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Intrafamilial adolescent sex offenders: psychological factors and treatment issues

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Report to the Criminology Research Council
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* We agree that the term 'adolescents who engage in sexually inappropriate behaviour' is preferable to 'adolescent sex offender' because of its emphasis on the behaviour rather than the criminality of the behaviour. However, most researchers use the latter term and to be congruent with the literature as well as for parsimony, we use 'adolescent sex offender'.

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EXECUTIVE SUMMARY

This report presents the findings of research designed to enhance our understanding of intrafamilial adolescent sex offenders and their treatment. The literature suggests that multifaceted treatment approaches that include cognitive behavioural, relapse prevention, and family interventions are more effective in reducing relapse than individual therapy alone. Despite this evidence, few family based programs operate in Australia or abroad, and the little available research on these interventions tends to be descriptive rather than evaluative. The present study attempted to bridge this gap.

The research utilised a prospective design, recruiting intrafamilial adolescent sex offenders engaged in a specialised and multifaceted treatment program. The design included the use of both standardised measures of treatment targets, and qualitative data derived from interviews with the offenders and their parents.

The research examined the profile and effect of psychotherapy treatment on 38 intrafamilial adolescent sex offenders attending a community based treatment program. Specifically it examined: 1) levels of psychopathology, coping skills, trauma symptoms, capacity for empathy, psychosexual characteristics, and general psychological symptoms; 2) the profiles of the families of intrafamilial adolescent sex offenders and the influence of the family structure on treatment attrition rates; 3) the value of a community based multifaceted psychotherapy treatment program to intrafamilial adolescent sex offenders; 4) the contribution of a multifaceted psychotherapy treatment program on the functioning of the adolescents' families; 5) the utility of existing typologies of adolescent sex offenders in understanding a community treatment sample of intrafamilial adolescent sex offenders.

The results reaffirmed some aspects of the picture of adolescent sex offenders slowly developing from the literature. For example, half of the study group was diagnosed with some form of psychiatric impairment including, most commonly, Attention Deficit Hyperactivity Disorder (1 in 4), Post Traumatic Stress Disorder, and developmental delay. Almost three in every four (71%) of the study group reported being victims of some form of abuse. Often the adolescent offenders were themselves victims of sexual abuse (47.5%).

However, they were not an entirely homogenous group. A typology of the study group based on elevated scores on an extensive clinical and personality inventory indicated three defined subgroups: i) antisocial; ii) anxious; and iii) narcissistic. This finding was congruent with previous research on typologies and indicates the need for some individualization of treatment.

Adolescents in the study group typically came from families where one parent was absent and/or were step parents. Often, at least one biological parent had a difficult relationship with various family members including the adolescent offender. Most families reported difficulties communicating with each other. Relationships between family members were described as problematic, communication between family members as aggressive or non existent, and parents had little idea how to deal with inappropriate behaviour or set boundaries outlining acceptable behaviour. Family members were often openly abusive towards each other and conflicts were rarely resolved satisfactorily. Rules regarding

acceptable behaviour and personal boundaries were in many cases nonexistent or inconsistent. Offending adolescents were described by parents as impulsive and isolated with few ties to family or friends.

The study was limited by the small numbers of offenders and an attrition rate, which, although at the lower end for this treatment population, prevented any statistically significant evidence being gathered about the actual clinical impact of the treatment. The 12 to 18 month treatment program represented a significant commitment on both the part of the adolescent and his/her family. Changes, as measured by psychometric tests, were slight and for the most part, not statistically significant. However, parents and adolescent sex offenders reported changes in the family system at the end of treatment. For the adolescents, these changes were confirmed by significant changes in scores on a measure of family cohesion and communication.

In addition, parents and adolescents expressed satisfaction with the treatment program and the progress made to improve family life. Following treatment, parents reported that learning how to deal with the sexual abuse within the family and other family related issues such as conflict and setting boundaries were the most useful aspects of the program. Parents also reported that they were better able to cope with conflict and were making a greater effort to communicate effectively with one another. In turn, most parents felt that their children were also communicating more effectively. Generally the adolescent offender was described as more mature, less impulsive, and more likely to have established age appropriate friendships.

The adolescents identified talking to someone about their problems and feelings of acceptance by staff as the main benefits of attending the treatment program. Participants also reported that they learned some important skills whilst in the program such as self control, problem solving, communication, and social skills.

The implications of this study are primarily that intrafamilial adolescent sex offenders:

1. are highly likely to be victims of sexual and/or physical abuse within the family;
2. have a large number of co-occurring psychological, social, and family problems;
3. are a heterogeneous group with different personality factors contributing to the offending;
4. require a holistic, individualized, and comprehensive treatment that deals not only with offending behaviour, but with all contributing factors, particularly family dysfunction.

In conclusion the study also has implications for policy and practice impacting on adolescent sex offenders. It is suggested that these need to be reviewed, where possible, to accommodate the dual nature of the tragedy of intrafamilial adolescent sex offender as both victim and offender. This is important not only to ensure an appropriate, compassionate, and effective response to young offenders but also to reduce the likelihood of intergenerational offending and victimisation.

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ACKNOWLDEGEMENTS

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We would like to acknowledge SafeCare, the agency where the data was collected for their participation in the project from the early design stages to the final report. Collection of data puts additional pressures on therapists, administrators and managers that can be burdensome in an agency. In particular, we would like to thank the therapists involved for their assistance in collection of data and for the additional work involved, in an already very busy agency.

We would also like to acknowledge the very significant contributions of Amanda Thompson, who worked for three years on the project as a research assistant.

Finally, we would like to thank the participants and their parents for agreeing to participate in the project. Without their willing contribution, we would be unable to progress our understanding of this very significant offender group and their families.

CHAPTER 1: INTRODUCTION

The sexual abuse of children has an enormous impact on the child, the family, and the community (World Health Organisation, 2002). While it is now well understood that sexual offending against children is a crime of devastating impact, it is still not widely appreciated that much of that offending against children is actually perpetrated by other children and, in particular, brothers of the victim. Adolescent sex offenders (ASOs) represent the full tragedy of child sex offending, bridging, as they do, the intergenerational transmission of abuse and the complex acting out of early childhood trauma through the victimisation of other vulnerable children close to them. The ASO is a largely unrecognised problem that defies simple stereotypes and often leads to a research and policy vacuum at the place where intervention and help is most needed. While the literature on adolescent sex offending has rapidly expanded in recent years, there is comparatively little focus specifically addressing the issue of adolescent sibling incest. Yet, it is estimated that between 40-90% of intrafamilial abuse occurs between people from the same generation (Bentovim, Vizard, & Hollows, 1991; Ryan, Miyoshi, Metzner, Krugman, & Fryer, 1996).

Overall, research on the intrafamilial ASO population is very limited. Research on treatment programs and the contribution of that treatment to improved functioning, particularly on those adolescents who present voluntarily for treatment, is even more restricted (J. Grant, Thornton, & Chamarette, 2006; Rasmussen & Miccio-Fonseca, 2007). In addition, most of the research on adolescent sex offending does not differentiate between extrafamilial and intrafamilial offenders or between community treatment populations and custodial treatment populations.

Thus, there is an urgent need for research evidence on intrafamilial ASOs, their families, and the impact of treatment programs, especially in the Australian context (Tomison & Poole, 2001). We need to know, for example, how treatment affects different subgroups of ASOs (Caldwell, 2002). Although clinicians have developed a taxonomy of essential therapeutic aims for the treatment of ASOs (Worling & Curwen, 2000), little published research has evaluated the changes achieved by the adolescents in respect to these targets, or the impact of the treatment on the family.

The present study was designed to address some of these deficits. The major purpose of the study was to provide a rich, layered, and detailed description of intrafamilial ASOs engaged in a community based treatment program (SafeCare). This analysis was designed to be comprehensive and include the perceptions and experiences of offenders and family members in relation to treatment, and how treatment had influenced their coping. There were five specific aims in this study.

Research Aims

1. To provide a profile of intrafamilial ASOs, including levels of psychopathology, coping skills, trauma symptoms, capacity for empathy, psychosexual characteristics, and general psychological symptoms.

2. To provide a profile of the families of intrafamilial ASOs and the influence of the family structure on treatment attrition rates.
3. To assess the value of a community based multifaceted psychotherapy treatment program to intrafamilial ASOs.
4. To understand the potential contribution of a multifaceted psychotherapy treatment program on the functioning of the adolescents' families.
5. To compare a community treatment sample of intrafamilial ASOs to existing typologies of ASOs in order to consider similarities, differences, and implications for treatment.

In summary, this research aimed to focus very specifically on intrafamilial adolescent sex offenders (IASOs) engaged in community treatment. This should help to address questions about this specific population, their treatment needs, their family structures, their experiences of treatment, and whether they are similar to other groups of ASOs. The study attempted to address some of the gaps in previous research in order to add to the evidence about this population. Understanding the population, their families, and how to intervene effectively with them is critical in order to prevent both current and future abuse from occurring, as these adolescents move into adulthood and have families of their own. Interrupting the cycle of abuse early and effectively will help to prevent the terrible impact of abuse on future generations. However, we need to understand who we are treating, how they engage in treatment, and how they and their families experience the treatment process.

CHAPTER 2: LITERATURE REVIEW

Overview

While the literature on adolescent sexual offending has expanded in recent years, there remains comparatively less literature with a focus on adolescent sibling incest. However, there is growing evidence that sibling incest is more common than parent to child incest. For example, Bentovim et al. (1991) reported that 90% of intrafamilial abuse occurs between people from the same generation. As more child sexual abuse is discovered, the extent of victimisation that is actually the result of offending by other children (albeit adolescents) will continue to challenge how we think about this offence and how we should respond to it. It is likely that if our response is to be guided by the principle of minimising as much damage and harm as possible we will need to approach the issue of the ASO as a matter of priority. In this literature review we will attempt to illuminate what is known about the prevalence, the characteristics, and the treatment options in regard to ASOs. Essentially, the review is structured by the key questions in regard to ASOs: How much adolescent sex offending is there? How should we think about or understand the ASO? What causes adolescent sex offending? And how can we treat the ASO? The review of the literature presented here thus provides an overview of the prevalence of adolescent sexual offending. This is followed by a description of the known characteristics of ASOs and typologies that have been proposed. Then follows a brief overview of the explanations or theories of adolescent sex offending. Finally, the review concludes with an overview of treatment interventions including a review of the treatment outcome literature.

At this point it is important to provide several definitions. In the ASO literature, the use of the term "intrafamilial" is generally applied to sibling relationships (Cyr, Wright, McDuff, & Perron, 2002). Siblings include biological, step, half, adopted and foster relationships (Rayment-McHugh & Nisbet, 2003; Worling, 1995a). By default, "extrafamilial" refers to individuals who are not siblings. For example, Rayment-McHugh and Nisbet defined ASOs in the extrafamilial category as those who offended against peer aged and adult victims. However, SafeCare have taken a wider definition of "intrafamilial" to include other blood relationships such as cousin or niece/nephew as well as close family friend and neighbour. SafeCare uses this broader definition of intrafamilial because family friends and neighbours, for instance, are often in positions of trust within the family system. Further, communities such as Aboriginal, apply a broader definition of kinship. It is important to note that the ASO literature rarely differentiates between intrafamilial and extrafamilial offenders. Where possible, emphasis will be placed on the intrafamilial data.

Prevalence of Adolescent Intrafamilial Sexual Abuse

Estimating the prevalence of intrafamilial sexual abuse is obviously a difficult task given the secrecy surrounding the issue. It is widely acknowledged that reported cases of child sexual abuse make up a small proportion of the real incidence rate (Nisbet, 2000). Conservative estimates indicate that one in three girls and one in six boys experience some form of sexual abuse before reaching adulthood (Dunne, Purdie, Cook, Boyle, & Najman, 2003). It is also estimated that between 30-50% of these sexual offences are committed by adolescent perpetrators (Ryan & Lane, 1997). Further, it is estimated that 40% of abuse is committed by

an adolescent, biological relative (Ryan et al., 1996), with sibling incest suggested to be three to five times more prevalent than father-daughter incest (Cole, 1982).

At the very outset research in this area is challenged to distinguish sexual behaviours between children/adolescents that may be experimental and that which is abusive. The question of what behaviour constitutes "abuse" is vital so that we can separate non harmful sexual experimentation from damaging victimisation. In the current research the emphasis is on harmful, exploitative, and abusive behaviour sometimes defined as involving a developmental age difference between the abuser and the victim. In regard to criminal convictions, Western Australian data indicate that adolescents accounted for approximately 12% of the total sexual offence convictions recorded for 1998 (Allan, Allan, Marshall, & Kraszlan, 2002). Naturally this figure will vary not only with the underlying rate of adolescent sex offending but the ability of a society to detect and respond to these offences. It is fair to conclude that at present the vast majority of such offending behaviour does not come to the notice of any public authority.

Characteristics of Adolescent Sex Offenders

Introduction

ASOs are a heterogeneous group and may be different, in significant ways, from adult sex offenders (Hunter & Lexier, 1998; Nisbet & Seidler, 2001; Prendergast, 2004). In particular, they appear to differ from adult sex offenders in levels of psychopathology and paraphilic arousal. There is evidence that adolescents who offend sexually, particularly females and prepubescent males, appear to have greater developmental trauma and family dysfunction than their adult counterparts (Hunter & Becker, 1994). Further, research suggests that ASOs share more similarities with non sexual offending adolescents than differences (Hoghughi, Bhate, & Graham, 1997). This section reviews the reported characteristics of ASOs derived from Australian and overseas literature.

Prior Victimisation

Sexual Abuse

A commonly cited aetiological factor for ASOs is their own history of victimisation. Indeed, several studies have linked prior victimisation, and in particular, sexual abuse, to adolescent sexual offending (Boyd, Hagan, & Cho, 2000; Gray, Pithers, Busconi, & Houchens, 1999; Veneziano & Veneziano, 2002; Worling, 1995b). Obtaining an accurate representation of prior victimisation rates is a difficult task, influenced by the traumatic nature of the victimisation experience and the likely impact such a disclosure would have. Linked with this issue is the timing of the disclosure. In a review of several studies, Worling (1995b) found that compared to pretreatment disclosure rates, the disclosure of prior sexual victimisation of ASOs was significantly greater following participation in therapeutic intervention (22% and 52% respectively). Evidently, the existence of a supportive therapeutic environment in fostering disclosure of prior victimisation is implied (Worling, 1995b). Furthermore, this finding, based on a large sample of 1,268 male ASOs, suggests that many investigations may actually underestimate victimisation rates. A cautionary note, however, is the lack of

distinction between the types of ASOs participating in these studies and the precise nature of their victimisation experiences.

An additional consideration is the possibility that offenders may report sexual victimisation in order to mitigate their own offending behaviour (Barbaree & Langton, 2006). Ryan et al. (1996) found in a sample of 1,600 ASOs, that almost 4 in 10 reported prior sexual victimisation. Manocha and Mezey's (1998) investigation found that almost a third of ASOs reported a history of sexual abuse and James and Neil (1996) reported that less than one in five ASOs in their study reported no history of abuse.

Prior victimisation has been linked with the age of onset of disclosed sexual offending behaviour (Murphy, DiLillo, Haynes, & Steere, 2001). These authors reported that ASOs who had been sexually victimised began offending at an earlier age compared to adolescents who did not report prior victimisation (based on adolescents' self-reports). Similarly, Taylor (2003) reported that participants who exhibited inappropriate sexual behaviour before the age of 12 were more likely to have an alleged history of victimisation.

Although the majority of studies examining prior victimisation among ASOs often fail to differentiate between different types of offenders, several investigations have specifically addressed intrafamilial ASOs. For example, O'Brien (1991) compared adolescents who offended sexually against a sibling to extrafamilial ASOs and those who offended against an adult or peer (non child). O'Brien found that incest offenders reported a higher rate of sexual and/or physical victimisation (42%) compared to the other groups (40% and 29% respectively). Consistent with this finding, Worling (1995a) also found a significantly higher number of sibling incest offenders reported a history of sexual abuse (38%) compared to adolescents who offended outside of the immediate family (16%). Another more recent study conducted by Rayment-McHugh and Nisbet (2003) found significant differences of prior sexual victimisation between sibling incest and extrafamilial ASOs (38% versus 16% respectively).

Prior victimisation has also been linked to the gender of the victims. Taylor (2003) found that adolescents who offended against males were more likely to have a history of sexual abuse than those who offended against females. O'Brien (1991) found that ASOs who were sexually abused by a male offender were more likely to offend against a male (68%) compared to those who were victimised by females (7%). He suggested this may reflect a process of conditioning, whereby the offender's own abuse may lead to feelings of arousal and fantasies of sexual interaction with other males, reinforced through masturbatory acts and sexual behaviours. Worling (1995b) found that ASOs who were themselves victims were more likely to victimise male children (75%) than female children (25%). In contrast, Benoit & Kennedy (1992) found no significant association between the nature of the offences committed by ASOs and their own victimisation experiences.

Physical Abuse

The link between prior physical victimisation and sexual offending in adolescence has been established in several studies (Adler & Schutz, 1995; Boyd et al., 2000). Consistent with the figures on sexual victimisation, 40% of ASOs reported experiencing prior physical abuse from family members and/or peers (Benoit & Kennedy, 1992). Studies have linked sexual

offending during adolescence to physical victimisation of the offender (Ryan et al., 1996) and witnessing domestic violence (Gray et al., 1999).

Psychological Factors

ASOs are a diverse group often diagnosed with comorbid conditions such as conduct disorder, attention deficit hyperactivity disorder (ADHD), antisocial behaviour (Prendergast, 2004; Shields, no date), and social skills deficits (Awad, Saunders, & Levene, 1984). Specifically, psychosocial deficits were most notable in offenders of younger victims (Hunter, Figueredo, Malamuth, & Becker, 2003). Specific deficits included social incompetence, anxiety, depression, and pessimism.

In general, studies have found that ASOs have higher levels of internalising and externalising behaviours, conduct disorder, behavioural problems, ADHD, and poorer social and interpersonal skills than control groups (Hummel, Thomke, Oldenburger, & Specht, 2000; James & Neil, 1996; Letourneau, Schoenwald, & Sheldow, 2004; Sheerin, 2004; Taylor, 2003; Zolondek, Abel, & Northey Jr., 2001). Specifically O'Brien (1991) found that sibling incest offenders were more likely to exhibit various behavioural difficulties associated with conduct disorder, compared to extrafamilial ASOs and non child sex offenders. However, other studies have found that these traits are associated with general offending, including sex offending, rather than adolescents who are sex offenders only (Butler & Seto, 2002; Caputo, Frick, & Brodsky, 1999). Academic difficulties are one of the most consistent problems associated with ASOs (Epps & Fisher, 2004). Epps and Fisher suggested that learning difficulties were more severe amongst ASOs than non sexual offenders.

Gray et al. (1999) found that 96% of 6-12 year olds in their study who had displayed inappropriate sexual behaviour had been diagnosed with conduct disorder. In contrast, Shields (no date) compared 52 ASOs with 800 non ASOs. ASOs were just as likely as the control group to display antisocial behaviour, to have been expelled or suspended from school, and /or to have prior convictions. Various studies have found that up to 50% of adolescent offenders (sexual and non sexual) suffered from emotional problems or had received psychiatric care (Awad et al., 1984; Manocha & Mezey, 1998; O'Halloran et al., 2002; Taylor, 2003). The most commonly reported behaviours were lying, stealing, low self esteem, loneliness, impulsive and aggressive behaviours, and unhappiness.

The need for adolescents to be accepted by their peers is well recognised (Prendergast, 2004). Many ASOs have difficulty establishing and maintaining peer relationships (Awad et al., 1984; Manocha & Mezey, 1998). Social skills within this group are generally poor and ASOs are often characterised as withdrawn and anxious with few friends (Hoghughi et al., 1997). They have poor social relations, are often isolated, and have limited involvement with adolescents of the opposite sex. Peer relationships, or lack thereof, may influence the type of sexual offending with isolated adolescents turning to children to fulfil their emotional needs (Epps & Fisher, 2004).

Family Factors

A number of reviews and studies have found that family dysfunction is more evident in families where sibling incest has occurred (Bera, 1994; Burton, Nesmith, & Badten, 1997;

Hardy, 2001; O'Brien, 1991; Righthand & Welch, 2001; Worling, 1995a). Within these families there is evidence of chemical dependency, sexual abuse of the ASO by an adult caregiver, physical and emotional abuse and neglect, parental rejection, parental experience as an abuse victim, single parent homes, multiple parental partners, step or half siblings, and negative family environment. Prendergast (2004) found that poor communication between adolescents and parents was the defining factor in adolescent sexual offending, often with parents unaware of what their children were up to. Benedict and Zautra (1993) found that child sexual abuse is more likely to occur in families where one of the parents is absent from the home.

A comprehensive study of 90 ASOs found that incest offenders reported higher levels of family dysfunction than nonsibling offenders (Worling, 1995a). The incest offenders were more likely to report a history of childhood sexual abuse, marital discord, physical abuse, rejection, and less satisfaction with their family environments. Incest offenders were significantly more likely to have younger siblings living in the home than nonsibling offenders. Worling (1995a) suggested that the negative family environment coupled with the availability of a younger sibling victim served as a catalyst for offending behaviours. He further suggested that a heightened sexualised family environment might also provide conditions conducive to sexual offending.

Female Adolescent Sex Offenders

The literature regarding female ASOs is sparse and the available research largely consists of descriptions and case studies (Grayston & De Luca, 1999; Johnson, 1989; Lewis & Stanley, 2000; Miccio-Fonseca, 2000). It is difficult to estimate the prevalence rate because female ASOs are rarely identified by authorities. Offending behaviours are likely to be underreported by male victims and female offenders can disguise their abuse as normal caretaking activities e.g., bathing and dressing the victim (Johnson; Lewis & Stanley).
Female sex offenders seem to begin offending behaviours at a younger age than non sex offenders. Miccio-Fonseca (2000) suggested that female sex offenders were either sexually irresponsible and promiscuous; or became sexually active at a young age.

A study of preadolescent female sex offenders by Johnson (1989) found that these young girls performed poorly academically and socially. They displayed oppositional behaviours with adults and were involved in fire setting, stealing, and running away. Some researchers have noted a high incidence of psychiatric impairment in female sex offenders (Green & Kaplan, 1994). Green and Kaplan described a group of female sex offenders as avoidant or dependent personality types with poor impulse control.

Summary

Key Features of Intrafamilial ASOs:

- Longer offence histories and more likely to engage in penetrative acts
- More likely to have multiple victims
- More likely to be victims of sexual abuse
- Dysfunctional families
- Psychological impairment

- Poor interpersonal and social skills

Typologies of Adolescent Sex Offenders

Introduction

Although acknowledged as a heterogeneous group, researchers have generally approached all types of ASOs as a single group. There has been little research into the differences between offenders based on offence characteristics. Further, there have been no studies into the types of offenders who do, or do not, continue to offend into adulthood. The following section outlines some of the typologies developed to help focus attention on qualitatively distinct groups of ASOs. However, it is important to note that while these typologies may be useful for practitioners or for exploring treatment options, they are yet to be empirically tested (Veneziano & Veneziano, 2002). The first group of typologies are based on victim and/or offence characteristics, the second group differentiate offenders on the basis of dominant personality characteristics.

Typologies Based on Victim/Offence Characteristics

O'Brien and Bera (1986) distinguished between types of male ASOs on the basis of victim characteristics (i.e. sibling, child non relative, peer/adult, or multiple victims). Although in need of further empirical verification, the authors claimed this typology demonstrated good interrater reliability. The typology consists of seven offender subtypes as shown in Table 1. This typology does not take into account offenders who may fit into more than one category. Although this typology has not been empirically tested (Oxnam & Vess, 2006) it does highlight some of the important distinctions between types of ASOs.

Table 1

O'Brien and Bera's Typology of Adolescent Sex Offenders

(Source: O'Brien & Bera, 1986)

Typology	**Characteristics**	**Motivation**
Naïve Experimenter/Abusers	little history of delinquent behaviour, sexually naïve, offending is situational and isolated	exploration and experimentation
Undersocialized Child Molester	socially isolated, low self-esteem, socialise with younger children, may use manipulation or bribery, victims usually known to the offender	a desire for self importance
Pseudosocialized Child Molesters	little history of delinquent behaviour, adequate social and academic skills, history of abuse,	gratification of sexual needs with a much younger child

	offending may occur over a number of years	
Sexual Aggressive Adolescents	dysfunctional and/or abusive families, good social skills, history of antisocial behaviours, offending usually involves force or threats, victims may be children, peers or adults	power or anger
Sexual Compulsive Offenders	emotionally disengaged families with rigid role boundaries, unable to express negative emotions appropriately, narcissistic traits, engage in repetitive, sexually arousing behaviour	autoeroticism with little or no connection to the victim
Disturbed Impulsive Offenders	history of psychological illness, family dysfunction, substance misuse or learning difficulties, offending is impulsive and may be a single event or a pattern of abusive events	complex, may be the result of substance misuse, disordered thought patterns or failure of impulse control
Group Influenced	no history of delinquent behaviour, offending behaviour is a result of group pressure with the victim usually known to offender/s	group pressure or expectations (follower); or attention or approval (leader).

A contrasting approach classified ASOs according to the age of first offence and the timing of offending behaviours (Burton, 2000). Early offenders, according to Burton's schema, are those that began offending before the age of 12; teen offenders began after the age of 12; and continuous offenders offended both before and after the age of 12. Continuous offenders were involved in all forms of sexual offending at higher rates than the other two categories. The author believed this group was most at risk of future offending.

Another approach investigated the offence and victim characteristics of ASOs (Langstrom, Grann, & Lindblad, 2000). Langstrom et al. based their typology primarily on victim and offence characteristics obtained from historical file information. Langstrom et al. undertook a cluster analysis which yielded five distinct groupings as shown in Table 2. Based on their data, Langstrom et al. (2000) found that clusters 1 and 2 were more likely to reoffend sexually compared to clusters 3, 4, and 5. However these estimates were based on small sample sizes (n= 46).

Table 2

Typology of Sexual Offending Based on Victim and Offence Characteristics

(Source: Langstrom et al., 2000)

Cluster	Victim	Type of Offence	Level of Violence
One	unknown male child	at least one act of oral penetration	low-moderate
Two	female peers or adults, multiple victims	non-contact exhibitionist behaviour	low
Three	unknown female victims	at least one contact offence	moderate-high
Four	known child	multiple offences, penetration occurred in most cases	low
Five	known adolescent or adult female victim	included genital penetration	moderate-high

Hunter et al. (2003) differentiated between adolescents who targeted either pubescent or prepubescent victims. The authors found that adolescents who offended against pubescent victims exhibited higher levels of aggressiveness. Those who offended against prepubescent victims evidenced greater deficits in psychosocial functioning and were more likely to be related to the victim. However, these findings were based on a small number of adolescents in the pubescent victim group (n= 25) and the results would need to be replicated on a larger group to claim support for a robust typology.

Typologies Based on Personality Characteristics of Offender

The typologies discussed above have approached the issue of ASOs from the point of view of demographic data, offending history, or victim type but another way to approach the issue is to consider the nature or problems of the offender. An early attempt examined the Minnesota Multiphasic Personality Inventory (MMPI) profiles of ASOs (W. R. Smith, Monastersky, & Deisher, 1987). From the cluster analysis of the MMPI profiles (see Table 3) the authors identified four distinct groups.

Table 3

Adolescent Sex Offender Typology Based on MMPI Profile

(W. R. Smith et al. 1987)

Typology	Dominant Characteristics
Immature	primarily shy, over controlled and socially isolated, tend to worry

Personality Disordered	narcissistic, demanding, argumentative, insecure, and resort to fantasy measures as a means of coping with problems
Socialised Delinquents	well adjusted socially and emotionally, tendency to overly regulate emotions, and respond sometimes aggressively
Conduct Disordered	impulsive, alienated, and distrusting, poor social skills, tend to act out in relation to perceived threats

Worling (2001) generated a typology for ASOs based on patterns of responding on the California Psychological Inventory (CPI). Worling's categories also consisted of four clusters of offenders (see Table 4). This typology suggested differing aetiological pathways and treatment needs for the four clusters (Worling).

Table 4

Typology of Adolescent Sex Offenders Based on CPI Profile

(Source: Worling, 2001)

Typology	**Dominant Characteristics**	**Offence Characteristics**
Antisocial/Impulsive	previously victimised, exhibited externalising behaviour problems	violent offences, typically against older victims
Unusual/Isolated	isolated and distant from others with more internalising behaviour problems	
Overcontrolled/ Reserved	avoidant in expression of emotion	believed to be a consequence of shyness
Confident/Aggressive	outgoing and confident, narcissistic qualities	attributed to self-centredness and lack of empathy

More recently, Richardson, Kelly, Graham and Bhate (2004) developed a personality based taxonomy for ASOs, derived from cluster analytic procedures utilising the Millon Adolescent Clinical Inventory (MACI). Their analysis revealed five distinct subtypes on the basis of the ASOs "Personality Pattern" profiles on the MACI (see Table 5). However, these subtypes did not distinguish between different types of offending behaviours giving further support to the heterogeneity of this group (Richardson et al., 2004). The small sample size also limited the power of this analysis (Oxnam & Vess, 2006).

Table 5

Typology of Adolescent Sex Offenders Based on MACI Profile

(Source: Richardson et al. 2004)

Typology	**Dominant Characteristics**
Normal	minor personality difficulties (however there was evidence of underreporting)
Antisocial	high elevations on the scales associated with Conduct Disorder related behaviours, negative view of family life, disregard for social norms and the rights and feelings of others and towards the consequences of actions, impulsive, self-indulgent and excessively expressive of their own needs and feelings
Submissive	excessive dependence on others, deferring to authority and subsuming their own needs to the wishes of others, significant levels of social or generalised anxiety
Dysthymic/Inhibited	socially withdrawn and isolated, apathetic and lacking motivation to socialise with peers, moderate to severe depressed affect, a sense of failure, lack self confidence and social anxiety
Dysthymic/Negativistic	evidenced severe levels of psychopathology, chronic and incapacitating dysthymic mood, employed intimidation tactics to achieve their needs and resented limits on their behaviour, negative self perception and low self-esteem, low self-control and an overall indifference to the feelings/rights of others, negative view of family life

Finally a study by Oxnam and Vess (2006) used the 12 personality pattern scales on the MACI to categorise ASOs. Their original analysis produced a three group solution (N=25) while a later study produced a four group solution (N=82) (Oxnam & Vess, 2008). Table 6 displays the profiles for the two analyses. For all of these studies, group size limited generalisability but further research is warranted to extend knowledge in this promising area.

Table 6

Oxnam and Vess Typologies Based on MACI Profiles

(Source: Oxnam & Vess, 2006; 2008)

	Cluster One	**Cluster Two**	**Cluster Three**	**Cluster Four**
Three Group Solution	Antisocial	Inadequate	Normal	
Percentage in each	44%	28%	28%	

group				
Four Group Solution	Antisocial	Withdrawn / Socially Inadequate	Conforming	Passive / Aggressive
Percentage in each group	13%	31%	24%	32%

Theories of the Development of Sexual Offending Behaviour

Introduction

The purported "causes" of adolescent sex offending reflect closely the literature on the aetiology of adult sex offending. Possible factors include biological, developmental difficulties, the impact of prior victimisation, social learning, psychological deficits, dysfunctional parenting, and dysfunctional families. Naturally these individual factors that have been linked to adolescent sex offending are not mutually exclusive and more than one factor or set of factors is likely to be present. Explaining how the identified risk factor(s) actually lead to a propensity for sex offending has been examined by a number of theories of adolescent sex offending that will be discussed here.

Several multifactorial frameworks have been developed by various theorists in an attempt to provide a comprehensive explanation of adolescent sex offending. A large issue in this area is that there are few theories that address adolescent sex offending behaviour specifically (Morenz & Becker, 1995; Ward & Siegert, 2002); rather the theories that have been applied to ASOs have generally been developed with reference to adult sex offender models. It is a common assumption in this field that adult models can be applied to the adolescent context, although this view is changing with increasing awareness of the factors associated specifically with adolescent sex offending.

Theories relevant to understanding adolescent sex offending are usually traced back to Finkelhor's pioneering work on trying to understand the motives (of adults) involved in sexually offending against children (O'Reilly & Carr, 2004). Finkelhor drew attention to the findings from his research that many sex offenders were emotionally immature, had low self esteem, and poor interpersonal skills. There were often developmental delays, particularly sexual, and these typically related to prior sexual victimisation. Sexual offending was therefore understood as a function of an inability to mature and develop appropriate skills.

This continues to be a common theme in other theories such as Marshall and Barbaree's (1990) integrated theory which is essentially one of development and bonding. These authors argued that the lack of development of, or severe disruption to, secure attachment bonds with caregivers presents significant problems for normal development in particular, with regard to interpersonal and intimacy skills. As a result, individuals learn to manage relationships with disruptive and demanding behaviour and develop a limited range of relationship styles (Marshall & Barbaree). This theory also integrated aspects of social learning to explain the development of sexually aggressive behaviours. It was argued that

the child's aggressive behaviour is reinforced and modelled by aggressive parents. The child generalises these maladaptive patterns of relating to other areas impeding the development of social skills and the ability to maintain meaningful relationships with others. The manipulative and coercive behaviours learned from attachment figures are then directed towards others, for example younger children.

Theories on Child Sex Offending with a Focus on the Adolescent Sex Offender

O'Brien and Bera (1986) were among the first researchers to focus on developing a theory of adolescent sex offending. Their model attempted to draw together the many characteristics and factors discussed in the literature that may lead to adolescent sex offending. Factors that supported the propensity towards sex offending included family issues (absent parent, neglect, domestic violence, and attachment issues), prior victimisation of the adolescent, poor socialisation, psychological issues, and exposure to pornography. According to this theory there are seven key aspects of adolescent sex offending (Table 7). Understanding the interrelationship between these provides a basis for treatment of the ASO.

Table7

O'Brien and Bera's Seven Key Factors in the Development of Adolescent Sex Offending

(Source: O'Brien & Bera, 1986)

Factor	**Examples**
Motivations	Arise from social attitudes and individual factors and may include desire for intimacy, affection, control, affiliation, power or arousal.
Situational Opportunity	Access to potential victim may be opportunistic but after successful offending encounters the adolescent may create further opportunities to be with the victim.
Internal Inhibitors Overcome	Thinking errors, minimisation, or excuses may be used to overcome internal deterrents to offending.
Victim Resistance Circumvented	Includes grooming, threat, bribes, manipulation, or coercion
Sexual Abuse Act	Abusive act may result in release of tension and sexual gratification. If there are no negative consequences may lead to rehearsal and fantasy.
Fantasy & Masturbatory Reinforcement	Abuse may be reinforced through fantasy and masturbation.
Rationalisations / Thinking Errors	Statements such as" she asked for it / liked it" allow fantasy to continue and overcome inhibitions to reoffend in the future. With no break in the cycle (intervention) offender may return to

	beginning of cycle.

Another theory that attempts to integrate a range of known links with adolescent sex offending is Lane's theory of the cycle of sexual abuse (Lane, 1997). Lane argued that sexually abusive behaviour in adolescents is a maladaptive response to stressful events. A stressful event creates feelings of powerlessness and low self-esteem in the adolescent, contributing to feelings of helplessness, and manifesting in the adolescent becoming withdrawn and isolated. This "victim stance" precipitates externalisation of blame for any problems the adolescent may have, and the adolescent engages in power and control seeking behaviours. Retaliatory fantasies develop, becoming sexual in nature and the adolescent mentally rehearses these offence fantasies until ultimately they are enacted. Initially following the commission of the offence, the adolescent experiences feelings of adequacy, however this soon turns to fear of the negative consequences. Cognitive distortions serve as a coping mechanism for these fears, including justifications and rationalisations for offence related behaviours to suppress the negative affect experienced as a consequence.

Central tenets of Lane's (1997) model include:

1. Sexual abuse- sexual behaviour without consent, may involve exploitation, manipulation, coercion, force, some prethought, and unhealthy expression of sexual needs.
2. Control seeking and dominance - seeking control over environment and other's, dominance, and enhancing sense of self-adequacy.
3. Attempt to compensate for negative affective states.
4. Sexual arousal and anticipation reinforce behaviour and self-soothing mechanism.
5. Cognitive distortions –different themes promote progression throughout the cycle – e.g., negative self-perceptions, rejection/disrespect from others, justification/rationalisation of criminal/antisocial behaviour, misperceptions of victim's experience, and thoughts that suppress feelings of guilt.
6. Addictive and compulsive characteristics of behaviour – e.g., compulsions and impulsive urges, need for excitement and danger, relief of unpleasant internal states, and maladaptive coping skills.

Given the importance of understanding how adolescent sex offending can be the result of prior sexual victimisation of the offender it is worth also considering Rasmussen, Burton and Christopherson's (1992) model of the effects of trauma. Whilst not specifically focused on explaining adolescent sexual offending the model is relevant as it posits sexually abusive behaviours are one possible response to a traumatic experience. The model emphasises the underlying processes which differentiate those who go on to perpetrate, as compared to those who do not. Specifically, the authors proposed three possible responses to traumatic victimisation (sexual or otherwise):

1. Recovery - the child is able to express and resolve issues surrounding his/her experience of victimisation.
2. Self-victimisation - the child internalises the thoughts and feelings associated with the trauma ('trauma echoes' or distorted messages given by the perpetrator) and manifests maladaptive thoughts, feelings and behaviours towards self.
3. Assault - the child identifies with the perpetrator's rationalisations, externalises these trauma echoes, justifies the abuse, and engages in abusive behaviour towards others.

Rasmussen et al. (1992) further extended their conceptualisation with five underlying precursors that they believed increased the vulnerability of the child going on to perpetrate abuse, as opposed to those who recovered and those who experienced self-directed victimisation. These included prior traumatisation (physical, sexual or emotional, including experiences of early sexualisation), inadequate social skills (resulting in poor support networks), lack of social intimacy, impulsiveness, and lack of accountability.

The Treatment of Adolescent Sex Offenders

Introduction

> "The child maltreatment literature contains relatively little information pertinent to assessment and intervention with sibling offenders abused as children." (Caffaro & Conn-Caffaro, 2005, p. 610)

In the main, adolescent treatment programs are based on research and treatment programs developed for adult offenders (Eastman, 2004). Current understanding emphasises the role of family dynamics; learning, especially through prior victimisation; and cognitive distortions and rationalisations in facilitating offending behaviours (A. Grant, 2000). Cognitive behavioural treatment programs, for example, aim to modify such thought processes. A number of methodological problems are associated with the ASO treatment research. For example, much of the research is nonexperimental. These studies fail to use standardised measures of treatment targets, and rarely include detailed descriptions of the treatment interventions (Vizard, Monck, & Misch, 1995). Many evaluative studies do not adequately discriminate between types of offending (rape, paedophilia, incest), thus confounding the treatment implications for various offender subgroups. Studies utilising arrest and conviction rates as measurements of recidivism will clearly substantially underestimate sexual offending as noted by Vizard et al. (1995).

Placement of adolescent offenders in treatment programs enables professionals to redirect their sexual misbehaviour (Bremer, 1992). However, the sexual behaviour of the offence is likely to be secondary to the abusive element in regard to the damage done, and the developmental and phenomenological issues relating to the adolescent need to be the focus of treatment. A. Grant (2000) suggested that a holistic, developmental treatment approach is most beneficial. Similarly, G. E. Davis and Leitenberg (1987) recommended the use of a comprehensive treatment program consisting of a variety of therapeutic methods used simultaneously.

Treatment programs must also consider the role of the therapist, the goals of therapy, and the risks of divulging sensitive information to statutory bodies (Hunter & Lexier, 1998). Disclosure of abusive behaviour can have ongoing consequences for the adolescent and may lead to criminal charges. Denial of sexual misbehaviour will naturally be rewarded by the lack of formal charges that might otherwise be laid. These dilemmas go to the heart of social policy conflicts regarding how to deal with all sex offenders but are so much more poignant with ASOs who are often both offenders and victims. For treatment to be meaningful it needs to be built on bedrock of trust and full disclosure and acknowledgement by the offender. However, at the present stage of its evolution our criminal justice system appears ill equipped to cope with this and demands that any acknowledgment be public and punishable.

Treatment Outcome Research

The lack of treatment outcome research evaluating the effectiveness of various approaches targeted at ASOs has been noted by a number of authors (Eastman, 2004; Weinrott, Riggan, & Frothingham, 1997). Given the dearth of research there is little evidence to support any one treatment method or modality (e.g., residential vs community based) (Ertl & McNamara, 1997; Sciarra, 1999). Claims made in regard to the effectiveness of different treatment approaches lack a supporting base of empirical research. This lack of empirical research is not surprising given the considerable methodological and ethical challenges in conducting this type of research (Nisbet, 2000). There is some evidence that recidivism rates for ASOs who have undergone treatment are lower than those who have not (Worling & Curwen, 2000). However, even if these findings are accepted, it remains unclear which treatment components affect recidivism rates.

The following section examines the available outcome research that has been conducted with ASOs. Many of the studies reviewed do not include comparison groups, are based on retrospective data, evaluate a single treatment outcome, and have methodological flaws. Outcome measures, where studies are conducted, tend to focus on recidivism rates (with limited accuracy) rather than other treatment goals such as social competence, self esteem or sexual knowledge (Eastman, 2004). For the purposes of this review only studies that have clearly defined treatment protocols, evaluation methodologies, and treatment outcomes were included.

Cognitive Behavioural Therapy (CBT)

CBT is the most common form of therapeutic intervention with ASOs and widely used around the world (Robson, 1999). CBT targets particular characteristics of ASOs including sexual arousal to prepubescent children, poor sexual impulse control, deficits in victim empathy and social skills, and cognitive distortions (Hunter & Santos, 1990). CBT emphasises the effect of internal events such as thoughts, fantasies, and perceptions on behaviour (Wood, Grossman, & Fichtner, 2000) because these events precede behaviour and are amenable to change. According to the CBT approach, insight into offending behaviour is the catalyst for positive change. However, CBT may not be as effective with adolescents because competing feelings of guilt and shame can interfere with the process of insight, understanding, and change (Robson). The major components of CBT based therapies include cognitive restructuring, victim empathy, decreasing deviant sexual arousal, social skills

training, and relapse prevention. Table 8 presents some of the major CBT treatment studies to date.

Table 8

Cognitive Behavioural Treatment Studies

Study	Sample	Treatment	Measures	Major Findings
(Hunter & Santos, 1990)	12 male offenders of male victims 15 male offenders of female victims	Satiation therapy, covert sensitisation, group and individual therapy	Penile plethysmograph	33.5% reduction in arousal to deviant cues (female victims) 39.1% reduction in arousal to deviant cues (male victims)
(Weinrott et al., 1997)	69 male offenders Treatment group Wait list comparison group	Outpatient program Vicarious sensitization 25 sessions	Phallometric measures Adolescent Sexual Interest Cardsort Self Perception Profile for Adolescents	Reduced arousal to prepubescent girls No reduction in wait list group prior to treatment
(Worling & Curwen, 2000)	148 adolescent sexual offenders (n=139 male; n=9 female) Treatment group (n=58) Comparison group (n=90)	Individual, group and family therapy; deviant sexual arousal, relapse prevention; social skills, anger management, victim empathy	Recidivism rate	Significant differences between treatment and comparison groups across offence categories Sexual reoffence (5% vs 18%) Violent non sexual (19% vs 32%) Non violent (21% vs 50%)
(Kelley, Lewis, & Sigal, 2004)	35 adolescent offenders in residential treatment No control group	Social skills training, covert sensitisation, empathy training, special education, relapse	Pre and post scores on CBCL and ACLSA Change in incident reports by residential staff	Significant reduction on social problems and delinquent subscales Improvement in competence score Significant improvement on social

		prevention		relationships and sexuality and intimacy subscales

Cognitive restructuring

CBT assumes that the individual holds faulty thoughts, feelings, or beliefs that have led to the offending behaviour. CBT links faulty thinking with the subsequent behaviours (Sciarra, 1999). Cognitive restructuring aims to correct cognitive distortions as well as improve social and communication skills (J. Shaw, 1999). Therefore, the focus in therapy is on the beliefs and distortions that permit the offending behaviour to occur, such as permission giving statements – "the victim wanted to" (Becker, 1990; Ertl & McNamara, 1997; Sciarra). Many offenders develop myths and distortions about normal sexual functioning. For example, a common belief is that children can give meaningful consent. An important component of cognitive restructuring is an admission by the offender of the cognitions and self-statements used to justify their deviant sexual behaviour with the aim of challenging those beliefs (Ertl & McNamara). Without addressing cognitive distortions behaviour change is unlikely to be long lasting (Print & O'Callaghan, 2004).

Deviant sexual arousal

A key task of adolescence is the development of a sexual identity (Smallbone, 2006). The emerging sexual identity is influenced by childhood attachment experiences and cognitive development. Deviant sexual arousal is understood to be a function of learning through modelling and conditioning. Sexual impropriety in adolescence has been linked to unstable early attachment bonds, child maltreatment, and exposure to sexually explicit material (Epps & Fisher, 2004; Smallbone, 2006). Further, deviant sexual arousal has been associated with higher rates of sexual recidivism. Treatment, therefore, involves changes to these patterns of arousal to more appropriate stimuli. Some researchers argue that deviant sexual arousal needs to be addressed with ASOs to avoid the development of particular sexual interest patterns into adulthood (Print & O'Callaghan, 2004). However, there is no evidence to suggest that adolescents who offend against children are primarily interested in children as sexual objects. Sexual arousal patterns are changed using CBT techniques (satiation training, covert sensitisation, systematic desensitisation, psychopharmacological treatments) and medication.

Satiation methods utilise repetition of the deviant fantasy leading to boredom and extinction (Ertl & McNamara, 1997). Satiation methods allow for reinforcement of arousal to appropriate stimuli whilst suppressing arousal to deviant stimuli. Verbal satiation uses repetitive verbalisations until satiation to the deviant stimuli that previously aroused the individual occurs (Ertl & McNamara). Covert sensitisation requires the offender to imagine and verbalise feelings and/or emotions he/she experienced prior to committing the offence. The offender is then presented with aversive images portraying the negative consequences of acting out the sexual offence. Ethical concerns have limited the use of satiation training with ASOs. There are also practical difficulties including lack of motivation and the use of explicit material which may reinforce the deviant arousal patterns.

Several researchers have examined deviant sexual arousal in the treatment of ASOs. Hunter and Santos (1992) found that arousal to deviant sexual stimuli declined over the treatment period whilst baseline rates to non deviant stimuli remained stable. However, no control group was included in the study and arousal patterns were the only reported outcomes measures for this group.

Response to these treatment methods has been mixed with findings suggesting that younger ASOs do not respond as well as adult sex offenders (Hunter & Becker, 1994). There is no empirical evidence demonstrating the effectiveness of these methods or which elements are essential for change (Veneziano & Veneziano, 2002). Further, satiation can be faked leading to reinforcement of deviant arousal (Bourke & Donohue, 1996). There are ethical concerns with the use of these techniques with adolescents, especially where there is little motivation to change.

Empathy

An understanding of empathy and more importantly, empathy deficits in sexual offenders is not well understood in the sexual offending literature. Indeed, this area of research is hampered because definitions of empathy vary across studies (Pithers, 1999). However, it is generally understood that empathy is the ability to understand the feelings of others (Seagrave & Grisso, 2002). The ability to perceive how others feel develops during adolescence. It is not unusual, though, for adolescents to behave less empathically during this phase of development.

Developing victim empathy entails an acknowledgement of responsibility and articulation of the consequences for the victim. The ability to empathise with one's victim is difficult to quantify as evaluations are generally based on self-reports (Ertl & McNamara, 1997). There is some debate as to what aspects of empathy are lacking in the individual and how it relates to sexual aggression and sexual offending (Print & O'Callaghan, 2004). A study by Eastman (2004) found that treated offenders showed an improved ability to identify with the negative feelings of others. However, upon release into the community this ability declined suggesting that therapeutic gains with regard to empathy were not sustained.

Social skills training

ASOs are often socially isolated and some lack basic social skills (Prendergast, 2004; Sciarra, 1999). A lack of social competence affects all areas of functioning, particularly interpersonal relationships (Worling, 2004). ASOs are taught communication skills such as active listening, how to handle criticism, providing negative feedback, and assertiveness, particularly when dealing with antisocial peers. The social skills component of CBT has not been adequately assessed (Ertl & McNamara, 1997).

ASOs frequently use aggressive behaviour as part of their abuse – indeed the abuse is often part of a more general continuum of aggressive behaviours. The primary goal of anger management is recognition of aggressive cues, understanding the difference between passive, assertive, and aggressive responses to a problem, thinking about a problem from different points of view, working on listening skills, and noticing the body's reaction when angry (Prendergast, 2004).

Group therapy

Group therapy is an important component of many approaches including CBT. Group membership is organised around a number of common factors such as age, psychosocial development, and sexual issues. Group therapy provides a supportive environment in which to explore issues specific to ASOs (Bourke & Donohue, 1996). One of the strengths of group therapy is that it makes it difficult for individuals to minimise or deny their offending behaviours to the group (Sciarra, 1999; J. Shaw, 1999). A successful group can foster group cohesion and peer acceptance during a period of adolescent development when these issues are of great importance (Prendergast, 2004). The influence of the group therapy component of CBT has not been adequately researched with ASOs.

Relapse prevention

The relapse prevention approach focuses on helping ASOs cope with situations that might threaten their control over their inappropriate sexual arousal (Ertl & McNamara, 1997; Prendergast, 2004). This involves identification of high risk situations, learning coping strategies for dealing with high risk situations, self-monitoring contracts with family members, and regular meetings. The relapse prevention approach developed through the treatment of drug misusers and has subsequently been adapted for the needs of sex offenders (J. Shaw, 1999). It is predicated on the understanding that abusive events do not occur on the "spur of the moment" but are triggered by a number of characteristics significant to the individual. As with skills for coping with an addiction, it is the "high risk" situations which have been found to be the key factor. Thus the approach teaches the individual that his/her cognitive emotional state is a precursor to his/her offending path or sexual assault cycle (J. Shaw; Wood et al., 2000). An intention not to offend is considered, by itself, insufficient to prevent offending from occurring (Wood et al.). However, there is little empirical evidence on the effectiveness of relapse prevention plans with ASOs (Bourke & Donohue, 1996).

Individual Counselling and Education

Individual counselling and education is based on the premise that ASOs need to address sexual dysfunction (Lab, Shields, & Schondel, 1993). Components of individual counselling will likely include an emphasis, to varying degrees, on sex education, anger management, social skills training, empathy training, relapse prevention, and victim awareness (Lab et al., 1993). Table 9 sets out a range of treatment programs that incorporated sex education into the treatment package.

Table 9

Individual Counselling / Educational Treatment Studies

Study	Sample	Treatment	Measures	Major Findings
(Mazur & Michael,	N = 10	Sexuality education,	Self report relapse data	No relapse reported despite opportunity

1992)	(13-17 years) No control group Outpatient program	relapse prevention		(6 months post treatment)
(Graves, Openshaw, & Adams, 1992)	30 ASOs (12-19 years) n = 18 treatment group n = 12 control group	Traditional therapy , Social skills training - treatment group only	Parent-Adolescent Relationship Inventory; CBCL and Piers-Harris Self Concept Scale	Improved social skills for both groups but treatment group scores significantly higher No improvement in problem solving ability
(Lab et al., 1993)	n = 46 treatment group (low/medium risk) n = 109 control group (high risk)	Sex education, victim awareness, empathy, coping skills, prevention plans, anger management	Recidivism rate post treatment	Recidivism rates similar for both groups for sexual (2.2% & 3.7%) and non sexual (24% & 18%) offences
(Hagan, King, & Patros, 1994)	50 ASOs in residential treatment program	Sex education, human sexuality, group therapy, anger management,	Recidivism rate 2 years post treatment	Recidivism rates – 58% reoffended 10% sexual assault
(Hagan & Gust-Brey, 2000)	50 ASOs who had completed a treatment program	Group therapy, sex education, behaviour management	Recidivism rates 10 yrs post release into the community	20% reoffended sexually 60% reoffended non sexually
(Hagan, Gust-Brey, Cho, & Dow, 2001)	100 ASOs 50 non sexual offender comparison group	Group therapy, sex education, behaviour management	Recidivism rate	ASOs more likely than non sexual offenders to commit a sexual offence

Many ASOs have limited actual sexual knowledge and awareness. Sex education is thus relevant and may be seen as an important component of a multifaceted treatment program. Sex education with ASOs is generally designed to address faulty cognitions (Bourke & Donohue, 1996). Eastman (2004) had success with the sex education component of a residential treatment program, with significant change in sexual knowledge recorded from pre to posttesting. However, there has been little mention in the research literature of the use and/or efficacy of sex education in relation to ASOs.

Family Therapy

Families are important influences in the lives of adolescents regardless of the quality of family relationships (Thomas, 2004). A holistic approach to therapy recognises that adolescents respond best when supported by family members (Print & O'Callaghan, 2004). Family therapy targets communications and family support networks and provides sex education including how to disrupt the abuse cycle (Sciarra, 1999; J. Shaw). Family and group therapy provides an opportunity to deal with family issues that may have contributed to the offending behaviours. Parent group therapy provides an opportunity to discuss issues with parents who have had similar experiences and feelings. Sibling groups provide opportunities to express emotions and deal with the impact of sex offending in the family. For the offender, there are opportunities for vicarious learning and modelling by peers. In addition, competition and peer pressure can help motivate change. Table 10 sets out several studies that have adopted a family therapy approach.

Table 10

Studies Using a Family Therapy Approach

Study	Sample	Treatment	Measures	Major Findings
(Bremer, 1992)	193 participants post release, No control group	Sex education, empathy training, cognitive distortions	Recidivism rate	6% conviction rate 11% self report rate
(Hunter & Figueredo, 1999)	N = 204 No control group	Sex education, social skills training, cognitive restructuring, relapse prevention, anger management	Program compliance measured by completion of Psychopathology Sexual Maladjustment	50% remained in program for 12 months 75% of non deniers at intake successfully completed course 25% of deniers successfully completed course 33% expelled as

				treatment failures

Family therapy is considered most helpful when there has been incest perpetrated because it is within the family that many of the offender's beliefs, attitudes, and feelings towards sexuality have developed (J. Shaw, 1999). Family therapy is particularly useful where there is intergenerational abuse (Thomas, 2004) and to help parents deal with their own feelings of victimisation and stigmatisation. However, this form of therapy poses difficulties for therapists who must engage and work with chaotic family systems. To date, few studies have examined the efficacy of family therapy with ASOs (Thomas).

Bremer (1992) investigated an intensive program for ASOs (N = 193) which included peer group treatment and family therapy. Areas addressed in treatment were personal accountability, victim empathy, the sexual assault cycle, sex education, and personal victimisation. Upon follow up, conviction rates were 6% for ASOs and 11% upon self-report. There were no measures of psychosocial functioning taken and no control group. The time spent in therapy varied widely between participants. However, the low recidivism rate reported for this large group supports this type of treatment program.

Multisystemic Therapy (MST)

According to MST proponents, behaviour problems are multidimensional and multidetermined; ASOs are embedded in multiple dysfunctional systems (Swenson, Henggeler, Schoenwald, Kaufman, & Randall, 1998). MST targets characteristics of the ASO, his/her family, school, and peer relationships; addressing cognitive deficits such as denial, empathy, and cognitive distortions; family relations such as cohesion and parental supervision; and dysfunctional peer relationships. Families of ASOs are often characterised by domestic violence, drug and/or alcohol misuse, neglect, and other difficulties (Borduin, Henggeler, Blaske, & Stein, 1990). Therefore, treatment programs need to be flexible enough to encompass the diverse areas where problem behaviours are manifested (Swenson et al., 1998). To make effective changes, interventions must consider changes to the adolescent's environment as well as changes to the individual. MST has been effective in a range of adolescent problem areas (Borduin & Schaeffer, 2001) and although more evidence is needed there is reason to believe that it is likely to be effective with regard to the problem sexual behaviours of adolescents. Table 11 sets out some of the MST based studies that have dealt with ASOs.

Table 11

Multisystemic Treatment Studies

Study	Sample	Treatment	Measures	Major Findings
(Borduin et al., 1990)	16 male offenders (mean age 14 years) MST group n = 8 Individual	MST programme (cognitive deficits, family relations, peer relations, school	Recidivism rates 3 years post treatment	MST group recidivism rate 12.5% sexual offences; 25% non sexual offences IT group recidivism rate

	therapy group n = 8	performance) Individual counselling focus on personal, family, academic issues		75% sexual offences; 50% non sexual offences
(Borduin & Schaeffer, 2001)	24 adolescents assigned to MST programme 24 adolescents assigned to control group	Personalised MST intervention	Recidivism rates 8 years post treatment	Recidivism lower for MST vs control group for sexual (12.5% vs 41.7%) & non sexual (29.2% vs 62.5%) offences

In a multisystemic approach to treatment, interventions target problem areas in the individual's system determined by individual and family circumstances. However, generally, MST treatments target deficits in the adolescent's cognitive understanding, family relations, and school performance (Borduin et al., 1990; Swenson et al., 1998). MST engages parents as "agents of change" for their children (Swenson et al., p. 333). Therefore, parents have a major role in the therapeutic interventions implemented. These interventions are based on empirically validated research. Strategic family therapy, structural family therapy, behavioural parent training, and cognitive behavioural therapies are examples of the interventions used in MST.

The strength of MST is that the process is well documented and interventions for individuals and families are clearly delineated (Swenson et al., 1998). MST provides an opportunity to improve the adolescent's support network by utilising a holistic approach to intervention (Swenson et al.). Research by Borduin et al. (1990) suggested that participants who received MST rather than individual therapy were less likely to reoffend sexually or generally. They surmised this was due to the systemic approach to therapy considering the importance of the various systems in the adolescent's life. The researchers believed that MST is successful because the focus of treatment is multidetermined, there is ease of access for clients, families are engaged in the treatment process, and emphasis is placed on treatment adherence (Swenson et al.). Treatment is offered to families at a location convenient to them, considered an important factor in minimising attrition rates.

Borduin et al. (1990) utilised a social ecological treatment model designed to meet the multidimensional needs of ASOs. The researchers compared MST, where adolescents were treated within the social context (family, peer relationships, and school adjustment) to individual therapy (focused on personal, family, and academic issues). Participants were randomly assigned to either experimental or control groups but sample sizes were small (8 in each group at intake and 5 by completion of the programs). The researchers found that the recidivism rate was significantly lower for the MST group for sexual offences (12.5% v 75%) but not for nonsexual offences (25% v 50%). More evidence is needed to support the efficacy of MST.

Synopsis of Studies

A general problem with treatment studies is that they fail to measure components of the intervention to determine treatment efficacy. For example, Lab et al.'s (1993) study failed to find a difference in recidivism rates between a sex offender specific program and a general offender program. However, recidivism was measured using court records only. As is widely understood, many offences, both of a sexual and nonsexual nature, go undetected. Further, the study did not examine outcomes for specific treatment components to determine whether such things as victim awareness, empathy, and sexual knowledge had improved.

Mazur and Michael (1992) evaluated a 16 week treatment program which included psycho-education and relapse prevention components. At a 6 month follow-up there was no self-reported reoffending in the treatment group. However, the small sample (N = 10), lack of control group, and short follow-up period make it difficult to draw conclusions about the efficacy of this program.

Graves et al. (1992) compared a traditional treatment program (n = 12; 8 completed) with a combination of individual therapy and social skills training (n = 18, 16 completed). Participants were randomly assigned to treatment or control groups. The researchers assessed parent-child relationships, social skills, behavioural problems, and self-concept upon completion of the treatment programs. Although the social skills of both groups improved, greater improvement was shown by the experimental group, particularly in the areas of communicating with parents, internalising and externalising behaviours, and self concept. However, the parents did not agree with the researchers that externalising behaviours had improved. The small sample size and vague descriptions of the treatment programs make it difficult to determine which components, or, combinations were responsible for positive change.

Individual psychotherapy has several drawbacks. It is easier to manipulate the therapist, maintain denial, and there are fewer opportunities for confrontation of denial and minimisation, learning social skills, and developing victim empathy from others (Prendergast, 2004; J. Shaw, 1999). There has been considerably more success in these areas using a group therapy approach. Further, individual psychotherapy does not address other factors (ecological, family) that may facilitate an abusive environment (Swenson et al., 1998). Therefore, individual psychotherapy is unlikely to be effective as the sole means of treatment for ASOs (Bourke & Donohue, 1996; Ertl & McNamara, 1997). Because of its highly individualised nature, individual psychotherapy methodologies may not be generalisable to the community setting (Bera, 1994).

CBT appears to be the most widely accepted treatment program for ASOs and has had some success in reducing recidivism rates. More research is needed to understand which components are successful and in what ways. More outcome measures need to be reported which target specific skills such as social skills or sexual knowledge. Further, it would be desirable to know which group of ASOs (e.g., intrafamilial vs extrafamilial) would most benefit from CBT.

It is difficult to determine which components of CBT, if any, are responsible for positive change. For example, the treatment program evaluated by Hunter and Santos (1990) included verbal satiation, cognitive restructuring, covert sensitization, insight oriented group and individual therapy, family therapy, social skills training, sex education, values clarification, and relapse prevention. Following 2 months of treatment the 20 ASOs in the study demonstrated significant decreases in physiological arousal to paedophilic cues. No control group was used and arousal levels were the only measure of treatment outcome. There was no measurement of change for any specific skill targeted in the treatment program. Therefore it is unclear which components of the program, or which combination of components, was responsible for the recidivism rate achieved.

Current State of the Literature

There are a number of issues that need to be addressed in the ASO literature. First, there are methodological problems associated with the ASO research. For example, a large number of studies are nonexperimental or do not include a control group for comparison. The use of a control group is however, a contentious issue as it is seen as unethical to withhold treatment. Many studies do not provide a detailed description of the treatment interventions (Vizard et al., 1995). This makes it difficult to compare treatment effects between interventions and to determine which components of a treatment are effective in reducing offence rates. Further to this, there is a lack of standardised measures specifically for ASOs to assess treatment targets (Eastman, 2004).

Second, there is a lack of discrimination between, and operationalisation of, types of offending (e.g., intrafamilial and extrafamilial) in the literature confounding the treatment implications for offender subgroups (Tomison, 2002). Development of a theory of adolescent sexual offending is ongoing. An understanding of the aetiology of adolescent sexual offending will guide assessment and treatment.

Finally, current measures of recidivism underestimate the true prevalence of adolescent sex offending (Vizard et al., 1995). Vizard et al. suggested that interviewing the offender, family members, and professionals provided the best possibility of accurately assessing reoffence rates. Early detection and intervention provides the best opportunity of treating the problem before it becomes entrenched. Considering that many adult offenders begin to offend in adolescence closer attention to the development of sexual deviance at a younger age is warranted. Better intervention at this level may prevent considerable damage, not only to the offender, but also to the victims. However, the question of where in the development cycle that sexual deviance is established remains unanswered.

CHAPTER 3: METHODOLOGY

Study Design

Given the aims of the research study it was important to develop a design that could accommodate multiple sources of information. The methodology also needed to investigate the perceptions and experiences of participants and parents in some depth and with considerable sensitivity.

This was an exploratory study that utilised method triangulation (Patton, 1990). Examining both qualitative and quantitative data from a number of sources allowed a convergence of data in order to provide a detailed psychological profile of intrafamilial ASOs. The qualitative components of the study were designed to achieve a richer, more holistic understanding of the impact of treatment, including which components work and which do not work – from the perspective of the participants and their parents. The quantitative aspects were designed to provide data suggestive of treatment outcomes and a psychological profile of the population.

Participants

The study group was drawn from all consenting male and female intrafamilial ASOs (12-18 years) who were treated in the SafeCare Young People's Program between August 2004 and June 2007. The final study group consisted of 38 adolescents and their parents (see Table 12). Ninety-one per cent of all adolescents treated during this period consented to participate in the study. Participants included adolescents who had come to SafeCare through different routes including family self-referrals and agency based referrals from statutory bodies (e.g., Department of Corrective Services, Department of Child Protection). Information and Consent Forms were provided to participants and their parents or caregivers outlining the general purpose and relevance of the study. Selection Criteria required that:

- participants were intrafamilial sex offenders aged between 12 and 18 years;
- participants (and their caregivers) acknowledged the sexual offending;
- participants were willing and able to commit to treatment for sexual offending;
- primary caregivers were able to provide support and participation in the treatment;
- participants had adequate cognitive abilities;
- where relevant, psychiatric conditions were adequately stabilised.

Table 12

SafeCare Study Group

Number of families...	**Total (%)**
who attended SafeCare	42

participated in study	38 (91%)
who left study prior to completion	15 (39%)
who continued in study	23 (61%)
who completed treatment by June 2007	15 (39%)
referred by government agencies	28 (74%)
self referred	10 (26%)

Treatment Program

SafeCare Young People's Program (YYP) is a community based family treatment program that offers specific assessment, treatment, and long term support to families affected by child sexual abuse. The program specialises in the support and treatment of the child or adolescent sexual abuse victim, the adolescent offender, and their family. YYP provides each family member with individual and group therapy, as well as couple, family, and reunification sessions when required. The YYP is a multifaceted model that integrates well recognised theory, research, and treatment approaches including Giarretto (1982), Worling (1995a), and Worling and Curwen (2000). The program utilises cognitive behavioural, psychoeducational, psychodynamic and family systems approaches.

Data Collection

Qualitative Methodology

The qualitative methodology was chosen to provide the detail, depth of analysis, and 'thick' description that could illuminate the issues relevant to practice. Qualitative approaches were considered useful because of our focus on trying to understand, from the perspective of the individual and in a more detailed way, the crucial elements that impact change (Patton, 1990). Qualitative methods were also indicated because the study was clearly exploratory (McLeod, 2001; Patton). Given the paucity of research on both population characteristics and the contribution of treatment programs to the functioning of intrafamilial adolescent sex offenders (IASOs), triangulation that included qualitative and quantitative methods was used to provide the strongest and most detailed data. Semistructured interviewing was used in order to understand the experience and impact of treatment on participants and their families, and to capture the depth of the experience.

Qualitative data was collected in the following ways:

1. Semistructured clinical interviews were conducted for participants during the 6 week assessment phase of the program. These utilised the clinical interview developed for use in the assessment of ASOs (Hoghughi et al., 1997). It included a range of questions about a number of relevant domains, such as nature of offences, a family genogram, developmental history, history of abuse, family structure, and family functioning, which

are consistent with recommendations for the assessment of adolescent offenders. Clinicians conducting interviews transcribed answers onto interview pro forma.

2. Semistructured clinical interviews were used to gather data from the parents of the adolescent offenders during the 6 week assessment phase of the program. Clinicians conducting the interviews transcribed participant answers onto interview pro forma.

3. Closing clinical interviews were conducted for participants on completion of the program. An adaptation of the closing clinical interview developed by Byers (1994) was used to examine the following domains: i) perceived impact of the treatment program ii) perceived program impact on sexual offending behaviours iii) program impact on family functioning iv) general value of the program v) views about what elements were most helpful and which were least helpful vi) views about elements of the program that were most memorable and challenging vii) views about their relationships with both their group and individual therapists. Interviews were conducted by members of the research team (tape-recorded and transcribed verbatim) following NHMRC ethical guidelines for human research.

4. Closing clinical interviews were conducted with parents of the participants on completion of the program, also based on an adaptation of the Byers (1994) semistructured interview, that explored the following domains: i) parental experience of the treatment program ii) program impact on sexual offending behaviours iii) program impact on family functioning iv) their views about the general and specific impact of the program on their sons/daughters v) their views about which elements of the family intervention program were most helpful and which were least helpful. vi) views about their relationships with both the agency and therapists. Interviews were conducted by researchers, tape-recorded and transcribed verbatim.

Qualitative Analysis

Interpretive Phenomenological Analysis (J. A. Smith, 2001) was used to analyse the data, allowing for both 'thick description' and 'thick interpretation' (Denzin, 1989). Interpretive Phenomenological Analysis is designed to gain understanding of the participant's experience of an event. It incorporates both a phenomenological and an interpretative framework (R. L. Shaw, 2001). Because it is data-driven, it enables exploration of particular experiences, while allowing emergence of unanticipated thematic material (R. L. Shaw).

Members of the research team constructed an initial map of domains based on an immersion approach to analysis. That is, interviews were read multiple times to gain a sense of overarching domains, before formal coding transpired. The entire research team then overviewed the domains and themes for analysis of the different variables explored in the interviews and revised the themes. The QSR N-Vivo 7 program for qualitative analysis was used to formalize coding and analysis. Domains and themes were somewhat revised as formal coding proceeded.

Quantitative Methodology and Analysis

The quantitative section of the study comprised three parts:

1. A descriptive study to provide a psychological profile of IASOs and their families based on a battery of psychometric assessments.
2. A comparative study, using the *Millon Adolescent Clinical Inventory* to ascertain whether a community treatment sample of IASOs were similar or different to existing typologies of ASOs which often include custodial populations and extrafamilial sex offenders.
3. A one group repeated measures design, wherein participants were administered a series of psychometric instruments relevant to program treatment goals, to ascertain whether results were suggestive of treatment effectiveness.

Formal Hypothesis

From pretest to posttest and from pretest to follow-up, there will be increases in levels of empathy, social/coping skills, and family functioning, and corresponding decreases in symptoms, cognitive distortions, and psychopathology.

Quantitative Design

The quantitative part of the study was designed to provide descriptive and quasi-experimental data about this treatment group. Although randomised controlled trials are often the preferred experimental design, it was not possible to safely or ethically utilise a control group with this treatment population. Once these adolescents have been identified and referred for treatment, it would have been unethical to delay treatment, because younger children were at risk of further abuse. Thus, wait-list, no-treatment, or placebo control groups were not an option. Nonequivalent control groups were also considered problematic because of the battery of psychometric measures utilised. Given the paucity of research and relatively recent development of practice in this area, this study was clearly exploratory. Thus, triangulation was used to provide methodological rigour for the study.

Quantitative Analysis

The formal hypothesis was tested for each of the five outcome measures by conducting one-tailed related samples *t* tests comparing pretest scores to posttest scores and pretest scores to follow-up scores. Because the 'false alarm' rate across 10 *t* tests was predicted to be high, a Bonferroni correction would normally be applied to the per-test alpha level in order to reduce the number of "false alarms". Because this was an exploratory study, however, we were prepared to tolerate a high "false alarm" rate in order to reduce the probability of "missing" a real intervention effect. An uncorrected per-test alpha-level of .05 was therefore used for each *t* test.

Psychometric Measures

A review of potential psychometric measures appropriate to this population was conducted through an investigation of the existing research literature as well as conversations with experienced clinicians in the area. The following measures were selected as most appropriate in terms of both screening the population, providing a psychological profile of the sample, and measuring any changes that might occur as part of treatment. Measures

were also chosen on the basis of the symptoms, behaviours, and functioning targeted in the treatment program.

- *Family of Origin Scale (FOS) (Hovestadt, Anderson, Piercy, Cochran, & Fine, 1985)*

  The FOS is a 40-item instrument designed to measure levels of family functioning, focusing on the key concepts of autonomy and intimacy. The total score is used as a general measure of satisfaction with family relationships. It has been shown to have excellent internal consistency and test-retest reliability with adolescents (Manley, Searight, Skitka, Russo, & Schudy, 1991) and has been successfully used with adolescent sibling incest offenders (Worling, 1995a).

- *Adolescent Coping Scale (ACS) (Frydenberg & Lewis, 1993)*

  The ACS allows adolescents to examine their use of 18 distinct coping strategies (e.g., worry, seek social support). The ACS includes 80 items that take 25 minutes to administer and score. ACS items demonstrate moderate test-retest reliabilities and factor analytic research supports the construct validity of the test design (Frydenberg & Lewis, 1993; 1996). The ACS is the most comprehensive instrument of its kind and the first to be developed in an Australian context.

- *Trauma Symptom Checklist for Children (TSCC) (Briere, 1995)*

  The TSCC is a self-report measure of posttraumatic symptoms appropriate for use with children ages 8-17 years. The TSCC includes 54 items and yields two validity scales, six clinical scales (e.g., posttraumatic stress, dissociation), and eight critical items (e.g., suicidality, expectation of sexual maltreatment). It is quick to administer and score (25 minutes). The TSCC is standardized on a large sample of racially and economically diverse children, provides norms according to age and gender, with validity well established (Fricker & Smith, 2002).

- *Interpersonal Reactivity Index (IRI) (M. H. Davis, 1983)*

  The IRI is a 28 item self-report measure of empathy that assesses perspective taking ability, empathic concern, fantasy, and personal distress. The IRI is increasingly utilized in adolescent empathy research and has recently been used to distinguish between sexual offending and nonoffending adolescent males (Burke, 2001). Research supports the reliability and construct validity of this test.

- *Millon Adolescent Clinical Inventory (MACI) (Millon, 1993)*

  The MACI is a 160 item (true-false) self-report inventory written at a 6th-grade reading level and designed to give a comprehensive look into the maladaptive personality characteristics of troubled teens. The MACI includes 12 personality scales, 9 clinical indices, and 8 expressed concern scales (e.g., identity confusion, body disapproval). Most adolescents will complete the MACI in 20 minutes. Research supports the reliability and validity of the MACI (Millon & Davis, 1993). The MACI has been used to discriminate between sex offending and nonoffending adolescents (Mattingly, 2000).

- *Multiphasic Sexual Inventory-Juvenile Version (MSI) (Nichols & Molinder, 1984)* The MSI-JV is a 21 scale instrument designed to assess the psychosexual characteristics

of sexual offenders. The MSI includes scales assessing sexually deviant behaviours, acts, cognitive processes (e.g., distortions, justifications, beliefs), and deceptive styles (e.g., denial, dishonesty). Research supports the reliability and validity of the MSI (Kalichman, Henderson, Shealy, & Dwyer, 1992), which has been commonly used with adolescent offenders (Hunter & Becker, 1994). Only 4 scales of the MSI-JV were used: i) treatment attitude, ii) justifications, iii) cognitive distortion, and immaturity, and iv) child molest. This decision was taken because the clinicians were extremely concerned that the sexually explicit detail in some of the scales had the potential to introduce sexual ideas or fantasies that did not previously exist in the population (e.g., questions about bondage, cross-dressing, or sado-masochistic practices).

- *Brief Symptom Inventory (BSI) (Derogatis, 1979)*

  The BSI is a 10 minute 53 item self-report symptom inventory designed to assess psychological symptom patterns on nine dimensions (e.g., depression, anxiety, and hostility) and three global indices of distress. The BSI has been used with adolescent community populations and demonstrates sensitivity in measuring change in treatment outcome studies (Derogatis & Lazarus, 1994).

Procedure

During an initial intake interview attended by both the adolescent and his/her parents, all referrals satisfying the subject selection criterion were invited to participate in the present study. Information sheets outlining the study (Appendix A) and consent forms (Appendix B) were given to participants and their parents. Both parties needed to consent to be included in the study. The study was approved by the Higher Research Ethical Committee at Curtin University and the Board of SafeCare.

Consenting participants then commenced a six session assessment phase. During the assessment phase participants were administered a battery of psychometric instruments and their caregivers a psychometric measure of family functioning (see Table 13). Participants also underwent a semistructured clinical interview (Hoghughi et al., 1997) and their caregivers participated in an intake interview.

Immediately following assessment, clients commenced an individualised treatment program lasting nine to twelve months. Participants completed the BSI at intake, exit, and every three months during treatment. At the conclusion of treatment subjects commenced a reassessment phase. During reassessment subjects were again administered the psychometric test battery (and their caregivers the family functioning measure), and the participants and their parents were separately interviewed with a semistructured closing interview.

Table 13

Research Design

Pretreatment **Assessment Phase**	**Treatment Phase**	**Posttreatment**
• Adolescent Coping Scale • Trauma Symptom Checklist • Interpersonal Reactivity Inventory • Millon Adolescent Clinical Inventory • Multiphasic Sexual Inventory • Family of Origin Scale • Brief Symptom Inventory • Clinical Interview-Adolescents • Parental Intake interview	Brief Symptom Inventory administered every three months.	• Adolescent Coping Scale • Trauma Symptom Checklist • Interpersonal Reactivity Inventory • Millon Adolescent Clinical Inventory • Multiphasic Sexual Inventory • Family of Origin • Brief Symptom Inventory • Closing interview for adolescents • Closing interview for parents

CHAPTER 4: RESULTS

Quantitative Analysis

Demographic Description of Study Group

The study group consisted of 38 participants (35 male, 3 female) who had committed a sexual offence against a sibling, family member, or friend. Table 14 provides a summary of the relevant demographic details. The age range of index offence was 4–18 years with a mean age of 12.95 years. Several participants were not referred for treatment until a considerable time after the offending commenced and in the case of the 4 year old who was referred at age 15, he had committed his last offence at age 12.

Table 14

Summary of Demographic Data Relating to Study Group

Characteristic	Mean Score / Percentage
Age at Referred Offence	12.95 yrs
Type of Offence	
Penetrative	63%
Touching	37%
Age of Victim	6.37 yrs
Number of Victims	1.34
Gender of Victim	
Male	39%
Female	50%
Both	11%
Relationship to Offender	
Sibling	61%
Cousin	21%
Niece / Nephew	2%
Family Friend / Neighbour	16%
Prior Victimisation of Offender	
Physical Abuse	18%
Sexual Abuse	42%
Multiple forms of Abuse (including sexual)	5.5%
Experience of Domestic Violence	5.5%

Unknown		29%
Psychological Condition		
PTSD		10%
ADHD		26%
Asperger's Syndrome		2%
Intellectual Impairment	2%	
Developmental Delay		8%
Other Psychological Disorder		2%

Description of sexually inappropriate behaviour

The sexually inappropriate behaviour that led to the initial referral for treatment covered a range of behaviours from fondling breasts and genitals over clothing to vaginal and anal penetration. There was little difference in the spread of ages between participants who committed touching or penetrative offences although the youngest offender committed one of the most serious offences. More participants committed penetrative offences (63%) than touching offences (37%).

It was difficult to determine the number of offences and victims for the study group. Most participants stated that the current victim was their first. There were a total of 51 victims, with the number of victims per participant ranging from 1 to 4. The mean age of the sexually abusive adolescents appeared similar to that reported in the literature.

Victims

The treatment provided is for intrafamilial sex offenders, therefore, all of the victims were known to the offenders though the victims were not necessarily related to the offenders. However, 84% of victims were a blood relative with the largest number of victims being siblings. The remainder of victims were either neighbours or children of close family friends. All of the victims were younger than the offending adolescent. In 24% of cases the age difference between victim and offender was less than 5 years; often used as a guide to differentiating abuse from sexual exploration. The male offenders were more likely to offend against a female victim (51%) than a male victim (37%) or both male and female victims (12%). Due to the small number of female offenders it was not meaningful to report data separately.

Prior victimisation

Most offenders reported prior victimisation, with almost half (47.5%) of the participants being victims of sexual abuse. Of those who did not (11), six had received less than 4 months of therapy. It is possible that prior victimisation may be disclosed at a later date. Three of the four adolescents who offended against both genders, were victims of domestic violence. Most of the participants who had multiple victims (67%) were victims of sexual abuse plus either physical abuse or domestic violence.

Individual characteristics

Half of the participants had been diagnosed with a psychological condition. The most common diagnoses were ADHD (26%) and Post Traumatic Stress Disorder (PTSD) (10%).

Family characteristics

Most of the study group had experienced disruptive relationships with parents or parental figures. Only 21% of participants came from an intact nuclear family. Thirteen percent lived with foster parents; 12% lived with a non parent relative with the remainder living in step families. Seventy-four percent of participants either had no contact or minimal contact with at least one biological parent.

Psychometric Description of Study Group

Each participant was administered a number of psychometric tests according to the schedule described earlier. The results of the t tests are reported in a later section. Following is a brief description of each psychometric test with pretest means for the study group.

Adolescent Coping Scale (ACS)

The ACS allows adolescents to examine their use of 18 distinct coping strategies (e.g., worry, seek social support). The measure provides three different coping styles: Solving the Problem, Reference to Others and Non-productive Coping. The participants (N = 38) at pretest were more likely to use solving the problem to cope with difficulties than either of the other two coping styles. However, this coping measure was used only "some of the time". In addition, although mean scores were similar to published community sample scores (Frydenberg & Lewis, 1993) in terms of strategies that were productive or used reference to others, they were considerably higher than the norm in using non-productive coping strategies.

Brief Symptom Inventory (BSI)

The BSI is a 53 item self-report symptom inventory designed to assess psychological symptom patterns on nine dimensions (e.g., depression, anxiety, hostility), and three global indices of distress. The global severity index has been used in a number of studies as an indicator of overall distress. A score greater than 63 is considered a positive case. The mean score for the study group was 49.73 (S D = 12.45).

Family of Origin Scale (FOS)

The FOS is a 40 item instrument designed to measure levels of family functioning, focusing on the key concepts of autonomy and intimacy. The total score is used as a general measure of satisfaction with family relationships. Whilst there are no normative scores for the FOS, the original research was based on 278 Texan college students (Hovestadt et al., 1985). The mean total FOS score for this group was 147.0 for black students and 144.1 for white students. The mean score for the study group (n = 36) was 138.06 (SD = 21.64). This test was also administered to parents (n = 20) at intake. The mean score for the parents was 131.80 (SD = 29.92) indicating that adolescents viewed their family of origin slightly more favourably than did the parents.

Interpersonal Reactivity Index (IRI)

The IRI is a 28 item self-report measure of empathy that assesses perspective taking ability, empathic concern, fantasy and personal distress. The pretest total score for the IRI was 53.22 (n = 37). Although there are no norms for this measure, the study group overall mean and subscale means were not significantly different to a published study with an Australian adolescent control group (mean = 56.02) (Moriarty, Stough, Tidmarsh, Eger, & Dennison, 2001).

Millon Adolescent Clinical Inventory (MACI)

The MACI is a 160 item (true-false) self-report inventory designed to give a comprehensive look into the maladaptive personality characteristics of troubled teens. The MACI includes 12 personality scales, 9 clinical indices, and 8 expressed concern scales. No mean scores for the study group fell in the clinically significant range. However, several variables scored between BR 60 and BR 75 denoting problematic areas. These elevated scores are presented in Table 15.

Table 15

MACI Pretest Scores in the Slightly Problematic Range

Variable	Mean	Standard Deviation
Unruly	67.75	16.77
Oppositional	60.06	19.32
Sexual Discomfort	61.28	22.37
Family Discord	72.84	15.56
Impulsive Propensity	68.38	19.54
Depressive Affect	64.81	28.11

Multiphasic Sexual Inventory-Juvenile Version (MSI-JV)

The MSI-JV is a 21 scale instrument designed to assess the psychosexual characteristics of sexual offenders. Only 4 scales of the MSI-JV were used with this cohort: treatment attitude, justifications, cognitive distortion and immaturity, and child molest. There are no norms for these scales. Participants are placed in a category according to their scores on each scale. The study group results are displayed in Table 16.

Table 16

Pretest Mean Scores on MSI-JV

Scale	Mean Score (SD)	Category
Child Molest	9.19 (5.23)	Minimalized Sexual Outlet
Treatment Attitudes	3.69 (1.69)	May not be Motivated
Cognitive Distortions And Immaturity	5.13 (2.96)	Cognitive Distortions / Immaturity
Justifications	3.75 (2.72)	Justifies Sexual Deviance

Trauma Symptom Checklist for Children (TSCC)

The TSCC is a self-report measure of posttraumatic symptoms. The TSCC includes 54 items and yields two validity scales, six clinical scales, and eight critical items. Scores over 65 are clinically significant. Scores between 60 and 65 are suggestive of difficulty. Sexual concerns and its subscales scores over 70 are considered clinically significant. The TSCC was administered to 36 participants. No mean scores fell in the clinical range.

Youth Self Report (YSR)

The YSR obtains self reports of the competencies and problems of 11 to 18 year olds. The YSR contains externalising and internalising subscales plus Internal and External scales and a Total score. Scores are reported as T-scores. T-scores above 70 are in the clinical range and scores between 67 and 70 are in the borderline range. For the Total score the cut off is 60-63 for the borderline range with scores above 63 in the clinical range. Pretest scores for the study group are presented in Table 17. The total mean score for the study group fell in the borderline clinical range.

Table 17

YSR Pretest Mean Scores and Standard Deviations for Internalising, Externalising and Total Score Scales

Scale	Mean	Standard Deviation
Internalising	59.58	10.85
Externalising	59.92	9.29
Total Score	61.87	10.25

Quantitative Data Analysis

Due to the number of participants, a small number of t tests were conducted to analyse change over the 12 month treatment period. For all instruments, except the MACI and FOS, complete data were available for 15 cases in the pre- and posttest groups. For the MACI, data were available for 13 cases in each group. For the parent and adolescent FOS pretest comparisons 20 cases were available in each group.

The statistical significance of pre- and posttest differences were evaluated using a series of 1-tailed repeated measures t tests. The means, standard deviations, and tests of significance for family and individual functioning variables are displayed in Table 18. Tests for violations of homogeneity were not significant.

Table 18

Means, Standard Deviations and Tests of Significance for Variables of Family and Individual Functioning.

Variable	Pretest Scores		Posttest Scores		t
	Mean	SD	Mean	SD	
Family Functioning					
FOS (adolescent) Total Score	135.20	19.15	146.40	16.53	-2.465*
Family Discord (MACI)	69.69	16.55	67.08	11.03	.458
Individual Functioning					
Empathic Concern (IRI)	15.93	4.14	14.33	3.88	1.141
Personal Distress (IRI)	10.07	5.13	8.67	5.13	1.044
Impulsive Propensity (MACI)	65.15	18.45	61.85	22.28	.607
Unruly (MACI)	69.38	18.99	63.92	21.39	1.255
Attention Problems (YSR)	60.73	7.56	58.33	7.27	1.082

Note: M = Mean, SD = Standard Deviation.

*p< .05

Family Functioning

With respect to family functioning, there were no significant differences between parent and adolescent total FOS scores at pretest. The adolescent participants viewed their family of origin more favourably at pretest. However, there were significant differences between pre- and posttest adolescent total FOS scores,

t *(14) = -2.465 < .05*. At posttest the adolescent FOS scores were significantly higher than at pretest. There were no significant differences between the pre- and posttest adolescent scores for family discord on the MACI.

Individual Functioning

With regard to personal functioning, there were no significant differences between pre- and posttest scores on any of the variables tested (empathic concern, personal distress, impulsive propensity, unruly, and attention problems). It should be noted that the mean posttest score for attention problems was below the clinical range (60-63) for this measure. The pretest mean score was in the clinical range.

Comparison of Program Completers vs Non Completers

Comparisons were made between participants who completed the treatment program and those who did not. Treatment completion was defined as those participants who completed at least 12 months of therapy plus pre- and posttesting. Program completers (n = 23) and non completers (n =15) were compared on a number of factors including offence and victim characteristics, prior victimisation, and family characteristics. Table 19 summarises the differences between the two groups.

Table 19

Differences between Program Completers and Non Completers

Characteristic	Completers	Non Completers
Gender of Victim		
Male	7 (30%)	8 (53%)
Female	12 (52%)	7 (47%)
Both	4 (18%)	0
Offence Type		
Touching Offences	9 (39%)	5 (33%)
Penetrative Offences	14 (61%)	10 (67%)
Prior Victimisation		
Sexual Abuse	9 (39%)	7 (47%)
Physical Abuse	4 (17%)	3 (20%)

	Multiple Abuse	0	2 (13%)
	Domestic Violence	2 (9%)	0
	Unknown	8 (35%)	3 (20%)
Total Exposed to Prior Victimisation		15 (65%)	12 (80%)
Family of Residence			
	Intact Family	8 (35%)	0
	Foster Family	2 (8%)	3 (20%)
	Non Parent Relative	1 (4%)	3 (20%)
	Step Family	10 (43%)	9 (60%)

Utility of Known Typologies to this Study group

A cluster analysis of the MACI results at the beginning of treatment (n = 32) was undertaken. It yielded a somewhat different profile to previous typologies. This typology is shown in Table 20.

Table 20

SafeCare Typology Based on MACI Pretest Scores

Group	**Elevated Scores on Subscales**	**% of sample**
Antisocial	Unruly, oppositional, family discord, delinquent predisposition, impulsive propensity	41%
Anxious	Anxious feelings, depressive affect, family discord, sexual discomfort	37%
Narcissistic	Dramatizing, egotistic, family discord	22%

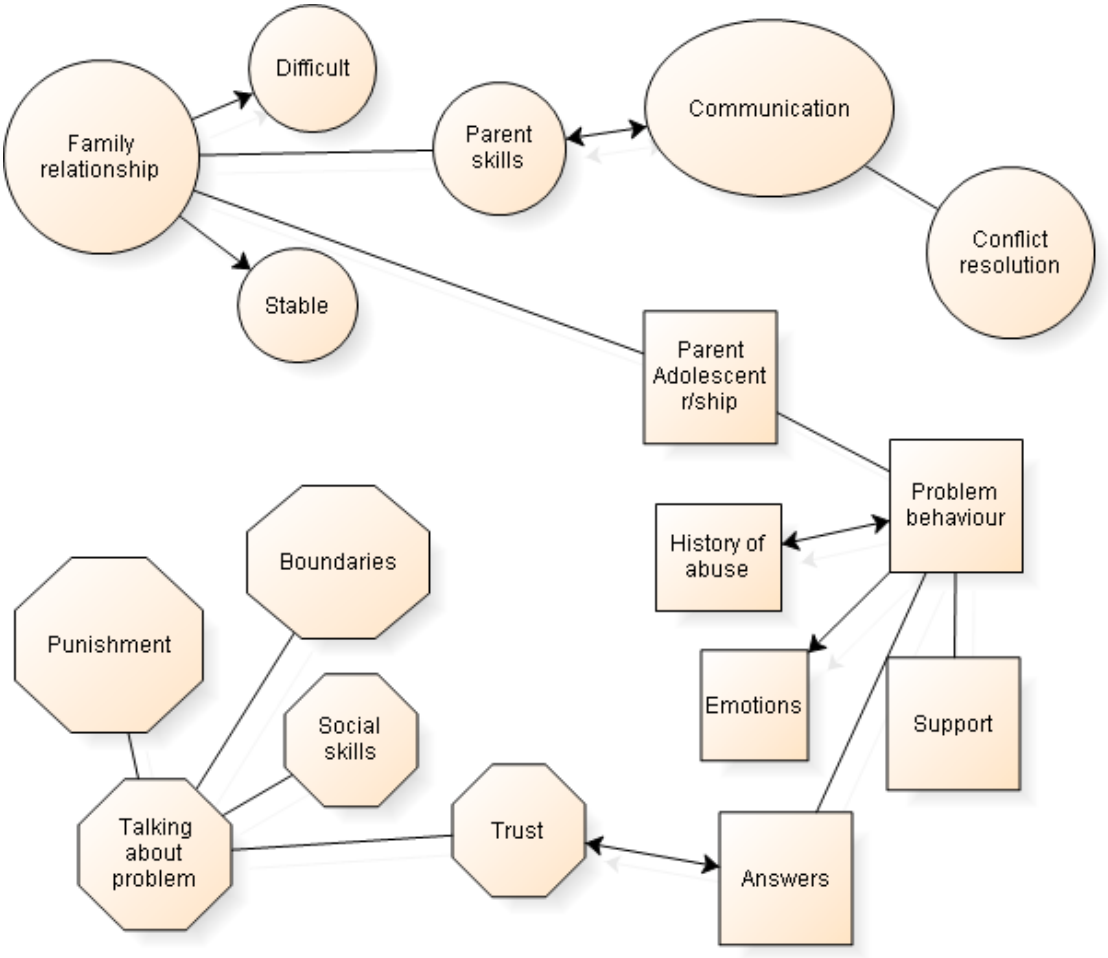
Qualitative Data Analysis

Parent Intake Interviews

Introduction

Most parents (n = 21) reported that there were already problems within family relationships prior to disclosure of the adolescent's offence. They also reported difficulties with parenting and communication patterns within the family. At the time of disclosure, the prevalent issues for all parents related to the anger, guilt, and shame they felt. Most parents expressed a need for support of the adolescent offender, the victim, and other family members. They struggled to understand and make sense of the offence and expressed concern about the quality of their relationship with the offender. In many cases disclosure also led to reemergence of issues related to a family history of past sexual abuse. After disclosure, parental concerns focused more on the need to access the support necessary to enable the adolescent to move forward. Some parents also needed to talk about the inappropriate behaviour, to understand the reasons for the offence and to establish the capacity to trust their offending child again. Figure 1 displays the dominant domains and themes elicited from the parent intake interviews. The parents interviewed spoke about their experiences of treatment and any issues or problems they had with the service provided.

Figure 1 Parent intake interviews: Domains and themes elicited from the parent intake interviews.



Note: → / ↔ indicate an effect between themes/domains; — indicates an association between themes/domains.

Prior to Disclosure

Family Relationships

One third of parents interviewed described their families in positive terms, while the remainder described families that could be categorised as being either volatile or disengaged. For those who described their family in negative terms, most had one or both biological parents absent from the family unit and, generally, contact with the noncustodial parent was intermittent. In addition, the relationship between the separated parents was often strained or openly abusive. In some families, both biological parents were absent and care was provided by relatives or family friends. In one instance, a foster parent was left with a baby she thought she would be minding for the evening:

> *"Like she (mother) left him to baby sit when he was 2 months and I've had him ever since."*

A number of families with nonsupportive extended family members spoke about their difficulties with sadness. The following is a typical comment reflecting this:

> *"Our family is a broken down family. There's 7 of us … no one talks to no-one."*

In these families, an intergenerational pattern of broken relationships was commonly reported. Of those parents who reported sound family relationships, most recognised their (offending) child's mistakes but reported an acceptance by family members:

> *"No-one has judged (X) for it; everyone has been very understanding."*

Parenting and Communication Skills

Some parents quite openly admitted that they needed help when it came to their parenting skills:

> *"I'm not strict enough with him…And I don't, I don't enforce or haven't in the past, enforced consequences to actions and things like that. Where his mother is very strict with him."*

At times, some parents reported being at a loss as to how to provide their children with rules and regulations, with several parents finding it difficult to enforce family rules consistently. Other parents admitted that their indulgent parenting style was an attempt to "make up" for the difficult life the children had lived so far. Some of these parents had their own issues with drug addiction and domestic violence. SafeCare was often seen as a place where the adolescent could be "straightened out" and parents would be given an opportunity to learn more effective parenting skills.

The lack of effective communication was an important issue for most parents interviewed. In many instances, family members felt they needed to overpower others to have a voice. In some cases, there was a dominant family member, usually the adolescent offender. A number of parents stated that their children shouted at each other in order to communicate.

Many parents explained that they were either at a loss to change this pattern of relating, or did not believe that this form of communication was problematic. It appeared, based on parent interviews, that children often did not listen to parents and many parents reported that they had no way of controlling the situation, except by being louder and angrier than the children.

Most parents interviewed reported that conflicts usually were not resolved well within their families and that they tended to close down arguments without providing any opportunity for a negotiated resolution. The most commonly used conflict resolution technique was a form of time out where siblings spent some time apart. Often parents did not step in until the arguments had escalated to physical violence. Alternatively, some parents admitted that at times it was easier to say "I'm the boss and that's the end of it" rather than work on the conflict between the siblings.

Disclosure

Emotions

Families not only had to deal with the offending adolescent, sibling victim, and other siblings but also their own feelings of guilt, shock, and anger surrounding the offending behaviour, often with little or no family support. At this time, some parents learnt that their adolescent was not only a perpetrator of a sexual offence but also a victim. All parents reported being unsure how to move forward or who to talk to about this issue at the time of disclosure.

History of Abuse

For some parents, a family history of abuse was repeated despite their efforts to avoid this. These parents' experiences of prior abuse were not generally known about within the immediate family. The parents believed they were protecting their children from the family history of abuse by remaining silent and were shocked to find that it had been repeated. Often the adolescent offenders were themselves victims of abuse but this was not always known in the family until after disclosure, some times months later.

One of the more common fears among parents was that the cycle of sexual abuse would be repeated generation after generation, especially if it had occurred within the parents' generation. Foremost, parents wanted this behaviour to end and felt that SafeCare could provide them with both the knowledge and the ability to pick up on cues that something was "not right" in the future:

> *"Like I found out things that I didn't know about the cycle of abuse and all that kind of stuff and it made me much more aware."*

Parent Adolescent Relationship

Disclosure of the abuse strained the parent child relationship and led to divided loyalties, especially when the victim was a member of the immediate family. In some cases, families found themselves divided between the victim and offender. This was especially true when the offender and victim were members of a step family. These parents were conflicted about how to deal with the situation. They did not want to abandon their offender/child whilst

understanding that they must deal with the inappropriate behaviour. This sometimes led to parents aligning themselves with either the victim or the offender:

> *"I sometimes think that my husband thinks that it's (X) and I and he's on the outer."*

After Disclosure

Answers

All parents came to treatment wanting to know why the offending behaviour occurred. An explanation, they felt, would provide some relief and possibly the knowledge to prevent it happening in the future. Some parents also questioned how their adolescent victim could become an offender. In their minds, the trauma of being a victim should be enough of a deterrent to prevent someone from becoming an offender:

> *"I need to understand the reason why a child that is a victim in his life grows into a predator."*

Trust

Most parents struggled with the issue of trust, openly questioning whether they or other family members could ever trust the adolescent again. They were fearful that the adolescent could not be trusted to behave correctly in the future although they hoped this would be so. These parents hoped that SafeCare would be able to provide them with some guidance.

Talking about inappropriate behaviour

Most parents found it difficult to talk with their adolescents about what had happened. In particular, these parents had problems explaining the behaviour or the reasons for it. They also found it difficult to find the right words to use when talking about the inappropriate sexual behaviours to anyone. Not many parents spoke directly about inappropriate sexual behaviour. Only three parents were able to use terms that directly related to sexual offending. Most parents used words such as "it"; "doing things"; "bad choice"; or "done wrong":

> *"They're (siblings) aware that (X) has made some bad choices"*

Some parents were unable or unwilling to talk to their adolescent about his/her offending behaviours. Some felt that this would or should be dealt with by the therapists. Others did not know how to approach the subject with their child.

Moving forward

Once parents had dealt with the initial shock of disclosure they focused on what was needed to improve the situation for both the adolescent offender and the family. At this point, most parents believed that there was little they could personally do to change the situation. When probed about family issues the view was that these issues had little or no impact on the adolescent offending against a family member. Instead, they felt that changes to the adolescent, particularly in the area of social skills, would have the desired results:

> *"He needs to get on better with other people, he needs to make friends. I don't think he has any friends at school."*

Relapse prevention

All parents interviewed were more aware of the need to know where their children were and what they were doing. They spoke of the need to be vigilant with safety issues concerning their adolescent and also the need for their children to learn about personal boundaries and how to keep themselves safe.

Some parents also spoke about boundaries for their adolescents and the importance of maintaining these boundaries in order to prevent future offending. These boundaries were either discussed in relation to the reasons they suspected led to the offending in the first place (poor impulse control) or inappropriate sexual activity specifically.

SafeCare

How the families spoke about SafeCare

On the whole SafeCare was spoken about in a positive light. Despite the length of the program and the difficulties getting in touch with SafeCare initially all parents were generally happy and relieved to be a part of the programme:

> *"I'm glad we're here, because we would have been stuck. We didn't know where to turn when we discovered what we discovered."*

Problems and issues

Although, generally, families were happy with SafeCare at the initial interview, several comments were made about problems with the service. These mainly concerned lack of availability of services and the difficulty in getting in touch with an appropriate service immediately after disclosure. Several parents found that the times clinicians were available were not suitable when therapy sessions were being scheduled for school aged children. Of some concern was the amount of time it took to get in touch with SafeCare initially and the difficulty finding someone who knew about SafeCare or could put them in touch with an appropriate counselling agency. One parent suggested that an anonymous hotline would have been useful when disclosure occurred. Several parents were concerned that their children were seeing someone for therapy and they had little idea of what transpired between the therapist and their child:

> *"I guess the openness with (X). I don't know, understand the confidentiality and they (therapists) won't talk to us about what is discussed with (X), but just some sort of progress...briefing".*

Parent Closing Interviews

Introduction

8 parents (2 male, 6 female) were interviewed at approximately 12 months into the treatment program. Of these 8, six families had completed the program with 2 families remaining in the program. All parents reported some personal changes as a result of attending the treatment program. For most parents there were improvements in relationships between family members as well as communication patterns and parenting skills. Most parents commented on perceived changes in the adolescent. Finally, all parents discussed SafeCare's program including their experiences in group therapy, relationships with therapists, and whether they would use SafeCare's services in the future. Figure 2 displays a flow chart of the domains and themes elicited from the parent exit interviews.

Influence on Parents

Most parents commented positively on personal changes. These parents expressed a greater awareness and understanding of how their role as a parent had influenced family functioning, both positively and negatively, in the past. They reported that this greater awareness had improved their parenting skills and their ability to cope with the demands of raising a family. This sentiment was echoed by a number of parents who found that the parents group, in particular, provided an opportunity to learn and discuss parenting skills with people who were experiencing similar problems:

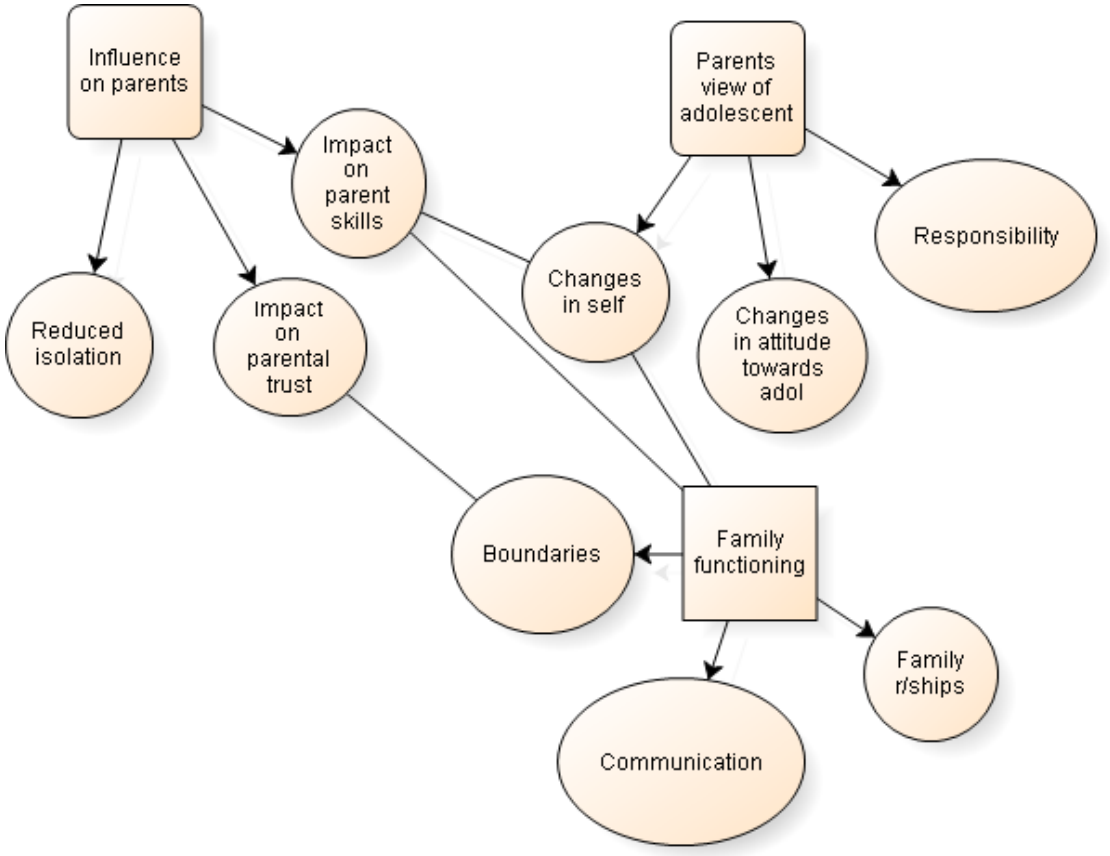
> *"But I think it does give you definitely gives you more parenting skills or skills in life"*

All parents spoke primarily of their relief once they learnt that they were not the only family to deal with adolescent sex offending. Parent group therapy sessions provided a forum for discussing these feelings of isolation, learning how other families were coping with this problem, and providing a sense of normality – they were normal families dealing with an extraordinary problem.

Trusting the adolescent offender was an important issue for most parents and one that also linked with treatment. If the parents thought the treatment had been effective they felt more confident trusting their adolescent. However, with knowledge of sex offending and the fact that it had already happened in their family this trust was tempered with caution.

Figure 2

Parent closing interviews: Domains and themes elicited from the parent exit interviews



Note: → / ↔ indicate an effect between themes/domains; — indicates an association between themes/domains.

Parents' Views of Adolescent

At the end of the program most parents felt there had been some important advances in their family life, children, and the family's ability to cope with difficult situations. These parents reported a number of positive changes in the adolescent including greater confidence and sociability, greater empathy, less impulsivity, and more awareness of how one's actions impact on another:

> *"Yeah he's just more, I don't know, he behaves properly now. Fits in to society, I think."*

Most parents were able to see their adolescent as "normal" dealing with the ups and downs of adolescent development. This was particularly true when parents, in hindsight, commented on their adolescent going through a period of being withdrawn (as a result of the offending behaviours and/or their own sexual victimisation). They spoke about being able to separate the child from the behaviour rather than view the child as the behaviour.

An important issue for all parents, at intake, was for the adolescent offender to understand and accept responsibility for his/her inappropriate sexual behaviour and either apologise or in some way atone for what he/she had done:

> *"Well he's done the right thing. By admitting what he's done wrong and sticking to his programme."*

Family Functioning

A number of parents described the atmosphere at home as much calmer at the end of the program with a more positive attitude towards family life:

> *"Quite peaceful, it's quite calming. It's relatively normal you know it's not really confrontational."*

For some families, relationships between siblings had improved and this was attributed to an attitude change by the adolescent offender. For other parents there was no change in family life and family members who were antagonistic towards each other 12 months previously were still unable to get along. Some parents were more sanguine about family relationships, acknowledging that no matter what, relationships do change over time.

Most parents were making an effort to talk more often and more effectively with both their partners and children. Greater effort was made to keep in touch with their children even though their adolescents were, at times, unresponsive. In general, parents reported that communication between family members was calmer and more constructive. Most parents were less likely to describe situations where siblings screamed at each other to be heard. Communication was used to keep in touch with how their children were going. These parents explained that their more open style of communication, in turn, helped their children to communicate more openly with them.

Communication skills were used to convey family rules and regulations. One parent commented that he was clear, in his own mind, on family guidelines but was uncertain whether he had discussed these with his children. Not all parents were able to break down the barriers to open communication. Some parents struggled with communication and expressed difficulty understanding adolescents.

Finally, all parents understood the need to keep their children safe, including the adolescent offender. Some parents mentioned during the intake interviews that the adolescents were often impulsive, doing things without thinking about the consequences. Thus, most parents were more likely now to have clear behavioural guidelines that were communicated to their children. However, boundaries were linked with trust; if the parent did not trust the adolescent then there were stricter rules curtailing freedom.

All parents entering the program wanted to know why the sexual offending occurred and at the end of treatment parents were often still asking this question. Some continued to search for answers, whereas others felt they knew why their son had offended:

> *"I guess I would have liked to know why he offended and I still don't know that. And I would have loved reassurance that he's not going to do it again, and we can't have that."*

SafeCare Evaluation

All parents reported being satisfied with the treatment provided for their families. In particular, the parent group was universally approved by all the parents who were interviewed, although a couple of parents had reservations about the adolescent offender and victim groups. On the whole, group sessions allowed parents to share ideas and problems and to be with others in similar situations. Most parents reported improvements both personally and for the family:

"I have been very happy all the way along."

Negative comments by several parents focused on the issue of confidentiality between the adolescent and his/her therapist. Parents were provided only with general information about the adolescent's progress. However, issues of particular concern, either from the therapist or parent, were addressed at family conferences. One parent felt that the mix of participants for both the adolescent offender and victim groups was not appropriate.

Changes to the program suggested by parents centred on administrative issues. Several parents mentioned problems with staffing levels and the difficulties of getting appointments out of school hours. They acknowledged that funding restrictions limited the availability of staff members. One parent felt that the information provided was inadequate and came too late into the treatment program. In reality, this is the case for many parents as they are in a state of shock for several months and find it difficult to take in information. Two parents commented that they had to travel long distances to get to SafeCare. SafeCare is the only option available and some families travelled from country areas to receive treatment.

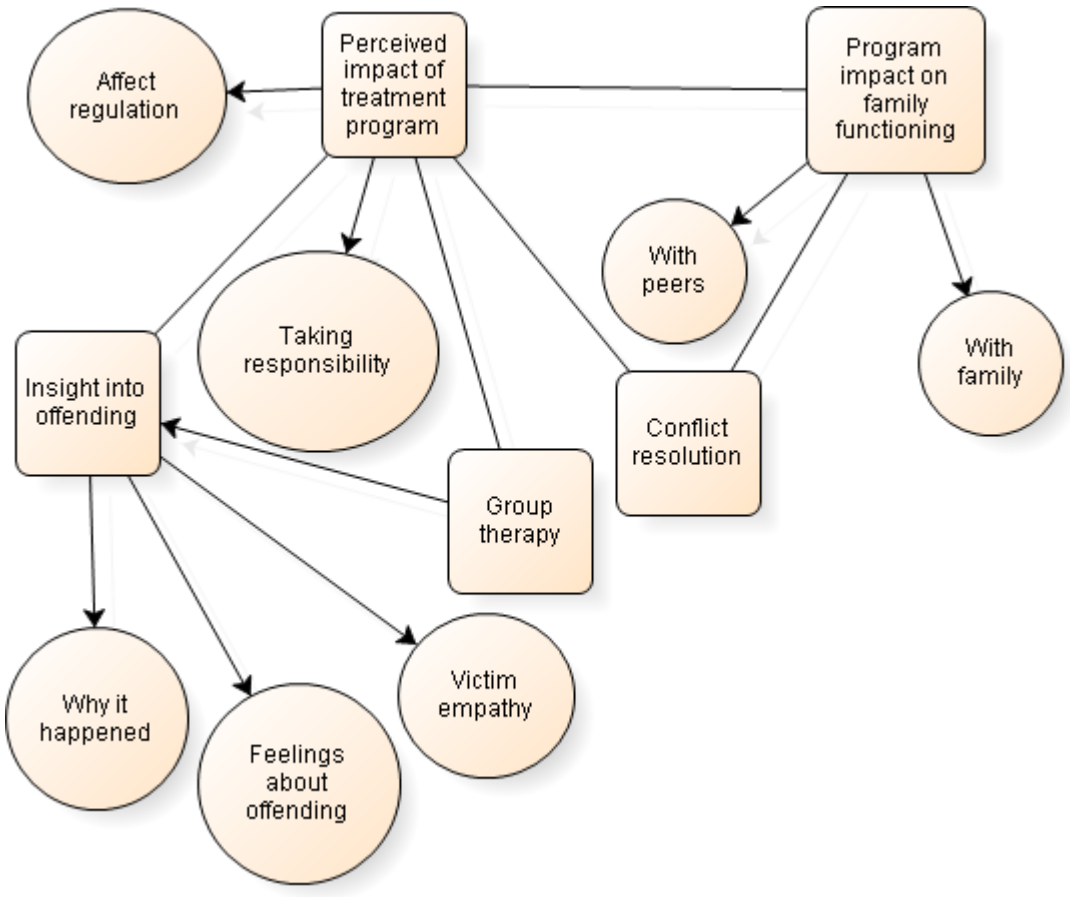
Adolescent Closing Interviews

Introduction

Participants (n = 12) who had completed 12 months of a community based sex offender treatment program were asked questions relating to service delivery, treatment progress, and family functioning. Most participants reported improvements in family and/or peer relationships, expressed optimism about the future, and all stated that they would not reoffend sexually in the future. Figure 3 presents a flow chart of the domains and themes elicited from the adolescent exit interviews.

Figure 3

Adolescent closing interviews: Domains and themes elicited from the adolescent exit interviews



Note: → / ↔ indicate an effect between themes/domains; — indicates an association between themes/domains.

Perceived Impact of Treatment Program

All participants spoke about perceived changes in self control (impulsivity), taking responsibility for their actions, and emotional changes, especially feeling less angry towards others. However, there was little evidence of improvement in the area of empathy and over

one third of participants felt that there had been no personal changes. Some participants were able to name emotions and contrast the way they felt prior to treatment to the way they felt and reacted to emotions after treatment. They reported feeling happier within themselves and getting angry less often than they used to:

> *"I've calmed down a bit and not gotten into as many fights, listen to people more."*

These participants attributed this calmness to the opportunity of discussing problems with a third party. At first, the therapist fulfilled this role, however by the end of treatment, 10 of the participants felt that there was at least one person in their family they could talk to if they needed help. All participants were able to describe ways to calm down in stressful situations such as bike riding or removing themselves from the situation. Further, some of the participants reported that they were now able to take responsibility for their mistakes.

Program Impact on Family Functioning

There was a mixed response from the participants, some who felt that relationships with parents, siblings, and peers had improved whereas others felt that changes in relationships were minimal.

With family

Some of the participants talked about how their relationships with family members had improved since starting the treatment program. These participants stated that talking to family members and becoming involved in family life helped to improve relationships within the home. They believed they had a better understanding of how their parents and siblings felt about the offending behaviours. They reported that they communicated more effectively with family members and were able to talk to their parents if they needed help with their problems:

> *"Mum is like really, cos she hated me for a while. At the start, but now we're getting along better, so yeah. So it's like brought us closer."*

Further, most participants reported that relationships with peers had also improved. A number of participants stated that they had developed new friendships over the past 12 months, particularly at school. They reported being more socially active both at school and out of school hours.

Changes in family relationships were also reflected in the ways conflicts were resolved. Some participants were able to articulate effective strategies they used during times of conflict with parents and siblings. However, participants who felt that family relationships had not improved also reported that conflicts were not resolved satisfactorily.

Insight into Offending Behaviours

Most participants were reluctant to discuss their offending behaviours in any detail expressing shame and embarrassment about what they had done, and finding it difficult to discuss their offending behaviours with a stranger. However, they credited much of their understanding of their offending behaviours to their therapists.

All participants reported feeling isolated upon disclosure of their inappropriate sexual behaviours to a third party:

> *"I thought I was the only person that did stuff like that."*

Most participants reported that they gained insight into their offending behaviours through discussing what happened with the therapists. Although some stated that they knew prior to engaging with SafeCare that their behaviours were inappropriate they felt that they were unlikely to change without intervention of some description. However, not all participants felt they had an understanding of the reasons why they offended in this way.

When asked how they felt about their victims, none of the participants appeared to provide an empathic response. Where the victim was a sibling, their attitudes towards the person could not be disentangled from "normal" sibling relationships:

> "So how do you feel towards your sister (victim), how do you feel towards her now?
>
> *I don't know. I don't really talk to her anymore.*
>
> No?
>
> *I never really talked to her to start with.*
>
> How do you feel towards her?
>
> *Don't know she's just there."*

Relapse prevention

Each participant was asked specifically about his/her relapse prevention plans. Eight were able to articulate at least one strategy he or she could use if necessary. The strategies most often identified by the participants involved some form of distraction from thoughts of offending. This was in the form of either physical removal from the situation or using something to distract one's thoughts, such as playing a computer game. Other strategies included talking to either a family member or therapist. For three participants the idea of returning for another 12 months of treatment was considered a considerable deterrent from offending. Only one participant stated that he had no relapse prevention plans.

Group Therapy

Although most participants found it difficult to engage in group therapy initially, citing shame and nervousness with strangers as the major obstacles, all felt that they made some important progress during group therapy. Each participant was eventually able to talk about his/her offending to the other group members:

> *"Cos you were kind of talking with people who had pretty much done the same thing."*

All participants found it beneficial to share experiences and feelings with other group members who had had similar histories. Talking about offending in group therapy provided some participants with the understanding that what they had done was wrong, by listening to other members' stories.

Only two participants made negative comments about group. The first participant has intellectual difficulties and found it hard, at times, to follow the conversations. The second participant has Asperger's Syndrome and found it difficult to participate in a group situation.

SafeCare Evaluation

Most participants felt positively about being involved in the program. The positive feedback centred on the acceptance of all participants by staff members and the help they received through the treatment program. For most, the opportunity to talk about their problems with people who understood what they were going through was the most important aspect of the program.

Negative comments centred mainly on missing school and the need for more detailed information at the beginning of the treatment process. Table 21 displays the negative comments made about the SafeCare program.

Eight participants thought it was necessary to attend the treatment program. Two felt that it was okay to attend but stated that they could have stopped offending on their own. Two felt that they did not need to attend at all. Those participants who felt it was necessary to attend treatment felt that they would be unable to stop offending without help. Nine participants stated that they learnt something from attending SafeCare. Foremost, participants learnt that sexual offending is wrong. However, a number of participants stated they had learnt specific skills such as self control, problem solving, communication, and social skills. One participant stated that he had learnt nothing.

Table 21

Negative Feedback Regarding the Young People's Program

Comment (Number of complaints)	**Quote**
Missing School (3)	"It was also a pain in the bum because I kept missing out on classes that I really liked."
Programme not explained (3)	"Not explained to me, I didn't know what was going to happen throughout the year."
Travel (3)	"It is a bit of a hassle getting from school straight here, given the time periods, the distance."
Testing (2)	"Maybe the tests a little bit. They were a bit hard. *A little bit hard in what way?* In like the question forms and the certain instructions you give, they're a bit confusing at times."
Individual Therapy (1)	"I didn't really like coming to the individual sessions...I didn't get anything out of them. Thought it was just a waste of

	time."
No Fun Activities (1)	"There was hardly anything to do and it's … pretty … like why am I coming all the way from where I live down here?"

Finally, most participants were happy with the program and could not think of anything they would like to change. Table 22 presents those alterations that were suggested by the adolescent participants.

Table 22

Suggested Changes to the Young People's Program

No change	Easier Questions	More Group Sessions	Art Therapy	More Information
7	1	1	1	2

CHAPTER 5: DISCUSSION

Introduction

The current study aimed to explore the needs of IASOs and the potential contribution of community based treatment. In the process it also reaffirmed many features of the picture of ASOs slowly developing from literature on ASOs worldwide. The current study had five specific aims: to develop a psychological profile of IASOs; to gain an understanding of the families of IASOs; to assess the value of a community based multifaceted psychotherapy treatment program on IASOs and their families; and to consider the utility of existing typologies of ASOs for the group of IASOs receiving community treatment.

This discussion begins by considering some of the characteristics of the study group and their families. It then examines the value of the proposed typologies, the value of the community treatment program, and finally the implications of this study. The implications of this study can be seen largely in terms of implications for treatment and policy including criminal justice responses.

At the outset there were several limitations to this study that should be noted. The data analysed was based on a small group of participants attending a community based treatment program. As no comparison group was used it is not possible to fully understand how the program affected group progress. Nor is it possible to make too many comparisons with other research as few studies differentiate between intrafamilial and extrafamilial ASOs. Further, such a small group reduces the ability to detect significant pre- and posttest differences. All participants in this study volunteered to take part. There may be significant differences for those families who declined to participate in the study. The attrition rate, although not high for this area, was also of concern. Almost 4 in ten (39%) families did not complete the 12 month treatment program and attendance by some clients was sporadic. It was particularly difficult to keep the IASO engaged in the program when the family was not. These problems unfortunately reflect the nature of the problem being dealt with but pose particular problems for research in this area.

Characteristics of Intrafamilial Adolescent Sex Offenders

Trauma and psychological adjustment

The most commonly described factors associated with adolescent sexual offending include separation from a parent, prior victimisation, social isolation, psychopathology, and behavioural and school problems (Veneziano & Veneziano, 2002). These factors were all evident in an analysis of the study group.

In line with the international literature discussed earlier almost three quarters of the study group (71%) reported being victims of some form of abuse. Almost a third (29%) of the study group was exposed to aggressive socialisation through exposure to domestic violence and physical abuse. A further 47.5% were victims of sexual abuse.

Half of the study group was diagnosed with some form of psychiatric impairment including, most commonly, ADHD (1 in 4), PTSD, and developmental delay. The rate of ADHD is estimated to be 12 times higher than that of the rest of the adolescent population of the

state[7]. Many parents of the IASOs in the study group spoke of their adolescents as "loners", with few peer aged friends and difficulties establishing peer relationships. Many of the adolescents in the study group were described as impulsive with poor problem solving techniques. Reflecting the literature, the adolescents were typically impulsive, aggressive, lacked interpersonal skills, and had few peer aged friends. The IASOs, generally, behaved in an aggressive manner towards other family members, especially siblings.

The family environment

The family environments of the IASOs were usually disorganised and unstable, characterised by parental absence and rejection. Three quarters of the ASOs were members of blended or step families. Less than a quarter (21%) of the study group came from intact families, at the time of referral to SafeCare. Parents typically displayed an authoritarian parenting style and had difficulty coping with the day to day demands of parenting. Upon interview it became apparent that a number of parents maintained poor personal boundaries and demonstrated ineffective conflict resolution skills.

The stories of abuse and subsequent treatment disclosed by the adolescents and their families potentially provide insight into how the family system interacts with sibling sexual abuse. As discussed earlier, "intact" families were the exception rather than the rule in the study group. Often, at least one biological parent was either absent from the family or had a difficult relationship with various family members, including the adolescent offender. The adolescent who was referred for treatment was often characterised as the family "trouble maker" - impulsive and with few peer aged friends. On top of this, disclosure of the abuse usually resulted in a number of conflicting emotions, with parents sometimes wishing to protect the child victim as well as the child offender. At the time of referral, families were often in crisis and were unsure of how to proceed to provide the necessary help for their families.

The lack of family support was evident to treatment staff in a number of ways. For example, a number of participants were not accompanied to treatment and these parents had minimal contact with SafeCare. As discussed in the literature review, parents of ASOs are often unable to meet the emotional needs of their children; a number of parents did not attend SafeCare contending that the problem was solely the adolescent's to deal with. For many of these families, the offending behaviours of the adolescent were seen as a problem only for the adolescent, and there was little understanding how family factors could impact on child behaviour.

Many families did not recognise the difficulties they were facing until disclosure of the offending behaviours occurred. At interview, some parents described their families as normal, despite a number of family problems including intergenerational sexual abuse, parental rejection, and fractured family relationships. Some parents described family environments that were tense and combative, with little connection between family members or extended family. Family life was characterised by warring siblings and conversations often degenerated into unresolved arguments. Ongoing conflicts were

7 Western Australia Health Department data for 2003/04 reported that 2.2% of adolescents aged between 2-17 years were prescribed stimulant medication for the

common in most families. Communication styles in the families were usually adversarial and negative with arguments rarely resolved. Arguing siblings were often separated, the conflict was ignored, one child was blamed, or parents shouted to "close down" the argument.

In summary, in most families of adolescents presenting for treatment, relationships between family members were not close, communication between family members was aggressive or non existent, and parents had little idea how to deal with inappropriate behaviour or set boundaries outlining acceptable behaviour. In this environment offending adolescents were described by parents as impulsive, with few ties to family or friends. Families were often isolated with few resources to call on in times of crisis.

The Value of Typologies of Adolescent Sex Offenders

Although acknowledged as a heterogeneous group, researchers have generally grouped all types of ASOs together. There has been little research into the differences between offenders based on offence characteristics.

The two major types of typology of ASO that have been proffered are those based on personality/psychopathology on the one hand and those based strictly on the criminological features of the offending behaviour, on the other. The latter category of typologies (e.g., Burton, 2000; Langstrom et al., 2000; Hunter et al., 2003) largely examine how the age of onset and age of victim relate to the severity and nature of the offending behaviour. The earliest typologies were those based on clinical features. For example, O'Brien and Bera (1986) provided a typology consisting of seven offender subtypes grouped mainly according to the level of socialisation and impulsivity displayed by the offender.

There have been a number of typologies published which are based on the personality/psychopathology of the ASO (Oxnam & Vess, 2006, 2008; Richardson et al., 2004; W. R. Smith et al., 1987; Worling, 2001). The cluster analysis of the MACI in the present study indicated a three-group typology consisting of antisocial, narcissistic, and anxious groups. Although each analysis has produced somewhat different typologies, there appear to be commonalities across the groupings. There is clearest agreement that there is an *antisocial group* (antisocial, conduct disordered, passive-aggressive, socialized delinquents), and a *narcissistic group* (narcissistic, confident/aggressive, personality disordered, passive-aggressive, dysthymic/negativistic). Then, there appear to be two more broad groupings which are less clear cut: an *inadequate group* (inadequate, immature, unusual/isolated, submissive, anxious) and an *overcontrolled group* (overcontrolled/reserved, conforming, dysthymic/inhibited).

The analysis of different types of ASOs is important because each of these groups of ASOs will have different treatment needs and pose different challenges to those offering treatment. For example, those who are high on antisocial characteristics may need a focus which also addresses their propensity for delinquency and aggression, while those who are highly anxious will need strategies to manage their anxiety. Although all will need treatment modules which address their overt offending behaviour, some of the other personality and behavioural issues will also need to be addressed in order to reduce the risk of reoffending.

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treatment of ADHD (Department of Health, 2005).

The Value of the Treatment Program

One of the effects of treatment appears to be changes to family functioning. There were significant positive changes in pretreatment to posttreatment scores on a measure of family functioning completed by the IASOs. Although this may be a result of growing maturity as well as work done in therapy, this finding was also supported by posttreatment interviews with parents. There were few other significant effects shown in the analysis of pretreatment/posttreatment data. However, adolescents in the study group stated that after treatment they were less impulsive and were able to articulate strategies to help in stressful situations. They felt that the home environment was calmer and that they were also calmer. Social skills training, a component of SafeCare's treatment of ASOs, was one area that improved during treatment, with adolescents stating that they were able to develop and maintain peer friendships, or as one participant stated "found where I fit in". They attributed some of these changes to the opportunity to talk to someone about their problems. Parents also expressed the view that family life was less tense and relationships between siblings had improved to some extent.

Although changes were not statistically significant on most measures used, parents and ASOs reported that they felt differently. It appears that even slight changes to the family system and the individual translate into important changes for those involved. Parents and adolescents who were interviewed after treatment expressed satisfaction at the progress made to improve family life.

The importance of a family focussed holistic treatment model

The SafeCare families presented with multiple problems manifesting as the adolescent's inappropriate sexual behaviour with his/her sibling or close family member. Upon assessment it became apparent that without addressing these additional problems within the family environment, progress with the IASO was likely to be limited. Parents engaged in the program reported that they gained valuable insight into the sexual offending cycle and the role of the family in maintaining an environment where offending behaviours occurred. Further, parents gained valuable skills that enabled them to parent their children more effectively and the strength to deal with problems that might arise in the future. Greater progress and understanding was demonstrated by adolescents and parents where at least one parent was also engaged in therapy. However, when only one parent was involved in therapy, it was noticed that the other parent often struggled to come to terms with what had happened.

Upon completion of the treatment program, parents and adolescents described the family environment as more harmonious, although not completely problem free. In general it appears that parents felt more confident about their skills as a parent. Parents spent more time talking to their children, conveying family rules and discussing family life, issues, and problems. The IASOs felt they had a better understanding of the pressures of parenting and more confidence in taking responsibility for their own behaviours.

As many of the children came from homes where one or both parents were either totally absent or maintained only intermittent contact with their children there were particular

problems presented. The relationship between the separated parents was often strained or openly abusive. When the sexual abuse was disclosed, parents found it difficult to support both the victim and the IASO. Changes to the family system or functioning were noted in some families attending for treatment, most notably when the parents were also engaged in therapy.

A comparison of "program completers" versus "non completers" indicated that intact families[8] were more likely to complete the program. In addition, prior victimisation of the adolescent was associated with non completion of the program. This suggests that non intact families may find it more difficult to commit to, or carry through with, a lengthy treatment process. Alternatively, it may be that some families require more intensive support at the assessment stage to engage them in therapy. For these families it may be important to focus, initially, on problems that can be resolved expediently.

Group therapy

Group therapy was the single most important treatment modality endorsed by both adolescents and parents of the study group. Group therapy provided a forum to discuss both the offending behaviours and other issues that affected individuals and families. Group therapy reduced the isolation felt by the IASO and his/her family surrounding sexual offending. Group therapy also provided a forum to confront behaviour that could possibly be avoided in individual therapy.

Group therapy was universally approved by the parents interviewed. The appeal of group therapy was the opportunity to speak to other parents in similar situations and to work on issues that were relevant to all group members. The adolescents attending group therapy found the initial sessions difficult because of the shame and guilt surrounding their offending behaviours. However, once they were familiar with the other group members they felt they benefited by gaining perspective and that hearing the stories of their peers reduced their sense of isolation.

The only negative comments regarding the group therapy sessions related to the mix of children in both the adolescent and victim groups. Several parents felt the children were not matched either in age or offence type. Interestingly, this was not considered an issue by either the adolescents or therapists.

Implications

Treatment

It is clear that most IASOs will present with a variety of psychological difficulties, many of which are associated with their family dynamics. Treatment needs to be holistic, varied, and flexible to meet the needs of the individual circumstances. There is still a need for understanding the various contributions of education, psychotherapy, and social intervention. Based on the results of the current study, treatment programs can provide valuable help for parents of the IASO. Parents found learning how to deal with the sexual

[8] "Intact" in this context means families with one or two parents or parent figure that had existed as a family unit for most of the adolescent's childhood

abuse within the family and how to deal with other family related issues such as conflict and setting boundaries the most useful aspects of the program.

In regard to assessment there is a distinct need in this area for appropriate assessment instruments. It was difficult, in the conduct of the present study, to source psychometric tests appropriate for this specific group of offenders. Most of the tests for ASOs have been modified from adult tests (Shaw, 1999). The research team found the MACI and YSR were the most useful in terms of identifying problem areas. Although as a group there were no significant deficits, individually, almost all participants scored above BR 75 on several scales on the MACI, indicating a significant clinical issue in at least one area.

As discussed in the methodology section, the lack of an appropriate instrument for measuring sexual dysfunction in adolescents was important. Research and development of psychometric tests designed specifically for children and adolescents is urgently required. At the moment there are no tests designed specifically for ASOs. Tests that accurately evaluate levels of psychopathology and sexual dysfunction in ASOs will enable researchers to better understand this population.

There are a number of issues directly impacting on treatment that may be considered policy issues as they dictate to victims, offenders, and their families the terms on which they can receive treatment. For example, there should be clear guidelines on the appropriate action to take upon disclosure and referral for treatment. Too often general practitioners, police, and social services staff did not know where to refer families for treatment. Services need to be advertised better in the health care arena. Many of the health services personnel were unaware of community based programs like SafeCare. Pamphlets with information about intrafamilial sex offenders and treatment options would be useful for all parties. There also needs to be a greater public awareness of the issues and risks of adolescent sexual offending.

Another policy concern directly impacting on treatment relates to the technical aspects of access and the difficulty in finding and accessing an appropriate treatment program. SafeCare is not well known or well resourced. For many families, attending SafeCare represented a significant undertaking in and of itself. Finding help at the time of disclosure was an issue for many of the families. Staffing levels created problems as therapists were not always available when needed and session times were limited. Practical issues such as parking and transport to SafeCare were problematic for some families. There is no such treatment program in the country and some families had to travel to Perth from country areas to receive treatment.

The referral process to SafeCare was time consuming and often first meetings were several months after disclosure occurred. This was due to some outside agency staff (e.g. Police, Department of Child Protection, Juvenile Justice) not knowing that SafeCare existed, and the difficulty of scheduling new clients who required 3 to 4 staff members for the initial family assessment. Families felt they were not fully briefed on the treatment process. All this information is provided at the initial session but may not be taken in by families in crisis. Although this information is also available on the SafeCare website the lack of awareness suggests the need for a comprehensive and far reaching campaign to ensure accessible

information about the availability of community based and holistic treatment reaches a wide audience of service providers and “at-risk” families.

Policy

The sexual abuse of children is a problem that has, unfortunately, been with us for a long time. However it is a problem that is increasingly coming to public awareness. The increasing awareness of the extent of child sexual abuse, particularly in Indigenous communities, has already led to some radical policy commitments – the Northern Territory intervention being the most notable.

Whilst the true extent of child sexual abuse in our communities remains hidden there are already some established “facts” about its nature which emphasizes its importance. Perhaps the most compelling fact about child sexual abuse is its tendency to be intergenerational in nature. The sexual abuse of the child victimizes and potentially damages the child, but in so doing lays down the psychological conditions for this tragedy to spread to others that the individual will develop close personal relations with throughout their lives.

The sexual abuse of children does have intergenerational components and can not be viewed as a tragedy visited upon an individual and having no other consequences. Perhaps part of the reason that we resist seeing the problem in its entirety is that we are unwilling or unable to hold the notion of the individual being a victim and an offender together at the same time. However this is exactly the task that is required. It is this dual “role” that is at the heart of the cycle of abuse. It is now well understood that a propensity to domestic violence is “transmitted” generation to generation and we readily recognize now the “cycle of violence” within academic and policy communities. However, perhaps because of understandable sensitivities we are yet to see sexual abuse in the same light, particularly that perpetrated by a young person. The children coming forward for treatment at SafeCare are both offenders and victims. The extent and tragedy of their victimization has been documented throughout this report as has the extent and tragedy of their offending. The policy implications therefore are to approach ASOs as victims who have become offenders.

Seeing sexual abuse as cyclical and intergenerational will also allow us to gain a more realistic and holistic picture of the problem and allow in a range of interventions to help the parents and other family members, the identified victim/offender, and other “at-risk” children. At the heart of this intervention must be a set of principles that can guide and support what we are doing so that we optimize the chances of making a contribution. It is argued that the best position to start from is one that articulates our goals within a meaningful holistic frame of reference, appropriate to what we know about the psychological and sociological embeddedness of this problem.

It would be productive to develop policy that seeks to balance competing policy initiatives so that the overall level of harm and damage is reduced to the lowest possible level. Our responses thus far in dealing with adolescent sex abuse have largely been guided by archaic, simplistic, and possibly damaging principles of crime and punishment. In so far as we refuse to accept that intrafamilial sex offending is a damaging response from a damaged individual we see it as a wanton response from a criminal. This kind of thinking leads to an impoverished conceptualization of the issues surrounding the behaviour and feeds into the

media sensationalism of sex abuse. This feeds a politicization of policy precisely at the point where it does the most damage and where a compassionate approach or simply a detached and understanding approach is most needed. When the sexual offender is a child there is a special opportunity to change our emphasis somewhat and conceptualize the problem primarily as a health issue rather than primarily a moral one. Adopting the principle of reducing and preventing harm to all parties involved would allow this kind of productive focus.

Once we have established that our approach should be based on these principles we should also ensure that we see adolescent sex abuse as involving more than just the offender as part of the required treatment approach. At the very least the parents and other family members should be engaged because, as demonstrated by the current study, it is more than likely that the offending is but one manifestation of problems within the family and potentially much harm could be reduced by taking a systemic approach.

The results of this study if taken in its entirety have many implications for the criminal justice system. First, the fact that at present we only see the "tip of the iceberg" in terms of the extent of child sex abuse. If we truly want to minimize harm in the community we need to do more to reach out to the community and offer help to families where sex abuse is a problem. As illustrated in the present study these families know there is a problem but few know what can be done about it. Only a minority will wish for the issue to be processed through the criminal justice system. However, we have not established pathways to make the disclosure of sexual abuse easy. We have not offered to support and assist families where sexual abuse is a problem. Basically we have done everything we can, through our policies, to ensure it remains hidden and will only be uncovered years later. Punishment of the ASO may have the advantage of conveying the seriousness of the offence but does mean that young people are labelled as sex offenders at a time in their lives when they are most vulnerable.

Given the widespread, complex, and intergenerational nature of child sex abuse and adolescent sex offending a more holistic approach focussed on treatment needs to be the guiding philosophy of the intervention. The preference for criminal justice interventions means that individuals such as police officers who are ill-equipped to help victims are pushed into a position of investigating these crimes. It also pushes victims who are usually related to the offender to overcome family loyalties and act in a manner far above that expected for their age. Basically, the response punishes everyone involved and is seen by family members and the offender as an option that will actually make things worse and not better. It is quite possible that they are accurate in this perception. So the implications are for a policy approach that is guided by a principle of harm reduction, that seeks to approach the problem holistically, and one that reaches out into the community to those sectors and individuals that might need help. For those individuals that do respond to an offer for assistance, should they be reported to the police?

Obviously to do so would reduce the likelihood that they will seek treatment. However this is exactly what we do by passing legislation that requires mandatory reporting. Despite all the evidence that mandatory reporting is a failed policy that has absorbed massive amounts of resources whilst delivering very little help it continues to be favoured as the problem of

child sexual abuse is politicized. These are issues beyond the scope of the present research project and much has already be written on these topics but the subject matter of the current research once again raises issues about mandatory reporting and the benefits of providing a confidential life line to families in need in this area.

The final policy implication that we would like to touch on here concerns how to engage with families and ASOs. Although this could hardly be considered in isolation from the issues discussed above it is worthwhile to consider the strategic dimensions of any effort designed to reduce the prevalence of adolescent sexual offending. There are some factors that make adolescent sexual offending much more likely. Typically these areas are indicated by the presence of many of the commonly coexisting problems discussed in the current study. The available evidence suggests that many of these coexisting problems could be seen as "indicators" of risk. In terms of reaching out we should be cognizant of the high risk areas and a special effort made to reach out to families and individuals in these areas to offer support and assistance and also perhaps to draw attention to the existence of problems that might have been denied or in some other way dismissed.

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APPENDIX A

Parent Information Sheet

SafeCare, in conjunction with Curtin University's School of Psychology, are undertaking a study which examines the experiences of adolescents who complete SafeCare's Young People's Programme (YPP). This project aims to explore the experiences and perceptions of the adolescents and their families who take part in the programme, in addition to examining issues relating to risk factors and treatment outcomes. It is anticipated that the findings from this project will further our knowledge of effective treatment options for young people who engage in inappropriate sexual behaviour, and the risk factors that may lead to this behaviour.

Should you agree to take part in the study, while you and your family are involved in the programme, your participation will consist of:

- Allowing the researchers access to information obtained from questionnaires and interviews that you will complete as part of the treatment programme. All information will be unidentifiable, and reported as general trends.
- A closing interview upon completion of the programme (child and parent). This will explore participants' experiences of the treatment programme, views of the programme, and its impact on both the child and the family.

The study has been approved by the Curtin University Human Research Ethics Committee and has been funded by the Criminology Research Council.

Participation in this project is voluntary and participants are free to withdraw from the study at any time. Any information provided will be held in strict confidence in line with SafeCare's policy. Participants in the study will remain anonymous; all identifying information will be removed from the interview transcripts. All documentation and transcripts will be stored in a secure facility with access only to those members of the research team. Results from the project will be used for publication in scientific journals.

Any questions concerning this study can be directed to Gail Boyle, Andrea Halse, and Amanda Thompson listed below, or to the Project Coordinator Associate Professor Jan Grant, Curtin University (9266 7231).

Thank you for your time and consideration. Please find attached the consent form for you to complete should you agree to participate. Please retain this information sheet for your own records.

Adolescent Information Sheet

SafeCare and Curtin University are conducting a project to look at the experiences of the young people who take part in the Young People's Programme (YPP). This project aims to find out what the young people and their families think about the programme and how well it helps those involved deal with their problems. It is hoped that the results from the project will add to our knowledge of helping young people who engage in inappropriate sexual behaviour.

If you agree to take part in this research, your involvement will consist of:

- Allowing the researchers access to information obtained from the questionnaires and interviews that you will complete as a part of the programme. Your name will not be linked to any information.
- An interview at the end of the programme, to find out what you thought about the programme, what you would change, keep the same etc. Your parents will also take part in a separate interview to see what they thought of the programme.

Your involvement in the project is voluntary and you can stop taking part at any time during the project. Leaving the project will not affect your participation in the treatment programme. Any information that you give will be kept confidential in line with SafeCare's policy. Your personal details, such as your name, will not be kept with the information we collect, so you won't be able to be identified. The information will be used to improve the Young People's Programme and for publication in research journals. However, at no time will anyone be able to identify you from the information used.

If you have any questions about the project you can speak to Gail Boyle, Andrea Halse, and Amanda Thompson listed below.

Thank you for your time. Please find attached the consent form for you to sign if you would like to take part in the project. Please keep this information sheet.

APPENDIX B

Parent Consent Form

I, _____ confirm that:

- I have read and understand the information sheet
- I was given the opportunity to ask questions
- All of my questions have been answered to my satisfaction
- No pressure is being put on me to participate and I understand that participation in this study is completely voluntary and that I can withdraw my consent at any time.

I give consent for my child, _____ to participate in this project and further agree to take part in interviews at the beginning and end of the programme. I understand that these interviews will be tape recorded and the transcripts will be kept in a secure location so that no-one other than the researchers will have access to them.

I give consent for information derived from both myself and my child's interviews and questionnaires to be incorporated in publications for scientific journals. I understand that all information will be presented in general terms and that neither my child nor myself will be identifiable in any resulting publication.

_____ _____

Parent Signature Date

_____ _____

Researcher's Signature Date

Adolescent Consent Form

I, _____

- Have read and understand the information sheet
- I was given the chance to ask questions
- All of my questions have been answered
- I understand that taking part in this project is voluntary and that I can leave the project at any time. This will not affect my place in the programme.
- I understand that the project includes taking part in a taped interview and that no-one other than the research team will have access to the tape recorded interview.

I understand that information from my interview and questionnaires will be used to improve the SafeCare Young People's Programme and may be published in scientific journals. I understand that this information will be presented in general terms and that I will not be identified in any publication.

_____ _____

Participant's Signature Date

_____ _____

Researcher's Signature Date