RESIDENTIAL TREATMENT PROGRAM CRITERIA AFFECTING THE LENGTH OF STAY OF ADOLESCENT SEX OFFENDERS

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RESIDENTIAL TREATMENT PROGRAM CRITERIA

AFFECTING THE LENGTH OF STAY OF

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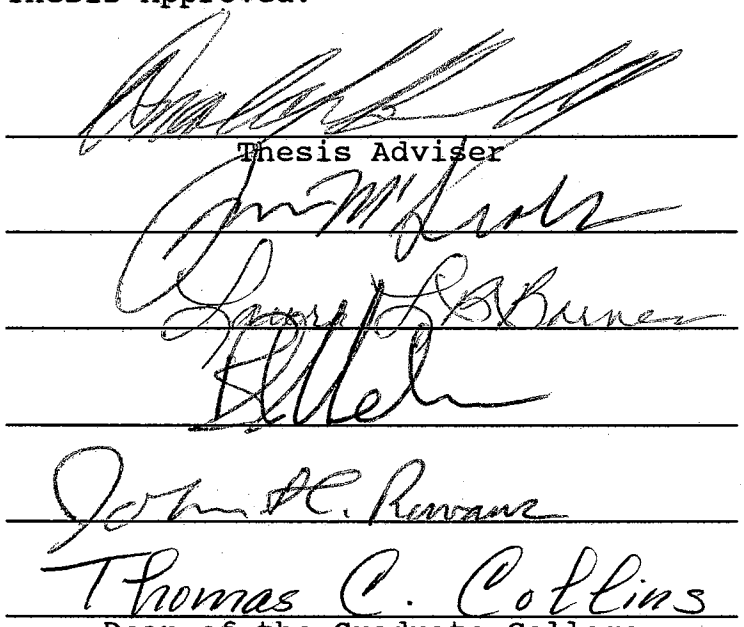

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CHAPTER I

INTRODUCTION

The commission of sexual offenses is a widespread problem in the United States. Groth and Loredo (1981) reported that over 50,000 rapes were reported each year and Groth and Birnbaum (1979) predicted that the actual incidence of rape was ten times that amount. In 1990, 85,647 sex offenders were incarcerated in state and federal prisons, one in six of all prisoners (Goleman, 1992). Until recently, most research has focused on the identification and treatment of adult sex offenders and their victims (Becker, 1988), but there is increasing evidence that these offenders begin their deviant behavior at a much younger age than previously suspected. Approximately 50% of all adult sex offenders reported that their first sex offense occurred during adolescence (Becker & Abel, 1985; Smith, 1984). A retrospective self-report study of 231 incarcerated adult sex offenders by Longo and Groth (1983) found that 35% of them reported an escalation of sexual aggression and chronicity beginning in adolescence. Offenders under the age of 18 accounted for approximately 30% of all rapes and 50% of all child molestations (Fehrenbach, Smith, Monastersky, & Deisher, 1986). Stickrod and Ryan (1987) found that adolescent sex offenders' sexually deviant patterns of thinking and behavior started as early as age five.

The need for early identification and treatment is

evident because the average incarcerated adult sex-offender has committed 533 sex offenses against 336 victims (Knopp, 1984) while the average adolescent sex offender has committed 6.8 sex crimes (Marshall, Laws, & Barbaree, 1989). Although early treatment is a laudable goal, the data on treatment of adolescent sex offenders are limited and the incidence of sexual offenses is rising dramatically.

A nation-wide probability study suggests that juveniles committed 450,000 sex offenses in 1976, based on self-report information (Knopp, 1982). In a sample of 863 adolescent males the rate of sexual assault per 100,000 juvenile males was estimated as being 5-16% of this population (Becker, 1988). During the five year period beginning in 1983, 1707 juvenile sex offenders were identified in Utah, representing a 55% increase over the previous five year period (Utah Task Force, 1989). In 1991, 4,766 juveniles were arrested for rape and more than 14,000 were arrested for lesser sex crimes, according to the FBI (Young, 1992). Although these numbers seem to be exorbitant, the actual rate of incidence of juveniles committing sexually aggressive behavior is distorted or unknown due to under-reporting, reliance on arrest rates, suspect reliability of self-reports and a lack of empirical studies (Becker & Abel, 1984).

Since the evidence indicates that adult sexual offending is frequently part of a pattern of behavior beginning in adolescence that can increase in violence during the adult years (Cotton, 1991), providing treatment

to the juvenile when the behavioral symptoms of sexual assault first appear would seem prudent. Bonner (1991) suggested that early treatment is more expedient because the behaviors are not deeply ingrained and are more responsive to treatment. The youthful offender may be more emotionally accessible during the initial stages of sexually acting out, increasing the likelihood of positive change in treatment (Groth & Loredo, 1981). Additionally, early intervention can significantly reduce the number of victims and, consequently, reduce the personal, emotional, and monetary costs of the sex offenses (Thomas, 1992). Knopp (1985) listed several benefits for early intervention with the adolescent sex offender: 1) deviant patterns are less ingrained and therefore easier to disrupt; 2) juveniles are still experimenting with means of sexual satisfaction and alternatives to deviant patterns may be substituted; 3) deviant thought patterns and distorted thinking are less deeply entrenched, resulting in greater success in attempts to redirect faulty cognitive patterns; 4) adolescents are better candidates for learning new social skills than are adults; 5) the community is protected by reducing victimization. Thus, the early identification and treatment of juvenile sex offenders would seem to improve the prognosis for the adolescent and thereby reduce the risk to the community.

A critical concern is that some effective intervention must be provided for adolescent sex offenders in order to

reduce the risk of continued offending. Early intervention may be problematic due to the lack of availability of resources. Knopp (1985) reported that:

> Though 40 states offer some type of private or public treatment for these young clients, very few states provide comprehensive assessment, treatment, and post-treatment services. As a result, courts usually have limited treatment options available and thus young sex offenders may be placed in settings highly inappropriate to their treatment and custodial needs (p. 7).

Sapp and Vaughn (1990), in a nation-wide survey of adolescent sex-offender programs, found that the average length of stay in an inpatient treatment facility for sex-offenders ranged from six months in some states to thirty-three months in others.

The rapid increase in the number of adolescents arrested for sex offenses and the limited availability of treatment beds has led to the creation of a chronic overload state (Knopp, 1985). Therefore, maintaining an adolescent sex offender in a secure placement for an extended period of time limits the number of offenders who can be served by the treatment facility, possibly increasing the risk of offending due to lack of availability of services. However, premature release of an offender may lead to additional offenses occurring as well. Bonner (1986) noted that long-

term studies evaluating the outcome of different treatment modalities, including length of stay, with adolescent offenders have not been forthcoming. One option available is to find ways to reduce the length of stay in secure placements while continuing to provide protection to the community and treatment to the offender.

The next decision facing the public is the type of treatment deemed necessary for the juvenile offender. Knopp (1985) noted that the treatment of the adolescent sex offender may take place in outpatient settings, residential and inpatient settings, and secure placements. The monetary cost differences of the various placements are astounding. A twenty-month program of outpatient services for offenders in California has an estimated cost of $6,871, compared to $151,166 for specialized sex offender treatment in a secure setting with the California Youth Authority (Cotton, 1991). The expense of institutional treatment versus community based treatment must be balanced against the risk of reoffending in the community by juveniles left in the home.

Purpose of Study

The purpose of the current study is to investigate what legal, clinical, and funding factors are influential in determining the average length of stay for adolescent sex offender programs. In addition, this study will be used to gather information about the type, if any, of exit criteria being used by residential treatment facilities. The study represents an attempt to provide basic information

concerning the use of exit criteria because, to date, few studies have addressed how the decision is made to release sex offenders from inpatient treatment. Information generated by the study will be instrumental in developing a framework to better understand programmatic issues affecting the delivery of treatment to adolescent sex offenders.

Research Questions

In an effort to gain an understanding of the relationship between programmatic features and length of stay in juvenile sex-offender programs, several questions were formed to explore the relationship. The following research questions were addressed in the current study:

1. What is the relationship between type of court sentencing, determinate, indeterminate, or mixed, and the average length of stay for adolescent sex offender programs?

2. What is the relationship between the existence of specific exit criteria and the average length of stay for adolescent sex offender programs?

3. What is the relationship between the number of sex offenders in the program and the average length of stay for adolescent sex offender programs?

4. What is the relationship between the number of years of experience of the treatment staff and the average length of stay for adolescent sex offender programs?

5. What is the relationship between the type of sex offense committed by the offenders at the program and the average length of stay for adolescent sex offender programs?

6. What is the relationship between the type of funding for the facility and the average length of stay for adolescent sex offender programs?

7. What exit criteria are presently being utilized by residential settings to make release decisions about adolescent sex offenders?

Definitions

Juvenile Sex Offender: The Utah Task Force (1989) describes a juvenile sex offender as any juvenile below the age of eighteen who commits a sexual offense. A sexual act is considered to be a sex offense if it meets any of the following criteria: 1) a three to five year difference in age or more among juveniles or children involved in sexual acts; 2) greater physical size, especially when size is used to intimidate the victim; 3) greater mental capacity, where intelligence or developmental maturity is used to overpower the victim; 4) greater physical capacity, such as physical handicaps that are exploited to gain power over another person; 5) the use of deferences in roles, such as one person being designated as being in charge of the victim as in babysitting situations; 6) the use of predatory patterns of behavior (e.g., stalking or manipulating the victim to gain trust); 7) any behavior which is used to intimidate or manipulate the victim into sex. The sexual act may include any of the following behaviors: fondling, frottage, penetration of the anus or vagina by any object, oral copulation or any hands-off offense such as voyeurism,

exhibitionism, or obscene telephone calls.

Length of Stay: The amount of time, measured in months, that a juvenile sex offender is required to stay in a residential treatment facility to complete necessary treatment for the offense.

Limitations

The data were collected by mailing survey forms to sites listed by Freeman-Longo et al. (1995) as facilities providing residential or secure placement of adolescent sex offenders. The list of placement sites was compiled from reviews of the literature and by self-report by the placement sites. Therefore the list of sites is not comprehensive and may represent a biased sample of the available sites. In addition, it is likely that not all of the sites surveyed responded completely or in a useable manner, further limiting the generalizability of the data collected.

In order to ease the collection and compilation of data, discrete survey questions were posed which limited the response set. A free response section was provided on the questionnaire to encourage feedback that may be of assistance in interpreting the data.

Another limitation in the study of inpatient and incarcerated sex offenders is the lack of literature and low rate of placement of female offenders. Johnson (1989) and Ramsey-Klawsnick (1990) completed studies indicating that approximately 25% of all sex offenders are females. Yet in

the same studies only one female in 21 was prosecuted. Wolfe's (1985) review of the literature found few studies of female sex offenders beyond isolated case studies. Davis and Leitenberg (1987) suggest that the dearth of research with female sex offenders and treatment of the offenders is an indication of society's double standard in which females' aggressive behavior is seen as desirable or at least viewed with less condemnation. Therefore, the current study predominantly reflects data relating to inpatient male adolescent sex-offender treatment programs, although some of the programs may include data relating to female offenders, and may not be applicable to female treatment programs.

CHAPTER II

REVIEW OF THE LITERATURE

Introduction

In this chapter, information is presented to support the development of the research questions. Research concerning length of stay in treatment for sex offenders, treatment staff, sex offender typologies, funding types, approaches to sentencing, and the development of specific exit criteria is considered. First, factors influencing the development of sex offender characteristics are discussed.

Etiological Factors

Adolescent sex offenders are a heterogeneous group and there the origins of their behavior appear to be varied (Becker, 1988). Although popular myth describes the juvenile offender as a hormone driven male experimenting with sex, it is more likely that sexual offenses are symptoms of unresolved developmental issues and the assault is the acting out of an unresolved early crisis in an attempt at resolution (Greer & Stuart, 1983). In a study of adolescent sex offenders by Becker, Cunningham-Rathner and Kaplan (1986) 82% had participated in legal, nongenital sexual behavior and 58% had participated in legal, genital sexual behaviors before the beginning of deviant sexual behavior. As the sex offense was not the first interpersonal sexual experience, the behavior did not represent naive curiosity or experimentation. Therefore, the sexual assault probably has little to do with sexual

needs, but rather reflects serious pathology, especially in the realm of interpersonal relationships, and is a demonstration of violent aggression and a need to gain power over the victim (Deisher, Wenet, Paperny, Clark, & Fehrenbach, 1982). The sex offender's need for power and control may be related to the offender's own history of abuse.

Research on juvenile sex offenders indicates the rate of them being victims of child sexual abuse ranges from 47% to 75% (Cotton, 1991; Longo, 1982). These figures may be misleading because the information was attained at intake and a recent study suggests that the adolescent sex offender is twice as likely to report a history of sexual abuse later in treatment than at admission (Cotton, 1991). Finkelhor (1981) theorizes that long-term sexual abuse may lead to the victim identifying with the abuser in order to regain a sense of control of his\her life situation. Another theory suggests that the strong sense of helplessness and low self-esteem, associated with sexual abuse, may lead to a cycle of sexual assault as the child attempts to overpower the victim in order to feel adequate (Ryan, Lane, Davis, & Isaac, 1987).

The cycle of abuse approach implies that the young male is especially vulnerable to becoming an abuser due to societal expectations for males, and he may perceive himself as responsible for his own victimization, refuse to reveal the assault, and internalize feelings of guilt and weakness

(Ryan et al., 1987). These sexually abused juveniles may carry unresolved feelings of anger which contribute to their subsequent sex offenses (Knopp, 1984). The National Task Force Report (1988) suggests that this pattern of helplessness and lack of control followed by the commission of sexual offenses is indicative of the sexual assault cycle, a generalized pattern of acting out sexually when emotions are elicited that are similar to those experienced during sexual victimization.

Groth and Birnbaum (1979) found that another common problem for the sex offender is a marked difficulty in negotiating interpersonal relationships. Lutz and Medway (1984) consider the dysfunctional relationships in the family to be the primary cause of sex-offending behavior. Markey (1950) in a study of 50 adolescent offenders found that the inappropriate sexual behavior of these youth was an indication of poor personality integration caused by familial trauma. The family is the initial social learning situation, and poor role modeling of social and assertive behaviors may lead to difficulty in relating to peers on a functional level (Becker & Abel, 1984). In addition, family problems may not be a separate factor from child abuse in the creation of a sex offender, as child molesters are more likely to be family members or other caretakers rather than strangers (Davidson, 1987).

Sex offenders tend to be socially isolated, have low self-esteem, and have deep-seated feelings of inadequacy

(Groth & Loredo, 1981). Maclay (1960) described insecure personality as a major contributing factor in the development of sexually assaultive behavior. Socially awkward and lacking involvement in appropriate peer relationships, the adolescent child molester tends to seek relationships with much younger children, often in the role of baby-sitter, due to the reduction in fear and feelings of superiority perceived in the presence of these children (Deisher et al., 1982; Fehrenbach et al., 1986; Hamer, 1985). The role of care-giver creates the trusting atmosphere and opportunity necessary for the sex offense to occur. Low self-esteem may perpetuate the cycle of abuse as well as being a causative factor, as the offender may believe that the resources to change do not exist (Lombardo & DiGiorgio-Miller, 1989).

Once the sex-offending behavior pattern is initiated it is difficult to extinguish without drastic intervention, since sexual offending can become a lifelong pattern of compulsive, addictive-like behavior (Cotton, 1991; Embry, Escobar & Johnson, 1991). As indicated earlier, most sexual assaults are not reported, leading to the commission of many offenses that are sexually and emotionally rewarding with no negative consequences (Becker & Abel, 1984). Ryan et al. (1987) report that the reinforcement comes from the thrill of secrecy, grooming the victim, stalking, fantasy, and the addictive qualities of increasingly deviant sexual assaults, which lead to the ingraining of habitual, deviant,

aggressive patterns of behavior.

It is difficult to ascertain if the increase in referrals to the juvenile justice system of sexual offenders is due to an actual rise in the incidence of sexual assault, an increase in the awareness of the public and court of the seriousness of sexual offenses, or an artifact of mandatory reporting laws concerning sexual abuse (Thomas, 1992). In the past, sexual behaviors that are now clearly perceived as being criminal or exploitive were viewed as adjustment problems or adolescent experimentation (Breer, 1987; Ryan, 1986). Official statistics underreport the severity of the problem for a variety of reasons: 1) many resources only include rape in data collection, excluding other forms of sexual assault; 2) victims under the age of twelve are not included in surveys of victims; 3) inconsistent data collection procedures from state to state; 4) complex and personal nature of the crime; 5) victim's familiarity with the offender; 6) age of the offender; 7) victims are often reluctant to report the offense; 8) offenders are reluctant to report the offense, even after arrest and incarceration; and 9) tendency of the juvenile justice system to negotiate a plea bargain or to defer adjudication (Thomas, 1992).

Placement Issues

As shown earlier, there is a tendency for sex offenders to have many victims and to commit numerous assaults. O'Connell, Leberg, and Donaldson (1990) suggest that most treatment programs for sex offenders perceive protection of

the community to be the primary goal, and that substantial external controls must be imposed in order to prevent reoffense while the offender is in treatment. Society's response has been to incarcerate the sex offender, often for long periods of time.

It is not difficult to understand the public's response to sex offenders. Most people in the community want these offenders placed in secure settings with severe punishment, as the common reaction is that of anger and fear rather than compassion for a disturbed youth (Heinz et al., 1991). Heinz et al. (1991) found that in many cases the juvenile sex offender was certified as an adult and sentenced to an adult prison with little opportunity for treatment. The method of treatment is institutionalization in a confined environment and away from the targets of sexual abuse (Groth, & Birnbaum, 1979). Goleman's (1992) research estimates that over 75% of incarcerated sex offenders receive no treatment at all. A review of statistics from several states of adult sex offenders released from prison with no specific treatment intervention found that from 35% to 80% of them reoffended sexually (Heinz, Ryan, & Bengis, 1991).

Once the offender has been identified and referred to juvenile court the issue of disposition is raised. Adolescent sex offenders tend to be very manipulative and try to avoid treatment or incarceration at any cost, although research indicates that without a mandate from the

court the offender will not remain in therapy and will continue to be at high risk of reoffending (Deisher et al., 1982; Embry et al., 1991). In general, these offenders receive probation or the case is dismissed; 35% of all juvenile sex-offending charges are dismissed, with only approximately 20% being placed outside the home (Thomas, 1992).

In some areas the only available way to access specialized treatment for juvenile sex offenders is through diversion programs (Heinz et al., 1991). The diversion from filing charges may support minimization of the offense by the teenager and limit the information available to courts in other jurisdictions, due to the lack of adjudicatory history (Utah Task Force, 1989). Lombardo and DiGiorgio-Miller (1989) suggest that the lack of immediate consequences for the offense, associated with diversion or dismissal of the charges, may lead to confusion and possible justification for the assaults by the offender.

In a sample taken by Saunders and Awad (1987) close to half of the adolescent sex offenders were placed in either residential treatment, secure treatment-holding facilities, or therapeutic foster-care type group homes. In a study conducted by Knopp (1982) there was a 5% recidivism rate for juvenile sex offenders who had completed a residential treatment program. In Utah, the recidivism rate jumped to 17% of the sample when half of the juveniles received no treatment (Utah Task Force, 1989).

In determining the appropriate placement site, several criteria should be considered. According to Groth, Hobson, Lucey, and St. Pierre (1981), the criteria to be considered in determining the appropriate placement site are: 1) the degree of force or threat used against the victim, 2) evidence of ritualistic behavior, 3) criminal history, either sexual or non-sexual, 4) psychopathology, including retardation, psychosis, substance abuse, and organicity, and 5) refusal to admit to committing the offense, by the client and by the family.

Once the juvenile offender has been identified, adjudicated, and the court makes placement recommendations, the system frequently grinds to a halt, due to a lack of available treatment options. In a review of the literature, Sapp and Vaughn (1990) found that the first juvenile sex offender rehabilitation program began operation in 1979. The traditional approach to treatment of sex offenders is to place them in secure settings, but there were only twenty-four juvenile prison sites offering sex-offender treatment in 1986 and thirty-two sites providing the services in 1988 (Knopp & Stevenson, 1988).

The lack of adequate or appropriate facilities for treatment is a barrier for providing early intervention with juvenile sex offenders, possibly leading to additional victimization by the offender. Thomas (1992) states that in a survey of juvenile probation agencies, only 25% of the agencies indicated that adequate placement and treatment

resources existed for adolescent sex offenders. The lack of appropriate treatment facilities leads to an overcrowding of the system, resulting in many adolescent sex offenders not receiving treatment.

Length of Stay

As stated earlier, while the financial cost of incarcerated treatment of juvenile offenders is exorbitant, perhaps not as obvious is the cost to the offender, and ultimately to society. Incarceration may result in the revictimization of the adolescent sex offender and cause additional damage to an already traumatized youth (Greer & Stuart, 1983). Marshall et al. (1989) suggest that incarceration used as punishment may in fact be a reinforcer of sexually deviant behavior. The inmate codes of deception, manipulation, and force, in combination with the danger of appearing vulnerable are at cross purposes with the goals of treatment.

The negative effect of incarceration is exacerbated by the extended length of stay often associated with the incarceration of juvenile sex offenders. Sapp and Vaughn (1990) found the mean length of incarceration for adolescents to be 17.5 months, with a range of 6 to 33 months. Although the twenty-seven month difference in length of stay is significant, no study has attempted to explain the difference in time needed for treatment.

In a study of the California Youth Authority's provision of treatment interventions with juvenile sex

offenders, Kahn and Chambers (1991) found that less than 25% of the offenders satisfactorily completed treatment, with the remainder either "aging out" of custody or being released by the court against treatment staff's advice. This further confuses the average-length-of-stay problem, in that the California Youth Authority quotes a twenty-two-month length-of-stay in incarcerated settings for juvenile sex offenders (Cotton, 1991), but as stated previously, most of these adolescents do not complete treatment, so the actual length of stay could be considerably higher than what is reported in the literature.

The use of labels facilitates the processing and storage of information, but labels can have a detrimental effect on the treatment of clients (Langer & Abelson, 1974). Walsh (1984) states that the labeling of a juvenile as a sex offender can have considerable negative impact on the individual. He found that sex offenders received harsher treatment, were more likely to be segregated from society than non-sexual offenders, and receive disproportionately more severe sentences. Rosenhan's (1973) classic study of colleagues entering a psychiatric hospital complaining of schizophrenic symptoms, who were not released even when all of the symptoms disappeared, illustrates the pervasive effect of labeling on clinical staff that is not easily overridden by new information.

While the risk of harm to the offender is present if he/she is maintained in a secure placement for an extended

period of time, the risk of premature release is borne by society through the possibility of reoffense. Fehrenbach et al. (1986) found that two-thirds of all of the victims of adolescent sex offenders were under twelve years old. The juveniles claimed that they chose infants and pre-schoolers as victims, not because they are attracted to this age group, but because these children are easy to overpower and control (Margolin, 1984). Pagelow (1987) suggests that the physical trauma related to the sex offense is frequently more severe with these young victims due to the differential in relative size to the victimizer.

The physical harm as well as the fear and anxiety evoked during the assault may lead to the development of a long-term anxiety disorder known as Post Traumatic Stress Disorder (PTSD) (Thomas, 1992). Another source of harm is the way that the victims tend to view themselves and the environment. The victims may come to believe that others are untrustworthy and the world is a dangerous place (Thomas, 1992). The trauma of child sexual abuse has far reaching effects on some adults, as they are twice as likely to be diagnosed with depression and tend to be at greater risk of revictimization as they often select abusive partners (Thomas, 1992). Finally, abuse takes its toll by diminishing self-esteem, inflicting grief, and encouraging a sense of helplessness (Utah Task Force, 1989).

Treatment Staff

The sex offender is often an involuntary participant in

the interview which further strains the relationship needed to gain usable information (O'Connell et al., 1990). By disclosing openly to the therapist, the offender risks an increased probability of incarceration, due to the reporting of previously unknown crimes, and the possibility of additional charges being filed (Greer & Stuart 1983). Damon, Todd, and MacFarlane (1987) suggest that this reluctance to disclose secret information may be related to the sexual abuse experienced by the offender. The child may have been threatened with physical harm if they told the secret about their abuser. The sexual abuse victim might incorporate repression and denial into their personality in an attempt to minimize the effect of abuse on their life. The sex offender may fear the shame and social stigma if their crimes become known, and try to suppress information about the charges (Greer & Stuart, 1983). This reluctance on the part of the offender limits the effectiveness of the creation of sex-offender profiles which may be helpful in predicting risk (Marshall et al., 1989).

Saunders and Awad (1988) state that the initial problem for the therapist is to correctly identify the juvenile sex offender, which can be difficult as the vast majority of adolescent sex offenders do not fit the criteria of paraphilia as specified in the DSM-IV (American Psychiatric Association, 1994). Superficially, sex offenders may appear normal in school and with peers, but despite the surface appearances these adolescents are usually quite disturbed

(Heinz et al., 1991). Sex offenders often lack appropriate empathy, guilt, or remorse for their victims and may not view the behavior as problematic, which is a clear indication to the clinician that the client is a troubled, individual frequently one needing a psychiatric referral (Deisher et al., 1982).

The clinical interview is the most frequently used method of diagnosis and assessment of the juvenile sexual offender (Becker & Abel, 1984). The problem is that the adolescent may underreport the extent of the aberrant behavior or deny deviant arousal patterns. Margolin (1984) notes that the need to manipulate and lie pervades the sex offender's life, and the client will typically deny the offense, minimize the violence used, project blame onto others, and resent questions about the offense.

It is important to keep in mind that it was this very ability to persuade and confuse that enabled the sex offender to create a situation in which to commit the sex offense in the first place (Deisher et al., 1982). The information available to the clinician is based on self-report, family interview, and court records (Thomas, 1992). Some difficulties seem inherent to this system (e.g., social norms encourage underreporting, complexity of the crime, age of victim may discourage reporting, victims may be reluctant to report, family may minimize the offense, offender reluctant to report, and the tendency of the juvenile justice system to plea bargain). The result is a decision

being made which is often based on incomplete or false information.

Manipulation and deception are integral parts of the offender's personality, increasing the risk of releasing a sex offender who is at risk of reoffense (O'Connell et al., 1990). In addition, the client-therapist relationship is unusual due to the requirements regarding mandatory reporting and the fact that the interview is being conducted to judge the risk of the offender to the community. The requirement to report may encourage the offender to be deceitful (O'Connell et al., 1990). The client traits of irresponsibility, lack of change, lack of motivation, and self-centeredness affect the therapy process in a negative way (Farrenkopf, 1992).

Smith and Monastersky (1986), in a study of clinicians' predictions of recidivism of juvenile sex offenders, found that experienced therapists tended to greatly overpredict the rate of reoffending. In the study of 223 adolescent sex offenders it was predicted that 58% of the sample were at high risk of reoffending, however in a twenty-month follow-up period only 7% had reoffended. In one sex-offender-specific program, the treatment staff was unable to predict recidivism, which is particularly discouraging, as these clinicians were highly trained in the treatment of juvenile sex offenders (Hall, 1988). One reason for the tendency to overpredict the risk of reoffending may be that mental health workers are concerned about risk of a lawsuit being

filed in the case of a client committing additional offenses after being released from treatment (Melella, Travin, & Cullen, 1987). There is also the risk to the therapist's professional standing and the associated guilt if other people are victimized due to an error in judgement on the part of the clinician. In consideration of this information, many therapists have stated that if they are going to make a mistake it will be in the direction of protecting society (Crain, 1982).

Another factor which affects the clinician's judgment relates to the impact that working with sex offenders has on the therapist. Yochelson and Samenow (1976) found that after several years on the job sex offender therapists developed a confrontive attitude and an intolerance of criminal thinking errors. In a study of sex offender therapists, Farrenkopf (1992) discovered that 54% of the therapists had diminished expectations of successful outcomes in working with sex offenders and had become cynical and pessimistic about the prospect of client change in treatment. Further, almost 50% of the therapists experienced emotional hardening, rising anger, and confrontation; 30% were frustrated with the correctional system; and 30% reported increased feelings of suspiciousness and vulnerability after beginning to work with sex offenders. Warnath and Shelton (1976) suggest that counselors may feel that their work is insignificant in bringing about change in the sex offender clients.

Research suggests that most therapists will experience vicarious traumatization, during treatment of sex offenders, that relates to their own personalities regardless of the therapist's history of sexual abuse (McCann & Pearlman, 1990). Lane (1986) reports that providing treatment to sex offenders may lead to social alienation for the therapist, identification with the victim or the aggressor, and other difficulties related to the constant exposure to graphic sexual content and the power/control behavior exhibited by the offender. The therapist may become less allied with the offender and identify more with the victim and society, with little room for doubt, assumption of guilt of the client, and a devaluing of client self-reports.

Typologies of Sex Offenders

It seems that the greater and more extensive the impairment to the functioning of the offender in coping skills, the greater is the risk of reoffense (Groth & Birnbaum, 1979). A 1986 study of 305 adolescent sex offenders found that juveniles commit a variety of sexual and non-sexual offenses and that the assaults are usually not isolated incidents, but that the offenses are a sign of the more general difficulties in adjustment (Fehrenbach et al., 1986). Goleman (1992) describes sexual offenses as a symptom of a deeper psychological problem. The offender may be acting out aggressively as a defense against the stressors which he perceives as overwhelming. The sexual offender may believe that the impulses and thoughts of

aberrant sexual behavior may be indicative of a mental illness, and attempt to keep these feelings a secret in an effort to defend himself\herself from fears of being stigmatized as a pervert (Stenson & Anderson, 1987).

In an effort to provide assistance to the clinician making the decision of recommending secure placement, several classification systems have been used. Two typologies will be considered here that have been used to assist in placement decisions.

Smith and Monastersky (1986), in their study of recidivism of adolescent sex offenders, created a three-tiered typology based on the level of sexual contact in non-consentual relationships. Rape was defined as sexual conduct which included penetration of the victim. Indecent liberties were defined as sexual conduct involving inappropriate sexual touching but excluding penetration. Hands-off offenses were defined as sexual conduct involving no physical contact (e.g., obscene phone calls, stealing underwear, or voyeurism). This information, combined with data concerning the age of the offender, characteristics of the family, and perpetrator-related information about her\his history, is used to make a decision regarding the risk of reoffense and the need for secure placement.

O'Brien and Bera (1980) suggest a typology based on a more complete explanation of the offense and the characteristics of the offender. Their typology, developed by the Program for Healthy Adolescent Sexual Expression

(PHASE), has seven separate groupings used to aid in assessing the risk of reoffense and understanding the offender. Naive Experimenters are seen as younger, sexually inexperienced adolescents with adequate social skills, and no history of acting-out problems, whose offense was non-violent and exploratory in nature. Under-Socialized Child Exploiters are characterized as having poor social skills, disengaged families, no history of other behavioral problems, and several instances of manipulating younger children into sexually exploitive situations. Sexual Aggressives are socially active, have a history of antisocial behavior, use drugs regularly, are oversensitive to criticism, have chaotic families, are emotionally labile, and use force against their victim. Sexual Compulsives engage in repetitive sexual behaviors, are quiet or withdrawn, have hands-off offenses, are perfectionistic, viewed as anxious, are emotionally constrained, have a rigidly enmeshed family system, and are typified by repetitive, cyclical behavior patterns. Disturbed Impulsives have offenses which reflect a lack of normal inhibitions due to some thought disorder, are acutely disturbed, and the offenses are unpredictable, uncharacteristic acts or bizarre patterns of ritualistic acts. Group-Influenced Offenders have no previous history of acting-out behaviors, normal families, and the offense was an effort to gain acceptance or approval from a peer group. Pseudo-Socialized Offenders are characterized by

high I.Q., narcissism, extended peer group, lacking intimacy skills, normal psychological test results, and a streak of sociopathic behavior, but usually avoid getting caught.

Although the O'Brien and Bera typology may help in gaining understanding of the sex offender, some weaknesses exist that should be considered prior to implementing a rationale for retention in treatment based on this classification system. First, the typology relies heavily on the ability of the rater to properly classify the offender, which may be problematic due to difficulties with rater reliability (Marshall et al., 1989). As discussed earlier, sex offenders are, almost by definition, deceitful and manipulative, which may lead to improper classification and inappropriate placement. The long-term nature of most placement sites and the possibility of further victimization of the adolescent, as well as the risk to the community, makes the decision for continued secure placement one not to be considered lightly. Second, the classification system depends, at least in part, on the type of offense the sex offender has committed. Knopp (1984) states that 80% of rapists began their deviant behavior with less intrusive sexual offenses. Therefore, a decision based on present behavior may be a poor predictor of future violent offenses. Over half of the adolescent sex offenders have a history of more than one type of sex offense (Saunders & Awad, 1988), further confusing the picture, especially for the inexperienced therapist.

Funding Type

Borchardt and Garfinkel (1991) in a study of adolescent inpatient placements, found that the type of treatment and the availability of treatment were the primary factors in determining length of stay in treatment. They report that a significant difference for length of hospitalization was noted between public and private funding sources, with length of stay being longer for facilities that are publicly funded. In addition, variables associated with dangerousness, whether of the adolescent or of someone else in the home, were not significantly associated with length of stay in treatment (Borchardt & Garfinkel, 1991).

Most community-based residential facilities are administered by private organizations, while most secure, institutional facilities are administered by government organizations (Curran, 1988). Mulvey, Arthur, and Reppucci (1993) found that private organizations tend to be more cost effective, develop programs faster, have higher quality staff, and retain staff longer when administering treatment programs than publicly funded organizations. Private organizations, however, tend to do worse in terms of accountability to the public, coordination of services, and monitoring the effectiveness of treatment (Mulvey et al., 1993).

Greenwood, Turner, and Rosenblatt (1989) in a survey of staff and residents at one private facility for adolescent offenders, found that the residents had better attitudes and

had a better success rate than randomized controls placed in two public training schools. The data yielded from Greenwood's research seems to be biased because 25% of the experimental group were ultimately removed from the sample due to behavioral problems and placed in a publicly funded institution. Curran (1988) found that private facilities do not accept the most difficult cases, which may affect the length of stay in treatment for those facilities.

Sentencing

Pallone (1990) describes three main types of sentencing used with sex offenders. Determinate sentencing has upper and lower limits of incarceration specified by the sentencing judge and parole is granted in consequence of some combination of time served and the offender's behavioral record while in the placement. There is no effort made to determine if the offender has received any benefit from placement. Indeterminate sentencing specifies only the upper limit of time that an offender can spend at a placement with no concern for proportion of the maximum possible time served. When an offender receives an indefinite sentence, release is entirely contingent on clinical judgement and has no relationship to the passage of time. The indefinite sentence resembles civil or criminal commitment because release from placement is based on the decision of the superintendent with the help of mental health professionals (Pallone, 1990).

Historically, adolescent sex offenders have received

indeterminate sentencing (Pallone, 1990). However, recently judges have begun to establish minimum sentencing for specific offenses. The public reaction to violent crime has lead to the development of policies that require offense-based punishments for some offenses, including sex offenses committed by juveniles, and the treatment of some adolescents as adults in court (Tate, Reppucci, & Mulvey, 1995). A sex offender who is confined for treatment is almost invariably assigned an indeterminate sentence with release dependent on the clinical judgement that he\she has been treated so successfully that she\he no longer suffers from criminal sexual psychopathy and is no longer a threat to society (Pallone, 1990).

Proposed Treatment and Exit Criteria

Groth and Birnbaum (1979) define treatment as any type of intervention implemented to reduce, inhibit, or eliminate the sexual aggression of the juvenile. Therefore treatment, according to Groth et al. (1981), must be directed at helping the offender recognize problems, discover methods of avoiding sources of stress, develop coping skills to negotiate unavoidable stressors, and become aware of situations of high risk of reoffending. The development of specific measurable exit criteria may be helpful in reducing length of stay because frequently the offender has little in the way of explicit, objective criteria that can be used to estimate progress in treatment or the probability of release (Pallone, 1990).

The most common intervention currently being utilized in the treatment of sexual offenders is psychotherapy (Groth & Birnbaum, 1979). This approach views the sexual assaultiveness as the result of internal conflicts, and the goals of treatment are to relieve these problems and to help the offender to gain an understanding and awareness of the underlying issues. Knopp (1986) recommends that, depending upon the needs of the individual adolescent, one or more of the following interventions should be used: 1) individual, group, and family therapy; 2) sex education; 3) social skills training; and 4) assertiveness training.

One of the initial focuses of treatment is on confronting the offender's denial. The denial is often very strong, and is supported by cognitive distortions and the public's desire to minimize the seriousness of the offense (Ryan et al., 1987). It is common for the offender to show little empathy for the victim. The offender may, in fact, place the blame for the offense on the victim in an attempt to avoid the responsibility and the associated guilt for committing a sex offense (Deisher et al., 1982). Ryan et al. (1987) reference the need to confront "thinking errors which rationalize and support the behaviors" (p. 387) of the juvenile sex offender.

Knopp (1985) recommends intervention from a cognitive-behavioral approach which includes: 1) admission of responsibility for the offense; 2) demonstrating an understanding of the sequence of events preceding the

offense; 3) application of learned procedures to control offending behavior; and 4) acquisition of prosocial behaviors to replace the antisocial behaviors. Psychotherapy is, by its nature, an interpersonal interaction, and is therefore preferred, since sexual offending is interpersonal by definition (Groth & Birnbaum, 1979).

In addition, as the dysfunctional family unit may help trigger sexual assault, or initiate it due to abusive modeling in the home, family therapy is viewed as an essential component in the successful treatment of juvenile sex offenders (National Task Force Report, 1988). Groth and Birnbaum (1979) recommend an education program be implemented, since sex offenders are usually uninformed about basic human sexuality, and the program may increase the person's understanding of the impulses related to the offense. Deisher et al. (1982) found that a juvenile sex offender's treatment seemed to hinge on understanding the effect the sexual assault had on the victim and the possible consequences on the life of the victim.

One specific intervention recommended for sex offender treatment is helping the client understand the cycle of sexual assault. The more detailed the offender becomes in describing the cycle of abuse, the greater the chance for intervention is increased (Hamer, 1985). The cycle is completed by the offender focusing on the feelings, circumstances, and self-esteem issues before, during, and

after the assault, which can offer hope to the offender to gain control over an aspect of life which seems uncontrollable (Lombardo & DiGiorgio-Miller, 1989). McGrath (1992) suggests that negative emotional states frequently are precursors to sex-offending, with anger being the dominant emotion prior to rape and depression and anxiety prior to child molestation. These feelings of anxiety, frustration, and anger, precursors to offending, are issues that the sex offender generally avoids addressing unless motivated (Groth & Birnbaum, 1979).

Conversely, the greater the resources and strengths of the offender, the more likely the juvenile is to discover alternative avenues for personal satisfaction of needs and the less the risk of reoffense. Lombardo and DeGiorgio-Miller (1989) recommend that to demonstrate the improved abilities of the sex offender prior to release, the client should be able to reliably describe the offense in detail, recognize the effect of the offense on the victim and demonstrate empathy, identify problems associated with the sex offense, and develop a plan of how to not reoffend. The National Task Force Report (1988) lists as additional factors for release an improvement in self-esteem, pro-social interactions, an increase in positive sexuality, positive family interactions, the ability to openly examine sexual fantasies, an increase in assertiveness, resolution of personal abuse issues, and demonstration of an ability to experience pleasure in normal situations.

Relapse prevention is a phrase describing a comprehensive training program to assist the sex offender in intervening in the sexual assault cycle at the earliest point possible, in order to reduce the risk of reoffending (Pithers, Kashima, Cummings, Beal, & Buell, 1987). An assessment is conducted in order to determine the situations in which the offender is at the greatest risk of reoffending. In addition, the coping skills that the offender possesses must be considered as a situation that is only a high-risk situation to the degree that the offender has difficulty coping with it (Pithers et al., 1987). This gives the offender the information needed to set realistic goals and intervene in a risk situation before it is too late.

Scriven (1977) found that clinical judgement was almost always less reliable than a simple regression equation. In fact, he found "that using linear equations with randomly assigned co-efficients will, on the average, do better than the clinician" (p. 5). In the study of risk prediction completed by Smith and Monastersky (1986), the experienced clinicians were incorrect at predicting the level of risk of sexually reoffending 88% of the time which exceeds the 50% error rate for chance. This is troubling, if a simple equation yields better results than the experience and training of the therapist. Faust and Ziskin (1988) suggest that professionals often fail to reach reliable or valid conclusions and the accuracy of their judgements does not

necessarily surpass that of laypersons. Therefore, it would seem beneficial to identify and utilize specific exit criteria to be used in making decisions about the release of juvenile sex-offenders.

Summary

Previous studies have shown a wide range in the average lengths of stay for juveniles in different residential sex offender treatment programs but have not attempted to explain the differences in length of stay. The current study will consider the effect of legal, clinical, and funding factors as related length of stay. Additionally, specific information regarding the existence and use of exit criteria in making the decision to release sex offenders from treatment will be gathered.

The task of sex offender therapists in residential settings seems to be formidable. The therapist may be called upon to assess and recommend placement for the offender, in addition, to providing treatment and deciding when the juvenile is ready to be moved to a less secure environment. Studies cited in this paper (Hall, 1988; and Smith & Monastersky, 1986) report that the experienced clinician may be a poor predictor of risk of reoffense for sex offenders. Other studies (Farrenkopf, 1992; Warnath & Shelton, 1976; and Yochelson & Samenow, 1976) suggest that experience in working with sex offenders reduces expectations of positive outcomes for therapists. In the current study experience of the therapists is defined as

years of experience with sex offenders as well as the number of sex offenders in the program.

The type of offense that an adolescent sex offender commits may be indicative of the level of overall disturbance of the juvenile. Sex offenses are viewed as being symptoms of psychological problems. The level of intrusiveness of the sex offense has been used (Smith & Monastersky, 1986) to determine placement needs historically and may be related to the length of stay needed for treatment. The most intrusive sex offense involves penetration (rape), next is physical contact without penetration (hands-on offense), and the least intrusive offense is one which does not include physical contact (hands-off offense).

In the general population of offenders in treatment, the length of stay has been consistently higher for offenders placed in publicly funded facilities. Community-based facilities have traditionally provided treatment for more cooperative and less dangerous offenders. The current study will explore if length of stay for juvenile sex offenders is consistent with the general trend regarding funding type.

While determinate sentencing specifies a minimum stay for offenders in placement and indeterminate sentencing does not, determinate sentencing mandates release within a predetermined length of stay and with indeterminate sentencing the maximum stay is variable. The public's

reaction to sex offenders has been to recommend long term separation from the community and therapists, who make recommendation about releasing sex offenders from treatment with indeterminate sentences, have generally overpredicted risk of reoffense resulting in extended stays in treatment.

If the goal of treatment is to reduce or eliminate sex offending behavior, one of the problems seems to be how to reliably assess when the offender has adequately reached the goal and is at reduced risk of reoffending upon return to the community. Specifically defined tasks that are to be completed by the offender prior to release may be helpful by providing direction to the treatment staff and the offender. Ascertaining the exit criteria presently being utilized and criteria suggested by treatment staff would be useful in creating specific exit criteria for release from residential placement for juvenile sex offenders.

The purpose of this study is to investigate some of the factors which influence the length of stay for adolescent sex offenders in residential settings. The information gathered in the current study is to be used in future research regarding the effectiveness of exit criteria in predicting reoffense rates.

CHAPTER III

METHOD

Introduction

In this section the method of data collection and interpretation of the data is presented. A discussion about the method of subject selection, is included as is the development of the instrument by the researcher, a review of the specific hypotheses, and the means of statistical analysis.

Subjects

Potential participants in the study were all program directors listed in the current directory of inpatient and residential adolescent sex offender treatment programs compiled by Freeman-Longo et al. (1995) in a nation-wide survey of adult and juvenile facilities providing treatment for sex offenders. This survey was completed by 1500 respondents across the nation and is considered to be the most comprehensive list of sex offender treatment programs available. This directory is updated annually by the Safer Society Press, an organization devoted to research related to sex offender treatment. The directory contained 173 facilities that report providing residential or inpatient services for adolescent sex offenders.

Program directors at 65 of the surveyed sites returned completed questionnaires. The data contained in the surveys represent 1554 adolescent sex offenders currently in residential treatment facilities across the country. Rape

was the most intrusive offense committed by a majority of the offenders with 1130 of the juveniles having committed rape as compared to 402 with indecent liberties and 22 with only hands off offenses. The programs which participated in the survey had a total of 655 treatment staff working with the offenders.

Instrument Development

The instrument used was a survey form developed by the researcher. In order to obtain content validity, a panel of three psychologists who were experienced in delivering treatment services to adolescent sex offenders in a residential setting were polled to generate a list of questions which would elicit the information needed for the study. Specifically, they were asked to formulate questions about program size, treatment experience, funding type, existence and content of exit criteria, and sentencing style. A three page survey form was developed based on this information. This survey was reviewed by two program directors, who supervised programs providing residential treatment for adolescent sex offenders. The program directors were asked to provide feedback concerning the clarity and ease of completion of the form. Revisions were made and the survey was resubmitted for review by the two program directors who determined the survey to be satisfactory.

Instrument

The survey (see appendix) contains a one page short

answer questionnaire, a one page list of possible exit criteria to be rated on a five point Likert scale, and a one page free response form seeking information relating to criteria used to make exit decisions from the placement setting. The questions addressed the average length of stay in months for sex offenders at the site; the number of years that the facility has provided services for sex offenders; the size of the program, in number of residents involved in sex offender treatment; type, if any, of exit criteria employed at the site; type of sentencing, or how residents are assigned to the site; the type of sex offense the juvenile committed and the type of funding for the facility. A third category of mixed was added to both funding type and sentencing type to include those programs with more than one means of funding or sentencing. A review of the current literature and interviews with treatment staff at an adolescent sex offender treatment program yielded information which was used to develop the exit criteria rating scale. The free response section asked the subjects to list exit criteria, if they exist, with a brief description of the exit process.

Procedure

A mailing list was created of all the possible sites listed in the Safer Society Press directory (Freeman-Longo et al., 1995) of residential and secure placements for adolescent sex offenders. The survey was directed to the listed program director or current director. A brief cover

letter explaining the purpose of the study was included. The cover letter contained the researcher's name, address, and telephone number and encouraged the subjects to make contact if there were any questions regarding the questionnaire or the goals of the research. Prior to the mailing of the survey, a brief letter to each of the program directors was mailed advising that the survey was coming and requesting the program director's participation in the study. This was done in an effort to increase the rate of return of the survey.

Hypotheses

The specific null hypotheses tested by this study are as follows:

1. Ho: There is no difference in the average length of stay for adolescent sex offender programs with regard to determinate sentencing, indeterminate sentencing, and mixed sentencing.

2. Ho: There is no relationship between the average length of stay for adolescent sex offender programs and the number of sex offenders in the program.

3. Ho: There is no difference in the average length of stay for adolescent sex offender programs with regard to the years of experience of the treatment staff in working with sex offenders.

4. Ho: There is no relationship between the average length of stay for adolescent sex offender programs and the level of intrusiveness of the offenders in the

program.

5. Ho: There is no difference in the average length of stay for adolescent sex offender programs with regard to public, private, or mixed funding of the facility.

6. Ho: There is no difference in average length of stay for adolescent sex offender programs with regard to the use of specific exit criteria or not.

Statistical Analysis

All data from the returned survey form were analyzed using SYSTAT (Wilkinson, 1985). The non-numeric responses, funding type, offense type and sentencing, were dummy coded for statistical analysis. When assessing the relationships among average length of stay and the programatic variables it is important to assess if relationships exist among the independent variables. If significant relationships exist among the variables then multivariate analyses are appropriate. Conversely, if the relationships are non-significant then univarariate analyses are appropriate. A Pearson's Product Moment Coefficient of Correlation matrix was computed to assess the possible correlations of the independent variables used in this research. The correlation matrix of the independent variables yielded no significant correlations among the variables. Therefore, univariate statistics are appropriate for analyses of data in this study.

In order to test Ho1, length of stay data were submitted to an ANOVA. Due to the small sample size of

programs using only determinate sentencing a t-test comparing indeterminate with mixed sentencing styles was performed. The independent variable was the type of sentencing. In order to test Ho2, length of stay and the number of sex offenders in the facility were correlated using Pearson's Product Moment Coefficient of Correlation. In order to test Ho3, length of stay data were submitted to a t-test. The independent variable was the mean number of years of experience of the clinical staff as being 5 or fewer years, or 6 or more years of experience. In order to test Ho4, the number of offenders in each intrusiveness category was converted to the percentage of the total number of offenders at each program, to control for variation in the size of the programs, and a Pearson's Product Moment Coefficient of Correlation matrix was created. In order to test Ho5, length of stay data were submitted to an ANOVA. Due to the small sample size of programs receiving only private funding, a t-test was performed comparing public and mixed funding styles. The independent variable was the type of funding for the facility. In order to test Ho6, a t-test was performed to determine if differences in length of stay exist between those programs with and those programs without specific exit criteria. All of the statistical analyses were reviewed for statistical significance at the $p < .05$ level of significance, and two-tailed tests were performed.

The Likert rating scale data were analyzed to determine the importance of the listed exit criteria by calculating

means, medians, and standard deviations. The free response answers were reviewed for content and a frequency chart was generated reflecting the incidence of different criteria being used at the different sites.

CHAPTER IV

RESULTS

Introduction

This chapter presents analyses of the collected data. The results of this study is reported in the testing of hypotheses and frequency charts of exit criteria. These results are discussed more fully in Chapter 5.

Characteristics of the Sample

The analyses of data were based on the responses to the questionnaire that was mailed to all 173 treatment facilities listed by Freeman-Longo et al. (1995) as providing residential or inpatient treatment for adolescent sex offenders. Eighty-two responses were received from the 173 questionnaires mailed; however, 17 (26%) of the responses stated that the program was either no longer in business (14) or no longer serving an adolescent population (3). Thus the return rate of completed questionnaires was 38% (65) and the rate of incomplete returns was 10% (17) for a total return rate of 47%. Data were collected to answer the research questions and to assess the importance of exit criteria.

Data generated by the survey indicate that 1554 adolescent sex offenders were being served by participating treatment programs. Rape was the most frequently indicated offense with 1130 offenders having committed rape, 402 offenders whose most intrusive offense was indecent liberties, and only 22 offenders with a hands off offense as

being the most intrusive sex offense. Forty-nine of the programs received only public funding, 4 of the programs received only private funding, and 12 programs received both types of funding. Specific exit criteria were being used at 46 of the sites surveyed and 19 programs had no specific exit criteria to make release decisions. Determinate sentencing was the only type of sentencing used in 6 of the programs, 38 programs used only indeterminate sentencing, and 21 sites used a combination of both sentencing styles. Forty-eight of the programs had an average of 5 or fewer years of experience for the treatment staff and 17 programs averaged 6 or more years of experience. The survey represented 655 treatment staff with 479 staff with 5 or fewer years of experience and 176 staff with 6 or more years of experience. The average length of stay for all of the responding programs was 17.8 months with a minimum stay of 6 months and a maximum stay of 36 months.

Testing of Hypotheses:

Six null hypotheses were used to test the relationship between the selected sex offender treatment program characteristics and the average length of stay for adolescent offenders in these programs. Each will be discussed individually.

Ho1:

There is no difference in the average length of stay for adolescent sex offender programs with regard to determinate, indeterminate, and mixed sentencing.

In order to test Ho1, a one-way analysis of variance was conducted, with sentencing type as the independent variable and length of stay as the dependent variable. Based on the results displayed in Table 1, it can be seen that sentencing type (determinate, indeterminate or mixed) did not contribute significantly to the variance in the average length of stay in residential or inpatient treatment of adolescent sex offenders. Due to the small sample size of only determinate sentencing, a t-test comparing indeterminate sentencing with mixed sentencing was performed. The t-test ($p=0.084$) was non-significant. Thus Hypothesis 1 is not rejected. Table 2 contains data regarding each of the sentencing groups in relation to length of stay.

TABLE 1

SUMMARY TABLE FOR THE ANALYSIS OF VARIANCE:

AVERAGE LENGTH OF STAY WITH REGARD TO SENTENCING TYPE

Source	SS	df	MS	F	P
Between Groups	115.750	2	57.875	1.592	0.212
Within Groups	2254.300	62	36.360		
Total	2370.05	64			

TABLE 2

MEAN AND STANDARD DEVIATION SCORES FOR AVERAGE LENGTH OF STAY IN MONTHS BY SENTENCING TYPES

Sentencing Type	N	Min.	Max.	Mean	SD
Determinate	6	7.0	24.0	18.67	6.44
Indeterminate	38	8.0	36.0	18.75	6.19
Mixed	21	6.0	27.0	15.81	5.60

Ho2:

There is no relationship between the average length of stay for adolescent sex offender programs and the number of sex offenders in the program.

In order to assess Ho2 a Pearson Product Moment Coefficient of Correlation was computed. Results indicate no significant correlation between the number of sex offenders in the program and the average length of stay (r = .241, p = 0.054). Therefore, Ho2 is not rejected.

Ho3:

There is no difference in the average length of stay for adolescent sex offender programs with regard to the average years of experience of the treatment staff in working with sex offenders.

In order to test Ho3, a two tailed t-test was calculated, with average years of experience for the clinical staff in the program as the independent variable

and average length of stay as the dependent variable. Based on the results displayed in Table 3, it can be concluded that the greater average length of stay is significantly related to the greater average number of years of the treatment staff. Thus, Ho3 is rejected.

TABLE 3

TABLE OF INDEPENDENT SAMPLES t-TEST ON

AVERAGE LENGTH OF STAY GROUPED BY STAFF EXPERIENCE

Group	N	Mean	SD
5 or fewer years	48	16.725	5.114
6 or more years	17	20.882	7.598
Pooled Variances*	t = 2.520	DF = 63	p = .014

* Pooled Variances used because F-max non-significant

Ho4:

There is no relationship between the average length of stay for adolescent sex offender programs and the level of intrusiveness of the offense by the offenders in the programs.

In order to test Ho4, three Pearson Product Moment Coefficients of Correlation were computed to assess the relationship among the three levels of intrusiveness of the offense (rape, indecent liberties, and hands off) by the offenders and the average length of stay. Data regarding the number of offenders in each category were translated

into a percentage of the total number of offenders at the program to allow for analysis. Results indicate no significant relationships between average length of stay and the percentage of offenders whose most intrusive offense was rape (r=0.111, p=0.377), percentage of juveniles committing indecent liberties (r=-0.087, p=0.491), and percentage of juveniles committing hands off offenses (r=-0.137, p=0.277).

Ho5:

There is no difference in the average length of stay for adolescent sex offender programs with regard to public, private, or mixed funding of the facility.

In order to test Ho5, a one-way analysis of variance was conducted with funding type as the independent variable and average length of stay as the dependent variable. Based on the results displayed in Table 4, it can be seen that funding type (public, private, or mixed) did not contribute significantly to the variance in the average length of stay in residential or inpatient treatment of adolescent sex offenders. Due to the small number of programs receiving only private funding, a t-test comparing public and mixed funding was performed. The t-test (p=0.213) was non-significant. Thus Ho5 is not rejected. Table 5 contains data regarding each of the sentencing groups in relation to average length of stay.

TABLE 4

SUMMARY TABLE FOR THE ANALYSIS OF VARIANCE:

AVERAGE LENGTH OF STAY WITH REGARD TO FUNDING TYPE

Source	SS	df	MS	F	P
Between Groups	68.499	2	34.250	0.923	0.403
Within Groups	2301.551	62	37.122		
Totals	2370.05	64			

TABLE 5

MEAN AND STANDARD DEVIATION SCORES FOR AVERAGE

LENGTH OF STAY IN MONTHS BY FUNDING TYPES

Funding Type	N	Min.	Max.	Mean	SD
Public	49	6.0	36.0	18.39	6.51
Private	4	12.0	18.0	16.50	3.00
Mixed	12	9.0	25.0	15.88	4.70

Ho6:

There is no difference in the average length of stay for adolescent sex offender programs with regard to the use of specific exit criteria.

In order to test Ho6, a two tailed t-test was calculated with the existence of exit criteria as the independent variable and average length of stay as the dependent variable. Based on the results displayed in Table 6, it can be concluded that the existence of specific exit criteria is not significantly related to the average length of stay of sex offenders in residential settings.

Thus, Ho6 is not rejected.

TABLE 6

TABLE OF INDEPENDENT SAMPLES t-TEST ON

AVERAGE LENGTH OF STAY GROUPED BY EXIT CRITERIA

Group	N	Mean	SD
No Specific Criteria	19	15.989	5.477
Specific Criteria	46	18.565	6.220
Pooled Variances*	t = 1.570	DF = 63	p = .121

* Pooled Variances used because F-max non-significant

Exit Criteria:

Nineteen proposed exit criteria were included in the questionnaire. The level of importance of each of the proposed exit criteria was rated on a 5 point Likert scale (1 = not important to 5 = most important). Table 8 presents the mean, median, standard deviation, and rank based on the means for the frequencies of responses to each of the Likert scale items.

TABLE 7

ANALYSIS OF PROPOSED EXIT CRITERIA

Rank	Criteria	Mean	Median	SD
1.	Knows risk factors	4.55	4.78	0.90
2.	Relapse prevention	4.51	4.84	1.08
3.	Knows Cycle of abuse	4.49	4.79	1.00
4.	Group therapy	4.46	4.71	0.94
5.	Disclosure of offense	4.39	4.62	0.91
6.	Individual therapy	4.05	4.27	1.08
7.	Affective display	3.89	4.00	0.97
8.	Education	3.85	3.96	1.02
9.	Own victimization	3.74	3.85	0.96
10.	Peer relationships	3.72	3.83	0.80
11.	Alternative placement	3.66	3.81	1.16
12.	Family involvement	3.52	3.68	1.05
13.	Staff relationships	3.48	3.48	0.81
14.	Drug abuse tx.	3.14	3.13	1.12
14.	Psychological testing	3.14	3.15	1.09
16.	Follows Rules	2.91	2.98	1.12
17.	Restitution	2.89	2.91	1.34
18.	Victim confrontation	2.83	2.86	1.28
19.	Age of resident	2.43	2.52	1.20

Eighteen of the respondents included additional exit criteria being used to make release decisions that were not listed in the survey. The suggested criteria and the

frequency of occurrence are listed here: victim empathy (8x), completion of sex offender workbook (4x), presence of mental illness (4x), identification of thinking errors (3x), progress in the programs level system (3x), end of probation (3x), lack of funding (2x), frequency of masturbation, victim related deviant fantasies, ability to show remorse, anger management, ability to pass a polygraph, peer confrontation, refusal to participate in treatment, and the age of the victims.

CHAPTER V

SUMMARY, DISCUSSION AND RECOMMENDATIONS

Introduction

This section presents a discussion of the results of the data analysis. Implications of the study, and recommendations for further research are included.

Summary

This research was designed to assess the relationships among several program variables and length of stay. Program variables included funding type, sentencing type, experience of the treatment staff, number of offenders in the program, existence of exit criteria, and level of intrusiveness. Length of stay in residential settings is an important factor in the provision of treatment for adolescent sex offenders due to possible costs to the offender and the community. Offenders who are maintained in secure settings for an extended period of time may re-experience the traumatic environment of their past and it may become a training ground for additional criminal behavior. Offenders who are released prematurely may present an increased risk of committing criminal acts in the community. This study examines some programatic features which may influence the average length of stay for adolescent sex offenders in residential settings.

Participants were mailed an initial cover letter which contained a brief description of the study and announced that the questionnaire would be arriving soon.

Approximately one week later the questionnaire was mailed which contained a cover letter, the survey form and a self-addressed stamped envelope. One hundred seventy-three questionnaires were mailed and 82 were returned for a total return rate of 47%. The return rate of completed questionnaires was 38% (65). Seventeen respondents stated that the program was no longer in service or no longer provided care for adolescents. The uncompleted responses represent 20% (17 of 82) of the surveys that were returned. The hypotheses were tested using correlational analysis, t-tests, and ANOVA. In addition, proposed exit criteria were evaluated regarding their relative importance for each program.

It was hypothesized that the six program and offender characteristics would contribute significantly to the variance in average length of stay. The level of experience of the treatment staff was the only characteristic that was found to be statistically significant. The number of offenders in the program showed substantial, though non-significant, relationship to the average length of stay for treatment programs.

In the present study six null hypotheses were tested. The hypotheses are as follows:

Hypothesis 1: There is no difference in average length of stay for adolescent sex offender programs with regard to determinate, indeterminate, and mixed sentencing. The hypothesis was not rejected because no significant

differences were found among sentencing types in relation to the average length of stay in treatment. The means for determinate and indeterminate sentencing were close, 18.67 and 18.75 months respectively, with the greatest difference being from programs with mixed sentencing types, mean of 15.81 months. The study confirms Pallone's (1990) statement that most sex offender treatment programs use indeterminate sentencing, 58%, vs. determinate sentencing, 9%, and mixed sentencing types, 32%.

Hypothesis 2: There is no relationship between average length of stay for adolescent sex offender programs and the number of sex offenders in the program. The hypothesis was not rejected because there was no significant correlation between number of offenders in the program and average length of stay. The correlation approached significance, and the calculated value of 0.241 is only 0.003 below the critical value of 0.244 which is necessary for significance at the $p < 0.05$ level of significance. A slightly larger N may have resulted in a significant correlation. The number of offenders in a program was selected as another means of assessing the level of experience of the treatment staff in treating adolescent sex offenders, this will be discussed later in this chapter.

Hypothesis 3: There is no difference in the average length of stay for adolescent sex offender programs with regard to the average years of experience of the clinical staff in working with sex offenders. The hypothesis was

rejected because the t-test yielded statistically significant results. The results indicate that the programs with clinical staff with an average of six or more years of experience in working with adolescent sex offenders tend to have a greater average length of stay with a mean difference of four months longer than programs with staff experience averaging five years or less. Farrenkopf (1992) and Yochelson and Samenow (1976) found that after clinicians have worked with sex offenders for several years, the staff tend to become pessimistic and cynical, and develop a confrontive attitude of intolerance towards sex offenders. This emotional hardening and pessimism may explain why the more experienced clinicians tend to have an extended average length of stay for offenders in the program. Conversely, programs with less experienced clinicians may release offenders prematurely.

Hypothesis 4: There is no relationship between the average length of stay for adolescent sex offender programs and the level of intrusiveness of the offenders at the program. The hypothesis was not rejected because there was no significant relationship between any of the levels of intrusiveness and average length of stay. One explanation for the lack of statistical significance may be that there may be little difference between the levels of intrusiveness with regard to the functioning of the offender as noted in Knopp's (1984) study that found that 80% of all rapists began their deviant behavior with less intrusive offenses.

Hypothesis 5: There is no difference in the average length of stay for adolescent sex offender programs with regard to public, private, or mixed funding of the facility. The hypothesis was not rejected because no significant difference was found among the funding types and average length of stay. The results do not support the findings of Borchardt and Garfinkel (1991) that privately funded facilities had a significantly shorter length of stay for sex offenders than publicly funded facilities.

Hypothesis 6: There is no difference in the average length of stay for adolescent sex offender programs with regard to the use of specific exit criteria. The hypothesis was not rejected. The results do not support Pallone's (1990) findings that specific exit criteria would reduce length of stay for sex offenders.

The proposed exit criteria were rated on a five-point Likert scale by the program directors. Seven items were rated as being at least very important in making decisions to release adolescent sex offenders from residential settings. The top rated items and the corresponding median listed in descending order are: knows relapse prevention plan (4.84), knows sex offender cycle of abuse (4.79), knows risk factors of reoffending (4.78), participates in group therapy (4.71), detailed disclosure of offense (4.62), participation in individual therapy (4.27), and appropriate display of affect (4.00). All of these items seem to be directly related to participation in sex offender education

programs and psychotherapy implying that the programs surveyed were utilizing a treatment model rather than a juvenile prison model.

A free response area was provided on the questionnaire in order to encourage respondents to list additional exit criteria not listed in the survey. The program directors offered 18 additional criteria. Most of the suggested criteria maintain the focus on completion of treatment, with the exception of lack of funding and end of probation.

Limitations

Several concerns regarding generalizability exist with the current study. The completed return rate of 38% is lower than expected and considerably lower than Gay's (1976) recommendation that return rates lower than 70% limit the generalizations that can be made about the research. However the reduced return rate may not be a significant problem because all known adolescent sex offender programs were surveyed rather than a small percentage of the known population as in most research. It is also difficult to assess the low return rate due to the relatively high percentage, 10% of the 173 programs surveyed, of questionnaires returned from facilities that were no longer in business or no longer served an adolescent population. The cover letter explained the purpose of the survey which may have limited the response rate. Comer and Piliavian (1975) found that some people may not respond to questionnaires if the stated goals are threatening or

counter to the respondents goals. Some program directors may find the study of funding type and staffing patterns to be threatening to that program.

Another problem with generalizability is the small number in some of the cells used for statistical analysis. There were only four programs receiving sole funding from private sources and six programs using only determinate sentencing. This was controlled for by removing the small cells and conducting t-tests between the two remaining groups.

Discussion

Results of the current study indicate that the differences in average length of stay at programs providing residential or inpatient treatment for adolescent sex offenders is not due to funding type, sentencing style, existence of exit criteria, or level of intrusiveness of the sex offense committed by the offenders at the program. The average number of years of experience in treating sex offenders is significantly related to the average length of stay in residential treatment. The correlation between number of offenders and average length of stay approached significance ($p = 0.054$), which indicates a possible relationship. This relationship may be another aspect of the level of experience of the treatment staff due to the increased contact with offenders.

The research provides demographic data which helps to clarify the current situation in the provision of treatment

for adolescent sex offenders. Knopp and Stevenson (1988) found only 24 sites providing residential sex offender treatment in 1986 and 32 sites in 1988. A total of 65 program directors responded in a usable fashion which represents a significant increase from the previous studies. A troubling finding is that 17 of the 173 surveyed programs no longer were providing services for adolescent sex offenders. This decrease may represent a new trend in the reduction of programs.

The mean length of stay found in the current study of 17.8 months with a range of 6 to 36 months is consistent with Sápp and Vaughn's (1990) findings of a mean length of stay of 17.5 months with a range of 6 to 33 months. Previous studies have not attempted to explain the range in stays.

Most of the adolescent sex offenders represented in the study, 73%, had been adjudicated for rape. Previous studies have not described the population of offenders in residential placements. In this study many of the respondents indicated that the adolescent sex offenders had committed sex offenses representative of more than one level of intrusiveness but only the most intrusive offense was considered in the study. Only 1% of the offenders had committed a hands off offense as the most intrusive sex offense.

Recommendations

The following recommendations are based on the findings

of the current study:

1. Further research concerning the large range in length of stay in residential settings for adolescent sex offenders is recommended. Specific suggestions include: investigating lengths of stay by geographic regions, comparing lengths of stay for sex offenders to adolescents adjudicated for other offenses, and seeking additional information on how the decisions to release offenders from treatment are made.

2. Future research investigating the efficacy of the treatment programs is recommended. Recidivism studies comparing the reoffense rate of offenders after completion of the program would be helpful in ranking the programs' effectiveness. This may further limit the response set, as one outcome study (Borzecki & Wormith, 1987) found that 55% of the programs surveyed did not have any evaluation post-treatment period.

3. Further research is recommended to ascertain what factors influenced the significant relationship between years of experience in treating sex offenders and an increase in length of stay for offenders. As previously stated, long-term work with sex offenders leads to a pessimistic view and it may lead to burn-out or apathy among the clinical staff.

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APPENDIX

Dear Director,

As part of a doctoral dissertation studying the length of stay of adolescent sex offenders in residential and inpatient settings, I am interested in your input regarding criteria which affect length of stay. Several previous studies have commented on the range of lengths of stay but have not attempted to explain the differences. This study is also investigating specific exit criteria being used.

I desire your help in this project. This survey is being sent to directors of residential and inpatient facilities providing sex offender treatment. Understanding the many demands made upon your time, I have designed this survey so as to minimize the time required to help with this research. I have provided a self-addressed stamped envelope for your convenience in returning this survey.

I want to assure you that your responses will be kept confidential and that only group data will be reported. I plan on sharing the findings through publication in an appropriate journal and will additionally send you the findings if you so indicate in the comments section of the questionnaire. If you have any questions you may contact:

Paul Cooper, M.S	Don Boswell, Ph.D.	Jennifer Moore
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Tulsa, OK 74105	OSU	OSU
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	Dissertation Director	IRB

I look forward to receiving your completed survey at your earliest possible convenience.

Sincerely,

Paul Cooper, M.S.

Sex Offender Treatment Survey

A. Please respond to the following questions in regard to inpatient or residential adolescent sex offenders currently in treatment at your facility. (average refers to the arithmetic mean)

1. How many inpatient adolescent sex offenders are at the facility? (please indicate number) _____

2. What is the primary type of funding for the facility?

   Public Private Both

3. Does the program have specific exit criteria for release of inpatient adolescent sex offenders?

   Yes No

4. Are adolescent sex offenders placed at the facility for a determinate or indeterminate length of stay? (circle one)

   Determinate Indeterminate Both

5. What is the number of years of experience in treating sex offenders for the clinical staff? (indicate the number of staff in each category)

   0-2 years ____
   3-5 years ____
   6-9 years ____
   10 or more years ____

6. For each of the categories below, indicate the approximate number of sex offenders who committed each of the following offenses. Indicate only the most intrusive category for each juvenile sex offender.

   Rape (any offense involving oral, anal, or vaginal penetration)_____

   Indecent Liberties (any sexual contact excluding penetration) _____

   Hands-Off Offenses (voyeurism, obscene phone calls, etc.)_____

7. What is the average length of stay, in months, for inpatient or residential treatment of adolescent sex offenders? Indicate approximate number for last two years) _____

B. Rate the level of importance of the following resident behaviors and characteristics as related to the decision to dismiss a sex offender from your facility.

1 = not important
2 = little importance
3 = moderate importance
4 = very important
5 = most important

1. Detailed disclosure of offenses	1	2	3	4	5
2. Detailed disclosure of own victimization	1	2	3	4	5
3. Appropriate display of affect	1	2	3	4	5
4. Peer relationships	1	2	3	4	5
5. Staff relationships	1	2	3	4	5
6. Involvement of family	1	2	3	4	5
7. Knows high risk factors	1	2	3	4	5
8. Participation in individual therapy	1	2	3	4	5
9. Participation in group therapy	1	2	3	4	5
10. Participation in education	1	2	3	4	5
11. Participation in drug abuse treatment	1	2	3	4	5
12. Victim confrontation	1	2	3	4	5
13. Payment of restitution	1	2	3	4	5
14. Follows facility rules	1	2	3	4	5
15. Psychological testing	1	2	3	4	5
16. Age of resident	1	2	3	4	5
17. Knows relapse prevention plan	1	2	3	4	5
18. Knows sex offender cycle of abuse	1	2	3	4	5
19. Availability of alternative placement	1	2	3	4	5

C. Please indicate any criteria not listed that are utilized in sex offender dismissal decisions.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

(please attach any exit criteria information that is used by your program)

Comments:

Thank-you, please use the enclosed envelope to return the survey.

VITA

Paul Cooper

Candidate for the Degree of

Doctor of Philosophy

Thesis: RESIDENTIAL TREATMENT PROGRAM CRITERIA AFFECTING THE LENGTH OF STAY OF ADOLESCENT SEX OFFENDERS

Major Field: Applied Behavioral Studies

Biographical:

Education: Graduated from Duncan High School, Duncan, Oklahoma in May 1975; received Bachelor of Arts degree in Psychology from Langston University, Langston, Oklahoma in May 1988; received Master of Science degree in Counseling Psychology from Northeastern State University, Tahlequah, Oklahoma, August 1990. Completed the requirements for the Doctor of Philosophy degree with a major in Counseling Psychology at Oklahoma State University, Stillwater, Oklahoma in December, 1996

Experience: Employed as a residential counselor at the Youth Services of Tulsa County Youth Shelter from 1988 to 1990; employed by the State of Oklahoma at the L.E. Rader Center as a psychological assistant, 1990 to 1995; practicum student at Tulsa Regional Medical Center, 1993 to 1994; pre-doctoral internship at Children's Medical Center, 1995 to 1996

Professional Memberships: American Psychological Association, Student Member; American Psychological Association, Division 17, student member; American Psychological Association Graduate Student Organization

OKLAHOMA STATE UNIVERSITY
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Date: 05-01-96 **IRB#:** ED-96-122

Proposal Title: RESIDENTIAL TREATMENT PROGRAM CRITERIA AFFECTING THE LENGTH OF STAY OF ADOLESCENT SEX OFFENDERS

Principal Investigator(s): Don Boswell, Paul Cooper

Reviewed and Processed as: Exempt

Approval Status Recommended by Reviewer(s): Approved

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ANY MODIFICATIONS TO APPROVED PROJECT MUST ALSO BE SUBMITTED FOR APPROVAL.

Comments, Modifications/Conditions for Approval or Reasons for Deferral or Disapproval are as follows:

Signature: _____ Date: May 8, 1996

Chair of Institutional Review Board