

## **A Collaborative Approach for Engaging Families in Treatment With Sexually Aggressive Youth**

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**Abstract** Programs attempting to provide a comprehensive response to juvenile sexual offending are challenged to explore meaningful ways of involving families who may appear unwilling, or unable, to participate. While group therapy in residential treatment remains the primary approach to juvenile sexual offending, youth returning home after placement are faced with the task of preventing relapse in the very environment that influenced initial decisions to commit sexual offenses. It is imperative that interventions take this context into consideration. Service providers can utilize salient elements of family therapy to enhance the potential for successful treatment outcomes. Families do have the ability to provide support and can be involved throughout the treatment process regardless of geographic location and limited resources.

### **Introduction**

The purpose of this paper is to address the importance of engaging family members, as an integral part of social support, into treatment with sexually aggressive youth. It will illustrate a collaborative approach for both residential and community-based settings. This model invites youth and their family members to explore strengths and resources for healing the pain of sexual abuse. It is not intended to restate well documented treatment approaches and recommended content areas for responding to juvenile sexual aggression (Becker and Hunter, 1997; Hunter and Figueredo, 1999; NAPN, 1993).

Treatment with sexually aggressive youth and their families remains an under investigated topic in the field of mental health (Chaffin and Bonner, 1998). Interventions have often been based upon research with incarcerated adult sexual offenders that does not take into account the developmental and life cycle differences of adolescents and children. During the last fifteen years clinicians and researchers have been grappling to make sense of the complex dynamics involved in the development of sexually abusive behavior (Hermann, 1992; Ryan and Lane, 1997), ways to prevent recidivism (Knight and Prentky, 1993; Prentky, Harris, Frizzell and Righthand 2000; Minor and Crimins, 1995) and curb the tide of sexual abuse.

Literature now includes comprehensive, multidisciplinary models addressing the full continuum of care (Bengis, 1986; Henggeler, Schoenwald, Broduin, Rowland and Cunningham, 1998; Trepper and Barrett, 1989). In 1988, and 1993, the National Task Force on Juvenile Sexual Offending published reports outlining guidelines for treatment with these youth. Those documents have served as standards for agencies interested in responding to the need for treatment with this population but do not provide empirically based data for application. Efforts to piece together the therapeutic puzzle required to respond effectively to the needs of these children and

their families remains a significant challenge.

This article is intended to introduce a therapeutic framework embracing leading edge research in family therapy that can inform interventions with sexually aggressive youth and their families. Research indicates that multisystemic family therapy (MST) is an empirically tested approach that influences successful treatment outcomes with delinquent youth and is cost effective. A study using MST with sexually aggressive youth shows promise with this population (Borduin, Henggeler, Blaske and Stein, 1990). Concepts derived from family systems theory, which provide the foundation for multisystemic treatment, can be integrated into all service provision. Family focused interventions need not be limited to the intensive home-based approach created by Henggeler and his colleagues. Programs do not have to struggle with an either/or dilemma of providing MST, or limiting interventions to traditional responses based primarily on outdated conventional wisdom.

Agencies intent on providing a therapeutic response to juvenile sexual offending based upon best practice strategies can integrate core effective components into a broad range of settings. The potential for more cost effective, successful treatment outcomes can easily be integrated into the fabric of all service provision.

### **Family Life Experiences**

Several studies of juvenile sexual offending have identified distinguishing factors prevalent in families of youth in treatment (Bagley and Shewchuk-Dann, 1991; Miner, Siekert and Ackland, 1997; Morenz and Becker, 1995). They have been described as dysfunctional (Araji, 1997), pathological (Bagley and Shewchuk-Dann, 1991), chaotic (Minor, Siekert, and Ackland, 1997) and unavailable (Smith and Isreal, 1987). Sexually aggressive children are growing up in families characterized by poor communication (Morenz and Becker, 1995; Stith and Bischof, 1996), instability, disengagement and poor attachment (Weinrott, 1996; Minor and Crimmins, 1995), high levels of parent-child conflict and marital stress (Bagley and Shewchuk-Dann, 1991; Kimball and Guarino-Ghezzi, 1996), substance abuse and mental health problems (Minor, Siekert, and Ackland, 1997). These families also have high incidences of members who are both perpetrators and victims of sexual abuse (Pithers, Gray, Busconi and Houchens, 1998a). Pither's study also revealed high levels of poverty in the youth's families of origin. After identifying a litany of problematic characteristics that describe families with sexually aggressive children, Araji has identified the family as the "primary source of the problem" (1997, p.87). Families of these children are often described in negative and demeaning ways. This being the case, why is the family not considered the primary location for focusing on harm reduction?

Histories of childhood abuse, most often experienced within the family context, and witnessing family violence, are correlated with juvenile sexual aggression (Kobayashie, Sales, Becker, Figueredo and Kaplan, 1995; Ryan, Miyoshi, Metzner, Krugman and Fryer, 1996). Furthermore, Ryan and colleagues (1996) identify anger, boredom and family problems as "triggers" identified by youth who committed sexual offenses. All three factors are common elements of family experience. One study found that sexually aggressive youth who were victims of child abuse perceived a lack of family support after disclosing their victimization (Hunter and Figueredo, 1999). Factors such as age of onset of victimization, type of abuse and severity have been identified as etiological factors relating to decisions to commit sexual crimes

(Prentky et al., 2000). The fact that child abuse occurs primarily within the context of relationship indicates the importance of addressing such salient factors within treatment venues that focus on the family. It is only through family involvement that parents can learn, and practice, conflict management, boundary identification and benevolent parenting in order to reduce risk factors for sexual offending.

Deficits in social interaction, peer relationships and isolation have been identified as significant risk factors for juvenile sexual offending (Becker, 1990; Knight and Prentky, 1993; Fehrenback, Smith, Monastersky and Deisher, 1986; Katz, 1990; Minor and Crimmins, 1995). Interpersonal skills are initiated and developed in family constellations. Additionally, antisocial behaviors, and an unstable home life, are predictors of recidivism (Prentky, et al., 2000; Minor, Siekert and Ackland, 1997). Issues such as these punctuate the need to intervene with the family where life skills can be enhanced and practiced. Supporting parents in an effort to model pro-social and benevolent behavior has potential to create a foundation for maintenance of therapeutic change long after treatment has ended. It is imperative that interventions focus on ways to reduce antisocial behavior and counter negative influences that support such dangerous conduct. Promoting social competency across all facets of a child's ecological context should be a keystone of treatment.

Literature addressing youthful sexual aggression has consistently illustrated the importance of involving families in the therapeutic process (Bonner, Marx, Thompson and Michaelson, 1998; Gray and Pithers, 1993; Stevenson, and Wimberley, 1990; Ryan and Lane, 1997). Recommendations are made for involving parents, or guardians, in the assessment and treatment process (Araji, 1997; Morenz and Becker, 1995; Becker and Hunter, 1997) and eliciting their cooperation (Gray and Pithers, 1993). Rasmussen (1999) maintains that family involvement is a critical component of effective programming and prevention of reoffenses.

We can no longer afford to pretend that utilizing group therapy, as the primary treatment modality for these children, is the recommended intervention of choice (Dishion, McCord and Poulin, 1999). While group and individual therapy continue to comprise the bulk of interventions with sexually aggressive youth, opportunities to impact ecological change remain woefully underutilized. By focusing on the context in which children live, and the primary relationships in their lives, we can provide much greater service to victims, the youth we serve, their families and communities.

### **Restraints to Involving Families**

It is hard to change established patterns of care. While many professionals are committed to the idea of engaging families in treatment with sexually aggressive youth, traditional systems of care have not been conducive to family involvement. Children are placed in residential treatment facilities significant distances from their homes, sometimes in out of state locations very far away. Historical focus on residential care has only recently begun to give way to community based programs. Even community-based programs focus predominantly on individual and group processes. Considering home-based interventions as the primary modality for treatment flies in the face of conventional wisdom (Chaffin and Bonner, 1998). Mythology that programs should either provide MST, or maintain traditional treatment services, creates a false dichotomy and limits potential for enhancing successful treatment outcomes and exploring more cost effective interventions. When multisystemic therapy is not an option, families can still play an integral role in

contributing to successful treatment outcomes.

Agency staff may have personal restraints to working with families that can stem from counter transference and experiences of parallel processes with the clients they serve (Goocher, 1994; Etgar, 1996). It is not unusual to hear well-meaning service providers refer to families in derogatory terms; engage in parent blaming; and make excuses for not involving parents in the treatment process. Behind closed doors, in clinical supervision, some staff acknowledge being fearful of family members and overwhelmed by perceptions of abusive power attributed to parents, and extended family members. Both professional and childcare staff have seldom received adequate specialized training, for providing a therapeutic response with families of youth who have committed sexual offenses.

Many families have significant restraints to participation in treatment. As previously mentioned, geography can wreck havoc on involvement. Even when families have time and financial resources, distance can be a great barrier to intimate involvement in the therapeutic process. Tightly packed schedules in treatment programs limit both visitation and time for therapy sessions. Parental feelings of shame and guilt, and perceptions of self-blame, often inhibit a family's willingness to consider involvement in their child's treatment. A treatment setting for sexually aggressive youth can represent a professional world that families are often fearful of, and loathe to be involved in. Successful therapeutic engagement embraces distrust and resistance that is normative in the early stages of treatment with sexually aggressive youth and their families. Open recognition of restraints to addressing the pain of sexual abuse creates a context of respect, care and concern for the development of trust in therapeutic relationships.

A program's inability to provide basic introductory information and expectations for family involvement can further hinder already hesitant parents from initiating and maintaining contact. Lack of defined treatment goals for family involvement can cause confusion among all parties and result in confounding parents and creating feelings of demoralization and estrangement. Such barriers need not create limitations in service provision.

Family members can be prepared for both the positive and negative impact that revelations of sexual abuse can bring about. Providing a therapeutic environment that invites participants to attend to their pain in an emotionally and physically safe manner may prevent it from being acted out in harmful ways. Program personnel and families have the ability to collaborate in the best interest of all children, family cohesion, and community safety.

## **Engagement**

The primary treatment goal for therapy with sexually aggressive youth is to support these children and adolescents in assuming responsibility for their destructive behavior in order to prevent future abuse. The first priority is to engage all participants in such a way that they are motivated to integrate positive change into their lives.

Webster's New World Dictionary defines the word engage as committed to, or

actively supporting a cause. For purposes of this article, engagement refers to a shared commitment between agency personnel and family members to actively support a child's effort to stop harmful sexual behavior. The rationale for such collaboration is to affirm a clear message to sexually aggressive youth that loving and caring adults can work together in the youth's best interest. Enhancing a range of services for families and maintaining genuine commitment to engaging parents in the therapeutic process can occur in a variety of creative and cost-effective ways.

The process of engagement is the most important step in insuring successful treatment outcomes (Jenkins, 1990; Miller, Hubble and Duncan, 1995). Key elements include warmth, empathy, genuineness, and a nonjudgemental attitude (Miller et al, 1995). Therapeutic engagement involves introducing and modeling interaction based upon respect, care and concern for other human beings. This issue is well documented in family therapy literature (Durrant, 1993; Freidrich, 1990; Haley, 1976; Minuchin, 1981).

Engaging families in treatment is not simply providing a social stage in which introductions and superficial conversation introduce a therapeutic process (Haley, 1976). Nor is it a marketing ploy, or cheerleading effort, to convince wary family members that their child's treatment program has all the answers to their family's problems.

Therapeutic engagement is not simply compliance. Learning to ask family members about their experiences and perceptions, rather than attempting to tell them what they should be doing, can enhance a sense of feeling valued as an important contributor to the healing process. Well meaning staff can confuse responsibility to support families with a myth that they are supposed to "fix" each youth and his, or her, family. It is important to remember that education does not equal therapeutic change. Telling people what is in their best interest, does not guarantee that they will heed such advice. As a reminder to practice this change, one treatment team created a sign for the staff lounge that simply said "ask, don't tell".

Family therapy invites each participant to attend to pain in an emotionally and physically safe manner so that they no longer need to act it out in dangerous ways. Courage and honesty are elicited as a means to address and heal the pain of sexual abuse in the family. Engagement occurs when participants embark on a reciprocal therapeutic process that guides a collaborative effort at harm reduction.

## **A Collaborative Approach**

A collaborative approach is founded on the premise that youth receiving treatment often face the task of harm reduction in the very environment that influenced initial decisions to commit sexual offenses. Historically, youth who return to their home communities after residential treatment have been alone in their efforts to maintain therapeutic change. Involving family members as a guiding principle of treatment, rather than as an adjunct component, can influence an ecological effort to stop sexual abuse.

This approach has evolved, in part, from exploration of common factors that influence successful treatment outcomes in psychotherapy (Hubble, Duncan and Miller, 1999; Miller et al., 1995). Recent analyses of outcomes studies indicate four primary factors that influence successful change in psychotherapy (Hubble et al.,

1999). The central indicator (40%) for success is the client, in this case the youth, and family, we serve. A child, and his, or her, family member's strengths, resources, social support, living environment and serendipitous experiences are all critical contributions to change. Each client's perception of the therapeutic relationship contributes 30% towards effective results. This perception is defined by a participant's ideas of warmth, trustworthiness, affirmation, encouragement of therapeutic risk taking, respect and empathy. Identifying positive expectations of the therapeutic process and instilling a sense of hope for the future account for 15% of therapeutic impact. Finally, therapeutic techniques also influence 15% of successful outcomes. Preparing and supporting youth, and family members, to learn to take good care of themselves by risking exploration into new understanding; embracing difficult emotions and vulnerability; and taming violent and sexually aggressive behavior are critical elements of psychotherapy.

A collaborative approach, congruent with the four factors, attempts to engage youth and families through a respectful and courteous process of introducing clearly defined program information and structure, such as program descriptions, handbooks, policies and procedures. Utilizing the factor of hope and expectancy can influence service providers to share stories of successful treatment experiences about other families involved in the process. Staff can model open, direct communication and desired behavior for the youth and family members.

Identifying potential members of a youth's social support network is a critical element of the initial assessment and continues throughout the treatment process. One young man told staff that he wanted his imprisoned father to be an active part of his treatment and social support network. Upon investigation, corrections personnel revealed that the youth's father was incarcerated for sexually abusing his daughter, the client's sister. Of equal concern was information in the court reports indicating that the youth may have been involved in the molestation. The young man expressed a high level of anger when the treatment team would not support his father's involvement with the youth until the father was actively taking responsibility for his own criminal behavior and participating in the sexual offender treatment program in the prison. Staff worked diligently with the youth to identify, and involve other family members who could act as role models and mentors to provide clear messages opposing sexual aggression.

A competency-based foundation (Berg, 1994; Durrant, 1993; Waters and Lawrence, 1993) reinforces strengths that each youth and his, or her, family members reveal in an effort to stop sexual abuse. This approach assumes a continuous process of assessment based upon all available resources (Bonner et al., 1998; Ryan and Lane, 1997; Prescott, in press).

Integrating underlying assumptions of systems theory (Hoffman, 1981) is central to a collaborative approach. Maintaining a belief that the sum is greater than the whole of its parts, illuminates the importance of engaging an entire family in a commitment to stop sexual abuse. This philosophy embraces an assumption that many people working together have a greater opportunity for success than a few working in isolation.

This model embraces the paradox that by slowing down we get there faster. Many programs in this field of treatment are understaffed and overload therapeutic schedules causing extreme limitations on time spent in meaningful dialogue with parents and caregivers. Most families have weathered a judicial experience, or social service process, that has brought shame to their family. By taking time to elicit

parental concerns and listen to their fears, worries and restraints, we can maximize the core effective factors relating to the client and therapeutic relationship.

While offense specific treatment challenges each youth to stop the destructive behavior, families receive support to make sense of painful experiences that have impacted their lives in negative ways. These youth and their families learn to destroy the powerful secrets of sexual abuse that may have influenced their lives for generations. Treatment addresses struggles with power, control, connection and secrecy that have often dominated the lives of these youth and their families.

Collaborating with family members in the creation of treatment goals, and monitoring progress towards those goals, solidifies a working relationship based upon constructive interdependence. Such an approach can reduce restraints to engagement and create a context for therapeutic reciprocity and mutual affirmation. As youth progress through treatment, families are encouraged to focus on reconciliation through atonement and forgiveness.

## **Therapeutic Tools**

### *Educational Material*

Contact with family can be initiated as soon as a youth is referred for treatment. They can be mailed, or provided with, a variety of introductory material geared towards reducing their restraints to participation. Parent and child handbooks that provide a program description and philosophy of care can help families learn about the agency's treatment approach and understand what to expect. Resources that can ease stress for the family should be provided immediately. These materials should be written in language that does not reflect clinical jargon, or multisyllabic words that have little meaning for families experiencing the complex stressors related to youthful sexual aggression.

Workbooks relating to the tasks of therapy can be provided and facilitated with children through a collaborative effort among adult family members and treatment team staff. These may include topics such as anger management; social skills development; understanding the dynamics of abuse; and human sexual development.

## **Family Systems Assessment**

Facilitating a family systems assessment can be conducted in tandem with the engagement process. Engaging parents, siblings and significant members of the extended family, while collecting salient information serves to streamline orientation into the therapeutic experience.

A family systems assessment explores all facets of family life in an ecological context. Collaboration may result in obtaining information that would not have been forthcoming through a less hospitable process. During an initial family meeting, a client's nine-year-old brother, who had not been identified as having sexual behavior problems, revealed participation in acts of bestiality. This information enabled the treatment team to address the problem as part of a holistic process for harm reduction and healing. That opportunity illustrated the importance of engaging the

entire family in a commitment to stop sexual abuse.

There is a disproportionate representation of sexually aggressive youth in the juvenile justice system that live in a social context of poverty and racism (Becker and Kaplan, 1993). Knowledge of the unique cultural experiences of each family, which takes into consideration race, socioeconomic status, gender and ethnicity, is explored in an effort to support understanding of coping strategies and the development of sexually aggressive behavior. Social, cultural and family beliefs about the use of violence in relationships can contribute to the creation of a high risk setting in which sexual abuse occurs. Understanding such influences can decrease the likelihood of reoffending (Trepper and Barrett, 1989). Exploring tenets of social learning theory (Bandura, 1973) enable youth to assess the influence that environment has in the decision to sexually offend.

Creating a family genogram (McGoldrick and Gerson, 1985) and timelines of salient family events reveal histories of family life experience that can lead to greater understanding of stressors and issues of pride and shame. A genogram is simply a family map that illustrates a minimum of three generations and punctuates family relationships and information about health and well being. A timeline traces the chronological order of significant family events that can illustrate connections and developments in the evolving family history. These techniques are used to assist families in understanding the impact that sexual abuse has had on their lives. They reveal a vast array of information that can help participants distill patterns of strength and vulnerability, harm and good. Factors that influence resiliency, such as supportive relationships, can be explored through the genogram and used as a foundation for engendering strength to continue in the therapeutic process. Most importantly, they provide opportunity to evaluate family events and legacies that reveal intergenerational patterns. It is reasonable to expect disclosures through the genogram and timeline, of traumatic experiences that may include significant family disruption, poverty, violence, substance abuse, racism, physical and mental illness. Genograms and time lines poignantly illustrate family history and provide a springboard for considering therapeutic change.

### **Trauma Outcome Process**

As mentioned in the introduction, these families have experienced disproportionate amounts of trauma. Such vulnerabilities often create restraints to participation in treatment. All family members are faced with the task of discerning the complex dynamics of sexual abuse with regard to the impact of perpetration and victimization. Understanding the effects that sexual abuse has on victims, family members, the youth being served, social services agencies, the criminal justice system and the community at large broadens the foundation for harm reduction. Conversely, understanding the context in which sexual abuse occurs can help service providers influence therapeutic change that may prevent recidivism.

A therapeutic tool that can help children and families make sense of pain in their lives, and the impact it has on behavior, is the trauma outcome process (Burton, Rasmussen, and Christopherson, 1998; Schladale, 2002). The trauma outcome process is a conceptual framework for mapping the influence of previous trauma on the lives of children and their family members. It provides a framework for tracking

sequential patterns of behavior and exploring strategies for developing new patterns that no longer involve harm to self or others.

Eliminating patterns of destructive behavior is the foundation for intervention and can easily be broadened to include any destructive behavioral patterns across the breadth of the family system. Family members are encouraged to explore how bad things that happen in life can have grave consequences for very long periods of time in a family's history. Participants are challenged to explore how individual coping strategies affect the lives of all family members. They are supported in their efforts to embark on a journey towards self-care that focuses on honor, integrity, empathy and compassion.

## **Narratives**

Narrative techniques (White and Epston, 1990) provide a way of voicing experiences related to destructive behavior in order to explore exceptions to sexually aggressive behavior. When a young boy's father was arrested and incarcerated the young boy was told that he was now the king of the house. Several years later while receiving treatment for sexually aggressive behavior, he was able to explore, for the first time, the impact of such a message. The young man identified how such a belief contributed to a sense of destructive entitlement that influenced his decisions to commit sexual crimes. Through examination of abusive power, control, connection and secrecy, the young man was able to consider the need to give up such destructive power and control. He decided to abdicate the throne in his desire to establish his rightful place in the family, that of first born son, not king of the house. The narrative journey led him to a place of congruent hierarchy (Minuchin and Fishman, 1981) in which he was able to make sense of how the inappropriate position of king had caused confusion, and misunderstanding about his position in the family.

Another young man, whose father was incarcerated out of state, and could not be contacted in any other way, was encouraged to write him. His father responded promptly and they began correspondence that influenced the young man's participation in treatment. His father consistently encouraged his son to embark on a different journey that focused on abiding by the law and learning to manage his anger in ways that no longer caused harm.

Children can be encouraged to communicate with family members even when they are far away and have had little contact in the past. Once a treatment team has established that contact will do not harm, encouraging meaningful dialogue can support healing. These clinical experiences provide an opportunity to create a new story based upon courage, honor, and a willingness to reject the young person's sexually abusive lifestyle.

## **Media Support**

A variety of options remain for families who are unable, or seemingly unwilling, to participate directly in the treatment process. Several years ago, the Commonwealth of Kentucky initiated an innovative approach for involving families whose children received services far away from home. Designated community-based staff received

specialized training and were provided with a camcorder and VCR/monitor that fit in the trunk of a car. Residential staff joined in partnership with children in facilities and created videotapes of the program that served as an orientation for the parents. Parents received the videos, created a corresponding tape with the community worker, and sent it to the child. This process served to maintain connection with a youth's family of origin; put faces to names for staff and family members; keep everyone abreast of changes in all of the family member's lives; helped the family to feel valued by the treatment team; maintained open avenues for communication; and assisted with family reunification.

Commercial videos are also useful when children and families are assigned to watch designated movies and television episodes to discuss how they are related to therapeutic issues in treatment. Depending upon the age of children, motion pictures such as *Ground Hog Day* can illustrate a vast array of therapeutic topics relating to patterns of destructive behavior and healing relationships. The classic Abbott and Costello comedy skit "Who's On First" is a wonderful illustration of communication problems. Treatment teams can use it to enhance the orientation process for clients through discussion of challenges that they may face throughout the therapeutic process. Younger children are able to explore the metaphors used in movies such as *Shrek* and *The Lion King*, in an effort to create a parallel process to their own experiences.

Television episodes can provide comic illustration of serious concerns. The Simpson's episode entitled "Homerphobia" is used to address sexual identity development. An episode of *Dinosaurs* entitled "The Quest For Male Supremacy" provides a humorous opportunity for addressing gender roles, sexism and destructive entitlement.

Restorative family processes can also be enhanced through creation of story time (Spees, 2002). Family members are encouraged to tell stories, or read aloud and discuss the meaning of famous children's books such as the *Velveteen Rabbit*, and *The Little Engine that Could*. Music is also a media resource with evocative healing power. Informal music appreciation, that takes into consideration everyone's interests, can help youth to identify meaningful lyrics and explore the influence that music can have on the development of healthy lifetime coping strategies.

## **Therapeutic Fun**

Play is considered a critical element of child development that influences social participation and problem solving (Rubin, Coplan, Nelson and Lagace-Sequin, 1999). Many young people who are in treatment for sexual behavior problems have way too little playtime in their lives, and are sometimes punished for having fun in treatment. Service providers can suffer from a heavy burden of responsibility for preventing further victimization by the children they serve. They can also suffer from a myth that all intervention must demonstrate a serious attitude with no room for nonsense.

Children learn through play and figure out lessons through metaphor and experiential activity (Freeman et al., 1997; Gil, 1994; Schaefer and Carey, 1994). An important tool for everyone involved is therapeutic fun. Treatment programs that employ expressive therapists, recreation specialists, and staff trained in experiential and wilderness therapies will do well to integrate such activities into family therapy. An introduction to therapy can involve the creation of a personal shield to use as a metaphor and normalize the basic human need for self-protection throughout the

treatment process. Masks are often used to illustrate a variety of therapeutic issues such as different parts of the self that reflect internal and external focus, victim and perpetrator, vulnerability and aggression. Art activities that reveal struggles with power and control through the use of mixed media such as clay, various types of paint, building materials and natural elements can loosen restraints to emotional expression.

Creating meaningful rituals and celebrations to punctuate the treatment process embraces all elements of the four factors that influence successful treatment outcomes. These techniques can instill a sense of hope while engaging the client and family in collaborative relationship. Ritual can punctuate a myriad of emotions that are often elicited in the process. Families are invited to create their own healing rituals, and rituals of transition, throughout their time in therapy. Poignant experiences often occur when youth successfully complete treatment and say good-bye to valued service providers. Families are invited to work with the child to create a celebration that reflects their experience of the therapeutic process. These settings provide an opportunity for everyone to share genuine feelings and reminisce about personal growth, successful initiatives, and future challenges.

## **Conclusion**

While there remains a great need for more research in this field of treatment, there is enough available to identify and integrate common threads for successful therapeutic outcomes with sexually aggressive youth and their families (Henggeler et al., 1998; Rasmussen, 1999; Weinrott, 1996). When professionals allow research from all mental health disciplines to inform interventions, potential for influencing successful outcomes facilitated in the most cost efficient ways, is greatly enhanced. Service providers will do well to explore strengths and resources that everyone in a youth's social support network can bring to the effort of reducing sexual aggression. Utilizing a systemic approach that takes into consideration the need for all family members to heal from the pain of sexual abuse increases opportunity to stop intergenerational patterns of sexual harm.

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