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EFFECTIVENESS OF UTAH LEVEL SIX TREATMENT PROGRAMS
FOR JUVENILE MALES WHO OFFEND SEXUALLY:
THE CLIENT PERSPECTIVE

by

Darren B. Brown

A thesis submitted in partial fulfillment
of the requirements for the degree

of

MASTER OF SCIENCE

in

Family and Human Development

ABSTRACT

Effectiveness of Utah Level Six Treatment Programs for Juvenile Males
Who Offend Sexually: The Client Perspective

by

Darren B. Brown, Master of Science

Utah State University, 2003

Major Professor: Dr. D. Kim Openshaw
Department: Family, Consumer, and Human Development

This study examined treatment effectiveness from the perspective of former clients of Utah level six treatment programs for juvenile males who offend sexually. Employing an anonymous, self-reported instrument, this study identified a high level of sexual recidivism (44%). In obtaining client perceptions of treatment effectiveness, this study also differentiated between the various components of level six treatment. Individual therapy was rated highest by the clients in helping them in their subsequent efforts not to recidivate. Drug and alcohol treatment received the lowest overall score, while remaining very important in the eyes of a few subjects. This suggests that clients benefit differently from the various components of treatment, and that it might be better to implement some components on an as-needed, case-by-case basis. Family involvement remains an important part of comprehensive treatment within the level six

system, acting as a bridge between their residence in treatment and their returning home. This study, though limited by its small sample size, suggests that the client's perspective, a previously overlooked source of information, can make a valuable contribution to the study of treatment effectiveness for juvenile males who offend sexually.

(127 pages)

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Darren B. Brown

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CHAPTER I

INTRODUCTION

Knowledge within the field of juvenile sexual offending has grown exponentially over the past several decades. Researchers originally recognized sexual behaviors among adolescents in the late 1940s. This recognition was general, however, as no differentiation was made between predatory and other sexual behaviors. Thus, sexual behaviors that are today considered to be crimes were initially misunderstood as being mere acts of immorality, and were generally considered to be harmless behaviors characteristic of normal adolescent development.

As society became more aware of juvenile sexual behaviors, researchers began examining the prevalence of these behaviors more closely. Empirical data suggest that approximately 20% of all rapes and as much as 50% of all sexual assaults on children are committed by adolescents (Barbaree & Cortini, 1993). Hand in hand with the recognition of the prevalence of juvenile sexual offending was the identification of its potentially devastating consequences on the entire social ecosystem. Individual victims suffer a host of both short-term and long-term effects of sexual offenses, such as anxiety, depression, and difficulty in relationships. The families of victims and of those who offend suffer from enervated relationships, and society, in turn, reaps the enormous economic costs of treatment, as well as interpersonal mistrust and fear.

The conceptualization of juvenile sexual offending was long in coming, however, as it took decades for the accumulating research to do away with the longstanding belief that juvenile sexual offending was an insignificant problem in society. Not until the

1980s did programs and organizations dedicated to the treatment of juvenile males who offend sexually (hereafter referred to as JMwOS) come into being. Beginning in the early part of that decade, the number of available treatment programs increased significantly as a result of the universal conviction that early intervention would be most effective in realizing the goal of eliminating sexual offending from society (Freeman-Longo, Bird, Stevenson, & Fiske, 1994). Now, with the proliferation of treatment programs locally and nationally, there is a desperate need to evaluate the effectiveness of existing programs; not only for purposes of funding, but more importantly so that treatment may become more effective in minimizing the risk of reoffense, and ultimately reduce the prevalence and effects of sexual offending in society.

Treatment programs have typically been evaluated through either program implementation studies or outcome research. Implementation studies are important in evaluating treatment programs, in that they examine the degree to which programs fulfill their intended design, as stipulated by various governing authorities. While implementation studies examine which components of treatment are being executed as planned, they do not provide information on the utility of these components in reducing or eliminating the behaviors presented for treatment. Outcome evaluation studies, on the other hand, usually evaluate treatment programs' effectiveness by examining client arrest records following treatment. Therefore, treatment programs have been deemed effective if clients who complete the programs have significantly fewer arrests than they did prior to treatment. This measure of recidivism is inadequate, because there is a significant under-

reporting of sexual crimes.¹ Moreover, recidivism is an inadequate measure of treatment effectiveness because a client may choose not to recidivate solely to avoid being placed in residential treatment again. Moreover, recidivism rates, by themselves, tell us nothing about the reasons why former clients choose to recidivate or not to recidivate.

In order to get a more complete picture of what constitutes effective treatment, existing evaluation literature needs to be supplemented by studies that look at the effectiveness of treatment in additional ways. The completed study incorporated a third method of evaluation by obtaining former clients' perceptions of treatment. By asking former clients about their treatment can we get a clearer understanding of their motives to not recidivate, as well as which components of treatment are most effective. Specifically, this study used an anonymous self-reported instrument asking former clients of Utah level six treatment programs to evaluate various aspects of their treatment programs. Level six programs are nonsecure residential programs designed to treat "adolescents with patterned, repetitious sexual offenses and acting out behavior" (Network on Juveniles Offending Sexually, 1996, p. 15).

While this study acknowledged that former clients may have recidivated since leaving treatment, an underlying assumption was that former clients will have had opportunities to recidivate in which they chose not to. The goal of this research was to

1

Definitions of recidivism are varied in the existing body of research, and often consider relapse into any illegal or maladaptive behavior as constituting recidivism. This study attempts to differentiate between sexual and nonsexual recidivism. Sexual recidivism, as opposed to nonsexual recidivism, is defined as relapse into illegal or maladaptive *sexual* behaviors.

identify what role, if any, specific components of treatment have played in their efforts to not recidivate, and to identify the relative effectiveness of each of the components of treatment. The following four research questions were addressed.

The first question was designed to identify whether treatment in general was helpful in preventing recidivism. The question was, "Is Utah level six treatment of JMwOS effective?" Because the subject base for this study included all those former clients of Utah level six treatment programs, whether or not they completed treatment, the question was answered by comparing the rate of recidivism of those who graduated from treatment to the recidivism rate for those who left treatment for other reasons. Clients were asked if they successfully graduated from treatment and whether or not they had been involved in any behaviors that would constitute recidivism. The hypothesis stated that graduating from treatment has no effect on subsequent rates of recidivism.

It has been suggested by several researchers (Camp & Thyer, 1993; Worling & Curwen, 2000) that there is a need for studies that look at specific aspects of treatment, rather than merely evaluating treatment outcome in general. Addressing this need, the second question answered by this study was, "What are the most effective components of Utah level six treatment of JMwOS?" Clients were asked to rate the effectiveness of individual components using a 5-point Likert scale. They were also asked which component was most helpful and why. The hypothesis stated that all components of treatment are perceived to be equally effective.

Graduates and nongraduates may differ in their perceptions of the effectiveness of various components of treatment. The third question was, "Is there a difference between

the perceptions between graduates and non-graduates as to the effectiveness of various components of treatment?" The hypothesis stated that there is no difference between the perceptions of graduates and non-graduates.

Of particular interest in this study was identifying the effectiveness of collateral therapy in treatment. Collateral therapy is therapy in which members of the client's family or other significant persons are included. Family involvement in therapy is crucial to the prospect of successful treatment, because the problem of juvenile sexual offending is multidimensional in nature, and because one objective of treatment is to have the client return to their family whenever possible. The fourth question was, "How effective is collateral therapy as a component of Utah level six treatment of JMwOS?" Clients were asked questions about collateral therapy during treatment, in which they indicated its effectiveness and why or why not they believed it was helpful. The hypothesis stated that collateral therapy has no effect on the effectiveness of treatment.

CHAPTER II

LITERATURE REVIEW

Juvenile Males Who Offend Sexually: The National Perspective

The development of the field of juvenile sex offending can be described as having occurred in four phases: recognition, conceptualization, intervention, and treatment evaluation. While these phases are not mutually exclusive, they provide a general chronology of how our understanding of juvenile sex offending has evolved.

Recognition

While a few professionals recognized deviant sexual behavior in adolescents as early as the late 1940s, the behavior was not initially understood to be a significant societal problem. Rather, the behavior was perceived as a "boys will be boys" phenomenon. Due to the limited knowledge and understanding about juvenile sexual behavior, the behavior was severely downplayed prior to the 1970s. For example, Markey (1950) categorized juvenile sexual offenses as acts of immorality rather than crimes.

Knowledge about juvenile sexual offending grew very slowly, as evidenced by the limited number of published articles on the subject prior to 1980. Before 1970 there were only nine studies that addressed the issue of juvenile sexual offending, most of which were based on popularly held myths about adolescent sexual behavior. The 1970s only produced an additional 10 studies (Barbaree, Hudson, & Seto, 1993), with the prevailing

notions still dominant. For example, Roberts, Abrams, and Finch (1973) thought juvenile sexual offenses to be relatively minor crimes associated with sexual maturation and curiosity. It was not until the early 1980s that society in general recognized juvenile sexual offending as a significant societal problem. A surge of literature in the 1980s, both from research and the popular press, brought about an understanding of juvenile sexual offending as a problem with negative sequelae.²

With the understanding that juvenile sexual offending was a problem that carried with it various negative effects, efforts began to identify the prevalence of juvenile sexual offending in society. Prevalence has generally been understood in two ways: by victim reports and by perpetrator rates.

Prevalence: victim reports. Child victimization studies estimate that between 10 and 40% of all girls and boys will be sexually abused during childhood (Russell, 1983). While these findings are alarming, they become even more so when the staggering number of juveniles who commit these crimes is taken into consideration. According to a study by Groth and Loredó (1981), 56% of all cases referred to the Child Sexual Abuse Victim Assistance Project in Washington, DC involved juveniles as those who committed the offenses, most of whom were between 14 and 16 years of age. Similar studies have

2

While female sexual offending is acknowledged by the current body of literature, and is a growing area of study, the vast majority of research on juveniles who offend sexually is conducted on males. This is probably due to the difficulties in obtaining sufficient research samples of female offenders, as they make up only 5% of sexual offense cases (Camp & Thyer, 1993). Thus, nearly all literature cited herein refers exclusively to the males who have offended sexually.

found that adolescents are responsible for a slightly more conservative 30-50% of all sexual offenses committed on children (Barbaree et al., 1993).

The existing data from victimization studies become even more troubling when held in light of the many findings that show that sexual crimes are often not reported. With the problem of underreporting of sexual crimes, it is hard to say just how many victims of sexual offenses there are in any given population. While adults who offend sexually admit to having dozens of victims (National Task Force on Juvenile Sexual Offending, 1993), it has been suggested that untreated adults may offend up to 300 times (Graves, 1993). And while JMwOS admit to having an average of eight victims (Ryan, Miyoshi, Metzner, & Fryer, 1996), untreated adolescents may have more than 380 sexual offenses over their lifetime (Abel, Mittleman, & Becker, 1985).

Prevalence: perpetrator rates. Surveying a general population of juvenile males, Ageton (1983) found that between 2 and 4% of all juvenile males admitted to sexually assaulting another person. In reviewing numerous additional prevalence studies, it was found that juveniles are responsible for between 10 and 30% of all rapes and between 18 and 50% of all sexual offenses in general (Barbaree & Cortini, 1993; United States Department of Justice, 1992). As with child victimization reports, studies that examine juvenile perpetrator rates may also underestimate the actual number of offenses, because a socially adept juvenile who offends may successfully evade being caught altogether.

Despite problems in obtaining accurate estimates, the prevalence of juvenile sexual offending in society has been adequately established to cause concern and warrant further investigation. Moreover, many studies have shown the prevalence of juvenile

sexual offending to have dramatically increased over the years. It should be noted, however, that the apparent increase in prevalence can be largely attributed to the evolution of the definition of juvenile sexual offending. Early definitions of juvenile sexual offending were narrow and only considered juvenile sexual behaviors to be crimes if rape was involved, thus ignoring the true breadth of the phenomenon (NOJOS, 1996). Reflecting this early definition of sexual offending, some states originally disallowed boys under 14 years of age to be convicted of sexual offenses because of the belief that they were incapable of sexual penetration (Groth, 1980). More recent definitions of juvenile sexual offending are much wider in spectrum, including inappropriate sexual touching, frottage, and even "hands-off" offenses such as voyeurism and exhibitionism (NOJOS, 1996).

In the decades preceding 1980, very little was known about the problem of juvenile sexual offending. Prevalence studies in the early 1980s helped do away with the commonly held notion that juvenile sexual offending was merely a rite of passage, unobtrusive to society. This was an important first step toward a better understanding of juvenile sexual offense and its subsequent treatment.

Conceptualization and Theoretical Framework

As the significance of juvenile sexual offending became formally recognized, concerned individuals began making efforts to conceptualize the phenomenon and to intervene in the lives of those who have offended. Among those individuals whose seminal works formed a basis for the conceptualization of juvenile sexual offending are

Nicholas Groth (1977), Robert Freeman-Longo (1981), Gail Ryan (1987), and Judith Becker (1988).

While early attempts at conceptualization were being made by these and other researchers, several national organizations were formed that furthered the efforts to conceptualize juvenile sexual offending. The Association for the Treatment of Sexual Abusers (ATSA) was incorporated as a nonprofit organization in 1984 by a small group of clinicians who were working with individuals who had offended sexually. Now with a membership of over 2,000 professionals, ATSA (2001) is dedicated to the advancement of professional standards and practices in the field of evaluation and treatment of those who offend sexually. Created in 1985, the Safer Society Foundation (2001a) is a national research, advocacy, and referral center on the prevention and treatment of sexual abuse. The Safer Society was incorporated as a non-profit organization in 1995 and conducts ongoing surveys on intervention strategies being used in treatment of those who offend sexually. An additional nationwide collaborative effort began in 1986 with the formation of the National Task Force on Juveniles Sexually Offending (1993). This organization examines current knowledge in the field and makes recommendations regarding treatment standards and procedures.

Over the years, various theories have been used as frameworks for describing juvenile sexual offending. Some of the more prominent theories found in the early literature include psychodynamic theory (Briggs, Doyle, Gooch, & Kennington, 1998), evolutionary theory (Thornhill, & Thornhill, 1983), feminist theory (Scully, 1990), and various learning theories (Wolfe, 1985). As the literature base grew, it revealed the

complex nature of juvenile sexual offending, and theorists began to emphasize the importance of using a more systemic perspective. Thus, systems theory, ecological theory, and integrated theories have become more popular in more recent literature (Becker, 1998; Swenson, Henggeler, & Schoenwald, 1998). The tenets of systems theory served as a guide for this study. A systems perspective offers a more comprehensive understanding of the problem of juvenile sexual offending by considering the problem within a larger context. Using a systems approach may lead to a more thorough understanding of the characteristics of those who offend and the effects of their actions, both on their immediate victims and on society. Systems theory also offers a rationale for seeking the perspective of the former client regarding their treatment. According to systems theory, not only to people act in a dynamic context, but people act based on personal meanings derived from interactions with that context. Communication is also fundamental to systems theory, because communication is how information is exchanged and reciprocated among members of a system. Collateral therapy, of particular interest in this study, examines these exchanges and seeks to improve the relationships existing within a given system.

Characteristics of those who offend. Since the mid 1980s conceptualization efforts have focused largely on identifying predictors of juvenile sexual offending, as well as understanding its effects. It was the hope of many researchers that by examining characteristics of those who offend they would be able to predict who would offend sexually and who would not. While these efforts resulted in a few typologies (Graves, 1993; Knight & Prentky, 1993; Weinrott, 1996), a large portion of the profiling literature

shows juveniles who offend sexually to be a heterogeneous group of individuals, making it difficult to place them in distinct categories. Blanchette's (1996) conclusions on this matter reflect those of many authors:

Sexual aggression is a complexly-determined phenomenon, with varied antecedents and sequelae. Perpetrators of sexual crimes differ in their personal and criminal histories, the circumstances preceding their offenses, their victim age and gender preferences, the attitudes and beliefs that support their deviant behavior, and the degree to which they have used force or brutality, or caused physical harm to their victims. Thus, sexual offenders are a heterogeneous group of individuals, with diverse evaluative and treatment needs. (p. 4)

While many authors consider juveniles who offend sexually to be a heterogeneous population, others have identified characteristics that do appear to be common among JMwOS. Juveniles who offend sexually tend to be male (Camp & Thyer, 1993). Several studies have shown that between 28 and 50% of JMwOS have a history of other criminal activity (Becker, Cunningham-Rathner, & Kaplan, 1986; Kahn & Chambers, 1991). JMwOS tend to have psychiatric problems (Awad & Saunders, 1989) and deficiencies in social competence and assertiveness (Becker & Abel, 1985). Related to their lack of social competence and assertiveness is their difficulty with intimacy (Groth, 1977) and their tendency toward social isolation (Fehrenbach, Smith, Monastersky, & Deisher, 1986). Many studies have found that JMwOS are often victims of sexual abuse themselves, with estimates upwards of 60 to 90% (Knight & Prentky, 1993). It is important to note, however, that some authors argue that a higher prevalence of abuse history among JMwOS is a myth, in that their studies found no difference in abuse history between populations of JMwOS and juveniles who offend nonsexually (Awad &

Saunders, 1991; Benoit & Kennedy, 1992). Taking the entire population of sexual offense victims into consideration, research has estimated that approximately one third of all victims will subsequently perpetrate sexually (Graves, 1993). Resiliency studies in general suggest that one third of individuals who live in at-risk conditions suffer various psychological effects, while another third are resilient (Werner, 1984).

Families of those who offend. Taking the family system of those who offend into consideration, one of the most commonly reported findings about characteristics of JMwOS is that they most often come from troubled families. Observing family characteristics of JMwOS, Awad, Saunders, and Levene (1984) identified several problems, including a history of domestic violence, parental drug and/or alcohol abuse, a history of sexual deviance, and ongoing occurrences of abuse. In another family characteristics study, Johnson (1988) found that over 70% of the JMwOS in her study had at least one alcoholic parent. In a study conducted by DeMartino (1988), adolescents' perceptions of family functioning were measured. Compared to nonoffending juveniles, those who had sexually offended perceived their families to be far more disengaged. In another study examining perceptions of JMwOS of the family environment, Eastman and Evans (1996) found that JMwOS perceived their family relationships to be less cohesive, less emotionally supportive, and more conflictual than a nonoffending comparison group.

Most of these characteristics are similar to those of adults who offend sexually. However, there are some characteristics, such as lack of social competence and assertiveness, that do show up more often in JMwOS than in adults (Boyd, Hagan, &

Cho, 2000). This needs further empirical consideration, because it could be argued that some of these characteristics show up more often in juveniles merely because of their developmental nature. This argument aside, one particularly concerning difference between adults who offend and juveniles who offend is that sexual crimes committed by JMwOS tend to be more frequent and more violent in nature than those committed by adults (Elliot & Smiljanich, 1994; Zolondek, Abel, Northey, William, & Jordan, 2001).

While there appear to be some characteristics that distinguish JMwOS from other populations, typology research has been riddled with problems, and thus no clearly demarcated typology has emerged. Concurrent research examining the effects of juvenile sexual offending, on the other hand, has been able to produce a fairly clear picture of its devastating effects.

Ecosystemic effects of offending. The ecosystemic perspective on juvenile sexual offending identifies both primary and secondary victims. Primary victims of sexual abuse experience both short-term and long-term effects. Some of the more commonly reported short-term effects include headaches, anxiety, fear, sleep and eating disturbances, anger and hostility, and behavioral problems (Barbaree et al., 1993; Koss & Heslet, 1992). While these and other short-term effects may be alleviated with time, the more debilitating long-term effects of sexual abuse may defy even extended treatment. Long-term effects often cited in the literature include chronic pain, high distress levels, low self-esteem, depression, difficulty in social relationships and sexual intimacy, social isolation, problems trusting others, posttraumatic stress disorder, psychopathology, and other emotional and psychological problems (Briere & Runtz, 1993). Child victims of

sexual abuse are at increased risk for long-term effects of sexual abuse, because their recovery process becomes complicated with the progression through various developmental stages (Conte, 1991; Pilkonis, 1993).

Worthy of note are the effects of sexual abuse on other parts of the ecosystem of individuals who offend sexually. Whether by the inability of victims or of those who offend to form good relationships with their own families, or by the increased likelihood that victims will offend sexually themselves (Ryan et al., 1996), the problem is perpetuated throughout the societal system. The cost of sexual offending incurred by society is enormous and includes various medical and psychological services provided to aid victims in recovery; the investigation, trial, and incarceration or treatment of those who offend; and citizen's fears of becoming victims themselves. Taking economic factors into consideration, Kaufman, Hennig, Daleiden, and Hilliker (1996) estimated the cost to society of each victim-perpetrator pair to be \$189,949. The Corrections Compendium (1991) conducted a national study and found that 85,647 individuals who had offended sexually were incarcerated, costing the United States over \$2 billion in that year alone. These data merely serve to reinforce the commonly held opinion that incarceration is only a temporary solution to the problem of sexual offending, in that it fails to address the underlying pathology of sexual offending. The universal conviction that specialized intervention is necessary in order to reduce the prevalence of sexual offending in society fostered the development of treatment programs for JMwOS.

Intervention

While the conceptualization of juvenile sexual offending continues even today, the literature base extant in the early 1980s provided sufficient evidence for the need to intervene in the lives of juveniles who offend sexually. Because the goal of any intervention is the elimination of an identified problem, and the literature had already identified the problematic characteristics and effects of sexual offending, the objective of treating JMwOS is to eliminate recidivism.

Recidivism. Due to the wide variations of definitions of recidivism, estimates of recidivism of JMwOS range from zero to 50% (Weinrott, 1996). Most of the early literature defined recidivism as a conviction on another sexual offense following treatment. Because many researchers thought this to underestimate the actual number of reoffenses, later definitions included any subsequent convictions, whether for sexual or nonsexual offenses (Furby, Weinrott, & Blackshaw, 1989; Gibbens, Soothill, & Way, 1981). The current study, in contrast, defined recidivism as any self-reported criminal offense following treatment, while differentiating between sexual and nonsexual offenses.

Researchers have tried to find ways to predict recidivism among JMwOS, because there is a growing concern over predicting recidivism, and mental health professionals frequently are asked to make decisions regarding the likelihood that a particular client will recidivate. While there are studies on predicting recidivism among nonsexually offending juveniles (Loeber, 1990), and among adults who offend sexually (Hanson & Harris, 2000; Hersh, 1999), literature on predicting recidivism of JMwOS is sparse. Some of the factors that appear to be related to recidivism of JMwOS include poor social

skills (Langstrom & Grann, 2000), a history of nonsexual offenses (Kahn & Chambers, 1991), being younger in age (Sipe, Jensen, & Everett, 1998), and having younger, male victims (Langstrom & Grann, 2000; Ryan & Lane, 1991; Worling & Curwen, 2000). Similar findings from additional research have been helpful in creating instruments for predicting recidivism of JMwOS, and many promising efforts are being made along these lines (Hanson & Thornton, 2000; Moore & Bergman, 1999; Quist & Matshazi, 2000; Righthand, Prentky, Hecker, Carpenter, & Nangle, 2000).

Treatment of JMwOS, then, aims to eliminate recidivism of sexual offense behaviors, and thus prevent the formation of inveterate patterns of offending in adulthood. Stenson and Anderson (1987) emphasized the importance of early intervention for JMwOS:

If treatment is effective in reducing deviant behaviors among juvenile offenders, then treatment of the juvenile could go a long way toward reducing the impact of sexual assault in our society. The literature not only suggests a progression from less to more serious offending but also provides an appalling picture of the damage being perpetrated by these young men. The argument that treatment should be directed toward the juvenile offender is made more potent by the suggestion that early intervention might be more efficacious, as it has the potential to treat the problem in an individual before the behavior becomes more entrenched in adulthood. (p. 11)

With this recognition, the number of treatment programs for JMwOS increased significantly through the mid 1990s.

Treatment modalities. Programs dedicated to treating JMwOS began as early as 1975 (Knopp, Freeman-Longo, & Lane, 1997), although initial efforts were not well guided by theory. As the body of literature grew, so did the number of available

treatment programs. While there was only one treatment program for JMwOS in 1975 (Knopp, 1985), by 1982 this number had grown to 22, by 1988 to over 500, and by 1992 to 755. Over 1,000 programs were identified by 1994 (Freeman-Longo et al., 1994) and 1380 by 1996 (Safer Society Foundation, 1996). Disturbingly, since 1996 the number of available treatment programs has dropped 41%, according to a recent report by the Safer Society Foundation (2001b).

Treatment programs vary in how they go about treating JMwOS. Early on, many treatment programs used a strictly behavioral model for treatment in which sensitization and satiation were used to counter condition deviant stimuli so that they would lose their capacity to reinforce sexual behavior (Dougher, 1995). Another common model of treatment is social skills training. In 1994, Freeman-Longo et al. (1994) found that 92 of existing programs used social skills training as a component of treatment. Sex education is also used as a major component of treatment programs (Abel, Osborn, Anthony, & Gardos, 1992). Probably the most popular model of treatment is cognitive behavioral therapy. Up to 96% of treatment programs use its techniques (Freeman-Longo et al., 1994), which focus on the thinking errors and dysfunctional thought patterns that drive the "sexual assault cycle." Freeman-Longo et al. (1994) also found that 39% of treatment programs use relapse prevention techniques, which aim at increasing self-awareness and control. In recent years researchers have also been looking at the utility of medication as a component of treatment of JMwOS (Lehne, Thomas, & Berlin, 2000).

Today, more programs are moving toward multimodal treatments, as more comprehensive treatments are being recommended by researchers, and are mandated by

practice standards (Marshall, & Pithers, 1994; NOJOS, 1996). For example, the Western Region Division of Child and Family Services (1996) stipulates that treatment programs include the following in their treatment of JMwOS: (a) cognitive strategies, (b) skills development, (c) behavioral strategies, (d) sex education, (e) group therapy, (f) individual therapy, (g) family therapy, (h) adjunct therapy as needed, and (i) recreation.

Of particular note are the stipulations for family and other multisystemic therapies in the treatment of JMwOS. As research on JMwOS has accrued, the picture that has developed shows juvenile sexual offending to be a complex, multidetermined phenomenon, existing in and affecting the larger system surrounding the victim and the offending juvenile. Thus, many researchers have emphasized that successful treatment of JMwOS requires family and multisystemic therapy. Because one of the primary goals of residential treatment is to place the adolescent back in their family of origin, if possible, family therapy in particular is seen as a crucial component of successful treatment of JMwOS. By working with the family system, family therapists can help eliminate patterns that may have contributed to the adolescent's offending behavior, and can help the family become the supportive network that the adolescent needs upon returning to the family and community systems at the completion of treatment. As Swenson et al. (1998) have argued,

[The prevailing individually oriented] treatment approaches for adolescent sexual offenders may not be effective for several reasons. First, these models do not address the known correlates of adolescent sexual offending in a comprehensive fashion. Second, existing treatments do little to change the natural environments (i.e., social ecologies) of youths in ways that support the development of healthy adaptation and attenuate risks for reoffending. Third, studies of individually oriented treatments for other

types of serious antisocial behavior. . . have not demonstrated effectiveness. Rather, we propose that multifaceted treatments that address the known risk factors for sexual offending with ecological validity hold the most promise for obtaining successful outcomes with this challenging population. (p. 330)

Multisystemic and family therapies have been shown to dramatically increase the effectiveness of treatment of JMwOS. In one study, Borduin, Henggeler, Blaske, and Stein (1990) compared multisystemic therapy, designed to treat adolescents in context of family and peer relationships, to individual therapy. Subjects were randomly assigned to one of the two treatment modalities. Recidivism data gathered on the subjects 21 to 49 months following treatment indicated that 12.5% of the boys who had received multisystemic treatment had been rearrested for a sexual offense, compared to 75% of the control group who had been rearrested for sexual offense. A study conducted by Hains, Herrman, Baker, and Garber (1986) compared different outcomes of multisystemic verses individual treatments. They found that, according to pre- and posttreatment scores on the Adolescent Problems Inventory, those who had received multisystemic treatment made significantly larger improvements in social competency. Mazur and Michael (1992) looked at the effectiveness of their treatment program in which caregiver participation was a primary component. Six months following treatment, none of the subjects reported having reoffended, although most did report that the opportunity to reoffend had presented itself.

While several studies have concluded that multisystemic and family therapies improve the effectiveness of treatment of JMwOS, these studies are often riddled with methodological problems that bring the validity of their findings into question, such as

small samples, no control groups, and short follow up periods. Nevertheless, many researchers maintain that families are vital to successful intervention, and that they are too often left out of treatment. As Worling and Curwen (2000) have commented,

Although we do not view families as responsible for the adolescent's choice to commit a sexual assault, we believe that the family is an important system in the adolescent's life and that the most significant change will result from family participation, wherever possible. (p. 968)

With the problem of juvenile sexual offending being recognized and conceptualized sufficiently to warrant specialized intervention, hundreds of treatment programs began springing up across the country in the early 1990s. Now it is imperative that the effectiveness of those programs be evaluated. Being able to evaluate the effectiveness of these programs may be important in justifying their continued funding. And only through evaluation can treatment programs ensure that they are successfully working toward the goal of reducing or eliminating juvenile sexual offending from society.

Treatment Evaluation

Obviously, not all juveniles who offend will benefit from treatment. Still, those who work with JMwOS are required to determine which interventions are most effective (American Association for Counseling and Development, 1988; American Association for Marriage and Family Therapy, 1991; American Psychological Association, 1992), and the National Task Force on Juvenile Sexual Offending (1993) recommends that program evaluation is an important element of an ideal intervention. Treatment programs have

typically been evaluated in two different ways: through program implementation studies and through outcome studies.

Program implementation. With the difficulties of outcome research, treatment evaluators have recently broadened the focus of treatment evaluation to include program implementation. Smith's (1995) argument makes the case for including implementation studies in treatment evaluation efforts:

It makes little sense to conduct outcome evaluations or make attributions to programs that fail to implement program goals because they are chaotic, poorly staffed, fail to provide educational or therapeutic interventions of sufficient length or intensity, and so forth. (p. 11)

The assumption behind implementation research is that treatment programs that more closely follow their implementation guidelines, as defined by various governing authorities, will be more effective in addressing juvenile sexual offending, and thus obtain better treatment outcomes.

In a landmark study in the state of Utah, Miller (1997) examined the implementation of seven nonsecure residential treatment programs. Using an inventory derived from guidelines stipulated by governing authorities, Miller interviewed clients and staff regarding implementation in several key areas. While satisfactory implementation was found in some of these areas, unsatisfactory implementation was found in the areas of intake criteria, treatment goal coverage, and tracking recidivism. Naturally, if these treatment programs are unable to execute their intended treatment design, their effectiveness will be sporadic and difficult to measure.

Treatment outcome. Because the overarching goal of any treatment of JMwOS program is to reduce or eliminate the chances for reoffense, the most common treatment outcome studies are studies that attempt to demonstrate treatment effectiveness in terms of recidivism. As stated previously, recidivism was initially defined in the literature as any subsequent conviction of sexual offense. Later studies broadened the definition to include subsequent convictions of any other criminal activity (Furby et al., 1989; Gibbens et al., 1981). Many authors have pointed out that data based on subsequent convictions severely underestimate actual rates of recidivism. Worling and Curwen (2000) summarized the argument well:

An entry in a police database for a sexual offense is dependent on many factors—in addition to the offender's decision to reoffend. Each sexual recidivism entry is contingent on the victim's willingness to report the crime, the ability of the police and/or child protection agency to investigate the complaint (if the report is made to them), the decision of police to lay charges that reflect the sexual nature of the crime, and the accurate and timely entry of the charge into a computerized database. Of course, when criminal conviction is used as the estimate of reoffending, the database entry is additionally dependent on charges not being dropped or altered to a nonsexual charge through plea bargaining and/or on the outcome of the trial. (p. 977)

Some researchers have tried to get a more accurate assessment of recidivism by using arrest rates instead of convictions, arguing that "the errors of commission associated with truly false arrests are believed to be far less serious than the errors of omission that would occur if the more stringent standard of conviction were required" (Blumstein & Cohen, 1979, p. 565). However, Abel et al. (1987) indicated that arrest rates may also severely underestimate actual recidivism by demonstrating that the probability of being arrested for any given sexual offense is only 3%. Based on this

finding, the number of arrests that actually resulted in a conviction would be even lower, and would therefore render the measure all but useless. Compounding this problem further is the fact that while some JMwOS leave their state after treatment, most recidivism studies have examined only local or state criminal records.

Other studies have tried to measure recidivism by using self-report data. While the honesty of self-reported recidivism rates has been called into question (Weinrott & Saylor, 1991), some researchers have been surprised to find that self-reported rates of recidivism actually exceeded those found in criminal records (Bremer, 1992).

Because most treatment programs are relatively new, recidivism has typically been measured within 10 years of treatment completion. While many agree that most reoffenses occur in the first few years following treatment, longer follow-up periods are needed in order to get a more accurate assessment of recidivism, because significant reoffenses can occur for up to ten years or more (Doren, 1998; Hagan & Gust-Brey, 1999).

Taken as a whole, evaluation studies that use recidivism as a measure of treatment outcome have obtained mixed results, largely due to methodological problems. Despite the problems in the existing body of recidivism research, the general view is that treatment is at least somewhat helpful, especially comprehensive treatments that emphasize cognitive-behavioral interventions and family involvement.

Recidivism alone is an inadequate method of assessing treatment effectiveness. Instead, a multi-modal approach to evaluation may provide a better picture. For example, some researchers have used the plethysmograph, an instrument used to measure

arousal response, as an additional measure of treatment outcome (Hanson & Bussiere, 1998). However, phallometric measurements have not become as popular, because many question the ethics of using such a measure on adolescents (Barbaree et al., 1993; Camp & Thyer, 1993; Worling, 1998). While debates continue about this and other outcome measures, researchers have recommended that treatment evaluation studies begin looking at program implementation and the effectiveness of specific components of treatment, rather than amassing more data on recidivism and treatment in general (Marques, 1999).

In summary, treatment evaluation has traditionally involved program implementation studies, which measure a program's ability to operate according to its intended design, and outcome studies, which typically measure recidivism rates to demonstrate treatment. Implementation studies, in and of themselves, say very little about whether or not the espoused interventions are successful in eliminating recidivism among JMwOS. Outcome studies have been riddled with methodological problems and are likewise ineffective as solitary measures of treatment effectiveness. Before an accurate picture of treatment effectiveness can emerge, more perspectives on treatment must be observed.

Treatment effectiveness: the client perspective. Clients have a unique and valuable, but often overlooked perspective on their pathology and its treatment. Applying general systems theory to the treatment of JMwOS, the central importance of the client perspective becomes apparent. One premise of systems theory is that human beings act towards things on the basis of the meanings those things have for them. Thus, a client's behavior toward or resulting from treatment (e.g., recidivistic or nonrecidivistic behavior)

is determined by the meaning that treatment has for them, or the meanings that they were able to derive from treatment in general, and from specific components of treatment. Thus, more than any other perspective, the client's own perspective is most valuable in understanding their behaviors, and in particular, which aspects of treatment are most meaningful to them in their continued efforts not to recidivate.

Outside of the field of juvenile sexual offending, the adolescent perspective has been considered important in research (Cobb, 2001). For example, adolescent perceptions are commonly examined in parenting literature (Lloyd, 2000; Openshaw, Rollins, & Thomas, 1984). While studies incorporating the perspectives of adolescents are fewer in the juvenile sexual offending literature, they do exist. Mentioned previously were the studies of DeMartino (1988) and Eastman and Evans (1996), which considered the client perspective important in examining the characteristics of families of JMwOS. Other profiling literature has considered the perspective of JMwOS important as well (Barham, 2001). Bremer (1992) was the first to study recidivism using the client perspective. Surprisingly, self-reported reoffense rates were higher than those obtained through criminal records, lending to the viability of adolescent perspective. As previously noted, however, recidivism is an ineffective outcome measure by itself.

Of particular interest in the current study will be the client perspective on various components of their treatment, because researchers have recommended looking at specific components of treatment instead of treatment in general (Camp & Thyer, 1993; Worling & Curwen, 2000). Bernou (1998) conducted a study in which emotionally disturbed adolescents in residential treatment centers were asked to evaluate various

aspects of their treatment. While the juvenile subjects of her study were not identified specifically as having offended sexually, the study showed the importance of obtaining the client perspective. By obtaining the clients' perspective on their treatment, she was able to identify that what the clients valued most about treatment were their relationships with staff and other residents. Miller (1997), working within the realm of treatment of JMwOS, had similar findings. Both of these studies, however, obtained the perspectives of clients currently in residence at their respective treatment facilities, instead of those clients who had previously left treatment. The perceptions of clients who have graduated or left treatment would be more meaningful, as the lapse of time since treatment would allow the clients to identify which components of treatment have been most helpful in their efforts to not recidivate since leaving treatment. Moreover, only data obtained from former clients will allow comparisons to be made between those who graduated from treatment and those who did not. Only one study was found that utilized former juvenile client perceptions to identify specific components of treatment that worked well (Brandt-De Moss, 2000). This study, however, looked at the experiences of delinquent adolescents involved in family-based treatment programs, and the subjects were not identified as having offended sexually.

Given the complexity and confounding factors related to treatment of JMwOS evaluation, even well-designed outcome studies make only a limited contribution to the empirical knowledge base for treatment of JMwOS. The current body of literature recommends that a multimodal assessment be used instead. In particular, it has been recommended that, rather than looking at treatment outcome in general, specific

components of treatment be examined in order to identify their effectiveness in successful treatment. One way to evaluate specific components of treatment, versus treatment outcome in general, is by asking former clients which components of their treatment they found to be particularly helpful. While there are currently no published studies that have addressed this overlooked method of evaluating treatment of JMwOS, former clients' perceptions of their own treatment programs may provide valuable insights into the effectiveness of treatment of JMwOS.

Juvenile Males Who Offend Sexually: The Utah Perspective

For the most part, juvenile sexual offending in Utah paralleled the national developments just described. Between 1974 and 1978, fewer than 20 court referrals for juvenile sexual offending were made in any given year (Matsuda, Rasmussen, & Dibble, 1989). In 1984, the number of referrals had increased to over 220, and 740 juveniles were reported for sex offenses in 1992 (Barbaree et al., 1993). It has been estimated that Utah juveniles are responsible for approximately 30 to 50% of all child sexual abuse cases reported in the state (Graves, Openshaw, Ascione, & Ericksen, 1996). The dramatic increase in referrals over this span of 18 years is comparable to what was happening nationally, and can be largely attributed to the increased awareness of the problem of juvenile sexual offending.

As occurred nationally, the increase in awareness and understanding about the prevalence and harmful effects of juvenile sexual offending has led to the formation of organizations in Utah dedicated to its further conceptualization and treatment. The Utah

Task Force on Juvenile Sexual Offending was created by the Fifth District Court in 1987 (Matsuda et al., 1989). In response to the Task Force's identification of an urgent need for treatment programs and ongoing evaluation of the JMwOS population, the statewide Network on Juveniles Offending Sexually (NOJOS) was formed in 1988. From its inception, NOJOS has been dedicated to providing information to programs regarding effective treatment of JMwOS. NOJOS published a plan for the treatment of JMwOS which outlined eight levels of treatment. Juveniles with minor offenses are allowed to stay at home, and under level one treatment they receive brief counseling and no court involvement. Juveniles in level eight treatment, on the other hand, have an average of eight felonies and 18 misdemeanors, and therefore are placed in a secure residential treatment facility (NOJOS, 1996). In 1994, the plan was expanded to include profiles of those who offend to assist in the accurate placement of JMwOS in the appropriate level of treatment (see Table 1).

Juveniles in level six treatment are described as "having displayed predatory or fixated patterns of offending (setting up their victims by bribes, threats, and so forth); sometimes using force or weapons in committing their sex offenses; and having a propensity to sexually act out with same-aged peers besides their victims" (NOJOS, 1996, p. 15). The Western Region Division of Child and Family Services sets standards for all aspects of level six treatment programs, including intake procedures, treatment modalities, supervision, staff qualifications and training, and client aftercare. Due to the moderate risk level six juveniles treatment are to the community, Western Region DCFS

(1996) standards specify that they receive intensive treatment in a residential setting (out-of-home) with maximum nonsecure supervision.

Table 1

The NOJOS (1996) Typology of Juveniles Who Offend Sexually

Level	Characteristics
One	Younger adolescents No previous reported history of sexual acting out Sexual incidents are isolated, exploratory, and situational in nature No use of coercion or violence
Two	Little or no history of prior sexual acting out behavior More extensive patterns of sexual behavior (e.g., greater number of offenses and victims when compared to level one) with younger children
Three	Some patterned and repetitious sexual offenses May have similar sexual patterns as in level two, but exhibit more extensive behavioral and emotional problems
Four	More serious than level three Adolescents who have displayed predatory patterns of offending, used force or weapons in committing their offenses, shown propensity to act out with same-aged peers, and/or displayed acute or chronic psychiatric disturbance
Five	Adolescent who presents a significant concern to the community of whom very little information is known
Six	Patterned, repetitious sexual offenses and acting out behavior May have displayed: (a) predatory or fixated patterns of offending, (b) use of force or weapons in committing their sex offenses, and/or (c) a propensity to sexually act out with same-aged peers besides their victims May also be appropriate for adolescents with extensive behavioral and emotional problems.
Seven	Mentally ill offenders demonstrating psychotic processes, self-destructive behavior, and/or severe aggression Offenses may be a single, unpredictable, uncharacteristic act or patterns of bizarre and/or ritualistic acts
Eight	Typically have an average of 8 felonies and 18 misdemeanors Sexual offenses are patterned and repetitious Have displayed predatory or fixated patterns of offending, use of force or weapons in their offenses, and/or a propensity to sexually act out with same-aged peers besides their victim

In Utah, very little research has been dedicated to evaluating treatment effectiveness. A few outcome studies have looked at recidivism among JMwOS (Barlow, 1998; Bench, 1995; Miller, 1997). However, due to various methodological limitations, these studies were only able to conclude that graduates of treatment programs appeared less likely to recidivate. Bench, among others, sees a need for more recidivism research in the state of Utah. Only one program implementation study was found to have been conducted in Utah (Miller). There are currently no published studies, either in Utah or nationally, that have attempted to evaluate the effectiveness of treatment of JMwOS by obtaining the perspective of former clients.

The Utah Division of Youth Corrections (DYC, 2000) seeks to promote ongoing research and evaluation of treatment programs. Dr. D. Kim Openshaw and his colleagues, established clinicians and respected researchers in the area of juvenile sexual offending, were selected by the DYC to conduct research designed to identify which components of treatment are most effective in reducing recidivism among level six JMwOS in the state of Utah. This study was an integral part of this research effort in that it attempted to evaluate treatment effectiveness by obtaining former clients' perceptions regarding the effectiveness of specific treatment components in helping them refrain from recidivating. The results of this study, taken together with data reported by other outcome and implementation studies, may provide a more complete and clear picture of the effectiveness of treatment of JMwOS.

Summary of Literature and Purpose of This Study

In summary, early efforts to recognize and conceptualize juvenile sexual offending fostered an expansive network of professionals and organizations committed to dealing with this societal problem. The resultant proliferation of treatment programs in the 1990s has created a large demand for evaluating the effectiveness of treatment. Because treatment programs depend largely on state and federal sources of funding, they must be able to demonstrate that the treatment modalities they espouse are effective. In light of recent cuts in program funding and the disturbing report by the Safer Society Foundation (2001b) that the number of existing treatment of JMwOS programs has dropped to 818 (41%) since the last official count in 1996, the case for needing to demonstrate the effectiveness of treatment is made. Therefore, program evaluation will continue to be fundamental to the future success of treatment of JMwOS.

Program evaluation must not rely on traditional implementation and outcome studies alone. To get an accurate picture of treatment, information should be collected from as many sources as possible. One overlooked source of information is the unique but valuable perspective of the clients themselves. Because JMwOS behaviors subsequent to treatment will be determined largely by the meanings they derived from treatment, obtaining the client perspective is of utmost importance. By obtaining the individual perspectives of former clients a more complete picture of treatment of JMwOS effectiveness may emerge.

Given the cost and time commitment of comprehensive treatment programs, and given the limitations of traditional evaluation measures, there is a great need to examine the effectiveness of various components of treatment, rather than looking at treatment outcomes in general. The Utah Division of Youth Corrections has recently commissioned Utah State University to undertake efforts in this regard. In determining which aspects of treatment are perceived by the clients to be most beneficial, examining the role of family therapy in treatment will be of particular interest. Obtaining the perspective of clients formerly referred to Utah level six treatment facilities regarding their treatment may help us better understand what components of treatment are most beneficial in preventing recidivism.

As Hanson (1995) noted, however, no single study can determine the specific mechanisms that reduce the risk of sexual offense. Rather, this knowledge will emerge from a collection and synthesis of data from numerous treatment evaluation studies. The findings of this study, combined with the results of other outcome and implementation studies, will yield valuable insights that may ultimately improve the effectiveness of treatment and reduce the harmful costs of juvenile sexual offending. The purpose of this study, therefore, is to examine the effectiveness of treatment of JMwOS by obtaining the perceptions of former Utah level six clients regarding their treatment.

CHAPTER III

METHODS

This study was designed to evaluate the effectiveness of the various components of Utah level six treatment for JMwOS by obtaining the perspective of former clients. The resulting recommendations were intended (1) to increase professional knowledge about what is most effective in the treatment of JMwOS, (2) to provide information to directors that will help them make their treatment programs more effective, including the use of collateral therapy as an integral component of comprehensive treatment, and (3) to make recommendations to serve those who would like to conduct similar research of their own.

Sample

This project employed a pilot study to examine the appropriateness and clarity of the items of the instrument. Based on the feedback received from juveniles and clinicians, appropriate revisions were made before using the instrument with the primary sample.

Pilot Study Sample

The pilot study consisted of a convenience sample of 20 clients in-residence at a Utah level six treatment program. Two level six residential centers were used in the pilot study: Wasatch Mental Health and Youth Trek. Clinicians from each facility selected ten

youth to act as participants in the pilot study. The participants from these residential centers were not included in the sample drawn for the primary study.

Primary Study Sample

The population represented by the sample of the primary study consisted of all JMwOS who had been discharged from Utah level six treatment programs between January 1994 and January 2001. Based on estimates given by agency administrators, the potential subject pool was estimated around 150 former clients. It was impossible to determine what the response rate to the invitation to participate would be, however, the researchers aimed to have 60 subjects complete the instrument, including former clients who had left treatment having successfully graduated as well as those who had left without graduating.

The agencies participating in the study provided only modest levels of cooperation, probably due to lack of incentive and limited amount of resources they were able to dedicate to the project. The researchers enlisted a representative of the Division of Youth Corrections to assist the agencies where possible. The researchers, with the support of NOJOS, also offered \$10 Media Play gift certificates as incentive for those subjects who volunteered to participate in the study. Still, limited resources, poor record keeping, and lack of a tracking system for JMwOS in general made it difficult for the researchers to obtain a representative sample. Early on during data collection the researchers solicited the participation of additional Utah level six treatment centers. All respondents that signed a letter of informed consent were included in the analyses. The

resulting sample for the primary study consisted of 20 former clients of Utah level six treatment programs. Results must be interpreted with caution due to the limited sample obtained in this study.

Ethnicity. Nineteen of the 20 subjects reported their ethnicity. These 19 included 16 Caucasians, 2 Native Americans, and 1 subject of Asian ethnicity. This breakdown is similar to that of previous Utah studies of individuals who sexually offend (Bench, 1995), in which the vast majority were Caucasian.

Religious affiliation. Fourteen respondents indicated specific religious affiliation. Of these fourteen, 12 reported belonging to The Church of Jesus Christ of Latter-day Saints (Mormon), one reported himself as Baptist, and one reported himself as Christian. One respondent reported himself as atheist, and five respondents said they had no religious affiliation.

Age and student status. The subjects ranged from 13 to 19 years old, and were 16.1 years old on average. The researchers had anticipated that the average age would be substantially higher. This unforeseen limitation was probably the result of the increased difficulty of locating former clients over time. Seventeen subjects (85%) reported being full-time students.

Time in treatment and time since treatment. Respondents reported having spent an average of 12.5 months in their last treatment program, and having been out of their last treatment program for an average of 8.6 months. Only 6 subjects reported having left their last treatment program prior to January 2001, the date requested by the researchers for selecting the sample. Sixteen of the subjects reported themselves as

currently living in a treatment program, two subjects were living with family at home, one with a proctor family, and one with a foster family. Six of the 16 subjects residing in treatment also reported themselves as having graduated from treatment. This unexpected characteristic of the sample probably came as a result of former graduates who, having reoffended, were sent to another treatment program. This also suggests the difficulty of tracking former clients, as it appears that it was much easier to locate those who had left treatment only to enter another, or who had reentered treatment after reoffending. This limitation further skews the results of this study, and may therefore explain the high recidivism rate reported.

Recidivistic behavior. Recidivism in this study was generally defined as any sexual or nonsexual crime committed since leaving treatment. Eleven subjects (69%, $n = 16$) reported having recidivated either sexually or nonsexually. This study also differentiated between sexual and nonsexual recidivism. On the item asking about nonsexual recivistic behaviors, 10 subjects (56%, $n = 18$) indicated having recidivated since leaving treatment. The most frequently reported of these behaviors was theft. On the item asking about sexual recidivistic behaviors, 7 subjects (44%, $n = 16$) indicated having engaged in sexual recidivistic behaviors since leaving treatment. Reporting of sexual recidivistic behaviors was evenly distributed between frottage, voyeurism, and exhibitionism. Despite the confidentiality of the study, recidivism may have been underreported for fear of being caught. Recidivistic behaviors may also have been lessened by the fact that most of the subjects were living in treatment facilities at the time

of completing the instrument, where constant supervision would greatly reduce the likelihood of reoffense.

Instrument

The Sex Offender Structured Interview Method (SOSIM) was developed by a group of experts, including the NOJOS consortium, consisting of clinicians, research consultants, law enforcement officers, and graduate students. The questions that make up the instrument were designed to gather information in several key areas: demographics, social desirability and validity, perceived treatment effectiveness, and post-treatment behavior. Each of these areas, in turn, is discussed below (see Appendix A for the complete instrument).

Demographic Data

Demographic data were collected for comparison purposes. The demographic questions asked about the subject's age, race, religiosity, education and employment status, and living and marital status. No questions were asked that would breach the confidentiality of the subject.

Social Desirability and Validity

This section consists of 30 items that were added to the SOSIM from the K scale of the Minnesota Multiphasic Personality Inventory-A (Hathaway & McKinley, 1967; hereafter referred to as the MMPI-A). These items are dispersed in different sections of the inventory to both break up the nature of the questions being asked, as well as to cause a

refocusing on the items to follow. These MMPI-A items attempt to assess intentional deceit or lying on the part of the respondent. The subjects answered these items by responding "Yes," or "No" to each of the 30 questions.

Perceived Effectiveness of Treatment

This section was designed to assess former clients' perceptions about the effectiveness of various aspects of their level six treatment. Question areas included staff involvement, therapist involvement, peer involvement, collateral therapy, and other components of treatment.

The internal consistency of the items within the therapist, staff, and peer sections of the instrument was determined. Cronbach's alpha for the therapist items was .90, for the staff items, .80, and for the peer items, .90. The items in each of these areas were therefore summed, creating one continuous variable each for the analysis of therapists, staff, and peers.

Posttreatment Behavior

The final section of the instrument was designed to assess the former clients' level of recidivism. This section asked about clients' criminal sexual and nonsexual behaviors, and their use of existing support structures such as friends and family. Sexual and nonsexual recidivistic behaviors were treated separately.

Psychometrics. The items developed for the SOSIM were critiqued by members of NOJOS, and revisions were made in accordance with the suggestions provided. Improvements to the instrument suggested by the pilot study were also implemented. The

validity and reliability of the instrument was determined in this study. However, by review of the said experts, it appeared to have face validity. The MMPI-A K scale included in the SOSIM has good reliability ($r = .75$) and internal consistency (coefficient alpha range is .70-.73).

Procedures

Ethical Considerations

Institutional Review Board approval. Approval of this study was obtained from two Institutional Review Boards (IRBs) before the project's inception, namely, the IRB of Utah State University, followed by the IRB of the Utah Department of Human Services. A copy of each IRB's letter of approval is located in Appendix B. Recommendations made by each IRB were incorporated in the study prior to its implementation.

Informed consent and confidentiality. Informed consent was obtained from each participant prior to administering the instrument (see Appendix C for the letters of informed consent). With both the pilot and the primary study, participant confidentiality was protected. Data were gathered by employees of the respective participating facilities. No identifying information was included in the data. Pilot data were not included in the primary study. Data collected from the study is being kept in a secure file cabinet by the primary investigator of the study.

Pilot Study

The SOSIM was an untested instrument, and as such, a pilot study allowed the researchers the opportunity to receive feedback prior to implementing the instrument with

the primary study sample. While the SOSIM was constructed by experts in the field of juvenile sexual offending, it was difficult to determine if the questions asked would be understood by the participants. A rhetorical review by a representative sample of subjects for whom the instrument was designed provided feedback about questions that may have been confusing or misleading.

Four questions identified the purpose for, and guided the pilot study. First, are all items included in the instrument critical in answering the questions posed by this study? Second, is the instrument of appropriate length so as to maintain the participant's interest in completing it? Third, are the questions worded so as to avoid confusing or misleading the participant, so that respondents will be less likely to not respond or to respond inappropriately? Finally, are the questions worded so as to minimize the possibility of the subjects experiencing negative reactions to the items of the instrument?

An alternate version of the SOSIM was used for the pilot study because many of the questions in the SOSIM were designed to get a former client's post-treatment perceptions. Because the subjects of the pilot study were in-residence at their respective treatment centers, participants were asked to imagine themselves having successfully graduated from treatment, and then to answer the questions "as-if" they were reflecting back on their treatment. This change in the administration of the pilot study did not affect the nature of the questions to be asked, and therefore, did not hinder the pilot study's ability to fulfill its purpose as explained above.

Therapists of the respective facilities selected potential subjects to participate in the pilot study. The selected subjects participated under their own volition, after signing

a letter of informed consent. If potential subjects were under 18 years of age, their parents were also asked to sign a letter of informed consent. After receiving the necessary consent, subjects were given the instrument. Participants' feedback was collected and reviewed by the researchers. Changes were then made to the instrument as necessary.

Primary Study

Two level six programs (Birdseye and Weber Human Services) were contacted, and verbally consented to assist in the data collection. Employees of the above-mentioned level six treatment programs were asked to call all former residents who left the respective program between January 1994 and January 2001. Speaking directly to the former client, the employee briefly described the intent of the study, and invited them to participate in the research project. Former residents indicating their interest to participate in the research project were then sent a letter of informed consent, with a self-addressed, prestamped envelope for returning the signed letter of informed consent. Parents of subjects who were still under 18 years of age were likewise called, and informed consent, in written format, obtained.

Following receipt of the signed letter of informed consent, the employee sent each subject the SOSIM instrument with a self-addressed, pre-stamped return envelope. Upon receiving the instrument back from the subject, and making sure no identifying information was found therein, the employee forwarded the completed instrument to the researchers for analysis.

The participating agencies did not provide the researchers with information regarding how many letters of informed consent were actually sent or returned. Due to the modest level of involvement by these agencies, additional Utah level six treatment programs were contacted and asked to participate in the study due to the limited numbers of subjects that the previously solicited programs were able to locate. Additional data were solicited following the same procedures outlined above. Data were kept by Dr. D. Kim Openshaw in a locked file for additional analyses or comparisons. All data were group analyzed with reporting of the findings as group data.

Analyses

An underlying assumption of this study was that former clients, having had opportunities to recidivate, have chosen not to do so. The goal of this research was to identify what role, if any, specific components of treatment played in former clients' efforts to not recidivate. This information was obtained by asking former clients their perceptions regarding the effectiveness of various components of level six treatment in their efforts to not recidivate. Unfortunately, the small sample size severely limited the ability of this study to provide conclusive answers to its main research questions.

The first research question to be analyzed was "Is Utah level six treatment of JMwOS effective?" The hypothesis to be tested in conjunction with this question stated that graduating from treatment would have no effect on subsequent rates of recidivism. This question was answered by using chi-square to compare graduates to non-graduates in terms of self-reported recidivism.

The second research question to be analyzed was "What, in the perception of the clients, are the most effective components of Utah level six treatment of JMwOS?" The hypothesis to be tested by this question stated that all components of treatment would be perceived to be equally effective. This question was answered using a Friedman test to compare mean rank scores where subjects were asked to rate the effectiveness of various treatment components on a 5-point Likert scale. Descriptive statistics were gathered, and pairwise comparisons conducted, to identify the difference in how subjects perceived therapists, staff, and peers. This question was also answered qualitatively by analyzing responses to questions in which the subjects explained why or how specific components of treatment were helpful in their subsequent efforts to not recidivate.

The third research question to be analyzed was "Is there a difference between perceptions among graduates and non-graduates as to the effectiveness of various components of treatment?" The hypothesis stated there would be no difference between the perceptions of graduates and non-graduates. A Mann-Whitney test was used to compare the mean rank of graduates and non-graduates in terms of perceived effectiveness of the individual components of Utah level six treatment. A *t* test was also used to identify differences in how graduates versus non-graduates perceived therapists, staff, and peers.

Of particular interest to the researchers was the fourth question to be analyzed, which asked, "How effective is collateral therapy as a component of Utah level six treatment of JMwOS?" The hypothesis tested stated that collateral therapy would have no impact on the effectiveness of treatment. This question was analyzed by using chi-

square, as well as a *t* test comparing the amount of collateral therapy clients participated in during treatment to self-reported recidivism and graduation. The question was also evaluated qualitatively by analyzing responses obtained to the question, "In what way was involvement of family or significant others in therapy helpful or not helpful?"

CHAPTER IV

RESULTS

Effectiveness of Utah Level Six Treatment Programs

Recidivism

In evaluating recidivism, 11 subjects (69%, $n = 16$) reported having engaged in sexual or nonsexual criminal behaviors since leaving treatment. Of the seven who did not recidivate either sexually or nonsexually, five were graduates.

Regarding nonsexual recidivistic behavior, 10 subjects (56%, $n = 18$) reported having been involved in criminal nonsexual activity since leaving treatment. Six of these 10 were nongraduates ($\chi^2(1, n = 18) = .90, \rho = .34$). Because of the small sample size, 50% or more of the chi-square cells had expected counts less than five, requiring caution in interpreting these results. While the chi-square value was not significant, it is worth noting the general trend suggesting that there were fewer graduates recidivating than nongraduates. Though the trend needs to be confirmed by additional research, these data provide some evidence, with limitations considered, that treatment programs may be effective in preventing some nonsexual recidivism, although the recidivism rate indicated by the data is still very high.

Regarding sexual recidivistic behavior, seven subjects (44%, $n = 16$) reported having been involved in criminal sexual activity since leaving treatment. Three of these were non-graduates ($\chi^2(1, n = 16) = .00, \rho = .95$). Again, the chi-square value was not significant. The general trend noted above for nonsexual recidivism did not hold true for

sexual recidivism; instead, these data suggest that graduates were more likely to recidivate sexually than were non-graduates. These data must be interpreted with caution due to the small sample size.

Perceived Effectiveness of Treatment Components

Fifteen subjects responded to the 5-point Likert items regarding the effectiveness of the nine treatment components. The values of the nine components were ranked from one to nine for each of the fifteen cases, using the Friedman non-parametric test. The mean ranks (reported herein as *MR*) resulting from the Friedman test showed individual therapy was perceived as the most effective of the nine components of treatment ($MR = 6.50$). By far the least effective component was drug and alcohol treatment ($MR = 1.77$) (see Table 2). These results were supported by the responses given to qualitative items, wherein eight (47%, $n = 17$) respondents named individual therapy as the most helpful component of treatment. The reasons given for this selection had the common theme of being able to talk more easily in a one-on-one setting; "I felt like I could open up more," and "I had a hard time talking in a group" were common responses. Still, group and skill development were not ranked far behind individual therapy. Seven respondents (50%, $n = 14$) named drug and alcohol treatment as being the least effective component of treatment, saying they had no need for it because they did not have drug and alcohol problems.

Descriptive statistics were gathered to compare the subjects' ratings of their therapists ($\bar{X} = 44.35$, $SD = 10.15$), staff ($\bar{X} = 41.45$, $SD = 11.18$), and peers

Table 2

Perceived Effectiveness of Components of Treatment

Components of Treatment	Mean	Std. Dev.	Mean Rank ($n=15$)
Individual therapy	4.60	.83	6.50
Skill development	4.40	.99	6.20
Group therapy	4.47	.64	6.03
Sex education	4.13	1.36	5.57
School	4.27	.96	5.50
Sexual victimization group	4.13	1.36	5.40
Collateral therapy	3.40	1.64	4.17
Encounter groups or home groups	3.53	1.30	3.87
Drug and alcohol treatment	2.13	1.30	1.77

($\bar{X} = 35.35$, $SD = 7.46$). These data suggest that clients perceive therapists as being slightly more helpful to level six treatment than staff, and staff more so than peers.

Results from pairwise comparisons showed a significant difference between ratings of peers and staff (\bar{X} difference = 6.10, $SE = 2.42$, $\rho = .02$) and between peers and therapists (\bar{X} difference = 9.00, $SE = 2.01$, $\rho = .00$). While these differences were significant, the difference between therapist and staff scores was not (\bar{X} difference = 6.10, $SE = 1.62$, $\rho = .09$).

Skills or knowledge gained from treatment were rated nearly equal, with the exception of drug and alcohol treatment. The mean rank for drug and alcohol treatment was 1.94, while mean ranks for each of the other skills ranged from 5.08 to 5.83 (see Table 3).

Eleven subjects (79%, $n = 14$) named drug and alcohol treatment as the least helpful of all skills or knowledge gained during treatment. Once again, the reasons given for this were that they had no problem with drugs or alcohol. The most common skills or knowledge listed as being most helpful included victim empathy ($f = 5$) and self esteem

Table 3

Perceived Effectiveness of Skills or Knowledge Gained from Treatment

Skills or Knowledge	Mean	Std. Dev.	Mean Rank ($n=18$)
Sexual offending cycle	4.22	1.35	5.83
Developing supportive networks	4.11	1.32	5.47
Relapse prevention	4.22	1.66	5.42
Understanding thinking errors or cognitive distortions	4.17	1.04	5.42
Positive social relations	4.22	.943	5.39
Victim empathy	4.06	1.39	5.28
Self esteem building	4.11	.832	5.17
Sex education	4.06	1.21	5.08
Drug and alcohol treatment	2.06	1.43	1.94

building ($f = 3$). Victim empathy helps clients develop the ability to show respect and establish appropriate boundaries through understanding the impact of their perpetration on another.

Mothers were rated as most influential in helping JMwOS progress in treatment ($MR = 11.26$), followed by therapists ($MR = 11.00$), staff ($MR = 10.97$), peers ($MR = 8.88$) and fathers ($MR = 8.71$). Interestingly, extended family ($MR = 7.26$) was ranked higher than brothers ($MR = 6.44$) or sisters ($MR = 6.32$), whereas extended family was rated lower than siblings as part of a posttreatment support network. Following treatment, the mother remained the most influential support ($MR = 10.93$) (see Table 4).

Different Perceptions of Graduates and Nongraduates

A Mann-Whitney test was used to compare the mean rank of graduates and non-graduates in terms of perceived effectiveness of the individual components of Utah level six treatment. JMwOS who graduated from treatment rated the components of treatment higher than did non-graduates. However, only one of these ratings was found to be significantly different, namely, skill development. Sex education approached, but did not reach significance. The mean rank given by graduates for sex education was 12.33 ($\bar{X} = 4.78$, $SD = .44$), while the mean rank given by nongraduates was 7.9 ($\bar{X} = 3.60$, $SD = 1.51$). This difference approached significance, $Z(n = 19) = -1.92$, $\rho = .06$. The mean rank given by graduates for skill development was 12.17 ($\bar{X} = 4.89$, $SD = .33$), while the mean rank given by nongraduates was 6.83 ($\bar{X} = 3.89$, $SD = 1.05$). This difference did reach significance, $Z(n = 18) = -2.43$, $\rho = .02$. The results of t tests indicated that

Table 4

Perceived Effectiveness of Support Networks

Person	During Treatment (n=17)			Following Treatment (n=14)		
	Rank	Std. Dev.	Mean Rank	Rank	Std. Dev.	Mean Rank
Mother	4.29	1.26	11.26	3.79	1.58	10.93
Treatment therapists	4.59	.79	11.00	3.57	1.70	9.68
Treatment staff	4.53	.62	10.97	3.21	1.63	8.68
Treatment peers	3.71	1.10	8.88	2.50	1.74	7.25
Father	3.47	1.81	8.71	3.29	1.86	8.54
Grandmother	3.24	1.64	8.24	3.00	1.62	8.71
Grandfather	2.76	1.85	7.26	2.86	1.66	7.96
Extended family	3.18	1.78	7.26	2.71	1.73	6.96
Brother	2.65	1.50	6.44	3.36	1.55	9.21
Sister	2.59	1.70	6.32	2.71	1.64	7.21
Close friends	2.41	1.80	6.00	2.14	1.46	6.14
Acquaintances	2.18	1.42	5.59	1.71	.82	4.96
Spouse	1.35	1.057	3.65	1.36	.93	4.11
Sexual partner	1.18	.73	3.41	1.57	1.28	4.64

graduates gave slightly higher ratings to their treatment peers than did nongraduates, but this difference, while following the same general trend of being rated higher by graduates, did not reach significance, $t(18, N = 20) = -.71, \rho = .49$. However, graduates did give

significantly higher scores to staff than did non-graduates, $t(18, N = 20) = -3.49, \rho = .00$. Some differences in perception also seemed to exist between those who recidivated sexually and those who did not. Only the difference in rating individual therapy reached significance at the .05 level, $Z(n = 16) = -1.95, \rho = .05$, but a general trend existed in that components of treatment were consistently rated higher in effectiveness by those who did not recidivate sexually.

The subjects that recidivated sexually scored therapists, $t(14, n = 16) = .96, \rho = .35$, and staff, $t(14, n = 16) = .63, \rho = .54$, lower in effectiveness than did their nonrecidivating counterparts. None of these differences were significant, but the general trend is important to note. Therapists, in particular, were rated nearly five points higher by those who did not recidivate. Further research would be necessary to more clearly identify these trends.

Collateral Therapy as a Component of Treatment

Fourteen of 20 respondents indicated that their family or other significant persons attended therapy during the course of treatment. The most common reason given for not having collateral therapy during treatment was that the family members lived too far away. The frequency of collateral therapy varied between 3 sessions in 10 months and 1 session per week. The most common frequency of collateral therapy was once per month ($f = 6$), followed by once per week ($f = 3$).

Collateral therapy did not appear to have an effect on whether or not the JMwOS graduated from treatment. Of 14 subjects who attended therapy, seven reported having

graduated and seven did not. The results of the chi-square were not significant, $\chi^2(1, N = 20) = .47, \rho = .49$. Frequency of collateral therapy likewise failed to show an effect on graduation from treatment, $t(1, n = 13) = .48, \rho = .64$. A *t*test was also conducted in order to identify the possible effect of the frequency of collateral therapy on recidivism. Once again, findings failed to reach significance, $t(9, n = 11) = .00, \rho = 1.00$. On qualitative items, those who reported collateral therapy as being a helpful component of treatment indicated reasons such as the motivation received from seeing family, and being able to work on or deal with emotions in their family relationships. A larger sample is needed before conclusions can be drawn regarding the effectiveness of collateral therapy on graduation from level six treatment, as well as its possible effectiveness in preventing recidivism.

CHAPTER V

DISCUSSION

Demographics

The sample for this study, though small, represents the general diversity found in the population of the State of Utah both ethnically and religiously. This suggests that sexual offending exists among diverse populations and is not isolated to any single group. This is consistent with the findings of previous studies (Barbaree et al., 1993; Graves, 1993).

The average age of the sample was much younger than expected, as was the average time since leaving treatment. This limits the ability of the study to examine recidivism because significant reoffenses may not occur until several years after treatment (Doren, 1998; Hagan & Gust-Brey, 1999). The young age of the respondents also precluded the researchers from examining the effectiveness of a spouse as an integral part of the support network of a recovering JMwOS.

Effectiveness of Utah Level Six Treatment

Recidivism

The subjects in this study reported a high level of overall recidivism (69%), exceeding the range of zero to 50% found in most literature (Weinrott, 1996), thus suggesting that Utah level six treatment may not be effective. Sixty-nine percent seems especially high, considering the fact that most of the subjects are still living under

supervision within a treatment system. This high rate could be due to the anonymous nature of the instrument employed in this study. Also, studies in the past have often relied on the number of arrests or convictions of crimes following treatment in order to measure recidivism, resulting in lower reported rates of recidivism, and overly optimistic reports of treatment effectiveness. While self-reported recidivism has been questioned on the basis of underreporting (Weinrott & Saylor, 1991), self reports often show higher rates of recidivism, and sexual offending behaviors in general, than do criminal records (Bremer, 1992; Zolondek et al., 2001). Thus, the accuracy of recidivism data is unknown, and more research is needed to clarify the difference in studies that report recidivism. Specifically, a method of collecting recidivism data needs to be developed to take into account the various mitigating factors that interfere with an accurate report. Through anonymous self-report, the current study suggests a high rate of recidivism existing among JMwOS, and suggests the need for additional attention from researchers, therapists, program directors, and legislators.

Treatment Components and Skills Learned

Until now, no data have existed that identify the perceived effectiveness of specific components of level six treatment programs. While limited by the small sample size, the findings of the present study are instructive, and provide a foundation from which to build future research to further clarify and conceptualize the importance and effectiveness of treatment components.

According to client perceptions, individual therapy is the most effective component of treatment. This finding is supported by the high rating given to therapists as part of an in-treatment support group. Individual therapy also was rated higher by those who had recidivated than by those who had not recidivated. The finding was supported by the qualitative assessments, which identified individual therapy as being the most helpful component in the treatment of JMwOS. In a one-on-one setting, the clients reported being more able to open up and deal with their most difficult issues. This is consistent with the theoretical framework of systems theory, which emphasizes the importance of communication between members of a system. When asked what was most helpful about their therapists, subjects often cited the genuine care and understanding that the therapists exhibited toward them. This kind of client-therapist relationship is vital to the success of treatment, because the JMwOS has been removed from the relationships within their natural family system and placed in a temporary treatment family system. It appears from these data that individual therapy is an effective means of creating this close, empathic relationship between the therapist and the client.

JMwOS who graduated from treatment particularly valued sex education and skill development. Skill development was rated significantly higher by graduates than by nongraduates of treatment, while the difference between these groups' ratings of sex education approached significance. If future studies confirm these results, added emphasis on these components in treatment may be warranted.

JMwOS commonly perceived drug and alcohol treatment as the least effective component of treatment. When asked why this component was the least effective, the

respondents universally said that they had no need for it, that their issues were with sexual offenses and not with drugs and alcohol. While these clients may be dishonest in their claim of having no problems with drugs or alcohol, this is less likely given the fact that the instrument was completed anonymously, and that they were still willing to self-report high levels of recidivism, both sexual and nonsexual. Still, a minority of respondents ($f = 3$) rated the effectiveness of drug and alcohol treatment four on a scale from one to five, with one meaning not effective at all, and five meaning very effective. This suggests that drug and alcohol treatment is still valuable to those clients who really need it. The present study therefore suggests that, instead of having all clients participate regularly in drug and alcohol treatment, it may be better to implement this in individual therapy or smaller groups for those clients whose presenting problems demonstrate a genuine need for this component of treatment, and as a precautionary intervention with those not using substances through a less intense modality.

When asked which skill gained in treatment has been most helpful since leaving treatment, the most commonly named skill was victim empathy. In answering why they thought this was the most effective skill they gained in treatment, the subjects commonly indicated that they saw the importance of understanding their victim's point of view. It appears that empathy is a concept that some JMwOS remember and utilize in their efforts to not recidivate. With this in mind, it is suggested that more emphasis be given this treatment area with further examination as to its relationship with recidivism, both with larger samples and over a longer time period from the time of treatment termination.

This study suggests that components of treatment are not perceived equally, and that some components may be more beneficial to treatment than others. From a systems perspective, the meanings that individual clients derive from the various components of treatment differ widely. With an understanding of which components tend to be most meaningful or least meaningful to JMwOS, program directors and therapists may be able to create more effective solutions for their clients.

Support Networks During and Following Treatment

Although mothers were identified as having the greatest influence on JMwOS, this was followed by therapists, who were rated more highly than were fathers of the youth. Further, extended family members were rated higher than were siblings during treatment. This study did not make the cause for this finding clear. There are several possible reasons. First, mothers are often more likely to be involved in family affairs while fathers tend to be more distant. Second, mothers are often more willing or able to be involved in therapy than are fathers. Third, therapists may be rated higher than fathers in that they develop a close relationship with the youth that may be lacking with the fathers of these youth. Extended family members may be more influential in the overall therapy than siblings because they can be more emotionally removed, and perhaps more objective, than immediate siblings. It is possible that some JMwOS did not have siblings, and therefore gave these a minimal rating. Finally, it is also possible that siblings were rated lower because they were victims of the offense. These suggested reasons for the

results need further investigation with a larger sample size in order to clarify the degree of certain individuals' helpfulness to the youth during and following treatment.

It is important to note that while therapists might have received a higher rating than fathers—perhaps due to the fact that they work more closely with the JMwOS than the fathers—mothers received an even higher rating than therapists. This is supported by the research of Openshaw, Thomas, and Rollins (1981), which showed that adolescent males' self-esteem was closely connected to mothers, while that of female adolescents was more closely connected to fathers. Still, fathers, while rated lower than mothers and therapists, may play an important role in the treatment of JMwOS. One qualitative response in support of this was this subject's turning point, "when I got my first letter from my dad."

The lower rating of some family members may also be a function of their lower frequency of participation in collateral therapy than mothers. Lower ratings, then, would suggest the need to involve other family members in collateral therapy, and having collateral sessions more frequently. In order to better understand the role of support networks in treatment of JMwOS, future studies will want to look more closely at family constellation and participation in therapy. Also, obtaining an older sample would be crucial to identifying the important role that spouses may play in the lives of JMwOS following treatment; spouses understandably received a very low score in the present study due to the young age of the subjects. It would also be interesting to see the changes in support networks as JMwOS leave treatment altogether; therapists probably retained a relatively high after-treatment score in this study because many of the respondents had

left one treatment modality merely to enter another, or had graduated and subsequently reentered treatment due to reoffense, thus retaining close and regular contact with therapists.

Collateral Therapy

The researchers' hypothesis that collateral therapy has a significant influence on graduation and recidivism was not confirmed by this study. This may be due to several reasons. Some clients' families did not participate in collateral therapy because the treatment program in which the clients resided was too far away. Others participated in family therapy too infrequently to realize significant benefit from it. The small sample size may have also contributed to these results.

This study did not identify who was attending collateral therapy. Because the residential treatment environment becomes a temporary family system for the client, future studies should identify the role of staff and peer involvement in collateral therapy as well as that of the client's own family. The high rank given to mothers may be an indication that they participated more frequently than did other family members. Whether or not this is the case is unclear, but mothers appeared to have a particularly important role in therapy, as evidenced by another subject's turning point in treatment, "My mom on a visit helped me to understand that my family does care about me." Several other subjects also reported the benefit of knowing their families cared about them. Having this assurance is important to the success of treatment, and may be enhanced by more complete and frequent participation of family members in collateral therapy. It may also

be effective to involve victims in collateral therapy, as doing so may greatly assist the JMwOS in facing his offences and in gaining a greater sense of victim empathy. In support of this possibility, consider the turning point of one respondent, "The session of when I first saw my victims for first time in two years." While no significant results were obtained by the present study regarding the influence of collateral therapy, studies in the past have identified its importance to the success of juveniles who have offended (Barlow, 1998; Colapinto, 1991; Henggeler, Borduin, Melton, & Mann, 1991), and it therefore should remain an important factor to examine in future studies so as to validate the role that it plays in treatment effectiveness and recidivism.

Limitations of the Study

The greatest limitation of this study had to do with the inability to track former clients of Utah level six treatment programs. Due to the strict confidentiality required in obtaining data from the population of JMwOS, the researchers had to rely on the ability of the various treatment centers to locate and solicit participation from former clients. During the process of data collection, it became apparent that the potential subject pool was much smaller than the agencies had initially estimated by agency representatives, not for lack of graduates or attendees, rather because of response to requests or locating those who had been in programs. The best information the agencies had to use was the contact information for the initial placement of the client following treatment. Some agencies did not even have this information. Once a client graduates from the program and moves

back into the community, contact is mostly lost, and files are no longer updated with changes in the client's residence.

Clients who leave treatment are placed in a variety of locations. The most common placements include family, proctor and foster homes, incarceration, or another treatment program. Clients who graduate successfully from the program and who return to the community are the most difficult to locate, while those who move to another treatment program, or who return to treatment due to reoffense, are the easiest to locate. Hence, in the current study, 16 of 20 respondents had moved to another treatment program, or had returned to treatment after reoffense. Two subjects were living with their own families, one was placed in proctor home, and another in a foster home. Having so many of the subjects of this study currently residing in treatment programs obviously skewed the results of this study.

Trying to track down former clients was burdensome to the agencies participating in the study. The longer it had been since the client left treatment, the more difficult it became to locate them. As a result, not only were the subjects in this study mostly residing in treatment programs, but they were also very young. This also affected the results of the study. Recidivism rates are more accurate if data are collected several years following treatment (Furby et al., 1989), instead of the relatively short time period the subjects of the current study had since leaving their level six treatment programs. Also, an older subject pool would allow more accurate assessment of the potential role that spouses and other persons may play in the recovery of JMwOS as they move away from the treatment environment.

Operating under the assumption that the agencies would be able to locate their former clients was overly optimistic. Upon realizing that there would be fewer subjects for the study than were originally anticipated, participation from additional agencies was solicited, but locating former clients was difficult for these agencies as well. In the future, researchers could enlarge the sample by conducting a longitudinal study, and by not limiting the subject pool to one state only. With a large enough sample, researchers could also compare the effectiveness of different treatment programs. It is believed that such data could also bring researchers closer to understanding which components of treatment are most effective in helping JMwOS successfully recover.

Therefore, the particular strength of the current study—seeking the client perspective—also became its greatest weakness. The short amount of time since leaving their last treatment program, together with the fact that most of the subjects were living in a treatment program at the time of completing the instrument severely limited the ability of this study to measure the effectiveness of treatment in reducing recidivism under “normal” societal conditions. Results of the current study, therefore, must be interpreted with caution. Still, these results, while inconclusive, provide information worth the consideration of additional research.

Implications

Implications for Research

Several implications for future research have been mentioned within this discussion. The most important implication is the need for a system of tracking former

clients of Utah level six treatment programs. Data collection became very difficult for the agencies involved because client files did not contain current contact information. Staff members tried to locate their former clients by calling their initial placements following treatment, but had only marginal success. The clients most easily located were usually those who had left treatment only to go to another treatment program, or who had returned to treatment. With a large portion of subjects residing in treatment programs, the results have been skewed. This may help explain the higher-than-expected recidivism rate obtained in this study, as these subjects probably returned to treatment as a result of reoffense. If these former clients did in fact return to treatment due to reoffense, this would suggest that treatment was not as effective as it might have been for these clients. With a larger, more representative sample, researchers could examine more closely the difference between graduates and nongraduates, as well as those who do not return to treatment, and those who return to treatment multiple times.

Future studies will need to take the necessary measures to ensure a much larger, more representative sample. A system for tracking former clients will require legislative support. It is unlikely that current contact information will be maintained anywhere unless juveniles who offend are mandated by state law to register this information on a regular basis. Extending Megan's law to include juveniles is one option worth further consideration, which some states are currently debating (Garfinkle, 2003; Trivits & Reppucci, 2002). Debates over whether or not collecting this information is necessary for the immediate safety of other children may continue unresolved, but there is a strong case that the information is necessary for the purposes of ascertaining a more accurate

recidivism rate so that treatment effectiveness can be better understood across time. If the contact information of JMwOS is maintained for several years following treatment, future studies will be able to obtain samples sizes sufficient for reliable results. If the necessary funding were made available, researchers could also conduct a longitudinal study to increase the sample size.

Future studies looking at the unique system of level six residential treatment should more closely examine the roles that staff and peers may play in collateral therapy, because they constitute members of a temporary treatment family. Studies would also be greatly enhanced by identifying which members of the client's own family participate in collateral therapy, and how frequently. Research has yet to differentiate between the influence of individual family members in collateral therapy with JMwOS.

Obtaining the client perspective has been shown to be important in other developmental areas of research, such as parent-adolescent interaction and discipline (Cobb, 2001; Lloyd, 2000), but has remained an unexplored source of information within research on JMwOS. Not only does the client perspective provide a more accurate picture of recidivism through self-report, it also can help identify which components of treatment are most helpful in the efforts of JMwOS to not recidivate. For example, future studies will want to confirm the finding in this study that drug and alcohol treatment is perceived as being the least effective component. Future studies will do well to explore the unique and valuable perspective of the clients themselves.

Implications for Practice

When a JMwOS enters a level six treatment program, he enters a new system. The system is a family of therapists, staff and peers, interacting within a framework of interacting treatments that are designed to help the client in the process of recovery. Even within a population homogenous in sexual offending, each new client presents with a unique set of treatment needs. The challenge for every program director and therapist is to organize the system so that it will have maximum impact on the successful treatment of each individual client.

One of the primary implications for practice suggested by this study is that clients do not benefit equally from all components of treatment. For example, while a few subjects in the current study valued drug and alcohol treatment, the majority reported it to be the least effective component of their treatment program. This component may be more effective if implemented as needed in groups or in individual and collateral therapy on a case-by-case basis where presenting problems identify a genuine need for drug and alcohol treatment.

Individual therapy will remain vital to the success of treatment, as a time when clients can open up and more easily discuss their individual issues. Building a strong rapport and trusting relationship with the client in therapy is crucial to the progress of the client in treatment. Clients considered individual therapy as one of the most effective components of treatment. When asked what could be done to make treatment more effective, one subject recommended having more individual therapy, and another suggested to have the whole program therapy-based.

This study, due to its limitations, was unable to demonstrate the importance of collateral therapy to successful level six treatment. However, studies in the past have identified its importance to the successful treatment of JMwOS (Barlow, 1998; Colapinto, 1991; Henggeler et al., 1991). In support of this proposition, some subjects in this study recommended that treatment include more collateral therapy, including staff involvement in therapy. According to the systems perspective of this study, collateral therapy should be an integral part of any treatment program whose goal is the successful return of the JMwOS to the natural family system and to society. Involving the client's own family in collateral therapy during treatment is important, especially where the dynamics of the family system may have played a role in the offending behavior of JMwOS. While the current study did not show collateral therapy to have a significant effect on graduation or recidivism, it did suggest that clients value family involvement in treatment. It appears that involvement of the client's mother is particularly beneficial, but therapists would do well to strongly encourage more participation from all family members. Future studies should examine collateral therapy so as to more thoroughly understand the role that it plays in treatment effectiveness and recidivism.

Conclusions

This study, despite some limitations, has made important suggestions for future studies, and as such could make a vital contribution to the existing body of research on JMwOS. This study suggests, together with previous research (Bremer, 1992) that a more accurate picture of recidivism may be obtained by implementing an anonymous self-

reported instrument. Most previous research has relied solely on post-treatment criminal records to establish rates of recidivism, resulting in overly optimistic reports of treatment effectiveness (Worling & Curwen, 2000). The current study suggests that recidivism of JMwOS continues to be a serious problem deserving of more attention by therapists, program directors, researchers, and legislators.

This study has also introduced the perspective in evaluating the effectiveness of treatment of JMwOS. By obtaining former clients' perceptions of treatment, researchers will be able to better differentiate between the several components of treatment and the role of each in the efforts of former clients to not recidivate. Of particular importance is the client's perceptions of family therapy during treatment, because family involvement in collateral therapy may create a bridge between the client's residence within the treatment program and their successful return home.

The results obtained by this study suggest the potential benefit of including the client's perspective in research treatment effectiveness for JMwOS. It is hoped that future studies, employing methodology similar to that used in this study, will reach a more complete understanding of treatment of JMwOS, and open the way for more effective solutions for this special population.

REFERENCES

- Abel, G. G., Becker, J. V., Mittleman, M., Cunningham-Rathner, N., Rouleau, J. L., & Murphy, W. D. (1987). *Self-reported sex crimes of non-incarcerated paraphiliacs*. (Final report No. MH 33678). Washington, DC: Public Health Service.
- Abel, G. G., Mittleman, M., & Becker, J. V. (1985). Sexual offenders: Result of assessment and recommendations for treatment. In H. H. Ben-Aron, S. I. Hucker, & C. D. Webster (Eds.), *Clinical criminology* (pp. 191-205). Toronto, Canada: MM Graphics.
- Abel, G. G., Osborn, C. A., Anthony, D., & Gardos, P. (1992). Current treatment of paraphiliacs. *Annual Review of Sex Research*, 3, 255-290.
- Ageton, S. (1983). *Sexual assault among adolescents*. Lexington, MA: Lexington Books.
- American Association for Counseling and Development. (1988). *Ethical standards* (Rev. ed.). Falls Church, VA: Author.
- American Association for Marriage and Family Therapy. (1991). *AAMFT code of ethics*. Washington, DC: Author.
- American Psychological Association. (1992). *Ethical principles of psychologists and code of conduct*. Washington, DC: Author.
- Association for the Treatment of Sexual Abusers (ATSA). Retrieved March 3, 2001, from <http://www.atsa.com>.
- Awad, G. A., & Saunders, E. B. (1989). Adolescent child molesters: Clinical observations. *Child Psychiatry and Human Development*, 19, 195-206.
- Awad, G. A., & Saunders, E. B. (1991). Male adolescent sexual assaulters: Clinical observations. *Journal of Interpersonal Violence*, 6, 446-460.
- Awad, G. A., Saunders, E. B., & Levene, J. (1984). A clinical study of male adolescent sexual offenders. *International Journal of Offender Therapy and Comparative Criminology*, 28, 105-115.
- Barbaree, H. E., & Cortini, F., A. (1993). Treatment of the juvenile sex offender within the criminal justice and mental health systems. In H. E. Barbaree, W. L. Marshall,

& S. M. Hudson (Eds.), *The juvenile sex offender* (pp. 243-263). New York: Guildford Press.

- Barbaree, H. E., Hudson, S. M., & Seto, M. C. (1993). Sexual assault in society: The role of the juvenile offender. In H. E. Barbaree, W. L. Marshall, & S. M. Hudson (Eds.), *The juvenile sex offender* (pp. 1-18). New York: Guildford Press.
- Barham, M. D. (2001). A comparison of juvenile sexual offenders, dual offenders, and nonsexual offenders on heterosocial skills, social self-efficacy, psychopathy, impulsivity and attitudes toward sexual abuse. *Dissertation Abstracts International*, 61, 3829.
- Barlow, K. (1998). Recidivism rates of Level Six residential programs for youthful male sexual offenders: 1995-1996. Unpublished master's thesis, Utah State University, Logan.
- Becker, J. V. (1988). Adolescent sex offenders. *The Behavior Therapist*, 11(9), 185-187.
- Becker, J. V. (1998). What we know about the characteristics and treatment of adolescents who have committed sexual offenses. *Child Maltreatment*, 3(4), 317-329.
- Becker, J. V., & Abel, G. G. (1985). Methodological and ethical issues in evaluating and treating adolescent sexual offenders. In E. M. Otey & G. D. Ryan (Eds.), *Adolescent sex offenders: Issues in research and treatment* (pp. 109-120). Rockville, MD: U.S. Department of Health and Human Services.
- Becker, J. V., Cunningham-Rathner, J., & Kaplan, M. S. (1986). Adolescent sexual offenders: Demographics, criminal and sexual histories, and recommendations for reducing future offenses. *Journal of Interpersonal Violence*, 1, 431-445.
- Bench, L. L. (1995). *A program evaluation of sex offender treatment*. Salt Lake city: Utah Department of Corrections, Research, and Planning.
- Benoit, J. L., & Kennedy, W. A. (1992). The abuse history of male adolescent sex offenders. *Journal of Interpersonal Violence*, 7, 543-548.
- Bernou, E. A. (1998). Residential treatment for severely emotionally disturbed adolescents: An outcome study. *Dissertation Abstracts International*, 58, 5106.
- Blanchette, K. (1996). *Sex offender assessment, treatment, and recidivism: A literature review*. Research Report, R-48. Ottawa: Correctional Service of Canada.

- Blumstein, A., & Cohen, J. (1979). Estimation of individual crime rates from arrest records. *Journal of Criminal Law and Criminology*, 70, 561-585.
- Borduin, C. M., Henggeler, S. W., Blaske, D. M., & Stein, R. J. (1990). Multisystemic treatment of adolescent sexual offenders. *International Journal of Offender Therapy and Comparative Criminology*, 25, 846-855.
- Boyd, N. J., Hagan, M., & Cho, M. E. (2000). Characteristics of adolescent sex offenders: A review of the research. *Aggression and Violent Behavior*, 5(2), 137-146.
- Brandt-De Moss, S. L. (2000). Understanding the experience of families involved in family-based treatment programs (adolescent treatment). *Dissertation Abstracts International*, 61, 1073.
- Bremer, J. (1992). Serious juvenile sex offenders: Treatment and long term follow up. *Psychiatric Annals*, 22, 326-333.
- Briere, J., & Runtz, M. (1993). Childhood sexual abuse: Long-term sequelae and implications for psychological assessment. *Journal of Interpersonal Violence*, 8, 312-330.
- Briggs, D., Doyle, P., Gooch, T., & Kennington, R. (1998). *Assessing men who sexually abuse; A practical guide*. London: Jessica Kingsley Publishers.
- Camp, B. H., & Thyer, B. A. (1993). Treatment of adolescent sex offenders: A review of empirical research. *The Journal of Applied Social Sciences*, 17, 191-206.
- Cobb, N. J. (2001). *Adolescence: Continuity, change, and diversity*. Palo Alto, CA: Mayfield Publishing.
- Colapinto, J. (1991). Structural family therapy. In A. S. Gurman & D. P. Kniskern (Eds.), *Handbook of family therapy* (Vol. II, pp. 417-443). New York: Harper Collins.
- Conte, J. R. (1991). Child sexual abuse: Looking backward and forward. In M. Q. Patton (Ed.), *Family sexual abuse: Frontline research and evaluation* (pp. 3-22). Newbury Park, CA: Sage.
- Corrections Compendium. (1991). Corrections Compendium Survey: Number of sex offenders in prison increases 48 percent. *Corrections Compendium*, 16, 9-16.

- DeMartino, R. (1988). School aged juvenile sexual offenders: A descriptive study of self reported personality characteristics, depression, familial perceptions and social history. *Dissertation Abstracts International*, 50, 1103.
- Division of Youth Corrections. (2000). *Annual report*. Salt Lake City, UT: Department of Human Services.
- Doren, D. M. (1998). Recidivism base rated, predictions of sex offender recidivism, and the "sexual predator" commitment laws. *Behavioral Sciences and the Law*, 16, 97-114.
- Dougher, M. J. (1995). Behavioral techniques to alter sexual arousal. In B. K. Schwartz & H. R. Cellini (Eds.), *The sex offender: Corrections, treatment, and legal practice* (pp.15-1 to 15-8). Kingston, NJ: Civic Research Institute.
- Eastman, B. J., Evans, N. H. (1996, April). *The family environment; A comparison of the perceptions of sexual and nonsexual adolescent male offenders*. Poster session presented at the 12th annual conference of the National Adolescent Perpetrator Network, Minneapolis, MN.
- Elliot, D. M., & Smiljanich, K. (1994). Sex offending among juveniles: Development and response. *Journal of Pediatric Health Care*, 8, 101-105.
- Fehrenbach, P. A., Smith, W., Monastersky, C., & Deisher, R. W. (1986). Adolescent sexual offenders: Offender and offense characteristics. *American Journal of Orthopsychiatry*, 56, 225-233.
- Freeman-Longo, R. E. (1981). Sexual learning and experience among adolescent sexual offenders. *International Journal of Offender Therapy and Comparative Criminology*, 81(3), 235-241.
- Freeman-Longo, R. E., Bird, S., Stevenson, W. F., & Fiske, J. A. (1994). *The nationwide survey of treatment programs and models serving abuse-reactive children and adolescent and adult sex offenders*. Brandon, VT: Safer Society.
- Furby, L., Weinrott, M.R., & Blackshaw, L. (1989). Sex offender recidivism: A review. *Psychological Bulletin*, 105, 3-30.
- Garfinkle, E. (2003). Coming of age in America: The misapplication of sex-offender registration and community-notification laws to juveniles. *California Law Review*, 91(1), 163-208.

- Gibbens, T. C., Soothill, K. L., & Way, C. K. (1981). Sex offences against young girls: A long-term record study. *Psychological Medicine, 11*, 351-357.
- Graves, R. B. (1993). *Conceptualizing the youthful male sex offender: A meta-analytic examination of offender characteristics by offense type*. Unpublished doctoral dissertation, Utah State University, Logan.
- Graves, R. B., Openshaw, D. K., Ascione, F. R., & Ericksen, S. L. (1996). Demographic and parental characteristics of youth sexual offenders. *International Journal of Offender Therapy and comparative Criminology, 40*(4), 300-317.
- Groth, A. N. (1977). The adolescent sexual offender and his prey. *International Journal of Offender Therapy and Comparative Criminology, 21*(3), 249-254.
- Groth, A. N. (1980). *Men who rape: The psychology of the offender*. New York: Plenum Press.
- Groth, A. N., & Lored, C. M. (1981). Juvenile sexual offenders: Guidelines for assessment. *International Journal of Offender Therapy and Comparative Criminology, 25*, 31-39.
- Hagan, M. P. & Gust-Brey, K. L. (1999). A ten-year longitudinal study of adolescent rapists upon return to the community. *International Journal of Offender Therapy and Comparative Criminology, 43*(4), 448-458.
- Hains, A. A., Herrman, L. P., Baker, K. L., & Graber, S. (1986). The development of a psycho-educational group program for adolescent sex offenders. *Journal of Offender Counseling, Services and Rehabilitation, 11*, 63-76.
- Hanson, B. G. (1995). *General systems theory: Beginning with wholes*. Toronto: Taylor and Francis.
- Hanson, R. K., & Bussiere, M. T. (1998). Predicting relapse: A meta-analysis of sexual offender recidivism studies. *Journal of Consulting and Clinical Psychology, 66*, 348-362.
- Hanson, R. K., & Harris, A. J. (2000). Where should we intervene? *Criminal Justice and Behavior, 27*(1), 6-36.
- Hanson, R. K., & Thornton, D. (2000). Improving risk assessments for sex offenders: A comparison of three actuarial scales. *Law and Human Behavior, 24* (1), 119-136.

- Hathaway, S. R., & McKinley, J. C. (1967). *Minnesota Multiphasic Personality Inventory manual*. New York: The Psychological Corporation.
- Henggeler, S. W., Borduin, C. M., Melton, G. B., & Mann, B. J. (1991). Effects of multisystemic therapy on drug use and abuse in serious juvenile offenders: A progress report from two outcome studies. *Family Dynamics of Addiction Quarterly*, 1(3), 40-51.
- Hersh, K. R. (1999). Treatment completion and recidivism among incarcerated sex offenders. *Dissertation Abstracts International*, 60, 6366.
- Johnson, T. C. (1988). Child perpetrators—children who perpetrate children: Preliminary findings. *Child Abuse and Neglect*, 12, 219-229.
- Kahn, T. J., & Chambers, H. J. (1991). Assessing reoffense risk with juvenile sex offenders. *Child Welfare*, 70(3), 333-345.
- Kaufman, K. L., Hennig, B., Daleiden, E., & Hilliker, D. (1996, June). Assessing the sexual history and fantasies of adolescent sexual offenders. Presentation at the annual meeting of the American Professional Society on the Abuse of Children, Chicago, IL.
- Knight, R. A., & Prentky, R. (1993). Exploring characteristics for classifying juvenile sex offenders. In H. E. Barbaree, W. L. Marshall, & S. M. Hudson (Eds.), *the juvenile sex offender* (pp. 45-78). New York: Guilford Press.
- Knopp, F. H. (1985). *The youthful sex offender: The rationale and goals of early intervention and treatment*. Syracuse, NY: Safer Society Press.
- Knopp, F. H., Freeman-Longo, R. E., & Lane, S. (1997). Program development. In G. Ryan & S. Lane (Eds.), *Juvenile sexual offending* (pp. 183-200). San Francisco: Jossey-Bass.
- Koss, M. P., & Heslet, L. (1992). Somatic consequences of violence against women. *Archives of Family Medicine*, 1, 53-59.
- Langstrom, N. & Grann, M. (2000). Risk for criminal recidivism among young sex offenders. *Journal of Interpersonal Violence*, 15(8), 855-872.
- Lehne, G., Thomas, K., & Berlin, F. (2000). Treatment of sexual paraphilias: A review of the 1999-2000 literature. *Current Opinion in Psychiatry*, 13(6), 569-573.

- Lloyd, S. (2000). Adolescent perceptions of parent-adolescent communication and adolescent pregnancy. *Dissertation Abstracts International*, 61, 1325.
- Loeber, R. (1990). Development and risk factors of juvenile antisocial behavior and delinquency. *Clinical Psychology Review*, 10, 1-41.
- Markey, O. B. (1950). A study of aggressive sex misbehavior in adolescents brought to juvenile court. *The American Journal of Orthopsychiatry*, 7(3), 77-93.
- Marques, J. K. (1999). How to answer the question "does sex offender treatment work?" *Journal of Interpersonal Violence*, 14(4), 437-451.
- Marshall, W. L., & Pithers, W. D. (1994). A reconsideration of treatment outcome with sex offenders. *Criminal Justice and Behavior*, 21(1), 10-28.
- Matsuda, B., Rasmussen, L. A., & Dibble, A. (1989). *The Utah report on juvenile sex offenders*. Salt Lake City: Utah Network on Juveniles Offending Sexually.
- Mazur, T., & Michael, P. M. (1992). Outpatient treatment for adolescents with sexually inappropriate behavior: Program description and six-month follow-up. *Journal of Offender Rehabilitation*, 18, 191-203.
- Miller, K. H. (1997). *An implementation study of nonsecure residential juvenile sex offender programs in Utah*. Unpublished doctoral dissertation, Utah State University, Logan.
- Moore, D. L., & Bergman, B. A. (1999). Predictors of sex offender treatment completion. *Journal of Child Sexual Abuse*, 7(3), 73-89.
- National Task Force on Juvenile Sexual Offending. (1993). The revised report from the National Task Force on Juvenile Sexual Offending, 1993, of the National Adolescent Perpetrator Network. *Juvenile and Family Court Journal*, 44, 1-120.
- Network on Juveniles Offending Sexually (NOJOS). (1996). *Juvenile sex offender specific protocols and standards manual* (2nd ed.). Salt Lake City, UT: Author.
- Openshaw, D. K., Rollins, B. C., Thomas, D.L. (1984). Parental influences on adolescent self-esteem. *Journal of Early Adolescence*, 4, 259-274.
- Openshaw, D. K., Thomas, D. L., & Rollins, B. C. (1981). Adolescent self-esteem: Symbolic interaction and social-learning explanations. *Adolescence*, 1, 317-329.

- Pilkonis, P. A. (1993). Studying the effects of treatment in victims of childhood sexual abuse. *Journal of Interpersonal violence*, 8, 392-401.
- Quist, R. M., & Matshazi, D. G. (2000). The Child and Adolescent Functional Assessment Scale (CAFAS): A dynamic predictor of juvenile recidivism. *Adolescence*, 35, 181-192.
- Righthand, S., Prentky, R. A., Hecker, J. E., Carpenter, E. M., & Nangle, D. W. (2000). *JJPI Maine Juvenile Sex Offender Assessment Protocol (JSOAP)*. Paper presented at the Annual Meeting of the Association for the Treatment of Sexual Abusers, San Diego.
- Roberts, R. E., Abrams, L., & Finch, J. R. (1973). Delinquent sexual behavior among adolescents. *Medical Aspects of Human Sexuality*, 7, 162-183.
- Russell, D. E. (1983). The incidence and prevalence of intrafamilial and extrafamilial sexual abuse of female children. *International Journal of Child Abuse and Neglect*, 7, 133-139.
- Ryan, G. (1987). Juvenile sex offenders: Development and correction. *Child Abuse and Neglect*, 11 (1), 69-85.
- Ryan, G. D., & Lane, S. L. (1991). Integrating theory and method. In G. D. Ryan & S. L. Lane (Eds.), *Juvenile sexual offending: Causes, consequences, and correction*, (pp. 255-298). Lexington, MA: Lexington Books.
- Ryan, G., Miyoshi, T. J., Metzner, J. L., Krugman, R. D., & Fryer, G. E. (1996). Trends in a national sample of sexually abusive youth. *Journal of the American Academy of Child and Adolescent Psychiatry*, 35 (1), 17-21.
- Safer Society Foundation. (1996). The 1996 Safer Society Foundation nationwide survey of treatment programs and models. Brandon, VT: Author.
- Safer Society Foundation. (2001a). The Safer Society Foundation, Inc.: A nonprofit agency for the prevention and treatment of sexual abuse. Retrieved March 3, 2001, from <http://www.saferociety.org>.
- Safer Society Foundation. (2001b). The 2000 Safer Society Foundation nationwide survey of treatment programs and models. Brandon, VT: Author.
- Scully, D. (1990). *Understanding sexual violence*. Boston: Unwin Hyman.

- Sipe, R., Jensen, E. L., & Everett, R. S. (1998). Adolescent sexual offenders grown up: Recidivism in young adulthood. *Criminal Justice and Behavior, 25*, 109-124.
- Smith, R. C. (1995). Sex offender program planning and implementation. In B. K. Schwartz & H. R. Cellini (Eds.), *The sex offender: Corrections, treatment, and legal practice* (pp. 7-1 to 7-13). Kingston, NJ: Civic Research Institute.
- Stenson, P., & Anderson, C. (1987). Treating juvenile sex offenders and preventing the cycle of abuse. *Journal of Child Care, 3*, 91-102.
- Swenson, C. C., Henggeler, S. W., & Schoenwald, S. K. (1998). Changing the social ecologies of adolescent sexual offenders: Implications of the success of multisystemic therapy in treating serious antisocial behavior in adolescents. *Child Maltreatment, 3*(4), 330-339.
- Thornhill, R. & Thornhill, N. W. (1983). Human rape: An evolutionary analysis. *Ethology and Sociobiology, 4*, 137-173.
- Trivitz, L.C., & Reppucci, B. D. (2002). Application of Megan's Law to juveniles. *American Psychologist, 57* (9), 690-704.
- United States Department of Justice. (1992). *Uniform crime report*. Washington, DC: U.S. Government Printing Office.
- Weinrott, M. R. (1996). *Juvenile sexual aggression: A critical review*. Boulder, CO: Institute for Behavioral Science, Regents of the University of Colorado.
- Weinrott, M. & Saylor, M. (1991). Self-report of crimes committed by sex offenders. *Journal of Interpersonal Violence, 6*, 286-300.
- Werner, E. E. (1984). Resilient children. *Young Children, 40*(1), 68-72.
- Western Region Division of Child and Family Services. (1996). *DST provider (Level 6 NOJOS): Quality assurance project*. Provo, UT: Author.
- Wolfe, S. C. (1985). A multi factor model of deviant sexuality. *Victimology: An International Journal, 10*, 359-374.
- Worling, J. R. (1998). Adolescent sexual offender treatment at the SAFE-T Program. In W. L. Marshall, Y. M. Fernandez, S. M. Hudson, & T. Ward (Eds.), *Sourcebook of treatment programs for sexual offenders* (pp. 353-365). New York: Plenum Press.

Worling, J. R., & Curwen, T. (2000). Adolescent sexual offender recidivism: Success of specialised treatment and implications for risk prediction. *Child Abuse and Neglect*, 24(7), 965-982.

Zolondek, S.C., Abel, G. G., Northey, W. F., & Jordan, A. D. (2003). The self-reported behaviors of juvenile sex offenders. *Journal of Interpersonal Violence*, 16(1), 73-85.

APPENDICES

Appendix A. The Sex Offender Structured Interview Method

Sex Offender Structured Interview Method (SOSIM)

This questionnaire asks about you and about your experience in Level Six treatment. Please write neatly and answer each question. Do not write your name on the survey. Your answers will be kept confidential.

When you are finished with the survey, seal it in the envelope provided and mail it to the researcher.

Section I – Demographics

Age / Race

1. How old are you today? _____
2. What race are you? (circle response)
- White
 Black
 Hispanic
 Asian
 Polynesian
 Other (specify) _____

Religiosity

3. On a scale from 1 to 5, to what extent do you consider yourself a religious person? (circle response)
- | | | | | |
|------------------------|---|---|---|------------------|
| 1 | 2 | 3 | 4 | 5 |
| (not at all religious) | | | | (very religious) |
4. On a scale from 1 to 5, to what extent does your relationship with God help you find meaning in the ups and downs of life? (circle response)
- | | | | | |
|---------------------|---|---|---|------------------|
| 1 | 2 | 3 | 4 | 5 |
| (strongly disagree) | | | | (strongly agree) |
5. What religion are you? (circle response)
- Catholic
 Protestant
 Latter-Day Saint (Mormon)
 Atheist
 No religion
 Other (specify) _____

Education and Employment Status

6. Are you currently – (mark all that apply)

- Attending school full time?
 Attending school part time?
 Employed full time?
 Employed part time?
 Unemployed, looking for work?
 Unemployed, not actively looking for work?
 In the military service?

7. What was the last grade you completed in school? _____

8. What kind of work do you do? (write actual response AND circle the most closely corresponding item below)

- _____
 Professional
 Clerical
 Skilled manual
 Manual labor, unskilled
 Services industry
 N/A Student
 N/A Unemployed

9. How long have you been at your current job? _____

10. How many jobs have you had in the past three years? _____

Treatment History

11. How many residential treatment programs have you been in? _____

12. How long were you in your last treatment program? _____

13. How long has it been since you left your last treatment program? _____

14a. Did you graduate from the last treatment program you were in? (circle response)

Yes or No

14b. If not, why?

Relationship and Household Status

15. Have you lived with a sexual partner within the past 5 years? (circle response)

Yes or No

16. How long have you lived with a sexual partner?
(include spouse, current or previous partners) _____

17. Currently you live – (mark all that apply)

- Alone
- With immediate family (parents and/or siblings)
- With spouse
- With friends (nonsexual partners)
- With a sexual partner (i.e., girlfriend)
- With extended family relatives
- In military housing (for enlisted persons or spouses)
- In a treatment program
- Changes too frequently to say (I moved several times in the past year)
- Other (specify) _____

18a. Your current marital status is– (circle response)

- Single, never married
- Single, divorced
- Separated
- Engaged
- Married
- Married, divorced previously (i.e., second marriage)
- Cohabiting

18b. If married, how long have you been married? _____

MMPI-A K scale (part a)

Please answer Yes or No to the following statements. (circle response)

1	I have very few quarrels with members of my family.	Yes or No
2	At times I feel like swearing.	Yes or No
3	At times I feel like smashing things.	Yes or No
4	I think a great many people exaggerate their misfortunes in order to gain the sympathy and help of others.	Yes or No
5	It takes a lot of argument to convince most people of the truth.	Yes or No

- c. Because of this person, I improved in self-awareness.

1 2 3 4 5
(not at all) (very much)

- d. Because of this person, I learned how to deal with my sexual offending impulses.

1 2 3 4 5
(not at all) (very much)

- e. Because of this person, I experienced a reduction in deviant arousal.

1 2 3 4 5
(not at all) (very much)

- f. Because of this person, I became more aware of my thought patterns, cognitive distortions.

1 2 3 4 5
(not at all) (very much)

- g. Because of this person, I became more confident, believed in myself more.

1 2 3 4 5
(not at all) (very much)

- h. Because of this person, I became more empathic.

1 2 3 4 5
(not at all) (very much)

- i. Because of this person, I improved my social skills.

1 2 3 4 5
(not at all) (very much)

- j. Because of this person, I improved my decision-making skills

1 2 3 4 5
(not at all) (very much)

- k. Because of this person, I developed other important skills.

1 2 3 4 5
(not at all) (very much)

- d. Because of my peers, I learned how to deal with my sexual offending impulses.

1 2 3 4 5
(not at all) (very much)

- e. Because of my peers, I experienced a reduction in deviant arousal.

1 2 3 4 5
(not at all) (very much)

- f. Because of my peers, I became more aware of my thought patterns, cognitive distortions.

1 2 3 4 5
(not at all) (very much)

- g. Because of my peers, I became more confident, believed in myself more.

1 2 3 4 5
(not at all) (very much)

- h. Because of my peers, I became more empathic.

1 2 3 4 5
(not at all) (very much)

- i. Because of my peers, I improved my social skills.

1 2 3 4 5
(not at all) (very much)

- j. Because of my peers, I improved my decision-making skills

1 2 3 4 5
(not at all) (very much)

- k. Because of my peers, I developed other important skills.

1 2 3 4 5
(not at all) (very much)

- 23l. What was most helpful about your peers in treatment?

Perceived Efficacy of Collateral Therapy

24a. Did your family or other significant persons attend any therapy sessions with you while you were in the program?

Yes or No

24b. If no, why not?

24c. If yes, how often? _____ times per month

24d. If yes, in what way was involvement of family or significant others in therapy helpful or not helpful?

MMPI-A K scale (part b)

Please answer yes or no to the following statements. (circle response)

11	It makes me impatient to have people ask my advice or otherwise interrupt me when I am working on something important.	Yes or No
12	I have never felt better in my life than I do now.	Yes or No
13	What others think of me does not bother me.	Yes or No
14	It makes me uncomfortable to put on a stunt at a party even when others are doing the same sort of things.	Yes or No
15	I find it hard to make talk when I meet new people.	Yes or No
16	I am against giving money to beggars.	Yes or No
17	I frequently find myself worrying about something.	Yes or No
18	I get mad easily and then get over it soon.	Yes or No
19	When in a group of people I have trouble thinking of the right things to talk about.	Yes or No
20	I think nearly anyone would tell a lie to keep out of trouble.	Yes or No

Perceived Efficacy of Treatment Program Components

25. The following are parts of a treatment program. On a scale from 1 to 5, how helpful was each of the following parts of treatment in helping you not reoffend since leaving treatment? (circle response)

a. Sex education

1	2	3	4	5
(not at all)				(very much)

b. Drug and alcohol treatment

1	2	3	4	5
(not at all)				(very much)

c. Individual therapy

1	2	3	4	5
(not at all)				(very much)

d. Collateral therapy

1	2	3	4	5
(not at all)				(very much)

e. Group therapy

1	2	3	4	5
(not at all)				(very much)

f. Sexual victimization (your own) group

1	2	3	4	5
(not at all)				(very much)

g. Encounter groups or home groups

1	2	3	4	5
(not at all)				(very much)

h. School

1	2	3	4	5
(not at all)				(very much)

i. Skill development

1	2	3	4	5
(not at all)				(very much)

e. Sex education

1	2	3	4	5
(not at all)				(very much)

f. Self esteem building

1	2	3	4	5
(not at all)				(very much)

g. Positive social relations

1	2	3	4	5
(not at all)				(very much)

h. Developing supportive networks

1	2	3	4	5
(not at all)				(very much)

i. Drug and alcohol treatment

1	2	3	4	5
(not at all)				(very much)

j. Other (specify) _____

1	2	3	4	5
(not at all)				(very much)

26k. Of the items above, which was most helpful?

26l. Why?

26m. Of the items above, which was least helpful?

26n. Why?

j. Close Friends

1 2 3 4 5
(not at all) (very much)

k. Acquaintances

1 2 3 4 5
(not at all) (very much)

l. Treatment therapist

1 2 3 4 5
(not at all) (very much)

m. Treatment staff

1 2 3 4 5
(not at all) (very much)

n. Treatment peers

1 2 3 4 5
(not at all) (very much)

o. Other (specify) _____

1 2 3 4 5
(not at all) (very much)

27p. Of the items above, who would you say had the biggest positive influence on your progress while in treatment?

27q. Why?

28. What did the staff in general do that was particularly helpful to you? (including all line staff and therapists)

29. What else would have been helpful in the staff that you maybe didn't get? (including line staff and therapists)

30. What about your treatment program was most helpful to you?

31. If you were in charge of a treatment program for juveniles with sexual offenses, what would you do with the program to be most helpful?

32. Can you remember a specific situation, event, or session while in treatment that was very powerful, like a "turning point" for you? Please tell me about it.

- 33a. Can you remember a specific situation, event, session while you were in treatment that had a very negative impact on you, like a "set back" for you? Please tell me about it.

- 33b. If you answered yes, how did you handle it?

- 33c. If the same thing happened again, how would you handle it?

MMPI-A K scale (part c)

Please answer yes or no to the following statements. (circle response)

21	I worry about money.	Yes or No
22	At times I am all full of energy.	Yes or No
23	I have periods in which I feel unusually cheerful without any special reason.	Yes or No
24	People often disappoint me.	Yes or No
25	I have sometimes felt that difficulties were piling up so high that I could not overcome them.	Yes or No
26	At periods my mind seems to work more slowly than usual.	Yes or No
27	I have often met people who were supposed to be experts who were no better than I.	Yes or No
28	I often think, "I wish I were a child again."	Yes or No
29	I find it hard to set aside a task that I have undertaken, even for a short time.	Yes or No
30	I like to let people know where I stand on things.	Yes or No

Section 3 – Post-Treatment Behavior

Recidivistic Behaviors

34. How often have you been involved in any of the following *non-sexual* activities since leaving treatment? (including those for which you weren't caught) Please be honest. Remember that all your answers are completely confidential. (mark an "x" in the appropriate column for each item on the left)

	Never	1-2 times	3-5 times	5-10 times	More than 10 times
Shoplifting					
Theft					
Arson					
Weapons offense					
Illegal substances					
Major traffic violations					
Forgery					
Vandalism					
Other (specify)					

f. Sister

1	2	3	4	5
(not at all)				(very much)

g. Spouse

1	2	3	4	5
(not at all)				(very much)

h. Sexual partner

1	2	3	4	5
(not at all)				(very much)

i. Extended family

1	2	3	4	5
(not at all)				(very much)

j. Close friends

1	2	3	4	5
(not at all)				(very much)

k. Acquaintances

1	2	3	4	5
(not at all)				(very much)

l. Treatment therapist

1	2	3	4	5
(not at all)				(very much)

m. Treatment staff

1	2	3	4	5
(not at all)				(very much)

n. Treatment peers

1	2	3	4	5
(not at all)				(very much)

o. Other (specify) _____

1	2	3	4	5
(not at all)				(very much)

37p. Which of the people above has been most helpful to you since leaving treatment?

37q. Why?

38. What has been your greatest accomplishment since leaving treatment?
(it doesn't have to be related to treatment)

39. How do you feel treatment changed you?

Thank you for taking time to fill out this survey. Your participation is very valuable in helping improve Level Six treatment programs.

Now that you are finished with the survey, seal it in the self-addressed envelope that came with the survey and mail it to the researcher.

Appendix B. IRB Letters of Approval

Utah State UNIVERSITY

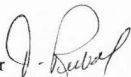
VICE PRESIDENT FOR RESEARCH OFFICE
1450 Old Main Hill
Logan UT 84322-1450
Telephone: (435) 797-1180
FAX: (435) 797-1367
Email: vpr@cc.usu.edu

12/19/2001

MEMORANDUM

TO: Kim Openshaw
Darren Brown

FROM: True Rubal, IRB Administrator



SUBJECT: Treatment Effectiveness and Efficacy of Level Six Juvenile Sex Offender Programs
in UT: The Client Perspective, Pilot & Investigative Study

The Institutional Review Board has reviewed your proposal and has granted full approval.

In giving its approval, the IRB has determined that:

- X There is no more than minimal risk to the subjects.
- There is greater than minimal risk to the subjects.

This approval applies only to the proposal currently on file for the period of one year. If your study extends beyond this approval period, you must contact this office to request an annual review of this research. Any change affecting human subjects must be approved by the Board prior to implementation. Injuries or any unanticipated problems involving risk to subjects or to others must be reported immediately to the Chair of the Institutional Review Board.

Prior to involving human subjects, properly executed informed consent must be obtained from each subject or from an authorized representative, and documentation of informed consent must be kept on file for at least three years after the project ends. Each subject must be furnished with a copy of the informed consent document for their personal records.



Michael O. Leavitt
Governor

Robin Arnold-Williams
Executive Director

Mark E. Ward
Deputy Director

Marie Christman
Deputy Director

State of Utah

DEPARTMENT OF HUMAN SERVICES
OFFICE OF THE EXECUTIVE DIRECTOR

www.dhs.state.ut.us

120 North 200 West #319
Salt Lake City, Utah 84103
(801) 538-4001
(801) 538-4016 (fax)
dirids@hs.state.ut.us

an equal opportunity employer

January 11, 2002

D. Kim Openshaw, PhD, LCSW
Utah State University
Department of Family and Human Development
6580 Old Main Hill
Logan, UT 84322-6580

Subject: Treatment Efficacy of Level Six Juvenile Sex Offender Programs in Utah: The Client Perspective, A Pilot and Investigative Study, DHS IRB # 010174 Final Approval

Dear Dr. Openshaw:

Based on the review and recommendations of the Department of Human Services Institutional Review Board (DHS IRB), and receipt of documentation of IRB approval from the University of Utah, I am pleased to notify you that I have approved the subject research proposal. After the pilot is completed, you will need to resubmit any changes necessary for the project phase of your protocol. **Please note this approval will expire on November 8, 2002 (one year from the date of review).** You may not conduct any research after this expiration date unless you submit an annual resubmission form that is approved by this committee.

If you suspect that your research will continue beyond the expiration date you must complete the attached form along with a status report, information concerning the number of subjects enrolled, a copy of the informed consent/assent document used to enroll the most recent subject, preliminary findings, any adverse events/complaints, and resubmit for subsequent review and approval at least one month prior to expiration. If we have not received your resubmission prior to the expiration date, and if the research is ongoing, you will need to resubmit a full protocol application and request for full IRB approval. Additionally, data collected and/or analyzed during any period of time in which there was not active IRB approval will have to be destroyed or discarded.

Kim Openshaw, Ph.D.

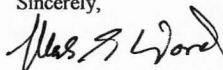
11 January, 2002

Page 2

In the event that any further changes are made to the research following this approval (e.g., changes in target population, materials to which subjects are to be exposed, procedures to be employed, etc.), please document these changes on the attached and send it to the DHS IRB.

If you need further assistance, please contact Dr. John DeWitt at 538-4333. Once your research is completed, please send a copy of your final report to the DHS IRB to allow its members and the Department to benefit from your research findings.

Sincerely,

A handwritten signature in black ink, appearing to read "Mark E. Ward". The signature is fluid and cursive, with a large initial "M" and "W".

Mark E. Ward, Deputy Director
Department of Human Services

Attachment

cc: John DeWitt, PhD, DYC
Mary Caputo, DHS IRB
Tom O Bray, BIRA

Appendix C. Letters of Informed Consent

Informed Assent: Pilot Study
*Effectiveness of Level Six Juvenile Sex Offender Treatment Programs
In Utah: The Client Perspective*
(Adolescent Form)

Introduction/Purpose

The purpose of this study is to find out what is most helpful about Level Six treatment. We would like you to take a survey that asks questions about your experience in treatment. We would also like to get your feedback about the survey questions.

Procedures

A representative from your treatment program recently contacted you. They invited you to take part in this study. You will take the survey in private. When you take the survey, imagine that you have already been released from treatment. Also, give us feedback about the survey itself. Are the questions relevant? Are the questions worded clearly? Is there something we missed? How long does it take to complete the survey?

Don't put your name on the survey. Seal it in an envelope before giving it back to the representative.

Risks

This study has minimal risk, if any. When you take the survey, you might remember something that makes you feel uncomfortable or agitated. If this happens, the representative can refer you to a therapist for help.

Benefits

Your participation can help others who are in treatment. Your responses will help researchers improve the survey. Also, your responses will be used to improve treatment.

New Findings

You will be notified if risks or benefits change during the study. This is so that you can choose whether or not to continue participating. If the study ever changes in a way that is relevant to you, we will get your consent again.

Explanation and Offer to Answer Questions

A representative has explained this study to you and answered your questions. If you have more questions, you may contact Dr. Openshaw at (435) 797-7434.

Voluntary Nature of Participation

Your participation in this study is voluntary. You may withdraw from the study at any time without consequence.

Confidentiality

Your confidentiality is important to us. To maintain your confidentiality, researchers will not be given any names. All informed consent forms will be kept with agency personnel. Also, surveys will be given to the Primary Investigator, Dr. Openshaw. He will keep all data in a locked file. Data will be destroyed once analyses, presentations, and publications have been completed.

Care if Harmed

If you are injured by participating in this study, Utah State University can reimburse you for emergency and temporary medical treatment not otherwise covered by your own insurance. If you believe that you have been injured by participating in this study, please contact the Vice President for Research Office at (435) 797-1180.

IRB Approval Statement

The Institutional Review Board (IRB) at Utah State University has approved this project. The Department of Human Services IRB (DHS IRB) has also approved this project. If you have any questions or concerns about this approval, you may contact the USU IRB Office at (435) 797-1821. You may also contact Dr. John DeWit of the DHS IRB at (801) 538-4330.

Copy of Assent

You have been given two copies of the Informed Assent. Please sign both copies. Return one signed copy to the agency representative. Keep the other copy for your file.

Investigator Statement

By my signature below, I certify that the research study has been explained to me. I understand the purpose, risks and benefits of the research. I know that my participation is voluntary, and I may withdraw from the study at any time. All my questions about the study have been answered. I am aware that I may ask other questions. Phone numbers have been given to me in case I have more questions.

Signature of Principle Investigator and Student Researcher

D. Kim Openshaw, Ph.D. , LCSW, LMFT
(435) 797-7434

Darren Brown, Student Researcher
(435) 797-7434

Signature of Participant

By my signature below, I indicate my willingness to participate in this study as it has been explained to me.

Participant's name (please print)

Signature of Participant

Date

Informed Consent: Pilot
*Effectiveness of Level Six Juvenile Sex Offender Treatment Programs
In Utah: The Client Perspective*
(Parent/Guardian Form)

Introduction/Purpose

The purpose of this study is to identify what is most helpful about Level Six treatment. The researchers are preparing a survey that asks questions about his experience in treatment. We would like your son to take the survey and provide feedback about the survey questions.

Procedures

With your permission, your son will be contacted by a representative of the treatment facility. This person will invite your son to take part in the study. Your son will be asked to take the survey as if he had already been released from treatment. He will take the test in private. He will identify any questions that are irrelevant or unclear. He will also suggest questions that we may have missed.

Your son will not put his name on the survey. He will seal it in an envelope before sending it back to the representative.

Risks

This study has minimal risk, if any. When your son takes the survey, he might remember something that makes him feel uncomfortable or agitated. If this happens, the representative can refer him to a therapist for help.

Benefits

Your son's participation can help others who are in treatment. His responses will help researchers improve the survey. Also, his responses will be used to improve treatment.

New Findings

You will be notified if risks or benefits change during the study. This is so that you can choose whether or not your son should continue participating. If the study ever changes in a way that is relevant to your son, we will get your consent again.

Explanation and Offer to Answer Questions

A representative has explained this study to you and your son, and answered your questions. If you have more questions, you may contact Dr. Openshaw at (435) 797-7434.

Voluntary Nature of Participation

Your son's participation in this study is voluntary. You may withdraw your son from the study at any time without consequence. Also, your son may withdraw from the study at any time without consequence.

Confidentiality

Your son's confidentiality is important to us. To maintain your son's confidentiality, researchers will not be given any names. All informed consent forms will be kept with agency personnel. Also, surveys will be given to the Primary Investigator, Dr. Openshaw. He will keep all data in a locked file. Data will be destroyed once analyses, presentations, and publications have been completed.

Care if Harmed

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Copy of Consent

You and your son have been given two copies of the Informed Consent/Assent. Please sign both copies. Each of you should return one signed copy to the agency representative. Keep the other copy for your file.

Investigator Statement

By my signature below, I certify that the research study has been explained to me. I understand the purpose, risks and benefits of the research. I acknowledge that I permit my son to participate of my own free will. I know that my son's participation is voluntary, and I may withdraw him from the study at any time. All my questions about the study have been answered. I am aware that I may ask other questions. Phone numbers have been given to me in case I have more questions.

Signature of Principle Investigator and Student Researcher

D. Kim Openshaw, Ph.D. , LCSW, LMFT
(435) 797-7434

Darren Brown, Student Researcher
(435) 797-7434

Parental/Guardian Signature for Minor

As parent or guardian I authorize _____ (print name) to become a participant for the described research. The nature and general purpose of the project have been satisfactorily explained to me by _____ (print name) and I am satisfied that proper precautions will be observed.

Minor's date of birth

Parent/Guardian Name (printed)

Parent/Guardian signature

Date

Informed Assent: Project
*Effectiveness of Level Six Juvenile Sex Offender Treatment Programs
In Utah: The Client Perspective*
(Adolescent Form)

Introduction/Purpose

The purpose of this study is to find out what is most helpful about Level Six treatment. We would like you to take a survey that asks questions about your experience in treatment.

Procedures

A representative from your treatment program or from the Division of Youth Corrections recently contacted you. They invited you to take part in this study. You indicated that you would be willing to participate in the study. If you choose to participate, and return this informed assent. You will then be sent a survey to fill out. The survey asks about you and your experience in treatment.

Don't put your name on the survey. Seal it in an envelope before sending it back to the researchers.

Risks

This study has minimal risk, if any. When you take the survey, you might remember something that makes you feel uncomfortable or agitated. If this happens, the representative can refer you to a therapist for help.

Benefits

Your participation can help others who are in treatment. Your answers and suggestions will be used to improve treatment.

New Findings

You will be notified if risks or benefits change during the study. This is so that you can choose whether or not to continue participating. If the study ever changes in a way that is relevant to you, we will get your consent again.

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Date

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Minor's date of birth

Parent/Guardian Name (printed)

Parent/Guardian signature

Date

Informed Consent: Project
*Effectiveness of Level Six Juvenile Sex Offender Treatment Programs
In Utah: The Client Perspective*
(Form for Youth 18 and older)

Introduction/Purpose

The purpose of this study is to find out what is most helpful about Level Six treatment. We would like you to take a survey that asks questions about your experience in treatment.

Procedures

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