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The Impact of Risk Factors on the Treatment of Adolescent Sex Offenders

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Abstract

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Headnote

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Although there is a plethora of literature on the effects and treatment of child sexual abuse, very little has been written to date on treatment outcomes of sex offenders, particularly juvenile offenders. Research on adolescent sex offendersis vital because of the high offending rate of this group as compared with the general population. According to the U.S. Department of Justice (see Weinrott, Riggan, &Frothingham, 1997), 20% of all rapes and approximately 25% of sexual abuse arrests involve perpetrators under the age of 21. Valliant and Bergeron (1997) reported that 30% to 50% of child sexual abuse cases are perpetrated by juveniles. In fact, at least a half million juveniles commit a sex crime every year (Weinrott et al., 1997). It is estimated that, without treatment, the average adolescent sex offender will go on to commit 380 sex crimes during his or her lifetime (Barbaree, Hudson, &Seto, 1993). This rate is most likely higher because not all offenses are discovered or disclosed by victims, and even when discovered by third parties, not all such offenses are reported to the authorities (Vizard, Monck, &Misch, 1995).

Unfortunately, some studies have not shown the efficacy of treatment for child sexual abusers. For example, O'Reilly et al. (1998) found that not all sex offending adolescents responded to treatment. Rather, low-risk cases showed treatment effects, whereas high-risk cases were found to have lower ability levels, lower levels of maternal and paternal care, and poorer levels of psychological and psychosocial functioning. Hall (1995) reported that in a

meta-analysis of studies that examined recidivism after treatment, 19% of the sex offenders committed additional sexual offenses. However, the author suggested that any reduction in recidivism is important because it reduces the harm done to victims and the monetary costs to society. It is also important to note that the base rate for recidivism is between 15% and 35% for untreated sex offenders (Craissati &McClurg, 1997). Another longitudinal study investigated the effectiveness of cognitive-behavioral treatment with sex offenders. Marques, Day, Nelson, and West (1994) found that when compared with groups receiving no treatment, the treatment group had the lowest reoffense rates for both sex crimes and other violent crimes. Main effects analyses did not yield conclusive results regarding the program's effectiveness. However, the authors explained that methodological errors (i.e., inappropriate comparison groups, using tests without adequate statistical power) may have interfered with finding statistically significant treatment outcomes.

Adolescent sex offendersenter treatment with various demographic characteristics that act as risk factors and may interfere with the success of treatment. These risk factors may include sexual and physical abuse; neglect; alcohol and drug use; dysfunctional family relationships; parental history of substance abuse, incarcerations, and psychiatric illness; criminal record; low social competence; problems at school; and previous placements. In reviewing the literature, Vizard et al. (1995) found that adolescent sex offendershave been reported as (a) being more socially isolated than their peers, (b) having dysfunctional families in which violence between parents and toward the children was common, (c) having parents with victimization in their own childhood, (d) displaying academic and behavioral problems in school, and (e) having low self-esteem and depressive/anxious symptoms. Knight and Prentky (1993) reported that sex offenders had significantly lower social competence, demonstrating significantly greater lifestyle impulsivity, criminal acts, and previous placements. Furthermore, sex offenders were more likely to come from abusive, dysfunctional families and to have had problems in school. Juvenile sex offenders also were more likely than delinquents who had non-sex-related problems to be diagnosed with a non-sex-related conduct disorder (France &Hudson, 1993). Breer (1996) reported that adolescent sex offenderstended to have criminal records that included non-sex-related offenses.

Alcohol use has been found to have a strong relationship with sexual offenses, including rape and pedophilia (Lightfoot &Barbaree, 1993). Approximately 40% to 50% of sex offenders have reported that they were drinking at the time they committed the offense, and about 50% were considered to have abused alcohol (Monson, Jones, Rivers, &Blum, 1998). One possible reason for this relationship is the abuser's desire to reduce inhibitions, thereby making it easier to commit the sexual acts. The overt act of exercising personal power interacts with the physiological effects of alcohol on human cognition to increase the likelihood that interpersonal violence will occur after drinking (Lightfoot &Barbaree, 1993). Adolescent sex offenderswho also are classified as chemically addicted create a challenging task for treatment interventions. Lightfoot and Barbaree recommended that treatment modalities be geared specifically to deal with added risk factors, such as substance abuse.

Criminal behavior of the father and parental substance abuse are two of the stronger and more consistently demonstrated characteristics of parents of aggressive and antisocial youths (Kazdin, 1994). When parents have experienced psychiatric problems, have a criminal history, and have had substance abuse problems, such a background is likely to interfere with both their ability to form attachment bonds with the child and with their parenting skills. These parents tended to show more periods of indifference, hostility, and rejection toward their children. When attachment bonds are characterized by insecurity, rejection, a lack of warmth, inconsistency, abuse, or disruptions in continuity, the child has a greater likelihood of developing a maladaptive interpersonal style (Marshall, Hudson, &Hodkinson, 1993).

However, the literature does not describe how risk factors may prevent the adolescent sex offender from benefiting from treatment. Therefore, the purpose of the present study is to identify the risk factors that may negatively and positively affect treatment. It is important to determine what factors may prevent successful treatment outcomes so that new intervention strategies can be developed. Risk factors may point to behavioral excesses and deficits that may be addressed therapeutically. By monitoring risk factors during treatment, therapists may be better able to confront and inform clients about elements of their relapse processes (Gray &Pithers, 1993). Such monitoring allows the clinician to assess the efficacy of treatment in an ongoing fashion. Our study correlated several risk factors of adolescent sex offenderswith treatment outcome. We hypothesized that specific risk factors would be correlated with poor treatment outcome. These risk factors included psychiatric history of the mother, criminal history of the father, substance abuse of the mother, the child's history of substance abuse, and the total number of previous placements.

Method

Participants

Study participants were 35 adolescent boys in a New Jersey residential facility for emotionally disturbed boys. All participants had been charged with committing sexual offenses and had taken part in the agency's sex offenders program. see Table 1 for the percentage of sexual offenses that were reported. Adolescents who have been criminally charged for their sexual offenses may have entered treatment with a Megan's Law status. Youths who commit sex crimes are governed by the same Megan's Law rules as adults are (May, 1999). The offender's potential risk to the public is rated and classified as Tier I (low risk), Tier II (moderate risk), or Tier III (high risk). Tier I offenders generally include those who have been convicted of one minor sex crime, such as lewdness, and have few other criminal offenses. Tier II offenders have committed more serious offenses, but they may have also preyed upon family members or others in their household. Tier III offenders have exhibited a pattern of compulsive, violent sex crimes (May, 1999). For clients who are ready to be discharged from treatment and who are subject to Megan's Law, the police department where the client will reside is informed in advance. Besides being sentenced for committing sexual offenses, reasons for placement can also include behavior problems (e.g., aggression, truancy, running away), psychological problems (e.g., suicide ideation, alcohol

abuse), and court ordered placements (e.g., theft, assault). All participants had been officially classified as being emotionally disabled by their school's child study team and had been clinically diagnosed on Axis I of Diagnostic and Statistical Manual of Mental Disorders (4th ed., DSM-IV; American Psychiatric Association [APA], 1994). The average length of stay at the residential treatment center is 12 months.

TABLE 1

Percentage of Reported Sexual Offenses

Sexual Offense	% of Offenses
Criminal charges	29
Rape (intrafamilial)	6
Male victim	0
Female victim	6
Rape (extrafamilial)	3
Male victim	3
Female victim	0
Forced sexual act (intrafamilial)	6
Male victim	3
Female victim	3
Forced sexual act (extrafamilial)	29
Male victim	9
Female victim	20
Molestation (intrafamilial)	37
Male victim	6
Female victim	31
Molestation (extrafamilial)	22
Male victim	11
Female victim	11
Bestiality	6
Voyeurism	3
Fetishes/other deviant acts	11
Sexual harassment/threats	26
Prostitution	3

Note. $N = 35$.

The mean age of the participants was 14.89 years (SD = 1.18). The ethnicity of the sample included Caucasian (77.1 %), African American (11.4%), Latino/Latina (5.7%), and biracial (5.7%) individuals. The highest average grade completed was 8.34 (SD = 1.26). The mean IQ of the participants was within average limits (M = 97.44, SD = 10.54). Written consent to take part in a research project was obtained from both participants and their legal guardians.

Treatment

The residential agency's sex offender program uses various therapeutic techniques that are based on a cognitive-behavioral approach to treatment. Treatment includes individual, group, and family psychotherapy; recreational, milieu, and adventure-based counseling; special education; and sex-offender-specific therapy. Individualized treatment planning is determined by treatment teams who incorporate input from the clinical coordinator, educational coordinator, program coordinator, psychiatrist, registered nurse, and the clinical director at the institution; the teams also encourage ongoing communication from other involved agencies. The program is targeted at deviant sexual arousal, cognitive distortions about sexual aggression, and social skills deficits. It is believed that establishing social skills will assist the offender in developing peer relationships instead of seeking social support and intimacy with weaker, less threatening, and often significantly younger persons (Hall, 1996). Deviant sexual arousal is reduced by pairing inappropriate sexual fantasies with probable

social consequences, such as being arrested and causing harm to a child. Cognitive distortions about children are challenged by encouraging an increased empathy for victims of an individual's sex offenses and highlighting negative consequences of distorted beliefs. The adolescent is taught more appropriate and prosocial beliefs and views. Hall (1996) reported that in combination with other treatment methods, efforts to reduce cognitive distortions have been found to be effective in reducing sexually aggressive behavior among adolescent and adult sex offenders. Relapse prevention strategies also are taught to help the offender cope with situational temptations to reoffend. These strategies include identifying and avoiding high-risk situations, stopping fantasies about sexual offending, self-control, self-monitoring, and identifying support systems (e.g., family members, probation officers, therapists).

Measures

Predictor measure. Child and family characteristics were obtained through the child's clinical record. The clinical record is a historical record of services the child has received since becoming involved with any social service agency in New Jersey. The information in the chart includes psychological assessments, social assessments, family assessments, criminal records, probation records, and medical records. In addition to the archival record, the admissions coordinator at the residential facility conducted a clinical interview with the child and his family to obtain missing or new information. The child and family characteristics were then transcribed onto a standard form for all study participants. The information on this form provided detailed information on the child's previous and present risk factors. The information was checked for accuracy by a second investigator.

The risk factor variables were obtained from the Child and Family Characteristics form (CFC), which is completed when the child is admitted to the treatment program. These variables include (a) psychiatric history of the mother, (b) criminal history of the father, (c) substance abuse history of the mother, (d) the child's history of drug and alcohol problems, and (e) the total number of previous placements before entering residential treatment.

Outcome measures. The Child Behavior Checklist (CBCL; Achenbach, 1991) was developed as a descriptive rating measure for determining both adaptive competencies and behavior problems in children. The CBCL combines a 113-item behavior problems checklist with a seven-part social competency checklist. The responses to items can be used to distinguish between typical children and those having significant behavioral disturbances. The composite scores consist of a Total Problems score, Internalizing score, Externalizing score, and Competency score. Various symptom scores can be derived that are consistent with DSM-IV (APA, 1994) diagnoses. These scores include Withdrawn, Somatic Complaints, Anxious/ Depressed, Social Problems, Thought Problems, Attention Problems, Delinquent Behaviors, and Aggressive Behaviors.

The Ansell-Casey Life Skills Assessment (ACLSA; Nollan et al., 2000) is a 140-item checklist that is completed by the clinician. Items, which measure either behavior or knowledge, are answered on 5-point Likert-type scales. The responses can be used to measure a child's competence and knowledge in 18 different areas: personal care, medical and health, food and nutrition, decision-making skills, basic education, work habits, career planning and

employment, emotional well-being, social relationships, communication skills, sexuality and intimacy, pregnancy/parenting awareness, leisure time, money management, household maintenance, transportation and mobility, community resources, and moral values/legal rights. When used in a pre/post fashion, the ACLSA shows the effectiveness of a treatment intervention. The internal reliability is reported to range from 0.77 to 0.87, and the test-retest reliability ranges from 0.40 to 0.80 when the caregiver completes the form (Nollan et al., 2000). Because the process of norming this measure is still in progress, validity coefficients have not yet been attained.

An incident report is filled out by direct-care staff whenever a child violates a program rule. The staff checks off the offense from a list of possible offenses, which can range from the child wandering around the campus to destruction of property, assault, and suicidal ideations. The rest of the report is in narrative form, describing in detail the behaviors leading up to the incident, what happened during the incident, and how the incident was handled by staff.

Procedure

The CBCL and ACLSA are completed upon intake and discharge by the child's clinician. Treatment success in this study was defined as the significant improvement in the second set of CBCL and ACLSA scores, as compared with the child's scores at intake. Treatment success was further defined as the reduction of incident reports and the reduction in severity of incidents. The risk factor variables were correlated with the discharge scores and the outcome scores for each measure. The outcome score was the difference between scores at intake and discharge. This correlation determined whether the predicted risk factors have an impact on treatment gain or loss of adolescent sex offenders. As part of agency procedures, upon admission for treatment, consent forms to take part in agency research were obtained from study participants and from their legal guardians.

Results

To determine statistical significance, an a priori alpha region of 0.05 was established. The data were entered into the SPSS program for statistical analysis. The tests that were used on the data included one-tailed paired t tests (unless otherwise specified) and Pearson product-moment correlations.

Treatment Outcome

Various treatment effects were demonstrated when using a paired t test to compare CBCL means at intake and discharge. The results of the analyses are presented in Table 2. The Competence score reflects how much time the child spends in different activities such as sports, jobs, and chores and how well the child performs each one as compared with other children of the same age. This score also reflects how the child gets along with others, how well the child works alone, and his performance in academic subjects. This score is important because it predicts the success of the child in the real world and in his future life after being discharged from treatment. It is believed that the more he engages in activities that are constructive, the less he will engage in problematic behavior. The result of this analysis demonstrated that these sex offenders showed significant improvement in their overall competence after 1 year of treatment.

There was also a significant difference between means for the intake and discharge Social Problems T-score and Delinquent T-score on the CBCL. A significant reduction on these two syndrome scores reflects a positive treatment effect.

Each subscale on the ACLSA is scored by calculating the percentage of items that the child is knowledgeable about and performs successfully. This score, called the percentage of mastery, is calculated by counting all the items in a subscale rated can do this or does this most or all of the time and dividing the total by the number of items in the subscale. For example, on the Money Management subscale, if a caregiver responded that a youth can do this or does this most or all of the time to 8 of the 11 items, the percentage of mastery for this subscale would be 72.7% (8 divided by 11, and multiplied by 100; Nollan et al., 2000). However, when analyzing the data, the scores are presented as a decimal (.727).

Several significant differences were found between means on the ACLSA, suggesting a positive treatment effect. The analyses are presented in Table 3.

Similar to what was found on the CBCL Social Problems Syndrome scale, a significant difference was found on the Social Relationships scale. This difference demonstrates that the staff members of the residential facility were effectively treating social skills deficits, which are common among sex offenders. Another very important treatment effect was found on the Sexuality and Intimacy subscale. The significant difference showed that the participants benefited from treatment in that when they were discharged, they understood the difference between appropriate and inappropriate sexual contact. Also, the finding that discharge scores, as compared with intake scores, on the Pregnancy and Parenting Awareness scale were significantly higher further showed that participants had psychosexual knowledge. Other significant treatment effects also demonstrated that participants had gained the knowledge they needed to safely transition into the real world.

TABLE 2

Difference Between Means at Intake and Discharge on the Child Behavior Checklist

	Intake		Discharge				
Scale/Syndrome	*M*	*SD*	*M*	*SD*	*t*	*df*	*p*
Total	66.23	10.21	62.80	10.31	1.34	29	.095
Internalizing	62.10	10.17	59.33	11.69	1.13	29	.134
Externalizing	66.73	10.72	62.80	11.56	1.50	29	.072
Total Competence	25.87	5.70	28.83	6.62	−2.30	22	.015*
Withdrawn	62.13	11.04	60.60	11.55	0.58	29	.283
Somatic	54.60	7.70	53.40	7.20	0.62	29	.270
Anxious/Depressed	65.33	11.32	62.07	10.41	1.41	29	.084
Social Problems	64.30	10.59	60.93	10.96	1.89	29	.035*
Thought Problems	60.90	10.51	59.33	9.47	0.75	29	.229
Attention Problems	63.07	8.62	59.80	9.35	1.60	29	.060
Delinquent Problems	69.87	11.08	65.97	9.47	1.74	29	.046*
Aggressive Problems	64.10	10.63	61.57	10.42	1.18	29	.123

*$p < .05$.

The incident reports were counted at three times: (a) the first 4 months of treatment; (b) the 5th, 6th, 7th, and 8th months of treatment; and (c) the last 4 months of treatment. The total

TABLE 3

Difference Between Means at Intake and Discharge on the Ansell-Casey Life Skills Assessment

	Intake		Discharge				
Scale	*M*	*SD*	*M*	*SD*	*t*	*df*	*p*
Personal Care	0.62	0.33	0.84	0.26	–2.14	15	.025*
Health & Medical	0.71	0.25	0.85	0.21	–1.60	15	.065
Food & Nutrition	0.27	0.34	0.53	0.38	–2.20	14	.023*
Decision-Making Skills	0.60	0.26	0.65	0.25	–0.94	15	.181
Basic Education	0.21	0.35	0.27	0.36	–0.59	13	.283
Work Habits	0.29	0.39	0.27	0.33	0.28	12	.393
Career Planning	0.69	0.28	0.78	0.35	–0.85	15	.204
Emotional Well-Being	0.64	0.19	0.66	0.26	–0.21	14	.420
Social Relationships	0.36	0.23	0.66	0.30	–2.72	12	.009**
Communication Skills	0.50	0.26	0.63	0.26	–1.23	15	.118
Sexuality & Intimacy	0.49	0.40	0.78	0.35	–2.43	15	.014*
Pregnancy Awareness	0.45	0.30	0.71	0.31	–2.71	15	.008**
Leisure Time	0.28	0.42	0.34	0.40	–0.45	15	.330
Money Management	0.22	0.27	0.33	0.30	–1.09	15	.155
Household Maintenance	0.31	0.35	0.49	0.27	–1.83	12	.046*
Transportation	0.68	0.22	0.83	0.24	–2.04	15	.030*
Community Resources	0.59	0.20	0.61	0.19	–0.40	15	.348
Moral Values	0.37	0.31	0.49	0.28	–1.23	15	.118

*$p < .05$. **$p < .01$.

number of incident reports for each time period was entered into the database and compared, using two-tailed paired t tests. A significant difference was discovered when comparing the means of the second time period (M = 13.33, SD = 15.74) and the third time period (M = 8.21, SD = 10.94), t(32) = 2.16, p = .0195. In other words, it was not until after the 8th month of treatment that treatment gains were made, as shown by a significant reduction in incident reports.

Correlation of Risk Factors and Discharge Scores

Simple descriptive analyses revealed the occurrence rate of risk factors in the current sample of sex offenders. Within the current sample, 31.4% had a mother with a psychiatric disorder, 37.1% had a mother with a chemical abuse problem, 25.7% had a father with a criminal record, 60.0% of the boys had a substance addiction. The average number of previous placements for the participants was 7.74 (SD = 3.37).

Pearson product-moment correlations were used to determine the relationship of the five risk factors to discharge scores on the CBCL and the ACLSA. Psychiatric history of the mother was found to be significantly negatively correlated with the Somatic scale (r = -.45, p <.05) of the CBCL. Drug abuse of the mother was correlated with the Total discharge score (r = .46, p <.05) and the Delinquent scale (r = .48, p <.05) of the CBCL. This result demonstrated that a chemical abuse problem of the mother was related to delinquent behavior and overall pathology that was resistant to treatment. Drug abuse of the mother was found to be negatively correlated with several scales on the ACLSA, including Basic Education (r = -.68, p <.05), Work Habits (r = -.84, p <.001), Social Relationships (r = -.71, p <.01), Leisure Time (r = -.70, p <.01), and Moral Values (r = -.56, p <.05). These statistically significant

correlations suggested that mothers who have a problem with substance abuse may be the parents of adolescent sex offenderswho have problems in school, who do not work well alone or with others, who have poor social skills, who cannot find constructive ways to occupy their time, and who do not understand universal moral values (e.g., respect for other people's property and other people's rights).

The criminal history of the father was found to be correlated with only one discharge score, that is Basic Education ($r = -.66$, $p < .05$), at a statistically significant level. Drug abuse of the child was found to be significantly correlated with the Social Problems scale ($r = -.44$, $p < .05$) and the Thought Problems scale ($r = -.36$, $p < .05$) of the CBCL. Because lower scores on the CBCL signify lower pathology, these negative correlations demonstrated an unexpected treatment effect. In other words, the greater the child's history of drug abuse, the fewer social and attention problems the child had after treatment. Drug abuse of the child also was found to be negatively correlated with the Basic Education scale of the ACLSA ($r = -.52$, $p < .05$), suggesting that these adolescents were having more problems in school, despite treatment. On the ACLSA, only one scale was found to be significantly correlated with previous placements, that is, Pregnancy and Parenting Awareness ($r = .49$, $p < .05$). It is interesting that the greater the number of therapeutic placements the participants had, the more likely it was that they would be exposed to other individuals' negative sexual behavior; thus, clinicians identified these youths as risks because of their sex offenses, a history of failed therapeutic interventions, and their lack of knowledge about the responsibilities of sexual behavior. Previous placements were found to be significantly correlated with the sex offender's incidence reports at the first 4 months ($r = .36$, $p < .05$) and second 4 months of treatment ($r = .36$, $p < .05$).

Correlation of Risk Factors and Difference Scores

Because discharge scores do not reveal how much the sex offenders gained from treatment, as compared to when they were first admitted, a difference score for each participant was calculated. This score was the difference between the discharge score and the intake score, yielding a numerical value of the treatment effect. The larger the difference score, the greater the treatment gains. The difference scores for the CBCL and ACLSA were correlated with the five risk factors.

The psychiatric history of the mother was found to be positively correlated with the Total difference score ($r = .73$, $p < .05$) and the Somatic difference score ($r = .48$, $p < .05$) on the CBCL. The positive correlations showed a treatment gain that was related to the aforementioned risk factor. Drug abuse of the mother was found to be negatively correlated with the Social difference score ($r = -.44$, $p < .05$) on the CBCL, demonstrating that sex offenders without this risk factor benefited more from treatment. On the ACLSA, drug abuse of the mother was found to be positively correlated to the Basic Education difference score ($r = .72$, $p < .05$), Work Habits difference score ($r = .62$, $p < .05$), and Leisure Time difference score ($r = .58$, $p < .05$). Because a treatment gain on the ACLSA would result in a negative number (i.e., an intake score of .20 minus the discharge score of .80 equals a difference score of .60), these positive correlations reflected a failure to benefit from treatment.

The criminal history of the father was found to be correlated with only one difference score, Transportation and Mobility ($r = -.78$, $p < .01$), which is reflective of an unusual treatment gain. Participants' drug abuse was not correlated with any of the difference scores. The number of previous placements also was not correlated with any of the difference scores, suggesting that it has no measurable effect on the treatment outcome of sex offenders.

Discussion

The present study lacked a control group and did not use random sampling, problems that are common when trying to use outcome measures in an actual treatment setting. Despite these limitations, the results of this study should not be overlooked. This study is an initial step toward determining why the rate of treatment failure and recidivism is so high for juvenile sex offenders. Indeed, this study succeeded in identifying some possible factors that might impede treatment, and we hope that future research will better investigate the extent to which these factors influence treatment outcome.

The literature has described the sex offender population as responding poorly to treatment (Marques et al., 1994; O'Reilley et al., 1998). If this population does indeed show a lack of treatment gains despite rigorous therapeutic interventions, one might wonder what specific factors impede positive treatment outcome. Knight and Prentky (1993) have described adolescent sex offendersas coming from dysfunctional families in which parents have substance abuse problems, criminal and impulsive behaviors, and psychiatric disturbances. Sex offenders have also been described as having coexistent chemical abuse problems (Lightfoot &Barbaree, 1993). Because treating these adolescents is challenging, they tend to have extensive histories of previous therapeutic placements.

Although the sex offender group did show treatment gains in the present study, these gains were small. Only a small number of scales on the outcome measures showed a significant difference when the discharge scores were compared with the intake scores. An interesting treatment effect was found with the incident reports. A significant reduction was found when comparing the mean number of incidents at the second time period and the third time period. The overall pattern demonstrated that when the child entered treatment, the number of incidents that he was involved with steadily increased and peaked at the 6th and 7th months of treatment. However, after 8 months of treatment, the rate of incidents dropped dramatically to its lowest point, which suggests that sex offenders need more than 8 months to begin showing treatment gains.

One way to explore why the participants showed so few statistically significant treatment effects was to correlate the discharge scores with the hypothesized risk factors. This analysis revealed risk factors that might impede treatment but might also facilitate treatment. One example is the psychiatric history of the mother, which was found to be negatively correlated with the Somatic scale of the CBCL, suggesting that it is less of a risk factor than the other hypothesized risk factors. Further analysis demonstrated that the largest treatment gains among sex offenders with a psychiatrically disturbed mother were found with the Total difference score and the Somatic difference score. These large Somatic difference scores of participants who had a mother with a mental illness reflected a high level of somatic

symptoms at intake and a significant recovery when these youths were taken out of a chaotic home environment and placed in the more stable environment of residential treatment. The psychiatric history of the mother was found to be associated with low discharge scores on the Communication Skills scale of the ACLSA. This correlation makes sense in that a psychiatric disorder can affect how the mother communicates with others. Dickstein et al. (1998) reported that maternal illness was associated with disruptions in maternal behavior and mother-child interaction. Furthermore, mothers who are depressed differed from healthy mothers in that the former were more negative, less contingently responsive, and more disengaged in interactions with their young children (Dickstein et al., 1998). Withdrawal by the mother often characterizes mental illness, making the mother uninvolved and less emotionally available (Zahn-Waxler, Kochanska, Krupnick, &McKnew, 1990). Therefore, somatic complaints by their children may reflect attention-seeking behaviors that are treatable in a clinical environment.

A mother who has a substance abuse problem seems to be more detrimental to the child's treatment outcome than does a mother who has a history of a psychiatric disorder. The sex offenders in our study continued to have high total pathology and delinquent scores at the end of treatment. They also showed little decrease in externalizing behaviors, withdrawn behaviors, and attention problems. They continued to demonstrate problems with school, social relationships, and with understanding moral values. When examining the difference scores, it became apparent that children who had mothers with a substance abuse problem actually demonstrated treatment loss in several areas, including the Social difference score on the CBCL and the Basic Education, Work Habits, and Leisure Time difference scores on the ACLSA. Because these problems persisted despite therapeutic interventions, this risk factor might make it harder to provide an adequate level of treatment for the child.

There are a number of characteristics that distinguish drug-abusing families from other seriously dysfunctional families. Among families in the former group, there is a higher frequency of multigenerational chemical dependency and other addictive behaviors; children then model the behavior of the parents (Heath &Stanton, 1998). Studies have suggested that exposing a child to substance abuse, and to the nonfulfillment of parental responsibilities that follows, affects the child by providing models and by reinforcing these behaviors (Kaminer &Bukstein, 1998). Also, there are more primitive and direct expressions of conflict in addictive families than there are in healthy families (Heath &Stanton, 1998). Kaminer and Bukstein (1998) reported that high stress; poor and inconsistent family management skills; more separation, divorce, death, prison terms; minimal family activities; and emotional neglect are some of the characteristics of addictive families. They further reported that children from such families had difficulty with identifying and expressing positive feelings and reported resentment, embarrassment, anger, fear, loneliness, depression, and insecurity. Newcomb and Burns Loeb (1999) reported that mothers whose own parents abused drugs may have developed impaired coping skills, which subsequently interfered with their own ability to develop adequate parenting skills.

The criminal history of the father seemed to have had an impact on the child's ability to succeed in school and to make responsible, moral decisions. Only one treatment gain was found in this group-Transportation and Mobility on the ACLSA. The adolescents in our study might not have learned basic independent living skills, perhaps because of a father who was not available due to incarceration, emotional uninvolvement, or other reasons. Parents serve as visible models to the child for teaching various important constructs such as social skills, problem solving, and moral values (Bandura, 1977). Social learning theorists believe that children's moral feelings and actions depend on the rewards, punishments, and examples they experience as they grow up (Wade &Tavris, 1990). Having a father who actively engages in criminal behaviors may teach the child at an early age to make poor decisions. Parents who have engaged in property crimes are reported to use cold, rejecting, and ineffective parenting skills (Newcomb &Burns Loeb, 1999). Furthermore, parents who had committed crimes against a person due to aggressive and confrontational behavior tended to control and dominate their child (Newcomb &Burns Loeb, 1999). Poor parenting and a lack of attachment bonds produce low self-esteem in children that may also contribute to poor school performance and social isolation. Myers, Smarsh, Amlund-Hagen, and Kennon (1999) reported that 70% of 166 children of incarcerated mothers showed poor academic performance, and 50% showed classroom behavior problems. Indeed, 50% of children showed problems in school after their father was incarcerated.

Adolescent substance abuse has been found to accompany various behavioral and psychiatric disturbances. Conduct disorder and aggression are reported to precede and accompany substance use at a rate of 50% to 80% (Kaminer &Bukstein, 1998). Mood disorders such as depression range from 24% to 50% and generally occur before or as a result of substance abuse in adolescents (Kaminer &Bukstein, 1998). Kaminer and Bukstein also reported that the prevalence of anxiety disorder ranged from 7% to more than 40%. With all of these documented and associated psychiatric problems, it is surprising to find a treatment effect for drug abuse on the Social and Thought Problems scales. One reason for this result may be that adolescents who use drugs tend to bond and spend more time with their peers rather than with their families. Peer relationships serve to initiate, develop, and maintain substance abuse. In addition, drug useis usually a social affair and may inadvertently lead to positive adaptations in social situations. In other words, sex offenders who abuse substances are able to practice relating to others in social groups. There are important differences between substance abusing sex offenders and most other sex offenders, who cannot relate to others and who have been described as being socially isolated from their peer group. On the other hand, a child's history of drug abuse was found to be associated with poor performance in school. Jessor (1987) reported a similar finding: Substance abuse in adolescents was negatively correlated with conventional behaviors and beliefs, such as church attendance, good scholastic performance, value given to academic achievement, and beliefs in the generalized expectations, norms, and values of society.

Our data indicated that the greater the number of failed previous placements the adolescent had, the greater the number of incidents he would be involved with during the first 8 months

of treatment. This finding suggests that the more placements a child has been through, the more aggressive that child will be upon entering residential treatment. Aggressive behavior may be a learned behavior that has helped him survive previous living environments, which can be frighteningly new, unpredictable, or even hostile. The aggressive behavior sends a message to others that he is not to be reckoned with, especially when entering a new situation. Previous placements also had a beneficial effect concerning sexual education, emotional well-being, and moral values. This finding suggests that the clinicians might have used a more intensive approach because of the sex offender's history of failed therapeutic interventions.

Limitations of the Study

There are several methodological problems with this study that may have influenced the results, which must be discussed. First, caution is urged when interpreting the results of this study because there was no comparison group. However, a "nontreatment" control group in studies that investigate the treatment of sex offenders poses an ethical problem (Craissati &McClurg, 1997). Second, because this was a single sample study, the results are not generalizable. It would have been better to include participants from multiple treatment facilities; however, this was not possible at the time we conducted this study. Third, because the sample size was so small, there was a lack of power when analyzing the data. More significant correlations may have arisen if the sample were larger, thus, caution must be exercised when interpreting the data.

Conclusion

Examining how risk factors affect the treatment of sex offenders is an important step in exploring why the rate of treatment failure and recidivism is so high among this population. Hall (1995) reported that there is no evidence that treatment effectively reduces recidivism. In addition, comprehensive treatment programs for sex offenders might have greater effectiveness than programs that are more limited in scope (Hall, 1995). By identifying the sex offenders' risk factors, treatment facilities can provide therapy that results in a positive and lasting therapeutic outcome because the entire problem is addressed and treated rather than just the sex offending behavior.

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