

## ***Tracking the Sexual Behavior-Specific Effects of a Foster Family Treatment Program for Children with Serious Sexual Behavior Problems***

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*ABSTRACT:* Few treatment programs exist for very young children with serious sexual behavior problems. Fewer still have produced data relating to their effectiveness, and the sparse data that have emerged have focused on global social adjustment or improvement rather than on sexual behavior-specific changes. This study tracked both frequency of problem sexual behaviors and care giver estimates of the propensity to re-offend of six initial clients referred to a treatment-intensive foster care program for sexually reactive children and pre-adolescent sexual offenders. A simple pre-post (basepoint-treatment) design was used, and in-treatment data gathered over a two-year interval are presented. Initial results indicate that the problem sexual behaviors of most of these youthful clients were effectively and immediately suppressed in the context of their treatment intensive foster placements, but that the program's impact on the clients' propensity to re-offend given the opportunity—a crude measure of treatment internalization—was much less immediate, less pronounced, and less predictable across clients. Recommendations based on these data are offered concerning the viability of foster care intervention for sexualized and offending children, as well as optimal durations for

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such treatments. The strengths and weaknesses of the novel progress tracking method are discussed.

**KEY WORDS:** Children; Sexual; Behavior; Problems; Evaluation.

Very young children who exhibit seriously aberrant sexual behavior present both an immediate and a down-range problem to society. The immediate dilemma concerns the provision of effective and age-appropriate placement and intervention strategies for them. While these clients do present safety issues to other children, the intervention literature on adult and adolescent offenders offers little guidance for work with younger populations. Most of the treatment settings (Cumming & Buell, 1997) and many of the intervention practices currently in use with adolescent and adult sexual offenders (e.g., Hindman, 1988; Wienrott, Riggan, & Frothingham, 1997) are clearly inappropriate for use with young children. Additionally, traditional child caring agencies and their methods were developed with little awareness or understanding of sexually abusive children (National Task Force on Juvenile Sexual Offending, 1993). Both the age and the characteristically grim histories of these young sexualized clients call loudly for alternative interventions; interventions that, at minimum, can be carried out in stable, normalizing, nurturing living environments. Social work and other child placement agencies charged with the management of these children are already searching for such interventions and environments.

Apart from the immediate safety risks they present to other children, research has consistently shown that adult and adolescent sexual offenders commonly begin their offending as preadolescents. If the problems of these children are not treated in childhood, they are highly likely to persist later in their lives. Groth and Burgess (1979) reported that one-third of adults convicted of sexual offenses began offending before they were nine years old. Awad and Saunders (1991) encountered similar results in a study of convicted adolescent sexual offenders. Ten percent of the adolescent sexual assaulters and 28% of the adolescent child molesters in their sample engaged in their first sexually deviant behavior before the age of 12.

Recognition that young children can exhibit serious sexual behavior problems and are capable of victimizing others has evolved relatively recently (see bibliographical review by Openshaw et al., 1993). Clinicians began reporting and treating isolated cases of sexually aggressive children in the mid-eighties (Yates, 1982; Johnson, 1988; Friedrich & Luecke, 1988; Cantwell, 1988; Johnson, 1989), but the development

of dedicated treatment programs for such children has proceeded slowly. In a recent overview of such programs, Sirles, Araji, and Bosek (1997) cited estimates of 38 residential programs nationwide by Freeman-Longo, Bird, Stevenson, and Fiske (1994), and of 35 specialized treatment programs for sexually aggressive children nationally by Gil and Briere (1994).

Successes in the treatment foster care arena for young clients with various emotional (McFadden, 1989), behavioral (Chamberlain, 1990; Hampson, 1988), medical (Barsh, Moore, & Hamerlynk, 1983; Gurdin & Anderson, 1987), and sexually-related behavior problems (Jones, Judkins, & Timbers, 1989) suggest the viability of focused fostering as an alternative to institutional or other congregate care for children with sexual behavior problems. While the foster care modality is conceptually appealing, its deliberate application with this population has been surprisingly limited. At this writing, only one study has appeared in the literature describing the systematic treatment of children with sexual behavior problems in the context of therapeutic foster care (Ray et al., 1995). That study was unique also in its effort to provide some preliminary data reflecting its efficacy with its clients, albeit data concerning global social behavior progress rather than sexual behavior-specific improvement.

The present study was predicated on the view that the first requirement of any program purporting to treat clients who may be sexually dangerous to others is that it be able to interrupt or contain the aberrant sexual behavior of its charges, whatever their age. A second issue facing such programs—save, perhaps, those involving long-term incarceration—is concerned with client internalization of the presumed effects of the treatment effort. In adolescent and adult programs, this question of treatment internalization is typically addressed after the fact via recidivism data. We attempted to track client internalization directly during treatment.

In this study we sought to provide preliminary data regarding both of these requirements with respect to the effects of a treatment foster care program for sexually aggressive children called the Professional Parenting Intensive Program.

### **The Hypotheses**

This research proceeded on the cautious speculation that the Intensive Program intervention would quickly and reliably reduce the fre-

quency of most of the problematic sexual behaviors observed prior to entry of the clients into the program. We further speculated that the propensity of these clients to re-offend might be favorably affected as well, though perhaps less predictably.

## **Method**

### *The Clients*

The first six clients served by the Intensive Program were the subjects of this study. Three of these children were male and three were female, three were African American and three were European American. They ranged in age from eight to 12 (mean = 9.5 years) at the time of their admission to the program. All had been removed from the custody of their biological families for reasons involving neglect and/or physical/sexual abuse. Furthermore, while systematic and uniform offender assessments were not available when the children were referred for placement, all had documented histories of serious sexual behavior problems, and two had been adjudicated in juvenile court for specific sexual offenses. The common factor precipitating their referrals to the Intensive Program was that they all had directed their sexual behaviors at others in ways that were both age-inappropriate and at least occasionally intrusive. Had these children been in their teens at the time of their referrals to the Intensive Program, most would have been directed into institutional treatment.

As a group these clients presented a wide range of sexual behaviors, often very sophisticated for their ages. The specific behaviors these children exhibited ranged from obsessive staring at others genitals at the low end of the spectrum, through exposing their genitals, frottage, oral-genital contact, attempted intercourse, intercourse, and anal intercourse at the high end of this range. Additionally, these acts were carried out along a continuum of victim consent ranging from mutual sexual contact to coercion and force, and varied in frequency across clients.

Because these children, as a group, presented a range of behaviors that varied widely as to topography, intrusiveness, and frequency, we have chosen to use a variety of descriptors in collective reference to them. All could be accurately characterized as children with sexual behavior problems, some could most aptly be described as sexualized or sexually reactive, and two were juvenile sexual offenders by legal

definition. Details of the relevant individual histories of these children are summarized as "Client Profiles" in Table 1.

### *The Intervention*

The independent variable of this study was a comprehensive, multifaceted, treatment-oriented foster care program called the Intensive Program, designed specifically for young children with sexual behavior problems who had been removed from the custody of their biological families. The core elements of the program included: (a) the provision of *intermediate-term foster care* with program families who were specifically recruited, selected, and specially trained to work with the sexualized children for whom the program was developed; (b) professional *family support* and guidance by a designated program manager (with a maximum caseload of five families) including weekly in-home consultation visits, on-demand crisis consultation, 24-hour telephone consultation, assistance with treatment planning and implementation, etc.; (c) vigorous *safety planning* that involved the cooperation of as many responsible adults (e.g., neighbors, teachers, school bus drivers, YMCA staff) as necessary to allow the clients protected but reasonably normal access to community services and activities; (d) twice-monthly *parent support group meetings* conducted concurrently with *educational group meetings* of the clients themselves (later increased to a weekly schedule), and; (e) quarterly *in-service training* sessions involving both the program families and the children placed with them. In addition, most program clients entered their placements after having begun individual counseling with various non-program therapists. Because this therapy was highly variable, involved a different clinician for each client, and proceeded substantially out of the control of the core program, it was not viewed as a formal part of the intervention.

### *Design and Measurement*

The overriding intent in designing this study was to obtain the most accurate available picture of each client's sexual reactive/offending behavior during: (a) the year prior to their admission to the Intensive Program, and; (b) at three-month intervals after that intervention began. Further, we sought to obtain the data with which to construct those pictures from the best-informed sources, however unconventional. The design that followed from those choices proved to be a simple, pre-post configuration in which each client's care givers during the one

**TABLE 1**  
**Client Profiles**

Client	Reactive/Offending Behaviors (estimated total frequency/week at basepoint)	Target(s)	Coercion	Abuse, Neglect, and Placement History
1	Coercive and aggressive oral, anal, and genital contact with children, including younger sister; seductive rubbing or grabbing of adults' breasts and crotch; genital touching of pets; killed a kitten and a dog (19.63/week)	Sister Children Adults Pets	Yes	Multiple oral and vaginal victimizations by mother, father, and grandfather; allowed to watch adults during intercourse; exposure to pornography; serious and frequent neglect; physical abuse; prior foster placement
2	Frequent masturbation; indiscriminate kissing; constant staring at adults' crotch areas; exposure of genitals; fondling and holding a B-B gun to infant's genitals (10.56/week)	Children Adults	Yes	Numerous oral and vaginal victimizations by stepfather, step-uncles, and two family friends; exposure to adult sexual behavior; serious and frequent neglect; frequent family moves; prior foster placement
3	Fondling children's genitals; attempted anal intercourse with 5-year old; touching genitals of pets; extensive, mutual, sophisticated sexual behavior with sister (client # 4); intercourse; oral genital contact (18.56/week)	Sister Children Animals	Some-times	Frequent and serious neglect; chronic maternal substance abuse; exposure to pornography and mother's sexual behavior; suspected sexual abuse; prior foster placement

4	<p>Seductive behaviors towards adult males; extensive, mutual, sophisticated sexual behavior with brother (client # 3); intercourse; attempted intercourse with and fondling genitals of toddler lured from park; oral genital contact (18.04/week)</p>	<p>Children Adults</p>	<p>Some-times</p>	<p>Frequent and serious neglect; chronic maternal substance abuse; exposure to pornography and mother's sexual behavior; suspected sexual abuse; prior foster placement</p>
5	<p>Fondling children's genitals; oral genital contact; extensive mutual sexual contact with older brother; touching genitals of pets (1.94/week)</p>	<p>Children Animals Adults</p>	<p>Yes</p>	<p>Frequent and serious neglect; frequent and serious sexual abuse; failed adoption</p>
6	<p>Fondling children's genitals; genital to genital contact; intercourse (.40/week)</p>	<p>Children</p>	<p>Some-times</p>	<p>Frequent and serious neglect; physical abuse; exposure to parent's sexual behavior; numerous foster placements; failed adoption</p>

year pre-placement interval provided the entry basepoint data, and each client's program parents contributed the subsequent in-treatment data at three-month intervals thereafter.

*The Instrument.* Data were gathered, using an instrument of our own construction, via interviews (most face-to-face, some by phone) with the adults who were in regular contact with the clients during the data collection intervals. Interviews with the clients' pre-placement care givers were more extensive than those with their program parents after placement because those first interviews were used to establish each client's specific *constellations of reactive/offending behaviors* as well as to gather basepoint data relating to those constellations. (Note: A refinement of this instrument, called the Jones-Ownbey Sexual Behavior Tracking Protocol [SBTP] will be available in early 2002.)

*The questions:* Care givers and others who contributed basepoint data were asked two sets of questions; the first to help us establish the offending patterns (the *offense constellations*) of the clients, and the second to anchor basepoints on the two dimensions of the reactive/offending behaviors we wished to measure, namely, sexual offending *frequency*, and likelihood or *propensity* of re-offending. The first set of questions concerning pre-placement offending constellations addressed the topography of the observed or reported problem behavior, the situations/circumstances in which it occurred, and the typical victim/target of the offending behavior. The specific questions were:

1. Reactive/Offending Behavior: "Describe, in your own words, the primary (or other) behaviors *that may have led to \*\*\*'s* referral to our Intensive Program."
2. Situation/Circumstance: "Where, when, and under what circumstances has \*\*\* been known to, or suspected of, engaging in this behavior?"
3. Typical Victim/Target: "If this behavior has been directed toward another person, animal, or object, or *category of people, animals or objects*, please identify those."

The offense constellations thus identified by pre-placement care givers for each client became the focus of inquiry for that client for the duration of the study. In practice, the third question, i.e., "Typical Victim/Target," proved to be the most meaningful offense constellation descriptor. Hence, for the duration of the study, we identified each

client's offense constellation(s) in terms of that client's victim category(ies). For example, as will be seen under Results, Client #1 entered placement with a history of offending against *children, adults, and pets*. Therefore, all basepoint and in-treatment data concerning this client were gathered in reference to these three victim categories or targets.

The second set of questions asked of pre-placement respondents were the same as those later asked of program parents, except for the time interval involved. With pre-placement respondents, the following questions were posed for each client's identified victim categories concerning the one year prior to the client's placement in the Intensive Program. With program parents during the in-treatment data collection intervals, these same questions were posed concerning the ". . . past three months." The questions were:

1. Estimated Frequency: "Based on your own *observations, suspicions* you've had, *documented* instances you may know of, and *reports* you may have heard, how often would you guess that \*\*\* has engaged in this behavior during the past year (three months for program parents)? [Data recorders entered this number as *occurrences per unit time*, regardless of how that was expressed by the respondents, and those numbers were later converted to "occurrences/week" for all clients.]
2. Estimated Propensity: "Considering \*\*\*'s behavior during the past year (three months for program parents), *how likely* would you say \*\*\* would be now to engage in this behavior given free opportunity, an available victim or object (if any), and complete privacy or other protection from discovery and/or consequences?" [Respondents cast their responses to this question on a 10-point scale on which 1 equaled "*Extremely unlikely*," and 10 equaled "*Extremely likely*." All responses were recorded as whole numbers along this scale.]

*The data:* The above procedures produced two sets of data, i.e., frequency and propensity for each offense constellation tracked with each client. Each set included a one-year basepoint and eight, three-month, in-treatment data points. To illustrate using the previous example, we tracked both offense frequency and offense propensity for each of Client #1's three victim/targets (children, adults, and pets), yielding six discrete sets of data for this client. Tables 2 and 3 and Figures 1 and 2 in the Results section are organized by client, around such data sets.

Each data set depicts averaged data from all respondents, usually two caretakers, who contributed data to the set. Inter-respondent reliability coefficients were calculated from the above data sets and are discussed at the end of the Results section.

*Notes on Design and Measurement.* At least three aspects of the method adopted bear clarifying comment. The first concerns the choice of retrospective verbal reports as the core data of the study, despite the possible utility of more objective measures (arrests and convictions [Lab, Shields, & Schondel, 1993; Miner & Dwyer, 1995; Quinsey, Rice, & Harris, 1995], self-report [Dwyer, 1997], polygraph-supported self-report [Blasingame, 1998; Hindman, 1988; Renshaw, 1994], and plethysmographic techniques [Howes, 1995; Kaemingk, Koselka, Becker, & Kaplan, 1995; Rea, DeBriere, Butler, & Saunders, 1998; Simon & Schouten, 1993]) described in the adult and adolescent offender literature. We decided to avoid client self-report data when, after conducting internal offender assessments with two of the clients, it became immediately apparent that even the youngest of them were fully aware that those of their behaviors we were interested in were socially inappropriate and, thus, to be hidden insofar as possible. (Our assessment attempts revealed that the clients would rarely reveal information about their sexual activities beyond that which they knew was previously known to the adults questioning them.) And, simply put, we weren't inclined to connect any of these children to intrusive instrumentation such as polygraphs or plethysmographs, nor would we recommend such procedures to others working with this age group. Finally, the young age of the participants negated the use of arrest and conviction information to assess recidivism. Instead, we chose to follow the examples set by researchers (Friedrich et al., 1992; Friedrich, Grambsch, Broughton, Kuiper, & Beilke, 1991) who have used mothers and primary care givers as the source of information about their children's sexual behaviors. Our decision was further strengthened by the work of others who have used or specifically suggested the use of parent reports (Kahn & Chambers, 1991; Ray et al., 1995) or informal reports of recidivism (Hanson, 1997; Marshall & Barbaree, 1988) to track sexual offending behavior.

Second, we chose not only to tolerate but to invite (by the construction of our interview questions) expansive, estimated, and even conjectural responses from our data providers for two reasons. First, because the problem under investigation—at least among clients in the age range of ours—was new to us, we were literally uncertain what nuances of behavior we might encounter. (Early on, we attempted to con-

struct an exhaustive taxonomy of all possible reactive/offending behaviors we might see, but this effort proved unworkable and was abandoned.) Also because this field of study is so new, we felt it reasonable to sacrifice some objectivity and even veracity in order to obtain a broad first picture of the kinds of reactive/offending behaviors sexualized children engage in, and a coarse but fairly quick sense of whether the Intensive Program had some hope of correcting those. Second, because the behavior of interest is, even among these children, surreptitious and often hidden, we felt justified in asking our respondents for speculations that went beyond what they had actually seen. Last, the novel dimension of *propensity to re-offend* attempted here inherently requires an estimate or projection about possible future events. We could think of no better way to obtain a rough estimate of treatment internalization, and felt this parameter was important enough to pursue, even crudely.

Finally, one unanticipated problem compromised our collection of basepoint data, and another issue placed practical constraints on our in-treatment data collection methods. Concerning the clients' offense constellations and basepoint data relating to those, we intended, as described above, to gather these data from each child's care giver(s) during the year prior to his or her referral to the Intensive Program (to make those data as comparable as possible to the in-treatment data we later collected from program parents). We quickly discovered that most of these clients came to the program either from biological parents from whom their custody had been removed (and who were either intimately involved in their children's sexual behavior problems and/or in significant denial about those problems), or from a series of failed or undocumented surrogate family or institutional placements. So, in practice, we sought out those responsible adults in each client's life who had the closest and most regular contact with the child during the year prior to the child's referral to the Intensive Program; most typically the child's longstanding social worker or workers, and/or prior foster or respite caretakers. Further, with two clients, we were forced to flesh out offense constellations from internal offender assessment data, school records, social histories, and other official documentation.

## Results

The core findings of the study will be presented with the aid of two tables, one concerning the frequency data, and the other the propensity data. In addition, to illustrate the global patterns that emerged

**TABLE 2**  
**Mean Frequency of Offending Incidents per Week**

Client	Target	Basepoint	3	6	9	12	15	18	21	24
#1	Child	12.00	9.50	3.63	4.50	5.00	.70	.21	.00	.00
	Adult	5.63	7.50	1.19	1.25	3.00	.25	.00	.00	.00
	Pet	2.00	2.00	.31	.33	.29	.25	.00	.00	.00
	Total	19.63	19.00	5.13	6.08	8.29	1.20	.21	.00	.00
#2	Child	.06	.00	.00	.00	.00	.00	.00	.00	.00
	Adult	10.50	.38	.00	.00	.00	.00	.00	.00	.00
	Total	10.56	.38	.00	.00	.00	.00	.00	.00	.00
#3	Child	17.06	.00	.00	.00	.00	.00	.00	.00	.00
	Pet	1.50	.00	.00	.00	.00	.00	.00	.00	.00
	Total	18.56	.00	.00	.00	.00	.00	.00	.00	.00
#4	Child	17.04	.00	.00	.00	.00	.00	.00	.00	.00
	Adult	1.00	.00	.00	.00	.00	.00	.00	.00	.00
	Total	18.04	.00	.00	.00	.00	.00	.00	.00	.00
#5	Child	.44	.00	.00	.00	.00	.00	.00	.00	.00
	Adult	1.00	.50	.00	.00	.00	.00	.00	.00	.00
	Pet	.50	.08	.00	.00	.00	.00	.00	.00	.00
	Total	1.94	.58	.00	.00	.00	.00	.00	.00	.00
#6	Child	.40	.00	.00	.00	.00	.00	.00	.08	.00
	Total	.40	.00	.00	.00	.00	.00	.00	.08	.00

across all clients, the collective offense frequency and propensity data for all clients for all reactive/offense constellations have been averaged together and will be discussed in connection with Figures 1 and 2, respectively. Last, correlations concerning the inter-observer reliability among treatment parents' data observations will be discussed.

Table 2 shows all data gathered on the reactive/offending frequency dimension of the study, sub-divided by each client's individual victim/target constellations. As has been mentioned, basepoint estimates reflect mean rate/week during the year prior to each client's referral and came from various sources, typically including the child's care givers and agency case workers during that year. Three-month in-treatment data are averages of each client's program parents' frequency estimates for the intervals indicated.

**TABLE 3**  
**Estimated Mean Propensity to Re-Offend**

Client	Target	Basepoint	3	6	9	12	15	18	21	24
#1	Child	9.50	10.00	8.50	9.00	9.00	6.00	6.50	4.00	3.50
	Adult	9.00	10.00	9.75	7.50	9.00	5.50	2.50	3.00	1.50
	Pet	5.50	8.00	7.00	6.50	5.00	5.00	2.50	2.50	1.50
	Avg.	7.83	9.33	8.42	7.67	7.67	5.50	3.83	3.17	2.17
2#	Child	9.50	10.00	5.00	10.00	9.00	9.00	6.00	7.00	8.00
	Adult	9.50	10.00	5.00	10.00	9.00	9.00	6.00	6.00	6.00
	Avg.	9.50	10.00	5.00	10.00	9.00	9.00	6.00	6.50	7.00
#3	Child	10.00	5.00	8.00	7.50	5.00	5.50	4.50	1.00	1.00
	Pet	7.00	5.00	8.00	2.00	2.00	4.00	3.00	1.00	1.00
	Avg.	8.50	5.00	8.00	4.75	3.50	4.75	3.75	1.00	1.00
#4	Child	7.00	4.00	3.00	2.00	1.00	1.00	1.00	1.00	1.00
	Adult	7.00	2.00	2.00	1.00	1.00	1.00	1.00	1.00	1.00
	Avg.	7.00	3.00	2.50	1.50	1.00	1.00	1.00	1.00	1.00
#5	Child	10.00	9.00	6.00	8.00	8.00	8.00	8.00	6.50	6.00
	Adult	10.00	10.00	8.50	7.50	7.50	7.50	7.50	6.50	6.00
	Pet	10.00	8.5	6.00	7.00	6.00	6.00	6.00	3.00	3.00
	Avg.	10.00	9.17	6.83	7.50	7.17	7.17	7.17	5.33	5.00
#6	Child	7.00	4.00	2.00	2.50	2.50	1.00	1.00	3.00	7.00
	Avg.	7.00	4.00	2.00	2.50	2.50	1.00	1.00	3.00	7.00

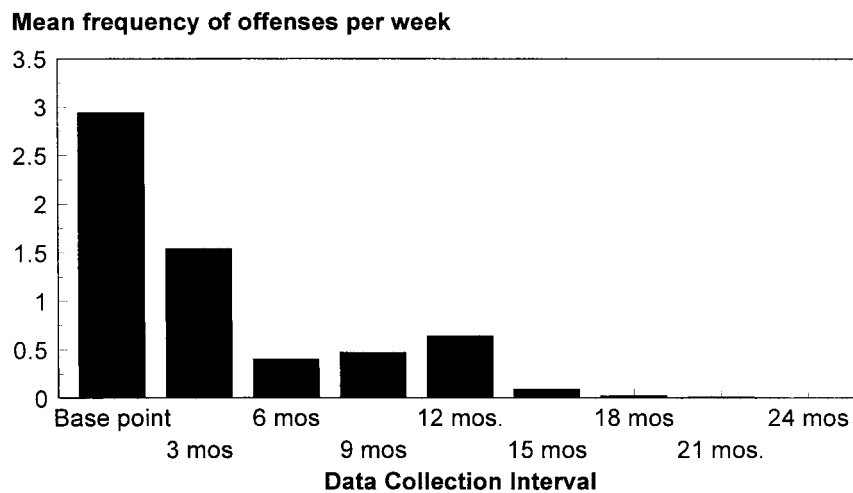
*Note:* 1.00 = "extremely unlikely to re-offend"; 10.00 = "extremely likely to re-offend."

By way of illustration, Client #1 was described as engaging in significant rates of offending behaviors against children (12 incidents/week), adults (5.63/week), and pets (2/week) at the time of her referral, and these relatively high rates persisted in all three target areas until the 6-month data collection interval. Her program parents saw gradual decay in the rates of these behaviors over the next several reporting intervals, but did not report complete containment of all sexual acting out until the 21-month reporting interval. By contrast, Client #5 was referred with relatively low initial rates of reactive/offending behaviors (also targeting children, adults and pets), and his problem sexual behaviors had been virtually eliminated by the 6-month data collection interval.

Similar data for each client's estimated propensity to re-offend, again sub-divided by each client's target constellations, are shown in Table 3. As in Table 2, basepoint estimates are for the year prior to the child's referral to the program, and three-month interval data are averages of program parents' propensity estimates (on the "1" to "10" scale noted under the table) for the intervals indicated.

### *Summary of Results*

The foregoing data reveal substantial variability from client to client on the two dimensions tracked in this study. However, amongst this variability were also distinct patterns relating to each measure. To illustrate the pattern that appeared with respect to frequency of offenses, averaged data for all offense constellations for all clients for the two-year period are shown in Figure 1 which portrays the fairly rapid containment of these children's offending behaviors during their first few months in the program. In fact, except for Client #1, only one other client—#6 at 21 months—was reported to have relapsed after the three-month reporting interval. (Note: Based on her offense history and our own early in-treatment data, we suspected Client #1 presented significantly more serious sexual behavior problems than did



**FIGURE 1.** Mean frequency of offending incidents per week (n = 6).

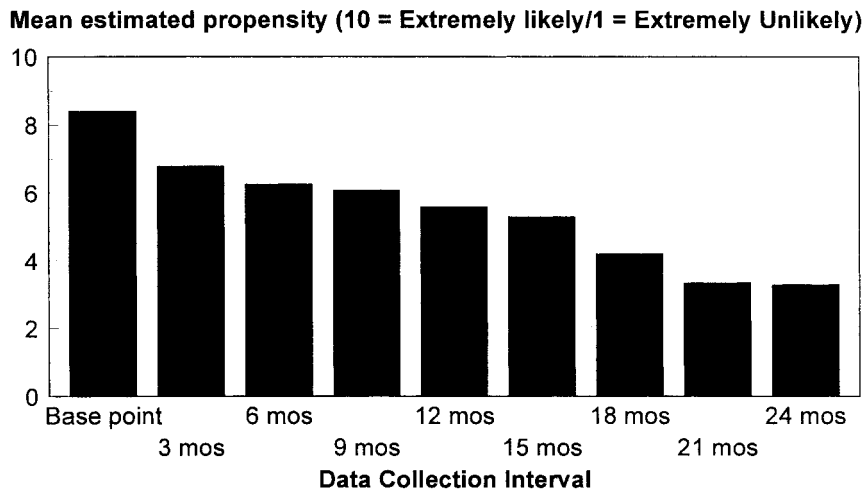
the other five children. That suspicion was supported by the results of a paper assessment of this child performed by Toni Cavanaugh-Johnson, a clinician who has pioneered assessment methods with pre-pubescent children who molest. Based on that assessment, Johnson [personal communication, November, 1998] described this client as "... one of the most problematic of the young children who molest ..." she had encountered in her clinical practice.)

By stark contrast, estimates of similarly averaged data on client propensity to re-offend dropped much less precipitously and less predictably as shown in aggregate in Figure 2. These data do convey, however, a persistent pattern of gradual decay on this measure over the two-year period.

*Reliability of Parent Observations*

Pearson product moment coefficients were calculated to determine the inter-observer reliability between the parents of all but one (Client #2, who had only one program parent) of the six clients for each of their respective offense constellations (targets) for both offense frequency and propensity data.

Two patterns were apparent from these calculations. First, correla-



**FIGURE 2.** Mean estimated propensity to re-offend (n = 6).

tions between all usable pairs of observations were positive. Second, the coefficients, though individually strong for both offense frequency observations (mean  $r = .87$ ) and for propensity to re-offend observations (mean  $r = .705$ ), tended to be significant at greater levels of confidence for offense frequency than on the propensity measure. All but one of the offense frequency coefficients proved significant at  $p < .05$  or greater, while only five (half) of the propensity to re-offend coefficients were significant at that level.

Several of the data pairs, however, were perfectly consonant (i.e., all were zeros) but, because of their invariance, a coefficient could not be calculated. Had these pairs been considered as perfectly correlated, the mean  $r$ -values just mentioned would have increased considerably, particularly with respect to the offense frequency observations.

Relevant here is the fact that program parents (our data providers) were specifically asked not to communicate between themselves about the observations they offered relating to our research but were encouraged, with respect to the program per se, to communicate freely and regularly about the sexual and other behaviors of their charges. The sum effect of these demand characteristics is indeterminate, but they may be presumed to have had greater bearing on the more objective (offense frequency) dimension of this study than on the more speculative measure (propensity to re-offend).

Practically, these data suggest that observations contributed by both treatment parents do tend toward reliability, though more strongly with respect to the objective observations we requested relating to offense frequency than to the projections we invited concerning propensity to re-offend.

## **Discussion and Conclusions**

Reducing the sexually inappropriate behaviors of the children served by the Intensive Program was both the paramount aim and the most confidently hypothesized outcome of this study. While the data obtained convey clearly that the sexual problem behaviors of most subjects were rapidly contained by the conditions that constituted the independent variable, this was clearly not the case with the companion measurement of treatment internalization, i.e., what we have called propensity to re-offend. The data on this second dimension, while promising, suggest a predictable lag of treatment internalization behind effective behavior suppression.

After two years in the program, treatment providers gauged the children in their charge to be about half as likely, on average, to re-offend as they were judged to be at the time they entered treatment. While this result is gratifying and suggests strongly that this treatment modality is effective, it also cautions that children prone to serious sexual behavior problems cannot be deemed safe without the intensive supervision afforded by such programs even after 24 months of intervention. Extrapolation from the decay gradients obtained would predict that typical clients will not start approaching the "Extremely Unlikely to Re-offend" region of our propensity to re-offend dimension (a rough index of safety in unsupervised contact with others) until they have experienced at least 2.5 to three years in treatment regimens like the Intensive Program. It is our intent to continue to gather data on at least some of these clients to confirm or challenge this extrapolation. However, the data at hand forcefully support intensive foster care interventions with the clients at issue for durations of at least two years and, optimally, for three or more.

The foregoing analysis hinges on two presumptions: first, that the two measures used were valid and; second, that the effects obtained can be reasonably attributed to the treatment protocol (as opposed, for example, simply to the normalizing effect of a stable, traditional foster family environment, *per se*). While the validity issue cannot be dismissed easily, the present methodology represents a significant first step toward the direct measurement of a uniquely problematic behavior that has proven historically unamenable to meaningful and accurate survey (Sapp & Vaughn, 1990). Hanson (1997), in a discussion on the difficulty of detecting such a covert act, noted, "It is impossible to study, however, that which remains hidden" (p. 131). Measurement choices were limited further by the age of the subjects of this study. Though data have been gathered in previous studies with similar clients in similar treatment environments concerning variables presumed to be concomitant with improved sexual behavior adjustment (Ray et al., 1995), no viable guidance has emerged from the current literature for the direct evaluation of changes in the focal behavior problems of this population.

Owing to the same design and measurement weaknesses, the issue of attribution of effects is also moot. However, Dwyer (1997), in a critique of her own long-term outcome study of sexual offender treatment makes the point that, even though the question of attribution cannot be answered satisfactorily, there is reason to believe treatment was the effective variable when the behavior change occurred during the

intervention. Additionally, we would forward the collective opinion of the on-line professional staff of the Intensive Program that, without the very vigorous safety planning and implementation (which required the energetic training of, and regular staff consultation to, the program parents), most of the clients in our sample would now be in secure placements.

In retrospect, however, there are a number of adjustments we would suggest to other researchers wishing to refine and strengthen the methods described here. First, we would recommend anything that might be done to make the gathering of pre-treatment basepoint (ideally, baseline) data more comparable to that of the collection of in-treatment data. For example, some programs might be in a position to identify and begin tracking such children prior to the commencement of their treatment for sexual behavior problems. Second, while we considered the possibility of using case or program managers as data providers (either instead of or in addition to treatment providers), we ultimately concluded that their observations would likely parallel, or at least derive from, the judgements of treatment parents. We chose to heed the recommendations of Ray et al. (1995) to seek data from the source in most regular and close contact with the clients. Related, however, among the treatment parent couples who contributed data to this study, the data gatherers felt strongly that the primary care giver of the couple (typically the foster mother) tended to have the most regular contact with and, thus, the most accurate knowledge of, changes in the child's problem behaviors.

Third, while truly randomized designs are inherently difficult to mount in human services environments, agencies serving large numbers of similar clients may be able to attempt those or variant comparative designs. Finally and related, we may be able later to cast the data presented here in a counterbalanced fashion as we continue to track these clients into adoptive or other post-treatment placements.

For the moment the present study is offered, with its acknowledged methodological shortcomings, as a first effort to bring relevant, practical data to bear on the recent and complex question of what may work in actual social work practice with young children experiencing serious sexual behavior problems. In keeping with those tactics recently proposed by Hanson (1997) for finding out "what works" with sexual offenders, we chose to measure and report within-treatment changes on the most dynamic and meaningful dimensions we could devise.

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