

**THE RELATIONSHIP BETWEEN THE TYPE OF DISCHARGE AND FAMILY
THERAPY INVOLVEMENT AT THE HENNEPIN COUNTY HOME SCHOOL**

By

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ABSTRACT

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The Relationship between the Discharge Status and Involvement in Family Therapy
(Title)

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This study tested the relationship between the discharge status of juvenile sexual offenders and the type of family therapy involvement. Three types of family therapy involvement were measured. The three types were negative, positive and none. Negative family involvement was determined by looking at family history records of drug abuse, criminology, and abuse within the family. Positive families were those families lacking this type of history and were also involved in the treatment of the subject. Families that were negative and chose not to partake in family therapy were put into the 'none' category. The discharge status of the juvenile sexual offender was determined by the progress the sexual offender achieved in treatment. The subject's therapist in the discharge report recorded the discharge status by stating if the subject had achieved success in the treatment program or not. Eighty subjects were used in this study. Chi Square nominal test of differences was used. It was concluded that if the family therapy involvement was positive then the level of success at discharge was higher then if there

was no family therapy involvement. Also, if the family was negative the subjects had a greater level of nonsuccess at discharge.

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CHAPTER ONE

Introduction

Introduction

A significant concern identified by correction personnel is that sexual offenders are at high risk to reoffend if they don't have the family support that they need (Kaufman, 1994). Many sexual offenders are treated in treatment centers and hospitals, yet these 'treated' patients are committing the same sexual offenses after they leave the treatment facilities (Kaufman, 1994). Attention needs to be directed to how best to establish and provide the sexual offender's aftercare needs. Follow-up of the subjects from the facilities could be beneficial, especially for those offenders who don't have the family support needed for successful living after treatment.

Aftercare is a concern; some subjects do not have the money or resources to get the aftercare treatment they need (Mendel, 1993). Some of the sexual offenders go to corrections and do not get the treatment for sexual perpetration needed; instead the problem is masked through treatment for disorderly conduct issues (Mendel, 1993).

A factor that could play an important role for success in treatment in the subject's young influential lives is the support from either family or a group that can emotionally provide support to the offender (Kaufman, 1994). This should be examined by the treatment facility. If the resident does not have a positive family support system then a careful thought out program should be engaged. Positive family support could be judged by the involvement in the offender's family therapy sessions. Once the aftercare program is set then the treatment facility could do follow-ups to evaluate whether the offender is completing the program. If the county is involved then more responsibility should be given to them to follow through with the offenders aftercare program. More ideally both the treatment facility and the county should follow through with the program and aftercare plan to help guarantee success for the offender.

This study focused on family support and participation in family therapy compared to the success each subject achieved by their discharge record. Family therapy

involvement was recorded by using positive, negative, or none ratings. Positive represented a positive family history and participation in family therapy. Negative represented a negative family history but involvement in family therapy. None represented a negative family and no involvement in family therapy.

This is a very serious issue because many tax dollars go into treatment programs for juveniles. One such program is the Juvenile Sexual Offenders Program at the Hennepin County Home School. If programs for Juvenile Sexual Offenders are not successful changes need to be made; possibly an alternative method can be used or better aftercare programs provided. Money that is used in Sexual Offender programs could be used for other programs for adolescents or to redesign the current program. More importantly the money could be used for those offenders that successfully graduate from the program and are in need for aftercare but can't afford it.

For the purposes of this study, it is hypothesized that those patients that have the family support would successfully complete the program at The Hennepin County Home. The results hoped for by researching these issues could help such treatment facilities like that of The Hennepin County Home School review their program to make it more successful. Alternative support groups or foster care could be effective.

This matter of Juvenile Sexual Offenders family support is a serious issue. Many of the files report that the subject offended a young family member and that some other family member had offended the offender. This pattern of sexual abuse, being sexually offended on, then offending someone else, is a vicious cycle that more times than not repeats itself unless intervened upon. This intervention is a crucial step to stop the cycle. It is important that the offender is not put back into a family that has this sexual abuse

history. This is crucial for the offender so that they can maintain a healthy, successful lifestyle.

There is a number of compelling reasons for focusing on juvenile sexual offenders' "modus operandi." This term refers to a continuum of behaviors:

- 1) The offender's preference for particular victim characteristics,
- 2) How he attempts to gain the victim's trust,
- 3) The types of non-sexual behaviors that he engages in with the victim prior to the abuse,
- 4) The offender's use of bribes and enticements as well as threats and coercion in completing sexual acts,
- 5) How the perpetrator attempts to maintain the victim's silence regarding the abuse (Mendel, 1993).

Offender's modus operandi behaviors represent key elements in the treatment process and may serve as cues for preventing future escalation to sexually assaultive behavior. In treatment utilizing a Relapse Prevention Model, knowledge of perpetrators' modus operandi is critical for identifying a "red-flag" for sequences of behavior that have previously led to sexual assaults. Moreover, the identification of these behavior patterns can be utilized to enlist the assistance of family member in monitoring offenders' actions (Kaufman, 1994).

The Hennepin County Home School is a state licensed residential correctional treatment facility for juveniles who have been adjudicated delinquent and committed there by the Court. The County Home School was established in 1903 and has served youth and their families since its inception. It is comprised of several programs and is a

division of the Department of Community Corrections. Among those programs is the Juvenile Sex Offenders Program (J.S.O.P.). This pioneering effort began in 1981 and has evolved into a comprehensive, long-term, intensive, open-ended, sex specific treatment program. Today the J.S.O.P. is comprised of one unit with 24 residents, half of whom are currently available for out-of-county/state referrals. J.S.O.P. is a certified residential sex treatment program. The Hennepin County Home School is financed by county tax dollars. In the J.S.O.P., juveniles are committed for indeterminate sentences. All residents at Hennepin County Home School have been found guilty of offenses which would carry the potential sanction of incarceration, had the offense been committed by an adult.

The clinical practices of J.S.O.P. are research driven and the theoretical foundation is cognitive behavioral. The J.S.O.P. has a structure and orientation that is carefully designed to work with a broad spectrum of adolescent sex offenders. The J.S.O.P. has a program focused on the mental health needs of youth from a developmental perspective.

Statement of the problem

The purpose of this study was to compare family therapy involvement to the offender's type of discharge. Information looked at included the discharge status of the offender. This was taken from the report on the offender's discharge summary. In the discharge summary there was a recommendation from the Hennepin County Home School as to whether the client was discharged successfully or if they were a threat to society. The family involvement was taken from the files kept on each subject. In the records there were papers with statements regarding whether the family came to family

therapy and if they did how successful the sessions went according to their willingness, open-mindedness and participation. Also, how often the family came to the family sessions was recorded. If travel and distance was an issue then the family's involvement in phone therapy was compared.

The subjects involved were residents at The Hennepin County Home School. All eighty male subjects between January 1995 until December 1999 were identified and being used in this research. The subjects ranged between the age of 13 to 18. The subjects were participants in the Juvenile Sexual Offender's Program.

Data was collected by reading discharge summaries located in their past files and gathering legal records on new offenses that have been prosecuted since their discharge. The collection was made in The Hennepin County Home School by pulling past files and reading them, charting data that pertains to this study. Contact was not made with the offenders, nor was there any identification as to who the offender was in the data collection.

Research Hypotheses

The hypothesis under investigation was that those Juvenile Sexual Offenders that had positive family support through successful family therapy would have a high level of success in the treatment program at the time of discharge. Reciprocally, those offenders who had negative family support, or those families who did not engage in family therapy were hypothesized to be at a higher level of unsuccessful treatment at the time of discharge.

Definition of terms

Juvenile is defined as a young person between the age of 13 and 17. To sexually offend someone is to cause displeasure sexually or to sexually attack someone. A juvenile

sexual reoffender is someone who is a young person that causes displeasure sexually to another person after already being found guilty of doing this on another occasion.

Assumptions

The files were assumed to be correct with information regarding the client. This researcher assumed the records with the subjects' criminal records concerning the acts of reoffending after being discharged from the Hennepin County Home School was accurate. Also, assumed was that all subjects involved in the Juvenile Sexual Offenders Program at the Hennepin County Home School were in fact Sexual Offenders and were not wrongfully accused and found guilty by the court. For the use of this paper it was assumed that the discharge summary was requested with the most reserved yet fitting recommendation concerning success while in The Hennepin County Home School and the aftercare recommendations.

Limitations

A limitation of this study was that the client could have manipulated the program and could appear to have completed the program successfully yet have consciously chosen to reoffend after discharge, therefore skewing the results of this study. Another limitation was that the files kept by the Hennepin County Home School could have been misplaced, therefore not every file from January 1995 through December 1999 was documented. Therefore, stating that all subjects that attended the Hennepin County Home School between January 1995 and December 1999 was part of this study may not have been true.

CHAPTER TWO

Literature Review

Introduction

This chapter will cover a review of literature in relation to sexual offenders and family therapy involvement. Also, this section of the paper will address 1) families, 2) roles of adolescents in family therapy, 3) sexual offenders, 4) treatment of sexual offenders, 5) incest in the family life cycle.

Families

Individuals both influence their environments and are influenced by them. “Processes of mutual influence generate change and development” (Longres, 1990, p.19). Each person in a family is part of the whole system. The whole is greater than the sum of its parts. Interaction between the parts is what brings the system to life. The study of the family must begin with the relationship and interactions each member has to each other. In systems theory, higher levels can control lower levels. The individual members are both unique individual and part family at the same time. The family is a bonded system in interaction with its environment. ‘Within the family boundary are its members and their roles, norms, values, traditions, and goals, plus other elements that distinguish one family from another and the social environment...families whose boundaries are open and flexible are the most healthy” (Longres, 1990, p.274).

Unhealthy family systems have (almost) closed boundaries with fixed and rigid connections or no connections whatsoever. The male figure that plays the father, whether it is boyfriend, uncle, grandpa or male cousin tend to have a leading role in the unhealthy family system that limits the behaviors and or roles of other family members by isolating the family system from socialization outside the home.

For families to be healthy, fathers and mothers must have a good sense of who they are, evidenced by good communication skills, healthy ego boundaries, and flexible roles (Bradshaw, 1988). Each of these skills are interdependent upon the other. If one is lacking or unfulfilled then the others are also (Bradshaw, 1988). Each parent must be healthy in order to have healthy relationships (Bradshaw, 1988). Today, due to the high volume of single parent households, it does not always hold true that this type of relationship has to be between a father and a mother. It does however, hold true for the child to see this between the people in their life that play that role of a mother and or father. One or the other (mother or father) does not have to be present just as long as the relationship the one parent has with others is positive. This demonstrates to the child a positive way to hold a relationship with another in respect to each other's needs (Bradshaw, 1988).

When one of the parents has been sexually abused, has not overcome that abuse, and has chosen to repeat it, then a healthy relationship cannot be developed with either a spouse or the child or children. This is where family therapy intervention is critical. Sexual abuse tends to repeat itself. The sexual behavior between family members or outsiders is learned through observation and participation (Calof, 1988). The participation often starts out unwanted and either remains that way or is learned that the sexual abuse is 'okay'.

Families are the primary social system that socializes children about rules and norms of the family and of the society (Gochman, 1968). Children inherit the rules and norms that their parents internalized from their families of origin and through their parents' interaction with their environment. Children readily accept most rules and norms

because they want and need to belong to their family (Gochman, 1968). Children are considered “good” if they obey. To disobey is to “rock the boat” and to risk being considered “bad” or “crazy”. In dysfunctional family systems, members often have to sacrifice their individual identities and relinquish boundaries to maintain the survival of the system (Bradshaw, 1988). Family therapy can be a threat to this type of family, especially if invasion of boundaries includes sexualized behavior. Children learn fast what they can tell others and what they can not. If a child senses something is wrong in their own family, like sexual abuse, but feels that they can’t share that because that would be ‘bad’ then most times children will keep that secret (Longres, 1990).

Denial and dissociation are the fundamental organizing principles of family life (Calof, 1988). The family maintains its homeostasis through rigid rules/norms and family members take on adaptive but dysfunctional roles. This dysfunction can be worked through in therapy. This would help the sexual offender feel supported by their family. It is very hard to maintain healthy relationships outside of the family when a child grows up seeing the dysfunction of the family around them. Dissociation is inevitable when a child doesn’t have the skills to associate or the boundaries to hold a relationship.

The role of denial, repression, and dissociation in individual, family, and community systems can’t be underestimated (Longres, 1990). These mental processes are learned early in life, are deeply entrenched, and are protecting and preserving the systems. Denial, repression and dissociation provide immediate relief from pain, are substitutes for healthy coping skills, and are used to avoid change. These mental processes explain why some people have poorly differentiated perceptual-cognitive

systems (Gochman, 1968). These mental processes need to be addressed by a profession in mental health that aims to improve the systems' functioning.

The family system, like all systems, needs to interact with its individual members and members of the larger systems to have “dynamic growth” and stay healthy (Gochman, 1968). The energy exchange across boundaries provides linkage between the systems. Open systems allow energy throughout and closed systems interact little with other systems. Over time, systems develop patterns of interaction with other systems based on the energy exchange and feedback it receives (Gochman, 1968). These patterns are flexible if the system is open and inflexible if the system is closed. Dysfunctional families exchange very little energy to other families (Longres, 1990). This helps to keep the secret of their dysfunction. The person in charge of the household prefers the family to be shut down and therefore enforces such limitations. Open systems feel the negative energy and /or lack of energy and therefore withdraw from interacting with a system that can't give energy back to their own system (Gochman, 1968).

Adolescents in Family Therapy

Specific changes, which are demanded of adolescence, are accommodated by family systems. Adolescents alone have much confusion, sadness, excitement and arousal of strong feelings (Erikson, 1968). Parents are often distraught by their adolescent children. Adolescents are trying to find their identity and more importantly need to be in control of finding their own identity while in most cases parents have trouble letting their children find their place in life. All these issues are dealt with in the natural development of adolescents.

Erikson (1968), a major contributor to the thinking about adolescence, described the adolescent's search for identity, not as a solitary process, but as a process of

recognition from the community. Adolescents are looking for some sort of approval or in a way of getting approval, by disapproval, in their search for identity (Erikson, 1968).

Erikson states a major contribution to the understanding of the psychology of adolescence for the family therapist is concentrated upon the process of identity formation and the crisis that it implies and engenders.

When an adolescent becomes a sexual offender this adds a much more complex approach to the family structure of an adolescent. Family therapy can be extraordinarily effective if it is undertaken in an appropriate situational context (Ackerman, 1966).

Ackerman found that adolescents respond well to treatment of the whole family. About the same time Ackerman found this Minuchin began publishing dynamic patterns of interaction between mothers and “acting-out” adolescents. The lack of reactivity from the parent creates a deficit in the child’s awareness of his impingement on others, and then the child acts up to get a response, acting as though he had a right to anything because of his early deprivation. This could be the result of sexual misconduct issues. Many times the sexual offenders have feelings that they can do anything they want and that the victim has no right to not engage in the sexual behavior (Ackerman, 1966). Then sexual force is used such as rape and by doing this the offender takes away the rights of that person.

Looking back upon Newton and Einstein, Newtonian physics studied the characteristics of objects, and divided the world into mind and matter, but Einstein stated that it is not possible to view an object separate from time (Ackerman, 1966). The analogy applies to family therapy in that the individual does not exist apart from his interactional context. The individual is, in fact, a collection of experiences of interaction.

It is believed that one can only know the individual by experiencing him/her in the context of his/her interaction.

Family therapy allows consistent responses or feedback from other people in order to have a consistent, supportive identity (Ackerman, 1966). An adolescent needs this feedback. Also, the parents may project certain parts of the family unconscious fantasy into the adolescent and in family therapy this can be examined. This method of therapy encourages family members to discuss and face the struggles for control, which are usually masked by ambiguous relationships and ambiguous hierarchies in a system. Haley (1980) actively explores family hierarchies because he believes unclear hierarchy's lead to an organization (family) in confusion, which leads to eccentric behavior in the adolescent.

Families sometimes approach a therapist or are willing to comply with a court order to see a therapist when the family system is under threat of change. Families may want the therapist to take away their pain without the threat of change; and that the mental health worker simultaneously become a combatant in the struggle between homeostasis and change. A family is a very powerful system and if pushed to change may look at the therapy as impotent.

Sexual Offenders

It was once believed that the stereotypical pedophile was a trench coat clad "dirty old man" lurking near the neighborhood playground. As awareness has grown, the facts have revealed that a pedophile can come in any shape or form, varying in economical background, religion, or race. A pedophile could be as close as the neighbor could and as friendly as the "fatherly" man down the street. There is no stereotypical type.

Sexual predators prey on people of innocence. Violating trust feeds the thrill of their sexual acts. They are sex oriented, to the point of obsession, with each having their preference, whether it is children, boys, girls, babies, or animals. They spend their time watching their victim and talking to them, and in efforts to evaluate their minds.

The typical child sex offender molests an average of 117 children, most of who do not report the offence (National Institute of Mental Health, 1988). About 95% of victims know their perpetrators (CCPCA, 1992). It is estimated that approximately 71% of child sex offenders are under 35 and knew the victim at least casually. About 80% of these individuals fall within normal intelligence ranges and 59% gain sexual access to their victims through seduction or enticement (Mendel, 1993). Data indicates that as many as 70% of sexual offenders (virtually all male) have or provide histories of having been abused (sexually or physically) as children (Orey, 1999). In one study of mentally ill sex offenders in England, four of eleven subjects studied had histories of having been abused by relatives (Craissati, 1992). It is always difficult to confirm such rates of reported abuse, but there is a strong clinical consensus that early physical or sexual abuse is highly correlated with subsequent sexual offending. Though probably only a small minority of individuals who are abused as children go on to become sexual offenders, many if not most male sexual offenders have probably been abused themselves.

Early physical or sexual abuse creates a form of self-hatred and rage that is turned outward, rather than inward, in the form of depression (Orey, 1999). It is as if the sexual offender needs to re-assert the power that was once taken away from him. Perhaps some men are biologically or genetically predisposed to such outward forms of aggression, as

suggested by adoption studies showing high familial rates of antisocial personality disorders in the close biological relatives of antisocial individuals (Orey, 1999).

Based upon the age difference between offenders and victims, juvenile sexual offenders are often categorized into rapists or child molesters. It was believed that adolescents do not commit sexual offenses of any serious consequence until recently. As a result, the adolescent sexual offender has been neglected in both the research and clinical literatures (Kaufman, 1994). Under-estimated factors that contribute include inconsistencies in definitions; exclusion of particular age ranges of victims and/or offenders in national statistics; and social pressures that lead many victims/families to suppress abuse reports.

In 1981, FBI Uniform Crime Reports suggested that juveniles were responsible for a significant proportion of sexual offenses (Kaufman, 1994). In 1990 an epidemiological investigation carried out by the Ohio Youth Services Network concluded that “sexual offending by adolescents is a serious problem in Ohio,” and that adolescents’ sexual offense are often violent and intrusive in nature (Kaufman, 1994). Twenty-eight percent of the 98,415 perpetrators arrested for sexual offenses in 1981 (excluding prostitution) were under the age of 18 years. These offenders accounted for twenty percent of the total number of forcible rapes reported to the FBI during that same year (Kaufman, 1994).

Offenders are predominantly white males with a history of non-sexual acting out behavior or delinquency, who either experienced or observed physical violence or sexual abuse while growing up (Kaufman, 1994). Offenders have typically been arrested at least once for a sexually related offense. Rapes committed by adolescent offenders, as opposed

to adult offenders, are less likely to involve coercion via a weapon or to result in physical harm. However, research also indicates that a substantial proportion of adolescent perpetrators (33% to 45%) have used some degree of physical force and/or threats to harm their victims. The majority of such offenses seem to occur in the victim's home, the perpetrator's home, or a home shared by the victim and the offender (Kaufman, 1994). The majority of victims of offenses involving physical contact are female, below the age of 12 years, and known by the offender (Kaufman, 1994).

Sexual Offender Therapy

Family therapy for a sexual offender can be difficult. Therapists need to be aware of the impact a client's family has on the therapy process (Ackerman, 1966). Many times the family has a history of sexualized behaviors and resists going through therapy. In some cases families are too far away to actively partake in their siblings therapy. Regardless of the family situation and participation, family therapy should be considered and used when possible.

Intervention activities occur at the boundary interfaces. Unhealthy systems need to allow for interaction and feedback to occur to break up their rigid patterns of interacting (Blume, 1990). For example, when a family is court-ordered to receive family counseling, the family boundaries are forced open to some extent. The individual members and the family as a system may then receive corrective feedback. Even if the family is unwilling to participate in family therapy, they are still there absorbing the material and can still gain many things. This includes:

1. Better choices- learning to look at the consequences of acts and making conscious decisions rather than just acting on impulses.
2. Increased self-esteem, getting in touch with one's own and others' feelings.

3. Increased self-understanding and empathy minimizes the need to act-out inappropriately and helps the offender see what effect his actions would have on the potential victim before he acts.
4. Sexual understanding- learning to differentiate between sex and affection, so the offender can maintain appropriate boundaries.
5. Social skills development- learning how to relate appropriately outside of the dysfunctional home.
6. Improved communication – increasing abilities to communicate needs and feelings appropriately.
7. Problem solving- everyone can increase these skills, which in turn increase available coping skills for all activities when stress or gratification needs are present, (sexual activity often derives from stressful situations) (Ackerman, 1966).

Sex offender therapy should be multi-faceted and contain a variety of cognitive and behavioral aspects. “A typical intervention requires the child to be removed from the home for a period of six months to a year, during which time all family members are involved in individual treatment” (Zastrow, 1986, p.202). The goal of keeping the family intact should never take precedence over keeping the children safe from abuse. One caveat is that the children may be pressured into agreeing to keep the family’s secrets, even when it is not in their best interests.

Tasks for family therapy include: promoting the equality of the role mother and father have between them, identifying and correcting dysfunctional family rules, improving communication in the family, and helping the family maintain healthy boundaries (Herman, 1981). “For the locus of the problem sexual perpetration, is

ultimately in the structure of the family” (Herman, 1981, p. 206). When the family structure cannot be improved upon the individual’s treatment could be depended upon.

Incest in the Family Life Cycle

Psychoanalytic views upon the nature of adolescence are rooted in the physiological changes that in turn require psychological adaptations. Freud (1905) points to the upsurge of sexuality in adolescence, and the possibilities presented to the youngster for full genital sexual experience. Freud noted that this possibility of genital heterosexuality carried with it a recrudescence, in the youngster’s self-experience, of a wide range of sexual fantasies and urges, including incestuous longings. Adolescents tend to have difficulty sexually expressing their selves appropriately. Adolescents tend to feel shame and guilt for having sexual urges and then acting upon them. Dysfunctional thinking can occur to use someone younger, weak and more vulnerable to help them please themselves. Also, one may use another that is of the same age or older, to please themselves sexually, with force. This is when sexual perpetration occurs.

Incest prohibitions are helpful conceptually because both generations seem to be implicated. Men may not exhibit dysfunctional behavior such as addictions and pedophilia to the marriage from his dysfunctional family of origin, until after children are born. The family may unwittingly adjust to the addict’s problem. Like other addictions and mental illness, the homeostatic bond preserves and protects their behavior. (Neil and Kniskern, 1982; Dahl, 1983) The pathology is rooted in the interaction of the two different systems: the family system and the individual’s addictive system (Carnes, 1989). In treatment the therapist sees this preserved by the client, many times, to protect the dysfunction in the family. Secrets are often held throughout the whole treatment

process, many times interfering with the therapy of the individual and more broadly with the family in therapy, if therapy occurs.

Family therapy seems to be important to the treatment success of an adolescent's recovery. Dealing with natural adolescent's sexual desires tends to be difficult and when an adolescent chooses to perpetrate it is even more difficult to deal with these natural instincts. Incest occurs in many cases of sexual perpetrators' history, leading the youngster to follow the same path. This study examines the relationship between family therapy involvement and the success of a subjects discharge status.

CHAPTER THREE

Methodology

Introduction

This chapter presents an overview of the methodology used in this study. It includes a description of the subjects and the selection of the sample. In addition, data collection, data analysis procedures, and methodological limitations will be discussed.

Subjects

The subjects were male juvenile sexual offenders that went through the Hennepin County Home School in Minnetonka, Minnesota. The subjects were between the age of 13 and 18. The subjects had attended the Hennepin County Home School between January 1995 and December 1999. Caucasian population consisted of 56%, African-American consisted of 39%, South East Asian consisted of 1%, and Hispanic consisted of 4% of the study. There were 80 subjects studied.

Selection of Sample

The subjects were given a random number so their names were not used. The subjects were unaware of this study being conducted. The subjects had left the Hennepin County Home School prior to this study. The subjects were picked starting from the most current discharges, December 1999 back until 80 subjects were used. This led the study back to January 1995.

Data Collection

The researcher obtained permission from the Director of Admissions to read files on the residents that were in the Juvenile Sexual Offenders Program while at Hennepin County Home School between the era of January 1995 through December 1999. Anonymity was kept by assigning numbers to the resident's data that is collected. The average amount of time spent on each file to obtain the information was an hour. This was due to the disorganization of the files. The information was put on a spreadsheet for compilation and was later pulled together for the most pertinent information for the purpose of this study.

The data received for obtaining the discharge status was taken from the family therapy notes the subject's therapist wrote after each session. Family status was given a title of negative by looking at past family history profiles. Issues such as criminology, drug use, abuse and lack of involvement in their children's treatment were considered as negative. Family status of positive was given if the family lacked the negative features. Family therapy involvement was taken from the discharge report that was found in their files written by their therapist. The therapist judged this by the level of investment the subject showed towards their treatment program.

Data Analysis

The data was analyzed by chi-square. The chi-square was chosen for this study because the data was in the form of frequency counts occurring in two mutually exclusive categories. The analysis determined whether there was a relationship between the type of exit and type of family therapy involvement. The type of exit was if the subject graduated from the program successfully and completed the requirements to leave the Hennepin County Home School. Family therapy involvement was recorded by the therapist of the subject in a file kept on the client. If the family tried and or completed therapy with their child the family therapy was considered positive for the purpose of this study. If the family didn't come to family therapy or came but was relectant to therapy and unwilling to cooperate the family therapy was considered negative for the purpose of this study.

Limitations of the Methodology

The limitations of this methodology may be that not all subjects were honest with their treatment. A limitation is that the subjects that graduated from the program successfully had, really manipulated the program and had made a conscious decision to

reoffend before they left the Home School. Therefore, this would skew the results. The information on the subjects given may not be representative of the population.

CHAPTER FOUR

Results

This chapter will present the results of the study of the level of difference between the type of exit and the family involvement in therapy. The demographic information and descriptive statistics will be reported first. Data collected on each of the research hypothesis will then be given. Last, results of analysis on the research hypothesis will be presented and discussed.

Demographic Information

All 80 subjects were male. All 80 subjects were adolescents in the Juvenile Sexual Offenders Program at the Hennepin County Home School between January 1995 and December 1999. All subjects were between the age of 13 and 18.

Hypothesis

It was hypothesized that adolescents with a positive family involvement in therapy would have a higher successful completion of the treatment program at the Hennepin County Home School. Data were collected by reading the subjects discharge summary and looking at the past files for therapy notes regarding family involvement in therapy. Data were also collected by reading the subjects therapy notes, to assess whether the results of family therapy were positive or negative.

Findings

A chi-square analysis was computed on the data pertaining to the hypothesis.

Table 1 shows the Family Therapy Involvement.

Table 1
Family Therapy Involvement

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|-------|------------|-----------|---------|---------------|--------------------|
| Valid | 1 positive | 17 | 21.3 | 21.3 | 21.3 |
| | 2 negative | 43 | 53.8 | 53.8 | 75.0 |
| | 3 none | 20 | 25.0 | 25.0 | 100.0 |

| | | | |
|-------|----|-------|-------|
| Total | 80 | 100.0 | 100.0 |
|-------|----|-------|-------|

Only seventeen of the eighty subjects had a positive family that participated in the family therapy sessions. Sixty-three subjects had negative families and twenty of those sixty-three families did not participate in family therapy.

Table 2 shows status outcome.

Table 2
Status Outcome

| | Frequency | Percent | Valid Percent | Cumulative Percent |
|-----------------|-----------|---------|---------------|--------------------|
| Valid Discharge | 44 | 55.0 | 55.0 | 55.0 |
| Successful | 36 | 45.0 | 45.0 | 100.0 |
| Total | 80 | 100.0 | 100.0 | |

Forty-four subjects of the eighty received a discharge status other than that of success. This discharge status was unsuccessful. The subjects did not complete the treatment requirements of the treatment program. Thirty-six of the eighty subjects successfully completed the treatment program.

Table 3 shows family therapy status outcome.

Table 3
Family Therapy and Status Outcome

| | Status Outcome | | |
|-------------------------|----------------|------------|--------|
| Family Therapy | discharge | completion | total |
| Positive | 4 | 13 | 17 |
| % Within Family Therapy | 23.5% | 76.5% | 100.0% |
| % Within Status Outcome | 9.1% | 36.1% | 21.3% |
| % Of Total | 5.0% | 16.3% | 21.3% |
| Negative | 25 | 18 | 43 |
| % Within Family Therapy | 23.7% | 41.9% | 100.0% |

| | | | |
|-------------------------|--------|--------|--------|
| % Within Status Outcome | 56.8% | 50.0% | 53.8% |
| % Of Total | 31.3% | 22.5% | 53.8% |
| None | 15 | 5 | 20 |
| % Within Family Therapy | 75.0% | 25.0% | 100.0% |
| % Within Status Outcome | 34.1% | 13.9% | 25.0% |
| % Of Total | 18.8% | 6.3% | 25.0% |
| Total | 44 | 36 | 80 |
| % Within Family Therapy | 55.0% | 45.0% | 100.0% |
| % Within Status Outcome | 100.0% | 100.0% | 100.0% |
| % Of Total | 55.0% | 45.0% | 100.0% |

There were seventeen subjects that had a positive family involvement in treatment. Out of the seventeen, thirteen received a successful treatment discharge status and four received an unsuccessful discharge. Sixty-three subjects had negative families and twenty of those sixty-three had no family therapy involvement. Out of the twenty with no family therapy only five had a successful discharge and fifteen did not have a successful discharge. Twenty-five of the negative family therapy involvement had a unsuccessful completion and only eighteen had a successful discharge of the negative family therapy involvement. The Pearson chi-square value was 10.206 with a level of significance is at .01.

Table 4

Chi-square analysis

| Successful discharge | | unsuccessful discharge | | total | chi square |
|----------------------|----|------------------------|--|-------|------------|
| | | p | | | |
| + family | 13 | 4 | | 17 | 10.206 |
| | | .01 | | | |
| - family | 18 | 25 | | 43 | |
| no family | 5 | 15 | | 20 | |
| total | 36 | 44 | | 80 | |

CHAPTER FIVE

Discussion, Conclusions, and Recommendations

Introduction

This chapter will include a summary of the study, discussion of the results of the study, and conclusions. The chapter will conclude with some recommendations for further research.

Summary

The purpose of the study was to determine if there was any relationship between the type of family therapy involvement and the success of the treatment program upon discharge. It was hypothesized that if a family was positive and involved in family therapy the subjects would have a greater success rate at discharge. Positive families were involved in their child's treatment and did not have a history of drug abuse, criminology, and abuse within the family. Negative families were the reciprocal of this.

Discussion and Conclusions

According to the research finding, there is a relationship between family therapy involvement and discharge status. Those subjects that had a positive family therapy involvement had a higher level of successful completion of the program. Those subjects that had no family therapy involvement had a greater chance of not successfully completing the program. Those subjects that had a negative family therapy involvement had a greater chance of not successful completing the program.

Adolescents are influential and need a support group, if not the family, than one that can help them with their recovery. When raised in a family with a history of crime and abuse a child views this as an acceptable way of life. Surviving is important in a dysfunctional family. Adolescents may believe that repeating the mistakes of their family is a path to survival.

It is important that in the treatment program an adolescent is not put back into the same negative family setting. When the family of a sexual offender in recovery does not

support their child, it is difficult for that child to maintain recovery. Different options of aftercare are crucial. Treatment centers would benefit by having a different option for the child to go to after treatment. A family that understands sexual perpetration and that supports a healthy recovery would be ideal. Also, a family that may be beneficial for a recovering perpetrator is where a family's own addiction, criminology, or abuse issues are not of concern for the child.

Due to the size of the study, further research is needed to have a better understanding of levels of significance in family therapy involvement and a subject's success of a juvenile sexual offender's treatment program. Also, due to the fact that this study was taken inside one treatment facility, further research is needed to have a broader sense of the success at discharge and family therapy involvement.

Recommendations for Further Research and Limitations of the Study

Several suggestions are offered for further research on sexual offenders and the success at exit of a treatment program. A recommendation for future research in this area would be to study a larger, more representative population, which would not only make the data more general, but also increase the possibility of finding significant differences of type of exit and involvement in family therapy. Also, gathering research from a different treatment center could be used and/or compared to that research of the Hennepin County Home School.

There were several limitations of this study. First, the sample size was not representative of the population. Also, the subjects were not evenly dispersed in the three classifications. Only six residents got discharged as an environmental threat and more than half, 44, residents had negative family involvement in therapy. Another limitation is that there were a number of different therapists involved in the 80 subject's treatment.

Different therapist had different ways of therapeutic intervention and could play a part in unsuccessful family therapy and/or individual treatment, which would affect the discharge status. Another limitation is that the subjects' I.Q. level was not taken into consideration of how able the subjects was able to comprehend the treatment available to them. Finally, a limitation is that there is a lack of well designed treatment outcome studies, it is difficult to draw conclusions regarding the most efficacious approach for the treatment of juvenile sexual offenders.