites the Sexual Assault Center in Seattle's criteria of inappropriate sexual behavior as 1) inappropriate age difference, and 2) coercion by violence or threat. She claims most experts agree that an inappropriate age difference is five years or more between the offender and the victim. Others (Thomas & Rogers, 1983) define an age difference of more than three years as abusive, and particular concern is evidenced when the interaction is between an adolescent and a pre-pubescent child.

The task of assessment, according to Groth and Loredo (1981) is to differentiate among what may be normative sexual activity which is situationally determined, from what

may be inappropriate, solitary sexual activity of a non-aggressive nature, from what poses some risk of harm to another person. "The first is a social matter; the second is a clinical matter; the third is a clinical and legal matter" (p.33). Groth and Loredo outline eight basic issues that need to be carefully assessed: 1) the age relationship between the persons involved; 2) the social relationship between the persons involved; 3) type of sexual activity, including conventionality, ritualistic elements and consistency with developmental level of the subject; 4) how the sexual activity took place, by negotiation, intimidation, threat, or violence; 5) the persistence of the behavior, including compulsivity, frequency and preoccupation with the activity; 6) evidence of escalation or progression either in the frequency or type of behavior, any increase in the aggression or force over time is ominous; 7) nature of the fantasies that precede or accompany the behavior; and 8) any distinguishing characteristics of the victim, especially handicapped, disadvantaged or vulnerable persons.

Commenting on the use, in a clinical setting of the eight issues outlined above, Saunders and Awad (1988) make the following observations. The first two are straightforward, but some of the others are not so easy to

assess and gain accurate information. Ascertaining the type of sexual activity can be difficult because of minimization and denial. It is important to ask for a sequential description of everything that happened prior to, during, and after the offense, including the youth's planning, his impressions of the victim's reactions during the offense, precautions he took to avoid discovery, his understanding of how he was discovered and his perceptions of his parents' and others' reactions to the disclosure. Determining the extent to which persuasion threats or coercion were used is often aided by the presence of the police report and victim statement. Their experience shows that discussion of fantasies is often very difficult with adolescents, and they note the peculiar absence of reports of any fantasies in regard to non-contact offenses such as voyeurism exhibitionism and obscene phone calls. Overall, the task of establishing the details of a sexual offense is often quite difficult and in many cases the motivation for the offense remains unclear.

In addition to the offense itself, the context of the offender's current life and home and developmental stage should be examined (Groth & Loredo, 1981). Factors to be considered include: previous abuse of the adolescent himself; current life stressors; family dynamics; family

attitudes about sexuality; role models for sexual and aggressive behaviors; attitude or reaction of family to his sexual offense; peer group involvement, and their knowledge of and reaction to the offense; and other problems such as chemical such as chemical dependency, mental illness, and mental retardation. Saunders and Awad (1988) suggest a comprehensive sexual history be taken and recommend that it be done after a comfortable relationship with the adolescent has been established. They also caution that most clinicians are neither trained nor comfortable taking an extensive history and suggest having an outline in mind before the interview.

Margolin (1984) mentions some obstacles in gathering accurate information about the offense. She includes the offender's proclivity to lie, the young age of the victim, who might lack the vocabulary and conceptual ability to explain what happened, and the offender's limiting his admissions only to reported offenses. Knopp (1985a) claims assessment is more effective if there is a strong focus on <u>what</u> happened, as opposed to a general mental health professional's propensity to focus on <u>why</u> the behavior has occurred.

Becker and Abel (1985) describe a structured clinical interview which is used to cover many of the issues proposed

by Groth and Loredo above. Monastersky and Smith (1985) report on the assessment routine used in the University of Washington's Juvenile Sexual Offender Program. It includes four clinical interviews, a combination of individual and family sessions, including siblings, and a battery of tests (i.e., MMPI, Rorschach, Thematic Apperception Test, Incomplete Sentences Blank, Family Adaptability and Cohesion Evaluation Scale, and the Dyadic Adjustment Scale) that assess both individual and family functioning. The victim's statement is crucial in their minds, and information from schools and the court is also gathered. In addition to issues listed above, they also assess academic history, history of delinquent and aggressive behaviors, and evidence of impulsive behavior.

Once it is decided that an adolescent sex offender is in need of clinical intervention, the first question is where should the treatment take place; in an outpatient, community-based program or in an institutional, residential setting (Groth et al., 1981). Actually, the options are severely limited in many areas of the country where few programs exist. Knopp (1982), who has traveled extensively visiting programs and collecting data on existing services, believes the community carries the responsibility to provide a range of sex offender treatment programs suited to both

the remedial need of the adolescent as well as the safety requirements of the community.

Smith (in Knopp, 1985b) suggests four distinct clusters of items to be considered when assessing youthful sex offenders for placement: a) seriousness of referral offense; b) treatability or manageability of the offender; c) probability of sexually re-offending; and d) likely danger to the community. A 62-item risk assessment inventory has been developed by Monastersky and Smith (1985). This tool has not been validated, but has been shaped by the clinicians' long-term experience with adolescent sex offenders.

Wenet (in Knopp, 1982) concludes that residential placement is deemed appropriate for: rapists; offenders who used a weapon, violence or physical force; offenders who exhibit an escalation of deviant behavior; and those offenders who are chronic substance abusers. Others appropriate for residential care are those in denial at the end of the evaluation period, those who continue violence even after the victim hurt and asks him to stop, and those who refuse to discuss sexuality.

In general, outpatient treatment is more appropriate disposition when the sexual offense: was non-violent; did not involve any bizarre or ritualistic interpersonal acts;

is a first offense and there is no history of chronic anti-social or violent behavior; and there is no evidence of psychopathology. Other factors indicating outpatient treatment include the offender who acknowledges his offense and is motivated for treatment, with dependable agents to supervise and monitor his daily life, general competent functioning in society, and the existence of dependable treatment and support services available in the community (Groth et al., 1981).

There was a tendency in the early literature to consider adolescent sex offenders as a homogeneous group for whom similar treatment is appropriate. Some recent publications (Margolin, 1984) still seem to consider adolescent sex offenders as homogeneous. Others (Knopp, 1985a; Monastersky & Smith, 1985; O'Brien, 1985) warn against assuming that all adolescent sex offenders are similar and should be treated as such. They call for a consistent typology that would distinguish one type of adolescent sex offender from another. To date, no universal typology exists, though O'Brien and Bera (1986) have identified seven different types, an expansion of an earlier hypothesis that only two types of adolescent sex offenders existed. The seven types are:

1. Naive Experimenters;

2. Undersocialized Child Exploiters;

3. Pseudo-Socialized Child Exploiter;

4. Sexual Aggressives;

5. Sexual Compulsives;

6. Disturbed Impulsives; and

7. Peer Group-Influenced Offender.

Various motivations, individual, and family characteristics distinguish the seven, and certain types of treatment are recommended for each type. Outpatient treatment is usually indicated for the first three types, and for the seventh type if the incident is an isolated one and seemingly more motivated by peer pressure. Inpatient, residential care seems appropriate for the other types, depending on the frequency and duration of their behavior. Treatment to address chemical dependency or mental illness of the disturbed impulsives is also called for.

Treatment

The first coherent and comprehensive treatment program began in 1975 when the University of Washington School of Medicine's Adolescent Clinic was asked to evaluate and treat a group of adolescent sex offenders from all over the state. Since that time, treatment programs for juvenile offenders have increased steadily and the field is rapidly evolving into a highly specialized discipline (Knopp, 1985a).

Knopp and Stevenson (1989) gathered information on existing services as of September, 1988 and identified 573 specialized juvenile sexual offender treatment programs. Specialized services for adolescents had increased 66% from 1986 to 1988. The Pacific coast states account for 28% of the programs. The East and West-South-Central states were most poorly represented, providing only 2% and 4% respectively. The ratio of community-based outpatient to residential services is 80% to 20%. Indicating the lack of comprehensive services, 25% of the states offering juvenile services identify none that are residential. The private sector supports 48% of the community-based outpatient programs and 42% of the residential services. Of the residential services, 27% exist in juvenile prisons, 24% in mental health facilities, 42% are private facilities and 7% are housed in court-related facilities. In terms of community-based outpatient services, 47% are private, 43% are in mental health, 7% are court-related, and 3% are community-based prison-related services.

Knopp and Stevenson (1989) also surveyed adult offender programs and compared treatment methods used in the two types of programs. Much similarity exists between the treatment of adolescent and adult offenders; many adolescent programs have been based on previously tested methods used

with adults. A few areas differed significantly, though. Differing by more than 10% were the use of Alcoholics Anonymous, masturbation satiation, masturbatory conditioning, Depo-Provera, and the use of the penile plethysmography, with adult programs using these methods more often than programs serving adolescents.

Knopp (1985a) has concluded that there is a general difference between sexual offenses committed by adults and adolescents, "because of the adolescent's stage of physiological and sexual development, an impressive number of their offenses appear to be sexual in nature but acted out through power. This is in contrast to our understanding of adult sex offense patterns, which are characterized as power and anger acted out through sexuality" (p.19, emphasis is hers).

As was mentioned earlier, sex offenders do not self-refer, so usually they are mandated to treatment. The right of society to be protected must be weighed against the right of the individual. Groth et al. (1981) prefer to have treatment mandated to insure participation and to maintain continuous involvement during stressful times, when sex offenders characteristically withdraw from treatment. Treatment can be stipulated as a condition of: a) continuation of the case; b) deferred sentencing; c)

probation; d) placement elsewhere; e) as an alternative to court proceedings; or f) through a special education plan by the local Department of Education. They believe it is imperative to have an agency that can and will enforce the treatment plan. Thomas and Rogers (1983) have found that juveniles and families who enter treatment under diversion (i.e., agreeing to treatment in lieu of court proceedings) are motivated to accept treatment, but that the degree of motivation is closely tied to the strength of the government's case.

Becker and Abel (1985) suggest developing a contract that states clearly what behavior is expected of the client and what role the therapist will play. They also inform the offender about how reports to the criminal justice system will be handled and share those reports with the client.

Involvement of the law enforcement system enhances the leverage of the therapist, but in cases of intrafamily abuse the involvement of the justice system may increase, rather than decrease, family stability, at least temporarily (Thomas & Rogers, 1983). Parents align themselves with the victim throughout the legal process. On the other hand, the juvenile's attorney, while discharging his professional obligation, takes the side of the offender, which can reinforce the adolescent's psychological distance from the

family. Involvement in this adversarial legal system can alienate the offender even further and can undermine parental authority.

Once treatment begins, intervention is initially aimed at putting the client's sexual offense into some perspective, to look at the sexual behavior in the context of the total person (Groth et al., 1981). The significance and meaning of the offense to the juvenile must be explored. It is essential that the sex offense itself be directly confronted, not ignored, avoided or minimized. The clinician must feel comfortable discussing the offense, as "the youngster himself is struggling with this problem in silence because it would appear that it is too uncomfortable for others to listen to or respond to" (Groth & Loredo, 1981, p.38). To engage the client, the intervenor must offer support, concrete help, consistency and persistent outreach (Groth et al., 1981).

The National Adolescent Perpetrator Network (1988) lists the following as areas that should be addressed in the treatment process of every juvenile offender: (p. 28-29)

1. Accepting responsibility for behavior without minimization or externalizing blame;
2. Identification of pattern or cycle of offense behavior;

3. Ability to interrupt cycle before an offense occurs and control behavior;

4. Victimization in the history of the offender;

5. Development of victim awareness and empathy, seeing victim as a person;

6. Power and control/helplessness and lack of control;

7. The role of sexual arousal in offenses, reduction of deviant sexual arousal;

8. Develop a positive sexual identity for self;

9. Understand the consequences of offending behavior to himself, the victim and his family;

10. Family issues or dysfunctions which support or trigger offending;

11. Cognitive distortions, irrational thinking or "thinking errors" which support or trigger offending;

12. Identification and expression of feelings;

13. Appropriate social relationships with peers;

14. Appropriate levels of trust in relating to adults;

15. Addictive/compulsive qualities contributing to reinforcement of deviancy;

16. Role of substance abuse in functioning;

17. Skill deficits which interfere with successful functioning;

18. Need for relapse prevention; and

19. Options for restitution/reparation to victims and community.

Groth et al. (1981) strongly suggest using an interagency team approach to treatment with a written contract outlining expectations, specific goals, standards for evaluation, and consequences for failing to keep agreements. Treatment should be broken down into distinct stages of reasonably short duration, with each having a special focus to allow for immediate feedback and reinforcement that is suited to the short attention span and frustration tolerance of adolescents.

Treatment programs for adolescents have relied heavily on adult models, and Monastersky and Smith (1985) warn that it is important for adolescent treatment specialists to recognize that adolescents who commit sexual offense are in their own unique stage of development that must be incorporated in building a theoretical model. Their model comprises two general areas. It considers the adolescent within a developmental frame work and includes a family model that addresses the structure of the family as a growing and changing system. Becker and Abel (1985) purport a social learning theory model which considers the behavior as learned. This treatment approach emphasizes recall of the initial deviant sex act during masturbation/orgasm

activities (i.e., reinforcing the behavior), and stresses the significance of social and interpersonal skills. Groth et al. (1981) understand the sexual assault to be a product of defects in development, typically the product of insufficient love and inadequate discipline in the offender's upbringing. Groth et al. further view the offense as a signal that the individual is in a state of psychological distress and it is an attempt to protect the individual from the stresses he feels overwhelmed by. "It is maladaptive, but at this point in his psychological development, it is the best he can do" (p. 267).

Margolin (1983) considers "hands on" adolescent sex offenders as a homogeneous group and suggests a common treatment approach. They tend to be superficially conforming and make good, outwardly compliant clients, are driven by a desire to please and be seen as "good boys," and yet below the surface try to get their way through subtle manipulation and lying. A need to control others' responses pervades the offender's every social interaction. The problem, she concludes, is a social and moral one. Likening her clinical model to a pilgrimage, Margolin says, "the offender is thrust into a state of ambiguity, a sea with no familiar markers in which his previous navigational training seems almost totally without relevance" (p.6).

Offenders' attempts to control others are blocked at every turn, resulting in a mounting ambiguity and eventual desire to test out new, more healthy ways of interaction.

Monastersky and Smith (1985) cite limitations of some of the theoretical models. Psychoanalysis may offer explanations for sexual deviancy, but it does not offer a treatment plan with measurable outcomes. Family systems theory does not hold the offender accountable and also does not assess for a pattern of sexual offense outside the family. Behavioral intervention offers specific treatment with measurable outcomes, but is limited to a linear cause-and-effect model that categorizes all sexual offenders as sexual deviants. Current thinking has considered all of these theories, and at this time, incorporates elements of many theories into a multi-modal, multifactor theoretical model. Sexual aggression is a complicated, multi-determined behavior problem and it is recognized that not every offender is the same and that application of theory must be individualized within the treatment process to meet the complex needs of the individual (National Adolescent Perpetrator Network, 1988). Knopp and Stevenson (1989) report on the general methods used in treatment. Programs that emphasize behavioral methods, positive sexuality and the sexual assault cycle will now be briefly reviewed.

Behavioral Treatment

Knopp (1985a) reports that behavioral treatment methods are often used in combination with some of the psycho-socio-educational methods. These methods attempt to assess and recondition deviant fantasies and arousal. Some use penile plethysmography to measure arousal and erection to various deviant stimuli. Conditioning exercises ranged from the least intrusive simple thought-stopping and thought-changing exercises to use of electric shock ("mild" and applied to the fingers) in one program. Other aversive methods included playing tapes of sounds such as police sirens, vomiting, someone being chased, and introducing foul odors such as ammonia, placenta culture or valeric acid. Often the various aversions are combined to decrease or disrupt the arousal. On the other hand, several clinicians advocate increasing appropriate arousal by encouraging masturbation to age-appropriate pictures and fantasies. Others encourage masturbation as a sexual outlet but do not encourage fantasizing to any particular theme. Many states are apprehensive about using behavioral methods. Issues of consent, permission and legal liability and other factors influence these reluctant attitudes (Knopp, 1985a).

Becker and Abel (1985) found that many adolescents experienced discomfort in carrying out masturbatory-

satiation treatment. If the adolescent or parent finds masturbation objectionable or immoral the treatment is not required. Instead, the offender satiates fantasies by talking them into a tape recorder without masturbation. Saunders and Awad (1988) caution against the use of phallometric testing (i.e., measurement of penile erection in response to different kinds of sexual stimuli) with adolescents because of the lack of data on the validity and reliability with adolescents, ethical considerations regarding exposure to deviant sexual stimuli, and consent is often difficult to obtain. They use such methods only with the most serious offenders and even then only as an adjunct as part of an overall assessment.

Positive Sexuality Programs

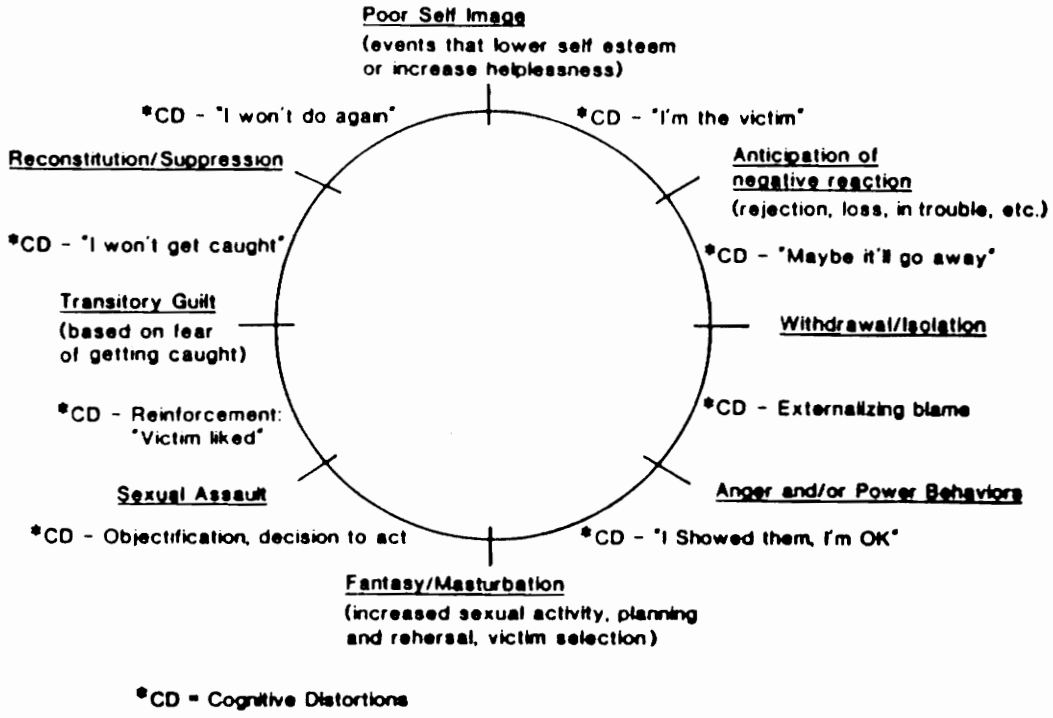
While many programs offer traditional kinds of sex education, only a few programs educate about positive, pleasurable and appropriate sexuality. The Personal Social Awareness (PSA) Program in Minneapolis resists using the label "sex offender" and opts for the contextual definition, "those who have violated sexual norms to the extent it is causing the family or some public agency considerable concern" (Knopp, 1985a, p. 17). PHASE (Program for Healthy Adolescent Sexual Expression), also in Minnesota, attempts to "phase out of" a pattern of inappropriate sexual

expression and "phase into" a healthy, responsible sexual lifestyle and identity. Families must participate in the program (Knopp, 1982).

In the PSA program, every two months each group (there are three ongoing groups, including one exclusively female group) embarks on a 27-hour marathon session held overnight at a retreat center. Each client brings a list of therapeutic goals that are posted on the walls and evaluated at the end of the marathon. The same rules and expectations apply as in the regular weekly group. The retreat center has a pool, whirlpool and sauna that, along with massage sessions conducted by trained professionals, help participants get in touch with their bodies and senses in a positive, healthy way.

Sexual Assault Cycle

Ryan et al. (1987) propose a cycle of sexual assault that has been developed from their extensive clinical experience with adolescent sexual offenders. The model is presented below (p. 390):



Sexual assault cycle.

The cycle provides a framework on which offenders can attach their individual feelings, thoughts, and behaviors, seeing themselves as unique individuals while identifying what they have in common with each other. After mastering their understanding of the cycle and seeing how it applies to them, the offenders then practice identifying the times in their past in which they responded similarly and the situations in their present life which trigger the beginning of the cycle or signal that they are in the early stage of the cycle. They must identify the errors in their thinking

which enable them to progress through the cycle, and practice new ways to respond which will interrupt the cycle before the offending behavior occurs. The ultimate goal is to interrupt the cycle at the beginning. This process, according to the authors, may take months or even years.

Treatment Modalities

Group Therapy. Given the developmental stage of adolescence, with the focus on peer approval and interaction, and providing other inherent advantages, group therapy is the treatment of choice for adolescent sex offenders. Knopp (1985a) found that those programs not using group therapy were not doing so because there were not enough participants to make for an effective group. She also found that many adolescent sex offenders are treated in mixed-offense therapy groups, a practice most specialists consider less effective that using offense-specific groups. Often, group therapy is complemented by individual work and family therapy.

Margolin (1984) has found it exceedingly helpful to do group work, using the best experts on the knowledge and experience of sexual offending (i.e., the offenders themselves) to confront the rather consistent lying and minimizing that occurs. Group members discuss details of their offense, with one participant often breaking the ice

and then expecting others follow. In her group, the boys vote on the truth of the report and confront inconsistencies and points that do not fit with their experiences. She goes on to say that some of the most accurate information about the sexual assault comes from group reports, and is more reliable and truthful than reports obtained through individual interviews, police reports or victim statements.

Disclosing to the group and confessing details of criminal past experiences expresses positive values which are in opposition to the abusive behavior. Self-disclosure can also provide the opportunity for previously unknown victims to receive counseling regarding the assaults. Margolin (1984) has found these revelations particularly helpful for siblings of offenders who may have been abused for years but have been afraid to talk about it openly. A description of two groups will follow, the first a residential group for serious violent offenders and the second an outpatient one for less serious sex offenders.

The Closed Adolescent Treatment Center (CATC) has developed a specific group for high risk adolescent sex offenders, most of whom are rapists (Lane & Zamora, 1984). The group is exclusively male, and open only to sex offenders who have shown some progress in the general program at CATC. Held daily, it is led by a co-therapy team

of a male and female, and is kept confidential from other treatment. Participants keep a daily journal, recording fantasies, reactions, experiences, and perceptions, especially those evoking anger or in which they felt helpless or controlled. The work progresses through five distinct phases: 1) Penetrating the denial and dealing with the sexual assaults the youth has committed; 2) Identification of the sexual assault cycle to generalize the assault to other behaviors and patterns of interaction, including awareness of "institutional rapes" such as invasive looks, threats, intimidation, "accidental" touches, etc.; 3) Working with unresolved emotional issues, particularly around his own victimization and fears of being controlled or rejected; 4) Skill deficit training, with lots of practicing of new behaviors in the group; and 5) Transition - Community reentry, gradually increasing the amount of time spent in the community, predicting and role-playing possible scenarios. Much time is also spent in group addressing issues raised in the journals and group leaders respond in writing to one group member's writings each week.

Many similarities are noted in a discussion of the outpatient group that follows (Smets & Cebula, 1987). They too have five stages or levels, are led by a male-female co-

therapy team, and the group is the primary intervention within a total treatment approach which includes assessment, individual and family therapy. The key elements are peer interaction and a system of incentives to move on in therapy, both of which are believed to be crucial in treating adolescents most effectively. Attendance is mandatory; unexcused absences are reported immediately to the probation officer. Members are told the group will not end until all reach level five, the final stage. While progressing through the steps, the participants acknowledge their adjudication, detail their offenses and personal sexual development, enhance their insights into their behavior and sexuality at large, and plan how to avoid offending again. Group members also write a weekly letter in which they include their reaction to group, any thoughts or new insights, and any questions or concerns. The letter is sent to the leaders for review prior to the next weekly meeting. Each member proclaims when he is ready to "take a level" and move on to the next step by doing what is prescribed on the levels below (p. 249):

0 - I am not saying anything and will not cooperate;

1 - I can say why I am here (what the charges were against me) and I am also willing to cooperate;

2 - I have shown that I want to cooperate by contributing without having been asked. I also helped others to join and participate;

3 - I am now ready to tell about all the details of what I did to assault a minor. I will tell about whom I did it to, how I led up to it and exactly what happened;

4 - I can talk about my own sexuality, the good parts and the bad. I have learned to feel OK about discussing sex. I also opened up about having been a victim myself. There are no more secrets; and

5 - I have made a plan to deal with my victim and my perpetrator. I know also how to deal with my sexual desires in the future. I have also received a vote of confidence from the group members.

The group concludes with one or two meetings in which everyone, including the leaders, gives and receives feedback. The end of group may not mean the end of treatment; individual or family therapy might continue for quite some time. A pizza party is the scene for good-byes.

There seems to be a consensus that groups for adolescent sex offenders are ideally led by two people, with a strong preference that one is a woman (Lane & Zamora, 1984; Margolin, 1983; Smets & Cebula, 1987). A woman is desirable as a means of correcting the members'

misconceptions about women (Margolin). Smets and Cebula report that the boys initially feel scared about having a female therapist present, but apprehensions give way to genuine admiration. These boys seem to have had little experience with strong female role models. Lane and Zamora (1984) note that the presence of a female seems to trigger feelings and responses that do not arise when only a male is present. They further noted that the group does not appear comfortable when the male leader is absent. They mention some important qualities of the co-leaders. The female should be able to be direct and confrontive in a caring, supportive manner; be able to set limits without being excessively controlling; be willing to allow youth to attempt new social behaviors with her; and be open about sexuality without being seductive. The male should convey a feeling of strength and confidence without seeming to be aggressive, withdrawn or excessively "macho", and be self-assured and socially aware enough not to relate to females as subordinates.

Family Therapy. The studies are virtually unanimous in identifying the family as a crucial influence in the development or elicitation of the offender's behavior (Monastersky & Smith, 1985). Factors contributing include: failure to provide emotional support; confused family

relationships; seductive maternal behavior; abuse by parents; scapegoating; and denial or minimization of previous sexual offenses. Thomas and Rogers (1983) concur, seeing sexual abuse as a family problem, where family norms, interpersonal boundaries, role definitions and similar characteristics of the family structure often contribute to the development and maintenance of the sexual abuse. Ageton (1983) also found that the number of family crises reliably differentiates the juvenile sex offender from the non-offender delinquent.

Knopp (1982, p. 59) after interviewing numerous therapists working with adolescent and adult offenders concluded: "Family systems factors are at the root of the sexual behavior ...of both adults and youths. Thus in both groups, family involvement in treatment is increasingly seen as essential for success." Family therapy is considered inappropriate only when it is counter-therapeutic or these is a clear decision on the part of the family not to attempt to reunite (Groth et al., 1981; Thomas & Rogers, 1983). Programs that do not include family therapy cite, as reasons for this omission, lack of staff, unavailability of parents and inability to cope with family therapy (Knopp, 1985a). Generally, states can mandate the adolescent to treatment, but usually not the family (Weiks & Lehker, 1988).

There are consistent reports from adolescents of earlier sexual, physical and emotional abuse, particularly by fathers (Knopp 1982). A poor father-son relationship is consistently noted, with the father often being either physically or emotionally removed. Fathers also are especially resistant to treatment, especially those not living at home, but Knopp found that once in, the resistance generally diminishes. Thus, while many programs place a strong emphasis on redefining roles with women, an important emphasis on nurturing relationships with men is also emerging. "The father has assumed a new, appropriate focal point for clinical concern--a position once occupied almost exclusively by the mother" (Knopp, 1982, p. 37).

The abuse and its disclosure generate individual reactions from various members which must be dealt with and ultimately overcome. These reactions frequently include anger directed at the abuser, the abused child or outside intervenors, and other reactions such as shame, guilt and depression (Thomas & Rogers, 1983). Saunders and Awad (1988) state that it is not always necessary to remove the offender from the home in cases of intrafamily abuse. If parents can assure that the offender is never left alone in the home with the victim and that the victim gets coaching about how to avoid potentially dangerous situations, the

family can stay intact.

Some typical goals (O'Brien, 1985) for family work include: increasing family communication; increasing family intimacy, especially between father and son; restructuring family boundaries; realigning family roles; and working through unresolved abuse issues in the family. Victims may also be angry at one or both parents for not protecting them from being sexually abused, and there is often competition with siblings (Lane & Zamora, 1984).

From their work with families which contained an adolescent sex offender, Lankester and Meyer (1988) suggest five family configurations which provide the first rough family typology: 1) Authoritarian; 2) Sexual confusion in the single parent family; 3) Remarried single parent; 4) Blended families; and 5) Chaotic. Different dynamics seem to be at work in each of these five types.

Two programs are noteworthy for their work with families. The Juvenile Sexual Offender Program in Washington will not accept an adolescent into their treatment program unless the family agrees to participate in treatment. Family sexuality and aggression are important areas of focus (Monastersky & Smith, 1985). The Personal Social Awareness Program mentioned earlier for their positive approach to sexuality, also includes several

ways for parents to be involved (Knopp, 1982). A parents' group meets weekly for two hours and parents identify and work on their own issues and provide support to one another. Family therapy occurs every two weeks and includes all siblings and ideally and divorced or separated members. Family Learning Experiences are educational events held every two months. They provide a lecture\workshop format led by a guest expert on topics such as shame and guilt, spirituality and values, family sex education, relaxation and stress, etc. Finally, held twice a year, The Family Journey, led by a large staff of approximately fifteen people, invites all participating families to an exploration of feelings, attitudes, myths, realities and values surrounding sexuality in our culture and in the lives of their families.

A controversial family therapy approach to adolescent sex offenders has been developed by Madanes (1990) and colleagues. Sixteen steps are outlined, one of which involves the offender kneeling before the victim and family and asking for forgiveness. They claim that this dramatic act helps families to move beyond the anger and pain often associated with responses to sexual offenses.

Community-Based Outpatient Programs. Community-based services for sexually abusive youth can be found in such

diverse settings as converted houses or schools, hospital outpatient wings, mental health centers, universities, and professional office buildings (Knopp, 1985a). New programs are usually modeled after the specialists who initiated them or they may take on characteristics of the "regional specialty". Oregon and Washington seem to have the greatest cluster of programs with a behavioral treatment orientation. Minnesota programs have the strongest focus on positive sexuality. In the wake of A. Nicholas Groth's many training sessions nationwide, his psycho-socio-educational models appear to flourish.

Community-based services are inexpensive to implement, since they do not require capital investments for new physical plants (Knopp, 1985b). Duration of treatment usually ranges from a low of six to nine months to an average of one year. Most use a combination of guided peer group therapy, individual, and family therapy. Michigan has a pilot program in which an outpatient program is located in a juvenile court setting (Weiks & Lehker, 1988). The proposed advantages are an increased likelihood that clients will perceive a closer link between the court's authority and the treatment program, enhanced interaction between therapist and court probation officers, with the goal of closer monitoring and greater chances of maintaining the

treatment.

Residential Programs. Sex offense-specific treatment for youth housed in residential facilities is a very recent development and many states still do not provide this service (Knopp, 1985a). Most residential programs do not provide separate cottages or quarters for sex offenders. Usually they live in the general population and attend offense-specific groups at least once a week. The Hennepin County Home School in Minnesota, one of the most highly developed residential programs for adolescent sex offenders, began housing sex offenders separately a few years ago and have found several advantages to the arrangement for both youth and staff, including shorter successful stays in the program. Staff have received specialized training and are able to provide a 24-hour milieu treatment specifically designed for sex offender. Boys are able to discuss important issues such as masturbation and homosexuality more openly, and the sexual offenses are dealt with directly, which did not occur with as much ease prior to separate housing. In such a living environment, residents have been able to develop and demonstrate appropriate physical contact, such as hugs or other signs of affection that would not be as likely to occur in the general population (Knopp, 1985a).

The need for residential programs is great; states lack the type of homelike facilities that gives more structure than many families provide but not as much structure as a medium-security unit demands. Many states are moving towards providing a continuum of care to meet the needs of various types of offenders, with specific sex offense treatment, ranging from outpatient to secure residential. Sadly, too many adolescent sex offenders wind up in adult maximum-security prisons where there are no services, little hope for restoration and a high potential for sexual victimization (Knopp, 1985a).

Treatment Effectiveness

Longitudinal studies are generally non-existent, but preliminary results are encouraging in terms of low recidivism rates (Knopp, 1985a). Doshay (1943) followed 108 offenders for a period of six years, and found a recidivism rate of only 2%. A 3% rate was identified by Atcheson and Williams (1954), (n=125). More recent studies by Smith (1984) and Smith and Monastersky (1986) showed recidivism rates of 7% and 14% respectively, with the latter study following clients for a longer period of time (i.e., a minimum of seventeen months).

Studies comparing the success of various types of treatment and ones comparing treatment versus non-treatment

outcomes are virtually non-existent (Davis & Leitenberg, 1987). One study compared the efficacy of multisystemic therapy and individual therapy with adolescent sex offenders (Borduin, Henggeler, Blaske & Stein, 1990), and found that multisystemic treatment was more effective, based on three-year follow-up. Evaluating the effectiveness of programs for adolescent sex offenders is difficult for several reasons, including the limited number of programs, a lack of valid dependent measures, and the ethical considerations regarding withholding treatment (Becker & Abel, 1985).

Though the effectiveness of treatment is not conclusive, indications are encouraging. Specialized community-based treatment has been shown to be cost-effective, and treating low-risk offenders is much less expensive than later institutional treatment for more serious offenses. Knopp (1985b) cites the annual cost per client in a specialized sex offenders community-based treatment program in New York as $900 per year. The annual cost to incarcerate one juvenile in a secure facility is approximately $80,000. The Michigan Adolescent Sexual Abuser Project (1988) performed a cost analysis of treatment of ten offenders in an outpatient setting, at a cost of $27,000. These same ten youth would have cost the county $420,000 if placed in residential facilities and most likely

would not have received any specific treatment related to their offense.

Conclusion

Research and treatment of adolescent sexual offenders has burgeoned in the last few years. Some consider the current stage of development as similar to the awkward stage of the adolescents whom they treat. Much has been done to provide descriptive and theoretical foundations upon which to build, and much remains yet undone. Several areas need to be addressed in the near future to continue the growth and development of the field. More rigorous, controlled treatment outcome studies need to be performed to determine the effectiveness of various types of treatment for certain types of offenders. Very little is known about "normal" sexual experimentation by adolescents and information needs to be gathered on which to base comparisons to others identified as sexual abusers. Specialized treatment for specific groups of offenders, most notably females and low-functioning or mildly retarded offenders has not kept pace with the demand (Knopp & Stevenson, 1989).

Recent reports (Friedrich & Luecke, 1988; Johnson, 1988) have discovered the alarming existence of child sexual offenders, children as young as four years old who engaged in coercive sexual contact with younger children. Very

little is known about this age group and the problem has been denied and ignored as were adolescent offenses until recently. States must continue to plan for and develop a continuum of services that balances the safety of the community and the right of the individual to treatment. Society at large must continue to examine the confusing massages about sexuality and aggression that influence our children, and move towards more healthy expression of ourselves as human and sexual beings. Much is at stake, and the field is here to stay. Continued commitment and efforts are required, though, to further the development of the field and propel its growth through adolescence into a mature and stable adulthood.

References

Atcheson, J. D. & Williams, D. C. (1954). A study of juvenile sex offenders. American Journal of Psychiatry, 11, 366-370.

Becker, J. V. & Abel, G. G. (1985). Methodological and ethical issues in evaluating and treating adolescent sex offenders. In E. M. Otey, & G. D. Ryan, (Eds.), Adolescent sex offenders: Issues in research and treatment. Rockville, MD: USDHHS.

Borduin, C. M., Henggeler, S. W., Blaske, D. M., & Stein, R. J. (1990). Multisystemic treatment of adolescent sexual offenders. International Journal of Offender Therapy and Comparative Criminology, 34, 105-113.

Davis, G. E. & Leitenberg, H. (1987). Adolescent sex offenders. Psychological Bulletin, 101, 417-427.

Doshay, L. J. (1943). The boy sex offender and his later career. Montclair, NJ: Peterson Smith.

Friedrich, W. N. & Luecke, W. J. (1988). Young school-age sexually aggressive children. Professional Psychology: Research and Practice, 19, 155-164.

Groth, A. N., Hobson, W. F., Lucey, K. P., & St. Pierre, J. (1981). Juvenile sexual offenders: Guidelines for treatment. International Journal of Offender Therapy and Comparative Criminology, 25, 265-272.

Groth, A. N. & Loredo, C. M. (1981). Juvenile sexual offenders: Guidelines for assessment. International Journal of Offender Therapy and Comparative Criminology, 25, 31-39.

Johnson, T. C. (1988). Child perpetrators--children who molest other children: Preliminary findings. Child Abuse and Neglect, 12, 219-229.

Knopp, F. H. (1982). Remedial intervention in adolescent sex offenses: Nine program descriptions. Orwell, VT: Safer Society Press.

Knopp, F. H. (1985a). Recent developments in the treatment of adolescent sex offenders. In Otey, E. M. & Ryan, G. D. (Eds.), Adolescent sex offenders; Issues in research and treatment. Rockville, MD: USDHHS.

Knopp, F. H. (1985b). The youthful sex offender: The rationale and goals of early intervention and treatment. Syracuse, NY: Safer Society Press.

Knopp, F. H. & Stevenson, W. F. (1989). Nationwide survey of juvenile and adult sex-offender treatment programs and models. Orwell, VT: Safer Society Program.

Lane, S. & Zamora, P. (1984). A method for treating the adolescent sex offender. In R. A. Mathias, P. DeMuro, & R. S. Allinson (Eds.), Violent juvenile offenders: An anthology, (pp. 341-363). San Francisco: National Council on Crime and Delinquency.

Lankester, D., & Meyer, B. (1988). Sex gone wrong: Adolescent sex offenders and their families. Family Therapy Networker, 12, 43-45, 86-90.

Madanes, C. (1990). Sex, love and violence: Strategies for transformation. New York: W. W. Norton.

Margolin, L. (1983). A treatment model for the adolescent sex offender. Journal of Offender Counseling, Services and Rehabilitation, 8, 1-12.

Margolin, L. (1984). Group therapy as a means of learning about the sexually assaultive adolescent. International Journal of Offender Therapy and Comparative Criminology, 28, 65-72.

Michigan Adolescent Sexual Abuser Project (1988). Sexual offenses by youth in Michigan: Data, implications and recommendations. Detroit: Safer Society Resources of Michigan.

Monastersky, C. & Smith, W. (1985). Juvenile sexual offenders: A family system paradigm. In E. M. Otey & G. D. Ryan (Eds.), Adolescent sex offenders: Issues in research and treatment. Rockville, MD: USDHHS.

National Adolescent Perpetrator Network (1988). Preliminary report from the national task force on juvenile sexual offending, 1988. Juvenile and Family Court Journal, 39, 5-67.

O'Brien, M. (1985). Adolescent sexual offenders: An outpatient program's perspective on research directions. In E. M. Otey & G. D. Ryan, (Eds.), Adolescent sex offenders: Issues in research and treatment. Rockville, MD: USDHHS.

O'Brien, M. & Bera, W. (1986). Adolescent sexual offenders: descriptive typology. Preventing Sexual Abuse, 1, 1-4.

Ryan, G. D., Lane, S. Davis, J., & Isaac, C. (1987). Juvenile sex offenders: Development and correction. Child Abuse and Neglect, 11, 385-395.

Saunders, E. B. & Awad, G. A. (1988). Assessment, management and treatment planning for male adolescent sexual offenders. American Journal of Orthopsychiatry, 58, 571-579.

Smets, A. C. & Cebula, C. M. (1987). A group treatment program for adolescent sex offenders: Five steps toward resolution. Child Abuse and Neglect, 11, 247-254.

Smith, W. R. (1984). Patterns of re-offending among juvenile sexual offenders. Unpublished manuscript, University of Washington, Juvenile Sexual Offender Program, Seattle.

Smith, W. R. & Monastersky, C. (1986). Assessing juvenile sexual offenders' risk for reoffending. Criminal Justice and Behavior, 13, 115-140.

Thomas, J. N. & Rogers, C. M. (1983). A treatment program for intrafamily juvenile sexual offenders. In J. G. Greer & I. R. Stuart (Eds.), The sexual aggressor: Current perspectives on treatment. New York: Van Nostrand Reinhold.

Weiks, J. C. & Lehker, D. (1988). Specialized treatment of adolescent sex offenders in a juvenile court setting. Juvenile and Family Court Journal, 39, 29-35.

Appendix C:

Extended Literature Review:

Juvenile Delinquency and the Family:

Theories of Family Influence

The role of the family in the etiology of juvenile delinquency has been documented extensively (Anolik, 1983; Geismar & Wood, 1986; Thornburg, 1986; Wells & Rankin, 1985). This review will address several theories of family influence upon juvenile delinquency. A biosocial perspective will be addressed initially, followed by an extensive discussion of family structural and functional variables correlated with delinquency. Next, a psychosocial model is presented which considers the likelihood of juvenile involvement with deviant peers, given certain characteristics of parent-child interaction. Two typologies of juvenile delinquents will then be detailed, providing evidence that juvenile delinquents are not a homogeneous group. This is followed by a higher level of analysis, using a family systems theory of delinquency, along with some findings on the success of family therapy with this population. Finally, a comprehensive, multi-level, family-ecological systems approach to juvenile delinquency will be offered as a more complete and useful theory for understanding and treating juvenile delinquency.

Biosocial Theory

Anolik (1983) cites two trends in the study of the relationship between family background variables and juvenile delinquency. One is the psychosocial, which will

be explored later; the other is biosocial. The latter focuses on genetic and physiological predispositions to delinquent behavior in the presence of maladaptive relations within and outside the family. These predispositions, it is argued, potentiate the biological tendencies for delinquency.

Biological and family influences interact in the etiology of many childhood and adolescent disturbances, including juvenile delinquency. Certain personality characteristics, such as temperament, are genetically influenced, and patterns of family interaction are complimentary with genetic tendencies or counter hereditary factors. When parents do not accommodate to their child's dispositions, the child may be exposed to maladaptive circumstances which could lead to psychological disturbances (Anolik, 1983). For example, a very active child may need to be restrained by parents, who perhaps lack the necessary knowledge or motivation. The child may get hurt or not learn adequate social controls and hence be rejected by peers or engage in deviant activity later when similar behaviors are repeated outside the home. Mednick and his colleagues (in Anolik, 1983) report that the autonomic nervous system of criminals may be different from that of non-criminals, thus making it harder for criminals to alter

their behavior through punishment. These individuals experience a delay in their response to rewards and punishment and therefore find it difficult to associate rewards or punishment with the targeted behavior.

There is some evidence that personality traits can be altered through environmental pressures (Anolik, 1983). However, there must be a certain level of agreement between the child's biological predisposition and the parents' child-rearing style. The biosocial theory is not very popular in explaining the etiology of juvenile delinquency, yet it is significant to note that parent-child interaction is extremely important, even in the presence of biological or genetic predispositions.

Geismar and Wood (1986) report two major categories of family variables in the research on family influence upon juvenile delinquency. Structural variables include such items as family size, birth order, maternal employment, sibling configuration and family intactness. Functional variables include the tasks or roles of a family (e.g., socialization, protection) or family environmental conditions (e.g., atmosphere, activities or tone) and include factors such as parental affection/acceptance, family relations/communication, parental supervision/discipline, and family deviance. These

variables have low explanatory power, but generally are moderately correlated with delinquent behavior (Geismar & Wood, 1986).

Structural Variables

While subject to some dispute during the past several decades, the idea that a breakdown in the family may be a primary cause for increasing rates of juvenile delinquency has recently drawn renewed interest among social researchers (Wells & Rankin, 1985). Despite more than half a century of research, our knowledge about the empirical impact of the broken home (i.e., children living with other than both natural parents) is tentative and uncertain. A review of the literature concludes that there is a consistent positive association between broken homes and general delinquency. However, the magnitude of this relationship is rather modest, certainly smaller than recent social policy arguments would suggest (Wells & Rankin, 1985). Effects of age of the child when the breakup occurs, gender, race, and the variety of post-breakup family structures confound the impact. Wells and Rankin (1985) caution that a broken home is not a simple dichotomous variable and various blended family and single-parent family arrangements should be differentiated in future research.

In analyzing the impact of family structure, Dornbusch et al. (1985), report that in contrast to adolescents in households with two natural parents, youth in mother-only homes are perceived as more likely to make decisions without direct parental input and are more likely to exhibit deviant behavior. Family structure correlated to deviance for both sexes, but the impact appears to be stronger for males. The presence of an additional adult in a mother-only household, especially for males, is associated with increased parental control and a reduction in various forms of adolescent deviance. Steinberg (1987b) considered the impact when the additional adult was a stepparent and found conflicting evidence. He found that youth in stepfamilies were equally at risk for involvement in deviant behavior as were their peers growing up in single-parent households, and that youth living with both natural parents were less susceptible to pressure from friends to engage in deviant behavior.

Farnworth (1984) explains some limitations of the broken homes thesis. Studies supporting the thesis use records of official contact with the law as a measure of delinquency. Stability of the home environment may be a mediating factor for legal involvement in the first place (i.e., youth from less stable home environments are more often referred to the legal system), thus creating a sort of

self-fulfilling prophecy. Findings for research employing self-report of delinquency, while relatively few in number, challenge the broken home theory of delinquency. The theory also ignores overarching aspects of family life (e.g., SES or race) that could effect both family intactness and delinquency. Farnworth challenges the use of the broken home notion particularly for low-income black families, though the theory was originally used to explain delinquency in this group. She contends the matricentral focus, extended kinship system and the norm of single-parent families among low-income black families make the theory less applicable to this group. She further reports that black females are not as likely as males to be affected by broken homes, and that economics play a more significant role than family structure for low-income blacks.

In a study (LeFlore, 1988) comparing chronic delinquents and non-delinquents, an assessment of structural variables found that the delinquent group had larger sibling subsystems, and that more delinquents were middle-born children. Family intactness and total number of people in the household were not significantly related to delinquent status. In her analysis of various family structures of low-income blacks (Farnworth, 1984) only one type of family was significantly related to escape misbehavior (e.g.,

running away, marijuana and other drug use). Boys in families where the father was present and employed and mother was also employed were found to be less likely to engage in behavior of this kind. No other family structure correlated significantly with any of several types of delinquent behavior. An interesting finding provided evidence that male predominance (i.e., more boys) in the sibling subsystem favors the development of antisocial behavior in boys and the presence of more sisters seems to suppress potential for antisocial behavior (Jones, Offord, & Abrams, 1988).

Overall, family interactional style and the home environment are more direct indicators of the family's role in delinquency than are family structural variables (LeFlore, 1988; Tolan, Cromwell, & Brasswell, 1986). In addition to family structure, family functional and family environmental variables may contribute a greater influence on the development of delinquent behavior.

Functional/Environmental Variables

Several reviews of the literature (McGaha & Fournier, 1988; Thornburg, 1986; Tolan et al., 1986) found functional and environmental family variables related to juvenile delinquency to include the following: a) difficulty in establishing consistent rules and expectations; b)

difficulty resolving conflicts; c) negative family affect; d) incomplete or negative attachment between adolescent and parent; e) inadequate or aggressive modeling by parents; f) parents less likely to praise children or show interest in their activities; g) communications often defensive, lacking focus, or dominated by one family member; h) equalitarian or child-skewed power distributions in family decision-making; i) frequent parental disagreements and conflicting directives to children; j) misperception of a greater proportion of communications; and k) a larger proportion of communications that indicate an unwillingness to compromise.

There is a great deal of evidence that child-rearing techniques are among the best predictors of all juvenile delinquency (Loeber & Dishion, 1983). In an extensive review of the literature, the authors conclude that parental family management techniques were the best predictors; family criminality also played an important role. Patterson and Stouthamer-Loeber (1984) support the significance of certain family management practices, particularly parental monitoring (i.e., knowing where the child is, with whom the child is and what the child is doing) in the etiology of delinquency. Monitoring seems to play a dual role. Initially, it may determine which youth become engaged in delinquent activities, and further, it may determine which

delinquents become recidivists. Indeed, the authors found that parental monitoring was the only variable to differentiate chronic from moderate offenders.

LeFlore (1988) studied the perceived family environment of delinquents and non-delinquents and found non-delinquents score significantly higher in the area of personal growth. The non-delinquent family environment also could be distinguished by a more positive perception of the family's moral-religious emphasis, and more achievement and active-recreational orientations. The delinquents perceived their family relationships as less cohesive and less expressive than did non-delinquents. In addition, Paperny and Deisher (1983) show the association between adolescent abuse by a parent and subsequent violence and delinquent behavior by the adolescent.

Early investigations of gender differences in juvenile delinquency thought that female delinquency was attributed almost solely to personal or familial factors, while social structural forces are also used to explain male delinquency. Parent-child relations were thought to be more relevant to female than male delinquency (Johnson, 1987). A study by Johnson (1987) did not confirm these beliefs. He found no differences between males and females in their level of attachment to either parent, and that both boys and girls

were more strongly attached to their mother. Family variables seemed to have a slightly greater impact on male misbehavior. The father's role related to delinquency appears to be somewhat greater than the mother's role. Increased distance, especially openly hostile relations (i.e., active detachment) with father was strongly correlated with increased delinquency for both girls and boys. This finding was confirmed by Kroupa (1988) in a sample of incarcerated female delinquents, who reported ambivalent perceptions of the mother-daughter relationship compared to clearly negative perceptions of the father-daughter relationship.

Though there is strong evidence that many family environment variables are related to juvenile delinquency, it is not clear that the family is the cause of delinquency. Thornburg (1986) cautions about interpreting the results of these studies, citing the limitations of self-reports at the time of offense and the difficulty in distinguishing and controlling for the additional stress and impact of the delinquent behavior and involvement in the legal and court systems on family relations.

There is also some question as to whether the effects of family environment are consistent across various ethnic and racial groups. Two studies of homogenous racial groups

comparing delinquents and non-delinquents did not show significant differences in perception of family environment. Weller and Luchterhand (1983) grouped boys in a low-SES black neighborhood by recommendations from people in the community who had regular contact with youth. Community persons were asked to list youth who they thought were "among the promising" or "headed for trouble." Little difference was found between the two groups regarding the boys' perceptions of their family relations. In a study of Mexican-American youth (Martinez, Hays, & Solway, 1979) there was no difference in perception of family environment between delinquents and non-delinquents.

Psychosocial Theory

As was mentioned earlier, Anolik (1983) described two trends in the study of the relationship between family background variables and juvenile delinquency . The first, biosocial theory, has already been discussed. Psychosocial theory differs from biosocial theory due to the inclusion of intrafamilial influences or influences outside the family. These influences are seen either as causes of delinquency themselves, or as contributing factors, exacerbating biological predispositions. Environmental conditions outside the home, particularly the adolescent's peer group, are included in this theoretical perspective. Two important

variables are considered: a) inadequate socialization in the family; and b) environmental forces outside the home which reinforce delinquent behavior (Anolik, 1983). Inadequate socialization can occur due to a variety of reasons. Weak parent-child attachment, outright rejection by the parent(s), overprotection by parents (more common among middle-class families), or the low status of the child in the home can cause the child to attempt to meet his/her needs outside the home. By so doing, the child becomes susceptible to deviant peer influences which often raise the status of the youth, at least on a short-term basis.

A variation of general psychosocial theories is the control theory, espoused by Hirschi (1969). Control theory emphasizes a strong parent-child attachment, characterized by the child's sensitivity to the parents' wishes or opinions. The greater the sensitivity, the more likely the child is to consider the wishes and opinions of his/her parent when contemplating a deviant act. The presence of control, via parental support, is seen as inhibiting delinquent behavior. Weak attachment is characterized by low sensitivity to parental wishes, thus enhancing the likelihood of delinquent acts and involvement with a delinquent peer group. Poole and Regoli (1979) conducted an interactional study of parental support and delinquent

friends to examine the influences postulated in control theory. They found that both parental support and delinquent friends exerted independent influences on delinquency, but delinquent friends have a greater impact when parental support is weak than when it is strong. Attachment to parents minimizes the impact of delinquent associations, thus providing support for the tenets of control theory.

Anolik (1983) calls for an integration of biosocial and psychosocial theories of juvenile delinquency due to the deficiencies in each. Biosocial theory fails to incorporate the probability that some juvenile offenders do not have dysfunctional nervous systems or other physical abnormalities. Psychosocial theories, on the other hand, do not adequately consider the possibility that biological abnormalities in children may trigger maladaptive relationships in families, a bi-directional view, which may lead to antisocial conduct by youths. Anolik proposes an integration of the two theories by delineating a typology of several different subgroups of delinquents, some exhibiting physical characteristics and others possessing normal physiology. Interestingly, a similar solution is offered to make sense of the conflicting research regarding the influence of family structural and functional variables.

Typologies of Delinquents

Quay (1975) delineates three subgroups of juvenile delinquents which provide an integration of biosocial and psychosocial theories. 1) Socialized-subcultural delinquents. This group includes youth who tend to be loyal to delinquent gangs, commit crimes in groups and generally come from lower SES communities. The influence of peer and family relations accounts for delinquent behavior, with biological factors not playing an important role. Characterized by poor parent-child attachment, whose families are unstable and rejecting, these youth frequently become involved with delinquent gangs whose members then reinforce each others' antisocial behavior. 2) Unsocialized-psychopathic delinquents. They tend not to form close relationships with others, engage in chronic antisocial behavior, and experience little guilt or remorse from their delinquent acts. Biological factors are thought to play a significant role. These individuals find it difficult to avoid behaviors which are punished. 3) Disturbed-neurotic delinquents are generally unhappy and depressed and tend to express guilt over the crimes they commit. This group is the least understood, perhaps partly due to the diverse etiologies (e.g., anxiety and fears, mental retardation, and attention deficit disorder) these

youth seem to experience. There is some evidence that their family relations, especially for the males, are often high in conflict and dominated by mothers (Quay, 1975).

Steinberg (1987a) suggests that the delinquency literature also indicates that three types of delinquents exist. For Steinberg, the groups are distinguished by seriousness of delinquent acts, consistency and frequency of acts, and by the delinquents' response to getting caught and punished. Most importantly for Steinberg, these groups are distinguished by the age at which they begin their delinquent behavior, and by an associated form of parental neglect. Hanson et al. (1984) support the significance of age of onset of delinquent behavior in their study, but Steinberg's typology has not been tested.

Establishing different groups of delinquents clears up confusion and controversy in the literature (Steinberg, 1987a). 1) Middle adolescent onset delinquents are characterized by onset at about 15 years of age, infrequent acts, low likelihood of adult involvement in criminal activities, average psychological development, a wide range of family backgrounds, and a low likelihood of committing violent acts. Most American adolescents fall in this category, as self-report research shows 80% of all American adolescents commit a chargeable offense at least once. The

associated parental quality for this type of delinquent is an absence of parental vigilance and insufficient monitoring; parents simply often don't know where their kids are or what they are doing. 2) Early adolescent onset delinquents begin at about ages 11-14, have a high probability of repeated offenses during adolescence, but low probability of trouble with the law as an adult, are somewhat psychologically immature, exhibit low scores on measures of self-reliance, leadership and self-esteem, date and have sexual relations relatively early, and are more likely to be more peer-oriented and influenced. Parental permissiveness characterizes this group. Parents are tolerant, accepting of child's impulses, avoid exercising parental authority or control, make few demands and offer few rules for structuring the child's daily schedule. This permissiveness can occur with high affection (i.e., enmeshment) or with hostility (i.e., disengagement). 3) Preadolescent onset delinquents are the most serious and commit the most violent crimes. They stand apart from peers at an early age, are aggressive, impulsive, exhibit poor social skills, and their antisocial acts continue through adolescence and into young adulthood. These delinquents are usually male, from poor, disorganized families where adults provide little supervision, are likely to have delinquent

siblings, and are distinguished by the chronicity and frequency of misbehavior and general resistance to intervention. Family relationships are characterized by significant disruption in the parent-child relationship, with high levels of hostility and coerciveness and low levels of nurturance and support. Parents are generally emotionally immature and socially isolated, and the child's constitutional make-up interacts with poor parental qualities in a bi-directional manner resulting in insecure attachment.

The theories discussed thus far, though divergent, are consistent in their level of analysis. Linear causality has been assumed; poor parent-child attachment causes delinquency, or a child's physiological predisposition in the presence of parenting that does not adapt to the child's idiosyncracies may result in antisocial behavior. Except for occasional isolated remarks about bi-directional influences, the theories have assumed a uni-directional approach. The following theories assume a bi-directional influence, thus the child's constitutional makeup impinges on the parenting style at the same time the parenting style impinges on the child's behavior. Circular, rather than linear causality will be inherent in the following theories. The level of analysis will be expanded. By way of analogy,

the theorists thus far have been like coaches on the sideline, removed from the action, but close enough to see the effects of the actions and reactions on the field. This next level assumes a wider perspective, much like the coach high above the field who can see the plays develop, can spot patterns related to the accumulation of the plays and may even see the influence the coach on the sideline has upon the plays on the field.

Family Systems Theory

Disenchanted with linear causality, family systems theorists began to assert that behavior must be examined within the context of the natural social organization for individuals - the family. Mutually causative systems whose behaviors complement, reinforce and perpetuate one another establish family interactions. Behavior that perhaps does not make sense initially takes on a new meaning when viewed within the contexts that individuals function within. The locus of malfunction moves from within the individual to the interactional processes between people, particularly between and among family members (Taylor, 1985). This notion of reciprocity is integral to family systems theory. Behavior is imbedded and maintained in an ongoing, continuous process of interactions between and among people.

Another significant contribution of family systems theory is the notion that behavior, even behavior viewed on the surface to be bad or dysfunctional, serves some positive function or purpose within the family system. This positive connotation of behavior opens up new ways of thinking about and intervening in human problems. Behavior is viewed in light of the environment of the individual, as parts of the family system interact to maintain homeostasis or balance. For example, a father is laid off work; he becomes depressed and withdrawn from the family. His wife begins to nag and prod her husband to seek work, resulting in increased withdrawal by the husband and more nagging from the wife. The son connects with some delinquent friends and gets in trouble with the law. This crisis rallies the family, pulls dad out of depression, and unites mom and dad in a common cause. Soon after, the parents begin to worry about their son and the upcoming court involvement, thus once again leading to dad's depression, mom's subsequent nagging....and the son again commits a delinquent act as the cycle repeats (Taylor, 1985). The son's symptom actually serves to balance the family, re-involve dad in the family, and reunite mom and dad. The deviance is a sign that structural changes may be necessary for the family's healthy survival. This frame of reference allows for more points of

intervention, thus, in this example, mom can be encouraged to work for a while as dad attempts to begin a business with the help of the son.

Delinquency serves as a homeostatic device that signals a failing family system. This process may bring aid to the family from extended family, social agencies or the community under the guise of helping the family to cope with or reform the delinquent. At the same time, the delinquent organizes a dysfunctional family system by becoming the scapegoat for the family, in a manner that could be seen as sacrificing and protective (Tolan et al., 1986).

Using an assessment device designed to determine adaptability and cohesion in the family system, McGaha and Fournier (1988) found significant differences between a study sample of juvenile court referrals and national norms. Families with a delinquent were significantly less cohesive and much more rigid. The dimensions also distinguished families in which violent crimes or property crimes were committed.

The interactional processes inherent in the family systems model are not easily tested. Such notions as the positive function of the symptom are actually beyond the realm of traditional scientific investigation. New models are being developed to assess interactions between people,

but much more needs to be done.

Many family systems theorists, especially those with a clinical bent, argue that the question of whether these notions are true is not important. Their significance lies in the utility of these concepts; usefulness outweighs proving their existence. Alexander, Waldron, Barton and Mas (1989) report on the utility of positively connoting delinquent adolescent's behavior. They found that "relabeling" or positively connoting the delinquent's behavior helped to shift a negative focus to a more positive, non-blaming, relational view, thus decreasing resistance and negative tone in therapeutic interactions with the family of the delinquent adolescent. They also found that once negative, blaming attributions are developed, they are harder to undo. Indeed, many of the earlier theories would result in a blaming, negative view either of the parents or the adolescent, handicapping efforts at change.

Research indicates that family systems therapy with juvenile delinquents is effective. Tolan et al. (1986) conducted an extensive review of the outcome research of family therapy with delinquents. Citing 37 studies, they concluded that, given limitations of several studies, family systems therapy with delinquents has shown consistent

positive effects. Those studies with more rigorous designs have provided some of the more positive evidence. In addition, there is evidence that family therapy is more effective with this population than are other therapeutic modalities or traditional juvenile justice interventions. McGaha and Fournier (1988) further support those findings, concluding that family-based therapies, particularly systems therapy, incorporates a broader theoretical perspective in assessing the adolescent's problem and provides for a more comprehensive, effective approach. In a follow-up study (Klein, Alexander, & Parsons, 1977) of family therapy with delinquent adolescents, not only did delinquent behavior improve, but the non-treated younger siblings showed significantly less delinquent behavior, suggesting a true primary prevention effect.

Family systems theory and therapy is not a panacea; even those within the field suggest it is not a cure-all, and should be but a part of an overall assessment and treatment plan (LeFlore, 1988; Taylor, 1985). Individual and social contexts must also be assessed in order to develop an effective and comprehensive plan. Schleser and Rodick (1982) draw attention to some of the limitations of family systems theory and therapy in the etiology of juvenile delinquency. These family therapy models address

the most important system that concerns the adolescent, but generally ignore the impact of extrafamilial systems in the treatment of juvenile delinquency and other childhood psychopathologies. They claim that family therapists wrongly assume that structural change must take place in the family for maladjusted behavior to cease. A more comprehensive approach which takes into consideration individual factors and extrafamilial systems, while maintaining the philosophical and theoretical underpinnings of systems therapy, is suggested.

Expanding the earlier analogy, a shift is made from the view of the coach in the box to a much broader perspective, like that from the blimp hovering over the stadium, from where other systems such as the fans, the transportation network, the neighborhood, the city, etc. can be seen. At the same time the perspective is broadened, the cameraman has the capacity to zoom in on individual players, fans, coaches, or citizens, providing the possibility to view both larger systems and their interrelationships, and individuals within those systems. The result is a comprehensive, multi-level ecological perspective.

Family-Ecological Systems Theory

The family-ecological systems approach provides a broad panorama which, in addition to the family, addresses

developmental and community issues. This approach also considers the interrelationships among adolescent behavior, the family, and extrafamilial systems. It recognizes the primacy of the family, but postulates that the family is not the only system in which to intervene to remediate dysfunctional adolescent behavior (Schleser & Rodick, 1982). This approach also gives attention to individual developmental and constitutional factors of the adolescent.

The family-ecological systems approach is based upon the literatures of social development, cognitive development, childhood psychopathology, family therapy models and community mental health (Henggeler, 1982). The adolescent is embedded in and interacts with several systems and subsystems. Like systems theory, this approach assumes a bi-directional, reciprocal process of interaction and posits that deviant adolescent transactions are often quite adaptive when viewed from the adolescent's ecological context, whether that be the family, school, neighborhood, peer group or other system.

Central to this approach is Bronfenbrenner's (1977) ecological approach to human development, a multi-level, interrelational model. Bronfenbrenner delineates several systemic levels to be included in a comprehensive ecological analysis. The <u>microsystem</u> is the complex of relations

between the developing person and each separate environment in an immediate setting containing that person (e.g., home, school, workplace). The interrelations among major settings containing the developing person at a particular point in life constitute the mesosystem. The exosystem is comprised of other specific social structures that do not contain the person but impinge upon and encompass the individual; included are major societal institutions such as the world of work, the media or the neighborhood. Finally, the macrosystem includes general prototypes or models that convey the values, beliefs, and assumptions of a culture.

The family-ecological systems approach, like Belsky's (1980) modification of Bronfenbrenner's ecological model, includes individual characteristics, but does not label those as ontogenic developmental issues as Belsky does. Henggeler's (1982) family-ecological systems theory does not concisely organize information within the multi-level Bronfenbrenner model as clearly as Belsky does in his ecological etiology of child maltreatment. Finally, Belsky's analysis lacks the mesosystem level that Bronfenbrenner originally included. The model proposed here is intended to resemble Belsky's modification of Bronfenbrenner's model (i.e., including ontogenic developmental issues) but differs from Belsky due to the

reinsertion of the mesosystem.

Family-Ecological Developmental Systems Theory (FEDS)

The family-ecological developmental systems theory provides a more comprehensive model for understanding juvenile delinquency and for determining interventions designed to treat and decrease the incidence of juvenile delinquency. It includes all the characteristics and advantages of Henggeler's (1982) family-ecological systems approach, but organizes information more systematically. This systematic organization allows for a more thorough understanding of juvenile delinquency, sheds light upon conflicting research findings, helps to develop interventions targeted at various systems and relations between systems, and provides a framework from which additional research can be designed, particularly at the intrasystemic and intersystemic levels. The organization of existing knowledge in the field of juvenile delinquency into this model is beyond the scope of this paper. What is presented here is merely an outline by which existing knowledge and theories can be organized and evaluated.

Ontogenic Developmental Issues. Individual developmental issues of both the parents and adolescents would be included in this level. Parental factors would incorporate such items as history of criminality, history of

abuse, psychological development, mental illness, substance abuse, parental attachment, occupation, education, parenting style, values, and other personal characteristics and developmental experiences.

Individual child/adolescent developmental issues would include such considerations as constitutional predisposition, intelligence, birth order, physical health, cognitive ability, and capacity to respond to rewards and punishments. In a study of individual factors (Levine et al., 1985) violent adolescent delinquents could be distinguished by higher levels of childhood health problems, particularly recurrent head trauma, loss of consciousness, seizures, perinatal complications, and other serious forms of injury. They also found that learning disabilities, especially expressive language skills, visual perception, sequencing, and motor coordination showed a difference between delinquents and non-delinquents.

Levine et al. (1985), while identifying many distinguishing individual characteristics, qualified their findings to suggest that individual factors alone would not necessarily lead to delinquency. Indeed, they noted that evidence exists to conclude that children exhibit a resiliency to overcome these limitations if other areas are positive. Some of these other areas will now be considered

within this model.

Microsystem. The microsystem is the complex of relations between the developing person and the environment in an immediate setting containing that person. The adolescent is embedded in several significant settings (i.e., microsystems) that greatly impact upon his/her life and daily activities. The family is assumed to be the most significant in this model. LeFlore (1988) reminds us of the subtle influence of the family in determining the area in which the youth grows up and in deciding the amount of social, economic or political power the youth has, which greatly affects the chances of becoming delinquent. Family influences upon juvenile delinquency were established earlier, and this microsystem setting has received considerable attention in research and theory development.

Other settings also exert a great influence upon adolescents. The peer group takes on increased significance during this developmental stage. Much of juvenile delinquency occurs in the presence of and with the support of peers. School is another setting in which the adolescent is embedded and spends a considerable amount of time. A positive educational environment and healthy involvement in extracurricular activities could provide a notable deterrent to delinquency, even in the face of other risk-enhancing

influences. The adolescent's workplace must also be considered as an important setting. Steinberg (1986) reports that two-thirds of all teens did something either delinquent or otherwise deviant at work within the first two months on their first paid job. These areas - peer group, school, and work - all deserve more attention in future research and in the development of theoretical and treatment models.

Consideration of settings in which parents and other family members are contained would also be included in this comprehensive model. Among those settings to be addressed are: parents' workplace; parents' peer group and social life; extended family contact and involvement; and siblings' school, peer group and workplace.

Mesosystem. The interrelations among major settings containing the developing person at a particular point in life constitute the mesosystem. This level, rather than being merely descriptive, addresses interactional influences among the major settings in which a person is involved. Little research currently exists that confronts these interactional influences. More research like the interactional study of parental support and delinquent friends (Poole & Regoli, 1979) is called for. Other interactional relationships, such as those between school

performance and involvement with delinquent peers, or between the family and workplace could be examined. Analyses of various combinations of variables among the family, school, peer group, and workplace would reveal important interactions and identify nuances thus far unnoticed. Identification of meaningful relationships between and among settings could do much to advance understanding of the combination of factors that interact to increase or decrease the likelihood of engagement in delinquent activity.

Exosystem. The exosystem embraces other specific social structures that do not contain the person but impinge upon and encompass the individual. Significant societal institutions at this level are the neighborhood and the juvenile justice system. Cohen, Poag, and Goodnight (1982) highlight the impact of the neighborhood on juvenile delinquency. Certain environmental factors of inner city neighborhoods have been correlated with delinquency. It is not clear, though, whether juvenile delinquency is more a function of lower SES in urban areas or of inherent neighborhood features. Greater distances between adolescents in rural settings also have an impact; the car and associated "cruising" become more important to counter the physical distances and lack of easy access to peers

afforded in urban areas.

The juvenile justice system is a crucial institution in understanding juvenile delinquency. In 1967, the President's Commission on Law Enforcement and Administration of Justice concluded that efforts had not been successful in rehabilitating troubled youth or in stemming rising crime rates among juveniles (in McGaha & Fournier, 1988). The report emphasized the importance of the family as a vital component in stemming crime rates and recommended strongly that counseling and therapy for families be made easily available. Despite these recommendations, McGaha and Fournier (1988) explain that, twenty years later, true family-oriented programs are rare in juvenile court programs; they are the exception rather than the rule. It was also mentioned earlier that involvement in the juvenile justice system is itself stress-inducing and possibly serves to maintain dysfunctional family interactions or negative attributions by blaming one or more components of the family. Many question the utility of punishing a juvenile by costly placement in an institution without treating the family, when these youth almost always return to the same unchanged family environment. Barker (1982) challenges the fairness of removing an adolescent from the home or society, what he terms "delinquent-ectomies", which simply remove

what may actually be merely a symptom of social pathology. Society seems to be punishing the results of its own values and norms, some of which will be considered next.

Macrosystem. This level includes general prototypes or models that convey the values, beliefs and norms of a culture. Steinberg (1987a) cites two sets of factors in contemporary society that contribute to juvenile delinquency. One is a change in child-rearing from a posture of "protection" to one of "preparation" by which younger children are exposed at earlier ages to experiences previously reserved for those who are older, thus "hurrying" them toward adulthood. The other set of factors is the limited contact young people have with their elders, a common phenomenon in most industrialized nations. Steinberg puts juvenile delinquency into perspective as one of many adolescent problems, claiming that similar trends exist for adolescent pregnancy, school failure, and drug/alcohol use. Two groups of adolescents who in the past have shown lower rates of problem behavior are early adolescents and female adolescents. In recent years these groups have shown the fastest rates of increase in many of these problems areas. Steinberg (1986) earlier concluded that the prevalence of delinquency says something significant about the nature of adolescence in contemporary society.

Indeed, when 80% of all adolescents report at least one chargeable offense, and when two-thirds of all adolescents commit some deviant act within the first two months on the job, one must consider overarching societal values and norms rather than individual or family dysfunction. Several explanations have been suggested. Changes in family structure without the accompanying political and economic structures to support these new family forms is forwarded as a contributing factor (Taylor, 1985). Thornburg (1986) emphasizes the impact of social change on the family. Changes in role patterns are occurring without attached changes in values.

Industrialization, urbanization, gender role shifts, divorce, family planning and economics all play a role. Thornburg also mentions a societal decline in adult authority and an emphasis on individuality, with adolescents showing a greater inclination to defy authority and expect equal rights in relationships with adults. The absence of meaningful roles for young people and their disengagement from the social order, along with the inherent nature of peer pressure among contemporary youth (Steinberg, 1986) may further play a role. Delinquency could also be related to attempts to acquire objects (e.g., car, money, alcohol, drugs, latest clothes) needed for membership in the youth

culture, and rises in female delinquency have been associated with changing sex roles and increasing involvement by females in a broader spectrum of activities (Thornburg, 1986).

Conclusion

The family-ecological developmental systems model provides a useful framework to organize existing findings and to highlight areas deficient in knowledge and understanding. This comprehensive model, with an inherent ability to focus on components from detailed individual characteristics to broad societal values, encompasses factors that more limited models could not include. For example, Steinberg's (1987a) typology of delinquents with associated forms of parental neglect, would lead one to believe that a large percentage of parents were neglectful, when instead, larger societal values can be understood as the umbrella under which late adolescent onset delinquency occurs. A fundamental advantage of this model is the capability not only to design research within levels, but also to consider interactional processes between and among levels, resulting in qualitatively better and more useful information. Delineating various levels promotes the creation of interventions designed to impact at certain levels or at junctures between levels to develop more

comprehensive and effective preventive and remedial treatment. Thus, adoption of this family-ecological developmental systems model represents a subtle, yet revolutionary, shift in focus which can have far-reaching consequences for practice, research methods, and public policy.

References

Alexander, J. F., Waldron, H. B., Barton, C. & Mas, C. H. (1989). The minimizing of blaming attributions and behaviors in delinquent families. Journal of Consulting and Clinical Psychology, 57, 19-24.

Anolik, S. A. (1983). Family influences upon delinquency: Biosocial and psychosocial perspectives. Adolescence, 18, 489-506.

Barker, P. (1982). Residential treatment for disturbed children: Its place in the '80's. Canadian Journal of Psychiatry, 27, 634-638.

Belsky, J. (1980). Child maltreatment: An ecological integration. American Psychologist, 35, 320-335.

Bronfenbrenner, U. (1977). Toward an experimental ecology of human development. American Psychologist, 32, 513-531.

Cohen, R., Poag, C. K., & Goodnight, J. A. (1982). The impact of physical setting on the adolescent. In S. W. Henggeler (Ed.), Delinquency and adolescent psychopathology: A family-ecological systems approach (pp. 163-185). Littleton, MA: Wright-PSG.

Dornbusch, S. M., Carlsmith, J. M., Bushwall, S. J., Ritter, P. L., Leiderman, H., Hastorf, A. H. & Gross, R. T. (1985). Single parents, extended households, and the control of adolescents. Child Development, 56, 326-341.

Farnworth, M. (1984). Family structure, family attributes and delinquency in a sample of low-income, minority males and females. Journal of Youth and Adolescence, 13, 349-364.

Geismar, L. L. & Wood, K. M. (1986). Family and delinquency: Resocializing the young offender. New York: Human Sciences Press.

Hanson, C. L., Henggeler, S. W., Haefele, W. F., & Rodick, J. D. (1984). Demographic, individual and family relationship correlates of serious and repeated crime among adolescents and their siblings. Journal of Consulting and Clinical Psychology, 52, 528-538.

Henggeler, S. W. (1982). The family-ecological systems theory. In S. W. Henggeler (Ed.), Delinquency and adolescent psychopathology:A family-ecological systems approach (pp. 1-10). Littleton, MA: Wright-PSG.

Hirschi, T. (1969). Causes of delinquency. Berkeley, CA: University of California Press.

Johnson, R. E. (1987). Mother's versus father's role in causing delinquency. Adolescence, 22, 305-315.

Jones, M. B., Offord, D. R., & Abrams, N. (1980). Brothers, sisters and antisocial behavior. British Journal of Psychiatry, 136, 139-145.

Klein, N. C., Alexander, J. E., & Parsons, B. V. (1977). Impact of family systems intervention on recidivism and sibling delinquency: A model of primary prevention and program evaluation. Journal of Consulting and Clinical Psychology, 45, 469-474.

Kroupa, S. E. (1988). Perceived parental acceptance and female juvenile delinquency. Adolescence, 23, 171-185.

LeFlore, L. (1988). Delinquent youths and family. Adolescence, 23, 629-642.

Levine, M. D., Karniski, W. M., Palfrey, J. S., Meltzer, L. J., & Fenton, T. (1985). A study of risk factor complexes in early adolescent delinquency. American Journal of Diseases of Children, 139, 50-56.

Loeber, R. & Dishion, T. (1983). Early predictors of male delinquency: A review. Psychological Bulletin, 94, 68-99.

Martinez, M., Hays, J., & Solway, K. (1979). Comparative study of delinquent and non-delinquent Mexican-American youths. Psychological Reports, 44, 211-215.

McGaha, J. E. & Fournier, D. G. (1988). Juvenile justice and the family: A systems approach to family assessment. Marriage and Family Review, 12, 155-172.

Paperny, D. M. & Deisher, R. W. (1983). Maltreatment of adolescents: The relationship to a predisposition toward violent behavior and delinquency. Adolescence, 18, 499-506.

Patterson, G. R. & Stouthamer-Loeber, M. (1984). The correlation of family management practices and delinquency. Child Development, 55, 1299-1307.

Poole E. D. & Regoli, R. M. (1977). Parental support, delinquent friends and delinquency: A test of interaction effects. The Journal of Criminal Law and Criminology, 70, 188-193.

Quay, H. C. (1975). Classification in the treatment of delinquency and antisocial behavior. In N. Hobbs (Ed.), Issues in the classification of children (Vol. 1, pp. 377-392). San Francisco: Jossey-Bass.

Schleser, R. & Rodick, J. D. (1982). A comparison of traditional family therapy and the family-ecological systems approach. In S. W. Henggeler (Ed.), Delinquency and adolescent psychopathology: A family-ecological systems approach (pp. 11-26). Littleton, MA: Wright-PSG.

Steinberg, L. D. (1986). Parents: Neglectful and neglected. Today's Delinquent, 5, 7-50.

Steinberg, L. (1987a). Familial factors in delinquency: A developmental perspective. Journal of Adolescent Research, 2, 255-268.

Steinberg, L. (1987b). Single parents, stepparents and the susceptibility of adolescents to antisocial peer pressure. Child Development, 58, 269-275.

Taylor, L. S. (1985). The family as an adaptable and enduring social unit: A case for assessing delinquent behavior from a family systems perspective. Today's Delinquent, 4, 69-97.

Thornburg, H. (1986). Adolescent delinquency and families. In G. K. Leigh & G. W. Peterson (Eds.), Adolescents in families (pp. 358-380). Cincinnati, OH: South-Western Publishing.

Tolan, P. H., Cromwell, R. E., & Brasswell, M. (1986). Family therapy with delinquents: A critical review of the literature. Family Process, 25, 619-650.

Weller, L. & Luchterland, E. (1983). Family relationships of "problem" and "promising" youth. Adolescence, 18, 93-100.

Wells, L. E. & Rankin, J. H. (1985). Broken homes and juvenile delinquency: An empirical review. Criminal Justice Abstracts, 17, 249-272.

Appendix D:

Introduction Letter

VIRGINIA POLYTECHNIC INSTITUTE AND STATE UNIVERSITY

DEPARTMENT OF FAMILY AND CHILD DEVELOPMENT -
NORTHERN VIRGINIA GRADUATE CENTER - (703) 698-6035

Dear

I appreciate your interest in the research about which I spoke with you over the phone. As you may know, doing research on adolescents can be difficult. I would greatly appreciate any assistance you can provide in executing this important research on adolescent sexual offenders and other juvenile delinquents.

Here's what would be expected if you decided to assist in this research:

-Complete (if youth is in your custody) or have parent/guardian complete a permission form prior to giving the adolescent a questionnaire.
-Explain and distribute the questionnaire, or for residential programs, arrange for a time when I could come and distribute them, whichever is more feasible.
-Collect and return both completed and non-completed questionnaires, ensuring confidentiality.
-Remind youth about completing questionnaire, so an acceptable response rate is achieved.
-Complete a brief form stating your program/facility's cooperation with the research project.

Instructions and all necessary forms will be provided and postage will be paid by the research project. Basically, your commitment is one of time, encouragement and follow-up.

I would be happy to share the results of the study with you when the project is complete, and your cooperation will be acknowledged in my final paper.

If you have any questions, please contact me.

Thank you for your consideration.

Sincerely,

Gary P. Bischof
4837 N. 25th St.
Arlington, VA 22207
Ph: H (703) 522-8265
W (703) 335-7888, D.C. Metro #: 631-1703, ext. 7888

Appendix E:

Summary of Study

VIRGINIA POLYTECHNIC INSTITUTE AND STATE UNIVERSITY

DEPARTMENT OF FAMILY AND CHILD DEVELOPMENT –
NORTHERN VIRGINIA GRADUATE CENTER (703) 698-6035

Summary of Study

Adolescent Male Sexual Offenders' Perceptions of their Family Characteristics

Thesis by Gary P. Bischof
Virginia Tech, Northern Virginia Graduate Center
Department of Family and Child Development
Sandra M. Stith, Ph.D., Thesis Advisor

Introduction:

Research on adolescent sexual offenders (ASOs) has increased dramatically the past few years. Much of existing research has been concerned with individual characteristics of offenders and offenses, but little is known about the family environments of these offenders. Until recently, most ASOs were treated and placed in facilities in the same manner as other juvenile delinquents. Experts now advocate offense-specific treatment and placement for ASOs. It is unclear how, if at all, ASOs and their families differ from other juvenile delinquents who have committed either violent or non-violent non-sexual offenses. The family is thought to be crucial in the development or elicitation of sexual offenses by adolescents, but it is not clear how this occurs. Few studies have addressed family structure or family environment, though families are frequently involved in treatment.

Objective:

The objective of this study is to compare the perceptions of ASOs, violent juvenile delinquents and non-violent juvenile delinquents on several family variables. These variables include: family structure (intactness, size, birth order and sibling configuration), family adaptability and cohesion, family environment, parent-adolescent communication, sources of sexual information, and communication about sexuality with parents. Demographic factors such as age, race, and income, occupation and education of parents will also be considered. These above variables will be compared in an effort to identify factors that distinguish the groups. Findings are likely to enhance services to these families, promote continued development of theories on the etiology of sexual offenses, and help foster early identification of at-risk families.

Method:

Questionnaires will be administered to at least 30 ASOs, and to a like number of violent and non-violent juvenile delinquents. Instruments with established reliability and validity will be used to measure the above variables. Instruments include:

*Family Adaptability and Cohesion Evaluation Scales (FACES III)
*Family Environment Scale (Moos)
*Parent-Adolescent Communication Scale
*Family Sex Communication Quotient
Subjects will also be asked to complete a self-report instrument of delinquent behavior and sexual offenses.

The Virginia Tech Institutional Review Board for Research Involving Human Subjects has approved this research and has determined that subjects are at minimal risk and that proper safeguards have been taken. These safeguards include:

A. A letter will be requested from each program/facility that agrees to be involved in the research, indicating their understanding of the research and expressing their cooperation.

B. Written permission will be obtained from each youth's parent/guardian/custodian. If parents have official custody, but are not available or their whereabouts are unknown, written permission from an adult responsible for the youth will be obtained. Signed parent/guardian/custodian informed consent forms will be coded to correspond to a like code on the youth's questionnaire. Consent forms and completed questionnaires will be kept separately to ensure confidentiality. Only research staff will know which completed questionnaire corresponds with which consent form.

C. Youth will be provided information about the study, its purpose and use of the results. Other information on confidentiality, voluntary participation and instructions for completion of the questionnaire will be provided in the questionnaire immediately following the cover page. Youths will be asked not to put their name on the questionnaire. Completion of the questionnaire will be understood to imply informed consent on the part of the youth.

Gary P. Bischof, Principal Investigator
Work: (703) 335-7888, D.C. Metro number: 631-1703, ext.7888
Home: (703) 522-8265 (Answering machine)

Appendix F:

Letter to Participating Programs

VIRGINIA POLYTECHNIC INSTITUTE AND STATE UNIVERSITY

DEPARTMENT OF FAMILY AND CHILD DEVELOPMENT--
NORTHERN VIRGINIA GRADUATE CENTER (703) 698-6035

Dear

Thank you for being willing to assist me in my research on juvenile delinquents and adolescent sexual offenders. I greatly appreciate your help. Enclosed are the necessary materials and instructions which will expedite your part in this project. Attached you will find:

-A Statement of Participation to be completed by you, as the individual treatment provider or program representative. This form can be completed by someone else in your program if that is more appropriate. Please return it with any completed surveys and permission forms.

-A Parent/Guardian/Custodian permission form(s) to be completed by the adolescent's parent or legal guardian. This form is coded by a number appearing directly below the zip code on the bottom of the form. After completion of the permission form, a questionnaire may be given to the adolescent. The code on the questionnaire (appearing at the end of the last line on the title page) should correspond to the number on the permission form. These codes will be used for record-keeping purposes, and will be used by research staff only. No individual scores will be reported. Youth's confidentiality will be protected.

-A Questionnaire(s), "Adolescent Perceptions of their Families", with an envelope attached. Subjects should fill out the survey, following the instructions on the second page, which you may want to be familiar with. Completed surveys should be placed in the envelope and sealed by the adolescent.

-A pre-addressed, stamped envelope to be used to return permission forms, completed questionnaires and the statement of participation form.

If you have any questions or comments, please contact me.

Thank you for your assistance; it is greatly appreciated. I will send you a summary of the results when the study is complete.

Sincerely,

Gary P. Bischof
Ph: H (703) 522-8265
W (703) 335-7888, D.C. Metro #: 631-1703, ext. 7888

2990 Telestar Court, Falls Church, Virginia 22042-1287

Appendix G:

Parent/Guardian Consent Form

VIRGINIA POLYTECHNIC INSTITUTE AND STATE UNIVERSITY

DEPARTMENT OF FAMILY AND CHILD DEVELOPMENT –
NORTHERN VIRGINIA GRADUATE CENTER (703) 698-6035

Dear Parent/Guardian,

We are conducting a study about family environment, family communication, and sex education of various subgroups of juveniles who have gotten in trouble with the law. This research is being done through the Department of Family and Child Development of Virginia Tech. The information we are looking for is not available from any other source, so your cooperation will be greatly appreciated. Results of the study will help to understand and assist young people in the future.

Each young person participating in the study will be asked to voluntarily complete a questionnaire. No names will appear on the questionnaire and the research project staff only will have direct access to the questionnaires. Results will be reported for groups as a whole; no individual information will be revealed. Results of the study or participation will in no way effect your youth's status or disposition.

The program/facility that your youth is involved with has given their support and endorsement of this study.

If you have any questions, please feel free to call either of the persons named below at (703) 698-6035.
Thank-you for your consideration.

Sincerely,

Gary P. Bischof
Principal Investigator

Sandra M. Stith, Ph.D.
Assistant Professor

I give permission for _____
(Print name of son or youth in your care)

to participate in this study by VA Tech's Dept. of Family and Child Development.

_____ _____
Parent/Guardian/Custodian Signature Date

(Return to program/facility with which youth is involved)

2990 Telestar Court, Falls Church, Virginia 22042 – 1287

Appendix H:

Program Statement of Participation

VIRGINIA POLYTECHNIC INSTITUTE AND STATE UNIVERSITY

DEPARTMENT OF FAMILY AND CHILD DEVELOPMENT
NORTHERN VIRGINIA GRADUATE CENTER (703) 698-6035
NOVAFCD@vtvm1
FAX (703) 698-6062

Statement of Participation

The below-named treatment provider/program/facility has agreed to participate in this research project sponsored through Virginia Tech's Department of Family and Child Development of the Northern Virginia Graduate Center. The study, entitled "Adolescent Male Sexual Offenders' Perceptions of their Family Characteristics", is understood to be part of the thesis requirement for Gary P. Bischof, Master's student in Marriage and Family Therapy. We understand the instructions and procedures that will need to be carried out to ensure subjects' confidentiality and safeguarded involvement.

We agree to contact Mr. Bischof or Dr. Sandra Stith, Advisor, should questions or concerns arise related to the research.

Name:_____

Address:_____

_____

_____

Phone:_____

_____ _____
Signature Date

Would you like a summary of the results of this study? YES NO

7990 Telestar Court Falls Church, Virginia 22042 - 1287

Appendix I:

Research Questionnaire

ADOLESCENT PERCEPTIONS OF THEIR FAMILIES

A Survey of Family Environment, Family Communication, and Sex Education

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Virginia Polytechnic Institute and State University
Department of Family and Child Development
Northern Virginia Graduate Center

About This Survey

The purpose of this survey is to gain information from adolescents like you about how you perceive your family. The information you provide is very important and can be very valuable in understanding and helping young people like yourself. We appreciate your taking the time to complete this survey.

There are several different types of questions. Please take time to read instructions and questions carefully.

Your responses will be kept confidential and you will not be personally identified in any way. Your answers will be used together with others from people similar to you. Scores will be reported for groups as a whole. You may withdraw from the survey at any time and you may choose not to answer a question . There will be no consequences if you decide not to participate.

Please do not put your name anywhere on the survey.

The attached survey contains copyrighted materials.

THANK YOU for your participation.

Gary P. Bischof
Principal Investigator

Sandra M. Stith, Ph.D.
Assistant Professor

Part A

First, we would like to request some general information from you.

1. How old are you? (in years) _____

2. Which one best describes your race or ethnic group? (**circle** number)

1	White (Caucasian)	4	Asian
2	Black	5	Other (specify)
3	Hispanic		_____

3. What is your sex? (**circle** one) Male Female

4. What is the employment status of your parents? (**Circle** number for **each parent.**)

Father		**Mother**
1	Employed Full-Time (more than 35 hours/wk)	1
2	Employed Part-Time (less than 35 hours/wk)	2
3	Not Employed Outside Home	3
4	Retired	4
5	Disabled	5

5. What kind of work does each of your parents do?

Father _____

Mother _____

6. What is the **highest amount of education** each of your parents has? (**Circle** number for **each parent.**)

Father		**Mother**
0	Elementary school	0
1	Some high school	1
2	High school diploma or G.E.D.	2
3	Vocational/technical school	3
4	Some college	4
5	College graduate	5
6	Some graduate school credits	6
7	Master's degree	7
8	Doctoral degree	8

7. What was the approximate income of your family last year? (**Circle** the number next to your answer.)

1	Less than $10,000	6	$50,000 - $59,999
2	$10,000 - $19,999	7	$60,000 - $79,999
3	$20,000 - $29,999	8	$80,000 - $100,000
4	$30,000 - $39,999	9	more than $100,000
5	$40,000 - $49,999		

8. What is the marital status of your parents? (**Circle** number for **each parent.**)

Father		**Mother**
1	Married (first marriage)	1
2	Remarried	2
3	Separated	3
4	Divorced	4
5	Widowed	5
6	Other (specify) _____	6

9. Please indicate who you lived with at the time of your offense or when you began treatment and who you've lived with most of your life.

Time of Offense, Began Treatment		**Most of your Life**	
1	Both natural parents	1	Both natural parents
2	Mother only	2	Mother only
3	Father only	3	Father only
4	Mother and step-father	4	Mother and step-father
5	Father and step-mother	5	Father and step-mother
6	Other relative	6	Other relative
7	Other non-relative	7	Other non-relative
8	Adoptive parents	8	Adoptive parents

10. Please list below **all** brothers and step-brothers and **all** sisters and step-sisters that you have and show their **ages** in years.

	Brothers	**Step-Brothers**	**Sisters**	**Step-sisters**
Example:	*Tom 10*			*Amy 6*

11. Please list any other people that usually live in your home and tell what their relationship is to you.

	Name	**Relationship**
Example:	*Jim*	*Uncle*

12. The total number of people living in your house is: Most of the time : _____
At the time of my offense or when treatment began: _____

13. The number of bedrooms in your house is _____

14. What kind of grades do you usually get? (**Circle** the number of the correct answer.)

1 Mostly A's	4 Mostly B's & C's	7 Mostly D's
2 Mostly A's & B's	5 Mostly C's	8 Mostly D's & F's
3 Mostly B's	6 Mostly C's & D's	9 Mostly F's

15. Have you ever been held back or had to repeat a year in school? (**Circle** one.)
YES **NO** If yes, how many times? _____

Part B

Using the following numbers, describe your family at the time of your offense. (Place the number of your answer on the blank.)

1	2	3	4	5
ALMOST NEVER	*ONCE IN A WHILE*	*SOMETIMES*	*FREQUENTLY*	*ALMOST ALWAYS*

____ 1. Family members ask each other for help.
____ 2. In solving problems, the children's suggestions are followed.
____ 3. We approve of each other's friends.
____ 4. Children have a say in their discipline.
____ 5. We like to do things with just our immediate family.
____ 6. Different persons act as leaders in our family.
____ 7. Family members feel closer to other family members than to people outside the family.
____ 8. Our family changes its way of handling tasks.
____ 9. Family members like to spend free time with each other.
____ 10. Parent(s) and children discuss punishment together.
____ 11. Family members feel very close to each other.
____ 12. The children make the decisions in our family.
____ 13. When our family gets together for activities, everybody is present.
____ 14. Rules change in our family.
____ 15. We can easily think of things to do together as a family.
____ 16. We shift household responsibilities from person to person.
____ 17. Family members consult other family members on their decisions.
____ 18. It is hard to identify the leader(s) in our family.
____ 19. Family togetherness is very important.
____ 20. It is hard to tell who does which household chores.
____ 21. Our family sits down and has meals together.

Part C

These next questions have to do with your communication with your mother.

Use the following categories to mark how much you **AGREE** or **DISAGREE** with each statement. (**Circle** the most appropriate answer for each question.)

SD *Strongly Disagree*	**D** *Disagree*	**N** *Neither Agree Nor Disagree*	**A** *Agree*	**SA** *Strongly Agree*

01.	I can discuss my beliefs with my mother without feeling restrained or embarrassed.	**SD**	**D**	**N**	**A**	**SA**
02.	Sometimes I have trouble believing everything my mother tells me.	**SD**	**D**	**N**	**A**	**SA**
03.	My mother is always a good listener.	**SD**	**D**	**N**	**A**	**SA**
04.	I am sometimes afraid to ask my mother for what I want.	**SD**	**D**	**N**	**A**	**SA**
05.	My mother has a tendency to say things to me which would be better left unsaid.	**SD**	**D**	**N**	**A**	**SA**
06.	My mother can tell how I feel without asking.	**SD**	**D**	**N**	**A**	**SA**
07.	I am very satisfied with how my mother and I talk together.	**SD**	**D**	**N**	**A**	**SA**
08.	If I were in trouble, I could tell my mother.	**SD**	**D**	**N**	**A**	**SA**
09.	I openly show affection to my mother.	**SD**	**D**	**N**	**A**	**SA**
10.	When we are having a problem, I often give my mother the silent treatment.	**SD**	**D**	**N**	**A**	**SA**
11.	I am careful about what I say to my mother.	**SD**	**D**	**N**	**A**	**SA**
12.	When talking to my mother, I have a tendency to say things that would be better left unsaid.	**SD**	**D**	**N**	**A**	**SA**
13.	When I ask questions, I get honest answers from my mother.	**SD**	**D**	**N**	**A**	**SA**
14.	My mother tries to understand my point of view.	**SD**	**D**	**N**	**A**	**SA**
15.	There are topics I avoid discussing with my mother.	**SD**	**D**	**N**	**A**	**SA**
16.	I find it easy to discuss problems with my mother.	**SD**	**D**	**N**	**A**	**SA**
17.	It is very easy to express all my true feelings to my mother.	**SD**	**D**	**N**	**A**	**SA**
18.	My mother nags/bothers me.	**SD**	**D**	**N**	**A**	**SA**
19.	My mother insults me when she is angry with me.	**SD**	**D**	**N**	**A**	**SA**
20.	I don't think I can tell my mother how I really feel about some things.	**SD**	**D**	**N**	**A**	**SA**

Part C

These next questions have to do with your communication with your father.

Like before, use the following categories to mark how much you **AGREE** or **DISAGREE** with each statement. (**Circle** the most appropriate answer for each question.)

SD *Strongly Disagree*	**D** *Disagree*	**N** *Neither Agree Nor Disagree*	**A** *Agree*	**SA** *Strongly Agree*

21.	I can discuss my beliefs with my father without feeling restrained or embarrassed.	**SD**	**D**	**N**	**A**	**SA**
22.	Sometimes I have trouble believing everything my father tells me.	**SD**	**D**	**N**	**A**	**SA**
23.	My father is always a good listener.	**SD**	**D**	**N**	**A**	**SA**
24.	I am sometimes afraid to ask my father for what I want.	**SD**	**D**	**N**	**A**	**SA**
25.	My father has a tendency to say things to me which would be better left unsaid.	**SD**	**D**	**N**	**A**	**SA**
26.	My father can tell how I feel without asking.	**SD**	**D**	**N**	**A**	**SA**
27.	I am very satisfied with how my father and I talk together.	**SD**	**D**	**N**	**A**	**SA**
28.	If I were in trouble, I could tell my father.	**SD**	**D**	**N**	**A**	**SA**
29.	I openly show affection to my father.	**SD**	**D**	**N**	**A**	**SA**
30.	When we are having a problem, I often give my father the silent treatment.	**SD**	**D**	**N**	**A**	**SA**
31.	I am careful about what I say to my father.	**SD**	**D**	**N**	**A**	**SA**
32.	When talking to my father, I have a tendency to say things that would be better left unsaid.	**SD**	**D**	**N**	**A**	**SA**
33.	When I ask questions, I get honest answers from my father.	**SD**	**D**	**N**	**A**	**SA**
34.	My father tries to understand my point of view.	**SD**	**D**	**N**	**A**	**SA**
35.	There are topics I avoid discussing with my father.	**SD**	**D**	**N**	**A**	**SA**
36.	I find it easy to discuss problems with my father.	**SD**	**D**	**N**	**A**	**SA**
37.	It is very easy to express all my true feelings to my father.	**SD**	**D**	**N**	**A**	**SA**
38.	My father nags/bothers me.	**SD**	**D**	**N**	**A**	**SA**
39.	My father insults me when he is angry with me.	**SD**	**D**	**N**	**A**	**SA**
40.	I don't think I can tell my father how I really feel about some things.	**SD**	**D**	**N**	**A**	**SA**

Part D

We would like next to give you some statements about families.

If you think the statement is **TRUE** or **MOSTLY TRUE** of your family, circle **T** for true.
If you think the statement is **FALSE** or **MOSTLY FALSE** of your family, circle **F** for false.

You may feel that some of the statements are true for some family members and false for others.
Circle **T** if it is true for most members, or circle **F** if it is false for most members of your family.
Remember, we want to know what your family seems like to **you**.

1.	T	F	Family members really help and support one another.
2.	T	F	Family members often keep their feelings to themselves.
3.	T	F	We fight a lot in our family.
4.	T	F	We don't do things on our own very often in our family.
5.	T	F	We feel it is important to be the best at whatever you do.
6.	T	F	We often talk about political and social problems.
7.	T	F	We spend most weekends and evenings at home.
8.	T	F	Family members attend church, synagogue, or Sunday School fairly often.
9.	T	F	Activities in our family are pretty carefully planned.
10.	T	F	Family members are rarely ordered around.
11.	T	F	We often seem to be killing time at home.
12.	T	F	We say anything we want to around home.
13.	T	F	Family members rarely become openly angry.
14.	T	F	In our family, we are strongly encouraged to be independent.
15.	T	F	Getting ahead in life is very important in our family.
16.	T	F	We rarely go to lectures, plays or concerts.
17.	T	F	Friends often come over for dinner or to visit.
18.	T	F	We don't say prayers in our family.
19.	T	F	We are generally very neat and orderly.
20.	T	F	There are very few rules to follow in our family.
21.	T	F	We put a lot of energy into what we do at home.
22.	T	F	It's hard to "blow off steam" at home without upsetting somebody.
23.	T	F	Family members get so angry they throw things.
24.	T	F	We think things out for ourselves in our family.
25.	T	F	How much money a person makes is not very important to us.
26.	T	F	Learning about new and different things is very important in our family.
27.	T	F	Nobody in our family is active in sports, Little League, bowling, etc.
28.	T	F	We often talk about the religious meaning of Christmas, Passover, or other holidays.
29.	T	F	It's often hard to find things when you need them in our house.
30.	T	F	There is one family member who makes most of the decisions.
31.	T	F	There is a feeling of togetherness in our family.
32.	T	F	We tell each other about our personal problems.
33.	T	F	Family members hardly ever lose their tempers.
34.	T	F	We come and go as we want to in our family.
35.	T	F	We believe in competition and "may the best man win."
36.	T	F	We are not that interested in cultural activities.
37.	T	F	We often go to movies, sports events, camping, etc.
38.	T	F	We don't believe in heaven or hell.
39.	T	F	Being on time is very important in our family.
40.	T	F	There are set ways of doing things at home.

41. T F We rarely volunteer when something has to be done at home.
42. T F If we feel like doing something on the spur of the moment, we just pick up and go.
43. T F Family members often criticize each other.
44. T F There is very little privacy in our family.
45. T F We always strive to do things just a little better the next time.
46. T F We rarely have intellectual discussions.
47. T F Everyone in our family has a hobby or two.
48. T F Family members have strict ideas about what is right and wrong.
49. T F People change their minds often in our family.
50. T F There is a strong emphasis on following rules in our family.
51. T F Family members really back each other up.
52. T F Someone usually gets upset if you complain in our family.
53. T F Family members sometimes hit each other.
54. T F Family members almost always rely on themselves when problems arise.
55. T F Family members rarely worry about job promotions, school grades, etc.
56. T F Someone in our family plays a musical instrument.
57. T F Family members are not very involved in recreational activities outside work or school.
58. T F We believe there are some things you just have to take on faith.
59. T F Family members make sure their rooms are neat.
60. T F Everyone has an equal say in family decisions.
61. T F There is very little group spirit in our family.
62. T F Money and paying bills is openly talked about in our family.
63. T F If there's a disagreement in our family, we try hard to smooth things over and keep the peace.
64. T F Family members strongly encourage each other to stand up for their rights.
65. T F In our family, we don't try that hard to succeed.
66. T F Family members often go to the library.
67. T F Family members sometimes take courses or lessons for a hobby or interest (outside school).
68. T F In our family, each person has different ideas about what is right and wrong.
69. T F Each person's duties are clearly defined in our family.
70. T F We can do whatever we want to in our family.
71. T F We really get along well with each other.
72. T F We are usually careful about what we say to each other.
73. T F Family members often try to one-up or out-do each other.
74. T F It's hard to be yourself without hurting someone's feelings in our household.
75. T F "Work before play" is the rule in our family.
76. T F Watching T.V. is more important than reading in our family.
77. T F Family members go out a lot.
78. T F The Bible is a very important book in our home.
79. T F Money is not handled very carefully in our family.
80. T F Rules are pretty inflexible in our household.
81. T F There is plenty of time and attention for everyone in our family.
82. T F There are a lot of spontaneous discussions in our family.
83. T F In our family, we believe you don't get anywhere by raising your voice.
84. T F We are not really encouraged to speak up for ourselves in our family.
85. T F Family members are often compared with others on how well they are doing at home or at school.
86. T F Family members really like music, art and literature.
87. T F Our main form of entertainment is watching T.V. or listening to the radio.
88. T F Family members believe that if you sin you will be punished.
89. T F Dishes are usually done immediately after eating.
90. T F You can't get away with much in our family.

PART E-1

Below you will find several different types of acts that are committed by some juveniles. After each group of acts, you will be asked if you have committed <u>any act</u> in that group or if you have ever been held by the police or convicted of an act in that group.

Group 1

a. Caused the death of another person without legal excuse or accidentally killed someone through gross negligent conduct (homicide, manslaughter).
b. Had sexual intercourse with someone by force or threat of force (forcible rape).
c. Took or attempted to take someone's property by force or threat of force to that person (robbery).
d. Hurt someone else physically or attempted to hurt them with the use of a deadly or dangerous weapon (aggravated assault).

Have you committed an act from this group? (Circle one) **YES NO**
Have you been held by the police or convicted for doing one of these acts from this group? (Circle one) **YES NO**

Group 2

a. Stole a car or other vehicle. (motor vehicle theft, joyriding).
b. Stole or attempted to steal other's property without the use of force (larceny, shoplifting, pursesnatching).
c. Entered or attempted to enter others' residence, building or vehicle with intent to steal (burglary, breaking & entering).
d. Damaged or attempted to damage others' property (vandalism, arson).
e. Bought, sold or knowingly had stolen property in your possession (stolen property offenses).
f. Trespassed on to another's property (trespassing).
g. Forged a check or other document, used or tried to use someone's credit card, gotten money from someone by threats or stealing (forgery, extortion, fraud).

Have you committed an act from this group? (Circle one) **YES NO**
Have you been held by the police or convicted for doing one of these acts from this group? (Circle one) **YES NO**

Group 3

a. Hurt someone physically (not seriously) or tried to hurt someone without the use of a weapon (assault, simple assault).
b. Verbally harassed others, kidnapped someone, held someone against their will, made others do something illegal, caused harm to others due to your reckless behavior (harassment, kidnapping, unlawful restraint, reckless endangerment).

Have you committed an act from this group? (Circle one) **YES NO**
Have you been held by the police or convicted for doing one of these acts from this group? (Circle one) **YES NO**

Group 4

a. Exposed private areas to others in public (indecent exposure).
b. Made phone calls of a sexual nature to others (obscene phone calls).
c. Watched or tried to watch others naked or in the act of sex (peeping tom, voyeurism).
d. Did sexual acts for pay or paid others for sex (prostitution).
e. Involved in the making of sex movies or pictures (pornography).
f. Had sexual contact or was involved in someone having sexual contact against someone's will (taking advantage of a drugged or drunken person, plotting with others to sexually molest).

Have you committed an act from this group? (Circle one) **YES NO**
Have you been held by the police or convicted for doing
one of these acts from this group? (Circle one) **YES NO**

Group 5

a. Had sexual contact with a child or tricked or bribed a child to have sexual contact with you (child molesting).

Have you committed an act from this group? (Circle one) **YES NO**
Have you been held by the police or convicted for doing
one of these acts from this group? (Circle one) **YES NO**

Group 6

a. Sold, bought or had a deadly or dangerous weapon that was against the law for you to have (carrying or possessing a deadly weapon).
b. Been drunk or under the influence of some drug in public, or drove under the influence of alcohol or drugs (public intoxication, driving under the influence).
c. Disturbed the peace, caused a riot, hung out where not supposed to, pulled a fire alarm falsely or called "911" falsely (disturbing the peace, inciting a riot, loitering).
d. Lied in court, bribed others to lie or not testify, violated probation, failed to report a crime (obstruction of justice).
e. Bought, sold or had in your possession or used illegal drugs or other substances.

Have you committed an act from this group? (Circle one) **YES NO**
Have you been held by the police or convicted for doing
one of these acts from this group? (Circle one) **YES NO**

Group 7

a. Ran away from home or other facilities you were staying at (running away).
b. Did not attend school, beyond just skipping a few days (truancy).
c. Bought, sold or consumed alcohol as a minor.
d. Acted in ways that were beyond your parents' or guardian's control (incorrigible, unmanageable).
e. Violated curfew.

Have you committed an act from this group? (Circle one) **YES NO**
Have you been held by the police or convicted for doing
one of these acts from this group? (Circle one) **YES NO**

Next, we'd like to ask you some questions about your family's communication about sexuality.

Use the following categories to mark how much you **AGREE** or **DISAGREE** with each statement.
(**Circle** the most appropriate answer for each question.)

SD *Strongly Disagree*	**D** *Disagree*	**N** *Neither Agree Nor Disagree*	**A** *Agree*	**SA** *Strongly Agree*

01.	Sex should be one of the most important topics for parents and children to discuss.	**SD**	**D**	**N**	**A**	**SA**
02.	I can talk to my parents about almost anything related to sex.	**SD**	**D**	**N**	**A**	**SA**
03.	My parents know what I think about sex.	**SD**	**D**	**N**	**A**	**SA**
04.	It is not necessary to talk to my parents about sex.	**SD**	**D**	**N**	**A**	**SA**
05.	I can talk openly and honestly with my parents about sex.	**SD**	**D**	**N**	**A**	**SA**
06.	I know what my parents think about sex.	**SD**	**D**	**N**	**A**	**SA**
07.	The home should be a primary place for learning about sex.	**SD**	**D**	**N**	**A**	**SA**
08.	I feel comfortable discussing sex with my parents.	**SD**	**D**	**N**	**A**	**SA**
09.	My parents have given me very little information about sex.	**SD**	**D**	**N**	**A**	**SA**
10.	Sex is too personal a topic to discuss with my parents.	**SD**	**D**	**N**	**A**	**SA**
11.	My parents feel comfortable discussing sex with me.	**SD**	**D**	**N**	**A**	**SA**
12.	Much of what I know about sex has come from family discussion.	**SD**	**D**	**N**	**A**	**SA**
13.	Sex should not be discussed in the family unless there is a problem to be resolved.	**SD**	**D**	**N**	**A**	**SA**
14.	Sex is too hard a topic to discuss with my parents.	**SD**	**D**	**N**	**A**	**SA**
15.	I feel better informed about sex if I talk with my parents.	**SD**	**D**	**N**	**A**	**SA**
16.	The least important thing to discuss with my parents is sex.	**SD**	**D**	**N**	**A**	**SA**
17.	I feel free to ask my parents questions about sex.	**SD**	**D**	**N**	**A**	**SA**
18.	When I want to know something about sex, I generally ask my parents.	**SD**	**D**	**N**	**A**	**SA**
19.	I feel comfortable talking with my mother about sexuality.	**SD**	**D**	**N**	**A**	**SA**
20.	I feel comfortable talking with my father about sexuality.	**SD**	**D**	**N**	**A**	**SA**

Overall, how often have you talked with each of your parents about human sexuality?
(**Circle** the appropriate answer for each parent.)

Mother	**Rarely/Never**	**Seldom**	**Occasionally**	**Often**	**Very Often**
Father	**Rarely/Never**	**Seldom**	**Occasionally**	**Often**	**Very Often**
Stepmother (if have one)	**Rarely/Never**	**Seldom**	**Occasionally**	**Often**	**Very Often**
Stepfather (if have one)	**Rarely/Never**	**Seldom**	**Occasionally**	**Often**	**Very Often**

These next few questions have to do with how your physical and sexual development compares with other people of your age.

These numbers will be used as answers for these next questions.
(Put the number of your answer on the blank. If you have not experienced an item, leave it blank.)

1 Earlier than most people my age.
2 About the same time as most people my age.
3 Later than most people my age.

Compared to other people your age, when did **you** experience:

_____ 1 A big growth in your height?
_____ 2 A change in your voice?
_____ 3 Growth of facial hair, when you first needed to shave?
_____ 4 Growth of pubic hair in your private areas?
_____ 5 Growth of body hair on your legs and under your arms?
_____ 6 An interest in girls?
_____ 7 Kissing a girl?
_____ 8 "Going out with" or dating a girl?
_____ 9 Having sexual intercourse with a girl?

Do you have other comments or ideas about family relations, family communications, sexuality, or other issues which you think are important for us to know? If so, please share your comments in the space below:

_____

_____

_____

_____

_____

_____

Thank you very much for your cooperation.

When finished, please fold the survey and place it in the envelope provided.

THE END

Appendix J:

Additional Tables

Table 10: ANOVAS for Study Samples for Age and Family Income

Variable	ASO n=39	VJD n=25	NVJD n=41	F-Ratio
	Mean	Mean	Mean	F
Age	15.39	16.16	16.34	6.41*
Family Income	$38,400	$41,000	$52,000	4.44*

*p < .01.

Table 11: Occupation of Mothers and Fathers of Samples.

Variable	ASO n=39	VJD n=25	NVJD n=41	Total n=105
Occupation:				
Mother:				
Category 1	6.1%	15.0%	15.4%	12.0%
Category 2	36.4%	45.0%	33.3%	37.0%
Category 3	42.4%	35.0%	35.9%	38.0%
Category 6	-.-	5.0%	5.1%	3.3%
Category 7	15.2%	-.-	10.3%	9.8%
				(χ^2=6.9)
Father:				
Category 1	10.3%	35.0%	31.3%	24.7%
Category 2	13.8%	10.0%	6.3%	9.9%
Category 3	37.9%	30.0%	31.3%	33.3%
Category 4	3.4%	-.-	-.-	1.2%
Category 5	13.8%	15.0%	18.8%	16.0%
Category 6	17.2%	10.0%	12.5%	13.6%
Category 7	3.4%	-.-	-.-	1.2%
				(χ^2=9.3)

Neither was significant.

Category 1: Admin, engineering, scientific, teaching.
Category 2: Technical, clerical, sales.
Category 3: Service occupation, including military.
Category 4: Farming, forestry, fishing, hunting.
Category 5: Precision production, craft & repair.
Category 6: Operators, fabricators, laborers.
Category 7: Homemakers, housewives, students.

Table 12: Paired t-Tests Comparing Violent Juvenile Delinquents' Communication with Mothers and Fathers.

Type of Communication	Mean	t-Value
Open Communication Mother.....	31.16	.35
Open Communication Father.....	30.05	
Problems in Communication Mother...	28.21	-.81
Problems in Communication Father...	30.10	
Overall Communication Mother.....	59.37	-.15
Overall Communication Father.....	60.16	

n = 19
None were significant.

Table 13: Paired t-Tests Comparing Non-Violent Juvenile Delinquents' Communication with Mothers and Fathers.

Type of Communication	Mean	t-Value
Open Communication Mother.....	31.64	2.24*
Open Communication Father.....	27.33	
Problems in Communication Mother...	29.30	.84
Problems in Communication Father...	28.09	
Overall Communication Mother.....	60.94	1.73
Overall Communication Father.....	55.42	

n = 33
*p < .05.

Table 14: Paired t-Tests Comparing Non-Problem Adolescents' Communication with Mothers and Fathers.

Type of Communication	Mean	t-Value
Open Communication Mother.....	36.03	5.08**
Open Communication Father.....	33.35	
Problems in Communication Mother...	30.56	.20
Problems in Communication Father...	30.47	
Overall Communication Mother.....	66.58	3.28*
Overall Communication Father.....	63.82	

n = 426
*p < .01; **p < .001.

Appendix K:

Additional Figures

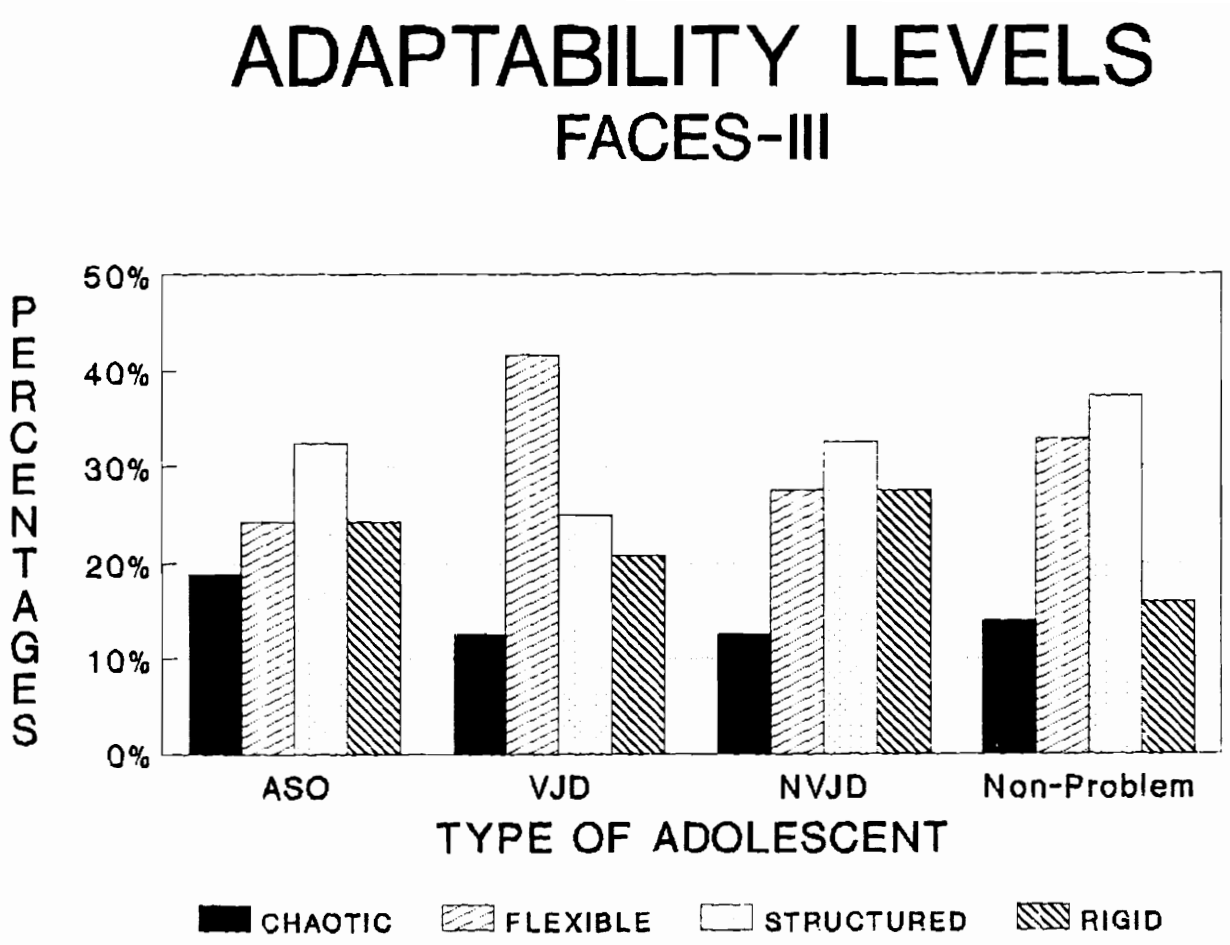

Figure 9: ADAPTABILITY LEVELS

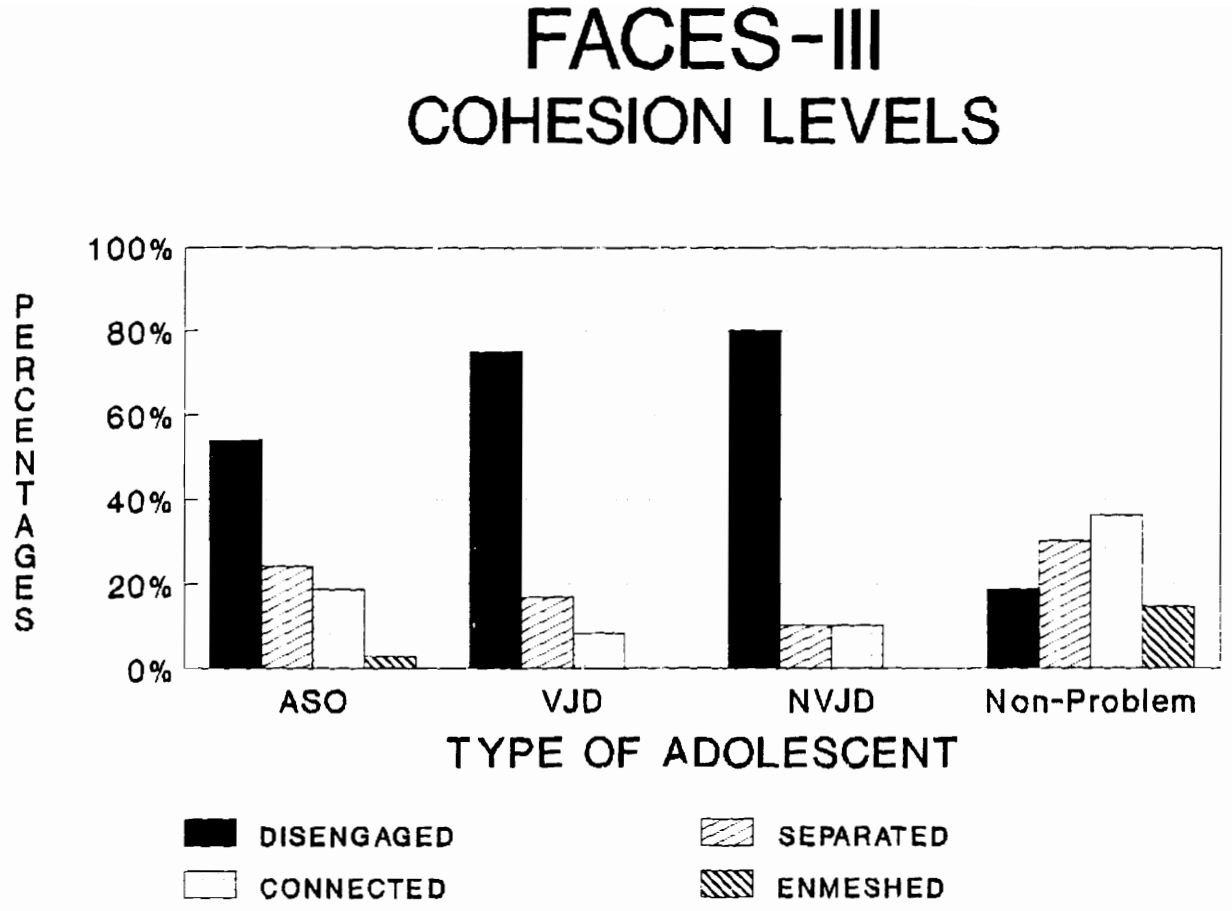

Figure 10: COHESION LEVELS

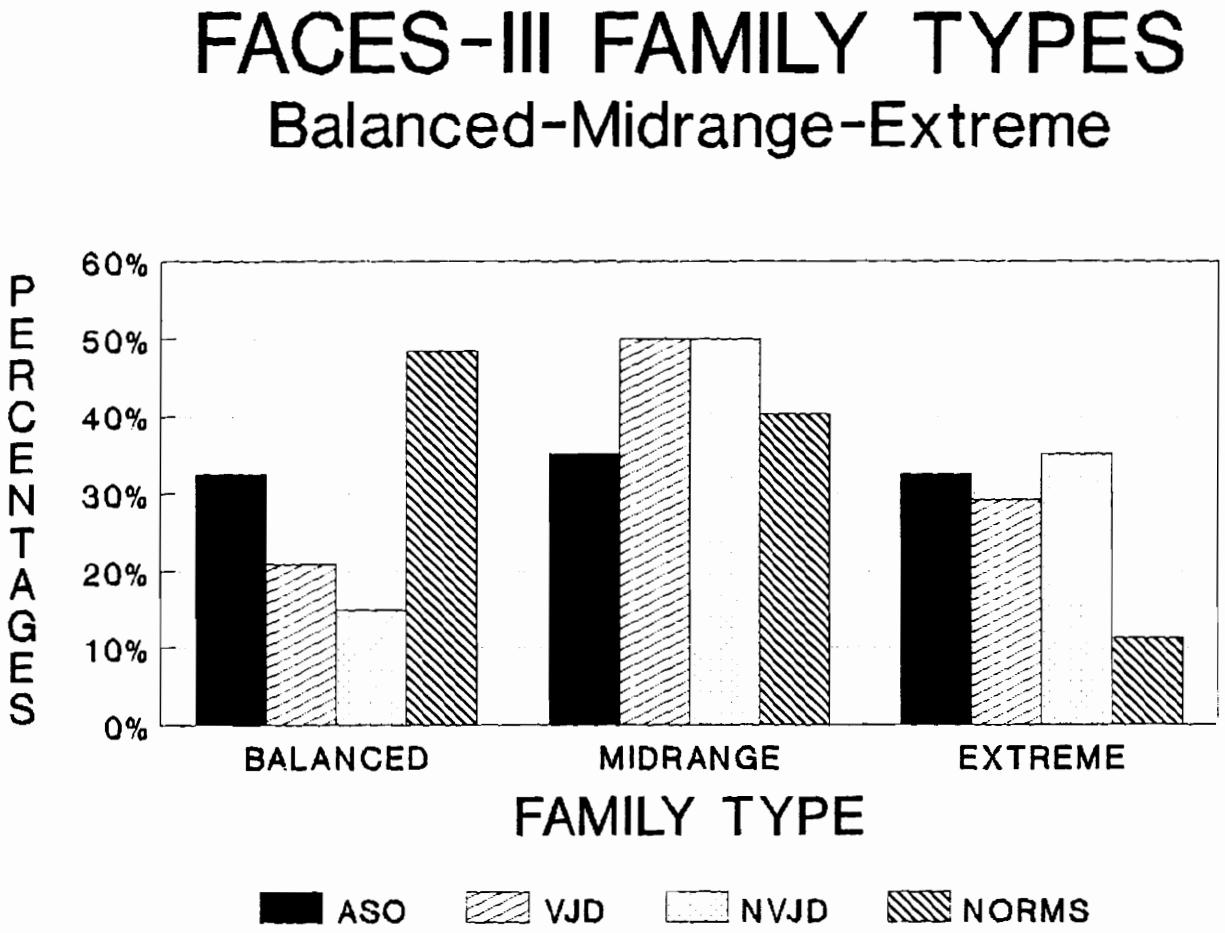

Figure 11: FACES-III FAMILY TYPES

Appendix L:

List of Participating Programs

Programs & Treatment Professionals Who Participated:

-Straight, Inc., Springfield, VA, Carolyn Armstrong, Joan Mackel.

-Youth for Tomorrow, Bristow, VA, Lloyd Chadwick.

-Fairfax House, Annandale, VA, George Young.

-Boys' Probation House, Fairfax, VA, Rice Lilley.

-Community Based Services, Inc., Fairfax, VA, Sally Wilklow, Rod Baber.

-Karma Academy for Boys, Rockville, MD, Renee Jones.

-Prince William County Group Home for Boys, Woodbridge, VA, Curt Harstad, Ray Williams.

-Family Service, Charleston, WV, Leah Whitten.

-Youth Services Training Center, Inc., Pittsburgh, PA, Michael Whitaker, Cindy Castle.

-Gail Bethea-Jackson, Oxon Hill, MD.

-Prince William County Crisis/Detox Program, Manassas, VA, Dan Blymyer.

-Center for Family Services, VA Tech, Falls Church, VA, Sergio Ceuto.

-Rockbridge Area Community Services Board, Lexington, VA, Christina Duggan, Jackie Bryant.

-Fairfax County DSS, Fairfax, VA, Beth Iddings.

-Roanoke Area Sex Offender Program, Roanoke, VA, Isaac Van Patten.

(Note: Programs/professionals are ranked by number of participants included in study, with highest first.)

Appendix M:

Vita

GARY PAUL BISCHOF

4837 North 25th St.
Arlington, VA 22207

Home: (703) 522-8265
Work: (703) 335-7888

WORK EXPERIENCE:

SENIOR THERAPIST, Prince William County Crisis/Detox Program, Manassas, VA, Oct. '89-present; Staff Therapist, May-Oct., '89. Provide outpatient and residential mental health crisis stabilization and substance abuse detoxification services in public mental health clinic. Serve families, couples, individuals and groups using a brief, solution-oriented family therapy approach with live supervision and regular teamwork.

FAMILY THERAPIST INTERN, Center for Family Services, Falls Church, VA, Sept. '88-Nov. '89. Provide counseling to families, couples, and individuals with a variety of mental health and substance abuse problems, using family systems approach utilizing live, group and individual supervision of cases.

LINE COUNSELOR, PIERRS (Pilot Information, Education, Resources, and Referral Services), Fairfax, VA, Sept.'88-Nov. '89. Cover telephone crisis line and provide crisis counseling, information and referrals to Eastern Airline pilots and families, spanning wide range of mental health and substance abuse issues.

GRADUATE ASSISTANT to Assistant Professor, VA Tech Dept. of Family and Child Development, Aug.'88-Dec.'89. Conduct literature searches, write drafts and help prepare papers for publication, particularly in the areas of domestic violence and substance abuse treatment. Prepare and edit videotapes for presentations. Execute special projects to aid in classroom teaching.

ASSISTANT CLINIC COORDINATOR, Center for Family Services, Aug.'88-May'89. Assist in operation and administration of family therapy clinic, including marketing, intakes, developing forms and procedures, and training clinicians in the use of audio-visual equipment.

GROUP HOME COUNSELOR, Prince William County Group Home for Boys, June '87-Aug. '88. Relief Counselor, Aug. '88-May '89. Conducted individual, group and occasional family counseling in a community group home with a capacity for 12 adolescent boys. Responsible for case management, crisis intervention, treatment plan development and implementation, supervision of youth, and overseeing relief counselors and volunteers. Received Departmental Service Award through nomination by colleagues.

RESIDENTIAL COUNSELOR, Boys and Girls Homes of Montgomery County, Jan. '87-June '87. As a floating substitute, provided individual, group and crisis counseling and supervision of troubled adolescents at five of the agency's facilities.

COUNSELOR, Support Services Network, Charleston, WV, Nov. '85-Jan. '87. Recruited program participants, planned and conducted pre-employment skills workshops, and placed low-income youth (ages 16-21) in jobs. Helped agency achieve an excellent efficiency rating, 4th out of 80 such state programs.

OTHER RELATED WORK EXPERIENCE:

Child Care Worker, Davis Child Shelter, South Charleston, WV, Apr.'86-Dec.'86, part-time. Residential Counselor, Caithness Shelter Home, Silver Spring, MD, Nov.'84-June '85. Youth Minister, Charleston, WV, Sept.'82-'84.

EDUCATION:

Purdue University, PhD Program in Marriage and Family Therapy. Have been accepted and will begin Fall '91.

Virginia Tech, Northern VA Graduate Center, **Master's Program in Marriage and Family Therapy.** Will complete and defend thesis May 22, 1991 for final requirement for M.S. Coursework has included family systems theory and therapy, families under stress, assessment, abnormal behavior, ethics, neuro-linguistic programming, group counseling, human sexuality, parent-child interaction, gestalt group therapy, and couple's therapy. Successfully passed comprehensive exams in field, April, 1988, with adolescent substance abuse selected as special area of interest. Thesis research is on adolescent sexual offenders. Current GPA of 3.95.

Bethany College, Bethany, WV. Obtained **B.A. in Philosophy**, 1982. Graduated first in class with GPA of 4.0, while attaining a well-rounded liberal arts education.

OTHER TRAINING:

In-service training has included areas such as strategic family therapy, social setting detoxification, medication management, solution-oriented therapy, and first aid/CPR.

Participated in seminars on basic counseling skills, adolescent development, substance abuse, suicide, sexual and physical abuse, and crisis intervention while serving in residential facilities. Youth Ministry training included workshops on sexuality, communication techniques, listening skills, substance abuse, and the Myers-Briggs personality type indicator.

Conferences/Workshops:(Attended)

-Contextual Residential Care, May, '91, Michael Durrant, 8 hrs.
-Solution-Oriented Brief Therapy with Families, Apr.'91, Matthew Selekman, 8 hrs.
-Brief Therapy with Depressed Clients, Mar.'91, Michael Yapko, 8 hrs.
-AAMFT, Oct.'90, Michael White, Michael Durrant, Michael Yapko, Sal Minuchin, Jay Haley, and others, 3.5 days.
-VAMFT, Apr.'90, Paul Dell, Gus Napier and others, 12 hrs.
-Intervention in Child Sexual Abuse: Offenders, Victims & Survivors. Rape, Incest & Molestation: Investigation, Assessment and Treatment, Apr.'90, Nicholas Groth & Suzanne Sgroi, 3 days.
-Families and Their Belief Systems, Southeastern Council on Family Relations, Mar.'90, 3 hrs.
-Family Therapy Network Symposium, Mar.'90, volunteer and attendee, 12 hrs.
-Brief Solution-Focused Therapy, Mar.'90, Insoo Kim Berg, 8 hrs.
-Solution-Oriented Brief Therapy, Dec. '89, Bill O'Hanlon, 8 hrs.
-Ericksonian Hypnosis, Dec. '89, Bill O'Hanlon, 16 hrs.
-Treating Adolescent Mental Health, Alcohol and Drug Abuse Problems, ADAMHA, Oct. '89; attended sessions on family therapy for substance abuse, juvenile sexual offenders, family therapy outcome research, family therapy across a continuum of care and others, 2 days.
-Brief Solution-Focused Therapy, May '89, Insoo Kim Berg, 4 hrs.
-Family Therapy Network Symposium, Mar.'89, volunteer and attendee, 12 hrs.
-Solution-Oriented Brief Therapy, Sept.'88, Michele Weiner-Davis, 6 hrs.
-Violence Hits Home, Domestic Violence, Apr.'88, volunteer and attendee, 10 hrs.
-Family Therapy Network Symposium, Mar.'88, volunteer and attendee, 12 hrs.
-Children, Drugs and Alcohol: What Professionals Can Do, Oct.'87, Michael Elkin, 8 hrs.
-Interpersonal Skills with Youth, VA Dept. of Corrections, July,'87, 16 hrs.
-Family Therapy Network Symposium, Mar.'87, volunteer and attendee, 12 hrs.
-Sexual Abuse/Normal Sexuality, Chesapeake Institute, Inc., Feb.'87, 6 hrs.

Presentations Given:

Brief Solution-Oriented and Michael White's Approaches to Family Therapy, taught 3-hr class session for family therapy graduate course, Va Tech, Mar.'91.
"Family Dynamics of Adolescent Sex Offenders", Family Preservation Conference, Richmond, VA, Feb.'91.
"Detox at Home: Focus on Solutions and Social Networks", AAMFT annual conference, Washington, DC, Oct. '90.
"Family Therapy Training in the Trenches", annual meeting of VAMFT, Harrisonburg, VA, Apr.'90.
"Belief Utilization: A Solution-Oriented Treatment Approach", Families and Their Belief Systems, annual conference of the Southeastern Council on Family Relations, Charleston, SC, Mar.'90.
"Detox at Home: Solution-Oriented Family Therapy Approach", to student interns, Prince William County Community Services Board, Nov. '89.

PUBLICATIONS:

Stith, S., Crossman, R., & Bischof, G. (1991). Alcoholism and marital violence: A comparative study of men in alcohol treatment programs and batterer treatment programs. Alcoholism Treatment Quarterly, 8, (in press).

Bischof, G. et al. Outpatient detoxification: An annotated bibliography. Alcoholism Treatment Quarterly, 8, (in press).

OTHER: Television interview, invited as guest expert on single parenting issues for local cable program, aired Fall '90.