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Families of Juvenile Sex Offenders
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the parents. Awd & Saunders (1991, as cited in Kemper & Kitzner, 2007) stated that the juvenile sex offenders vary in history of physical or sexual victimization, as many as 29 percent appeared to be severely depressed. Becker, Kaplan, and Tenke (as cited in Becker & Hunter, 1997) emphasized the importance of evaluating whether juvenile sex offenders are depressed, especially if they were victims in childhood, because it begins in a smaller number of adolescents. Others feel that it usually develops during adolescence.

Some juvenile sex offenders were sexually abused as children, some were neglected, others excessively punished, and others deprived of close relationships (Sawit & Keat, 2001; Berlin, 2001; Hewitt, 1995, as cited in Comer, 2004). Awd and Saunders (as cited in Graves et al., 1996) stated that research has only modestly addressed the parental psychiatric history in these cases. Parental psychiatric conditions have been conceptualized in general terms, and present findings contradict each other. It also may be a consequence of other factors involved in the larger system. Where specific disorders were mentioned, it was usually depression. Graves et al. stated that combined family studies suggested that 20 percent of adolescent male offenders had a diagnosis of fathers of sexually offending youth were identified as having a psychiatric illness.

A review of the literature shows that conduct disorder diagnoses have been observed in juveniles who sexually offended, as stated by Miner, Siekert, and Kear, 2001; Berlin, 2001; Hewitt, 1995, as cited in Comer, 2004). Awd and Saunders (as cited in Graves et al., 1996) stated that research has only modestly addressed the parental psychiatric history in these cases. Parental psychiatric conditions have been conceptualized in general terms, and present findings contradict each other. It also may be a consequence of other factors involved in the larger system. Where specific disorders were mentioned, it was usually depression. Graves et al. stated that combined family studies suggested that 20 percent of adolescent male offenders had a diagnosis of fathers of sexually offending youth were identified as having a psychiatric illness.

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therapy’s task becomes helping the family learn to express anger, sadness, and other emotions in appropriate, safe ways. Interpersonal relationships within the family can become a part of the family’s development over time, and the family may be a part of the family’s history. In physical and/or sexual abuse. Accountability becomes a huge issue in terms of family members needing to learn to protect and respect one another. I have worked with some families with as many as three or four generations of history of sexual abuse. Family secrets enter in and are used by families to prove loyalty, project power, and to protect family members from punishment. Consequences, including the dissolution of the family. Another issue is blunted role boundaries with parents behaving like children and children like parents in some families. To the surprise of some, there is often confusion about sexuality in these families and a need for good information about positive sexuality. Another issue is the importance of not forgetting the needs of other siblings in the family. Divided loyalties may make ears and may make the child or children who cannot give consent. Grooming may be ritualistic and involve

Deviat sexual behavior: This is behavior that may be counter to our values or seem inexplicable. It may reflect the mores or customs of a specific culture or given time period of history. Another way that it is defined is a persistent preference for non-consensual sexual statutes. It may be behavior that is abusive and damaging to others, in some cases.

Paraphilias: This involves sexual response to unusual stimuli, such as children or other non-consenting persons, pain or humiliation, or nonhuman objects. The person must have acted on the impulse, or be greatly distressed by them, to have the psychiatric diagnosis for paraphilia.

Juvenile sex offender: A heterogeneous group of adolescents that may include some with long-term issues of attraction to children or other deviant behaviors. It also may include those involved in a one-time activity that has harmful effects on a victim. A more appropriate term would be “adolescents with sexual behavior problems.

Psychosexual evaluation: An evaluation of the juvenile’s psychological condition, family history and patterns, and possible risk of sexual re-offense. It involves getting a detailed family and individual history, as well as standard testing instruments to look at risk, family, and psychological issues.

Thinking error: This is a distortion or excuse a juvenile uses to justify his or her sexual offending of another person. It is part of what juveniles must examine in treatment and be aware of to not be caught in a cycle of abuse of others.

HRS: These are high risk situations that a juvenile must be aware of that contributed to his or her past offense and can be a risk for possible sexual re-offense.

Grooming: This is how a juvenile “sets up” his or her victim for a sexual offense. It has been compared to flirting and trying to get the other person interested in sex, except in this case the victim is usually someone who cannot give consent. Grooming may be ritualistic and involve promises, bribes, games, rewards, threats and intimidation.

Mature and Immature Sexuality: This has become an area of research in recent years with the immature sexuality in teenagers seeming to come out of lack of supervision by parents and the mobility of our youth. In terms of their contribution to this issue it is clear that many adolescents do not spend time talking to their adolescents about sexuality. The results can range from a teenager becoming pregnant or having an STD, to youthful sexual offending that comes from experimentation or expressing feelings in inappropriate and destructive ways.

**Terminology**

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also be added to psychosocial ones as the need presents itself. MST and FFT have promise and empirical backing for use as clinical interventions in this area.

In a number of families with an adolescent with sexual behavior problems, the sexual acting out behavior spreads out over several generations. This can be from two to four generations, in some cases. Sometimes, an adolescent who was sexually abused may abuse other children of his own age or may carry the behavior to his own children when he grows up. This raises the question about family patterns possibly repeating themselves. Miller, Anderson, and Keuls (2004) suggest that there is substantial evidence that levels of individual and family functioning transmit over generations. A good example is a study showing that there is multigenerational transmission of violence (Alexander, Moore & Alexander, as cited in Miller, Anderson, & Keuls, 2004). Bowen’s theory of intergenerational transmission of behaviors and functioning is a good theoretical approach to examine juvenile sex offending. Most research in intergenerational transmission ignores Bowen’s theoretical viewpoint, so more research is needed with this perspective. I have used this theory in working with these families to examine family-of-origin issues in order to improve their understanding of family patterns and to develop behavior plans that break this cycle.

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References