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Philadelphia College of Osteopathic Medicine  
School of Professional and Applied Psychology

THE RELATIONSHIP BETWEEN WITNESSING DOMESTIC VIOLENCE  
AND CRIMINAL RECIDIVISM AMONG JUVENILE SEX OFFENDERS

Shamyra Marie Shaw, MSW, LSW, MS

Submitted in Partial Fulfillment of the Requirements for the Degree of

Doctor of Psychology

May 2018

**PHILADELPHIA COLLEGE OF OSTEOPATHIC MEDICINE  
DEPARTMENT OF PSYCHOLOGY**

**Dissertation Approval**

This is to certify that the thesis presented to us by Shamyr Shau  
on the 8<sup>th</sup> day of August, 2018, in partial fulfillment of the  
requirements for the degree of Doctor of Psychology, has been examined and is  
acceptable in both scholarship and literary quality.

**~~Committee Members' Signatures:~~**

**Chairperson**

**Chair, Department of Psychology**

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### **Abstract**

This correlational archival dissertation focuses on the relationship between exposure to domestic violence and criminal recidivism among juvenile sexual offenders. The study examined archival criminal arrest records and self-reported data gathered from a sample of 67 male juvenile sexual offenders in a residential treatment facility. Given the somewhat limited explanations for and research into the causes of juvenile sexual re-offending and the importance of identifying its determinants, this topic may be viewed as having substantial importance to future research and criminal justice policy. Findings did not support the primary hypothesis that prior exposure to domestic violence would be positively correlated with rates of 1-year post-treatment recidivism, or the exploratory hypothesis that prior exposure to domestic violence would be positively correlated with rates of disruptive behavior during treatment. The low rate of 1-year recidivism ( $n = 4$ ) precluded analysis of the secondary hypothesis that certain factors including being raised in a physically or emotionally neglectful environment, having criminally involved parents, or having parents who use or abuse alcohol or other psychoactive drugs would moderate the relationship between exposure to domestic violence and criminal recidivism. Significant associations were found for the relationship between physical neglect and emotional neglect, domestic violence and emotional neglect, family incarceration and family addiction, and recidivism and physical neglect. There was also a statistical trend for the correlation between recidivism and domestic violence.

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## **Chapter 1: Statement of Problem**

Research on the prevalence, harm, and etiology of juvenile sexual offending is a relatively new topic of discussion in society. Until the early 1970s, juvenile sexual offenses were considered to be a part of childhood experimentation and curiosity about the body of the opposite sex (Fagan & Wexler, 1988). Beginning in the late 1970s, juvenile sexual offending began to be viewed as a critically important social issue. The new outlook on juvenile sexual offending largely resulted from retrospective sexual history interviews conducted with adult sexual offenders that revealed that many adults who were in prison for sexual crimes began their sexual offending during adolescence (Lobanov-Rostovsky, 2015). As this topic came to light, researchers began to examine and identify potential contributors to these behaviors, including child history of sexual and physical abuse, neglect, and exposure to domestic violence (Ford & Linney, 1995).

Although research has continued to develop improved evidence-based treatment for juvenile offenders, little is still known about the factors that may be associated with recidivism following treatment ( $\approx$  25% violent offenses; 13% sexual offenses). While certain factors, such as exposure to physical and sexual abuse and neglect, have been identified as predictors of recidivism, little attention has been paid to the effects of exposure to domestic violence. Given the high rates of exposure to domestic violence (approximately 70%; Pithers, Gray, Busconi, & Houchens, 1998) among juvenile sexual offenders, and the fact that domestic violence is considered a form of child abuse, it is critical to examine its relationship to risk of recidivism. Examining the relationship between exposure to domestic violence and sexual and violent reoffending may be useful for better tailoring interventions for juvenile sexual offenders.

### **Definition and Scope of the Problem**

For some, it may be surprising to learn that juveniles are found to be the offenders in over one-third of all child sexual abuse cases (Caputo, Frick, & Brodsky, 1999; Finkelhor, Ormrod, & Chaffin, 2009; Groth, Longa, & McFadin, 1982; Ratnayake, 2013) and more than one quarter of all sexual offenses against adults, peers, and younger children (Finkelhor, Ormrod, & Chaffin, 2009). Statistics from the FBI's Uniform Crime Reporting Program (UCR) revealed that adolescents committed 19% of all forcible rapes reported to the FBI in 2014 (Office of Juvenile Justice and Delinquency Prevention, 2016). Recent research has also indicated that 12,700 cases involving violent sexual offenses by juveniles were handled in 2010 by juvenile courts (Sickmund & Puzzanchera, 2014).

An article titled "Recidivism of Juveniles Who Commit Sexual Offenses", revealed the following:

"24 to 75 percent of the adult sex offenders reported committing sexual offenses that were unidentified by authorities and 24 to 36 percent reported sexual offending that began when the respondent was a juvenile... [there was a] reported juvenile history of indecent exposure and voyeurism" (Lobanov-Rostovsky, 2015, p. 3).

These findings suggest the possibility of unidentified youth who have engaged in sexual offenses. Consequently, there may be an even higher prevalence of juvenile sex offending than authorities are aware of.

### **Importance of the Problem**

Considering the information given, juvenile sexual offending is a significant problem that impacts the lives of children, adolescents, and adults. This issue constitutes one of the most

widespread public safety and health concerns in the United States because, victims of these juveniles' offenses suffer various forms of trauma and health hazards. These risks range from possible development of mental health issues to disease and unplanned pregnancy. Mental health concerns can include depression, anxiety, Post-Traumatic Stress Disorder (PTSD), and suicide (Kilpatrick, et al., 2000; Kilpatrick, et al., 2003). Physical health issues relative to sexual offending consist of sexually transmitted infections (STIs) and HIV/AIDS (Seña et al., 2015). In terms of unplanned pregnancy, research shows that about 5% of female individuals of reproductive age become pregnant as a result of rape (Holmes, Resnick, Kilpatrick, & Best, 1996).

Juvenile sexual offending appears to cause an abundance of public health hazards and mental health problems for its victims. As a result, this study focused on the connection between witnessing domestic violence in childhood and juvenile sexual and violent re-offending. The study also viewed parental factors that may moderate the effects of domestic violence exposure on the rates of sexual and violent reoffending in juveniles, including the juvenile being raised in a physically and/or emotionally neglectful home, parental criminal involvement, and parental substance use or abuse.

## **Chapter 2: History and Literature Review**

### **General Forms of Violence and Their Prevalence in the United States**

Violence, in the general sense, is defined as the intentional use of physical force either threatened or actual against oneself, against another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, deficits in development, or loss of something (World Health Organization, 2014). There is ongoing debate regarding the commencement of violence in society. Some say that violence began as early as the time of the hominid pedigree by our primate ancestors (Wrangham & Peterson, 1996). Primatologists and anthropologists have identified fights over food, female monkeys, territory, and status as being common practice among our primordial ancestors. Results from 50 years of research on 18 chimpanzee and bonobo communities have not only supported prior findings but has also shown that most violent attacks between the primates were used as a method to increase access to food or mating partners (Wilson et al., 2014).

The first documented form of violence among humans using a weapon is reported to have occurred in Africa. Through inspection, anthropologists and other researchers have concluded that subsequent to the hominid within Africa, human beings took 30,000 years to learn how to use fire as a means to harm each other (Gabriel, 2007). Similarly, human beings spent 20,000 years learning to create spears and other weapons of the sort, and another 60,000 years learning to make the bow and arrow (Gabriel, 2007).

Research has shown that while violence has declined in recent years, it is still an ever-occurring issue that poses concerns for public health and the safety of all individuals (Haegerich & Dahlberg, 2011; Pinker, 2011). Scholars have revealed that more than 6 million adolescents and adults in the United States are victims of violence annually (Funk, Baldacci, Pasold, & Baumgardner, 2004). In a study focusing on students' exposure to general forms of violence,

such as violence within the community, 3,735 high-school students aged 14 to 19 were surveyed. More than half of the participants (52 %) were female, 35% were African American, 33% were Caucasian, and 23% were Hispanic. Researchers found that of those surveyed within their respective high schools, 45% endorsed that they had been exposed to a person being shot within the past year; and another 75% reported that they witnessed a person or people being beaten within the past year (Song, Singer, & Anglin, 1998).

Another study, focusing on victimization, found that almost 900,000 children experienced abuse by parents or other caregivers (Moylan et al., 2010). In a national survey of children between the ages of 2 and 17 years, researchers found that of every 1,000 children, 530 had experienced a physical assault within the past year, 82 of them had been victims of sexual victimization, and 357 had witnessed other individuals being subjected to various forms of violence (Sisco & Becker, 2005).

### **Sexual Violence**

Sexual violence is generally a crime of power and control. It is defined as a sexual act committed against someone without his or her given consent (Centers for Disease Control and Prevention, 2016). Some researchers have posited that most juveniles who engage in sexual violence typically do so as a result of sexual inquisitiveness (Cochrane, 2010). Other researchers hold that juveniles who engage in these problematic behaviors tend to have mental health deficits that contribute to their lack of impulse control and/or ability to understand the depth of their behaviors (Appelbaum, 2009). Researchers have also suggested that some of these juvenile offenders may have a history of violating other individuals' rights or crossing other people's personal boundaries without regard for their feelings (Finkelhor, et al., 2009). With the various speculations, however, still no definitive explanation exists for the occurrence of these behaviors in the juvenile population.

In terms of categorizing this crime, sexual violence can be divided into several clusters. These include: (a) completed or attempted forced penetration of the victim(s); (b) completed or attempted alcohol and/or drug-facilitated penetration of the victim(s); (c) completed or attempted forced acts during which the victim is prescribed to penetrate the perpetrator or another victim who is involved; (d) completed or attempted alcohol/drug-facilitated acts in which the victim is made to penetrate a perpetrator or another victim who is involved; (e) non-physically forced penetration that occurs after the victim(s) is pressured through intimidation or misuse of authority to consent to sexual contact; (f) unwanted sexual contact; and (g) non-contact unwanted sexual experiences, involving such behaviors as the perpetrator engaging in acts of exhibitionism, masturbating in front of the victim(s), or making the victim(s) engage in exhibitionism behaviors directed toward the perpetrator (Centers for Disease Control and Prevention, 2016).

Juvenile offenders may engage in any of the various forms of sexual crimes listed (Finkelhor, et al., 2009). However, the most common forms engaged in by juvenile male sexual offenders specifically include: completed or attempted forced penetration of the victim and unwanted sexual contact of the victim (Finkelhor, et al., 2009). Research suggests that completed or attempted acts of forced penetration appear to be most common when a juvenile victimizes a child who is about 12 years or older in age (Finkelhor, et al., 2009). At this age, a child is typically old enough to know that the sexual acts that they are being exposed to are wrong, and they are old enough to refuse to comply. On the other hand, non-physically forced penetrations may generally be used in situations during which the perpetrator is engaging in sexual contact with a child younger than 12 years old. Victims at this age range are typically more susceptible to manipulation and threats of physical violence (Butler, Fukurai, & Dimitrius, 2001).

In addition to the specific types of sexual crimes, there are various forms. These consist of (a) rape, which involves involuntary oral, anal, or vaginal intercourse with the victim(s), and (b) fondling, which consists of the perpetrator touching the victim(s)' genitalia outside of or underneath of his or her clothing, but does not involve any penetration (Finkelhor, et al., 2009). Other types of sexual crimes include sexual assault with an object; sodomy; molestation, which involves engaging in sexual acts with a child; and exhibitionism, which can include the perpetrator exposing his or her body parts to the victim(s) or the perpetrator forcing the victim to show his or her body parts to the offender. Additional offenses include Internet offenses, which can be categorized as non-contact offenses that typically involves the perpetrator's viewing of child pornography (Rape, Abuse, and Incest National Network [RAINN], 2016). Many juveniles may engage in a combination of various types of sexual crimes with their victim(s). They may also escalate their sexual behaviors if the victimization continues for a long period of time without their getting caught (Cashwell & Caruso, 1997; Riser, Pegram, & Farley, 2013).

With regard to types of sexual crimes, those most common to juvenile sexual offenders are rape and fondling (Finkelhor, et al., 2009). Currently, definitive conclusions have not been reached as to why most juvenile sexual offenders predominantly engage in these two forms of sexual violence. Nonetheless, researchers hold that such factors as mental health problems, interpersonal skills deficits, and a lack of proper sexual education could contribute to these specific behaviors (Becker & Hunter, 1997).

Sexual violence dates as far back as the ancient Greek and Roman times, when women were regarded as property without any rights over their bodies (de Brouwer, Ku, Römken, & van den Herik, 2013). Because women were viewed as mere possessions during these times, rape of women was considered a property crime that only affected women's owners, namely their



husbands, sons or brothers (de Brouwer et al., 2013). During periods of war, sexual violence, specifically rape, was perceived as normal or socially acceptable behavior within the rules of combat and warfare (Brownmiller, 2013). Because sexual violence was commonplace during this time period, indications of the magnitude of sexual violence are unknown (Heineman, 2011).

During the Middle Ages, sexual violence was used as a form of punishment for women who posed a threat to social order and/or chose to be politically active (Heineman, 2011). Not until after World War I, were sexual crimes, such as forced prostitution and rape, regarded as severe violations of the traditions and laws of war (Campanaro, 2001). Following World War I, Japanese commanders were prosecuted for the first time, for not preventing rape and sexual slavery of women (Argibay, 2003; Campanaro, 2001). This was the first time that the Council Law explicitly listed rape as a crime against humanity (Campanaro, 2001).

Unlike during the ancient Greek and Roman times and the Middle Ages, sexual violence during the 21<sup>st</sup> century is not viewed as a form of punishment or tradition of war. It is primarily regarded as a crime of desire that involves gaining and/or maintaining power over others (Lisak, 2008). Researchers have posited that many people who commit sexual crimes feel a sense of entitlement relative to having sexual relations with anyone to whom they are physically and sexually attracted (Lisak, 2008). Other researchers have suggested that most perpetrators may adhere to unyielding custom gender roles that tend to highlight the inequality of women and girls (Abbey, McAuslan, Zawacki, Clinton, & Buck, 2001). This view of women and girls as unequal to men and boys allows those who commit sexual crimes to treat female victims with no regard or respect (Abbey et al., 2001).

In addition to male juvenile offenders who target women and young girls, others offend against different genders, classes, and age groups (Heil, Ahlmeyer, & Simons, 2003). This

specific subset of sexual predators is categorized as *crossover offenders*, as they have no preference in terms of whom they offend against (Heil et al., 2003). Research has shown that crossover offenders typically commit sexual offenses based on opportunity (Rebocho & Gonçalves, 2012). That is, offenders who fit into this category of sexually criminal beings sexually assault anyone if they are in a situation in which the opportunity arises for them to offend against anyone with whom they feel they want to engage in sexual activity (Rebocho & Gonçalves, 2012).

### **Prevalence of Sexual Violence in the United States**

Given the nature of sexual violence and the reasoning behind these acts, it is not surprising to learn that the extent of sexual crimes is extensive. Sexual violence is one of the most pervasive and serious public health issues in this country. According to research conducted by the Centers for Disease Control and Prevention (2015), nearly 1 in 5 women have been raped at some point in their lives. Every year, 1.3 million women are raped (Black, et al., 2011). According to a study conducted by the National Victim Center, 1 in 3 women aged 18 and older in the United States are forcibly raped each minute. These numbers translate to 1,871 women per day or 683,000 women per year who are subjected to sexual victimization (Kilpatrick, Edmunds, & Seymour, 1992). In addition, nearly 1 in 2 women and 1 in 5 men have experienced sexual victimization other than rape in their lifetimes (Black et al., 2011).

In terms of children and adolescence, studies have shown that 1 in 4 girls and 1 in 6 boys are victims of child sexual victimization (Tikkanen, 2005). During a 1-year period in the United States., 16% of youth between the ages of 14 to 17 years are sexually victimized, and over the course of their lifetimes, 28% of youth in the United States between the ages of 14 to 17 years are sexually victimized (Finkelhor et al., 2009). Notably, of all reported cases of sexual violence

committed, an estimated 23% of those crimes are perpetrated by individuals younger than the age of 18 years (Durham, 2003). Research has shown that when categorized into specific types of sexual crimes, juvenile sexual offenders generally engage in 24% of all rapes, 12.5% of sexual crimes involving sodomy, 4.7% of sexual assaults with an object, 49.4% of crimes consisting of acts of fondling, and 9.5% of non-forcible sexual offenses (Department of Justice, Federal Bureau of Investigation, 2004; Finkelhor et al., 2009).

Taken into consideration the facts and figures described, these rates suggest that the severely high sexual crime rates continue to grow. These numbers also highlight intense safety concerns that are likely to surface as a result of the high incidences of sexual crimes. Furthermore, these extreme rates not only point to threats to public safety, but also provides proof for a substantial need for treatment for those who commit sexual crimes.

### **Recidivism Rates of Sexual Violence**

Recidivism rates for juveniles who commit sexual offenses are generally lower than those observed for adult sexual offenders (Lobanov-Rostovsky, 2015). A meta-analysis involving nine studies and 2,986 predominately male juvenile sexual offenders, found that 13% recidivated within 59 months. This finding was much lower than the juveniles' nonsexual or violent recidivism rates of 25% from within the same time frame (Reitzel & Carbonell, 2006). Another meta-analysis involving 63 studies and a combined sample of 11,219 juveniles adjudicated on sexual offense charges found a significantly lower recidivism rate of 7% at 59 months. However, the weighted mean for recidivism of any other type of crime was a substantially higher rate of 43% (Caldwell, 2010).

Low recidivism rates relative to sexual offenses could symbolize a decrease in sexual offending upon release from treatment and/or detention. However, low rates of recidivism may

highlight the fact that recidivism rates do not always necessarily capture the true extent of sexual re-offense, either because of victim underreporting or other factors that may limit the full impact of recidivism findings (Lobanov-Rostovsky, 2015). In other words, juveniles may actually stop offending sexually upon treatment release. Conversely, they may continue to reoffend sexually; however, recidivism data may be skewed, as some juveniles may be charged with crimes that do not directly reflect sexual offending.

Evidence shows that many juveniles who reoffend sexually are offered plea deals for their crimes (Kraus, 2016). Juveniles who take plea deals generally receive charges for crimes that involve less time in treatment or juvenile detention (Kraus, 2016). In addition to a reduced sanction, plea deals generally result in criminal charges for the juvenile that do not reflect the initial reason for arrest. That is, charges for juveniles' actual crimes are reduced to a lower sanction, and sexual crimes or crimes similar to in nature may not be on their record (Kraus, 2016). Research has shown that sexually violent offenses recorded on police databases are underrepresented by approximately 25 to 35% of the actual number of sexually violent offenses detected by the police (Quinsey, Harris, Rice, & Cormier, 2006). Plea deals not only may have a potential negative impact on recidivism rates, but also may misrepresent the rates and give a false sense of safety to society, regarding the number of juveniles who actually re-offend upon release from treatment or juvenile detention centers.

### **Recidivism Risk Factors of Sexual Violence**

Although recidivism rates for juvenile sexual offending tend to be low, regarding the criminal charges, recidivism risks of juveniles can vary in range, as there are many risk factors that can impact each juvenile specifically. According to literature, as well as to the Estimate of Risk of Adolescent Sexual Offense Recidivism (ERASOR) assessment, which is used to measure

recidivism risk levels for juvenile sexual reoffending, numerous risk factors are involved in juveniles committing sexual crimes. Generally, these risk factors fall into several different categories. These include: preoccupations/interests, attitudes, behaviors, interpersonal relationships, and family.

**Preoccupations/interests.** Preoccupations/interests include, the risk factor of perpetrators' deviant sexual interests. These interests typically involve the offender being sexually aroused by younger children and/or the thought of engaging in sexual violence against a young child. In a study conducted by Worling and Curwen (2000), results showed that self-reported sexual interests of juvenile sexual offenders, including past or present sexual fantasies of children, child-victim grooming behaviors, and sexual assault activities with children, were a significant predictor of sexual reoffending.

Another risk factor is juvenile offenders' obsessive sexual interests and preoccupation with sexual thoughts, behaviors, or gestures. Researchers hold that adolescents who offend sexually and are preoccupied with thoughts and images of sexual activity are more likely to reoffend (Gibson & Vandiver, 2008). Typical behaviors associated with the risk factor of obsessive sexual interests and preoccupation with sexual thoughts, behaviors, or gestures are seen in frequent acts of masturbation, excessive use of sexual fantasies or behaviors to cope with negative feelings, or deviant pornography use (Kaplan & Krueger, 2010).

Although adolescent exploration of pornographic material is common, many juvenile sexual offenders tend to view deviant pornographic sexual acts (Kingston, Fedoroff, Firestone, Curry, & Bradford, 2008). These acts may include child pornography, scenes that involve an individual being tortured, or any other instances of violence (Singer & Singer 2001). These

aberrant forms of pornography may serve to promote and, in cases of recidivism, reinforce juveniles' already problematic sexual behaviors (Kingston et al., 2008).

**Attitudes.** An additional risk factor is supportive attitudes toward juvenile sexual offending behavior. Juveniles who view inappropriate sexual interactions as being desired by victims are most likely at higher risk to continue committing sexual assaults. One study found that juveniles who blamed their victim(s) for the sexual contact were more likely to re-offend than those who did not (Kahn & Chambers, 1991). In another study by Hanson and Harris (1998), results corroborated the findings of Kahn and Chambers (1991), showing that attitudes supportive of sexual offending behaviors were related to sexual re-offending.

**Behaviors.** Prior sanctions for sexually assaultive behavior are another aspect that has been viewed as a risk factor for re-offending. Researchers have indicated that juveniles who have committed sexual offenses previously are at risk of continued sexual criminal acts against others (Caldwell, 2002). In a review of 25 studies concerning recidivism rates for juvenile sexual offenses, results showed that youth who commit sexual offenses have as much as a 12.8 % chance of re arrest and up to an 18 % chance of reconviction for another sexual offense (Caldwell, 2002). Researchers have posited that juveniles who continue to commit sexual offenses despite having been detected and penalized may possess more deviant sexual interests, obsessive sexual interests, or attitudes supportive of sexual offending (Worling & Curwen, 2001). Additionally, adolescents who continue to commit sexual offenses following sanctions are more resistant to altering deviant sexual interests/attitudes and possibly possess antisocial-like personality features in terms of respect for others' personal boundaries (Worling & Curwen, 2001).

**Interpersonal relationships.** Lack of intimate peer relationships has also been regarded as a risk factor. Research has shown that an adolescent who sexually offends and reoffends is typically described by others as a “loner” (Rich, 2015; Worling, Bookalam, & Litteljohn, 2012). These individuals are usually unable to form emotionally intimate peer relationships as a result of social isolation, either on their own accord or because they are not accepted by the peers with whom they would like to associate (Hunter & Figueredo, 2000). Researchers propose that when denied social interactions with peers their own age, adolescents are likely to turn to youth who are significantly younger for social acceptance, interactions, and sexual contact (Lipsey & Derzon, 1998). Therefore, social isolation prohibits adolescents from forming and maintaining emotionally and physically intimate relationships with age-appropriate peer, thereby putting them at risk to reoffend sexually (Tudiver, 2000).

In addition to experiencing difficulty with peer relationships, juveniles who offend and reoffend may lack social competence relative to interpersonal interactions (Quinsey et al., 2006). Specifically, research conducted by Katz (1990) compared three groups on various measures of social skills. The three groups were adolescent "child molesters," juvenile delinquents who had not committed sexual offenses, and a comparison group recruited from a local high school (Katz, 1990). Results of the study revealed that the juvenile sexual offenders were more socially unskilled than either of the other groups and evidenced more social anxiety and fear of heterosexual interactions (Katz, 1990).

**Family.** High-stress family environments is another issue that had been linked to juvenile reoffending of sexual violence (Worling & Curwen, 2001). Researchers offer the idea that adolescent sexual offenders who live with family members where the home environment and family relationship are plagued by frequent arguments and dissonance are at an increased risk of

reoffending sexually (Carpentier & Proulx, 2011). Such issues as marital division and poverty may contribute to feelings of insecurity in the adolescent. Additionally, feelings of emotional neglect, experiences of physical and sexual abuse, separation of a family member from the family, or death of a family member may lead juveniles to feel a sense of low self-worth and/or depression (Worling & Curwen, 2001). The adolescent's experience of intense negative emotional states is likely to lead to reoffending (Carpentier & Proulx, 2011).

While many risk factors for recidivism of sexual reoffending in juvenile delinquents have been studied and categorized as aspects of juvenile offenders' lives that contribute to their criminal behavior, one factor that has received less attention is exposure to domestic violence. The ERASOR mentions primary risk factors, such as social relationships, high-stress family environments, and juveniles themselves being subjected to sexual and physical abuse and emotional neglect. However, the measure does not have predictors that focus on or take into account exposure to domestic violence specifically.

### **Domestic Violence**

Domestic violence is categorized as any physical, sexual, or psychological abuse used against a current or former intimate partner (Burton, 2008). Similar to the general form of violence, domestic violence refers to various criminal behaviors, including assault and battery, sexual abuse, stalking, harassment, homicide; and other offenses that occur within the course of domestic disputes (Burton, 2008). Domestic violence is an appalling human rights and public health issue that has been a harsh reality for women for thousands of years. The topic of domestic violence dates as far back as 735 BC, when the justice system viewed women as the property of their husbands, thereby creating legislation in which wife beating was accepted, as abuse was regarded as a way for men to exercise their authority over their wives (Felter, 1997;



Siegel, 1996). During this time, in parts of Rome, “The Laws of Chastisement” permitted wife beating by stick, belt, or rod (Felter, 1997). However, in the early 1500s, the laws changed to “The Rule of Thumb”, which specified that husbands were allowed to hit their wives with a stick or a rod no thicker than the size of their thumb. This rule became a guideline for more than 1000 years (Felter, 1997; Siegel, 1996).

In 300 A.D., churches, along with the legal system, re-affirmed a husband’s authority to discipline his wife. This re-affirmation came with no restraint on the form of chastisement that women received (Patzner, 2014). The re-affirmation led to extreme forms of abuse and, at times, murder of many women at the hands of their husbands. One well known example was the Holy Roman Emperor’s, Constantine the Great’s, burning of his wife after he concluded that she was of no use to him anymore (Patzner, 2014).

The 1500s brought about added abuse for women. More specifically, laws in portions of England condoned marital rape if men became aroused and felt the urge to engage in sexual intercourse with their wives. Laws of this time held that a husband could not legally be found guilty of rape because marriage was a contract between a man and his wife (Patzner, 2014; Schechter, 1982). Therefore, when a wife gave herself to her husband, she could not retract her consent. Along with the disregarded rape of married women by their husbands, during this same time period in Russia, churches issued an ordinance that made legal a man’s beating or killing of his wife for disciplinary purposes. However, if a Russian woman killed her husband as a result of any wrongdoings against her, she was penalized by being buried alive with her head above the ground, and left to die (Patzner, 2014). Similarly, in England, women and children were taught that obeying the man of the house was their duty. If they engaged in behavior contrary to the

man's wishes, violence perpetrated against both women and children was deemed acceptable (Patzner, 2014; Schechter, 1982).

By 1800, the American Society for the Prevention of Cruelty to Animals and the Society for the Prevention of Cruelty to Children were founded. These organizations were created before any organization for the protection of women and women's rights (Patzner, 2014; Schechter, 1982). During this era, men were permitted to beat and rob women of economic and political power. Acts of violence against women during this time generally consisted of being mutilated, tortured, blinded, trampled, burned, and murdered (Patzner, 2014). Not until the late 1800s was wife beating viewed as an issue. In 1882, Maryland became the first state to pass a law, making domestic violence a crime punishable by whippings and a year in jail (Schechter, 1982). By the late 1800s, many states began to pass laws banning the abuse of women by their husbands. Then, in 1895 in England, the Married Women's Property Act was passed, which deemed convictions for domestic assault an adequate reason for a woman to divorce her husband (Schechter, 1982).

### **Prevalence of Domestic Violence in the United States**

Domestic violence is prevalent in every community and affects all people regardless of age, socioeconomic background, nationality, or gender (National Coalition Against Domestic Violence, 2015). Although men and women are both victims of domestic violence, women are victims in cases of domestic abuse at significantly greater rates than men (Catalano, 2012). In the United States, the Department of Justice reports that from 1994 to 2010, 4 in 5 victims of domestic violence were women, compared to 1 in 4 men who experienced victimization (Catalano, 2012; National Coalition Against Domestic Violence, 2015). Additionally, while incidents of domestic violence are typically underreported, research on publicized occurrences has revealed that 1 in 3 women are abused in intimate partner relationships and 1 in 5 women

experience severe forms of domestic violence. These numbers liken to more than 10 million victims of domestic abuse annually (National Coalition Against Domestic Violence, 2015).

Researchers estimate that between 25 to 30% of women in America experience physical abuse at the hands of their partners at least once throughout the relationship (Osofsky, 2003). In terms of severe forms of domestic violence, one study found that approximately 1.8 million women were severely assaulted by male partners over the course of 1 year. Additional findings showed that women experiencing violence including physical, sexual and verbal abuse, within intimate relationships were at rate as high as 65% (Osofsky, 2003). These numbers suggest that domestic violence in the United States is a significant issue that negatively affects a wide range of intimate partners.

### **Prevalence of Domestic Violence Worldwide**

Statistics on the prevalence of domestic violence indicate that this problem is rampant not only in the United States, but also worldwide. A 2006 report of the World Health Organization (WHO) entitled, “Prevalence of Intimate Partner Violence: Findings from the WHO Multi-Country Study on Women’s Health and Domestic Violence,” found that domestic violence encompassing physical or sexual abuse affected between 25 to 50% of women worldwide, with the most prevalent type of violence against women being physical in nature (Garcia-Moreno, Jansen, Ellsberg, Heise, & Watts, 2006). Additionally, WHO report research from 2013 estimated that 38% of all female murder victims were killed by their intimate partners during the course of a domestic dispute. This estimate is likely much higher, as most domestic abuse cases go unreported (World Health Organization [WHO], 2013).

### **Prevalence of Children Exposed to Domestic Violence**

Approximately 3.3 million children are witnesses to physical and verbal domestic violence incidents each year (Edleson et al., 2007; Osofsky, 1995). Studies conducted on adults' accounts of exposure to domestic violence during their teenage years led researchers to believe that rates of exposure to domestic violence may be even higher (Straus, 1992). Specifically, as many as 10 million teens may be exposed to domestic violence within their homes each year (Edleson et al., 2007). Results of an additional study have raised estimates of childhood exposure to 10 to 20% (Carlson, 2000). These findings suggest that approximately 7 to 14 million children witness domestic violence within their homes annually (Carlson, 2000; United States Census Bureau, 2000). These abuse cases are believed to range in severity from verbal insults and physical attacks to fatal attacks resulting from weapons use (Jaffe, Wolfe, & Wilson, 1990; Osofsky, 1995).

### **Effects of Exposure to Domestic Violence**

Research on the effects that exposure to domestic violence has on children identified various severe effects on children's mental health and overall well-being. Of those identified, the issues most widely studied include the effects that exposure to domestic violence may have on children in relation to the development of anxiety and depression in childhood and adolescence and substance use in adolescence and young adulthood (Kolbo, Blakely, & Engleman, 1996; Margolin, 1998; Smith, Elwyn, Ireland, & Thornberry, 2010). In a review of 29 studies that compared children exposed to domestic violence with children from nonviolent homes, researchers found that those who were exposed to domestic violence were more likely to exhibit problematic internalizing behaviors, such as anxiety, depression, and low self-esteem (Kolbo et al., 1996).

Other research on domestic violence revealed that school-aged children who are exposed to family violence are affected similarly to those exposed to general forms of violence, such as that within their communities. These children typically show a greater frequency of internalizing behaviors such as anxiety and social isolation as well as other problematic behaviors such as aggression (Bell & Jenkins, 1993). Two additional studies, one with children ages 6 to 10 years in Washington, D.C. (Richters, & Martinez, 1993), and another with children aged 9 to 12 years in New Orleans (Osofsky, Wewers, Hann, & Fick, 1993), also indicated a significant link between the witnessing of domestic violence and symptoms of anxiety, in addition to other symptoms, such as fear of leaving the home and a numbing of affect. Additionally, 40% of the mothers in the New Orleans sample and 20% in the Washington, D.C. sample expressed constant worry for their safety while in the home.

In terms of substance use, studies have shown that domestic violence puts children at increased risk for engaging in substance use in adolescent and young adult years (Carliner, et al., 2016; Carlson, 1990; Silvern, et al., 1995; Sternberg, et al., 1993). In a study conducted by Carliner et al. (2016), the researchers focused on the connection between substance abuse, specifically marijuana, cocaine, nonmedical prescription drugs, and a combined use of them all, in relation to potentially traumatic events such as exposure to interpersonal violence. The study was conducted on 9,956 adolescents aged 13 to 18 years. Results from the study showed that exposure to any potentially traumatic events before age 11 years was reported by 36% of the sample and was associated with higher risk for use of marijuana, cocaine, prescription drugs, and multiple drug use (Carliner et al., 2016). A positive continuous relationship was observed between number of potentially traumatic events and marijuana, other drug, and multiple drug use. These findings meant that as the instances of exposure to traumatic events increased, so too

did the amount or kinds of drugs that the adolescents used. Specific to interpersonal violence, a link was found between exposure to relational violence and all drug use outcomes (Carliner et al., 2016).

In another study, conducted by Funk, Medermeit, Godley, and Adams (2003), the researchers found that 71% of teens in treatment for substance abuse were exposed to some form of trauma, including exposure to domestic violence. Additional studies have also provided evidence of a link between children exposed to domestic violence and long-term problems with anxiety, depression, and substance abuse. Researchers have found that children who are exposed to domestic violence may react in ways that increase their risk for negative outcomes, such as running away from home, which increases their risk of homelessness, victimization, and further substance use (Carlson, 1990; Sternberg, et al., 1993).

There is also some research that has shown that exposure to domestic violence in childhood is not likely to result in future issues with substance abuse. In a study focusing on the impact of adolescent exposure to intimate partner violence and its connection to substance use in early adulthood, researchers examined a sample of 508 adolescents from the Rochester Youth Development Study. The sample consisted of primarily urban, minority individuals who were at high risk of engaging in antisocial behavior and drug use. Results of the study showed that while exposure to severe forms of domestic violence increased the chances of adolescents engaging in alcohol use during early adulthood, exposure to domestic violence in a less severe form did not increase the chances of substance abuse by adolescents (Smith, Elwyn, Ireland, & Thornberry, 2010).

Taking into account the research findings on the effects of domestic violence exposure, it appears that although all children are not affected by exposure to intimate partner violence in the

same manner, exposure to domestic violence does lead to detrimental outcomes both in the short and long-term for an abundance of children and adolescents. These effects can range from detrimental psychological impacts to substance addictions that stem from individuals' inability to effectively cope with the trauma of witnessing domestic violence.

### **Potential Moderators of Exposure to Domestic Violence on Sexual and Violent Recidivism**

#### **Emotional and/or Physical Neglect**

Despite the effects of exposure to domestic violence some moderators may impact the relationship between domestic violence and juvenile sexual and violent re-offending behavior. These moderators include emotional and/or physical neglect during childhood, parental criminal involvement, and parental substance use or abuse. In terms of emotional and/or physical neglect, social learning theory posits that people learn from exposure to others who model the behaviors that they are supposed to exhibit (Bandura & Walters, 1977). Therefore, if a child or adolescent has never been shown love and affection and was also never supported by his or her parents, according to social learning theory, this child would be less likely to show love, affection, and empathy for others. Furthermore, if a child or adolescent witnesses a parent or caregiver exhibit emotions that are "cold" or neglectful, he or she may, in turn, identify that behavior as a way that one is supposed to act and treat others.

Research suggests that adolescents who offend and reoffend do so as a result of unmet developmental needs, or childhood neglect (Thomas, 2016). These unmet needs could range from adolescents' feelings of not being loved or protected from danger to adolescents' beliefs that their caretakers have not adequately addressed their physical needs such as being consistently fed and having a stable place to live.

Additional research conducted by Smith (2011) further supports the idea that physical and/or emotional neglect can be moderators for juvenile sexual and violent reoffending. His research indicated that early experiences of parental affection, more specifically from a maternal figure, helps to set the foundation for the development of consideration and care for others. Consequently, if a child does not have an emotional attachment to a mother figure, or if the attachment has been severed during early childhood, the child's ability to form emotional attachments to and/or empathize with others may not come to fruition (Smith, 2011). As such, the child may mature into someone who is emotionally distant, experiences difficulty with trusting others and forming meaningful relationships, and displays antisocial-like behaviors, such as engaging in various criminal acts. This information suggests that children who are raised in emotionally uninvolved, unloving, or authoritarian homes may grow to become interested in meeting their needs, even at the expense of others. As such, they may react impulsively to their desires, increasing the likelihood of sexual or violent reoffending.

The connection between childhood neglect and future reengagement in delinquency has been further supported by a longitudinal study of 676 abused or neglected children, from 1967 to 1971. These children were matched with 520 children who were part of a control group. All participants were interviewed when they were approximately 29 years old. Results showed that participants who had been abused or neglected were 38% more likely than the matched controls to have been arrested for criminal acts including sexual crimes, than children who did not experience neglect (Widom, 1989; Widom, 1992). The abused or neglected participants were also 53% more likely to have been arrested as a juvenile (Widom, 1989; Widom, 1992).



### **Parental Criminal Involvement**

In addition to physical or emotional neglect experienced during childhood, research has shown that parental criminal involvement may also be an added factor in juvenile sexual and violent reoffending. In a study conducted by Glueck and Glueck (1950,1968), results showed that criminally involved juveniles were more likely than non-delinquents to have criminally involved parents. Researchers Laub and Sampson (1988) examined Glueck and Gluecks' study and maintained their results. They also found that parents involved in criminal activity did not directly aid their children in becoming delinquent. However, parental criminal involvement disrupted social control within the home, ultimately leading to delinquency.

A longitudinal study of British boys further substantiated Glueck and Glueck's research when it found that male adolescents who were involved in criminal behavior tended to have fathers who were also involved in some form of criminal activity (West & Farrington, 1973; West & Farrington, 1977). They also found that although the fathers research in the study did not directly involve or encourage their children to commit crimes, and tried to shelter their sons from exposure to crimes just as much as noncriminal parents did, the amount of supervision over their children was lax in comparison to that of their noncriminal parent counterparts (West & Farrington, 1973; West & Farrington, 1977).

Furthermore, a study conducted in St. Louis, on parents of African American children involved in criminal activity found an association between the children's criminal involvement and the arrests of one or both parents in adulthood and the parents' histories of juvenile delinquency (Robins, West, & Herjanic, 1975). The researchers also found that the children whose mothers and fathers were both involved in criminal activity had higher instances of juvenile delinquency than those with one criminally involved parent (Robins et al., 1975). These

results suggest that children who are born to criminally involved parents may be more susceptible to engaging in forms of criminality, including sexual and violent crimes than children whose parents are not criminally involved.

### **Parental Substance Use or Abuse**

Along with parental criminal involvement, parental substance abuse has also been shown to present issues with regards to juvenile sexual and violent reoffending. Parental substance abuse and its effects on adolescents may be similar to emotional and/or physical neglect of children in the context of social learning. When considering social learning theory and the connection between witnessing a behavior and repeating the behavior that one sees, if a juvenile sees that drinking and/or using drugs seems to help his or her parent cope with life's stressors more effectively, as evidenced by the parent appearing happier when they are intoxicated, adolescents may be more likely to engage in substance using behaviors. Risk arises when children and/or adolescents engage in substance use and participate in behaviors that they may otherwise not associate themselves with as a result of lack of impulse control, which is caused by intoxication (Romer, 2010).

Supporting the idea of social learning theory in relation to adolescent substance abuse, a study conducted by Miner, Siekert, and Ackland (1997) on juvenile sexual offenders revealed that approximately 60 % of the biological fathers of the juveniles had substance abuse histories. This information raises the possibility that being raised in a home where parental substance abuse is present may contribute to sexual and violent reoffending in juveniles. Parents' substance abuse may also be one of many reasons that most of these children come from homes where they experience emotional and/or physical neglect.

Regarding research involving the link between parental substance use and juvenile sexual and violent recidivism, a study conducted by Kelley, Lewis, and Sigal (2004) found that juvenile sexual offenders who received sexual offender treatment in the past, were at a significantly higher risk for sexual reoffending if they experienced dysfunctional family relations, had parents who abused substances, were victims of sexual and physical abuse, or had themselves abused drugs and/or alcohol. Researchers noted that these risk factors pose such high for sexual and violent reoffending because they can affect the success of treatment (Kelley et al., 2004).

### **Treatment for Juvenile Sexual Offenders**

Specialized treatments for juveniles who have engaged in sexually problematic behavior have been widely available since 1985 (Knopp, Rosenberg, & Stevenson, 1986). As in the past, services to juvenile sexual offenders are offered at community-based and residential facility levels. The primary modalities of treatment delivery are group and individual therapy. Some programs also offer family therapy sessions if deemed appropriate or if otherwise requested (Dopp, Borduin, & Brown, 2015). Early treatments were modeled after those designed for adult sexual offenders, with few developmental adaptations for juveniles (Center for Sex Offender Management [CSOM], 2018). As is still true today, early programs adhered to a cognitive behavioral therapy (CBT) model with a focus on relapse prevention (Becker & Kaplan, 1993). An additional treatment modality used in the treatment of juvenile sexual offenders is dialectical behavior therapy (DBT); this modality was introduced into the treatment of juvenile sexual offenders in 2004 (Berzins & Trestman, 2004; Carr, Fitzgerald, & Skonovd, 2011).

### **Cognitive Behavioral Therapy**

In terms of treatment, CBT is the most common form used for juvenile sexual offenders. Research on current programs indicated few substantive changes since the development of

specialized treatment juvenile sexual offenders, as 80.1% of treatment provided to this population at both the community-based and residential level, adheres to a CBT model with emphasis on relapse prevention (Dopp et al., 2015; McGrath, Cumming, Burchard, Zeoli, & Ellerby, 2010). CBT interventions for treatment of juvenile sexual offenders focus on factors that have been historically shown to increase chances of recidivism. As such, the techniques aim to reduce or eliminate youths' cognitive distortions about their sexually problematic behavior, their victim(s), and the circumstances that led to their offense; help youth to build empathy for their victim(s); get adolescents to and take responsibility and remain accountable for their offense(s); teach new and/or adaptive social skills including establishing and maintaining healthy interpersonal relations, managing and coping with interpersonal conflict, and techniques to aid in identifying and coping with anger, and increasing support networks (McGrath et al., 2010; Dwyer & Letourneau, 2011; Dopp et al., 2015).

Additional CBT techniques utilize a relapse prevention emphasis, aimed at teaching juvenile sexual offenders when they may be entering into a cycle of behavior that could lead them to reoffend. Juveniles learn about their cycles of behavior with the help of therapists who assists them to identify factors (e.g.: triggers to stress, maladaptive coping strategies, negative and/or distorted thoughts) that initially led to their offenses. Juveniles are then assisted with finding coping strategies and healthier counter thoughts to aid in preventing recidivism (Becker & Kaplan, 1993; Dopp et al., 2015).

Research findings regarding the effects of CBT on the treatment of juveniles have been mixed in terms of its effectiveness in reducing recidivism. Although some research offers support for its efficacy, with declines in sexual, violent, and general recidivism reaching 40% after use of CBT interventions (Hanson et al., 2002), other studies highlight short comings of the

research on CBT and effectiveness of the treatment modality for the juvenile sex offender population. In terms of research supportive of CBT treatment for the reduction in juvenile sexual recidivism, Guarino-Ghezzi and Kimball (1998) examined treatment outcomes for 75 adolescents with a history of at least one sexual offense. Youths were assigned by juvenile court to one of 40 residential treatment programs. Of the 40 facilities, 27 specialized in the treatment of juvenile sexual offenders and typically involved group therapy sessions within a CBT-relapse prevention component. The remaining 13 programs were not specialized in sexual offender treatment, and as such have limited discussion about juvenile sexual offending behavior. Instead, the facilities provided psychoeducation on such topics as life skills and sex education (Guarino-Ghezzi & Kimball, 1998).

Results showed that youth who participated in the specialized CBT programs had increases in social support and reported greater knowledge and understanding of relapse prevention strategies relative to their sexually problematic behavior. These youths also reported greater decreases in denial of their crimes and their deviant cognitions about sex, compared with those in nonspecialized programs (Guarino-Ghezzi & Kimball, 1998). These findings provide hope for an effective way to treat sexually deviant juveniles and decrease the chances of recidivism.

Additional research consisting of a pair of studies examining the effects of the Sexual Abuse: Family Education and Treatment (SAFE-T) program on juvenile sexual recidivism used a sample of 148 Canadian juvenile sexual offenders who had completed at least 1 year of treatment in the program (Worling & Curwen, 2000; Worling, Littlejohn, & Bookalam, 2010). This group was compared to a pooled group of youths who had dropped out of the program before 12 months, refused to participate in the program, received treatment elsewhere, or only received a

pretreatment assessment. The SAFE-T program consisted of group, individual, and family therapies in a CBT/relapse prevention format. For each study, data on the juveniles' criminal charges were obtained from the national registry of criminal arrests at 6.2 years (Worling & Curwen, 2000) and 16.2 years post-recruitment (Worling et al., 2010). Results revealed significant reductions in sexual recidivism for the group who participated in the SAFE-T program at both times of follow-up with a large Cohen's *d* effect ( $d = 0.85$ ) at 6.2 years and a medium effect ( $d = 0.63$ ) at 16.2 years (Worling & Curwen, 2000; Worling et al., 2010). Even though the researchers used long-term follow-up periods and the collection of nationwide criminal records to track recidivism, the study's results were weakened by the use of treatment dropouts and refusers in the comparison group. This is because, those in the comparison group would be more likely to have worse outcomes than those who completed the program.

A study carried out by Lab, Shields, and Schondel (1993) compared a court-based CBT program to standard juvenile sexual offender services in the treatment of 155 juvenile sexual offenders. The CBT program consisted of weekly 2 to 3 ½ hour group sessions over a period of 20 weeks with supplemental individual and family sessions. Standard services involved participation in community-based treatment programs or incarceration in detention facilities, neither of which was specific to juvenile sexual offending. Results revealed no significant difference in the reduction of recidivism for juvenile sexual offenders provided with CBT versus those provided with the standard justice department treatment of juvenile sexual offenders (Lab et al., 1993).

Research by Gillis and Gass (2010) showed findings similar to those of Lab et al (1993) when they employed a matched group design to compare a CBT-based program to residential/detention services in the treatment of 285 juvenile sexual offenders. Participation in

this program involved placement for an average of 1 year in a residential community setting that featured wilderness/adventure programming and a therapeutic milieu based on a CBT model. Youths in the comparison condition were placed in either residential treatment programs or in state-operated youth detention facilities. These facilities did not provide the CBT orientation of specialized treatment of juvenile sexual offenders or the wilderness/adventure programming. At a 3-year follow-up using court records, no significant between-group differences in recidivism for sexual and violent offenses ( $d = 0.17$ ) (Gillis & Gass, 2010).

Overall, the current literature provides limited support for the effectiveness of CBT in reducing recidivism of juvenile sexual offenders. Most of the studies to date have had serious methodological limitations, such that interpretation of findings remains tenuous. Additionally, the CBT techniques used to treat juvenile sexual offenders fail to view the youths' problematic behaviors in their entirety. That is, these studies fail to treat other life factors that may have contributed to the youths' perceptions of the crimes they have committed.

### **Dialectical Behavior Therapy**

Like CBT, DBT interventions for juvenile sexual offenders typically focus on factors that have been shown to increase the likelihood of recidivism. The difference between the two modalities in the context of work with forensic populations is that DBT focuses more on the social factors and aspects of neglect that serve as predictors to sexual recidivism. As such, DBT is used to teach various skills aimed at assisting these youths in effectively managing their emotions, effectively interacting with others, and pursuing reasonable wants and needs in a manner that does not violate the wants and needs of others (Linehan, 1993). These services include gaining skills with interpersonal effectiveness, emotional regulation, distress tolerance, and practicing mindfulness and grounding techniques as a way to cope with negative feelings in

the moment (Linehan, 1993).

As DBT is a fairly new treatment modality relative to serving forensic-based populations, available research is limited with regard to DBT's effects on juvenile sexual and violent recidivism. Nonetheless, the information that is available offers varied results. For instance, a pilot study conducted by research staff at the Washington State Institute for Public Policy examined the effects of DBT on juvenile sexual and violent recidivism; results showed reductions in recidivism for the DBT participants compared to juveniles who did not receive DBT treatment. However, the differences between the two groups regarding recidivism reduction were not statistically significant (Drake & Barnoski, 2006).

Additional research on the effectiveness of DBT in helping to reduce juvenile sexual and violent reoffending involved a secondary analysis of a sub-sample of 38 male adolescents who showed difficulty with aggression, impulsivity, and effectively coping with distressing feelings. The youths were taught standard DBT skills of mindfulness, interpersonal effectiveness (with an integration of conflict resolution skills), distress tolerance, emotion regulation, and self-management techniques. Results showed a decrease in disciplinary tickets from pre to posttest ( $t = 2.529$  to  $t = 2.753$ , respectively), and correctional officers indicated that they observed an overall improvement in aggressive and impulsive behavior following the DBT interventions of mindfulness and interpersonal effectiveness (Shelton, Kesten, Zhang, & Trestman, 2011). Nonetheless, improved scores were not statistically significant.

Findings from these studies could possibly highlight the need for a focus that incorporates treatment aimed at increasing social skills and the ability to cope with and manage feelings of distress and anger, along with working through other social factors that may have set the foundation for the behavior that these youths display. Research shows that juvenile sexual



offenders typically have histories of traumatic childhoods that are marked by physical and sexual abuse, neglect, instability within the family home, and familial conflict (Finkelhor et al., 2009; Leversee, 2015; Veneziano & Veneziano, 2002). Research also shows that these factors, while discussed in treatment when a direct link between a behavior and the child's experience are rarely given the same amount of focus as the standard form of sexual offender treatment (Levenson, 2014). As a result of this information, recent research has pointed to the importance of incorporating trauma-informed care into the treatment of juvenile sexual offenders as a way of better serving this population (Levenson, 2014).

### **Trauma-Informed Care**

Since childhood experiences of trauma have been shown to result in maladaptive coping methods, interpersonal deficits, and ultimately to lead to sexually or physically abusive behavior, one can conclude that traumatic childhood experiences shape juvenile sexual offenders' cognitions and behaviors, affecting the way they interact with others and seek to get their needs met. Consequently, it is important for sexual offender treatment to incorporate trauma-specific work into the treatment of juvenile sexual offenders. Although some treatment facilities integrate trauma-focused work into their treatment programs, namely in a group format, research has shown that trauma-focused treatment is not emphasized as much as standard sexual offender treatment (Elliot, Bjelajac, Falot, Markoff, & Reed, 2005; Levenson 2014). Moreover, additional issues, such as exposure to domestic violence, which can also be viewed as a form of abuse and is equally as traumatic as direct abuse, have not been considered potential risk factors for juvenile sexual and violent recidivism and therefore, have not been added to treatment protocols for juvenile sexual offenders (James, 1994; Weithorn, 2001).

Although manualized treatments are needed to ensure consistent and cohesive service delivery to clients, emphasis on individualized treatments must be increased, in order to effectively respond to the youths' unique risks, needs, and responsivity to treatment. Specifically, a one-size-fits-all method to treating juvenile sexual offenders has little likelihood of being effective at significantly decreasing rates of recidivism (Andrews & Bonta, 2010; Willis, Yates, Gannon, & Ward, 2013). Because these treatments fail to recognize the role of individual life experiences and how they shape human cognitions and behavior, it is important for clinicians to consider the impact of early experiences of trauma and the effects that trauma may have on their clients' abilities to integrate and apply the new skills that they are being taught through use of the standardized DBT and evidence-based CBT treatments.

Research suggests that a balance of standard sexual offender treatment along with therapeutic services that are aimed at assisting the youths at identifying their traumatic experiences and understanding how those experiences have shaped who they are and how they interact with others, may be better able to reduce recidivism rates (Elliot et al., 2005). Through understanding how traumatic events have impacted clients' assumptions of the world, others, and themselves, clinicians can structure therapy around new ways that these youths can understand the world and those around them. Knowing this information, clinicians can also assist clients in obtaining coping skills that best combat their underlying core beliefs about themselves, others, and the world; and possible cognitive distortions that they may have about building relational connections with others.

Trauma-informed sexual offender treatment can be best described as a method of treating the entire person, not solely the behaviors that led to the person's offense(s) (Anda et al., 2006). Trauma-informed care is important to the entire biopsychosocial process of each youth, as each

life experience has an impact on later behaviors and experiences. Anda et al. (2006) described the biopsychosocial model in the context of childhood experiences of trauma and its effect on developmental factors that have been linked to juvenile sexual offending by stating, “environmental stressors stimulate the overproduction of stress-related hormones...inhibiting the growth and connection of neurons and contributing to lasting effects such as dysregulation, deficits in social attachment, and cognitive problems.”

These social, emotional, and cognitive impairments ultimately result in the acceptance and implementation of high-risk behaviors, such as unprotected sex and substance use, as methods of coping. These high-risk behaviors finally develop into illness, disability, or offending behavior that causes issues in the social context (Felitti et al., 1998).

The aforementioned information seems to show that an equal balance of trauma-informed care and basic sexual offender treatment may be needed in order to decrease the rates of juvenile sexual and violent reoffending. Nevertheless, additional forms of trauma, namely exposure to domestic violence, need to be researched and established as potential risk factors for recidivism in order to combat the full effect of trauma and its influence on juvenile criminal recidivism.

### **Summary**

To date, the explanations and research into the cause of juvenile sexual offending behavior are limited. Additionally, research that focuses on juvenile sexual offending examines domestic violence as a possible connection along with other factors, instead of studying the issue exclusively. Perhaps the most widely supported etiological theory for juvenile sexual offending behavior and its connection to domestic violence is social learning theory (Bandura & Walters, 1977). Additional theories that could be used to understand the link between exposure to

domestic violence and juvenile sexual offending include sex role theory, intergenerational transmission of violence theory, and general strain theory.

In terms of social learning theory, psychologist Albert Bandura proposed that learning is a cognitive process that takes place in a social environment through the direct process of observational learning (Bandura & Walters, 1977). Relative to domestic violence, social learning theory states that children imitate behavior to which they are exposed (Mihalic & Elliott, 1997). Violence, both general physical and sexual, is behavior learned from family members within the home. These family members, typically parents, serve as role models, both directly and indirectly, for behavior (Bandura & Walters, 1977; Mihalic & Elliott, 1997). In addition to teaching violence, the family may also reinforce violent behavior through constant exposure (Mihalic & Elliott, 1997; Tontodonato & Crew, 1992). Through continuous exposure to domestic violence, children may begin to believe and accept violence as the “appropriate” way to behave in intimate relationships and settle disagreements between themselves and their partners (Mihalic & Elliott, 1997).

A subtype of social learning theory, known as sex-role theory suggests that early sex-role socialization teaches boys and young men to be dominant in their intimate relations; to preserve a place as head of the household; and to maintain power and control in the relationship by any means necessary, even if doing so requires the use of force (Mihalic & Elliott, 1997). Young men and boys who are raised in a home where traditional sex roles are taught or modeled for them may learn sex roles that could lead them to believe that they are supposed to establish and maintain power over women. Believing that they are supposed to conserve power and control could make the juveniles vulnerable towards becoming perpetrators of crimes that involve a display of power through the use of force and control, namely sexual crimes.

Researchers of sex-role theory have also posited that domestic abuse within the home can occur when women who do not follow traditional sex roles get into conflict with men who have been raised in the presence of traditional sex roles (Mihalic & Elliott, 1997). Exposure to violence in an environment where viewpoints conflict relative to the structure of power in the home may still lead juveniles to offend because they will still be exposed to displays of victimization of a woman at the hands of a man.

Similar to social learning theory, the intergenerational transmission of violence theory states that children learn aggressive behaviors through witnessed violence. This theory further adds that violence is also learned through experienced personal victimization (Mihalic & Elliott, 1997; Sisco & Becker, 2005). In a study focusing on physical aggression in children in Grades 2, 3, 6, and 8, it was found that aggressive behavior was linked with children's witnessing of domestic violence (Osofsky, 1995). Since perpetrators of domestic violence often sexually abuse their victims as well, child and/or juvenile witnesses of these occurrences may grow up believing that sexual aggression is fitting in response to altercations with loved ones or when they become aroused. As they mature, juveniles may produce the actions that they learned in early childhood relative to physical and sexual violence (Osofsky, 1995; Stith et al., 2000).

General strain theory (GST) posits that stress and strain from the external environment lead to anger and aggression. In response to the anger and emotional buildup, individuals are likely to engage in violent, aggressive, and criminal behavior (Agnew, 2001). Criminal behavior is said to be the method used to reduce the stress that persons in this situation feel. According to GST, strain results from a lack or loss of positive stimuli, such as occurs after the loss of a loved one, or from a lack of positive role models; exposure to negative stimuli, such as physical

violence; and goal blockage, which may include failure to achieve satisfactory grades in school (Agnew, 2001).

While direct research on GST is minimal as it relates to juveniles specifically, GST has been researched in relation to adult sexual offenders quite extensively. Research on GST relative to adult sexual offenders holds that those who engage in sexual crimes, do so as a result of stressful events that they view as unjust, see as high in magnitude, associate with low social control, or believe create pressure or incentive to engage in sexually criminal activities (Agnew, 2001). These forms of strain include stressors that juveniles may view as unfair; recent and therefore more likely to be viewed by the juvenile as more intense because of their recency; erratic parental discipline, homelessness, or parental rejection; and stress that reinforces criminal behavior (Agnew, 2001).

### **Purpose of the Study**

Research has identified a number of robust predictors of juvenile violent and sexual reoffending following treatment for sexual offenses. These predictors include experiences of childhood trauma, physical and/or emotional neglect, and parental substance use. Despite efforts to improve treatment, high rates of juvenile sexual and criminal offending remain. High rates of sexual and criminal juvenile offending may be caused in part by other potential contributory factors, such as exposure to domestic violence, which has been researched much less. Research conducted by Ford and Linney (1995) posited that witnessing domestic violence may be a potential risk factor for juvenile sexual offending. Unfortunately, Ford and Linney's conclusion was speculative and did not directly study the link between domestic violence and sexual and violent reoffending. This dearth of research on exposure to domestic violence as a contributory factor to sexual and violent reoffending may result from it being "normalized" and being viewed

by society as an everyday part of life. Because this possible predictor has been ignored, it is generally not addressed in the treatment of juvenile sexual offenders. Finding an association between exposure to domestic violence and juvenile criminal recidivism may indicate the need for domestic violence to be addressed as another important topic in treatment.

### **Chapter 3: Hypotheses**

Owing to the increased interest in and lack of research done on the relationship between exposure to domestic violence and recidivism of juvenile sexual and violent offending, this research explored the relationship between witnessing domestic violence and recidivism of juvenile sexual and violent offending by examining juveniles' exposure to domestic violence within the home and subsequent recidivism rates of sexual and violent offending behavior. The purpose of the study was to examine the correlation between witnessing domestic violence during childhood and recidivism rates of juvenile sexual and violent offending.

For this study, domestic violence was defined as the willful intimidation, battery, psychological abuse, emotional maltreatment, and physical or sexual assault against an intimate partner. Additional forms of violence or intimidation may be less physical in nature but were also deemed forms of domestic violence. These forms included isolating the victim from his or her loved ones and preventing the victim from working or attending school as a means to gain power and control of the individual and his or her every move. Finally, in the context of this study, domestic abuse could occur between opposite or same-sexed partners who are married, in a courting relationship, and/or cohabitating.

Recidivism was defined as any arrest for a sexual or violent crime occurring within 1 year of treatment completion. A sexual crime was considered any act committed against an individual without his or her given consent. Any sexual act(s) involving a person who is unable to consent to any form of sexual contact because of his or her their age, mental capacity, lack of unconsciousness, or involvement with mind-altering drugs and/or alcohol were also considered sexual crimes. An act involving any of the aforementioned conditions was considered sexual recidivism if the crime was committed within 1-year post release from residential treatment.



A violent crime was defined as a crime in which an offender used or threatened force upon a victim. Violent crime entailed instances in which the violent act was the objective and crimes in which violence was the means to an end. A violent crime was considered for acts involving forcible rape (FBI Uniform Crime Report, 2010).

The experiment investigated the following questions:

1. **Primary:** Does exposure to domestic violence during childhood increase the risk of juvenile sexual and violent re-offending following treatment?
2. **Secondary:** Do certain parental factors, including being raised in a physically and/or emotionally neglectful home, parental criminal involvement, and parental substance use or abuse, moderate the effects of exposure to domestic violence on rates of sexual and violent reoffending in juveniles?
3. **Exploratory:** Does exposure to domestic violence during childhood increase the risk of behavioral misconduct during residential sexual offender treatment?

Taking into account the questions posed, the study's hypotheses were as follows:

1. **Primary:** Juvenile sexual offenders completing residential treatment will be more likely to recidivate if they were exposed to domestic violence as a child.

**Rationale:** Exposure to domestic violence during childhood is believed to increase the rate of recidivism in juvenile sexual and violent offending following treatment, because exposure to violent behavior is hypothesized to normalize aggressive behavior and lead juveniles to accept the behavior as appropriate (McFarlane, Groff, O'Brien, & Watson, 2003). It is also theorized that being raised by physically and/or emotionally neglectful parents will moderate the effect of exposure to domestic violence on

recidivism. Social learning theory posits that individuals learn from exposure to others who model the behaviors that individuals are supposed to exhibit (Bandura & Walters, 1977). Therefore, if a child was never shown love and affection and was also never supported by his or her parents, according to social learning theory, this child would be less likely to show love, affection, and empathy for another person. Additionally, because these children were exposed to a form of boundary crossing in terms of physical domestic abuse, they may generalize that unacceptable behavior to other forms of undesirable behavior and therefore engage in sexual crimes against others (Bandura & Walters, 1977).

2. **Secondary:** Being raised in a physically or emotionally neglectful environment, having criminally involved parents, and having parents who use or abuse alcohol or other psychoactive drugs will moderate the relationship between exposure to domestic violence on recidivism following residential treatment.

**Rationale:** The moderating effects of several other factors including parental criminal involvement, and parental substance use or abuse are also hypothesized to increase recidivism rates of sexual and violent offending upon completion of residential treatment. According to the differential association theory, crime and criminal behavior are intergenerational (Siegel, 2016). As such, children whose parents engage in deviant, criminal, or negative behaviors are more likely to become criminals themselves and/or to engage in problematic behaviors (Siegel, 2016). That said, if juveniles are raised in homes where their parents are

involved in criminal activity and/or problematic behavior, such as substance use, these children themselves are presumed, more likely to become criminally involved through perpetration of sexual and violent crimes.

3. **Exploratory:** Juvenile sexual offenders currently enrolled in residential treatment who were exposed to domestic violence as children will be more likely to engage in disruptive behavior and experience difficulty, thereby resulting in more incident reports during treatment than those who had no history of exposure to domestic violence.

**Rationale:** Exposure to domestic violence during childhood is also hypothesized to lead to an increase in disruptive behavior and trouble during treatment, resulting in incident reports. Research on school-aged students showed that in addition to internalizing the trauma they experience, children raised in homes where they are exposed to domestic violence were also more likely to externalize the stress of the domestic violence exposure through behavioral misconduct, which led to negative consequences at school (Emanuel, 2016). Such behavioral issues typically involved the children engaging in aggressive behaviors, such as yelling at teachers, throwing chairs and being generally disruptive when their teachers are unable to comply with their requests, and bullying classmates. General strain theory posits that some people react to the various stressors in life via unhealthy coping mechanisms, such as acting out or turning to crime (Brezina, 2017). Thus, if children have been exposed to domestic

violence within the home and are stressed, they may be prone to express their feelings and/or try to indirectly seek help through engaging in bouts of aggressive behavior toward others, being disruptive in settings where that behavior is deemed inappropriate or disregarding general rules of their setting.

## Chapter 4: Methodology

### Design

The study used a correlational longitudinal design using archival data. Archival data from individuals who completed treatment over the previous 4 years allowed the researcher to examine the hypotheses in a sufficient time frame.

### Facility

The setting for this study was a residential treatment facility that serves male individuals aged 12 to 20 years who have been convicted of offenses ranging from rape to problematic sexual behaviors. Many of the youth have themselves also been victims of physical, sexual, or emotional abuse and neglect. The residential treatment program aims to rehabilitate each youth, challenging him to fully admit his sexual misconduct; fully appreciate the harm he has caused his victims, their families, and his community; and find ways to avoid re-offending. The facility provides a variety of forms of clinical therapeutic treatment ranging from intelligence, psychosexual, and trauma assessments, to group, individual, and family therapies. The predominant treatment modality provided by the facility is CBT with aspects of DBT used when necessary.

In terms of treatment, residents who have been deemed successful in their completion of clinical services are discharged home to their families if they have been considered eligible for re-unification and have completed the re-unification process; are discharged to a foster home and referred to out-patient therapy that specializes in sexual offender treatment; or are assisted with transitioning into independent living if they are 18 years of age or older upon discharge. Residents who are considered a failure to adjust (FTA) normally receive numerous incident reports for misconduct ranging from inappropriate/lewd comments to antagonistic behaviors and

failure to follow staff instruction. Residents deemed FTA are sent back to juvenile detention, where they receive the clinical services offered at the particular facility by its staff. Residents are not returned to program. Instead, they complete their sentences in the detention center and are discharged according to their individual needs.

### **Participants**

Participant information was obtained from the residential treatment facility. Information was obtained from a 4-year (i.e., May 1, 2011 through May 1, 2015) archival data set of juvenile male individuals who were adjudicated on sexual-offense charges. Data were not collected on any juveniles before the year 2011, as collection of central data (Adverse Childhood Experiences - ACEs) to the project began in 2010, and it could not be determined with certainty that all data collected during that time was done correctly. Participants ranged in age from 12 to 20 years old and came from various racial and ethnic backgrounds, although most residents were likely to be of European descent. The residential treatment program is located in a large city in Pennsylvania; however, residents came from a range of additional cities in Pennsylvania. In terms of socio-economic status, participants typically came from low income to middle-class family backgrounds.

### **Inclusion Criteria**

Although data were available on all juveniles within the residential treatment program ranging in age from 12 to 20 years, inclusion criterion for the data used consisted of adolescents between the ages of 12 to 17 years. This is because the program only accepts individuals 12 years and older, and anyone older than the age of 17 can technically be considered an adult by legal standards. In addition, eligible participants were fluent in English and engaged in their sexual crimes when they were no younger than the age of 12 years. Eligible participants were

also residents who committed their crimes in the state of Pennsylvania only, as many other states may have stricter laws on specific crimes and may charge an act as a sexual crime that the state of Pennsylvania may not.

Additionally, participants had to complete treatment at the residential treatment facility, either successfully and be reintegrated into the community, or unsuccessfully from the program after being deemed a “failure to adjust” (FTA). Lastly, the juveniles had to have been exposed to incidents of domestic violence between the ages of 3 and 12 years, before their offenses occurred. Research has shown that children exposed to trauma between the ages of 18 months and 2.5 years frequently report fragmented memories of traumatic and nontraumatic events, and their memories of the events are prone to increased error over time (Fivush, 1998). However, from approximately age 3 years and older, children can give reasonably coherent accounts of their past experiences and can retain these memories over long durations (Fivush, 1998). In a study conducted by Nelson and Greundel (1981), it was found that 3-year-old preschool children were easily able to remember and report routine familiar events in a generalized and temporally structured manner, the same way older children could.

The same was found for novel events. These events seemed to be distinct in the 3-year-olds’ minds, thus possibly aiding them in giving accurate, detailed reports of their memories (Fivush, 1998; Hudson & Nelson, 1986; Nelson & Greundel, 1981). In addition to memory, research has shown that events experienced before the approximately 18 months do not seem to be verbally accessible (Fivush, 1998). However, children aged 3 years and older have reasonably articulate verbal recall of events that they have experienced (Eisenberg, 1985; Fivush, 1998; Fivush, Gray, & Fromhoff, 1987).

### **Exclusion Criteria**

Participants were excluded if they were younger than the age of 12 years or older than the age of 17 years. They were also excluded if they were not fluent in English, engaged in their sexual crime when they were younger than the age of 12 years, or committed their crime outside of the state of Pennsylvania. Residents were also excluded from participating in the study if they were exposed to domestic violence only between the ages of 1 and 2 years, as those residents may have been less likely to have remembered any significant detail that could have impacted their criminal behavior. Additionally, residents who had a documented diagnosis of mental retardation or a pervasive developmental disorder were excluded from the study, as exposure to domestic violence may not be the cause of their inappropriate sexual behavior; rather, an inability to understand social cues and the difference between appropriate and inappropriate contact may serve as the reasoning behind their sexual offenses. Children who entered into treatment after 2013 were not included in the study, as most would not have been released by May 2015, and those who were released would have had less time in the community to recidivate compared to the other residents being studied. Furthermore, children who were discharged from the residential treatment facility after 2015 were not included, as they were less likely to have been released from the program, and if they were released, they would not have had the same amount of time out as the other residents studied to recidivate.

### **Measures**

**Criminal arrest records.** The primary subject of interest for this study was the binary dependent variable of whether or not participants were arrested for a sexual crime in the year following release to the community. Data came from the state juvenile probation office, where all arrest records for juveniles in the correctional system were kept.



**Adverse Childhood Experiences Questionnaire (ACEs; World Health Organization, 2012).** The ACEs is a brief 10-item questionnaire used to measure 10 forms of trauma and exposure to stressors in early childhood. Five such questions focus on personal trauma such as physical abuse, verbal abuse, sexual abuse, physical neglect, and emotional neglect. The remaining five questions are related to family members: a parent who is an alcoholic; a mother who is a victim of domestic violence; a family member in jail; a family member diagnosed with a mental illness; and the disappearance of a parent through divorce, death, or abandonment. Questions about emotional and physical abuse, and household dysfunction were derived from the Conflict Tactics Scale (Straus, 1979); sexual abuse was determined based on four questions from Wyatt (1985); parental substance abuse was assessed with questions from Schoenborn (1991); and physical and emotional neglect variables were based on the Childhood Trauma Questionnaire (Bernstein et al., 1994). Each type of trauma counts as one form of trauma; the highest score an individual can receive is a 10 (see Appendix).

The ACEs questionnaire was used to assess the types of trauma that each juvenile experienced throughout his life, ranging from physical abuse to witnessing domestic violence between parents within the home. Information related to exposure to domestic violence, physical neglect, emotional neglect, parental substance abuse and incarceration of a live-in family member was the only data used from this assessment, as only that information that was relevant to this experiment. While research has shown that repeated exposure to violence can lead to violent behavior, the ACEs assessment was used alternatively to see if a single exposure would also predict juvenile sexual offending.

Although many researchers remain skeptical about the validity of retrospective reports of adverse childhood experiences, research generally indicates that the ACEs questionnaire is valid

(Hardt & Rutter, 2004; Wingenfeld, et al., 2011). One study that has regarded the ACEs questionnaire as valid is that conducted by Wingenfeld et al. (2011). In this study, the researchers investigated 102 psychosomatic inpatients, as well as 99 students and 100 adults from the general population. The internal consistency of the ACEs questionnaire was considered satisfying. Furthermore, the researchers found associations between depression, anxiety, and bodily symptoms and the ACEs questionnaire scores within the low to moderate range. Overall, the researchers concluded that the ACEs questionnaire is reliable and valid for the retrospective assessment of adverse childhood experiences (Wingenfeld, et al., 2011). Nevertheless, some research has demonstrated less-than-optimal rates of predictive validity over extended periods (Maughan, Pickles, & Quinton, 1995; Williams 1994).

Several studies that have confirmed the reliability of the ACEs questionnaire, one of which examined a sample of 100 patients (Hardt, Sidor, Bracko, & Egle, 2006). Reliability of reports of family situation, physical abuse, sexual abuse, and protective factors was assessed. The results showed moderate to good reliability for most childhood experiences. Divorce and separation of parents had a score of .95, severe sexual abuse a score of .64, and regular harsh physical abuse a score of .56. Protective factors were in the .50 range. Researchers posited that the key features for obtaining good reliability seem to be the concreteness of the question and accuracy of the coding categories (Hardt et al., 2006).

### **Procedures**

The study consisted of juvenile male individuals, aged 12 to 17 years who were adjudicated on sexual-offense charges. The director of the residential treatment facility collected the majority of the participants' information through a database that the residential treatment program uses called Crediblebh. The remaining participant information was collected by the

director of the residential treatment program from a secure share-drive within the residential treatment facility's database and was converted into a deidentified spreadsheet and returned to the researcher. The information taken from the database in relation to each participant consisted of reason for arrest and post-release recidivism. This information was used to examine the primary hypothesis that early-childhood exposure to domestic violence predicted sexual reoffending. The information was also used to examine other potential predictors (i.e., physical neglect, emotional neglect, family criminal behavior, and parental substance abuse) that may have moderated the effect of exposure to domestic violence on recidivism.

The study focused specifically on arrest data relative to recidivism, instead of conviction data, because when adolescents reoffend, their convictions are often subject to plea bargain, thus possibly limiting the ability to find information on whether the juvenile's offense was initially a crime specific to sexually inappropriate behavior. Additionally, as much research has proved, sexual crimes are often unreported by victims because they fear being blamed or shamed. Data were examined using SPSS. Specifically, a logistical regression was utilized to examine exposure to domestic violence in relation to sexual reoffending.

## Chapter 5: Statistical Analysis and Results

Descriptive analyses were conducted for the entire sample on all demographic variables including age, race, whether the juvenile was raised in a physically and/or emotionally neglectful home, whether the juveniles' parents had any criminal involvement, and whether the juveniles' parents engaged in substance use or abuse, using means and percentages respectively. A logistic regression was used to examine the degree to which exposure to domestic violence (binary independent variable) predicted future juvenile sexual and violent offending (binary dependent variable) during the year following release from court mandated residential treatment. A power analysis estimating a baseline of 15% recidivism, with an alpha of .05 indicated that a sample of approximately 115 participants was necessary to obtain statistical power of .80 in a logistic regression. Correlations between a number of participant variables, including age, race, history of physical and/or emotional neglect, parental criminal involvement, and parental substance abuse, and the dependent variable, criminal recidivism, were examined. Any variable found to be significantly correlated with the dependent variable was entered as a covariate in the logistic regression model. In addition, correlations between these potential moderators were examined to identify any instances of multicollinearity. Finally, to analyze the exploratory hypothesis, a one-way analysis of variance was conducted to examine the between group mean differences in program incident reports for participants who did and did not have prior exposure to domestic violence.

### Participant Demographics

After controlling for the inclusion and exclusion criteria, a total of 67 participants ( $N = 67$ ) were in the data set. As shown in Table 1, the mean age of participants was 15 years ( $SD = 1.40$ ). In terms of race, 37% of participants were Caucasian, 36% African American, 18%

Hispanic, and 9% categorized as “other.” Participants were from nine counties throughout the state of Pennsylvania, with most residents representing Montgomery (38%) and Bucks (34%) counties, and two outliers representing the counties of Cumberland (2%) and York (2%).

Table 1:

*Participant Demographics*

Variable	Mean (SD)/ N (%)
Age (years)	14.96 (1.40)
Race	
African American	24 (35.8%)
Caucasian	25 (37.3%)
Hispanic	12 (17.9%)
Other	6 (9.0%)
County	
Bucks	23 (34.3%)
Chester	2 (3.0%)
Cumberland	1 (1.5%)
Delaware	2 (3.0%)
Lehigh	2 (3.0%)
Monroe	2 (3.0%)
Montgomery	25 (37.3%)
Philadelphia	9 (13.4%)
York	1 (1.5%)

Regarding recidivism, adjudication, and convictions 1-year post-treatment, a total of four participants recidivated. Of the four, two received convictions, and the remaining two were adjudicated for their crimes. In considering the types of recidivism the participants engaged in relative to Hypothesis 1, one participant engaged in violent recidivism, as his crime involved indecent assault by forcible compulsion and theft by receiving stolen property. The remaining three participants did not recidivate through involvement in any violent or sexual crimes. Their crimes consisted of failure to comply with registration as a sex offender, escape, and institutional vandalism of an educational facility (see Table 2).

Table 2:

*Types of Recidivism Committed by Participants one-year Post-treatment*

Outcome	Recidivism Type		
	Sexual % (n)	Violent	Other
Conviction	0 (0)	0	2
Adjudication	0 (0)	1	1

To examine the relationship between independent and dependent variables, and to ensure that there were no instances of multi-collinearity or suppressor variables, a bivariate correlation matrix was computed examining the variables of age, participant-endorsed experience of emotional neglect, indications of exposure to physical neglect, exposure to domestic violence, experience living with a family member suffering from drugs or/or alcohol addiction, and exposure to a live-in family member being sent to jail. As indicated in Table 3, significant associations were found for the relationship between physical neglect and emotional neglect ( $p = .248$ ), domestic violence and emotional neglect ( $p = .285$ ), family incarceration and family addiction ( $p = .220$ ), and recidivism and physical neglect ( $p = .296$ ). Although not a direct correlation, an inverse trend was found between recidivism and domestic violence ( $p = .057$ ).

Table 3:  
*Bivariant Correlation Matrix of Predictor Variables  
 and Participant Demographics*

<b>Variable</b>	<b>Age</b>	<b>Emotional neglect</b>	<b>Physical neglect</b>	<b>Domestic violence</b>	<b>Family addiction</b>	<b>Family incarceration</b>	<b>Recidivism</b>
Age	1.00						
Emotional neglect	.224*	1.00					
Physical neglect	.078	.248*	1.00				
Domestic violence	.003	.285**	.001	1.00			
Family addiction	.006	-.068	.050	.136	1.00		
Family incarceration	-.191	.042	.162	.036	.220*	1.00	
Recidivism	.054	.042	.296**	-.194 <sup>t</sup>	-.093	-.027	1.00
<i>Notes.</i> ** Correlation Significance at $p < .01$							
* Correlation Significance at $p < .05$							
<sup>t</sup> Trend ( $p = .057$ )							

**Hypothesis 1.** Juvenile sexual offenders completing residential treatment will be more likely to recidivate if they were exposed to domestic violence as a child.

Because only four participants recidivated, insufficient variance would not allow a logistic regression analysis. As such, non-parametric analyses were conducted. Originally, it was believed that a higher rate of recidivism would result based on prior research that showed that many adult sexual offenders began engaging in sexually criminal activities during adolescence (Lobanov-Rostovsky, 2015). Participants' exposures to adverse childhood experiences using the ACEs questionnaire were examined in relation to recidivism rates. Results showed that from the total number of participants who recidivated ( $n = 4$ ), none had been exposed to domestic violence ( $n = 0$ ; see Table 4).

**Hypothesis 2:** Being raised in a physically or emotionally neglectful environment, having criminally involved parents, and having parents who use, or abuse alcohol or other psychoactive drugs will moderate the relationship between exposure to domestic violence on recidivism following residential treatment.

The extremely low recidivism rates ( $n = 4$ ) precluded any analysis of the moderator effects posed in this hypothesis. Additional non-parametric analyses showed that of those who endorsed being exposed to emotional neglect during childhood ( $n = 28$ ), 7.1% ( $n = 2$ ) of participants recidivated. When reviewing the participants who indicated exposure to physical neglect, 75% ( $n = 2$ ) recidivated. Of the four participants who recidivated, 3.4% ( $n = 1$ ) endorsed having a family member in the home who suffered from drug and/or alcohol addiction, and 5% ( $n = 1$ ) of participants who had a live-in family member who was sent to jail engaged in criminal activity 1-year post-treatment (see Table 4).



Table 4

*Percentage of Participants with each Predictor Variable Who Recidivated*

Recidivism			
Predictor variable	Yes % (n)	No % (n)	Total (n)
Domestic violence	0% (0)	100% (4)	4
Emotional neglect	7.1% (2)	92.9% (26)	28
Physical neglect	25% (2)	75% (6)	8
Family addiction	3.4% (1)	96.6% (25)	26
Family incarceration	5% (1)	95% (19)	20

**Exploratory hypothesis.** Juvenile sexual offenders currently enrolled in residential treatment who were exposed to domestic violence as a child will be more likely to engage in disruptive behavior and experience difficulty resulting in more incident reports during treatment than those who had no history of exposure to domestic violence.

A one-way analysis of variance revealed no significant differences in mean number of incident reports for individuals who were exposed to domestic violence during childhood ( $M = 70.33$ ,  $SD = 53.07$ ) compared to those who were not ( $M = 57.86$ ,  $SD = 52.76$ ) exposed to domestic violence during childhood ( $p = .47$ ).

## Chapter 6: Discussion

Findings failed to support the primary hypothesis that exposure to domestic violence would predict recidivism 1-year post treatment completion. The extremely low recidivism rates ( $n = 4$ ) precluded any analysis of the moderator effects posed in the secondary hypothesis. In addition, no support was given for the exploratory hypotheses that exposure to domestic violence during childhood would increase the risk of disruptive behavior during treatment. Although the data failed to support the hypotheses posed, significant associations were found for the relationship between physical neglect and emotional neglect, domestic violence and emotional neglect, family incarceration and family addiction, and recidivism and physical neglect. A trend also appeared for the correlation between recidivism and domestic violence.

A plausible explanation for the lack of support for the first hypothesis is the overall limited number of participants in this study and the lower-than-expected rates of recidivism. This limited the range of variance within the study and created findings that are likely unrepresentative of the general public.

Two conceivable reasons are behind the lack of support for the second hypothesis. The first is that recent studies have shown that some individuals with a history of childhood experiences of neglect grow up to become passive and withdrawn as opposed to being physically aggressive (McBride, 2017; Nordqvist, 2018). As such, these individuals may be less likely to sexually or violently recidivate post-treatment. Another possible explanation for the failed support for the second hypothesis is the presence of positive adult role models and the structured environment within the residential treatment facility. Studies have shown that for some children who are raised in neglectful and negative home environments, positive relationships with other adults may help to reduce the effects of exposure to their negative experiences (Hurd,

Zimmerman, & Xue, 2009). Thus, living in a residential treatment facility with structure, consistent positive reinforcement, consequences for one's actions, and dependable adults who are available around the clock likely has been effective in minimizing the effects of the participants' past negative experiences, in turn reducing their chances of acting out and recidivating.

Similar to the second hypothesis, lack of support for the exploratory hypothesis may have resulted from the therapeutic environment. Social learning theory states that children emulate the behavior that is modeled for them (Bandura & Walters, 1977). Given that the staff at the residential treatment facility model appropriate behaviors, participants may have been less likely to become physically aggressive or exhibit sexually inappropriate behavior within the facility. This information is supported by the findings regarding the incident report data, as the vast majority of incident reports reflected antagonism and a failure to following staff instruction. Additionally, incident reports related to disruptive sexual behaviors did not include sexual acting out or aggressive behavior, but rather making lewd comments.

### **Limitations**

This study has a number of limitations to be considered, including (a) generalizability; (b) the inclusion of all children who have completed the program, either successfully or through being deemed a FTA; (c) the use of a self-report assessment; (d) internal validity; (e) and lack of statistical power. In terms of generalizability, findings of this study could be affected by the statutes of the state of Pennsylvania. Individuals referred to the residential treatment program are generally arrested in Pennsylvania, and therefore, their arrests, charges, and sentences may all be impacted by unique statutes that apply to this state but may otherwise not pertain to surrounding states. For example, according to the state of New Jersey Department of Law and Public Safety

(2017), the age range to qualify for sex offender treatment as a juvenile begins at age 14 years versus the treatment age of 12 years in the state of Pennsylvania. As such, findings may not extend to other states for many reasons including age.

Another limitation relative to generalizability is the specific facility from which the data are collected. The residential treatment facility houses male juveniles who have been convicted of sexual offenses. Therefore, these results are generalizable to juveniles who have committed crimes other than those of a sexual nature, even if they have been exposed to domestic violence or experienced any of the other adverse childhood experiences considered to moderate exposure to domestic violence. Additionally, because the residential treatment center focuses on treatment of specific sexually problematic behaviors, instead of punishing the children for their offenses, using these results to gauge treatment outcomes of children who are in juvenile detention facilities may be difficult, as the residents may receive very little clinical treatment while detained. Moreover, treatment in juvenile detention centers may differ in terms of the focus and format of the therapy. A final limitation regarding generalizability is the inclusion of successful completers and those deemed a failure to adjust in the study because including all residents causes the findings from the study harder to generalize to research that has focused solely on either successful or non-successful completers of residential treatment programs.

Including juvenile sexual offenders who were deemed a FTA and sent back to juvenile detention could have also negatively impacted results of the study given that those deemed FTA would experience a disruption in their sexual offender therapeutic treatment. As a result, findings may show higher rates of recidivism than could have been the case had only those who successfully completed treatment been included. Additionally, the juveniles who were deemed FTA and sent back to juvenile detention could have subsequently been released back into the

community at an earlier date than the researcher is aware of. Residents may have more opportunity to recidivate if they are released directly into the community upon leaving juvenile detention. Conversely, while keeping more severe offenders in the study may have skewed the results, keeping them in the study may have been the best approach, as those who successfully completed the program may have represented juveniles who did well in treatment because they may not have actually needed such an intense level of care.

The self-report format of the ACEs questionnaire may ultimately diminish its reliability. Although many studies have yielded results that support the ACEs questionnaire's reliability and validity, other studies have demonstrated some limitations to the instrument's reliability. For example, in a study conducted by Williams (1994), the validity of the ACEs questionnaire was examined with 129 women reporting histories of childhood sexual abuse. The majority of the sample was African American (86%) and had received treatment for documented severe childhood sexual abuse. Results of the study showed that upon being reinterviewed approximately 17 years after having been treated for sexual abuse, 62% of the women reported initial sexual abuse experiences that were consistent with documented abuse from the past (Hardt & Rutter, 2004; Williams, 1994).

Additional results showed that about two-thirds of the women reinterviewed about their experiences of severe sexual abuse reported sexual victimizations other than those originally recorded – in addition to or instead of the original event (Hardt & Rutter, 2004; Williams, 1994). Abuse reports of this kind could have been made as a result of the women being told that they were being re-interviewed as a follow-up of women who had received medical care at their local city hospital. Being reinterviewed could have led them to experience unusually high recall of

past events that could have been repressed or forgotten and therefore, not previously reported (Hardt & Rutter, 2004; Williams, 1994).

Further examination of the validity of the ACEs questionnaire was conducted by Maughan et al., (1995). In their longitudinal study, the researchers combined high-risk and general population samples, with parental accounts of parental negativity in childhood in an effort to survey on sexually problematic behaviors, the ways by which the behaviors in childhood (Maughan et al., 1995). Factor analyses showed that the rates of parental negativity were approximately 20%, and lower on retrospective reporting ranging from 10 to 15% (Maughan et al., 1995). The overall level of agreement over time was low, with kappa values of .19 to .24. Findings showed that when the participants recalled minimal negativity, concurrent accounts usually agreed (a false negative rate of .15 to .18). However, when they reported the presence of negativity, accounts often disagreed (a false positive rate of .59 to .65), despite higher rates of negativity reported by parents (Maughan et al., 1995). These results show that in longitudinal studies, sometimes validity can be diminished, and memories can be less valid.

When considering internal validity, many factors may affect results of the study, including (a) the specific treatment track that the resident is on; (b) the therapist who is providing treatment to each resident; (c) and randomization of the study participants. Residents' treatment track can have an immense effect on the study's internal validity, as many residents come to the program with various aspects that contribute to their offending. For example, some children are on the trauma focused track. Assignment to the trauma focused track means that a large part of their treatment will have an emphasis on their trauma and how their experiences have led them to offend. Other residents have issues with controlling arousal and therefore work with therapists on controlling arousal and identifying healthy arousal and ways to cope when aroused.

Some residents also who receive additional therapy that focuses on social skills and healthy relationships, as some children have never learned pro-social ways of interacting with others and therefore lack knowledge about appropriate social interactions such as appropriate touch and personal space. Although every juvenile will have standard therapy in terms of group counseling and focusing on sexually problematic behaviors, the ways by which the behaviors are worked through will largely incorporate the resident's history and any additional needs that have factored into his or her behavior.

The particular therapist working with the residents is also an important factor that may limit the results of the study. Some residents may fare better with a same-sexed therapist because they are more comfortable with talking about their sexual behaviors with a male therapist than with a female therapist and vice versa. Additionally, the therapeutic style of the therapist also impacts the alliance and rapport with the client and therefore affect the treatment. Furthermore, working with various therapists who specialize in or focus on specific portions of the residents' treatment can also impact the results, as work with numerous therapists provides residents with various forms of clinically therapeutic care, each aimed at treating sexually problematic behaviors and their underlying causes.

Lack of a randomized study was also a limitation, as there is difficulty with estimating the sample variability and identifying possible bias in the sample obtained. Additionally, reliability cannot be measured other than by comparing the results with available information about the population. Moreover, an unknown portion of the population that is not included in the sample group, lending itself to issues with generalizability to the population being studied.

Finally, and perhaps most importantly, the insufficient statistical power coupled with the limited variance in outcomes (i.e., recidivism) also posed a substantial limitation to this study.

The insufficient power and limited variance most certainly impacted the ability to detect any significant findings for the primary hypotheses, and precluded analysis of the secondary hypothesis.

### **Future Directions**

In considering additional research on this population, both the mental health and criminal justice field researchers could examine the link between violence and recidivism of other crimes as a function of domestic violence. Researchers may also want to study the link between exposure to domestic violence and recidivism in different age groups, as these topics have been studied by previous examiners. Conducting a similar study in another state would also be helpful for future research, as laws in Pennsylvania relative to juvenile sexual offending and treatment may differ from those in other states. Viewing the link between exposure to domestic violence and recidivism in female juvenile sexual offenders would help to expand knowledge on treatment of juvenile offenders of the opposite sex and may also highlight the similarities and difference in factors that contribute to sexually problematic behaviors in juveniles. Lastly, conducting a longitudinal study on this population that examines 2 or more years of recidivism data would be beneficial in possibly obtaining a larger sample size and ultimately obtaining statistical significance regarding the relationship between exposure to domestic violence and recidivism.

### **Advocacy**

In addition to expanding research relative to this population, professionals in the mental health and criminal justice fields should become involved in advocating for this population. Very few of these adolescents have the support they need to excel post-treatment, given the societal stigma attached to being labeled a sexual offender. Lack of support combined with the societal



stigma often leads to difficulty in accepting that they will be labeled as sexual offenders indefinitely and fear of how individuals in society will respond to them upon release. In a study conducted by Shultz, it was found that more than half of all convicted sex offenders fear re-entry into society because of the stigma they anticipate enduring from those within their communities.

Along with being labeled as sexual offenders, the majority of these adolescents often suffer from a mental illness stemming from their own experiences of trauma (Jencks & Leibowitz, 2018). The stigma associated with having a mental health diagnosis will likely compound the effects of the discrimination that these teens will experience as a result of their criminal charges. Additionally, since this is an adolescent population, they possibly will have years of obstacles to overcome in order to live a fairly normal life upon release from treatment. According to Shultz (2014), persons with combined sexual offense charges and mental health diagnoses have a greater likelihood of being homeless as a result of issues with finding housing and employment. These individuals are also much more likely than individuals who have committed other types of crimes to be abandoned by their families as a result of loved-ones' embarrassment and fear for their own safety in relation to being associated with a known sexual offender (Shultz, 2014).

Bearing in mind the aforementioned information, professionals in the field of psychology and criminal justice should advocate for persons convicted of sexual offense charges in various ways. Specific forms of advocacy may involve conducting research that highlights the necessity and utility of rehabilitation for sexual offenders. Additionally, research identifying residential treatment programs as an alternative to prison for specific classifications of sexual offenders may also serve as an important avenue of advocacy for convicted and adjudicated sexual offenders.

In addition to the fields of psychology and criminal justice advocating for this population, adjudicated offenders within this population must be assisted in learning to advocate for themselves. Mental health professionals can assist these adolescents in identifying and acknowledging their offenses while in therapy, as doing so is the first step toward rehabilitation. Mental health professionals can also help this population to identify cognitive distortions related to their offenses and the persons victimized, as well as distortions related to their mental illnesses. Apparently, working on these problem areas will serve to indirectly combat or reduce the stigma surrounding this populations' criminal charges and mental illnesses, as they will be better prepared to explain their actions and how they have worked through them to become productive members of society.

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