Smith College

Smith ScholarWorks

2009

Sorry is harder to say when you mean it : clinicians' perceptions of working with juvenile sexual offenders on taking responsibility for their offenses

Sheri E. Kurtz
Smith College

Sheri Kurtz
Sorry is Harder to Say When You Mean It:
Clinicians' Perceptions of Working with
Juvenile Sexual Offenders on Taking
Responsibility for Their Offenses

ABSTRACT

This qualitative empirical study explores the perceptions of clinicians helping

juvenile sexual offenders take responsibility for their offenses and how it enhances

treatment outcomes. Twelve clinicians from a single, residential treatment program for

male juvenile sexual offenders, ages 5-20, located in Northeastern United States, were

interviewed and asked a series of questions about how they work with juvenile sexual

offenders to take responsibility for the sexual offenses. Interview questions addressed a

variety of issues relating to taking responsibility, including the influence of

developmental and trauma histories, the disclosure process in different settings such as

individual, group and family therapy, assessing progress in treatment (and in the milieu),

effective clinical interventions and the influence of sociocultural factors such as sexual

orientation and socioeconomic status.

The major findings were descriptions, amongst interviewees, of common

approaches and experiences in working with juvenile sexual offenders around taking

responsibility for his offenses. Interviewees described the importance of the disclosure

experience, particularly to a student's family and underscored the similarities between

thinking and behavior patterns that led to the sexual offending and other problematic, but

non-sexual behaviors. Interviewees acknowledged the treatment benefits of a long-term

residential program for this population, such as being able to work with the "whole child"

to address the complexities that led to the sexual offending and support meaningful,

lasting change. Future research might investigate the clinical benefits of milieu treatment

with this population.

SORRY IS HARDER TO SAY WHEN YOU MEAN IT:
CLINICIANS' PERCEPTIONS OF WORKING WITH
JUVENILE SEXUAL OFFENDERS ON
TAKING RESPONSIBILITY FOR THEIR OFFENSES

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work

Sheri Kurtz

Smith College School for Social Work
Northampton, Massachusetts 01063

2009

TABLE OF CONTENTS

CHAPTER I

INTRODUCTION

The purpose of this study is to explore "How taking responsibility for his offenses facilitates or enhances treatment outcomes at a residential treatment program for juvenile sexual offenders?" Juvenile sexual offenders are not a homogeneous group with respect to category of offense (including type of victim), elements of the offending behavior (use of coercion, nature of contact), risk of future offending, history of interpersonal violence, mental health issues (including substance use), cognitive functioning or history of non-sexual delinquent behavior. Notwithstanding the absence of a meaningful, cohesive profile of juvenile sexual offenders, a cornerstone of treatment seems to center around taking responsibility (NAPN, 1993). In part, taking responsibility is an integral element of successful relapse prevention, but taking responsibility can be an important therapeutic process for both the offender and his victim, both direct and indirect.

For the victim, when the offender takes responsibility, he is making explicit that the victim is not to blame for the offending behavior, he is. Furthermore, he is acknowledging the harm he has caused, even expressing compassion for his victim and remorse for his behaviors. This may help the victim restore a sense of wholeness in herself, lessening the potentially lifelong, painful impact of the offending behavior. For the offender, part of the purpose of taking responsibility is to make amends to the victim,

to allow the victim to regain what she may have lost (such as believing the world is safe, or that people are trustworthy) due to the offense. The offender can also foster an appreciation and understanding of the affects of his actions, learn about and develop his decision-making skills, and even regain a sense of connection with his community.

The purpose of this study is to gather narrative information on how and why experienced clinicians focus their treatment with juvenile sexual offenders on taking responsibility. This information may help enhance clinical understanding of how and why taking responsibility is a crucial portion of successful treatment, which may then inform and guide future treatment with this population.

The present study consists of a qualitative, exploratory design using interviews administered to thirteen licensed, master's level mental health professionals who work with male, juvenile sexual offenders at a residential program. These interviews provide rich narrative data about clinical work on taking responsibility. The participants were all employed at a residential program for juvenile sexual offenders in the Northeastern United States. The intended audience for this study includes social workers, therapists and other mental health professionals that work with juvenile sexual offenders.

The importance of the present study consists of its practical, clinical utility for use with a specific population. In accordance with social work principles, this research aims to enhance clinicians' competence in addressing their work with a vulnerable population, juvenile sexual offenders, and, on behalf of, another vulnerable population, the victims. The ultimate aim of this study is better understand how and why taking responsibility for his offenses is such an essential part of treatment, and how it is considered a primary indicator of treatment success.

CHAPTER II

REVIEW OF LITERATURE

The following literature review presents previous research on juvenile sexual offenders, the role of empathy and taking responsibility in treatment. The first section of the literature review presents common characteristics of juvenile sexual offenders, including cognitive/emotional functioning, sexual/physical abuse histories, interpersonal skills (specifically empathic capacities), and diagnostic features. The second section of the literature review addresses attachment theory, the purpose of attachment-seeking behaviors, the development of particular attachment styles, the behavioral and interpersonal consequences of attachment styles, and a possible connection to the emergence of sexually offending behaviors.   The third section of the literature review presents relevant research on brain development, with a focus on the impact and implication of early attachment experiences on the development of empathic capacities in adolescents. With an understanding of both theoretical and neurological pathways toward the development of empathic capacities, the fourth section of the literature review specifically addresses what is meant by empathic capacities, how it might relate to juveniles engaging in sexually abusive behavior. The fifth section of the literature review addresses what are the implications for therapeutic work with juvenile sexual offenders around empathy and taking responsibility.

Common Characteristics of Juvenile Sexual Offenders

According to the 2000 data collected for the Federal Bureau of Investigation's Uniform Crime Report, approximately 15,000 children and adolescents under the age of 18 were arrested for sex crimes (defined as: forcible rape, "other" sex offenses and prostitution and commercial vice). This group of youth offenders is hardly homogeneous with respect to category of sexual offense (including type of victim), elements of offense (use of violence, nature of contact, etc.), risk of future offenses, history of interpersonal violence, mental health issues (including substance use), cognitive functioning and even sexual knowledge and experience (Barbaree, Marshall, & Hudson, 1993; Zimring, 2004). Nevertheless, it is possible to identify some common characteristics, providing a profile that can inform therapeutic responses and a description of these common characteristics will follow.

It can be cautiously asserted that the typical juvenile sexual offender is a fourteen year-old white male, with a low-to-average IQ. By age 14, most offenders have had several victims, with the average age for committing the first sexual aggression being ten. Roughly half of all juvenile sexual offending involves anal or vaginal penetration, and oral sodomy (Barbaree, Marshall, & Hudson, 1993; Becker & Hunter, 1997; Center for Sex Offender Management, 1999b; National Task Force on Juvenile Sex Offending, 1993; Rich, 2004; Righthand & Welch, 2001; Zimring, 2004) while the other half of juvenile sexual offending often involves flashing, public masturbation and frottage (rubbing one's body against a stranger's for sexual pleasure) (Righthand & Welch, 2001; Zimring, 2004).

Rates of juvenile sexual offenders who have experienced sexual abuse as children reportedly range from 40-80% (Becker & Hunter, 1997; Righthand & Welch, 2001). Such trauma histories of juvenile sex offenders have not consistently been found to contrast significantly from juveniles who have committed non-sexual offense suggesting that a history of trauma may correlate with offending behaviors in general, but not necessarily sexual offending in particular. However, a history of physical and/or sexual abuse may be related to the age of first offense (Becker, 1998) as well as impacting a juvenile sexual offender's capacity for empathy, ability to recognize appropriate emotions in others or taking another's perspective (Barbaree, Marshall, & Hudson, 1993; Knight & Prentky, 1993; Righthand & Welch, 2001).

Conduct disorders and antisocial behavior diagnoses are frequently given to juvenile sexual offenders (American Psychiatric Association, 2000; Righthand & Welch, 2001; Zimring, 2004) with some statistics indicating an 80% diagnosis rate (Center for Sex Offender Management, 1999b). Although in some circumstances, a diagnosis may be required, this number may be misrepresentative of the presence (or lack of presence) of legitimate mental illness. That is, juvenile sexual offending, arguably by definition, meets the criteria for a conduct disorder and/or antisocial behavior disorder diagnosis; in other words, the diagnosis may not add any meaningful, therapeutically relevant information to the understanding of an offender.

Poor social skills, social isolation and the lack of positive peer relationships have been identified as characteristics common to many juvenile sex offenders (Barbaree, Marshall, & Hudson, 1993; Knight & Prentky, 1993; Rich, 2004; Righthand & Welch, 2001; Zimring, 2004). In one study (Miner & Crimmins, 1995), the researchers asserted:

...the primacy of isolation and poor social adjustment as distinguishing characteristics of adolescent sex offenders, indicating that interventions that maximize the ability to build interpersonal attachments potentially affect the propensity to engage in sexually abusive and aggressive behaviors (pp. 9-11).

In another study Katz (1990), compared three groups on various measures of social competence – adolescent sexual offenders, juvenile delinquents who did not commit sex crimes and a comparison group from a high school. The findings indicated that the adolescent sexual offenders were more socially maladjusted, evidenced more social anxiety and fear of heterosexual interactions than either of the two other groups studied.

Those who possess effective social skills are often able to exhibit good decision-making abilities, impulse control, to develop a sense of mastery over their environment, and a positive self-identity (Erikson, 1963). Further, these skills facilitate engaging successfully with others, fostering a sense of belonging, as well as noticing, tolerating and managing internal states and conflicts. With respect to juvenile sexual offenders, it has been asserted (Beckett, 1999) that a deficit in social competencies can be considered a risk factor; in other words, "…poor social competency and deficits in self-esteem rather than paraphilic interests and psychopathic tendencies currently appear to offer the best explanation as to why [juvenile sex offenders] commit sexual assaults" (p. 224).

The cause of juvenile sexual offenders developing poor social skills is not clearly understood; however, the literature suggests early attachment difficulties, in addition to early intra-family dysfunction (including, communication style, divorce, and physical and sexual abuse) as likely candidates (Barbaree, Marshall, & Hudson, 1993; National Task Force on Juvenile Sexual Offending, 1993; Rich, 2006; Righthand and Welch 2001;

Ryan, 1999b). A brief overview of the main elements of attachment theory may be useful for understanding the potential connections to juvenile sexual offending.

Attachment Theory

Central to attachment theory, as developed by Bowlby (1969), is the assertion that attachment to a primary caregiver is a fundamental experience, an almost primal strategy for satisfying one's needs, with a biological basis. A child's attachment seeking behaviors (including crying, direct eye contact, and maintaining physical proximity to the caregiver) have several purposes that can have lifelong implications for interpersonal relationships in particular.

First, attachment behaviors are intended to maintain a sense of security for the child - through staying close and avoiding separation. Since an infant or young child is unable (literally) to survive on her own, establishing security in her environment and having her basic needs met would seem to be important (and universal) protective behaviors. Second, attachment seeking behaviors also serve to lay the foundation for the regulation of affect and arousal. In infancy, being in an "on alert" state, with the accompanying physiological sensations, is common and the infant can be susceptible to frequent states of disequilibrium.

The interactions between infant and caregiver have been described as transactional patterns of mutual regulation meant to relieve the infant's state of disequilibrium (Bowlby, 1969). For example, a successful transactional pattern might be as follows: a baby is hungry, she cries and the caregiver both notices the cries and interprets the cries as a likely expression of hunger and thereby feeds the baby. If there is repeated success of the transaction, the infant may develop skills for regulation of affect

and arousal, in essence internalizing self-soothing strategies for controlling negative emotions and distress. Conversely, according to many, including van der Kolk (1994), if there is a lack of success with the infant/caregiver transactions, the infant may develop difficulties in regulating negative emotions, failing to internalize self-soothing strategies and experiencing a state of hyper-arousal or simply being at the mercy of her strong impulses or emotions.

Attachment-seeking behaviors can also aid in the establishment of skills around expression of feelings and the ability to communicate. For example, if the caregiver is able to respond accurately to an infant's expressions, the infant can learn what the appropriate means (and intensity) of communication are in order to get her needs met. Again, if this transaction is not successful, the infant may learn either, that any communication is futile (because "nobody" is listening, nor will anybody respond) or that "exaggerated" communication is necessary (because short of something extreme, nobody will respond).

Finally, an important development of early attachment experiences with caregivers relates to what Bowlby (1969) referred to as the internal working model that reflects a system of thoughts, beliefs, memories, emotions and behaviors about self and other. This system shapes how we behave in order to satisfy our needs and how we interact with our environment, other people and even our own "self" (Rich, 2006)

Attachment Styles

Mary Ainsworth (1978), after conducting her Strange Situation experiments,[1]

categorized the specific qualities resulting from early attachment experiences into three

styles: secure; insecure avoidant; insecure ambivalent. Each attachment style is

distinguished by how a child experiences separation from, and the return of, her caregiver

as well as the child's experience of the presence of a stranger. A simplified definition of

each style is as follows:

1) Secure attachment indicates that a child, although protesting her caregiver's

departure, does not experience significant distress when separated from her caregiver.

The child will receive the return of, or contact initiated by, the caregiver positively, will

seek comfort from the caregiver, if she is frightened, and she prefers her caregiver over

strangers. Finally, a securely attached child is likely to venture away from the caregiver

and explore her environment;

2) Insecure-avoidant attachment indicates that a child avoids her caregiver, and

that the avoidant behaviors increase with longer absences by the caregiver. The child

does not seek comfort from, or contact with, her caregiver and does not exhibit a

preference of her caregiver over a stranger;

3) Insecure-ambivalent attachment indicates that a child experiences considerable

distress when separated from her caregiver but is not readily comforted or reassured upon

---

[1] In Ainsworth's Strange Situation experiments, a parent and child were alone in a room where the child explores the room without parental participation. A stranger enters the room, briefly interacts with the parent and approaches the child. The parent then quietly leaves the room, returning later to comfort the child. The child's behaviors during these events were observed with particular attention to when the parent returned, and these observations were the basis for the attachment style categories.

the return of her caregiver. Finally, an ambivalently attached child is very suspicious of strangers;

4) A fourth attachment style, disorganized/disoriented, was developed by Main and Solomon (1986) after reclassifying the two insecure attachment styles and this attachment style indicates a mixture of the avoidant and ambivalent styles. The child shows a lack of clear attachment seeking behaviors and can appear confused and apprehensive toward her caregiver. Despite the value-laden terms, each style is an adaptive constellation of behaviors aimed at establishing security and maintaining proximity; that is, all children will attach to perceived caregivers, in some ways without regard to the quality or reciprocity of the caregiving relationship (Rich, 2004) or whether the behaviors can (or should) be sustained over time.

Implications of Maladaptive Attachment Styles

As described above, attachment behaviors are intended, in part, to establish a sense of security in one's environment and, that one's needs will be met. To the degree that security is not established, a child learns that the world is not safe, others cannot be trusted nor depended upon, and even that the child herself (or her "sense of self") does not fully exist because, in some way, she is not noticed, taken care of sufficiently, nor experiences empathy herself, by her caregivers. Consequently, integration and differentiation, or the complex identity formation process, by which we organize and distinguish between good/ bad, self /other, and safe/ unsafe representations (Kernberg, 1990) can become a significant challenge for a child who has not had sufficient and consistent positive attachment seeking experiences. Furthermore, those who do not succeed at integration and differentiation, who do not gain "the ability to preserve the

whole of the psychic organization as a highly individualized, coherent entity," (Levy-Warren, 1996) may have limitations in their ability to recognize the existence, needs and experiences of another. Some assert that without success at integration and differentiation, developing empathic capacities becomes an almost impossible task (Kernberg, 1990); that is, one may be more likely to employ behavioral strategies that are primarily self-oriented and to view others as objects meant to satisfy one's own needs, first and foremost, without concern for any negative impact of these strategies. And, this one-dimensional, interpersonal orientation may be characteristic of juvenile sexual offenders with maladaptive attachment styles and is often described as a lack of empathy and/or poor social skills (Rich, 2006).

To be sure, the claim regarding the long-term negative consequences of early attachment difficulties is not new (Bowlby, 1979), nor unique to the understanding of juvenile sex offenders. Arguably, it is a well-established contention that if a child fails to form adequately secure attachments in her early life, she will likely struggle with developing and maintaining meaningful relationships, and may also fail to develop or experience empathy and mutuality in her relationships – regardless of committing sexually aggressive behavior (Rich, 2006; Ryan, 1998). And empathic deficits have been identified as (nearly) a hallmark characteristic demonstrated by juvenile sex offenders requiring specific treatment, if there is to be realistic hope of rehabilitation (Barbaree & Cortoni, 1993; Becker & Hunter, 1997 and NAPN, 1993). Barbaree & Cortoni (1993) asserted that, once denial and minimization of sexual offenses have lessened or ceased, the juvenile sexual offender can begin to empathize with the victim, and that the development of empathy is frequently the important first step in treatment. Similarly, it

has also been asserted that the first step in treatment involves helping the juvenile sexual offender take responsibility for his offending behavior (Barbaree, Marshall, & Hudson, 1993; Becker & Hunter, 1997; National Task Force of Juvenile Sexual Offending, 1993). For purposes of this study, the literature does not seem to indicate how this treatment step is formulated or implemented by the mental health professionals who work with juvenile sexual offenders.

Adolescent Development

It is important to have a foundational framework about adolescent development in general, with particular focus on brain development, the influence of attachment experiences and the refining of empathic capacities and prosocial skills. The major developmental tasks of adolescence (Steiner & Yalom, 1996) include: pubertal changes; cognitive changes; construction of identity; experience of peer relationships; and sexuality. Pubertal changes reflect physical and hormonal processes that have both behavioral and bodily consequences, with possibly the most significant consequence being the new ability to reproduce. With cognitive changes, the adolescent develops skills around abstract and future-oriented thinking, gains a new ability to examine previously unquestioned attitudes, values and behaviors and of particular relevance to this study is the ability to think about themselves as separate from others. The process of "constructing" an identity is related to cognitive changes in that the adolescent may begin to develop a sense of self - distinct from others (Erikson, 1964), particularly from parents. Also part of changes in identity, the adolescent may engage in role experimentation both within his family, but with his peers and larger community as well. The emerging importance of peer relationships is also relevant to this study. During this process, the

12

adolescent can shift her sense of belonging away from her family and immerse herself in her peer group. The peer group is often the context for exploring identity, and in the case of juvenile sexual offenders, this experience of belonging and/or establishing one's identity is often challenging, with the juvenile sexual offender having little or no success at forming peer bonds. Finally, attention to sexuality is often a part of the adolescent experience and can include exploration of sexual identity but also sexual behaviors. For some, there is limited guidance around sexuality, which may evolve into a facet of future sexual behavior problems.

Brain Development and Attachment

With the deepening expansion of neurobiological research, the interactive relationship between environment and biology has become clearer (Schore, A.N., 2003; 2001a; 1994). That is, neurobiology impacts behavior, behavior shapes experience and experience causes changes in neurobiology; in other words, there seems to be a complementary structure between external behaviors and internal neurobiology. Although a comprehensive presentation of adolescent brain development is beyond the scope of this project (and this researcher's knowledge), some basic concepts are useful.

Early interactions between infant/child and caregiver (nurturing, neglectful, abusive, or some combination thereof) stimulate electrical and neurochemical transmissions and impulses within the infant/child's central nervous system. These transmissions and impulses trigger hormonal releases, the firing of neurons over synaptic terminals, the production of synaptic connections, the emotional and chemical coding of memory, and the emergence of the neural self (Schore, 2001a; Siegel, 1999 & 2001). In this regard, attachment theory has some grounding in biological theory; that is, the

internal representations of self and others, the cognitive and emotional framework that influences thoughts and actions (Rich, 2006) are constructed through the infant-caregiver relationship, laying the groundwork for future relationships. Underlying behavior are cognitive and emotional maps, which are neurobiologically hard-wired, and the product of early caregiver responses (fulfilling or lacking) to the infant's expression of her needs. (Bowlby,1969; Schore, 2003; Siegel, 2001). As Siegel writes, "Coherent interpersonal relationships produce coherent neural integration within the child that is at the root of adaptive 'self-regulation'" (Siegel, 2001, p. 86).

Thus, in a case in which there is no "biological synchronicity" (Schore, 2003) between infant and caregiver, whereby the caregiver is unable to respond to, or repair, the infant's long-lasting disregulated states, there may be considerable, negative neurobiological consequences in the growing brain. Siegel (2001a) writes of the significance of the reestablishment of connection when synchronicity is absent: "Repair is…important in helping to teach the child that life is filled with inevitable moments of misunderstandings and missed connections that can be identified and connection created again" (p. 79).

In addition, these stress-induced, neuro-biochemical modifications, if occurring during periods of significant brain growth (such as early childhood), the long-lasting disregulated states become traits (Schore, 2003; Siegel, 1999), and as such, are rooted into the central structure of the brain, thereby impacting the developing personality (including cognitive and emotional functioning). van der Kolk (1987) has also written that disruptions in attachment during infancy may lead to far-reaching neurobiological change, creating a hyper- or under- activity of brain systems, such as self-regulation and

14

arousal. Not surprisingly then, in these cases, where there is inadequate attunement and fragile attachment, what can evolve is weak social skills, compromised relationships and a poor sense of self – some of the primary characteristics identified with juvenile sex offenders.

Empathic Capacities

With this simplified understanding of neurobiological development and its direct relationship to emotional and behavioral development, the juvenile sex offender's empathic capacity may be seen as still forming, susceptible to the influence of primary relationships and the process of negotiating the social world – there may even be a biologically-based empathic deficit. Empathy is not a simple concept, rather, a multidimensional trait involving both objective perspective-taking as well as subjective sympathy (Hoffman, 2000). In other words, one must be able to cognitively notice and identify emotional states of others, feel a subjective affective response within oneself in reaction to the experience of the other, triggering an empathic experience that motivates one to meet the needs of the other (Hoffman, 2000). Arguably, empathy encompasses both a feeling of sympathy and concern for others as well as a sense of social connection and accountability. So, a child who has not repeatedly had his expression of needs (i.e., crying) noticed, and then his actual needs (i.e., hunger) met, may not have developed either the neurological basis (Bowlby, 1969; Schore, 1999; Siegel, 2001) or the interpersonal skills necessary for demonstrating, or even feeling, empathy.

As stated earlier, juvenile sexual offenders seem to exhibit poor social skills and may experience intense social isolation, and this lack of a forum for social skills practice and success may lead to fragile empathic capacities. As Marshall, Serran and Franca

15

(2000, as referenced in Rich, 2003, p. 54) described: "[there are] theories that relate sexual offending both to chronic loneliness and deficits in intimacy… and sexual offenders are often bereft of intimacy and experience loneliness to a greater extent than both other offenders and non-offenders." A person's loneliness and social isolation may manifest itself through a lack of empathy or concern for others, or an inability to understand or care about the consequences of his behaviors on others, or even having the experience of remorse or guilt, which, according to Winnicott (1965) is critical in the development of healthy individuals.

A noteworthy feature of attachment theory is the element of consequence; that is, arguably, one engages in particular attachment-seeking behaviors with an eye (not explicit in infants or young children) toward an expected consequence. As expectations of consequences are (dis)confirmed over time, one can learn – not necessarily consciously – to repeat or discontinue particular attachment seeking behaviors. In short, one might come to appreciate, understand, and even predict, the impact of one's behaviors on others, which, as discussed below, is possibly a crucial component of empathy and taking responsibility.

Empathy and Adolescence

How adolescents fit into this framework is subject to their own developmental history and stage, which is likely to be less sophisticated, and more reactionary, to meeting their immediate needs (D'Orazio, 2002; Piaget, 1932). Mature, considered and sensitive decision-making is not a full-established skill of the adolescent who has early secure attachment experiences, and thus, the adolescent with traumatic (or even compromised) attachment experiences may be at a disadvantage, developmentally-

16

speaking. And with juvenile sex offenders in particular, empathy may, in fact, be more than simply a difficulty in noticing, and caring about, the emotions in others (a possible characteristic of most adolescents), but also, in actually feeling connected to others. Thus, empathic limitations may reveal an experience of alienation and disconnection, rather than a hard-hearted lack of sympathy (Fonagy, 2001a; Sims-Knight, 2004). Nevertheless, it is understood that empathic deficits, whether global (which may be an indication of severe psychopathology, not typical of the juvenile sex offender) (Rich, 2004), or victim- specific (an indication of a suppression of empathy or cognitive distortions) (Keenan & Ward, 1999) can create the potential for harmful, violent behavior. Consequently, treatment models that incorporate an understanding of adolescent development, with particular focus on the role of empathy development, may be more effective in restoring the victim's sense of wholeness, while also supporting the offender in his process of developing a healthy self-identity, establishing meaningful social connections, and decreasing the chance of re-offending (Rich, 2003; Zimring, 2004). With that said, an overview of existing treatments and the efficacy of treatment, will follow.

<center>Treatment and Juvenile Sexual Offenders – An Overview</center>

Recommended treatment content areas for juveniles who have sexually offended typically include: sex education, empathy training, correction of cognitive distortions, clarification of values concerning abusive versus non-abusive sexual behavior, anger management, strengthening impulse control and healthy decision-making skills, social skills training, reduction of deviant arousal and relapse prevention (Becker & Hunter, 1997; Hunter & Figuerado, 1999; NAPN, 1993). Burton and Smith-Darden (2001)

<center>17</center>

surveyed over 800 community-based and residential treatment programs for sexual offenders, including 357 programs specifically serving adolescents and children. For purposes of this study, presentation of the data gathered will be limited to that relating to adolescents in residential programs. Eighty-eight percent of the residential programs treated adolescents, compared to 12% that treated children, with an average length of stay for the adolescents being approximately 18 months. Burton and Smith-Darden (2001) found that each week, in residential care, adolescents attend on average: 1-2 fifty-minute individual therapy sessions; 3-4 eighty-minute groups and a little less than one sixty-minute family therapy session. Of the treatments provided, eighty-three percent focused on the sexual assault-dysfunctional behavioral cycle with the remaining treatment or services including art, drama and expressive therapy, sex education and EMDR.

Rehabilitation of the juvenile sexual offender ideally incorporates treatment of the whole person, with the understanding that many of the behaviors and thought patterns that led to the sexual offending have caused other legal, social and family problems within the offender's life (Rich, 2004, Zimring, 2004); however, as community safety is the primary objective of interventions with juvenile sexual offenders (Becker & Hunter, 1997; NAPN, 1993), successful treatment is typically equated with prevention of further offending (NAPN, 1993, Righthand & Welch, 2001). Consequently, sex-offender specific treatment – therapeutic interventions directly geared at the individual's sexual offending and other related behaviors – is often the primary treatment modality (Rich, 2004, Righthand & Welch, 2001). Yet, in many respects then, identifying and assessing treatment success is a tricky task. It requires knowing what has happened once a juvenile sexual offender leaves treatment, and, given the difficulty itself of tracking future

behavior, as well as tracking behavior (sexual reoffending) that is frequently secretive and unlikely to be revealed voluntarily.

Nevertheless, what seems to be generally understood is that treated juvenile sexual offenders who do get into continued trouble are more likely to get into trouble for continued nonsexual offenses than for sexually abusive behaviors (Association for the Treatment of Sexual Abusers, 2000; Center for Sex Offender Management, 1999b; Knight & Prentky, 1993; Weinrott, 1996). Further, it is thought that the recidivism rate for treated juvenile sexual offenders is between seven and thirteen percent over follow-up periods of two to five years (Hunter, 2000).

In a recent study by Fanniff and Becker (2006), the authors, in addition to reviewing evidence about assessment tools used with juvenile sexual offenders, also reviewed outcome research with respect to treatments used with juvenile sexual offenders. It is this second portion of their review that will be presented here. Their suggestions are similar to those found in other related literature (Rich, 2004; Righthand and Welch, 2001; Weinrott, 1996). However, as Fanniff and Becker point out, treatment programs "have been described in the literature without any discussion of systematic evaluation" (p. 272) and thus, limited their review to "only studies that evaluate a clearly defined treatment and describe evaluation methodology" (p. 272).

Fanniff and Becker presented reviews of cognitive behavioral treatments (CBT), psychosocial educational treatments and multisystemic treatments (MST). CBT, as used with juvenile sexual offenders, is aimed at addressing distorted thought, behavior and arousal patterns with a "cognitive restructuring" (p. 273) approach with the underlying belief (in overly simplified terms) that problematic behaviors are the result of problematic

thinking (Rich, 2004). Fanniff and Becker concluded that use of CBT with juvenile

sexual offenders "can only be considered a promising approach" (p. 275), in part, because

of the limits of the studies reviewed. Although the CBT programs studied indicated a

decrease in deviant arousal patterns of juvenile sexual offenders, and lower recidivism

rates with one treatment program in Toronto, the authors acknowledged the studies'

limitations to include a lack of a comparison group to those offenders who received

treatment, the small sample sizes, and the fact that there was a lack of random assignment

within the samples.

With respect to psychosocial educational treatments, which may or may not

coincide with CBT approaches, the treatment focus was around sex education (i.e., sexual

knowledge and attitudes, human sexuality, and social skills). Fanniff and Becker found

that "educational approaches do change the knowledge or attitudes of juvenile sex

offenders" (p. 278) but also noted, that due to limitations of the studies reviewed

(particularly not including recidivism rates as an outcome measure, as well as the lack of

a comparison group), conclusions could only be cautiously drawn.

Finally, in examining two programs that use the MultiSystemicTherapy (MST)

therapeutic approach, which included home-based, community and school interventions

around sexual assault cycles, taking responsibility for the offense, safety planning,

psychological restitution to the victim, supporting family reunification and development

of appropriate friendships (p. 278), Fanniff and Becker found that, "based on current

evidence, MST is one of the few interventions with methodologically sound data to

support its efficacy" (p. 279). The authors indicated that, in addition to an apparent

improvement in "positive psychosocial changes" (including school performance), there

was a notable decrease in recidivism rates compared to those juvenile sexual offenders who only received individual treatment (p. 279). Again, similar to the other studies reviewed, Fanniff and Becker noted the limitations to included small sample sizes and they raised a question regarding possible variations in how clinicians use the MST approach (p. 279).

The Fanniff and Becker findings seem to indicate that a more holistic, less narrowly focused treatment approach is likely to yield the most success, in other words, the lowest rates of recidivism. In part, this may reflect a more holistic and less narrowly focused understanding of what causes an adolescent to sexually offend, as well as recognizing the importance of an adolescent's family, social and school community in supporting his treatment success.

Similar to Fanniff and Becker, in his 2004 book, Phil Rich critiques the predominant treatment approaches, remarking that, although CBT has popular appeal because it is easily operationalized, there is no empirically sound research to support its efficacy as the only approach (p. 236). In fact, Rich asserts that a psychodynamic treatment approach, alongside CBT, is the most likely to yield positive treatment outcomes. However, measuring treatment outcomes with this population is both, extremely important to improving treatment success, but also somewhat elusive (p. 239).

However, whether juvenile sexual offenders require focused treatment on responsibility for abusive behaviors and the development of empathy for one's victims, more so than juvenile delinquents without sexual behavior problems, is not entirely clear (Fanniff & Becker, 2006; Zimring, 2004). According to Zimring (2004) at least for some adolescents who engage in sexual offending, the sexual offending is one of a "cluster"

21

(Zimring, p. 224) of problematic behaviors; therefore, a treatment approach that addresses "thinking, motives and patterns" (p. 223) of the non-sexual behaviors will likely also address the "thinking, motives and patterns" of the sexual behaviors.

Further, a study by Lab, Shields, and Schondel (1993) is consistent with Zimring's assertion about questioning the need for sex offender specific treatment. Lab, Shields, and Schondel compared the recidivism rates for juveniles treated in sex offender specific programs with juveniles being treated in community based treatment programs that did not have a specialized approach for sexual offenders. The study found that recidivism rates for both groups were low and the authors concluded, "These results suggest that the growth of interventions has proceeded without adequate knowledge of how to identify at-risk youth, the causes of the behavior, and the most appropriate treatment for juvenile sexual offending" (p. 543). Some have suggested that, in fact, the lack of significant differences in recidivism rates "are indicative of commensurate therapeutic needs for both sexual and non-sexual juvenile offenders" (Jacobs, Kennedy & Meyer, 1997; Milloy, 1994). In fact, Milloy (1994) points out that specialized treatment for juvenile sexual offenders typically includes components of sex education, social skills, acceptance of responsibility for one's offense, anger management and empathy for victims, and these components may be appropriate for juvenile offenders in general.

Treatment, Juvenile Sexual Offenders and Taking Responsibility

In treatment of juvenile sexual offenders, it seems centrally important to foster and nourish empathic states and experiences, both with respect to the offender experiencing empathy for others but also, equally important, the offender feeling empathically recognized and understood himself (Brown & Kolko, 1998). In addition to

employing psychodynamic treatment (as well as cognitive behavioral treatment) in individual, group and family therapy frameworks, the particular therapeutic approach referred to as victim clarification or awareness can address the roles of taking responsibility and empathy development.

When the victim of juvenile sexual offending is a family member (as if often the case, Rich, 2004), and family reunification is a desired outcome, the ability to demonstrate empathy and to take responsibility for one's offenses can be a complex and sensitive therapeutic process. The focused intervention of victim clarification has been described as a variant on family therapy – a process which is multi-faceted, with multiple, related purposes, and a likely goal of reconciliation and reintegration (in the case of intra-family offending) between the offender and his victim(s) (Mussack & Stickrod, 2002; Rich, 2004). The overarching treatment framework for victim clarification can be summarized as follows:

> (a) clarification to *self* in which the offender undergoes a process of personal change and preparation for making amends; (b) clarification to the *victim*, involving indirect and direct apologies, victim-abuser sessions, and other forms of restitution made to the victim; and (c) clarification to *others* who have also been harmed (italics added, Mussack & Stickrod, 2002, as cited in Rich, 2004, p. 349).

Although not all juvenile sexual offenders in treatment need to participate in victim-abuser sessions, most of the underlying therapeutic work around empathy and taking responsibility need to happen if treatment is going to be successful (Knight & Prentky, 1993; National Task Force on Juvenile Sex Offending, 1993; Rich, 2004 & 2006; Righthand & Welch, 1993). In important ways, the work done prior to victim-abuser sessions (the final piece of treatment before reunification might occur) is the culmination

of all the therapeutic work done by the offender on empathy and taking responsibility; that is, as Price (2004) writes:

> From the start [of sex-offender specific treatment], the abuser is expected to accept responsibility for the abuse, state and understand the harm of his or her actions to the victim, develop empathy for the victim and others, seek to make restitution he or she has caused, and seek to repair the damage the abuse has made to the family and society at large (p. 207).

The duration and particular process of victim clarification and awareness will vary depending on the nature and details of the offense(s), the psychological and cognitive capacities of the offender (and the victim), the clinicians' treatment style and discretion and other possible influences such as outside state agencies (Price, 2004; Rich, 2004).

However, helping the juvenile sexual offender develop healthy connections to others through a process of fostering empathy, building respect for others and establishing a sense of accountability for his actions seem to underlie victim clarification and victim awareness treatment. It is clear that the fundamental aim of work around victim awareness generally, and taking responsibility specifically, is to support the victim; that is, to heal damage, to demonstrate sincere remorse and to make whatever amends are possible (Rich, 2004). For this to happen, the juvenile sexual offender must engage in self-reflection, make (in)direct apologies, show genuine awareness of, and appreciation for, the victim's experience and feelings, and develop an understanding of his own behaviors. (Rich, 2004; Righthand & Welch, 2001).

The treatment vehicle for both engaging in, and making progress toward, meaningful victim awareness and taking responsibility is often the process of disclosing of the offense(s) by the juvenile sexual offender (Price, 2004; Rich, 2004). Typically, disclosing in individual and group therapy precedes disclosing in family therapy, in part,

because the victim is so frequently a family member and adequate and thoughtful preparations (by the victim and the offender) must occur before direct contact is therapeutically appropriate (Price, 2004; Rich 2004). Also, the offender's experience of shame can be an obstacle to him being ready to recognize openly his responsibility for his behaviors and the impact of those behaviors (Price, 2004).

Sometimes, prior to direct contact and disclosure, indirect communication, such as victim awareness and/or apology letters, can be an intermediate step, providing evidence of the offender's movement toward a more empathic stance; in other words, the offender can begin to express "true sorrow, empathy and restitution to the victim (Price, 2004, p. 201). Again, not all juvenile sexual offenders participate in direct victim/offender sessions; nevertheless, victim awareness and taking responsibility are critical treatment issues that can be addressed by other methods.

In fact, the research literature on the efficacy (for victim or offender) of victim awareness work that includes victim/offender sessions is scarce (DeMaio, Davis & Smith, 2006) in general, and nearly non-existent with respect to working with juvenile sexual offenders and their victims. DeMaio's study was intended to explore the victim clarification sessions used with incest victims and their victims, specifically examining when and how clinicians used the sessions and for what proposed purpose. DeMaio surveyed 483 members of the national group, Association for Treatment of Sexual Abusers (ATSA), asking questions regarding the members' practices and attitudes about victim clarification sessions. The study's findings indicated that the top two reasons identified (83% of responses) for utilizing the clarification sessions were for the perpetrator to assume all responsibility for the abuse and to decrease the level of self-

blame by the victim (p. 34). Interestingly, DeMaio's study exploring victim clarification

sessions with incest victims indicates that it may be the therapeutic work around taking

responsibility, which is done *prior* to actual victim clarification sessions, that is the most

beneficial for victim and offender (pp. 31-32); however, the study did not directly address

how and why this might be true. The means by which the offender communicates his

assumption of responsibility and the complementary reduction of blame of others may

not be the critical treatment question.

DeMaio identified several limitations of her study, notably that the participants,

all being members of ATSA, were not randomly selected. Further, only 9% of the

participants stated that they use formal outcome assessment tools, while the majority used

"informal" assessment tools, resulting in the bulk of the findings to be based on anecdotal

information from which it can be difficult to generalize. And finally, Demaio noted that

the survey itself "may have focused too heavily on the clarification meeting or meetings

between the offender and the victim" (p. 38) rather than examining victim clarification as

"a process, not an event" (p. 38).   For purposes of this study, which examines the

treatment focus of working with juvenile sexual offenders on taking responsibility for his

offenses, the DeMaio study's findings may be supported.

In addition to questions about the benefits of victim clarification, the potential

harm caused by direct victim/offender sessions is a consideration (DeMaio, Davis &

Smith, 2006). If the victim is not ready, nor adequately supported, the direct contact with

her abuser may be traumatizing, in and of itself. If the offender is disingenuous in his

apology and/or assumption of responsibility, possibly expressing blame for the victim,

that experience could also be traumatizing for the victim; that situation may also indicate

that the offender has not progressed sufficiently in treatment and thereby still is at risk of relapsing into future offending behavior (DeMaio, 2006; Rich, 2004, Stetson materials).

As mentioned above, family reunification is often the desired goal of victim clarification work; however, (and not surprisingly) the offender must do significant personal and reflective work before reunification can even be considered (DeMaio, et al, 2006; Price, 2004; Rich, 2004). And it seems well-accepted that the necessary groundwork for continued progress in treatment centers on the offender's demonstrated ability to acknowledge that he has victimized other(s), to gain insight into the causes of his offending behaviors, and to understand the likely impact of his behaviors (past and current) on his victim(s) (NAPN, 1993, National Task Force on Juvenile Sex Offending, 1993, Rich, 2004). However, there is a scarcity in the literature that explores how the component of treatment around taking responsibility is conceptualized and implemented by those who work with juvenile sexual offenders.

Summary

Taking responsibility and the development of empathy have been identified as key components of successful treatment with juvenile sexual offenders. In the absence of acknowledging his offense and its impact, and experiencing empathy for his victim, a juvenile sexual offender may reoffend, which is of primary concern, but he may also continue to lead a troubled life. Part of what must inform treatment approaches with juvenile sexual offenders is not only an understanding of the causes and characteristics of juvenile sexual offending, but also adolescent development as it may relate to brain development, empathic capacities, and attachment behaviors. The current study aims to identify how and why treatment work around taking responsibility and developing

empathy is important for treatment success. Much of the literature seems to make mention of these treatment foci, stressing their importance, but stops short of exploring why it is clinically important in terms of facilitating treatment progress. This study is intended to fill in some of that gap in the understanding of working effectively with juvenile sexual offenders.

CHAPTER III

METHODOLOGY

The purpose of this study is to explore the perceptions clinical staff, at a residential treatment program for juvenile sexual offenders, have of how taking responsibility facilitates or enhances treatment outcomes. The primary research question is: How does taking responsibility for his sexual offense facilitate or enhance treatment outcomes at a residential treatment program for juvenile sexual offenders? Limited research has been conducted on the function of, rationale for the inclusion of, and emphasis on, taking responsibility in treatment, sometimes referred to as victim clarification or awareness, with juvenile sexual offenders. Nevertheless, it appears to be a central component of the treatment juvenile sex offenders in this New England residential facility, and is typically used to measure progress, lack of progress, and meeting treatment outcomes.

A qualitative, exploratory research design was employed, allowing for the development of a rich, complex understanding of particular, lesser-known phenomenon (Anastas, 1999). Due to the limited research on the proposed question, a qualitative, exploratory research design allowed the researcher to access clinicians' perspectives of their work on this component of treatment with the juveniles. Semi-structured, in-depth

interviews were conducted with 12 clinicians. The findings from these interviews were analyzed according the major, recurrent themes, as well as divergent themes.

For purposes of this study, taking responsibility will be examined as part of the therapeutic treatment process as employed by the residential program being studied. Focusing on taking responsibility is a clinical intervention that can enable the juvenile to develop a new position in relation to his offense(s); and this new position is reflected both in his thinking and in reality. That is, at the core of the treatment process is the development of a clear understanding that there is a victim of the juvenile's offense, who that victim is, and that typically there is more than one victim of the offense.   This is often a process of fostering empathy, encouraging a sense of remorse and making amends to the victim.

Taking responsibility is defined as acknowledging that one has engaged in particular, negative behaviors and that those behaviors had an impact (direct and indirect) on others. Taking responsibility is comprised of components such as explicitly acknowledging behaviors and impact; that is, the process of verbalizing and directly communicating this acknowledgment to the relevant people (i.e., victim(s), family, therapist). Also, another element of taking responsibility centers on making amends, which may include apologizing or accepting the consequences for behaviors. Finally, a more subtle, but equally important element of taking responsibility is developing perspective-taking capacities and genuinely caring about the impact of one's behaviors – and this will be referred to as empathy.

The term juvenile refers to young people, typically from ages 11-18 years old; however, one clinician interviewed worked with a juvenile who was 8 years old. For this

study, the term sexual offender refers to young males who have engaged in sexual behaviors such as: touching, intercourse, oral sex or exposing themselves, that are either legally prohibited or cause for concern and response. Not all the students at the program studied have criminal charges as the basis for their referral to the school, for the non-court involved students it was determined that their sexual behavior necessitated admission to this program for intensive treatment at a very high level of care.

Setting

The setting for this research project was a 120 single-bed residential treatment program for males, ages 9-21, located in a small New England town. The program has an open referral system, with the majority of referrals coming from juvenile court, mental health professionals, schools and families. Prior to admission, there is an application and interview process. The average length of stay for students is eighteen months. In addition to the clinicians (who each work with an average of 9 students), the program staff includes case managers, residential staff, unit directors, teachers and teacher aides, kitchen and administrative personnel.

The stated mission of the program is to treat male youth with sexual behavior problems, with preventing future sexual victimization as the overarching purpose of the placement. The methods for achieving the purpose are multidisciplinary with a commitment to treating the whole child, not just his sexual behavior problems. The students participate in individual, family and group therapy with staff using integrated treatment approaches – including psychodynamic, cognitive behavioral, psychoeducational and trauma-informed frameworks. Students also participate in school, recreational activities and receive on-site healthcare. Finally, in addition to relapse

prevention goals, the program aims to support the students in becoming competent, capable adults with an "inner sense of compassion" and a commitment to personal and social responsibility. (Rich, 2004).

Sampling

A non-probability, purposive sample was recruited for the study. With a purposive sampling method, the participants are selected specifically by the researcher to serve the purpose of the study and Rubin and Babbie (1993) assert that a purposive sample is used on the basis of the researcher's own knowledge of the population, its elements and the nature of the research aims. This project was not intended to approximate representativeness or to provide a general description of a widespread phenomenon; rather, the interview process, with the selected participants, was meant to offer data that reflected a closeness of the participants' experiences with the therapeutic treatment focus on taking responsibility and victim awareness. In other words, the data gathered and analyzed from the interviews, in part, uses expressive language that offers a presence of the participants' voice (Anastas, 1999).

The target sample size was 12-15 clinicians. With respect to recruiting clinicians, selection criteria included employment at the school (as opposed to clinicians who may have worked with the juveniles prior to admission to the school), as a clinician (rather than a mental health counselor, case manager, school teacher, residential, kitchen or administrative staff) and being responsible for therapeutic treatment (including doing individual, group and family therapy) with the students. All participants needed to speak English in order to participate in this study due to the researcher's limitations as a monolingual English speaker.

With respect to the sampling method, there were approximately 17 clinicians who worked with the students at the school and met the selection criteria. In consultation with the clinical director, the researcher presented her study proposal (detailing the purpose and scope of the project) at the clinical staff meeting, during which she made a preliminary request for volunteers to participate. The researcher did not request an answer from clinicians at the staff meeting; rather, she answered questions and collected contact information. From this contact information the researcher followed up with the potential participants (by email), including a brief project summary, offering possible interview times, and requesting interested clinicians to reply within one week, indicating interview schedule preferences. Once all replies were received, the researcher established a schedule and notified each clinician of his or her interview time. One week prior to each interview, the researcher sent confirmation emails to participants.

As indicated, the participants were self-selected, volunteering to be interviewed. Although this may reveal that participants have relevant knowledge of the subject, a disadvantage of a self-selected sample may be a resulting lack of representativeness in the sample (Anastas, 277); that is, only those participants who believe they have something to say will volunteer, rather than the researcher interviewing all the clinicians who met the study criteria and then analyzing the data.

Participants

This study included twelve clinicians from a residential program for male juvenile sexual offenders. A brief demographic questionnaire was given to the interviewees at the end of the interview and all demographic information was gathered from interviewee responses to this questionnaire (Appendix C). The final sample consisted of 12

clinicians. Of the total sample ten identified as female (83%) and two identified as male

(17%). In terms of racial and ethnic composition of the sample, eleven identified as

white or Caucasian (92%) and one identified as Asian American (8%). Due to the fact

that all interviewees were mental health professionals, the socioeconomic status did not

vary greatly.   Of the twelve interviewees, eleven (92%) identified as middle-class and

one (8%) identified as lower middle class. With respect to professional degrees held by

the interviewees, six (50%) interviewees were licensed social workers, five (42%)

interviewees were licensed mental health counselors and one (8%) interviewee had

received a doctoral degree in clinical psychology. Eleven (92%) interviewees were

licensed in one New England state, with one (8%) stating that they were licensed in

another state, but their license in this same New England state was pending. Finally, the

average number of years working at the residential program was five years, two months.

Data Collection

The design for the current study was approved by the Internal Review Board of

the residential program studied (Appendix A). An Informed Consent form was signed by

all participants prior to the start of the interview. Open-ended, semi-structured interviews

served as the primary means of data collection.

Using an in-person interview as the data collection method in this study had

several advantages. The face-to-face experience allowed both the researcher and the

participant opportunities for clarification as well as elaboration, neither of which would

be possible with a written questionnaire. Further, the researcher could make

observations, gaining "observational data" (Anastas, p. 351) which could enhance

responses above and beyond what the interview was designed to elicit. In terms of

disadvantages of the interview method, although confidentiality was discussed, the researcher and participants were not anonymous to each other, which may have influenced responses. The interview can be an intrusive form of data collection so, if the participant was uncomfortable with the researcher (for reasons possibly relating to the race, gender or appearance of the researcher), the participant may be less forthcoming in her/his answers or may answer with responses that the participant believes the researcher will find acceptable (Anastas, 1999).

The researcher conducted all but one of the interviews in the participant's office. One clinician, at the last minute, needed to be home with a sick child, and the interview was conducted there (with the child occupied in another room). The length of the interviews ranged from the shortest being exactly one hour and the longest being one hour forty-five minutes. Each interview was recorded on an audio recorder and transcribed by the researcher. All identifying information was removed from the transcriptions and the researcher's field notes, and interviews were alphabetically coded to safeguard confidentiality.

Prior to conducting any interviews, participants signed consent forms. The Informed Consent Form for the participants clearly described the purpose of the study, the participation responsibilities for the subjects, the inclusion criteria and any potential risks and benefits related to taking part in the research study (Appendix B). Careful attention was paid to protecting participant confidentiality and these efforts were detailed in the consent forms as well as briefly discussed before starting the formal interview. Only the researcher had access to the raw data, all identifying information (relating to

clinician, program and students) was removed from transcripts, transcripts were given numerical codes and all interview-related materials were securely stored.

Data Collection Instrument

A semi-structured interview guide with 16 open-ended questions was used to gather data covering topics such as definitions of taking responsibility and empathy, the nature of therapeutic conversations about taking responsibility and approaches to disclosure of offenses. Questions asked included, how clinicians conceptualize and discuss taking responsibility with students they see in treatment, as well as how clinicians observe and assess progress (both within treatment and in the milieu) around taking responsibility. A portion of the interview questions were structured to elicit clinician perspectives on the taking responsibility focus of treatment, such as what is the clinician's understanding of the purpose of taking responsibility for sexual offenses in treatment progress, while a resident at the school, as well as once the student is discharged. The interview also included questions about the clinicians' experience of working with the specific, guided focus on taking responsibility; that is, how is progress observed, are there common points of resistance and/or growth, what theoretical framework is employed and what is the clinician's experience of offense disclosure like.

Data Analysis

The audio-taped interviews were transcribed to facilitate data analysis. Each transcript was read and reread several times before coding began. Interview transcripts were analyzed thematically for the purpose of identifying major themes and divergent opinions. Interview questions were designed to elicit rich, narrative descriptions of the clinicians' experience of the taking responsibility component of treatment. Content

theme analysis was applied to the narrative descriptions, exploring and identifying common experiences and perspectives through the data analysis process. Transcripts were also examined for divergent themes or significant issues raised by the participants not anticipated by the researcher. The coding process was structured around the questions asked, with attention to common and/or unique responses. For example, when asked about how working on taking responsibility in individual, group and family therapy might be different, there was consensus about group therapy being the most common (and often the first) setting in which a student might disclose details of his offense; while most interviewees responded that family therapy was considered the most crucial setting for disclosure in terms of a student's progress around taking responsibility. Thus, the findings are organized following the overall interview guide structure, with sub-categories presented based on the emergent themes elicited from the responses.

As with all research, concerns about the trustworthiness of the data must be addressed. For this project, a number of techniques were employed in an attempt to ensure data trustworthiness. First, the researcher randomly selected three transcripts for the initial coding process rather than starting with the first interviewee transcript. This was done with the intention of minimizing potential influences of first impressions or the premature formulation of particular ideas based on the early interviews. The development of these preliminary codes served as a template for future coding, allowing for coding consistency as well as leaving room for the addition of new codes. Second, the researcher had the assistance of her advisor in "checking out" (Anastas, 422) the codes, again to ensure consistency and appropriateness of codes. Finally, the researcher

maintained thorough (and secure) records of all data collection and analysis, creating an audit trail with the intent of enhancing the accountability of the data (Anastas, 423).

Although this study was intended to provide rich, in-depth descriptions of the experiences of clinical treatment focused on taking responsibility, it is understood that making major generalizations would not be appropriate. A qualitative, exploratory research design was selected for the purpose of examining a question not previously studied. However, limitations to this project's widespread application would include the small sample size (N=12) in addition to the fact that the sample participants were selected from clinicians working at a specific, all-male, residential treatment program for juvenile sexual offenders under the age of 21.

CHAPTER IV

FINDINGS

This chapter contains findings from interviews conducted with twelve master's or doctorate level mental health professionals who work with juvenile sex offenders at a residential treatment program for juvenile sexual offenders. The interview guide used by the researcher was designed to elicit rich, narrative data on how clinicians work with students on taking responsibility for their sexual offenses (Appendix D). Interview questions asked clinicians to define taking responsibility and to discuss both the therapeutic work on taking responsibility as well as their perceptions of its role and importance for treatment success.

The majority of the questions directly addressed the therapeutic process (in a sex offender specific residential program) around taking responsibility, what clinical issues might influence that process and how progress was observed. The interview guide, in part, provided a conceptual framework for the data obtained. Transcripts were examined for divergent themes or significant issues raised by the participants not anticipated by the researcher. The coding process was structured around the questions asked, with attention to common and/or unique responses. For example, when asked about how it might be different working on taking responsibility in individual, group and family therapy, there was consensus about group therapy being the most common (and often the first) setting in

which a student might disclose details of his offense; while most interviewees responded that family therapy was considered the most crucial setting for disclosure in terms of a student's progress around taking responsibility. The findings in this chapter will follow, essentially, the order of the questions in the interview guide. Interviewee quotes will be included to provide in-depth, experiential information about major themes that emerged from the data. Interviewees were randomly assigned a letter from A to L in order to identify their responses to questions.

Participant's Clinical Experience

All general demographic information about the interviewees is included in the Methodology Chapter. However two items provide relevant background information that may affect the nature of the responses to the interview questions. The first is the training experiences of respondents. Of the twelve interviewees, four responded that they had received training on working with juvenile sexual offenders at the program studied, and two of those interviewees also identified their weekly clinical supervision as training. Six interviewees responded that they had participated in relevant training for working with juvenile sexual offenders on taking responsibility. Finally, three interviewees left the question blank but did not provide explanations for the omission.

Second is the length of employment at the program and with what age group of students did the interviewee work. With respect to length of employment, the average was five years and two months, with the shortest time being two years and the longest time being a little over nine years. In terms of age of students, nine of the interviewees worked with students from ages thirteen to eighteen, one interviewee also worked with

students from ages eight to thirteen and, finally, two interviewees also worked with students, ages eighteen to twenty-one.

<center>*Talking about Taking Responsibility*</center>

Interviewees were initially asked about how they talk about taking responsibility with the students they see in treatment. A number of main themes emerged from their responses. Of the twelve clinicians interviewed, seven talked about taking responsibility as having important benefits for the student. One interviewee described taking responsibility in the following way:

> I try to explain the importance of taking responsibility as a prerequisite for exploring and understanding past sexual behaviors…to be able to identify contributing factors and triggers and what he was feeling and thinking at the time. To help the student make sense of his behaviors and help him recognize warning signs to help with relapse prevention (Interviewee F).

The focus on understanding past behaviors as a means to preventing future offenses was a central benefit to the student, as one interviewee stated "In order to be successful in treatment, they really need to take responsibility for the things they have done so we can figure out how not to do them again" (Interviewee C). Another interviewee responded with:

> If the goal is to work with the student so that he does not reoffend, [he] need[s] to have a pretty clear idea about what occurred during [his] offenses. Be aware of it, try to plan ahead, using different interventions and getting a better understanding" (Interviewee B).

One interviewee identified taking responsibility for past offenses as a necessity for preventing future offenses, stating, "To me, taking responsibility is everything in working with sexual offenders - if the kids don't take responsibility, or can't, they cannot move

forward in their treatment, in their lives even, and lower their risk level around reoffending" (Interviewee H).

Six interviewees highlighted the usefulness of identifying the prevention of future offending when working with students, appealing "to their tendency to just sort of look out for themselves and try to demonstrate how taking responsibility can be helpful for them" (Interviewee A). One interviewee also stated that, "taking responsibility can alleviate some of the shame for having committed offenses" (Interviewee B). Finally, one interviewee also indicated preventing future legal trouble as a benefit when she talks to the students :

> I also tell them that, at any time, a victim might come forward. If a kid
> has successfully completed treatment here, leaves and three years later a
> victim comes forward and reports an offense. The school will be
> contacted and we will be asked to show our records and asked if we talked
> about the new victim, if we've done treatment about this new victim. If
> that hasn't happened, chances are the kid is in legal trouble, will likely be
> sent to another program because he hasn't really done his treatment. So
> it's not worth it to hold back and take that risk (Interviewee C).

Five interviewees expanded the benefits for the students' future to include prevention of problematic, non-sexual behaviors that can often "have similar thinking and behavioral patterns" (Interviewee K). One interviewee stated, "I tell the kids right from the start that this is important, that they take responsibility for everything that they've done, and that includes [sexual] offending or any other behavioral cycles that they are in" (Interviewee H).

Six interviewees also specified the potential, and important, benefits to the victims, when talking about taking responsibility with the students, "that [taking

responsibility for sexual offenses] can be helpful for the person [the student] has hurt"

(Interviewee G).   One interviewee remarked:

> I tell the kids there is also a responsibility to those people they have
> victimized, so [the victims] can have an opportunity to get treatment
> themselves. If the kids don't [take responsibility], their victims don't get
> treatment and it's not fair to the victim (Interviewee C).

Ten of the interviewees identified emphasizing honesty (through the process of

disclosing details about sexual offense) as the crucial means for taking responsibility,

with one interviewee stating, "Throughout treatment I talk about how we cannot change

behaviors we are not honest about" (Interviewee A). Two interviewees indicated that

being honest about all their offenses provides the students with an opportunity to fully

understand their behaviors and they gave the following responses:

> To get a better understanding, [the student] needs to be completely honest
> about what has happened. If [he] leaves stuff out, then maybe some key
> factors will evade the student so it's less about 'you need to do it because
> we tell you to,' or even that it's the right thing to do. But more
> pragmatically, it seems to be beneficial to the students (Interviewee B).

> There might have been different causes or motivators for the other
> offenses, the pattern of offending might be different. If you don't talk
> about everything, you won't get the type of treatment you need
> (Interviewee C).

Seven interviewees described their particular approach or technique when talking

about taking responsibility with the students, with a common emphasis on attention to

timing and the characteristics of each student or "where they are." One interviewee

described her approach for encouraging honesty as part of taking responsibility in the

following way:

> I talk about how it's really important, as I ask about sexual behavior
> history, how it's really important to just say 'I don't want to answer a
> question,' rather than lie about it because that makes it more difficult later

in treatment to talk honestly. I kind of gradually introduce them to responsibility in this way and kind of let them make it a process because the more pressure that's put on them, the less they take responsibility later on. So, in some ways, I'm always talking about responsibility, but I am building a process for them to take responsibility that I try to make not so threatening (Interviewee A).

One interviewee, in addition to addressing many of the above-described considerations, identified the importance of being non-judgmental, with the response:

I ask them general questions about their behavior, not about sexual behavior until I've gotten to know them – maybe 3-4 sessions in. You hope by that point they feel a little more trusting of what your intentions are. I say it's important for them to be honest and that I'm not going to judge them, no matter what they say (Interviewee I).

This interviewee also stated that, at the start of treatment, they use writing exercises from a workbook about disclosure to help the student feel less threatened by the idea of disclosing details of his offense.

Overall, the interviewees all described the importance of talking about taking responsibility, identifying taking responsibility as a key element to both treatment progress and future behavioral success for the students. The distinctions between responses primarily reflected differences about emphasis on the purpose and result of taking responsibility, and approach or style.

Clinicians' Conceptualization of Taking Responsibility

When asked about how they conceptualize taking responsibility, themes emerged from interviewees answers that were distinguished in terms of focusing on active aspects that might be demonstrated through a student's actions or more abstract or cognitive aspects that might be reflected in a student's thinking about taking responsibility. One interviewee described taking responsibility as "layered" (Interviewee H) while another

answered that taking responsibility involved "three levels" (Interviewee F). In other words, the interviewees seemed to conceptualize taking responsibility as having to do with the student's relationship to the offending behavior; that is, admission and reparation of both the offending behavior as well as its impact.

With that said, all twelve interviewees presented answers that included both aspects of admission and reparation. For example, one interviewee stated, "Taking responsibility is the ability to acknowledge to myself that something I've done has caused an affect and also the ability and willingness to respond to the situation and affects. [Interviewee] then translates this for the kid [interviewee] is working with" (Interviewee E).

In describing the "three levels" of the concept of taking responsibility, the interviewee described:

> We tend to look at thinking errors and cognitive distortions, which maybe defines what taking responsibility is not. So taking responsibility for the role they played in what happened. One person could say 'I sexually abused this person but I was drinking at the time' so in one way they are taking responsibility because they are saying 'I did this' but if you go a little deeper, they aren't because they aren't taking responsibility for their motives or intent. And they aren't taking responsibility for the consequences of their actions. So fully taking responsibility involves three levels: taking responsibility for the action, for the motive or thinking and for the consequences (which would involve being in treatment) (Interviewee F).

For the interviewee who used a "layered" conceptualization, they stated:

> Taking responsibility means accepting what you did and being genuine and honest about it. I talk a lot to the kids about vulnerability because when you are vulnerable, you are being open, true and honest to who you are and so I really hope for all my kids that they will be vulnerable to an extreme, not raw but really open and honest with everything, taking responsibility for every thought, word and deed (Interviewee H).

Two interviewees described trying to assess whether a student is fully taking responsibility, with attention to acknowledging the impact of offending behavior with one interviewee stating:

> If someone is taking responsibility but they are not really acknowledging the impact they've had, that is important to me. So, if a kid is disclosing everything, but then acts like it was no big deal, like 'Yeah, yeah, I did it but she wanted it.' For me to really say, 'Yeah, this kid is really taking responsibility, it has to include acknowledging the hurt- taking responsibility for the pain they have caused, that for me, is a big part of it, not just admitting to the details of what occurred (Interviewee B).

Another interviewee also described that acknowledging the harm can be the most difficult part of taking responsibility:

> There's a bigger component of taking responsibility which is recognizing the harm that was done – that's the big piece. Some students can't say what they did out loud because they do see the harm in what they did and they are avoiding recognizing it. I think the bigger piece is recognizing harm you have done and letting people know that you know that and are aware of that (Interviewee D).

All twelve of the interviewees also made reference to the application of the concept of taking responsibility to non-sexual behaviors as well. One interviewee described it as "the little behaviors you see on the unit, like you take an extra cookie and then deny it, even though someone saw you" (Interviewee J).

One interviewee, although identifying similar thought and action aspects, spoke more broadly about the concept of taking responsibility:

> As a general statement, not just relating to the kids, [taking responsibility] is accepting that the things that happen in the world around us are more or less shaped by our own behaviors, interactions and actions and that we have a name for that – an internal locus of control. This has to do with recognizing the cause and effect of our behaviors and not just on other people but upon ourselves as well and the social medium through which we connect with other people (Interviewee L).

Finally, one interviewee added the issue of consent to the conceptualization of taking responsibility in stating:

> In addition to being honest about whatever their behavior was, the second part is understanding what consent is and what the consequences are for not having it. Some kids really don't have an understanding of what needs to be in place in order for there to be consent, so I talk about that. And then, taking responsibility is if they are being honest and have an understanding of consent, and then taking responsibility for the harm that they have caused (Interviewee I).

The responses about conceptualizing taking responsibility all centered around acknowledging offending behaviors, understanding how and why those behaviors happened, and then being willing to respond to the impact of those behaviors.

Clinicians' Conceptualization of Empathy

Interviewees were asked about how they conceptualize empathy, and from their responses a number of themes emerged. Similar to answers about conceptualizing taking responsibility, many of the responses identified a thinking, or cognitive, piece as well as an action, or behavioral, piece. However, all twelve interviewees also emphasized the importance of experiencing feelings for the development or enhancement of empathic capacities, with an overall theme of conceptualizing empathy as encompassing thinking, acting and feeling. Also, four interviewees included a student's developmental stage as influencing empathic capacities, asserting that cognitive and emotional abilities limit or enhance empathic skills.

The interviewees all identified "perspective taking" as essential for there to be empathy, with seven interviewees beginning their responses with "being able to put yourself in someone else's shoes" (Interviewees A, B, C, D, E, H and I). In defining

perspective taking, one interviewee described it as "seeing things from another's point of view" (Interviewee D); while another interviewee defined empathy as "thinking about how other people feel" and "exploring where other people are coming from" (Interviewee I). This interviewee also added the importance of "being interested in how other people feel and having that impact choices about behavior" (Interviewee I).

The dual aspect of caring about another's feelings and the influence on choices about behavior was included in the responses of eleven interviewees. One interviewee gave the following example to expand beyond simple perspective taking and to include behavioral indicators:

> I say empathy goes beyond noticing what the other person may be experiencing but to act in a way that you are showing that you care about the way the other person feels. So not only knowing that [your peer] is upset because her dog died but to be able to act in a way that you would want to be treated if it were you, saying things like "Hey, are you okay? That must be hard for you." (Interviewee F).

Another interviewee specifically identified empathy as an "active process" describing it in the following way:

> Empathy goes beyond compassion; it's not just a concept or a word. When [the students] leave [the program] to show true empathy, they have to not only be sorry for what they did, taken responsibility for what they have done, imagine and understand the victim's experience, but to give back to society and everyday remind themselves of what they did. Not to beat themselves up, but to help the victims carry the burden. The victims are carrying the burden of the offending their whole lives and unless the [student] is carrying that burden with them, I don't think it's a fair balance or taking responsibility by the offender. So empathy is really an active and detailed process for me (Interviewee H).

Three interviewees addressed the issue of the potential for developing empathy, with two describing it in terms of being able (and not being able) to "teach" empathy (Interviewees G and I), and one stating that, in some cases, the development of empathy is not possible

(Interviewee C). The response addressing teaching empathy was described in terms of whether or not a student has the capacity at all. One interviewee stated:

> I think when I started here, I thought you either have empathy or you don't, but I've seen here that you really can teach it. I used to think of it as black and white but I have a kid whose report said he had absolutely no remorse, but every now and then you see a glimpse and just when you think he doesn't care about anyone but himself, he will say, "I was in group and another kid was talking about how sad he was about his grandmother dying and I felt really bad for him" so you can see change that way (Interviewee L).

For the interviewee who responded that empathy couldn't be taught, empathy was defined as:

> An intrinsic element of being human…a natural condition that has to do with self awareness and awareness of others that develops in a social environment. I don't think we can teach empathy, we can teach concepts about empathy, but that's like teaching someone to see – they can already see, we may help them see better or recognize what they are seeing, but we can't teach them to see (Interviewee G).

Finally, one interviewee responded by stating, "Empathy is when a kid can see something from another's point of view and feel for them as if he were that person, but very few of the kids really end up getting that" (Interviewee C).

In general, elements of thinking, feeling and acting were present in all the interviewee's responses, with an overarching feature of perspective taking. A third of interviewees highlighted developmental stages and two interviewees raised the question of whether empathy can be taught. Only one interviewee indicated that for some students, developing empathic capacities (whether taught or enhanced) is not possible.

Issues of Diversity and the Impact on Taking Responsibility

When asked about the impact of issues of diversity (race, ethnicity, socioeconomic status and sexual orientation) on a student's ability to take responsibility

49

for his sexual offenses, the majority of interviewees stated these sociocultural factors, to varying degrees influence the treatment.

Nine interviewees responded that issues around sexual orientation can play an important role in working with students around taking responsibility for sexual offenses and they were specific in stating that the role it plays is amplified when the offending behavior was against another boy. A central theme was characterized by the student's confusion about his own sexual orientation - such as concerns about implications for his own sexual orientation, as well as concerns about what others might conclude about his sexual orientation. Three interviewees described a common experience of having a student ask, "Does this [offending a boy] mean I am gay?" (Interviewees B, E and J) while four interviewees spoke of students asking versions of the question "Does my being gay have anything to do with why I offended a boy?" (Interviewees A, E, I, and L).

In addressing these questions, five interviewees discussed the need for psychoeducation about sexual orientation (A, F, H, I and K) to help students "sort through" their confusion. While three interviewees emphasized the need to normalize diverse sexual orientations (Interviewees B, H, and J) with one interviewee stating that the program has a group for "gay, bisexual and questioning youth" (Interviewee H). One interviewee, in discussing the work around normalizing sexual orientation stated the following:

> I think you have to do a lot of education, explaining that it can be fine if a student is attracted to males, females or both, but, the rules are still the same, regardless. You cannot have sexual behaviors with someone below a certain age, issues around consent that is still the same. You'd be surprised how many kids believe "Oh, it's okay [offending another boy] for me, if I am gay" (Interviewee F).

While another interviewee described the process of "ferreting out" questions around

sexual orientation and sexual offending by using an analogy:

> I say to the kids, "Some kids here have sex with animals, does that mean
> they want to date animals? Probably not. We need to talk about this in
> order for you to be able to take responsibility, but I am not assuming you
> are telling me about your sexual orientation – there is a difference between
> your offending behaviors and your sexual orientation and we are not
> talking about the same things" (Interviewee A).

Six interviewees focused on students' concerns about what others will think,

including family and society in general. One interviewee responded with, "I think there

is a lot of internal work that has to be done because for many of the kids who have

offended boys have a hard time admitting it to themselves and worry about what their

families will think" (Interviewee I). Three interviewees made the distinction about the

students' perception that offending boys is considered a worse offense than offending

girls, that it is "more cause for concern" (Interviewee I) or that "[students] have a harder

time acknowledging offenses against males, where they will more readily acknowledge

offenses against females" (Interviewee A).

With respect to the other sociocultural factors of race, ethnicity and

socioeconomic status, when asked, seven interviewees were more likely to identify a

student's community (including family), which would reflect a myriad of sociocultural

factors, rather than a particular factor. One interviewee responded by stating:

> I'm not sure race or ethnicity or socioeconomic status individually have
> much to do with [taking responsibility]. We have middle class kids who
> came from dysfunctional families in which a kid did not get a sense of
> taking responsibility, but family or social dysfunction that might
> accompany drug abuse or economic stress, seems to affect the kid's lack
> of learning of prosocial rules (Interviewee E).

Another interviewee described the impact of the family culture "not the ethnic culture" as important, influencing "how a kid dresses, the music he listens to, and his attitudes toward women" (Interviewee A). One interviewee described the influence of community culture on taking responsibility as "giving kids different reference points, including how therapy is looked at" (Interviewee F).

Three interviewees specifically mentioned how some students enter the program coming from gangs or especially violent neighborhoods and that experience shaping expectations about being "tough" and the implications of how to take responsibility (while in the program and once they leave). One interviewee described working with a student in the following way:

> One of the things we talk about is how it is easier while here to work on taking responsibility, saying "I'm sorry" while looking someone in the eye, or saying "I didn't intend to hurt you. Do you accept my apology?" But where he comes from, if you look someone in the eye, they will consider that a challenge to fight. So it's a very different way of approaching taking responsibility and problem solving (Interviewee H).

While another interviewee stated, "If you're living in a section of a big city where violence is a normal thing, and rape is a kind of violence, the offending might just be perceived as normal rather than something that needs to be reported" (Interviewee L).

Three interviewees responded that they did not consider issues of diversity, or sociocultural factors, to have an impact on students' ability to take responsibility, but their reasons were different. One interviewee, prior to the interview, had looked back at students with whom she/he had worked, looking at who had, or had not, been able to take responsibility, and responded by stating, "I didn't really see a pattern, like, Hispanic students really have a hard time taking responsibility or something with kids who were

confused sexually, I didn't see any patterns emerging" (Interviewee B). However, this interviewee did indicate that if a student was referred to the program from a detention facility or another program that was not sex offender specific, that most recent "culture" could influence a student's willingness to be honest about his offending behaviors (Interviewee B). Whereas the other interviewee's response was:

> I don't think that stuff has that much impact at all. I have a hard time seeing kids as something like he's homosexual or he's Spanish – I don't see kids that way. I just look at people as people so I don't really take those things into account at all (Interviewee C).

The third interviewee simply stated that:

> I have worked with such diverse populations, in terms of race or socioeconomic status, and I haven't noticed a difference with being able to take responsibility. I can imagine those things might have an impact, but I haven't seen it" (Interviewee J).

Lastly, one interviewee, answering more broadly, described sociocultural factors as "social constructs, that are real, but I think they impede people because they make people more or less willing or open or capable, affecting their ability to grow and develop" (Interviewee K).

Impact of Developmental Stage and Early Trauma on Taking Responsibility

When asked how issues relating to a student's developmental stage and childhood trauma might impact his work on taking responsibility, there was overall consensus among the interviewees that early life experiences were very influential, primarily in the type of treatment work that needed to be done for the students to be successful. The emphasis, however, was more on the impact of trauma (both on treatment and development), than strictly developmental issues, even though trauma and development, in some ways, cannot be separated.

Beginning with the responses to issues of development, all twelve interviewees spoke to the significance of early developmental experiences, whether or not there was trauma, abuse or neglect. One interviewee simply stated, "Early development, even if it is positive, has so much to do with their family and their experiences with their family definitely affects how they take responsibility" (Interviewee A). One interviewee described the influence of development on treatment as follows:

> Some kids are from families where they learn more that what people do are these prosocial things and that people care about each other, and even though they offended someone and did these terrible things, they got enough of the 'good mothering' stuff that they have internalized, that that affects their ability to engage in treatment and think about who and how they want to be (Interviewee E).

This interviewee also spoke about how simple chronological maturation, specifically the passage of time while at the program, can enhance a student's treatment and his development of empathy:

> Developmentally, it seems as if somewhere between 14 and 16, kids' cognitive development allows them to see themselves and other people as different, more than they did before, and to have more of a sense of agency and insight about that and are then more able to take responsibility. They kind of get that they did something (Interviewee E).

Also, this interviewee added that it can be a treatment dilemma when treatment expectations may not match up with developmental realities:

> I really think that some of what we ask kids to do around empathy does not really make sense regarding what we know about empathy and brain development, particularly with boys. Fourteen year old male brains don't have a heck of a lot of empathy (Interviewee E).

Finally, this interviewee mentioned thinking about Piaget's ideas about moral development when working with students who are struggling through treatment.

Two other interviewees described the affects of maturing on a student's treatment

and ability to take responsibility. One interview stated:

> I think I have seen the impact of the developmental stages because I have
> seen them go from 12 to 15 years old. It is interesting to watch how they
> mature from when they started here. It is a different way of thinking at the
> beginning, like, "I didn't do anything wrong" or blaming someone else
> and then, over time, becoming much more accountable and mature about
> it. I've seen that within the same kid (Interviewee K).

Another interviewee described how developmental changes (particular to the brain)

occur, not just while the student is at the program, but also from the time that the

offending behavior occurred:

> There are the kids who, for whatever reason, when the offenses occurred,
> their brains hadn't developed. A 15 year old here, who offended maybe
> when he was 12 and now feels really bad, maybe at 12 he just didn't get it
> back then. Maybe, it's not so much the treatment, it's just that they've
> matured in those years. So development definitely plays a part
> (Interviewee B).

Another interviewee's response addressed the long lasting implications of developmental

experiences for how a student might do in treatment, regardless of the presence (or lack)

of a trauma history:

> Early and ongoing experiences shape the way the brain interacts with and
> experiences the world, influencing behavior and emotional development.
> Development affects neurology. It's not just an emotional change, but
> physiological as well. It affects the way peoples' emotions develop, how
> they understand and express themselves, how they behave in order to get
> their needs met. Those things are increasingly difficult to undo as time
> passes. For responsibility purposes, a student is going to have to
> overcome early developmental experiences and reform or rehabilitate the
> way he experiences the world (Interviewee G).

One interviewee, in addressing treatment approaches that incorporate an understanding of

developmental issues stated:

I would say we are working with kids who are developmentally delayed, emotionally or mentally or even physically, like failure to thrive kids. So you might be working with someone who is 14 years old, but emotionally he is more like 10. So I think it affects the work a lot in that you have to explain things as if they were younger (Interviewee F).

A theme among the responses about development and treatment focused on the role of the family in the students' lives while at the program. Addressing treatment implications, while also making a connection with family dynamics, one interviewee responded:

Some younger adolescent males seem like they don't want to rat out their family and they'll say their family is wonderful and it's just the kid who is bad. They really need to believe that when they are young because they need their family to be the caretaker and safety net. But as they get older, they can view the family as somewhat dysfunctional and they can talk about that. But when they are younger, they can't do that. There is a lot of loyalty and they can't take responsibility for their own stuff without feeling like they are blaming the family (Interviewee L).

Another interviewee, expressing frustration about the tenacity of early developmental experiences, elaborated with:

A kid can really be growing and working toward taking responsibility and then they see their mother, who is doing drugs, and the kid knows it, and the kid knows she is lying to me or to DSS and the kid knows that that is what is done in their family. And then it all goes to hell. Early development does that (Interviewee A).

This interviewee also described one treatment approach to lessen the negative impact of early development:

In group, I use peer pressure around taking responsibility and that's more effective than me and I find that that can also override, or start to override what their families are doing. If you have their peers push them along, they can maybe move past their family (Interviewee A).

Two interviewees, in discussing family and early development, stated that the undoing of negative family dynamics, particularly around taking responsibility can be

more difficult if a student will be returning home or if the student is not yet an adolescent (Interviewees C and J).

As with early developmental experiences, the interviewees all expressed similar responses about the considerable impact of childhood trauma on the students with whom they work, and the students' ability to take responsibility for their offenses. One prominent theme was the importance (and necessity) of working in treatment on trauma before shifting some treatment attention to sex offender specific work. However, aside from identifying the crucial work of stabilizing students before deepening the therapeutic work on trauma or addressing the sexual offending, there were differences with respect to why this therapeutic ordering of work was important.

Three interviewees described the initial focus on trauma as laying the foundation for a student to understand the connection between past experiences and his offending behaviors. One interviewee responded that, "In order for a student to develop any insight into his own behavioral problems, working on the trauma can help them see that there probably is a connection" (Interviewee F). Another described it as a dilemma for the student with the trauma history, "If a kid here has trauma, he's the offender and the offendee and that can be confusing and hard" (Interviewee C).

Three interviewees indicated that for some students, it is not until they realize the impact and hurt caused by their own trauma that they are able to recognize the impact and hurt caused by their offending behavior and may be more able to take responsibility. One interviewee specifically responded that understanding his own trauma can be "really helpful for the empathy piece, when a kid can reverse it and look at what someone has done to them" (Interviewee K). Another interviewee answered that the experience of

working on his own trauma can also help a student understand the difference between guilt and shame, stating, "For some kids, being able to say 'This is something I feel guilty about, so it is something I need to take responsibility for and that is not the same as something I feel shameful about' can be really important in treatment" (Interviewee E). However, one interviewee asserted that understanding his own trauma history can make it more difficult to take responsibility because of the fact of recognizing that he has caused the same harm to others that he experienced, and the shame that he feels (Interviewee L).

Four interviewees indicated that when a student experiences confusion around his trauma history, and its implications for taking responsibility, the student either does not understand that anything wrong was done to him or he experienced some degree of pleasure from the traumatic interactions. One interviewee described it in the following way:

> I know that there are times when the barrier for taking responsibility turns out to be something traumatic that happened way back so the kid is like, 'well, if I have to acknowledge that I did these things and that's bad, then I have to acknowledge that these things that were done to me by a favored relative are also bad and I can't deal with that' (Interviewee B).

Another interviewee provided an example of working with a particular student who experienced some pleasure from his childhood trauma:

> I had a kid who had been offended by an older man and he liked quite a bit of it. There were parts that he understands and that he feels shame about but he did experience some sexual excitement and satisfaction and I think that played into both his offenses and taking responsibility. I think he thought 'Well, I didn't mind it so maybe they [the victim] don't either (Interviewee I).

One interviewee described both the confusion and clarity that can be experienced by a student with an ambivalent relationship to his trauma:

If a kid is offended by people they really trusted and really liked, then sometimes they don't consider it traumatic. They just consider it something that happened. And then if it happens again, it's still not traumatic. But if we convince them how bad it was, then they can relate to it, 'Okay, I did something bad' and then sometimes it really hits them about their own trauma, 'Oh my god, that happened to me!' But sometimes initially, it's not trauma at all to them (Interviewee C).

Another theme that emerged, specific to taking responsibility, was regarding how trauma and abuse might have been addressed in a student's family. One interviewee described this as follows:

Some kids, people from their family offended them, or even from outside their family, and no one believed them. Or, noone pursued consequences for that person. Those kids are the ones that have the hardest time taking responsibility because, in their early development, they didn't see their primary caretakers taking responsibility or holding others responsible (Interviewee A).

Another interviewee expanded upon the theme of trauma, family and taking responsibility with the following response:

If a family member has been offended, like a mother or father, they might say, 'My kid did this [sexual offense]? No way.' They will not admit that because then that means their son is as bad as the person who victimized them. And if they have dealt with [their own trauma], it makes it really difficult to both do family work and to get the kid to take responsibility himself (Interviewee K).

A divergent theme emerged in the responses of three interviewees who described their experience with students with trauma histories who seemed to more easily take responsibility for their offenses. Two interviewees put it simply with the same response, "I think kids who have been really traumatized are more able to take responsibility ((Interviewee B and I). One interviewee expressed being surprised by this experience, raising the possibility of empathy as an explanation for a student's ability to take responsibility:

You would think that kids who have been offended themselves would say, 'Oh it's not my fault because I've been offended and that's why I did it. It gets me off the hook.' but that's not really what I see, they are more responsible – I don't know if it's that they are more accountable or that they feel like because it happened to them, they really understand it. Like it's part of the empathy experience for them (Interviewee H).

However, there was one interviewee who mentioned that some students with trauma histories have the experience of both not being able to take responsibility for the offenses nor address their own trauma:

I've found that the students who have difficulty taking responsibility for their own behaviors are also the same students who have difficulty acknowledging their own victimization. Or the kid cannot acknowledge it [the trauma] openly. It seems to me that that goes hand in hand. The kid might worry about getting someone else in trouble, so it's not always just about saying it out loud (Interviewee D).

Overall, each interviewee addressed the impact of both development and trauma on the students treatment work on taking responsibility. Some interviewees were specific in how development and/or trauma influences their treatment approach, while others remarked on the students' progress in treatment, development of insight and emotional experience in relation to their offenses. Finally, the role of the family was identified as significant for both the interviewee and the student when working on trauma and taking responsibility.

Taking Responsibility, Disclosure and Treatment Setting

While at the program, students participate in individual, group and family therapy. When asked about how the conversation about taking responsibility, through disclosure, might be different in individual, group and family therapy several themes emerged. Interviewees generally responded that the 'conversation' about disclosure might not be different (Interviewee G) but there were differences including: the sequence of treatment

setting in which disclosure typically happens, factors depending on students' age, their

comfort in the program, their relationships with their families, and the nature of their

offenses. For practical purposes, this section will present the responses organized around

each treatment setting, beginning with group therapy.

Eleven interviewees described group therapy as the place in which students are

most likely to first disclose details about their offenses. The responses indicated several

reasons for this: the role of peers (often referred to as the "culture of disclosure") and the

experience of feeling less discomfort around disclosing in group than in either individual

or family therapy. With respect to the role of peers, several factors were mentioned,

including peer support, peer pressure and role modeling. Six interviewees responded that

they help newer members of a group feel more comfortable with disclosing by describing

the disclosure experience of older members, "normalizing that disclosure is hard at the

start, but, over time, they will be able to do it" (Interviewee H) or "telling kids that most

kids don't disclose everything right away and that I expect they have more to tell and will

do so when they feel more comfortable" (Interviewee C). One interviewee described it in

the following way:

> When a new member comes in, I'll have an older member maybe talk
> about what it was like when he first started and how (and why) it was hard
> to be honest and what helped him. I'll say that we know most people have
> a hard time being honest in the beginning, that it can take awhile, but that
> it is important to talk honestly and openly about their behaviors
> (Interviewee I).

While another interviewee asserted:

> Peer groups are really important to hammer home the message [about
> disclosure] and I think it starts right from the beginning, so even a kid
> coming in today, they're going to group. In the group, you're likely to
> have a disclosure going on and the kids are talking about their offenses

61

and trying to take responsibility and the kids see that's just how things are done around here (Interviewee B).

One interviewee, also referencing to culture of disclosure, mentioned that since the program adheres to a "no secrets" policy, group members know that everything will be discussed in group, and that either the facilitator or another member will bring an issue or incident up:

> I make it clear in my group that if you don't bring it [i.e., problem behavior on unit] and it's something serious, I will. So they have pressure about whether they will take responsibility or if someone else will hold them accountable. So, some kids who have a hard time taking responsibility get sick of me bringing stuff up or other kids bringing stuff up and will eventually start bringing stuff up themselves and then things will change (Interviewee A).

One interviewee talked about, how, for some kids, the process of disclosing is incremental in group, often starting with simply agreeing with remarks made by other group members, "If a student feels too much pressure about an inability to put their thoughts into words, group can be helpful because they don't need to. Another kid can say something and the kid can agree, or join with what the other kid said" (Interviewee E). However, this interviewee also mentioned that, for some students, the "social aspect and pressure" of group is too much, especially if a student has a lot of shame, and, other than non-verbal participation (such as raising his hand to show agreement), disclosing in group is less likely than in individual therapy.

Eight interviewees specifically discussed the importance of peers taking an active role in the disclosure experience (including non-sexual behaviors) of a particular student. For example, one interviewee stated:

> The kids do a good job helping each other out, holding each other accountable. They'll call each other out on things like, 'I saw you take

that cookie from the other kid.' I don't really have to do that as much in
group because they mostly do it themselves (Interviewee H).

Similarly, another interviewee mentioned peers "confronting each other" (Interviewee

A), while another interviewee described groups as a "big asset" for facilitating disclosure,

providing the following example: "I had a kid in group who just kept on lying, holding

back details. Finally, another kid said, 'That's all you did? That's what I said when I got

here. I only reported one thing. What else have you done?'" (Interviewee C). Finally,

another interviewee talked about students "calling each other out, saying things like,

'*Only* two times? What's that? No way, only two times'" (Interviewee B).

One interviewee discussed using peer support (as opposed to pressure), not only

to encourage disclosure but also to demonstrate to a student that he will not be rejected by

the interviewee, or the group, if a disclosure reveals that a student was not telling the

truth earlier:

A lot of times kids have lied or left things out and we know that. Then we
highly recommend that they bring it to the group again. We don't pressure
them to, but when they do, I really play up that it is amazing to come back
to group and say that you were lying and I really try to spend time on that.
Then other kids who are lying might feel that they could still disclose and
take responsibility for something he was lying about (Interviewee A).

Three interviewees identified using one student as a role model for other students. One

interviewee described how using the progress of one student around taking responsibility

as an example of good work, particularly when the interviewee knows another student is

lying:

Sometimes it feels kind of manipulative, but sometimes the pushing [of a
student] is necessary. I'll start asking one kid how telling the truth and
taking responsibility helped, really being positive about it, because I want
the kid who I know is lying to hear about it from another kid, especially

63

one who has a leadership role, I want him to hear about his journey of
taking responsibility (Interviewee K).

Another interviewee mentioned that when a newer group member looks up to an older

group member, the older member is encouraged to be a positive role model, and the

interviewee considers the role modeling to be "active empathy, going beyond what is

really necessary to help another student not be in a cycle of offending, sexually or

otherwise" (Interviewee H).

Three other interviewees also described "pushing" in group work, responding that

the pace is different than in individual therapy (Interviewee A, D and G). One

interviewee used the term "group personality" as a benefit to group therapy, stating:

If the group is ready as a whole, you can use the group to explore,
illustrate and highlight what taking responsibility means and to put some
pressure on any individual member. That would be difficult to do as an
individual therapist (Interviewee G).

Three interviewees mentioned the beneficial interaction between group and individual on

disclosure and taking responsibility. One interviewee specifically responded that they

use group work to facilitate disclosure in individual work:

Some kids won't do disclosing in individual therapy and are being
resistant. But I can use what other kids are doing in group to help and
once a kid discloses in group, they know I talk to their individual therapist
and then their therapist will say, "I heard you acknowledged in group that
you offended your sister. Now let's talk about it and the kid will. I find
you can push them along in group where they might be more comfortable
(Interviewee L).

Another interviewee offered the following example, which, for the interviewee, amplified

the importance of group work and its influence on individual work:

I had a kid who came in to meet with me individually and he was talking
about group where another kid had disclosed and my kid said, "After that
kid disclosed in group, I asked him why he hadn't disclosed stuff in earlier

disclosures and then I realized that I hadn't either so I have more to tell
you." And that was really powerful for me (Interviewee I).

Finally, a third interviewee identified a technique (that seemed unique to them) that they

use in group to get students to disclose more in individual therapy:

When there is a kid who is really holding back or his stories really
conflict, sometimes I'll go into group and say, "I got a call from a PO
[probation officer] today who said that somebody here has a victim who
reported new stuff. Is it possible it could be one of you? Or one of your
victims? The PO didn't tell me who it was and I'm really concerned about
you. The PO wants to hear it from you or me, not the victim, so if you
have any more stuff to tell…" And then I have 3-4 kids running to my
office telling me more stuff. So I lie to them, but I get the work done
(Interviewee C).

Two interviewees specified that for some groups, depending on the age of the

members, there is a different expectation about the amount of details given in a

disclosure; that is, if the members are younger than 10, full details are not expected

(Interviewees A and F). The apparent rationale is a concern for the reactions of other

group members, specifically around students with trauma histories or who are highly

sexualized and might be stimulated by the details. Also, one of these interviewees, who

has a group of 9-12 year olds remarked that it seemed that the younger kids, rather than

primarily reacting to peers, are "more concerned with adult interactions. That is more

important to them to look good to staff who are there, than their peer group. And so

sometimes it feels like I have a group of eight individuals as opposed to a whole group"

(Interviewee F).

Although the work around disclosure and taking responsibility is interconnected,

no matter what treatment setting, the interviewees did identify differences between group

and individual work. One interviewee said, "I know I am stating the obvious, but

65

individual therapy is more individualized" (Interviewee G). Issues around pacing, the

comfort of the student in different treatment settings, and the clinician's ability to focus

on a student's individual needs were all discussed by most of the interviewees.

Seven interviewees identified the centrality of the therapeutic relationship in

influencing disclosing and working on taking responsibility. One interviewee described

the one-to-one aspect of individual therapy as a problem for some students, "that it is just

too intense to be having a conversation with just me, so they cannot really talk about

things the way they might in group" (Interviewee E). However, this interviewee also

described that "some kids can talk about their offenses in real direct ways in individual

work, but then are real quiet in group" (Interviewee E). Another interviewee asserted that

a difference might be about what the student's perception of individual therapy is, that

the student "comes into a session thinking 'Oh, I have to have my therapy head on' and

then they have their defenses up" (Interviewee F). However, another interviewee

explicitly mentioned the benefit of the one-to-one nature of individual therapy, "You can

talk specifically about what the dynamics are for the child, you can talk about incidents

that happened to them in a more detailed way because they are going to be more

contained. It feels safer" (Interviewee H). This interviewee also described how in group,

a student might feel pressure to act "more mature" in front of his peers whereas, in

individual he can "melt into the younger child, the part of him that was offended or might

be very needy" (Interviewee H).

Two interviewees highlighted their ability to more easily work with students

"where they are" without having to negotiate group dynamics. One interviewee

responded: "You can go wherever that individual is able to go. You are just working

with that individual, with that individual's development, the relationship with that student. You can meander in a way that is difficult in working with a group" (Interviewee G).   Another interviewee described group work as "…more generic in some sense. You can still express that you are not going to judge them, no matter what, and stress the importance of being honest, but your approach just cannot be as specific to the student" (Interviewee J).

Four interviewees mentioned the function of individual therapy in working with students in preparation for disclosing to their family. One interviewee responded with the following:

> What normally happens is that a student discloses in individual therapy
> and we'll work on that, processing that before going to family therapy,
> before disclosing there. In the family session, there has usually been some
> level of coaching or practicing in individual therapy so the kid can go into
> family therapy more prepared (Interviewee K).

Two interviewees described the dilemma some students experience when progressing positively in individual work and then having a setback after family therapy (Interviewees A and L), with one interviewee stating that the "student experiences "confusion about what they are supposed to be doing in his therapy" (Interviewee L).

One interviewee responded that they use behaviors on the unit, outside of therapy, to enhance the work in individual treatment stating:

> I can keep track of what they are doing on the unit that is non-sexual so I
> can really bring up examples of those behaviors and that introduces them
> to that process of how they are affecting other people and how they are
> responsible for all their behaviors (Interviewee D).

Two interviewees mentioned that in individual therapy they could more directly address inconsistencies in what students have disclosed (Interviewees C and I). One responded this way:

> If I ask a question often enough, getting mixed up answers, I'll start to write down the answers and stick it in a file. I'll then ask them again and check with what I wrote down. If the stories don't mesh, I'll confront the kid, "How come your stories don't mesh? Which one is really true? Tell me your story one more time. I'm confused." (Interviewee I).

Another gave an example of encouraging truthfulness, appealing to the student's self interest:

> I had one kid say, "That's my story and I'm going to stick with it." And I said, "That's helpful, everyone will then have the same story but everything's not there. If you tell me everything, then in your discharge summary I can report that more was reported, what happened and explain why it wasn't reported earlier. Then there is an accurate record when you leave and the court will know you did good treatment" (Interviewee C).

This interviewee also described their approach as including repeated and frequent asking of the question, "Do you have more to tell?" and informing students that it is normal to not tell everything initially, but that "It is better to disclose stuff sooner, rather than later, so we can work on it and move on" (Interviewee C).

All interviewees responded about how crucial family therapy is for working on issues of disclosing and taking responsibility, with one interviewee describing disclosing to the family as "a pivotal moment" (Interviewee B) for students. Despite its importance (or because of it), all interviewees also described family therapy as the most challenging of the three treatment settings and, in the later question about treatment obstacles, the family was identified most frequently. One common theme that emerged was the difficulty (for all involved) and the negative impact on a student's ability to take

responsibility, when a family is denying that the student committed the offense(s). Interviewees identified several reasons for family denial, including guilt or shame, other trauma histories within the family, and feeling betrayed by, and/or anger at, the student.

Three interviewees described the impact on the student when his family is in denial, with one interviewee stating that the student may believe he does not need to take responsibility since his family still believes he did not commit any offense (Interviewee K). Another interviewee's response included:

> The kid will say, "There's no proof that I did it and my family believes me." And my response is, "I can't treat someone who is denying anything happened and you're afraid to say it's true because your parents are denying that anything happened. I can understand you can't really admit it." But it's much harder if the parents don't really support that part of treatment [disclosure and taking responsibility] (Interviewee C).

A third interviewee identified a unique dilemma for a student who had one parent holding him accountable and the other denying the student's offense, "For this kid, his parents were at different places about his offense. One parent really thought it [the offense] wasn't the kid's fault and was blaming the victim and so the kid was stuck and that's a really hard place" (Interviewee J).

Four interviewees described their own clinical dilemma when families are in denial about a student's offense. One interviewee explained as follows:

> You need to connect with the family but stay connected with the kid and sometimes they are polar opposites. Sometimes the family dynamics were so horrendous that the kid acted in the only way he really could. Parents don't get that or want to hear that. If you go there too quickly, they won't come back. They'd rather abandon the kid then face some of this stuff (Interviewee A).

Another interviewee remarked, "Some families simply cannot tolerate as far as where the kid can go, so finding that match is part of the work" (Interviewee E) while another

69

interviewee echoed the same response with, "Trying to meet the family where they are at when they are in denial is a big part of the work" (Interviewee J). Lastly, one interviewee stated, "Every now and then you have a family that's like 'Why do you have to bring all that up? Can't we just move on? What's the big deal? He's admitted it, so enough'" (Interviewee B).

Six interviewees mentioned the stress students feel before disclosing to their family, with particular reference to: fear of abandonment, not wanting to disappoint their family, worrying that their family will fall apart and shame (particularly if the victim was a family member). One interviewee also added that it is difficult for students to take responsibility when they know their family is "just saying the right thing, and that it's not real" (Interviewee A). This interviewee did describe how they are able to use that dilemma to support a student in his work around taking responsibility:

> This student was able to say, "My mom was not really honest today," and then we could talk about like, "Wow, what would it be like for the victim if you weren't honest?" and he could start looking at his parents as separate from him and that seemed to help (Interviewee A).

Finally, this (and one other) interviewee also identified a difficulty if the student will be returning to the family, amplifying the necessity for "solid and lasting" family work (Interviewee K).

Three interviewees responded that, for family therapy to be more successful, the parents/caregivers need to "work on" their own issues. One described it as follows:

> If the sexual offending has passed through a family, and say it's happened to the mom and the mom hasn't dealt with it. You are trying to get the kid to deal with his stuff and you can't get the mom to look at it because she hasn't dealt with her own stuff and can't really help the child with what's happened. Like she's not available for him (Interviewee H).

Two interviewees, while acknowledging the challenge of family work, also remarked

how it can work. One interviewee described how referencing a parent's own experiences

around taking responsibility can help the parent support their son:

> Before a kid discloses to his family, in talking to the family about how
> difficult it can be to be honest, I might ask the mother if there is a time she
> can remember when she did something for which she was ashamed and
> had to admit it. If the family can talk about their own experiences (not
> sexual) and what it was like to admit it and be honest, it can make it easier
> for the kid to be honest, so I use the family as a way to talk about some of
> these difficult things (Interviewee I).

Two interviewees responded with the positive impact family therapy can have on a

student's progress in treatment, if the family is in support of treatment. One responded:

> I think the families do feel that it's really important for the kid to be
> completely honest about what has happened. It is one of the keys of
> treatment. I do think a pivotal moment for the kid's success in treatment
> revolves around the family being on the same page as us. Giving the
> message that 'We're upset with what you did – it's really bad what you
> did, but we still love you. And no matter what happened, it's important to
> tell what you did' (Interviewee B).

Finally, one interviewee specifically described the uniqueness of family therapy due to

the nature of the relationships, which are different than in group or individual treatment:

> It's a lifetime set of relationships – even if the family breaks up. With a
> group, the members really are individuals, separate from each other, not
> being affected by one another in the long term. Responsibility is
> potentially a very different animal with the family. This is especially true
> if a family member harms another family member (Interviewee G).

This interviewee went on to state:

> In a family, the level of the client is the whole family and in the group, it's
> the whole group. The basic ideas about disclosure and taking
> responsibility are the same, but you have different tools to work with
> because the tools in all cases are the other people in the room (Interviewee
> G).

The majority of interviewees described differences in approach and expectations when discussing treatment work around disclosing and taking responsibility while also emphasizing the importance of honesty, support and the relevant relationships. Family work was identified as frequently the most challenging but also crucial for students' progress in treatment and beyond. Interviewees also highlighted the experience of the student, both positive and negative, when working on disclosure and taking responsibility. Finally, many interviewees discussed the interconnection between the three treatment settings, and, that that can enhance the students' overall progress and positive change.

Clinicians' Experiences that have Informed Work on Taking Responsibility

When asked to identify experiences and/or words that have informed their work with students on taking responsibility, some interviewees spoke rather broadly and others spoke specifically; for example, when discussing the importance of the family to the students' treatment, some responses stopped at that, while another response might expand to include the importance of parents being in treatment themselves for the sake of students' treatment. One interviewee stated, "I have learned something and gained insight from every student I have worked with" (Interviewee F). The major themes that emerged involved responses about being a clinician at a residential program for juvenile sex offenders, the role of the family and wisdom gained from specific work with students.

Six interviewees spoke to experiencing the benefits of a residential program for working with juvenile sex offenders. Two benefits were identified as: the value in having the opportunity to do long-term, in-depth therapy with students whose needs are quite complicated and the fact that residential work allows clinicians to observe and learn

about students' behaviors in a variety of contexts, including school. One interviewee responded, "We are fortunate here to be able to work with kids for almost two years so we can get through the first layers of stuff – and picking and sorting through that can take a lot of time" (Interviewee A). Another interviewee in speaking to the benefits of a long-term residential program, also added the gradual, positive influence the milieu itself can have on students:

> Kids are here usually for at least 18 months and in that amount of time, they gradually break down because maybe they don't need to hold onto their toughness here. They get all kinds of rewards for positive behaviors so they don't hold onto the negative ones. And their sense of responsibility can come from watching adults just treat them fairly and treat them better than they were treated at home (Interviewee K).

With a similar answer about students being able to let go of "toughness," another interviewee responded:

> Sometimes the presentation of 'not giving a crap' is the kid kind of detaching themselves from the emotional aspects of what they did. If there was a way to hurry things up, we would do it. But it is just the progress, the time they are here, constantly getting closer, hearing stories over and over, getting closer and closer to the root. Everyone seems to have to take the time to get to that point, to get to those emotions (Interviewee B).

Another interviewee mentioned that, "Here, given the length of stay, there are many chances to address things because unless something unusual happens, you will be working with the student several times a week for almost two years" (Interviewee H). Two interviewees responded that, both for the clinicians and the students, there can be the possibility of seeing positive change over time, "even within the span of a few months" (Interviewee I).

The ability to use day-to-day behaviors to enhance treatment work was identified in the following response, "The patterns of behavior that lead to the offenses, you see here. You know, relationship patterns that the kids have had" (Interviewee B). Another interviewee stated:

> Even though this is primarily a treatment program, when I am thinking about a kid's progress, my assessment and thinking can meaningfully include much more than just clinical information, because I have information from school and residential staff and I have learned that that is important (Interviewee H).

The role of families and how to work with families was another theme that emerged as relevant to the interviewees work with students. Three interviewees responded that they more fully appreciate the role and impact of the family in working with the students, "that the student doesn't exist, and his offenses didn't happen, in a vacuum" (Interviewee J). Two interviewees spoke to working directly with the family, "Even though the child is the identified patient, there are times when you have to really work with the parent, maybe having one whole session with the mother helping her figure out why it is so hard for her to accept something" (Interviewee J). While another interviewee stated:

> How to word things with families can be difficult. Parents come in with a lot of defenses. They are already ashamed, or feel like they did a bad job, and feel like they are being judged by social services (and this program fits into that whole system). It's really important to get the family on board (Interviewee C).

One interviewee specifically mentioned the importance of parents being in treatment themselves, describing, "I recommend treatment to all the parents I work with because having a kid here is really difficult. I think I've learned it's important for parents to work

on their own issues, so that when the kid comes back, they are more available for the kid" (Interviewee E).

Several interviewees spoke to the growth of their experience as a result of the direct work with students. One interviewee mentioned that they have learned that it is important to treatment progress to pay attention to both what the student says and does not say (Interviewee D). Another interviewee mentioned a particular experience when identifying their countertransference toward a student was important to the treatment, "I realized that I was giving the student maybe too much of the benefit of the doubt in believing everything he was saying about his offenses. I really saw how much he was struggling and I couldn't see the full reality of what he had done" (Interviewee E).

Five interviewees described the importance to their work of not forgetting how hard it is to take responsibility. One interviewee stated:

> What the student has to overcome, in order to take responsibility, we have to be really sensitive to that. It really isn't an easy task to say, "Yes, I did that." It's much easier to not take responsibility than to take responsibility. So I think that has been a lesson for me (Interviewee G).

Another interviewee offered an example of working with a particular student, from which the interviewee learned about how challenging the "task" can be:

> A kid did victim disclosure sessions with two people in his family who he had offended. In the car on the way back he said, "It is so much harder saying sorry when you mean it." That has become a part of my thinking, that a lot of us are taught to say sorry when we mess up, but we don't really feel it (Interviewee I).

In discussing the difficulty of working on taking responsibility, two interviewees added remarks about students' "nervousness" about what is expected of him and how people will react to him (Interviewee B and J). Along a similar theme, three interviewees

mentioned the importance of being non-judgmental with the students, in part, because of

the above-described "nervousness." One interviewee stated:

> Obviously, being charged with a sex offense is very stigmatizing and they
> know how society views them and their parents know. A key for all of
> them is being able to come in and really talk about it [the offense] and not
> have people react like "You did what? Are you nuts? They need to be
> held accountable without feeling judged (Interviewee B).

While another described, "Trying to get them to really understand the harm they have

caused and doing so in a nonjudgmental way because I think they can sense when you are

disgusted with their behavior" (Interviewee H).

Two interviewees mentioned that their work has been informed by realizing, and

trying to accept that they may never truly know what a student has done in terms of

sexual offending and that, even if a student genuinely takes responsibility for his

offenses, he may still offend in the future (Interviewees A and G). One interviewee

added a statement about the implications of reoffending on future abilities to take

responsibility, stating:

> Even if it was a profound experience for them to take responsibility, it
> doesn't mean that that is really going to bring about change. And then, if
> they go out and do it again, it may make it twice as difficult, exponentially
> difficult, to take responsibility the next time (Interviewee G).

Observations and Evidence of Treatment Progress around Taking Responsibility

When interviewees were asked to discuss how they make determinations about

progress around taking responsibility, there were some common themes that emerged.

The responses included interviewees' observations within therapy itself, observations

outside of therapy (within the program's community), with discussions about the

conclusions drawn from both sets of observations; therefore, this section will follow this response structure.

When answering about treatment progress, all of the interviewees discussed the importance and therapeutic usefulness of being able to observe and incorporate information about student behaviors outside of therapy. It should be noted that at the program, there are regular and frequent staff meetings attended by clinicians, school staff, health services staff, residential staff and unit managers; therefore, communication between all staff about all students is an integral part of program functioning. One interviewee was clear that "communication with staff is huge, especially residential staff, who are with the kids for eight hour shifts and have a different kind of knowledge about the kids than I have. Their knowledge is important for treatment" (Interviewee F).

Four interviewees specifically identified this access to additional information, beyond what happens in therapy, as a central benefit of residential work for both clinicians and students. One interviewee who referenced prior clinical work stated, "I worked outpatient a lot before coming here, and I have to say, with this population in particular, residential works better. You are able to see on a daily basis how a kid is doing" (Interviewee J). Another interviewee, in addition to remarking on the opportunity to see behaviors on the unit, also mentioned the influence of the length of stay at this program as an opportunity to see changes with the following response:

> You can see change and support it and have the unit be just as much the therapy as in here. That is different than non-residential programs where the kid goes home, interacts with his family, where things may be undone and the kid never really gets to take what they were doing in therapy seriously. Here, the culture follows the kid around all day long, like flashing billboards (Interviewee E).

Five interviewees responded that since, for the students, it is so often the case that the thinking and acting patterns for sexual and non-sexual behaviors are almost the same, unit behaviors can be a "powerful therapeutic tool" (Interviewee K) around working on taking responsibility, offering "meaningful evidence" (Interviewee L) of whether or not there has been progress. Another interviewee used the term "real life moments" when describing unit behaviors that might be evidence of treatment progress, that the "patterns of behavior that lead to the offenses, you see here [on the unit]" (Interviewee B). One interviewee described part of their overall treatment approach as "linking everything back to the sexual offending behaviors" so unit behaviors "are a real resource to me, giving me examples I can use with a student for him to better understand himself or even for me to better understand him" (Interviewee H).

Several interviewees provided descriptions of the types of behaviors that are often indicative of the degree of progress in treatment around taking responsibility, such as: following (or not following) unit rules; meeting (or not meeting) expectations at school; handling (or not handling) feedback from staff or peers; getting into conflict with peers or staff; and, as one interviewee put it, "Generally acting like they are aware that other people exist and matter" (Interviewee C). One interviewee, in stating that, in assessing progress asks the question "Are they taking responsibility for their behavior on the unit?" and gave an example of how they used the problematic unit behaviors of a particular student in individual therapy, with the unexpected result of gaining insight about the student:

> I have a kid (with a trauma history) who is slowly making progress
> toward taking responsibility for his offenses, but he constantly lies on the
> unit. So I have said to him, "It's really hard for me to trust what you are

saying because when [staff person] spoke to you about seeing you take [peer's] stuff, you just denied it and it's not just about the offense, you need to take responsibility for other things you do." And when I asked him why he lied so much, his response was, "I feel like that when I was a kid, when I would lie about stuff, people would just leave me alone." So I realized it was deeper seeded than just avoiding trouble (Interviewee I).

Two interviewees spoke to being able to use positive or "prosocial" (Interviewee E) unit behaviors, bringing it back to therapy to support and encourage students in their treatment, "showing them their successes around taking responsibility" (Interviewee F). One interviewee described an example of a student's positive behavior that the interviewee believed was indicative of progress:

I had a kid who came into my office with his dinner and a glass of milk and he spilled his milk on the carpet and the first thing he said was, "We need to go back because I need to get my milk. He was totally unconcerned with the fact that he spilled the milk on the floor and it was going to smell. Later in treatment, we were walking into my office and he said, "[Clinician's name], will you hold my milk because I don't want to spill it on the floor." So, it's often some of the little things that tell me a lot (Interviewee E).

Despite the dominant theme that there are important connections between treatment and unit behaviors, the answers varied with respect to timing or order of progress when discussing treatment and unit behaviors. Some interviewees stated that "most often" behavior on the unit improves and then treatment work around taking responsibility "moves forward" while other interviewees responded that "it depends on the kid and where they are at, like, is there trauma?" (Interviewee L). However, four interviewees, in responding that identifying progress in treatment can be difficult, thus, if there are positive behavioral changes on the unit, "You can get more of a sense of what, from treatment, has been internalized" (Interviewee K). Another interviewee described positive behavioral changes on the unit as, "the kid trying stuff out in a setting where it

might be less threatening and, if he does a good job, he knows it will be noticed and brought back to me" (Interviewee A).

There was a divergent theme that emerged revealing that some interviewees "could not always trust good unit behaviors as showing really anything about progress toward taking responsibility" (Interviewee G). One interviewee responded that, sometimes, the students who present no behavior problems at all, can be the most concerning:

> There are kids who can sit through the program, say all the right stuff, do everything the right way and not really make it in the community after discharge. They were good at buffaloing people. The kids who look real good often scare me more than the kids who are acting out. Flying under the radar and noone catches it (Interviewee C).

While another interviewee mentioned that seemingly doing well in treatment cannot always be a reliable indicator of progress, if the student is having behavior problems on the unit:

> I know I would certainly have a concern if there was someone talking a good game about taking responsibility, but every time they do something on the unit they are not taking responsibility but they are blaming others. That would be striking for me (Interviewee B).

Three interviewees asserted that when meaningful progress around taking responsibility for sexual behaviors happens, they typically see progress with non-sexual, but problematic, behaviors as well. One interviewee responded, "When they start to realize that sexual and other behaviors are connected, that often translates into behaviors on the unit" (Interviewee D). Two interviewees described this connection with positive behavioral change as "applying the concepts" learned in therapy (Interviewees G and H).

One interviewee described the importance of applying the concepts and progress as

follows:

> Application has to equal everything else. When thinking about progress
> around taking responsibility, I ask two questions: Do they understand the
> concepts of sexual offending (cycles of behavior, thinking errors, triggers,
> etc.)? And then, can they apply the concepts? So, if they deny that they
> took someone's pen and are not being honest about it, then possibly they
> are not being honest about their offenses (Interviewee H).

Giving a similar response, another interviewee broadened the "applying the concepts"

beyond the program with the following answer:

> In some ways, it's really what happens outside of therapy that counts.
> Because that implies that whatever they are accomplishing in therapy, they
> can apply to their real life, if there is any retention of these ideas. So, an
> important question about progress could be, are they able to live a
> responsible life? (Interviewee G).

Lastly, one interviewee described, that for some students, if they manage to act out

sexually on the unit and then are confronted about their behavior that can be the moment

when meaningful treatment begins. The interviewee stated, "I had one kid who sexually

assaulted another kid here, and it really wasn't until that happened, that he did something

for which he could not deny, when he realized, "Wow, I still have a problem," that the

work on taking responsibility started" (Interviewee A).

Although the dominant theme in the responses about observing progress around

taking responsibility involved the role and importance of behaviors on the unit, an

equally important theme emerged from the responses about observing progress within

therapy. Seven interviewees' responses included describing when students initiate some

part of their treatment, such as asking to write an apology letter to the victim (Interviewee

K), coming into therapy saying, "I am ready to talk about that offense now" (Interviewee

A), or "Bringing up problems, rather than me having to do it" (Interviewee D). One interviewee stated that, "Within the program, clinicians and students use the term 'doing your treatment' when talking about being engaged in treatment, investing in their [the students] own progress" (Interviewee C).

One interviewee, described a similar theme of "doing treatment" but had a slightly different focus about how that progress was observed, with the following response:

> I know there is progress in therapy when a kid is no longer fighting against treatment. The words I look at are "Yes, but…" and then I know an argument is coming. When they are not challenging me so much and we are not having those power and control struggles, but they can take in suggestions or ask for help, rather than fighting it, then progress is there (Interviewee H).

Another interviewee described progress with a similar focus on students challenging treatment, stating, "It's significant for therapy when they give up their rigid thinking, which often comes out as constant fighting because they always have to be right" (Interviewee D).

Four interviewees mentioned they consider there to be progress around taking responsibility when students are able to demonstrate insight into their behaviors, to make connections between past and current behaviors as well as seeming to understand the causes for their offending behaviors. One interviewee stated that this sort of progress is often observed through "the conversations we have in therapy over time" (Interviewee L). Another interviewee described insight development as follows:

> Having a general awareness of what made them do it before and what they need to look at down the road, so they don't do it again. I have worked with kids who are behaving fine, but they don't really understand why,

what has changed. Out in the community they were a nightmare, but here they are fine. I have concerns about that. (Interviewee D).

Another interviewee spoke to the development of self-awareness, stating, "I think about how kids are talking about their history and their ability to draw connections to now. Is there honesty about their lives? (Interviewee A).

Three interviewees described a practical approach for assessing progress in therapy by "revisiting the intake report" (Interviewee F) or "looking at how they were when they got here and how they are now" (Interviewee C) to determine what changes may have occurred. One interviewee responded that reviewing the initial assessment with the student could provide valuable information about treatment progress:

> Sometimes I will recap the intake report and then I'll ask the kid, "Do you remember when you were like that? Do you remember what you were feeling then compared to what you are feeling now?" And if it's genuine progress, they'll be able to say "Wow! That used to be me." Then you might know that there have been internal changes (Interviewee C).

Another interviewee also spoke of observing changes over time, but gave an example of a particular exercise done with a student:

> I had this kid tell the story of the offense from the victim's point of view. I sort of interviewed him. He tells this harrowing story, and, at the end, I ask him how he is feeling, expecting something intense because he's just told this horrible story, but he says, "I'm feeling good because I am doing my treatment. A few weeks later, I read it to him and he looked really pale and said, "Oh god that is so awful." And after that, there began to be positive changes and movement toward taking responsibility for what he had done (Interviewee K).

All of the interviewees, whether discussing progress in treatment or outside of treatment, on the unit, described progress as often occurring with small changes. No interviewee responded with dramatic movement in the work around taking responsibility,

although many interviewees did provide examples of seemingly pivotal moments in treatment.

Details of the Offense and Working on Taking Responsibility

When asked whether treatment work around taking responsibility was influenced by the particular details of students' offenses (including age of victim, use of force and the duration or frequency of the offending behavior), two common themes emerged. First, interviewees generally answered that, in terms of treatment as a whole, the details are not explicitly influential in that all students need to take responsibility for their behaviors, no matter the specifics. With that said, the second theme was, in reality, for some students, the details are directly relevant to the work of taking responsibility; that is, the more egregious the offending behavior, the more treatment work might have to be done around making amends to the victim(s) and preventing future offenses (especially if a student is "exhibiting pedophilic tendencies as opposed to distorted thinking," Interviewee C). A third, less dominant, but notable, theme was present in some responses, with a few interviewees speaking to the fact that focusing on offense details is less important with some students in treatment that is, the treatment might be directed more toward why taking responsibility is not happening rather than using the offense details to "force" taking responsibility (Interviewee F), or as another interviewee stated, "We are trying to change the whole person, not just the sexually offending part" (Interviewee A).

Ten interviewees' responses mentioned the program's "philosophy" that all the offending behaviors, for which the students have been admitted, are equally concerning and serious and that "it is important that the students understand this" (Interviewee D). In

addition, interviewees spoke to the philosophy's rationale being about encouraging

openness and honesty. One interviewee's response reflected the answers of most

interviewees about the philosophy, with the following statement:

> We have to create an environment where the kids are going to open up and
> we have to instill the message that everyone's offense is the same, even
> though the reality is that there is a difference between raping a 3 year old
> and having drunk sex with someone and then finding out it wasn't
> consensual (Interviewee B).

This interviewee went to offer why this "all offenses are the same" approach is important:

> If we start giving the message, "Oh this kid is in real trouble and has major
> issues," then when the other kids hear that message, and then hear kids
> disclose, they might think, "Oh man, my offense is much worse than that"
> and they'll be hesitant, or really start to feel bad about themselves, and
> then are less likely to take responsibility (Interviewee B).

Interestingly, three interviewees also remarked that it did not seem, in their experience,

that the students make "better or worse distinctions" (Interviewee I) about each other's

offenses, and that that seemed to help students feel more comfortable being honest

(Interviewees C and I) and may reflect success at communicating the "all offenses are

equally bad" message (Interviewee D).

However, according to most interviewees, the "most important message"

(Interviewee J) is that, "It's all about the victim" (Interviewees A, B, H and K) and "there

is no way to quantify trauma from the victim's perspective" (Interviewee B). One

interviewee added that they supported the program's philosophy, but they would be

applying it "no matter" because of their personal philosophy that "abuse is abuse and

trauma is trauma and it's all horrible" (Interviewee H). While another interviewee's

response reflected a different perspective, stating, "The details may really amplify the

needs of the kid and take him further and further into taking responsibility" (Interviewee G).

When there is an "evaluative" focus on details, when working on taking responsibility, it "typically happens in individual, sometimes in family therapy, definitely not group" (Interviewee F). In addition to the reasons given above about an overall approach, interviewees spoke to being able to "attend to and minimize the kid's shame" (Interviewee L) in individual therapy. One interviewee described the "delicate balance of not wanting the kids to feel judged by me, like I am reinforcing their identity as a juvenile sexual offender, with being really clear that what they did was bad and they need to acknowledge that" (Interviewee A). Another interviewee added, "I think that when the offense is really bad, the student owes more to the victim, but also, there is a lot at stake for the student's future if they don't take responsibility for, and understand, their offending behaviors" (Interviewee G).

In discussing addressing the details in individual therapy, three interviewees spoke to thinking about where the sexual offending behaviors "fit into general, non-sexual behavior patterns. Like, does the offense reflect some degree of incompetence in getting their needs met or does it reflect something else?" (Interviewee E). Three interviewees also mentioned using the details to better understand students' behaviors in terms of the future, assessing risk level, and developing a "meaningful relapse prevention plan" (Interviewees D and F) that is "likely to work for the kid once he leaves" (Interviewee C). Finally, one interviewee, in echoing many responses about how to use details appropriately for each student, stated:

The thinking that all offenses are equally problematic is a good rule of thumb, but in its application to individual students, clinicians need to be ready to justify why they might do things differently with each kid, but, they should do things differently with each kid, otherwise you have 'one size fits all' treatment and that won't work (Interviewee G).

The details of students' offenses, according to most interviewees, need to be approached thoughtfully and within the right setting. The purpose of discussing details has the dual purposes of helping a student better understand his behavior patterns while also always keeping a primary focus of treatment around taking responsibility on the needs of the victim.

Disclosure and Taking Responsibility

When asked how they work with a student on the disclosure process, the responses were different depending on whether a student was disclosing in individual, family or group therapy and so each treatment setting will be addressed separately. However, all the interviewees described the disclosure experience, no matter what setting, as a crucial part of the work around taking responsibility, that "saying it out loud, to another person or persons, can usually make the difference in a kid's progress" (Interviewee K) and all of the interviewees stated that they "make it clear that disclosure is part of their treatment" (Interviewee D). In addition, most interviewees discussed both "normalizing disclosure" (Interviewee L), as well as letting students know that it is expected that most students will not disclose everything right away but will disclose "more and more details over time" (Interviewee C), with one interviewee using the phrase "a continuum of honesty" (Interviewee D). However, all interviewees also responded that the disclosure experience is different for every student (depending on age, nature of offense, particular details about students themselves), and although interviewees

spoke of different techniques they might use to encourage disclosure, particularly around timing (Interviewee F), no interviewee identified a correct or incorrect technique or disclosing style.

Disclosure in Group Therapy

As has been indicated in the discussion of other responses, there is a "culture of disclosure" that can have a considerable and positive influence on students' ability to talk openly and honestly about their offenses. One common response was that, for many students, disclosing in group is the "easiest place" (Interviewee J) because of the presence and influence of peers. The role of peers in group therapy, specifically with respect to role modeling, support and pressure, was identified by all clinicians as a key factor in enabling students to disclose in all the treatment settings. One interviewee described the role of peers and the group therapy experience as follows:

> You have so many opportunities here to convey that message [the importance of disclosing] in group. You can be like, "Wow, did you hear what he said? This is a big moment for him" And then asking the kid who disclosed in group, "How did you do that? Last week you were like, 'There's no way I'm disclosing in group,' so what changed your mind?" And then the kid who is struggling may become more ready to talk (Interviewee B).

Another interviewee described the benefits of peer role modeling around disclosure with this response, "Because someone is always willing to disclose, that influences the group as a whole, but it can also demonstrate to the individuals in the group that it's okay, it's even safe, to talk openly here – you won't melt into a puddle if you disclose" (Interviewee G).

Interviewees also mentioned peer pressure as helping with disclosure because, as one interviewee stated:

88

The kids definitely call each other out and confront each other about the details in a way that just would never work if I did it. I've seen it and even been surprised, when a kid who was saying he only had one offense finally talked about other offenses because some other kid in the group kept saying, "I don't believe you" (Interviewee I).

Three interviewees also spoke to situations when a student has told conflicting stories in group, is encouraged to tell the truth (Interviewee D) and then eventually "comes clean" (Interviewee F) and the fact that he "wasn't banished by his peers for lying" (Interviewee K) can be really important for helping a student be honest.

Two interviewees spoke about using the "culture of disclosure" in group therapy as a tool for encouraging disclosure in individual and family therapy, that, "Since they survived disclosing in group, they can do it in individual and family, that it's going to be okay and I will be there to support them" (Interviewee A).

Finally, one interviewee described having a specific day of the week that disclosures happen in their group and why, stating:

I like to do it that way so the kids know what to expect. Also, if I am working with a kid individually, who really isn't saying anything, I can encourage or even push him a little by saying, "Next week in group, it will be your turn. You don't have to say a lot, but you do need to start and you know that's what we do in that group" (Interviewee H).

Disclosure and Individual Therapy

An obvious difference between individual and group therapy is - there are no peers present in individual therapy, it is just the student and his clinician. Most responses reflected general ideas about how individual therapy works; that is, being able to work with the student "where they are" without having to consider the needs of others. Many interviewees' responses about working on disclosing in individual therapy were similar to this interviewees' remark, "Individual therapy is an opportunity to really focus on who

89

the kid is, and tailor your support and encouragement accordingly"(Interviewee H). Two

interviewees mentioned being more able to consider "issues of timing and disclosure"

(Interviewee E) in individual work, "which is not true with groups" (Interviewee I). One

interviewee added that, "When a kid has a trauma history, it is in individual that we can

really work on that and see how it might relate to disclosing" (Interviewee F). While

another interviewee spoke to being able to accommodate the needs of the student more in

individual with the response:

> If I'm working with a kid who is saying nothing and we are just going in
> circles, I can try different things, like using writing or art, to start the
> disclosure process. Sometimes having the kid do a timeline can help
> organize their thinking and then they figure out where to start their
> disclosure (Interviewee L).

Finally, five interviewees described individual therapy as a treatment setting that

can lay the groundwork for disclosing in group and family therapy without the "pressure,

shame and social awkwardness" (Interviewee E) that comes with group and family

therapy.

Disclosure and Family Therapy

Most interviewees described disclosing in family therapy as the "most important

and most difficult" (Interviewee C) disclosing experience, especially if the victim is a

family member (Interviewee A). One interviewee pointed out that family therapy is

somewhat unique in the sense that "nobody else is disclosing" (Interviewee G). Several

interviewees discussed the need "to practice and prepare" (Interviewee F) students before

disclosing to their family, with one interviewee responding, "I kind of work into it, when

they disclose in individual therapy I'll say, 'Well, we are going to have to work on telling

your parents about this when the time is right and you're ready.' I'm not forceful about

90

it" (Interviewee D). Some interviewees added the need to do direct, preliminary work

with the family prior to a student disclosing to them, stating:

> I will explain to the parent that being honest and disclosing is a really hard
> thing to do. Sometimes, I'll even ask a parent to try and talk about a time
> when they had to admit to doing something that they were ashamed of or
> really felt bad about. That can help both the student and the parents feel
> more comfortable (Interviewee I).

Another interviewee spoke to, "not wanting parents to be incredibly uncomfortable" and

having realized that "accepting that their child has done something like [sexual

offending] is not the hardest struggle but…for parents it's their own guilt that is the

biggest struggle" (Interviewee B). One interviewee described the importance of trying to

"establish a relationship with the family, so they can trust the process" (Interviewee L).

However, one interviewee described working with the families as:

> Easier because really, what's worse than your kid offending someone? In
> some ways, what secret could be worse than that? And I think they feel so
> desperate, that if they don't feel judged here, it might be the first time and
> then they might be more open to treatment and eventually can help their
> son more (Interviewee I).

Four interviewees mentioned that students' fears of disappointing or being

rejected by their family can make disclosure "really scary" (Interviewee A) with one

interviewee responding about how they use the student's fear to encourage disclosure, "If

a kid says he doesn't want to disclose anything because it will disappoint his mother, I

say, 'You're right, she will be disappointed but she'll be more disappointed if the victim

comes forward and that's how she finds out'" (Interviewee C).

The process and experience of disclosing was described as part of the culture and

expectations of treatment work around taking responsibility with several distinctions

being made depending on the treatment setting the disclosing happened. The role of

91

peers, the therapeutic relationship and the issue of timing were all identified as considerations when working on disclosing with students. Although all interviewees agreed about the importance of disclosure to a student's ability to take responsibility, there were no dominant themes regarding how to facilitate disclosure, no matter what treatment setting.

Common Obstacles in Treatment around Working on Taking Responsibility

When asked to identify obstacles in treatment, some responses included obstacles particularly for the student or obstacles particularly for the clinician. However, in many responses, interviewees described the obstacle as one in the same, as experienced by both student and clinician, such as "difficult family dynamics" (Interviewee C) and "the risk of additional charges if a student discloses new offenses" (Interviewee I).

With respect to obstacles for the interviewees as clinicians, the majority of answers mentioned working with families, with one interviewee stating that the family can be the "…biggest obstacle. Especially early in treatment when they have no relationship with me" (Interviewee L). Interviewees identified some possible reasons for difficulties in working with families, including shame or guilt, a trauma history within the family, anger and distrust of treatment. Three interviewees described the scenario when a student is denying his offenses and so is his family, with one interviewee responding, "When the family believes the kid, who is saying he didn't do it. If a kid initially has denied stuff, and the family thinks he was set up, that nothing really happened. For the kid, to have to be really honest about it to himself and then to also tell his family - it is really tricky" (Interviewee K). This interviewee went on to describe how that dilemma might be addressed in the treatment:

I do this workbook exercise with some kids, listing the reasons why it is hard to be honest. One typical answer is "I don't want to disappoint my family" and I'll say, "Let's not worry about that now too much. We'll get there and I'll help you tell your family. But if that part, the fear of disappointing your family, wasn't there, would you be able to be more honest?" And sometimes that can help (Interviewee K).

Another interviewee also talked about the impact of the family for the clinician, "If the family doesn't want this secret to come out, then you are going to have a lot harder time" (Interviewee F). One interviewee answered:

If your family doesn't agree with you or doesn't believe you – you're not going to report stuff. We've had kids who admit to all this stuff to their families and the family is like "No way, we never left you alone for two minutes. And even if the kid explains how it did happen, the parents are denying it in front of the kid. That's a really tough spot for me (Interviewee L).

Another interviewee gave a similar response, adding that families may make assumptions about the clinician's intentions, "A lot of families want to get back to normal and it's a tough thing to sort out. The kid then doesn't think what they did was a big deal and they think you are just making a big deal out of it because you are the therapist" (Interviewee A). This interviewee also mentioned that, sometimes, when the family does not trust the clinician, the family, "maybe with good intentions of protecting their son, give us distorted information and then not budge" (Interviewee A).

The confusion created for the student when his family is resistant was mentioned as a general obstacle for treatment, as indicated in the following response:

I think there can be a lot of family pressure not to talk about this stuff, even though their kid is here at this school. Either because it's still leftover from when the kid was in the family (like an unspoken rule about not talking about this sort of thing) or even when they are here, they get messages from their family like to not talk about stuff, don't trust these people, they don't need to know about this stuff (Interviewee D).

This interviewee also spoke to the pressure on the student to step forward, despite what his family is saying, "If the student has never been encouraged to be honest, they are the ones who have to come forward on their on, because noone else is" (Interviewee D). Another interviewee described it this way, "If the family is not buying into treatment, then the kid's going to get mixed messages about what to listen to, making it hard for the kid himself to buy into treatment" (Interviewee J). An added obstacle for students, when working on disclosing to their family is the fear of rejection or the loss of family love, as one interviewee stated, "[They worry] will my family still love me? That's another struggle and that's why the family work is so important - to have the family involved and aware of the process. Having a family come in and just hear what the student has to say is a big thing" (Interviewee B).

Although most interviewees mentioned the family as an obstacle, only one interviewee described the family as both an obstacle and a tool, stating, "If you work with the family, the obstacle, and make it into a tool, that's the goal in family therapy. If you work with the family and turn it around, that's what you want to do because then they can really help the kid" (Interviewee H).

Interviewees identified the risk of incurring additional criminal charges, if a student discloses new offenses as a difficult treatment dilemma when working on taking responsibility. One interviewee remarked that the possibility of prosecution and the consequences that follow is like "taking responsibility in the much, much broader sense, not just in your day-to-day actions" (Interviewee G). One interviewee described this dilemma as the "biggest obstacle" responding with:

> You try to encourage honesty, but you have to tell them that if they
> disclose something new, you are going to have to report it. I hate having
> to say that because you want them to be honest but you know they could
> get in more trouble. So even though they could be making progress, we
> could be making new charges against them (Interviewee I).

Another interviewee described the program as "…bizarro world, where in any other facility it's like 'never admit to anything' especially if you are being charged with something or what you say could bring more charges" (Interviewee B). However this interviewee, along with similar responses by two others (Interviewees C and K), stated:

> This dilemma can sometimes be mitigated by saying to the student "What
> is likely to happen is that the court is going to view it as something that
> you didn't have to admit to and you did, and the penalty would probably
> be treatment, which you are already doing, so it could work out." But it's
> hard for kids to truly grasp that, especially if they have a history with the
> court already (Interviewee B).

An additional obstacle relating to legal issues was identified by two interviewees, with one responding with the following, "If a kid is in the middle of an open investigation or has an upcoming hearing, his attorney is going to advise him to say nothing, at least until after the hearing. That can be a weird position for me" (Interviewee F). Lastly, one interviewee added another legal complication for treatment and stated simply, "How do you sell treatment to a kid who, no matter what they do, is going to have to register as a sex offender for 25 years, once they get out of here? What's in it for them? (Interviewee B).

One interviewee's response described three obstacles that are, in some ways, experienced by the student, but the burden for removing the obstacle is on the clinician, as described in the following answer:

> The clinician may not want to hear the truth because the clinician has
> adopted a particular position and has come to play a similar role as the

95

family in denial. [The clinician] is not open to the idea that there is more. The opposite can be true as well, where the clinician believes there is more to tell when there isn't and then there's sort of a forced confession. Or finally, the clinician is making it the client's job alone to come clean as opposed to facilitating and joining and helping. The clinician cannot carry the client over the bridge but she can get him there, cheer him on and describe the bridge to the client. The more difficult the behavior for which the client needs to take responsibility, the more help the client needs from the clinician. The clinician can fail to recognize that it isn't just two people in the room, the relationship, the alliance, is also in the room and the absence of that relationship means you just have two people sitting in a room and the client isn't going to make progress (Interviewee G).

Another interviewee also spoke to the clinician's obligations to support the students, remarking, "It's my responsibility to help the student take responsibility, because, chances are, he doesn't have enough on his own to do work around taking responsibility" (Interviewee E). In also referencing an obstacle specific to the therapeutic relationship, two interviewees mentioned the problem when the clinician does not like the student, or when there is a mismatch between clinician and student (Interviewees E and H). Four interviewees also spoke to the difficulty of having to accept that they cannot "really know what's going on inside a kid"(Interviewee F), or "simply not having all the information" and the need "to be careful not to assume that you do know, because then you can get duped" (Interviewee A). Two interviewees mentioned that it is more difficult to encourage a student to disclose and take responsibility when the student and the clinician both know that there are things about which the clinician does not know (Interviewee D and K).

Finally, four interviewees described the process of "trying to find the right balance" (Interviewee A) between pushing too hard or moving too fast, and "making sure the kid is doing his treatment" (Interviewee C). One interview stated, "If a kid is in a

gazillion fragmented pieces, it can be hard to know where to start. Or you ask the wrong

questions and need to find the right place to approach what you want or need to work on

with the kid" (Interviewee E). One interviewee responded with:

> You don't want to be too permissive, making them think it's okay to not
> take responsibility or that you're easy or sugarcoating the offenses, but at
> the same time, you don't want to push kids and humiliate them…It's the
> gentle nudging, finding the right balance of pushing but we're in this
> together. Strongly encouraged, but not coerced (Interviewee B).

This interviewee, echoing responses by Interviewees A and F, also spoke about possibly

having to justify your approach to an outside agency, "If you are taking a more gentle

approach, you'll have to answer to other people involved in the case who are wondering

what you are doing by saying, 'Oh good job, you admitted that you offended your sister'"

(Interviewee B).

  With particular regard for obstacles for students, six interviewees discussed the

fears, expectations and worries that students have about what other people (including

family, peers and the community) will think of them once their offenses are disclosed.

The specific concerns of students, according to the interviewees, related to being

perceived as gay, disgusting, untrustworthy, a pedophile, and/or stupid. One interviewee,

gave an example of working with a student who took a long time to disclose all of his

offenses, "I asked him why he hadn't disclosed everything sooner and he said, "I didn't

want anyone to believe I could do the same stupid thing more than once. That I was that

dumb" (Interviewee C). This interviewee also spoke of students' fears about being seen

as a pedophile:

> This is not the kind of stuff kids want to brag about, never mind even
> admit that they did it. It sounds bad, makes you look like a pedophile. If
> you did it once, maybe it was a mistake, but more than once and it is a

pattern and noone wants to admit to a pattern of sexualized behaviors that are not okay (Interviewee C).

Another interviewee described how some students may say they do not want to disclose because they are afraid of getting in trouble, but the interviewee speculated that worry about the reaction of others was the more likely explanation. To mitigate that worry, the interviewee spoke to trying to normalize the fear to try and support students with disclosing (Interviewee D).

A similar theme to the presence of fear and worry about what others might think upon hearing about a disclosed offense revolved around the students' experience of shame – shame about what others might think, but described as "equally as powerful was shame about who they are, what they have done and the harm they have caused" (Interviewee A). Another interviewee's answer focused on the shame a student can feel once they understand the issue of harm and the implications for his self image:

Having to acknowledge that they really hurt someone – that is a huge obstacle. Usually behind minimization or denial is that fear, that it will become real and the kid will think, "I'm going to have to truly admit that I did this and that I am a person who would do such a thing." Noone comes in here like "I want to be a sex offender, that's my goal, I want to hurt other people" so the cognitive dissonance is behind a lot of the difficulty in taking responsibility. That is a constant struggle (Interviewee B).

Although all interviewees were able to identify many obstacles to treatment work around taking responsibility, there were no answers indicating that any obstacle was insurmountable; rather, much of what was discussed seemed to be seen as within normal parameters of the work being done at the program.

Positive Experiences When Working on Taking Responsibility

When asked to identify positive or hopeful experiences in working with students around taking responsibility, the interviewees focused more directly on the experience of students (with particular attention to disclosure). Thus, most interviewees' answers involved seeing progress or positive change in the students, with very little mention of knowing they were doing a good job.

Seven interviewees responded that a positive experience was when a student, with whom they were working, had disclosed to his family, the family "didn't get up and run out of the room screaming" (Interviewee K) and so the student felt a "tremendous sense of relief" (Interviewee L). Two interviewees described experiencing hopefulness when seeing students realize they had "survived" (Interviewee H) disclosure and did not "melt into a puddle" (Interviewee G). One interviewee added a hint of reality with the response, "The kid survived disclosure and may then learn that things certainly did not get worse but they may also have not gotten better" (Interviewee G).

Three interviewees also spoke about disclosure and identified the positive experience being when students disclose "without prodding" (Interviewee C) or "take the initiative to disclose on their own" (Interviewee A). Another interviewee described the "voluntary" disclosure as a "sign of progressing through treatment" and as "evidence that the kid has become invested in treatment" (Interviewee J). A similar theme about engaging with treatment was reflected in one interviewee's response that, "When I have a kid who discloses additional victims and expresses a readiness to accept the consequences, I feel very hopeful for him" (Interviewee I). Another interviewee described a similar experience of hopefulness, not specific to disclosure, but stated,

"When I see kids being vulnerable, like a real tough kid who cried in group yesterday, I can think things are going to change for the better for this kid" (Interviewee H).

One interviewee offered another example of a positive experience when a student was vulnerable:

> I worked with a kid who had written a detailed plan to rape a staff. After we found the plan, he had a really hard time making repairs with that staff and the community. But after he had made some gesture toward apologizing, I went on the unit and said, "Oh, I'm going to take you out for lunch today." I purposefully took him alone because, one – I knew he wasn't going to rape me, but more than that I wanted him to know we cared about him. He was really surprised I would take him alone. So we went and had this big meal and on the way back, he fell asleep in the car, he let his guard down and that felt like a big deal for him, like he was going to be okay (Interviewee A).

Similar to the above example, three interviewees discussed the positive experience of finding ways to "breakthrough to kids who refuse to talk" (Interviewee E), even through "inadvertent remarks" (Interviewee C) and to see the change in how the student is in treatment, in the program community and "even with their family" (Interviewee C). Another interviewee described a particular exercise that they did with a student over a number of sessions that was a "gradual breakthrough":

> We would play with the dollhouse and my toys could never go into the damn house and he would have all these parties and he would not let me party with him. So I would just put my toys nearby and say, "Then they can just watch," but he would have me sit far away. And then the next session I would ask if I could come a little closer because I couldn't hear the music. He would just say, "Fine." The next session, he invited me into the house for a sushi party. He was literally and figuratively letting me in (Interviewee A).

Two interviewees gave responses that were unique to them. One interviewee described a positive experience as becoming more realistic about both the "extent of progress possible", and what their role in that progress "can and should be" (Interviewee I). The

interviewee added that working to "establish a connection with a kid actually gives me hope. And I think about, if I found out that one of my kids was arrested after leaving here, my hope would be that, maybe while sitting in jail, he would know that there was somebody who cared about him. I hope for that" (Interviewee I). The other interviewee identified an overarching positive experience in the following way:

> One thing that has always struck me with these guys, who, given all the horror stories, would be these depraved kids who don't care about anyone and actually, it couldn't be further from the truth. This has been much more rewarding than other work I have had. These guys really, really open up and really do good work and certainly are not monsters who you think are going to grow up into these heinous perpetrators. For the most part, the kids feel really bad about what they did and…all of them are not totally damaged (Interviewee B).

Interventions Used When Working on Taking Responsibility

When asked to identify interventions the interviewees perceived as helpful for working with students on taking responsibility, a few themes emerged. A dominant theme involved the disclosure process and experience, frequently referred to as the "culture of disclosure." Another significant theme focused on the importance of the relationships the students formed with their clinicians, other program staff, as well as with peers. Several interviewees identified specific techniques or exercises they have found to be helpful when working on taking responsibility. Finally, three interviewees stated that family therapy was a crucial intervention, with one interviewee stating that it was the "most helpful for students" (Interviewee D).

Nine interviewees mentioned disclosure as an important intervention in their responses, with three interviewees specifying disclosing to the family as the most important disclosing experience, especially "when the family doesn't reject them, but

really stays around for the kid" (Interviewee F) with another interviewee adding, "The experience of not being rejected by their family is so significant in helping them to take responsibility for things" (Interviewee B).

Four interviewees responded that hearing other students disclose "almost every day they are here" (Interviewee L), enables students to "open up and talk honestly about what they did" (Interviewee K), especially "when their peers are supportive and understand how hard it is" (Interviewee J). One interviewee spoke about "normalizing" disclosure, "Hearing other kids disclose helps them not feel like a freak. For kids who come from other, more generalized programs, they often talk about how they feel so much more comfortable here because they can talk about their stuff and not feel so judged" (Interviewee I). One interviewee referred to the "holding environment of the whole school, and the hopeful commitment of staff to the students, as crucial for these students who have such low self-esteem" (Interviewee H).

With a similar response involving the supportive environment around disclosing, another interviewee stated, "It's part of the milieu where people are allowing kids to be open without having to be defensive, and it eventually becomes their decision in a way to engage in their treatment. That's beautiful…And a lot can come out of that" (Interviewee B). Another interviewee described a student using a voluntary disclosure to his mother as a way to see himself as "someone who takes responsibility. He began to see who he wanted to be, someone who doesn't use others for his sexual stimulation. So he started acting that way when he disclosed" (Interviewee E). One interviewee spoke to the importance of disclosing in group, "When a kid finally gets to the point when he can say who they hurt and talk about the harm, it's a really big deal" (Interviewee A).

Six interviewees indicated the development of relationships is a very important intervention around taking responsibility. One interviewee's response was very clear about this, echoing the thoughts of many others :

> I could write a page of twenty interventions that could get kids to be more honest and take responsibility, but those interventions are not what's going to actually get the kid to be more honest, it's the relationship. In fact, I'm not going to know they are honest simply because they answered a question, I'm going to know on a relational level, because of the relationship – direct interactions and observations – that's clinical work (Interviewee G).

While another interviewee spoke to the therapeutic connection being an "opportunity for the kid to be with someone who isn't going to turn away from him when he admits stuff" (Interviewee L). One interviewee said that a student's desire to "not disappoint me" can be an important part of the relationship, "Most of these kids want to do well. They don't like being the people they were when they came in and they want to get better. So, if they feel connected to me, and know I care about them, that can motivate them" (Interviewee C). Finally, one interviewee described a student's remarks to him about what helped, believing the remarks were applicable to most students, "He just said that I was there for him, I was consistent in meeting with him and that made a difference for him" (Interviewee F).

Finally, several interviewees identified particular techniques and activities that they have found helpful with the work around taking responsibility. Two interviewees mentioned showing a specific video which features sexual assault victims talking about their experience; one interviewee stated:

> I think the biggest impact that video has had is that students can see that the harm caused by their offenses will be with the victims for all of the

victims' lives. The students begin to appreciate that and it can change
their thinking about their accountability to their victims (Interviewee H).

Describing a similar impact, but through different methods, one interviewee spoke about

having "fairly graphic conversations about their physiology and the physiology of their

victims, particularly when there is a large age difference. Because, sometimes having to

really face the physical harm and pain they have caused is the only way for them to

acknowledge all the harm they caused" (Interviewee J). One interviewee mentioned that

if a student is having a hard time disclosing and taking responsibility, the interviewee will

have the student draw a picture of the location in which the offense occurred and then it

"can be easier for the kid to talk about things with reference to this drawing that is

external to him" (Interviewee L). Two interviewees described psychoeducation exercises

around defining feelings and sexual orientation as influencing students' ability to begin

talking honestly about their offenses (Interviewee A and K). Finally, one interviewee

mentioned writing an apology, victim empathy and victim clarification letters can move

students toward taking responsibility "once they have written something down"

(Interviewee A).

<center>*Theories and Beliefs that Inform Working with Students*</center>

When asked about personal beliefs and clinical theories for working with juvenile

sexual offenders, interviewees discussed the usefulness of knowledge and experience

over time informing their work, as well as particular theoretical perspectives and general

treatment approaches.

Ten interviewees identified a "relational approach," and used the phrases

"importance of the relationship" or "forming a connection" when describing their

<center>104</center>

treatment framework, with five interviewees having the similar response that the relationship with, or connection to, the student was "really all that mattered" (Interviewee K). Another interviewee stated, "It's all about relatedness and feeling interconnected to other people. That can really help with having some wish to be responsible to other people" (Interviewee E). One interviewee responded, "If they can establish enough connections here, appropriate connections, they should be able to function much better in the real world" (Interviewee C). And another interviewee described the importance of the relationship as follows, "If they sense that I really do care about them, that they are really cared for by somebody, it makes it worth it for them to keep working at this stuff" (Interviewee J). Two interviewees, although not specifically identifying attachment theory, did include helping students develop "healthy attachments" as being an important component of their work (Interviewees A and H). However, one interviewee did make a distinction that "for the relationship to be meaningful and therapeutically productive for the student, it needs to be marked by connection and detachment. There needs to be both, otherwise, it's just a relationship" (Interviewee G).

For many interviewees, a common personal belief was the necessity of being non-judgmental in their work with the students. One interviewee said that, "not being judgmental is not always easy, because some of these kids have done horrible things to other people. But I have found that they are so sensitive to and expecting judgment, that I need to appreciate that" (Interviewee L). Another interviewee reported that part of the treatment approach needs to include helping the student "distinguish between the person and their behaviors so they learn that, even though what happened was their fault, or their choice, that taking responsibility is not about them necessarily, but about what they did.

They don't feel so judged that way" (Interviewee F). Finally, one interviewee spoke to

trying to communicate to the student that they do not consider themselves "better than"

the student while also normalizing some of the treatment work; so, "Saying to them, 'It's

not like I haven't made mistakes and needed to learn.' So they know I'm not standing up

on a pedestal, looking down on them and telling them they f*&ked up" (Interviewee I).

This interviewee also mentioned that, "what can also help is to validate for them how

difficult the work is."

      With respect to identifying more specific theoretical frameworks, the most

common response described the use of trauma-informed approaches. One interviewee

explained the importance of being trauma-informed "so we don't retraumatize the kids"

(Interviewee F). Another interviewee spoke to both trauma and the relationship, stating:

> I see trauma as a significant piece. When I know a kid has trauma, I really
> try to work with them on that because until they can heal from that, the
> rest is really difficult. If somebody can be with them, helping them
> through their pain, it is more likely they can take responsibility for what
> they have done because they feel supported in their own healing
> (Interviewee H).

One interviewee was particular in identifying the use of EMDR techniques in "helping

kids with their trauma so they can look at other peoples' experiences, like their victims"

(Interviewee A).

      Specific mention was also made of Cognitive Behavioral Therapy (CBT) in

several responses. Four interviewees described CBT as being an approach used at the

program as a whole, for the clinicians as well as the residential and school staff. Two

interviewees stated that for students with developmental or cognitive delays, CBT

concepts and tools were necessary "because of their limitations to maybe get the more

106

abstract stuff" (Interviewee A). One interviewee responded that they related their own

spiritual and meditative practice when applying CBT techniques:

> Meditation is, in its own way, cognitive work, the cycle of thinking errors
> and what erroneous emotions come out of that and then what behavior. So
> I try to help kids identify how they think about stuff and make decisions
> and have emotional relatedness to care about making responsible decisions
> (Interviewee E).

One interviewee's response was unique in asserting that CBT might be "necessary, but it

won't work for the long term" (Interviewee C).

Object Relations theory was singled out by two interviewees, with one

interviewee stating that their training was psychodynamic, with an emphasis on object

relations, so "I think about personality structure when I am formulating a case"

(Interviewee H).

Four interviewees made general reference to thinking about developmental issues,

with one interviewee stating:

> In terms of taking responsibility, I try to go back to their childhood, what
> shaped them developmentally and then make links to times when they
> didn't have control or were powerless and then connect it to their offenses.
> I can then say to them, "I can understand why taking responsibility might
> be hard for you, but there is another way" (Interviewee J).

Another interviewee responded, "I always keep developmental theory in mind, because

expecting the same from an 8 and 18 year old is just going to lead to disaster. You don't

want them to experience failure" (Interviewee D). This interviewee was also the only

one who mentioned, "having a forensic mindset. It is very important not to think like in

outpatient - to trust what client is saying, you can't do that here."

While many interviewees described their approach as "eclectic" or a combination

of theories (such as trauma-informed and relational), two interviewees responded that

they do not have a particular theoretical approach, with one stating what they know does not work is the "scared straight" method (Interviewee B).

This chapter presented the interviewees' perceptions of working with juvenile sexual offenders on taking responsibility for their offenses. The interviewees responses reflected their beliefs, theories and clinical experiences in working with this population in a residential treatment program. The following chapter will present a summary of the major findings as they relate to the literature, implications for social work research and clinical practice, limitations of the present study, and recommendations for future research.

CHAPTER V

DISCUSSION

The purpose of this qualitative, exploratory study was to obtain information about

the perceptions of mental health professionals, who work with juvenile sexual offenders,

on how working on taking responsibility enhances or facilitates treatment outcomes.

Interview questions served to elicit data on what types of clinical interventions are being

used and what factors (such as developmental stage, nature of offending behaviors, or

trauma history) might impact the implementation and conceptualization of these

interventions. Additionally, interviewees were asked about what interventions or

approaches appear most successful for this population. This chapter will contain a

discussion of some of the major findings as they relate to the literature, implications for

social work research and clinical practice, recommendations for future research and

limitations of the study.

Summary of Major Findings

In general, interviewees presented an understanding of the concept and

importance of taking responsibility as part of the treatment of juvenile sexual offenders

which was consistent with current research on the topic. Interviewees underscored the

need for juvenile sexual offenders to understand their offending behaviors (as well as

understanding the impact those behaviors have on both direct and indirect victims) in

order to facilitate treatment progress. The National Task Force on Juvenile Sex

Offending (1993) identified taking responsibility for his offenses to be of paramount

importance when working with juvenile sexual offenders. Although the interviewees

were clear that working to prevent reoffending (protecting community safety) was central

to treatment, they also emphasized the potential benefits to the juvenile himself.

All of the interviewees described the connection between taking responsibility for

sexual offenses and taking responsibility for non-sexual problematic behaviors as

important components of holistic change, not just sexual offending relapse prevention

work. This seemed to reflect not only the program's "whole child" philosophy, but also a

clinical understanding that, but for the few students with pedophilic inclinations, it was

not to be assumed that the sexual offending was a permanent feature of a student's

behavior patterns. However, it should be noted that many clinicians, in spite of a

commitment to treating the whole child with the hope of supporting meaningful change,

could not express complete confidence that treatment could prevent future offending.

The multidimensional approach is consistent with Fanniff and Becker's (2006)

findings that Multisystemic Treatment (which includes a range of therapeutic

interventions as well as involving family, school and community in treatment) can be

more effective, than a single therapeutic approach such as Cognitive Behavioral Therapy,

in reducing recidivism but also increasing prosocial psychosocial changes. Some

interviewees responded that improvement in behaviors on the unit (in terms of taking

responsibility, but also demonstrating empathy) is often a positive indication of treatment

progress around taking responsibility for the sexual offenses. This would seem to support

the idea that sexual offending behavior patterns are often part of a cluster of other

problematic behaviors such as lying or bullying. And this could raise questions about why taking responsibility for offenses is considered so central to working with juvenile sexual offenders but not so central in working with other juvenile delinquents. In other words, with respect to rehabilitative goals, the need to take responsibility for problematic behaviors may not be so unique to juvenile sexual offenders but could be a necessary piece of treatment for much broader populations.

In terms of the intersection between taking responsibility and issues of diversity, most interviewees identified questions about sexual orientation as a source of confusion for some students with whom they worked. Questions around his actual (or perceived) sexual orientation seemed to influence students' ability to understand the motives for their offenses if the victim was male, either presenting an obstacle to taking responsibility- for fear of being seen as gay- or as a justification for offending someone of the same sex. Interviewees acknowledged the importance of the culture of the community from which the student came from, regardless of race or socioeconomic status; that is, depending on the cultural norms around taking responsibility, as well as permissible sexual behavior, a student may have more difficulty in his own treatment around taking responsibility for his offenses. If a student has to unlearn, or go against, the norms of his community in order to take responsibility for his offenses, he may experience having to choose between staying connected to his community and/or doing his treatment.

Developmental issues and trauma histories were also identified by interviewees as important for taking responsibility. As indicated in the literature, it is estimated that between 40-80% of juvenile sexual offenders have a sexual abuse history (Becker &

Hunter, 1997) and the interviewees indicated that addressing a student's trauma history was a necessary piece of treatment for taking responsibility and developing empathy. The student's confusion around boundaries, appropriate sexual contact, and questions about consent, as well as whether a student's own abuser was held accountable, all influence how a student is able to take responsibility. Further, once a student realizes the harm he has experienced as a result of his own abuse, he may have more empathic capacity for his own victim. On the other hand, the reverse could also be true that the student with a trauma history cannot take responsibility for the harm he has caused because, having experienced that harm himself, he cannot admit he did the same to another. Previous literature suggests that a trauma history may impact a juvenile sexual offender's capacity for empathy (Righthand & Welch, 2001).

Most interviewees identified the impact of the juvenile sexual offender's family on his treatment work around taking responsibility. The family was described as "both an obstacle and a tool." Many interviewees indicated that family dynamics and communication styles, family norms around taking responsibility, and the presence of intrafamily trauma were all significant pieces of treatment. This is consistent with the literature that suggests that working with juvenile sexual offenders is most effective when the treatment is both holistic and inclusive of all aspects of the offender's life (Fanniff & Becker, 2006; Rich, 2004). That is, the offender did not live, or sexually offend, in a vacuum, but was influenced by those around him and those influences need to be addressed for there to be less chance of reoffending. Further, by bringing the family into treatment, the family may be able to deal with issues of shame and to relieve the burden

of keeping secrets about what has happened within the family – a process which mirrors and supports the work done by the student individually.

According to the interviewees, the process of disclosing the details of offenses is an established part of treatment at the program studied, with the intention of enabling students to understand their offending behaviors, as well as the impact of those behaviors. All interviewees described the process of disclosure as the crucial component for treatment around taking responsibility because of the importance of saying it out loud and experiencing the reactions, both supportive and critical, of others. That is, interviewees described how it often was not until a student actually said to others, "I did this act" that he made progress toward taking responsibility for that offense, in part, because denying the offense was no longer an option. DeMaio's (2006) study of victim/abuser clarification sessions supports this finding that clear and direct disclosure is significant both in terms of the abuser taking full responsibility for the abuse but also to remove any blame experienced by the victim.

In discussing disclosure, many interviewees described the importance of the "culture of disclosure" at the program for normalizing the experience and encouraging honesty. Students observe disclosure by their peers and come to understand that, although difficult, the disclosing student is supported and continues to be accepted by both staff and peers. For many of the students, being at this program was the first time they could talk openly about their offenses, giving them a meaningful opportunity to acknowledge and understand their behaviors. Most interviewees identified disclosing to his family as a pivotal point in treatment for the students with whom they worked, especially if the family does not reject and abandon the student.

113

Almost all the interviewees discussed the clinical benefits of residential treatment. Not only in terms of reinforcing the program's treatment philosophy of working with the whole child, but also in providing all program staff a range of settings within which to work, observe, and learn about the students. The benefits of the long-term, multidimensional treatment approach were integrated into the clinical work specifically in that most interviewees connected sexual offending behavior patterns with other problematic, but non-sexual behavior patterns, and used that connection to inform their clinical work. Additionally, interviewees indicated that being able to work with a juvenile sexual offender for, on average 18 months, provided an opportunity to go beyond the top layer of presenting issues and support the students in making meaningful change. Pervasive or tenacious issues and behavior patterns could be revisited frequently and in multiple settings, such as individual or group therapy, as well as in school or the residences.

Along the same theme of valuing long-term clinical work with juvenile sexual offenders, all interviewees also responded that, in most respects, the therapeutic relationship (with the individual clinician, but also other staff and their peers at the program) was the most significant component of treatment, the "critical intervention." The positive change made possible by the formation of healthy relationships is consistent with the literature that suggests that, "…interventions that maximize the ability to build interpersonal attachments potentially affect the propensity to engage in sexually abusive and aggressive behaviors" (Miner & Crimmins, 1995) given that poor social skills, social isolation and the lack of positive peer relationships have been identified as common

characteristics to many juvenile sexual offenders (Barbaree, Marshall, & Hudson (1993); Rich, 2004; Zimring, 2004).

Implications for Social Work Research and Clinical Practice

The current study aimed to fill a particular gap in social work research, specifically to explore clinicians' perceptions of working with juvenile sexual offenders to take responsibility for their offenses. Research is still needed in terms of clearly understanding how taking responsibility enhances treatment outcomes for juvenile sexual offenders, namely preventing future sexual offending. Possible future studies might explore juvenile sexual offenders' ability to take responsibility (as well as recidivism rates), if treated at programs that do not place clinical emphasis on the process of disclosure. Moreover, a comparative study of programs that use a variety of therapeutic supports, with those programs that do not, might reveal more about how taking responsibility affects recidivism rates, particularly over the long term.

This study focused on clinicians' perceptions on treatment around taking responsibility (i.e., discussing obstacles, progress, setting); however, for purposes of comparison, gathering similar data from juvenile sexual offenders about their experience of treatment could offer those who work with this population important and useful information. Further, this study was limited to a program that worked exclusively with male juvenile sexual offenders leaving open the possibility of further research about working with female juvenile sexual offenders. In the present study, interviewees all worked as clinicians at the same residential treatment program, thus, recruiting a larger number of participants from a range of settings might allow broader data on how interventions might be implemented in different settings. Future studies might assess the

efficacy of interventions used around taking responsibility from a variety of different theoretical perspectives and in a variety of settings. For example, many interviewees discussed, that by virtue of the number of students admitted to the program with a trauma history, addressing a student's trauma history was considered an important component of the work on taking responsibility. An investigation of the theoretical and treatment implementation connections between trauma-informed theory and juvenile sexual offending could influence clinical practice. Finally, this study did not explore the possible role of a juvenile sexual offender's spiritual beliefs or practices in his ability to take responsibility for his offenses, which could be an important consideration.

In terms of clinical practice, it is noteworthy that many of the respondents indicated that the milieu of the program was an important aspect of the success of effects to encourage juvenile sex offenders to take responsibility for past offenses. The milieu of treatment programs for sex offenders, whether juveniles or adults, might significantly affect the type and range of clinical interventions with this population, as well as the possibility for positive outcomes, such as a decrease in recidivism. Further, it would seem that milieu treatment may also address both the shame and secrecy that is often present in the behaviors and thinking of juvenile sexual offenders. That is, a meaningful opportunity for the juvenile sexual offender to not feel like a "freak" or "monster" may be a crucial clinical intervention.

Interviewees' responses point to the importance of providing a variety of therapeutic supports for juvenile sexual offenders, including individual, group and family therapy, addressing trauma histories, psychoeducation around sexual identity issues, and developing healthy relationship skills. Additionally, interviewees discussed the need for

family involvement and support, especially if a juvenile is returning home upon release. Ensuring family involvement and support to juvenile sex offenders seemed an important component of taking responsibility, especially if the family was willing to accept the juveniles past offenses without abandoning the youth.

Finally, a number of interviewees mentioned the legal dilemma faced by juveniles who disclose other offenses while taking responsibility, namely, admitting more offenses may mean more charges against the juvenile which can inhibit honest disclosure. Cross-discipline dialogue between clinicians who work with juvenile sexual offenders and the relevant juvenile justice professionals, with particular attention to balancing the competing interests of community safety, punishing illegal behavior and the rehabilitation of juvenile sexual offenders, may prove beneficial for all involved. In addition to a legal dilemma, there is a clinical dilemma. For clinicians who find themselves experiencing the (potentially) ethical dilemma about mandated reporting, research that examines how to, with clinical confidence, negotiate that dilemma, when they learn of more offenses from the offender, may provide importance guidance for clinical practice.

Limitations of Current Study

A qualitative, exploratory research design was chosen for the current study in order to develop information about how and why clinicians work with juvenile sexual offenders on taking responsibility for their offenses. Given that this aspect of social work practice has not been previously investigated, the study is intended to fill a gap in the current literature on juvenile sexual offenders and taking responsibility. While the

research design achieved this aim, generalizing the results to the larger population would not be appropriate.

Limitations of the current study include the small sample size (N=12), the exclusive data collection at a single residential treatment program for juvenile sexual offenders and that the program is only for male sexual offenders. Broad differences between clinicians interviewed and clinicians working in other settings surely exist and this may impact clinical perceptions as well as interventions used. Including participants from a variety of settings may have allowed for a greater range of responses. Additionally, including participants who worked with adolescent female sexual offenders may also have expanded the variety of responses.

In addition to the more general limitations of the study, the researcher likely also had her own biases in terms of her own legal training as well as her previous experiences as a social work intern working with adolescents. While the researcher made every effort to examine her own preconceptions and to analyze the research data in an objective manner, her previous experiences and training may have influenced her in the research process.

Conclusions

The researcher's hope for the usefulness of the current study is that it will fill a gap in current social work research, while also contributing to the clinical practice knowledge base for mental health professionals who work with juvenile sexual offenders. While the study provides practical clinical information about working with juvenile sexual offenders on taking responsibility, it is possible that broader social changes, including within the legal system, will be needed in order to both protect community

safety while also genuinely supporting juvenile sexual offenders in their rehabilitation efforts. As most of these juveniles will be returning to the community (while still children or adolescents), it seems important to provide the most efficacious treatment possible, which, according to those interviewed for this study, ought to have a broader focus than simply the sexual offending.

References

Ainsworth, M.D.S., Blehar, M.C., Waters, E., & Wall, S. (1978). *Patterns of attachment: A psychological study of the Strange Situation*. Hillsdale, NJ: Erlbaum.

American Psychiatric Association. (2000). *Diagnostic and Statistical Manual of mental disorders* (4th ed., text revision). Washington, DC: Author.

Anastas, J. 1999. *Research Design for Social Work and the Human Services*, 2nd ed. New York: Columbia University Press.

Barbaree, H.E., W.L. Marshall, & S.M. Hudson (Eds.) (1993), *The juvenile sex offender*. New York: Guilford Press.

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., & Hunter, J.A. (1997). Understanding and treating child and adolescent sexual offenders. In *Advances in Clinical Child Psychology*, vol 19, edited by T.H. Ollendcik and R.J. Prinz. New York, NY: Plenum Press, pp. 177-197.

Beckett, R. (1999). Evaluation of adolescent sexual abusers. In M. Erooga & H. Masson (Eds.), *Children and young people who sexually abuse others: Challenges and responses* (pp. 204-224). London: Routledge.

Bowlby, J. (1969). *Attachment and loss, Vol. 1: Attachment* (2nd ed.). New York: Basic Books.

Bowlby, J. (1979). *The making and breaking of affectional bonds*. London: Routledge.

Bowlby, J. (1988). *A secure base: Clinical applications of attachment theory*. London: Routledge.

Burton, D.L., & Smith-Darden, J. (2001). *North American Survey of Sexual Abuser Treatment Models: Summary Data 2000.* Brandon, VT: Safer Society Press.

Center for Sex Offender Management (1999b). *Understanding juvenile sexual offending behavior: Emerging research, treatment approaches and management practices*. Silver Spring, MD: Author.

Center for Sex Offender Management (2000). *Myths and facts about sex offenders*. Silver Spring, MD: Author.

DeMaio, C., Davis, J. & Smith, D (2006). The use of clarification sessions in the treatment of incest victims and their families: An exploratory study. *Sexual Abuse: A Journal of Research and Treatment, 18,* 27-39.

D'Orazio, D. (2002). *A comparative analysis of empathy in sexually offending and non-offending juvenile and adult males.* Unpublished doctoral dissertation. California School of Professional Psychology at Alliant University, Fresno.

Erikson, E. (1963). *Childhood and society*. (2nd ed.) New York: Norton.

Fanniff, A. & Becker, J. (2006). Specialized Assessment and treatment of adolescent sex offenders. *Aggression and Violent Behavior, 11*, 265-282.

Fonagy, P. (2001a). *Attachment theory and psychoanalysis*. New York: Other Press.

Hoffman, M.L. (2000). *Empathy and moral development: Implications for caring and justice*. Cambridge, England: Cambridge University Press.

Hunter, J.A. (2000). Understanding juvenile offenders: Research findings and guidelines for effective management and treatment. *Juvenile Justice Fact Sheet*. Charlottesville, VA: Institute of Law, Psychiatry, and Public Policy, University of Virginia.

Hunter, J.A., Figuerado, A.J., Malamuth, N.M., Becker, J. V. (2003). Juvenile sexual offenders: Towards the development of a typology. *Sexual Abuse: A Journal of Research and Treatment* 11(1): 49-67.

Jacobs, W.L., Kennedy, W.A., and Meyer, J.B. 1997. Juvenile delinquents: A between-group comparison study of sexual and nonsexual offenders. *Sexual Abuse: A Journal of Research and Treatment* 9(3): 201-218.

Keenan, T. & Ward, T. (1999). Child Molesters' Implicit Theories. *Journal of Interpersonal Violence*, 14 (8), pp. 821-838.

Kernberg, O. (1990). New perpectives in psychoanalytic affect theory. In R. Plutchik & H. Kellerman (Eds.), *Emotion: Theory, research, and experience: Vol. 5, Emotion, psychopathology, and psychotherapy*, San Diego: Academic Press, Inc.

Kohlberg, L. (1976). Moral stages and moralization: The cognitive-developmental approach. In T. Lickona (Ed.), *Moral development and behavior* (pp.31-53). New York: Holt, Rinehart, and Winston.

Knight, R.A., & Prentky R.A.,1993. Exploring characteristics for classifying juvenile sex offenders. In *The Juvenile Sex Offender*, edited by H.E. Barbaree, W.L. Marshall, and S.M. Hudson. New York, NY: Guilford Press, pp. 45-83.

Knight, R.A., & Sims-Knight, J.E. (2004). Testing an etiological model for juvenile sexual offending against women. In R. Geffner, K.C. Franey, T.G. Arnold, & R. Falconer (eds) *Identifying and treating youths who sexually offend: Current approaches, techniques, and research*. New York: Haworth Press.

Lab, S., Shields, G., and Schondel, C. 1993. Research note: An evaluation of juvenile sexual offender treatment. *Crime and Delinquency* 39(4): 543-553.

Levy-Warren, M. 1996. *The Adolescent Journey: Development, Identity Formation, and Psychotherapy*. Maryland: Jason Aronson.

Marshall, W.L. (1989). Intimacy, loneliness and sexual offenders. *Behaviour Research and Therapy, 27*, 491-503.

Marshall, W.L., Hudson, S.M., & Hodkinson, S. (1993). The importance of attachment bonds in the development of juvenile sexual offending. In H.E. Barbaree, W.L. Marshall, & S.M. Hudson (Eds.), *The juvenile sex offender* (pp. 164-181). New York: Guilford Press.

Marshall, W.L., Serran, G.A., & Franca, A.C. (2000). Childhood attachments, sexual abuse, and their relationship to adult coping in child molesters. *Sexual Abuse: A Journal of Research and Treatment, 12*, 17-26.

Milloy, C.D. 1994. *A Comparative Study of Juvenile Sex Offenders and Non-sex Offenders*. Olympia, WA: Washington State Institute for Public Policy.

Miner, M.H. and Crimmins, C.L.S. 1995. Adolescent sex offenders: Issues of etiology and risk factors. In *The Sex Offender: Vol. 1. Corrections, Treatment and Legal Practice*, edited by B.K. Schwartz and H.R. Cellini. Kingston, NJ: Civic Research Institute. pp. 9.1-9.15.

National Adolescent Perpetrator Network. 1993. Preliminary Report from the National Task Force on Juvenile Sexual Offending, *Juvenile and Family Court Journal* 38(2): 1-67.

National Task Force on Juvenile Sexual Offending (1993). The Revised Report on Juvenile Sexual Offending 1993 of the National Adolescent Perpetration Network. *Juvenile and Family Court Journal, 44*, 1-120.

Piaget, J. (1932). *The moral judgment of the child*. New York: Simon & Schuster.

Price, D. (2004). Rebuilding shattered families: Disclosure, clarification and reunification of sexual abusers, victims, and their families. *Sexual Addiction & Compulsivity, 11*, 187-221.

Rich, P. (2004). *Understanding, assessing, and rehabilitating juvenile sexual offenders*. New Jersey: John Wiley & Sons.

Rich, P. (2006). *Attachment and Sexual Offending*. New Jersey: John Wiley & Sons.

Rubin, A. & Babbie, E. (1993). *Research Methods for Social Work*. Ohio: Thomson Learning College

Schore, A.N. (1994). *Affect regulation and the origin of the self: The neurobiology of emotional development*. Hillsdale, NJ: Erlbaum.

Schore, A.N. (2001a). Effects of a secure attachment relationship on right brain development, affect regulation, and infant mental health. *Infant Mental Health Journal, 22*, 7-66.

Schore, A.N. (2003). Early relational trauma, disorganized attachment, and the development of a predisposition to violence. In M.F. Solomon & D.J. Siegel (Eds.), *Healing trauma: Attachment, mind, body and brain* (pp. 107-67). New York: Norton.

Siegel, D.J. (1999). *The developing mind: How relationships and the brain interact to shape who we are*. New York: Guilford.

Siegel, D.J. (2001). Toward an interpersonal neurobiology of the developing mind: Attachment relationships, "mindsight," and neural integration. *Infant Mental Health Journal, 22*. 67-94.

Siegel, D.J. (2003). An interpersonal neurobiology of psychotherapy: The developing mind and the resolution of trauma. In M.F. Solomon & D.J. Siegel (Eds.) *Healing trauma: Attachment, mind, body and brain* (pp. 1-56). New York: Norton.

Steiner, H. & Yalom, I. (1996). *Treating adolescents*. San Francisco: Jossey-Bass.

van der Kolk, B. (1987). *Psychological trauma*. Washington, DC: American Psychiatrist Press.

van der Kolk, B., & Fisher, R. (1994). Childhood abuse and neglect and loss of self-regulation. *Bulletin of the Menninger Clinic, 58(2)*, 145-168.

Weinrott, M.R. (1996). *Juvenile sexual aggression: A critical review* (Center Paper 005). Boulder, CO: University of Colorado, Center for the Study and Prevention of Violence.

Winnicott, D.W. (1965). *The maturational process and the facilitating environment*.
London: Hogarth Press & The Institute for Psychoanalysis.

Zimring, F. (2004). *An American travesty: Legal responses to adolescent sexual offending*. Chicago: University of Chicago Press.

Appendix B

CLINICIAN CONSENT FORM

My name is Sheri Kurtz and I am from the Smith College School for Social Work. I am conducting a qualitative research study. This study is for my master's thesis in social work. I am asking your consent to take part in this research study because I am trying to learn more about the role and function of victim clarification in the treatment of adolescent students at this school.

You are being asked to participate in this study if you are a clinician directly responsible for the therapeutic treatment of students at this school. As a participant in this study, you will be asked to participate in an approximately 2-hour audiotaped interview.

If you consent to participate in this study, you will be asked to participate in a face-to-face interview with me. This will take approximately 60-90 minutes. The interview will be conducted at the school. I will be asking you questions about the victim clarification portion of treatment work with students at this school. Interviews will be tape recorded, with your permission. Tapes and transcripts will be coded numerically to ensure your confidentiality. Interview tapes will be transcribed and I will be doing all the transcription myself.

The potential emotional risks of participating in this study are likely to be minimal given the topic area and the nature of the questions being asked. However, there may be some professional discomfort in possibly discussing particular treatment experiences. As I am conducting the research, as opposed to the school, there should be no legal risks to participation. If necessary, you may contact the school's clinical director for support around your participation.

The potential benefits of participation in this research study may include knowing that you have directly contributed to the body of clinical research that informs our practice with vulnerable populations. In addition, participation may offer you an opportunity to think about, and reflect upon, past and current clinical experiences. There will be no financial payment for participation in this study.

Strict confidentiality of the data obtained will be maintained, as consistent with federal regulations and the mandates of the social work profession. Confidentiality will be protected by removing your identifying information from the tapes and transcripts of the interviews, coding the information and storing the data in a locked file for a minimum of three years. If I should need to keep these data beyond the three-year period, the information will be kept in a secure location and will be destroyed when no longer needed. Your identity will be protected, as no actual names will be used in the analysis of the data. In the academic use of this research, data will be presented as a whole and

any quotes or vignettes will be carefully disguised. The data will be used in preparation for my master's thesis and for possible publication and presentations. My research advisor will be the only other person with access to the data, and this will happen only once all identifying information has been removed.

Participation in this study is completely voluntary. However, at any point during this study you may withdraw and/or you may decline to answer any or all interview questions.

You may ask questions at any time about this study. You can contact me at skurtz@smith.edu or by phone at 413-320-8996.

YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION AND YOUR RIGHTS, AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

Clinician signature:

Date:

Researcher signature:

Date:

Appendix C

DEMOGRAPHIC QUESTIONNAIRE

Please provide the following information. I am asking these questions in order to be able to address inquiries from readers or listeners about the diversity of my sample. Please feel free to skip any questions you do not wish to answer.

What is your gender?   FemaleMale   Transgender

How do you identify your race/ethnicity?

What is your socioeconomic status?

What mental health professional license do you currently hold?

In what state(s) are you licensed?

How many years of experience do you have in clinical work with juvenile sexual offenders?

Please describe any training you have received related to the issue of juvenile sexual offenders taking responsibility, either during graduate school or on the job.

Appendix D

INTERVIEW GUIDE

For how long have you worked at the school, and with what age group of students?

How do you talk about taking responsibility with students you see in treatment?

How do you define or conceptualize "taking responsibility"?

How do you define or conceptualize "empathy"?

How might issues of diversity, such as race, ethnicity, socioeconomic status or sexual orientation affect a student's work on taking responsibility?

How might issues relating to a student's developmental stage and early life experiences (including trauma) affect his work on taking responsibility?

How might this conversation be different in individual, group and/or family therapy?

Were there particular experiences or words that a student shared that helped inform your work with him?

How do you observe a student's progress or regress in your treatment work on taking responsibility? And outside of treatment (such as during school, meals, community activities, etc.)?

What informs your determination around meeting (or failing to meet) treatment outcomes?

How is your work on taking responsibility influenced by the specifics of the student's sexual behavior problems (such as age of victim, use of force, duration/frequency of behavior)?

How do you work with a student on disclosing his offending behavior (timing, to what "audience", form of disclosure, etc.)?

What are some common obstacles in treatment around working on taking responsibility? For student? For you?

Can you identify some positive, hopeful experiences in treatment around working on taking responsibility? For student? For you?

What interventions have students identified as most helpful and/or meaningful in their work on taking responsibility? And does this comport with your clinical experience/knowledge?

What particular clinical theories or experiences inform your treatment with students around taking responsibility? Is this consistent with other clinicians?

Is there anything else you would like to add? For example, can you think of any questions that I should have asked but did not? And are there any suggestions you would like to make about this project?