

GROUP WORK WITH PARENTS OF ADOLESCENT SEX OFFENDERS: INTERVENTION GUIDELINES

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Abstract: *Interest and attention to adolescent sex offenders has increased greatly over the past twenty years. Allegations of adolescent sexual improprieties are known to have profound and disruptive repercussions on the entire family, especially the parents of the offending adolescent. Adolescent criminal acts, in general, result in a myriad of disconcerting emotions experienced by the parent(s). Although a great deal of attention is currently being focused upon treatment of adolescent sex offenders, little is being written about intervention with parents of these adolescents. This paper reviews the clinical and research literature pertaining to the family dimensions of male adolescent sexual offending behavior and offers a set of guidelines for use in group practice with parents of these adolescents.*

Key Words: *parents of adolescent sex offenders; male adolescent sex offenders; intervention guidelines*

INTRODUCTION

The problem of adolescents who commit sex offenses is commanding increased attention in recent years. This group of offenders has been defined by the National Adolescent Perpetrator Network as comprising "youth ranging from puberty to the age of legal majority who commit any sexual interaction with a person of any age against the victim's will, without consent, or in an aggressive, exploitive, or threatening manner (Lakey, 1994, p. 755)." It has been estimated that adolescents may be committing 34% to 60% of all sexual offenses (Cashwell & Caruso, 1997); and Snyder & Sickmund (1999) report that they are responsible for 20% or more of reported forcible rapes and child molestations in the United States. The Uniform Data Collection System of the National Adolescent Perpetrator Network indicates that the majority of adolescent sex offenders were found to be first time offenders with an average of seven victims (Bischof & Stith, 1995). Estimates regarding the number of youths committing sexual assaults involving force range from 195, 000 to 450,000 yearly (Weinrott, Riggan, & Frothingham, 1997). This figure does not take into account child molestation which is the most common sexual offense committed by juveniles. Also, it is important to bear in mind that many incidents of adolescent sex offending go unreported. This may be due to the offense being dismissed as mere experimentation or curiosity or general reluctance to report an adolescent due to fear of labeling them as a sex offender. Cashwell & Caruso (1997) have suggested that, due to unreported cases, there may be as many as 70% of adolescents committing sex offenses who receive neither services nor

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incarceration for their offense. It is of little surprise that programs designed to treat adolescent sex offenders have emerged in growing numbers. The mounting concern for this significant social problem has heightened as a result of information that indicates that most adult sex offenders committed their first sexual offense when they were adolescents (Barbaree & Cortoni, 1993; Becker & Hunter, 1997). In 1982, Knopp identified only 22 programs in the United States specifically designed to treat adolescent offenders. (Knopp, Freeman-Longo, & Lane, 1997). However, by 2000 there were 391 specialized offender treatment programs serving this population along with 66 programs treating pre-adolescent children (Burton & Smith-Darden, 2001). Over time the field has witnessed a wide variety of treatment approaches serving sexually offending youth. As Chaffin (2001) observed, these programs have included, "general and non-specific mental health treatment (e.g. individual psychotherapy, family therapy, inpatient milieu therapy), delinquency focused treatments (e.g. standard Multi-Systemic Therapy, boot camps, juvenile group homes) as well as programs designed specifically for, and limited to, adolescent sex offenders (e.g. cognitive behavior sex offender group therapy, relapse prevention, and arousal reprogramming techniques" (p. 91). Many of the services available to adolescents consist of sex offender-specific programs combining core treatment modules, case-specific treatment components, and parent components (Chaffin, 2001). It is believed that parental involvement in treatment can serve to: a) enhance the support and guidance available in behalf of behavior change, b) help assure necessary supervision and monitoring of the adolescent, and c) make possible early recognition of re-offending risks (Chaffin, 2001). While most professionals working in the field would probably acknowledge the importance of parental involvement in sex offender treatment, there is a scarcity of literature pertaining to practice with them. In speaking to this dilemma, this article: 1) reviews the clinical and research literature pertaining to the family dimensions of adolescent offending behavior, and 2) presents a set of practice guidelines applicable to treatment of parents in a group context.

RESEARCH ON FAMILIES OF ADOLESCENT SEX OFFENDERS

Research indicates that adolescent sex offenders come from all socioeconomic classes, ethnicities, and racial groups (Becker & Hunter, 1997; Moody, Brissie, Kim, 1994; Oliver, Nagayama-Hall, & Neuhaus, 1993). In a meta-analysis of empirical data concerning the demographic information and parental characteristics of adolescent sex offenders, Graves, Openshaw, Ascione, and Erickson (1996) found that 59% of the offenders were of low socioeconomic status, while 44% were of middle class origins.

Comparing the family environments of adolescent sex offenders, violent, and non-violent delinquents with a normative sample of adolescents, Bischof & Stith (1995) found no significant differences between the groups relative to parents' employment level or occupation. Several characteristics have been associated with families of adolescent sex offenders. In general, these families have tended to exhibit low warmth and cohesion (Bischof, Stith, & Wilson, 1992; Blaske, Borduin, Henggeler, & Mann, 1989) and high rates of parental difficulties characterized by frequent family violence, physical abuse, substance abuse, and family disorganization and instability (Awad,

Saunders, & Levene, 1984; Ford & Linney, 1995; Ryan & Lane, 1997; Smith & Israel, 1987). A study by Fagan and Wexler (1988) found that spousal abuse, child abuse, and child sexual molestation were more characteristic of adolescent sex offender's families when compared to the families of violent delinquents. In their meta-analysis, Graves, et al. (1996) reported that the families of adolescent sex offenders were usually dysfunctional and that those classified as pedophilic offenders and sexual assault offenders tended to come from chaotic/rigid as well as disengaged/enmeshed families. Bishof & Stith (1995) found that families of adolescent sex offenders tended to exhibit less cohesion, less expressiveness, and have lower levels of independence than families of non-delinquent adolescents. In another study by Bishof, et al. (1992), adolescent sex offenders perceived their families as having low emotional bonding, closed internal boundaries, rigid generational boundaries, and a general sense of separateness. Studying the families of adolescent sibling incest offenders, Worling (1995) found high levels of marital discord, parental rejection, physical discipline, and overall family dissatisfaction. Comparing the families of both sex offenders and violent nonsexual offenders, Blaske, et al. (1989) found both to have little positive communication and considerably more negative communication.

Some research has centered exclusively on examining the parental characteristics of juvenile sex offenders. Kaplan, Becker, & Martinez (1990) compared mothers of adolescent incest offenders with parents of non-incest sexual offenders and found that the majority of the incest perpetrators had mothers not living with adult partners. In addition, significantly more mothers of incest perpetrators reported having been physically and sexually abused themselves. A study by Kobayaski, Sales, Becker, Figueredo, & Kaplan (1995) discovered that bonding to the mother tended to decrease the level of sexual aggression in juvenile males. This study also found that sexual aggressiveness increased as a result of the adolescent being physically abused by his father and sexually abused by a male. In their study of parents of juvenile offenders, Graves, et al. (1996) found that mothers of pedophilic youth and mixed sexual assaulters were themselves often physically abused as children.

In general, to date most of the research pertaining to the family dimensions of adolescent sex offenders is descriptive, and much remains unknown concerning the causal role that family variables play in the development of adolescent sex offending behavior. In his comprehensive review of the research, Weinrott (1996) suggests that there is good evidence for the notion that lack of attachment and family instability are associated with more intrusive forms of adolescent sexual aggression. Commenting on the families of sexually abuse youth, Ryan and Lane (1997) suggest that "circumstances, experiences, and parental models in the early life environment may allow or support the development of sexual deviance or fail to develop the empathy and inhibitions that prevent exploitative behavior" (p. 137). They further observe that a cluster of family factors may play a defining role in this process: emotional impoverishment, lack of appropriate affect, family secrets, distorted attachments, and a history of disruptions in care (Ryan & Lane, 1997).

CURRENT TREATMENT PROGRAMS

While much remains to be learned about the role of family factors in the etiology of sexual offending behavior, few professionals in the field would dispute the importance of parental involvement in the assessment and treatment of this population. In some therapeutic regimes, parents are considered an integral, if not the central part of this process.

In multi-systemic therapy (Swenson, Henggeler, Schoenwald, Kaufman & Randall, 1998) emphasis is placed on "empowering parents or primary caregivers to be the change agent for their children" (p. 333). Parents or caregivers participate in individual sessions with the therapist, conjoint sessions with the offender and therapist, family sessions, and all contacts with external systems. Treatment interventions are oriented toward the modification of family and parental behaviors that contribute to and/or sustain the offender's behavior. These interventions draw heavily from strategic family therapy (Haley, 1976), structural family therapy (Minuchin, 1974), behavioral parent training (Munger, 1993), and cognitive-behavioral therapies (Kendall & Braswell, 1993). Given that adolescent sex offenders and their parents are often socially isolated, interventions also focus on developing their social skills and problem-solving capacities.

Thomas (1997) describes a comprehensive, family oriented intervention program that combines individual family therapy, multi-family therapy groups, a psycho-education group, weekend retreats, and a family informational packet/manual. This model proceeds through the following five-stages: 1) the crisis of disclosure, 2) family assessment, 3) family therapy interventions, 4) reconstruction and reunification of the family, and 5) termination and aftercare. Comprehensive strategies and interventions are identified for each of the respective stages.

A psycho-education program identified by Pithers, Becker, Kofka, Morenz, Sch-lank, & Leombruno (1995) treats children with sexual behavior problems by utilizing a model in which the children and their parents meet concurrently in separate groups for one hour and then come together for a half-hour session. Treatment is oriented to helping parents: establish safety rules; promote accountability for behavior; recognize, manage, and express emotions; promote healthy sexual development; recognize cognitive distortions; develop victim empathy; work through personal victimization issues; and prevent relapse (Pithers, et al., 1995).

Though groups for parents of offenders have been used in some programs, the literature discussing their use is limited despite their potential treatment value. As Kahn (1997) points out, groups provide a context in which parents receive support for what they are going through as well as education with regard to how they may aid in the treatment of their adolescent. Placing parents in groups with other parents who are experiencing many of the same emotions offers a safe forum for expression and discussion of these feelings. The mutual aid process operating in such group can give parents the feeling that they are not alone and offer needed support for their efforts to help their sons. In addition, the group becomes a valuable problem-solving resource as parents exchange ideas on how to cope with the challenges confronting them. While the case

for use of parent groups in offender treatment can easily be made, there is no literature providing guidance on how to maximize their use. Informed by the literature and their own practice experience with this population, the authors attempt to respond to this dilemma by setting forth a set of therapeutic guidelines for the implementation in treatment groups serving parents of adolescent sex offenders.

INTERVENTION GUIDELINES

The practice guidelines that follow are set out as a set of therapeutic tasks to be addressed by practitioners working with parents in a group context.

Guideline #1: Assess the potential role of family and parent factors in the adolescent's behavior

While much remains to be learned concerning the role of family and parent factors in the behavior of adolescents who offend, research and clinical literature would suggest that assessments should seek to understand the potential ways that the family's structure and functioning may give rise to or inadvertently serve to maintain the adolescents offending behavior (Shaw, 1999; Worling, 1995). In this regard, the following are among some of the potentially important areas to assess: 1) nature and degree of parental denial and/or minimization of the offense; 2) nature and extent to which parents hold the adolescent accountable for his behavior; 3) quality of harmony within the family (i.e. degree of cooperation, level of caring and affirmation, etc.); 4) provision for social/emotional needs of family members; 5) appropriateness of boundaries established in the family; and 6) firmness and fairness in setting and consistently upholding age-appropriate limits. Table 1 presents a checklist for assessing family constraints and resources along dimensions that the research suggests may represent potential risk factors for re-offending.

Guideline #2: Provide support as parents struggle with the emotional trauma surrounding the offending behavior.

For most parents, learning that their son has committed a sexual offense signals a period of emotional upheaval that can reverberate throughout the family system. This experience can be emotionally and psychologically catastrophic in proportion, not unlike that seen in traumatic stress responses. Common emotional reactions include shame, anger, disbelief, and confusion (Kahn, 1997). In addition, many of the following may also be present:

- Denial and/or minimization of the offense or specific aspects of it
- Guilt around not having been able to prevent the offense along with fears concerning the potential social repercussions
- A sense of social stigma that the offense occurred within one's family
- Sadness that such a problem could have befallen one's family
- Depression with accompanying sense of helplessness

Questions about how best to help and support the adolescent.

As parents confront their own distress around the offense(s), their emotional and psychological state can further threaten the stability of the family system. It is essential, therefore, that the clinician provides supports necessary to enable the parents to cope effectively in their efforts to respond to the total family unit in a constructive and helpful manner. The emotional turmoil experienced by parents provides a unique opportunity for them to benefit from the emotional support available in a group for parents. In the process of helping parents around the emotional dimensions of their struggle, clinicians should: 1) acknowledge and normalize the emotional impact of the experience; 2) allow for appropriate ventilation of feelings surrounding it; and 3) give space and time for parents to adequately come to terms with their emotions.

Table 1. Family Assessment Checklist

Communication	Do parents talk in clear and straight forward language? Are messages communicated in direct vs indirect ways? Do parents listen well and communicate their understanding?
Relational	Is there harmony between family members? Is caring/affection appropriately shown? Do parents spend time with their son? Is there evidence of cooperation between family members?
Boundaries	Do parents establish/reinforce age-appropriate boundaries with their son? Do parents establish/maintain appropriate boundaries between children? Are there indicators/signs of over-enmeshment between parents and children? Are there indicators/signs of disengagement between family members?
Leadership	Do parents set clear, age-appropriate expectations and limits? Do parents initiate appropriate consequences for misbehavior? Is discipline around infractions firm and fair? Are appropriate punishments/consequences consistently applied?
Problem-solving	Do parents confront problems needing attention in direct and timely ways? Do parents appropriately address relationship problems between family members? Do parents enable dialogue around problems oriented to solutions? Do parents allow negotiation around problem solutions when reasonable/appropriate?

Guideline #3: Provide parents the type of information that will help them respond and cope more effectively with the sexual offense

If parents are to be supportive allies on behalf of their son's treatment, they will need information that helps them understand the nature and dynamics of offending behavior as well as effective ways of coping with the problem. In this regard, it would make sense that the education dimensions of parent group treatment have some direct relationship to the core modules comprising the adolescent's treatment. The literature would suggest that some consideration be given to integration of the following kinds of information modules: 1) laws bearing on sexual behavior, 2) investigation process relative to sexual offending behavior, 3) effects of abusive behavior; 4) victim empathy; 5) personal risk-factors; 6) sexual attitudes and beliefs; 7) social skills; 8) human sexuality to include information pertaining to sexual myths/facts, physiology of sex, contraception, STD's, and HIV/AIDS; 9) anger management; and 10) relapse prevention (Becker & Hunter, 1997; Chaffin, 2001; Hunter & Figueredo, 2000; NAPN, 1993). While there is no one best way to assure that parents become informed on matters of importance, many resources are available to assist with the design and implementation of the education and instructional component of treatment including: select reading references, informational handouts, publications/brochures written especially for parents, written exercises, videotapes, group discussion, and joint adolescent-parent sessions (Gray & Pithers, 1993; Kahn, 1997).

Guideline #4: Address constraining influences in the family's functioning.

A comprehensive family assessment at the outset of treatment should provide basic information concerning those family issues of greatest clinical significance relative to the offending behavior under treatment (Cashwell & Caruso, 1997). Therapists should be particularly attuned to those family dynamics likely to heighten risk for re-offending and constrain the parents/family from effectively coping with all that follows from the offense. The literature suggests that the following are among the more common areas in which family functioning is apt to be compromised: 1) communication, 2) parent-adolescent relationship, 3) family boundaries, 4) leadership/discipline, 5) problem-solving and conflict-resolution. Each is briefly discussed below.

Communication: The importance of communication cannot be overly stressed. How parents and adolescents interact with each other can either heighten conflict and lead to impasse or can open doors to constructively talking about and working through some of the issues needing to be confronted (Cashwell & Caruso, 1997; Friedrich, 1990). The normal strains in communication between parents and adolescents are typically heightened as the parents struggle to address the issues around their son's offending behavior. Structured communication training processes can be integrated to bolster parent competence in such areas as active listening; expressing self in direct, open, and honest ways; checking out communication for understanding; providing constructive feedback; and making requests of one another in direct and constructive ways (Patterson & Forgatch, 1987; Robin & Foster, 1989). Beyond any efforts at sys-

tematic training in communication, therapists can provide ongoing coaching aimed at helping parents communicate in clear and direct ways and listen effectively to assure they accurately understand the needs of their son. Confronting and addressing indicators of poor communication when they present and using role-playing to help them find alternatives to communication breakdown have all proven to be instructive.

Parent-adolescent relationship: The relationship between offenders and their parents is typically a strained and conflicted one at the very least (Awad, Saunders, & Levene, 1984; Ryan & Lane, 1997). Normal struggles around separation, coupled with problems surrounding the offense often exacerbate conflict and compromise any bonding that may have existed prior to the offense. Signs of relationship disruption can be seen in many ways from lack of affirmation and caring to minimal interaction and lack of mutually shared activities (Marshall, Hudson, Hodgkinson, 1993; Weinrott, 1996). Therapists should reinforce and build upon positive threads in the relationship, looking for opportunities to strengthen and nurture the relationship by recognizing and affirming positive behaviors. During this process, it is especially important that parents find ways to more effectively reduce conflict, show affection in appropriate ways, encourage greater cooperation among family members, and make time for constructive interactions with their sons. Therapy groups can provide a useful context in which parents look more closely at the quality of relationship they have with their son and explore ways to strengthen it.

Boundaries: Families of offending youth often exhibit significant deficits relative to their ability to establish and maintain appropriate boundaries. They may not understand or value the importance of respecting the boundaries and personal space of others, or they may lack the ability to consistently define and model appropriate interpersonal norms (Smith & Israel, 1987; Straus, 1994). Family norms should be clear relative to such matters as entering bedroom/ bathrooms without knocking, dressing in front of others, and sharing information of a sexual nature. Parents should be encouraged and supported in their efforts to promote a family climate that supports and respects the boundaries between all family members and consistently invokes appropriate consequences when these are violated.

Leadership: The parents of many delinquents often lack the ability to provide appropriate guidance and leadership within the family system (Graves, et al., 1996). An adolescent's sexual offenses may, in part, be symptomatic of dysfunction in this area. Major therapeutic initiatives should extend to helping parents: a) set clear, age-appropriate expectations and limits, b) initiate appropriate consequences in the face of serious misbehavior, c) be firm but fair in the application of discipline, and d) apply consistent consequences appropriate to any violations of expected behaviors. Parents should be supported in their efforts to promote and model personally and socially responsible behavior. Adolescents should be held accountable for assuming an appropriate share of responsibility for household tasks. They should attend school regularly and on-time and maintain grades appropriate to their level of educational functioning. Curfew limits should be clear, reasonable, and consistently upheld. Consequences for violations of significant expectations and family ground rules should be firm and

consistently applied. Occasions of blatant disrespect of family members should be confronted.

Guideline #5: Emphasize strengths and positives residing in the family context and build upon these in promoting change.

Ryan & Lane (1997) have called attention to the strengths that may be found in families of juvenile sex offenders such as intense family loyalty; parents' own survivorship of their traumas in life; and their genuine parental concern for their child. Some of the newer therapeutic models underscore and build upon the strengths and resources residing in clients (Cowger, 1994; deShazer, 1985; Miller, Hubble, & Duncan, 1996; Saleebey, 1997; Walter & Peller, 1992). Based on the overriding assumption that clients have within them the strengths and resources to address and resolve the problems confronting them, strengths-oriented models direct clients toward imaging possibilities for change, getting in touch with and applying coping resources that worked for them in the past, and taking small steps centered on improving their situation. For example, if the focus of intervention is on facilitating better communication between parents and sons, the therapist's inquiry might center on the following kinds of questions: "Think back to a time when communication was better than it is currently, what was it like then?" Or, "What is one thing each you could do that would improve communication?" Similarly, if discussion centers on building cohesion and strengthening emotional bonds within the family, the therapist might ask: "As you look back in the past, what was one of the happiest times you can remember and what made it so?" Or, "What is one thing the family might do together that everyone is apt to enjoy?" Given that parents of offenders typically come to treatment demoralized and overwhelmed, solutions-oriented strategies constitute a useful therapeutic strategy for bolstering morale and hope by affirming and respecting the parents' strengths and immediately focusing on ways they can draw upon some of their own resources to more effectively address the struggles encountered with their sons.

Guideline #6: Maintain a present-oriented and problem-focused approach to the stressors confronted by parents

Given that most parents of adolescent offenders need help in the way they go about addressing problems and relationship conflicts (Bischoff & Stith, 1995), some treatment initiatives should be oriented to enhancing parental competence in the areas of problem-solving and conflict resolution. Parents should be assisted and supported in their efforts to effectively: a) confront individual and family problems needing attention in direct and timely ways, b) enable dialogue around those problems that is solution oriented, and c) establish a climate conducive to appropriate negotiation around these solutions. Family psycho-education models have demonstrated the potential residing in teaching parents rational and planful ways of addressing the problems about which they are concerned (Barkley, Edwards, & Robin, 1999; Robin & Foster, 1989). Parents and larger family units can learn through didactic/experiential processes how to select and clearly define problems to be resolved. By approaching some problems in more

planful, rational ways, parents can be helped to move beyond emotional reactivity in ways that can enable them to more clearly see potential coping solutions for themselves. Group psycho-educational strategies also represent a valuable problem-solving resource. They provide a context within which parents can be helped to identify problems and systematically develop the strategies necessary to resolve them. This cognitive process also helps parents develop a number of corollary skills, including how to: brainstorm around possible solutions; weigh the pros and cons of alternative courses of action; select preferred solutions or courses of action; and identify steps to follow in implementing them.

The parent group represents a resource-of-choice in helping parents deal with problems of greatest concern. A brief check-in at the beginning of each session allows parents to identify those issues around which they would like the group's assistance. Through the exchange that unfolds about problems and solutions, parents can develop a greater sense of personal agency. The process of being understood often serves to heighten parental openness to addressing important issues around parenting especially some of those centered on communication, conflict resolution, anger management, negotiation, and discipline.

Guideline #7: Structure treatment in ways that require the completion of weekly tasks and homework assignments

A major issue confronting all modes of intervention centers on the nature and extent to which learning from the therapeutic experience transfers or generalizes to important contexts outside of treatment. If parents are to develop greater competence and sense of self-efficacy, it is important that they be supported in their efforts to transfer insights and learning from the group to their day-to-day interactions with their son and other family members. To promote this kind of transfer, parents will need to be encouraged through weekly tasks and homework assignments designed to promote constructive action in behalf of those issues about which they are concerned (Robin & Foster, 1989). For example, where school performance is an issue, they will need to provide structure to assure that homework gets done. If the focus is on promoting more positive connections between family members, attention may be on scheduling and carrying-out a designated activity shared by all family members. In the face of school problems, parents may be supported in taking initiative to schedule a conference with key school personnel. A treatment process that promotes activity beyond the treatment session through relevant homework tasks/assignments can bolster the development of confidence and competence in acting on behalf of their own concerns and general well being.

Guideline #8: Integrate procedures for evaluation of individual progress and program successes and constraints

If treatment accountability and effectiveness are to be enhanced, it is incumbent on practitioners to structure for evaluation of the treatment experience. Evaluation activ-

ity on the part of the therapist should be oriented to both process and outcome and the group work literature provides a rich resource for informing the design and implementation of both (Corey & Corey, 1997; Gazda, Ginter, & Horne, 2001; Rose, 2001; Zastrow, 1997). Process assessments center on determining those aspects of the therapy that are perceived most and least beneficial/helpful relative to methods/techniques used, materials provided, group incidents or events. Such assessments should point to strengths and shortcomings in the on-going process of the group and also surface member suggestions for making the experience more beneficial. Formats for assessing process can range widely to include: tracking attendance and promptness, informal/formal discussion that elicits member feedback around their experience, post-session questionnaires/reaction forms, facilitator session critiques, and client satisfaction surveys and inventories. The use of brief written group reaction forms is but one example of a process-oriented method that allows for monitoring member satisfaction levels, pinpoints emerging trouble-spots in the group process, and informs session planning. Outcome-oriented evaluative activity centers on determining the nature and extent of individual change and progress relative to goals established for the treatment group. Evaluation data of this sort can come from therapist direct observation, self-report questionnaires, client satisfaction surveys, and follow-up interviews/group sessions. As an example, informal requests for feedback prior to the group's ending can reflect individual perceptions of session benefits and surface actual or potential constraints, e.g. dislikes, aversive experiences, etc.

SUMMARY

While there has been general acknowledgement of the importance of parent involvement in treatment programs for adolescent sex offenders, the literature on how best to go about this is sparse. Responding to this deficit, this article has put forth a set of practice guidelines to orient therapeutic work with parents in a group context. These guidelines are based upon the literature addressing some of the characteristics commonly seen in the parents and families of adolescent sex offenders. In order to help parents achieve a better understanding of the issues involved in the sex offense(s) committed by their son and to aid in reducing the risk of re-offending, practitioners are encouraged to utilize these guidelines in their work with parents. It is important that future developments in the treatment of adolescent sex offenders continue to expand the clinical and research literature oriented to intervention with parents and families of the offenders.

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