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Assessment and Treatment of Criminogenic Needs

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INTRODUCTION

In this chapter we will consider the assessment and treatment of criminogenic factors in young people who engage in sexually abusive behaviour. Evidence from the theoretical and research literature will be used to high-light the extent of this problem and the significant role played by a coercive style of family interaction in its aetiology. We put forward our view that a useful approach to tackling non-sexual criminal and anti-social behaviour among juvenile sexual offenders is with reference to the “what works” literature concerning young people who present with Conduct Disorder. Consistent with ideas presenting an aetiological role for dysfunctional family interaction in sexual and non-sexual criminal and antisocial behaviour, the what works literature provides an evidence base that points to a continuum of therapeutic response ranging from parental behavioural training, to functional family therapy, multi-systemic therapy, and special foster-care placement. We conclude the chapter by illustrating a functional family therapy approach to assessing, formulating, and intervening with a young person whose sexually abusive behaviour is part of more general criminal and anti-social activities with reference to a case example.

INSIGHTS FROM THE THEORETICAL LITERATURE
In recent years a number of theoretical models have appeared in the literature that aim to describe the development of sexually abusive behaviour (O’Reilly & Carr, in press a). While much of this literature is concerned with adults it has a relevance for juveniles who sexually abuse. A common feature of many theoretical models is that they either incorporate as a central component the development of aspects of individual psychological functioning that promote criminal behaviour, or alternatively, they divide sexual offenders into typologies, one of which usually represents a group whose sexual offending is part of a broader pattern of more general anti-social and criminal behaviour. In this section we will briefly outline relevant aspects of some of these theoretical models as they inform the clinical assessment and treatment of criminogenic needs in juvenile sexual offenders.

**The Marshall and Barbaree model**

A highly influential model that fundamentally incorporates the development of criminal and anti-social behaviour with the emergence of sexual offending is that of Marshall and Barbaree (Barbaree, Marshall & McCormick, 1998; Marshall & Barbaree, 1990). In their model they trace the individual origins of sexual offending to key experiences in early childhood. Marshall and Barbaree propose that a developmental pathway that has the potential to culminate in sexual offending begins with relationships with attachment figures (usually parents) that are of a significantly poorer quality than those experienced by most people, usually reflecting abusive, neglectful or non-nurturing home environments. In these circumstances although parents may be physically present they are frequently emotionally unavailable, often due to substance abuse or other personal difficulties. A young child in this type of home environment may seek parental attention through disruptive and demanding behaviour. When parents respond to the child’s disruptive behaviour with an aggressive, coercive, and manipulative parenting style, the child
experiences a model of parental behaviour that, on the one hand promotes aggression, coercion and manipulation, combined with a severely limited experience that models positive interpersonal skills. The next significant step in the Marshall and Barbaree model occurs when a child with developmental experiences predominantly characterised as above begins to attend school. Such a child is unlikely to successfully manage the many opportunities for pro-social development offered by the school environment. Instead of developing good relationships with peers and teachers, a child whose interpersonal style is predominantly aggressive, coercive, and manipulative, is unlikely to form stable and satisfying relationships. Consequently the developmental benefits offered by the successful formation of relationships outside of school do not accrue to the child. Instead he develops a negative self-image, a lack of self-confidence, and is further blocked in his potential for interpersonal development. Marshall and Barbaree regard the intermediate childhood outcome of this developmental trajectory as culminating in “A Syndrome of Social Disability” that has five defining features. These are (1) an inability to establish and maintain intimate relationships; (2) low self-esteem; (3) diverse anti-social, criminal attitudes and behaviours; (4) a lack of empathic skill; and, (5) cognitive distortions that support and justify criminal behaviour. From this point Marshall and Barbaree’s model continues by describing the emergence and consolidation of sexually abusive behaviour in adolescence and adulthood. However, from the point of view of the present chapter it is significant to note that according to the Marshall and Barbaree model, the developmental pathway that leads to sexually abusive behaviour is described as one that fundamentally promotes antisocial criminal attitudes and behaviours. This clearly provides a theoretical rationale that suggests that key aspects of assessment and intervention with young people who sexually offend ought to be concerned with understanding, and suitably intervening to tackle, any aspects of individual or family functioning that promote more general criminal and anti-social behaviour.
Further theoretical support for the need to assess and intervene with more general problems of anti-social and criminal behaviour in young people who sexually offend comes from Ward and Siegart (2002). They offer a model of sexual offending that attempts to integrate what they regard as the best elements other key models that have appeared in the literature. In doing so, they draw on the work of Marshall and Barbaree (1990), Finkelhor (1984), and Hall and Hirschman (Hall, 1996; Hall & Hirschman, 1991; 1992). In essence, Ward and Siegart’s integrative model outlines five distinct developmental pathways that may lead to sexual offending. These are (1) an intimacy and social skills deficits pathway; (2) a deviant sexual script pathway (where sexual behaviour is erroneously equated with the expression of interpersonal closeness); (3) an emotional dysregulation pathway; (4) an anti-social cognitions pathway; and (5) a multiple dysfunctional mechanisms (paedophilic) pathway. Of these five developmental routes to sexual offending, the anti-social cognitions pathway has the greatest relevance to our present discussion.

Unfortunately, Ward and Siegart are vague on the developmental experiences of those whose development is characterised by the anti-social cognitions pathway, but they do describe them in the following terms. Their sexually abusive behaviour is part of a wider pattern of more general criminal behaviour including substance abuse, theft, and violent assault. They commonly have impulse control difficulties, and frequently engage in behaviours that are consistent with a diagnosis of Conduct Disorder from early childhood. As their sexually abusive behaviour is part of more general criminal behaviour which often has a childhood onset, sexually offending for those on pathway four may begin at a relatively early age. Consequently, this group of offenders may be over-represented among adolescents who sexually abuse. This theoretical model implies the clinical connotation that unless those aspects of current psychological functioning that are
supportive of more general criminality are tackled for juveniles on pathway four, we can expect that interventions that are exclusively sexual offence specific will be less successful.

The Becker and Kaplan model

A final theoretical speculation that provides a useful insight into the importance of more general criminality among adolescents who sexually offend is that offered by Becker and Kaplan (1988). They suggest that there are three post-offence pathways that a young person may follow. The first is termed a “dead-end pathway” where the young person’s sexual offending comes to a dead-end and consequently discontinues. Its cessation may be reflective of the experience of negative consequences that have followed from the offence, or perhaps the positive impact of intervention. The second Becker and Kaplan pathway is a “deviant sexual interest pathway” where the young person perpetrates additional sexual offences, consolidating a paraphillic pattern of sexual arousal. They suggest that the following factors may be instrumental in promoting a young person’s development in this direction. They may have found their sexual offending to be very pleasurable. They may have experienced minimal consequences in response to their offending. They may reinforce their sexually abusive behaviour through fantasy and masturbation. They continue to have deficits in their ability to relate to age appropriate peers. The third post-offence pathway described by Becker and Kaplan is a “delinquency pathway”. Here the young person continues to engage in sexually abusive behaviour as part of a continued and broader pattern of engagement in other non-sexual crimes and anti-social behaviour.

Implications of theoretical models
Apart from illustrating the fondness of theorists in using analogies about pathways, these three models highlight four important features of criminogenic and anti-social behaviour among young people who sexually abuse. These are (1) that it is useful to consider sexual and non-sexual offending behaviour as at least sharing some common developmental features. (2) It is useful to think of young people who sexually abuse as a heterogeneous population some of whom, but not all, have substantial difficulties with more general criminal and anti-social behaviour. (3) The child and adolescent psychiatric diagnostic category of Conduct Disorder may provide a valuable construct that allows us to organise ideas that are useful and effective in tackling criminogenic and anti-social behaviour problems in young people who also engage in sexually abusive behaviour. And, (4) we need to consider post sexual offence development in terms of potential for both sexual and non-sexual recidivism. In the next section we will review some recent research literature that highlights pertinent information that adds to our understanding of criminogenic and anti-social behaviour among young people who sexually abuse.

**INSIGHTS FROM THE EMPIRICAL LITERATURE**

The empirical research literature on juveniles who sexually offend provides many insights into the extent of criminal and anti-social behaviour among this population. In a recent review Epps and Fisher (in press) make the following points: (1) A significant number of studies subsequent to that of Becker, Cunningham-Rathner, and Kaplan (1986) have consistently confirmed its findings concerning the extent of non-sexual anti-social and criminal behaviour problems among samples of young people who sexually abuse. Becker *et al.* reported that 55% of their sample of young abusers had a previous arrest for a non-sexual offence, while 63% met the criteria for a diagnosis of Conduct Disorder. (2) The variety of disordered conduct of young abusers is evident from a study by Bladon (2000). She reports the following levels of anti-social behaviour in a sample of 166
young people who had engaged in sexually offending: aggressive behaviour (70%); bullying (44%); vandalism (38%); fire setting (26%); cruelty to animals (20%); shop-lifting (20%); drug abuse (15%); and alcohol abuse (10%). (3) Considerable differences are found in the rates of anti-social behaviour among young people who sexually abuse depending on a number of variables. In particular, whether the sample in question is drawn from a residential or a community treatment programme, and whether certain behaviours are a feature of their sexual offending behaviour, such as, use of violence, or selecting victims who are peers/adults rather than children. Consistently, samples drawn from residential facilities, or whose sexual offending includes violence, or who offend against peers/adults are found to have higher rates of other anti-social and criminal behaviours. It is important that these variables are carefully identified and controlled in research investigating the psychological characteristics of young people who sexually abuse. (4) There is evidence that for young people who abuse, whose base rates of anti-social behaviour were high, that there is a considerable risk that they will recidivate non-sexually at alarmingly high levels. For example, Hagan, King and Patros (1994) reviewed 50 young people who sexually offended two years after release from a state correctional facility. They reported that while 8% had reoffended sexually, 46% had reoffended non-sexually.

Two studies that illustrate the importance of some of the distinctions highlighted by Epps and Fisher are those of Rubinstein, Yeager, Goodstein, and Lewis (1993) and Sipe, Jensen and Everett (1998). A particularly important feature of these two studies is that they provide information on sexual and non-sexual reoffence rates for adolescent abusers as they mature into adulthood. Rubinstein et al. report data on 17 adolescents who had sexually offended with violence, whose lives were characterised by multiple problems, in comparison with 41 youths who had perpetrated violent but non-sexual crimes. Recidivism rates using official police, FBI, and adult correctional facility records for both groups were established 8 years after they had been released from a
juvenile correctional facility. The average age at the time of follow-up was 24 years. The adolescent sexual offender group had a subsequent rate of first or second degree sexual offence of 37%, and a subsequent violent but non-sexual offence rate of 89% in adulthood (see table 1). In contrast violent non-sexual youths had a subsequent rate of first or second degree sexual offending of 10%, and a violent non-sexual offence rate of 69%. These findings suggest that the 17 young people who sexually offended in Rubinstein et al.’s study had a considerable potential for sexual and non-sexual offending. It also illustrates that some of those young people who come to the attention of authorities (10% in this study) for violent non-sexual offending are at risk of subsequently engaging in sexual crimes.

Sipe et al. (1998) reported data on a slightly different sample of young people who sexually offend, who they compared with a mixed group of non-sexual offenders. In their study they established the re-offence rates for 124 adolescents who, before they reached 16 years of age, had perpetrated non-violent sexual crimes against younger children. All young people whose sexual crimes included violent elements were removed from the study. The comparison group in Sipe et al.’s study were 132 juveniles who had committed a mixture of non-sexual crimes such as burglary, theft, assault, and robbery. All the young people in the study had attended the Idaho Juvenile Diagnostic Unit during the time period 1978 to 1993. Follow-up began when a young person reached 18 years of age. The average follow-up period was 6 years (ranging from 1 to 14 years). Sipe et al. report the following rates of reoffending for the two groups. Juvenile sexual offender group: sexual offence 9.7%, violent non-sexual offence 5.6%, property offences 16.1%, other non-sexual offences 15.3%, any subsequent arrest 32.3%. Juvenile non-sexual offender group: sexual offence 3%, violent non-sexual offence 12.1%, property offence 32.6%, other non-sexual offences 22.7%, any subsequent arrest 43.9%. Of these differing rates of reoffending between sexual and non-sexual offending juveniles only two reached statistical significance. The sexual offender group were more likely to
reoffend sexually while the non-sexual offender group were more likely to perpetrate property offences.

**INSERT TABLE 1 ABOUT HERE PLEASE**

Three studies that have attempted to identify individual factors associated with increased risk of reoffending provide additional insights. Most recently, Langstrom and Grann (2000) report data on 44 male and 2 females aged between 15 and 20 years of age (mean = 18.13 years) who were court referred for a forensic psychiatric evaluation following the perpetration of a sexual offence. Of the 46 participants in Langstrom and Grann’s study 28 were responsible for rape or attempted rape, 12 had committed non-rape but contact sexual offences, and 6 were convicted of non-contact sexual offences, typically exhibitionism. The average post-institutional release time for subsequent reoffending was 60.95 months. In their study Langstrom and Grann reviewed the research literature and identified 22 factors they deemed likely to predict subsequent sexual or general reoffending among young sexual abusers. They explored the retrospective value of each in light of the reconviction data for the 46 young people who had completed a full forensic psychiatric evaluation. At the end of the follow-up period 30 (65%) of the young people had been reconvicted of a subsequent crime. Of these, 9 (20%) had been reconvicted of a sexual offence. Four risk factors were retrospectively found to be sensitive to sexual reconviction. Young people were 3.5 times more likely to reoffend sexually if their assessment profile included any one of the following features: (1) sexual offending prior to the study’s index offence; (2) poor social skills; (3) having a male victim; and (4) offences against two or more victims. Five different factors, which did not predict sexual recidivism, were predictive of non-sexual criminal recidivism. These were: (1) Signs of conduct disordered behaviour before age 15 (excluding sexual misconduct) according to DSM-IV criteria; (2) any prior violent conviction; (3) 3 or more previous convictions for any type of
crime; (4) a score on the Psychopathy Check-List (Revised) of 26 or more; and (5) use of death threats or weapons as part of the index sexual crime.

Langstrom and Grann’s study adds to the knowledge gained from two previous investigations in this area. Smith and Monastersky (1986) report data on criminal recidivism over a minimum time period of 17 months in a group of 112 juvenile sexual offenders who had completed a community based intervention programme. They report that engaging in non-contact sexual offences, assaulting peer or adult victims (rather than younger children), having a male victim, and victimising a stranger, were factors associated with sexual offence recidivism. Kahn and Chambers (1991) reported data from 221 young people who had perpetrated sexual offences followed up over an average time period of 20 months. Subsequent sexual offending was associated with denial, blaming the victim for the sexual assault, using verbal threats during sexual offending, and juvenile offenders who were relatively younger. Non-sexual criminal recidivism was associated with school based behavioural problems, poor social skills, and juveniles who were relatively younger.

**Implications from the empirical literature**

These studies, which have reasonably good methodologies, clearly confirm a range of non-sexual criminal and anti-social behaviours as a significant feature in the lives of young people who sexually offend. Their severity reflects a number of factors, particularly the level of the anti-social behaviour at the time of the index offence, and the gender and age of the victim. It appears that to a certain extent different risk factors may be associated with sexual and non-sexual offending. The literature also suggests the need for good judgment in avoiding the development of one-size fits all intervention programmes that are sexual offence specific, but fail to tackle other types of non-sexual offending behaviour. Finally, it reminds us that just as juveniles who sexually offend have a
potential for non-sexual recidivism, some young people who come to the attention of authorities for non-sexual crimes also have a potential for future sexual offending.

CONDUCT DISORDER AS A USEFUL CONCEPTUAL FRAMEWORK FOR PLANNING EFFECTIVE ASSESSMENT AND INTERVENTION?

As we have seen in reviewing both the empirical and theoretical literature many authors have included reference to the diagnostic category of Conduct Disorder when considering the problem of general criminality in young people who engage in sexually abusive behaviour. The criteria for Conduct Disorder are outlined in table 2 and reflect a variety of criminal and anti-social activities which are of concern for a sub-population of young sexual abusers (American Psychiatric Association, 1992; World Health Organisation, 1992; 1996). The true extent of conduct disordered type problems among this population is a matter to be determined more definitively in further empirical research but is linked to factors such as severity of offending behaviour, and gender of victim. Diagrammatically it is useful to think of the relationship between sexual offending, Conduct Disorder, and general criminality that is of a sub-conduct disorder threshold, as illustrated in Figure 1. That is, some young people who abuse do not have difficulties with other types of criminal or antisocial behaviour. Others do to the extent that they also meet the criteria for a DSM-IV or ICD-10 diagnosis of Conduct Disorder. While others engage in sexual offending behaviour and, to some degree, other types of anti-social or criminal behaviour, but not to such an extent that they would meet the criteria for a Conduct Disorder diagnosis. It is clear from table 2 that the behaviours listed accurately reflect the main categories of criminal activities evident from studies (such as that of Blandon (2000) described earlier) with juvenile sexual abusers with broader acts of criminal behaviour. Consequently, in order to outline material in this chapter that may assist in assessment and intervention of criminogenic needs we will make reference to the category of
Conduct Disorder for the remainder of our discussion as it allows us to present approaches to clinical practice that have been evaluated and found to be effective in research studies that are of a high quality. In this way we hope to suggest an integration of important aspects of the Conduct Disorder literature in the assessment and treatment of young people who sexually offend who engage in broader forms of criminal and anti-social behaviour. The approaches outlined in the remainder of this chapter should be regarded as supplemental to a full clinical assessment that is informed by more offence specific aspects concerns such as that outlined by O’ Reilly and Carr (in press b).

**INSERT TABLE 2 ABOUT HERE**

**INSERT FIGURE 1 ABOUT HERE**

**WHAT WORKS IN ASSESSMENT AND INTERVENTION**

In recent years a number of authors have given serious consideration to reviewing the literature on what works in psychological intervention with a broad range of difficulties experienced by children, adolescents, and adults. Among many valuable sources of information on what is effective and not effective in the clinical management of anti-social and criminal behaviour in those who meet the criteria for a DSM-IV or ICD 10 diagnosis of Conduct Disorder are reviews by Brosnan and Carr (2000) and Wolpert et al. (2002). Brosnan and Carr (2000) reviewed empirical studies on the effectiveness of interventions in alleviating conduct disordered behaviours in adolescents. This is part of a more complete review of effective interventions with children, adolescents and their families for a wide range of psychological and psychiatric disorders. One of the features of these reviews is that they are based on a meta-analysis of studies that meet the criteria of
methodologically sound research as conceptualised by Carr (2000). Studies that do not meet criteria that allows them to be considered methodologically strong were excluded from the review. The outcome of this approach is that clinical guidelines are established on a solid basis of evidence. Wolpert et al. (2002) also addressed the question of what the evidence tells us works in clinical practice for young people and their families who present with a variety of psychological and psychiatric disorders, including disorders of conduct. However, their report differs from Carr and Brosnan in that it considered evidence that was deemed to methodologically strong in addition to useful tentative evidence based on studies that could be considered to be methodologically weaker.

In summary, Carr and Brosnan report the following based on their meta-analysis of the literature. A continuum of therapeutic intervention is an appropriate and effective response for adolescents who present with Conduct Disorder reflecting its severity. This continuum should range from training parents in the behavioural management of their children (over 45 hours of intervention in a 1 year period), to family therapy (up to 36 hours of intervention), to multi-systemic therapy (up to 20 hours for between 2 to 47 months), to special foster-care. Describing this continuum more specifically, intensive behavioural parent training supported by telephone contact may sufficiently improve parenting skill to effectively reduce adolescent recidivism during and after the intervention. The goal of functional family therapy should be to facilitate parents to co-operate and develop problem solving skills concerning the management of the teenagers problematic behaviour, and to improve family communication. This approach has been effective with adolescents with severe delinquent behaviour who hail from a range of socio-economic backgrounds. It can also help reduce arrest rates among the siblings of the referred client. In multi-systemic therapy the intervention is designed to target maintaining factors related to the young person’s conduct disorder which are features of the many social systems of which he is a part (such as family, peer group, school, and community). This approach has been found to be effective with repeat adolescent offenders from
low socio-economic backgrounds by improving family functioning, reducing behavioural problems at home, and halving recidivism. In special foster-care, the foster-parents are provided with specialist training, based on the principles of social learning theory, that they implement to help a young person resocialise their behaviour from more anti-social patterns. This approach can be effective with repeat offenders and those hospitalised because of severe conduct problems.

Wolpert et al. (2002) also make very clear statements on the clinical implications of the what works literature in relation to disturbances of conduct as follows. When children younger than 8 years of age present with Conduct Disorder parent training is the most appropriate intervention, especially in circumstances when there is less co-morbidity, moderate severity, and less social disadvantage. In children aged between 8 and 12 years, or in younger children with more severe disturbances of conduct, parent training should be supplemented with individual interventions for the child that offer problem solving and social skills training. For adolescents and younger children with moderate conduct problems, functional family therapy should be considered and combined with individual interventions focusing on reducing opportunities for anti-social behaviour, and promoting problem solving, coping, and social skills. For severe and long-term conduct problems in adolescents multi-systemic therapy is the most effective intervention. However, this is an approach that requires high levels of professional resources and consequently requires careful planning and targeting. Specialist foster care placements can be a useful aspect of intervention for chronic and severe conduct problems. There is insufficient evidence in the literature to allow us to make statements regarding the effectiveness of psychodynamic approaches to treatment. Although there is some, but limited, evidence to suggest that selected forms of psychotropic medication can lower aggressiveness, medication should not be used as the initial form of intervention for conduct problems.
Carr (1995, 2000) outlines a conceptual model of functional family-based assessment and treatment that lends itself to assessment and intervention of criminal and anti-social behaviour in young people who engage in sexually abusive behaviour. Carr’s model is based on the idea that within families an individual’s psychological dysfunction, such as conduct disordered behaviour in a teenager, can be understood according to a three-column formulation that reflects predisposing and precipitating factors, maintaining cognitive factors, and a pattern of interaction where the dysfunctional behaviour is expressed in interpersonal exchanges between family members. Through careful family interview, it is possible to develop for an individual family a three-column formulation that reflects their particular difficulties, that can be used collaboratively by the family and their therapist to develop solutions to the problems they face. In the next section of this chapter we will outline how this model of assessment, formulation and intervention can be implemented for a young person referred for sexually abusive behaviour who also presents with criminal and anti-social behaviour using a fictional but realistic case example. In doing so we will attempt to outline how this type of approach, indicated by the what works literature and reflective of the aetiological and maintaining role attributed to coercive patterns of family interaction, may be used to supplement interventions aimed more specifically at changing sexually abusive behaviour.

**CASE EXAMPLE**

Timmy is 14 years-old. He has been accused of sexually abusing James, his 6 year-old cousin, while babysitting. Timmy denied his offence at first. However, he later admitted to the behaviour after he was threatened with a beating by his father, George, if he did not tell the truth regarding the allegation.
Timmy’s parents report that they have always had problems with his behaviour. Timmy has a history of disruptive behaviour since he began to attend primary school. He was referred to the local child guidance service at 6 years of age because he repeatedly stole the belongings of other pupils and fought with them in the playground. He has struggled to make progress in class and has a specific reading difficulty. He is currently in 2nd year in secondary school and is frequently absent without permission.

Timmy is the oldest of 5 children who range in age from 5 to 14 years. His father George has an alcohol abuse problem. He has served a prison sentence for burglary and aggravated assault. Timmy’s family are known to the local community services due to past episodes of family violence related to George’s drinking. Timmy’s mother, Dorothy, has a history of depression. She is currently taking anti-depressant medication prescribed by her local General Practitioner. Her extended family refuse to have any contact with her as they disapprove of her relationship with George.

Timmy has three friends with whom he spends most of his time in the evenings and at the weekend. He frequently stays out with them until after mid-night, ignoring parental rules on curfew times. Most of their time is spent hanging around the local shopping centre. Timmy and his friends have been in trouble with the local police for shop-lifting, under-age drinking and marijuana use. He has been suspended from school for fighting, is suspected of serious bullying at school, and has a reputation as a trouble-maker within his local community. It is suspected that he has been involved in joy-riding [car theft]. Timmy’s father is not living in the house at present and has declined the invitation to take part in this assessment. However, his mum is prepared to attend.
The following is an extract from part of the assessment interview with Timmy and his mum, Dorothy. The therapist is trying to get a working description of a pattern of interaction within the family concerning the presenting problem of Timmy’s disruptive and anti-social behaviour. In doing so he asks them to describe a recent example of a time they fought. The therapist is interested in understanding what happened in the interaction, and the thoughts and feelings of Timmy and Dorothy. This segment will subsequently be used by the therapist to complete a three-column problem formulation that will be the starting point for Timmy, Dorothy and the therapist to problem solve alternative strategies they both can implement as they attempt to avoid this pattern of interaction repeating itself in the future. In adopting his model for practice with conduct disordered adolescents Carr (2000) makes a number of points regarding behavioural and cognitive features of family interaction that should be kept in mind when conducting an assessment. Firstly, the coercive style of interaction, common in the families of adolescents with conduct disordered, criminal, and sexually abusive behaviour, promotes the cognitive bias in individuals that social interactions are likely to lead to conflict. This increases the likelihood that ambiguous or neutral situations will be interpreted in a hostile manner. Secondly, the coercive style of interaction promotes the belief that there is something intrinsically wrong with the adolescent who presents with anti-social or criminal behaviour, making attempts to bring about change seem futile. Thirdly, there is usually an absence of positive interaction within such families. Among other things, this limits the development of positive self-regard in the adolescent, and limits his experience of healthy relationships and associated interpersonal and problem solving skills. Fourthly, the parents frequently, inconsistently, and ineffectively, “punish” the adolescent. Finally, the parents unintentionally promote anti-social behaviour in the adolescent by brief confrontation and punishment, followed by withdrawal from the situation when the young person intensifies his anti-social behaviour. In developing a three-column formulation based on this assessment session conversation with Dorothy and Timmy, the therapist will looking for these features in their interaction.
Therapist: You have told us that you and Timmy often fight at home. I wonder if you would both describe to me the last time this happened. As you do, it's important to remember that we simply want to get a description of what happened that includes everyone's perspective. For now it doesn't matter who was right or wrong. Can you remember when you last had a fight?

Dorothy: (Laughs). That should be easy! Probably yesterday when he refused to go back to school after lunch.

Therapist: Okay. Do you both agree that we can talk about this example of a time when you fought?

Dorothy: Yeah, that's fine.

Therapist: What about you, Timmy, is that okay?

Timmy: Suppose.

Therapist: Good. How did the fight start?

Dorothy: The same as always. It started with Timmy. He came in from school about 12 and I could see by his face that he was in a fouler [bad mood]. He barely grunted hello and went to his room. Isn’t that right?

Timmy: So what...

Therapist: (To Timmy). Okay, so what happened next?

Timmy: Nothin'. I just went to me room that’s all. I just went there and stayed there.

Therapist: What did you do while you were there?

Timmy: Watched t.v.

Therapist: Okay, so what happened next?

Dorothy: I asked him if he wanted anything to eat and he didn’t bother to answer.

Therapist: Why do you think he didn’t answer?

Dorothy: ‘Cos when he’s in one of his moods he is impossible to talk to.

Therapist: Did you hear your Ma ask you if you wanted something to eat?

Timmy: No

Dorothy: Yes you did.

Timmy: Yeah, well, only when you started shouting and banging on the door.

Therapist: So you both weren’t in the same room when you were having this conversation?

Dorothy: No (slightly annoyed at therapist). He was in his room and he locks the door and no-one can get in and he turns on the t.v. full blast so you have to shout or he doesn’t hear you. Not that he answers when he does.

Therapist: Err what happened next?
**Dorothy:** Nothing. He didn’t answer so I gave up.

**Therapist:** What were you thinking as you gave up?

**Ann:** Mm, something like ungrateful little…brat…

**Therapist:** What were you thinking at this point Timmy?

**Timmy:** Nothin’. Just glad she was gone.

**Therapist:** Alright. So what happened after that?

**Dorothy:** The usual, he refused to go back to school.

**Therapist:** Oh, how did that happen?

**Dorothy:** Well, he has to leave by half-twelve if he’s going to be back in school on time at a quarter-to-one. He knows this but he’s always late. Since he didn’t bother to answer me earlier I thought I’m not going to run after him to get him back to school. By a quarter-to-one he was still in his room so I banged on the door to remind him to get out. He told me to “fuck off” and to mind my own business. I’ll put up with a lot but my God I won’t have him talk to me in that kind of language in my own home. So, I made him open the door.

**Therapist:** How did you do that?

**Dorothy:** I told him I’d get his Da to sort him out later if he didn’t open the door.

**Therapist:** What happened after you opened the door?

**Timmy:** (Voice slightly raised). She was there, screaming like a bleedin’ madwoman. Screamin’ at me to get out so I got out.

**Therapist:** Did you go back to school?

**Timmy:** What?

**Therapist:** Where did you go to after you left the house?

**Timmy:** I just went out…I met Steo and Razor [friends] and we went to the field and hung around and played some footie [football].

**Dorothy:** A likely story.

**Therapist:** What were you thinking as you left the house?

**Timmy:** Dunno, eh, that its always the same. Its always bleedin’ me that she picks on. Its never the others, its always me, its not fair.

**Therapist:** How were you feeling, Dorothy, when Timmy left the house?

**Dorothy:** Me nerves were in shreds. He really upsets me. I know its terrible to say but I was just glad that he was out of my sight.
**Therapist:** When did you see him again?

**Dorothy:** I didn’t. At least not yesterday. He sneaked in after mid-night after I’d gone to bed. I was fed-up waiting for him to come back.

**Therapist:** Okay. Thanks both of you.

Within this model of practice the therapist applies the specific information gathered from the assessment conversation with Dorothy and Timmy to generate an individualised preliminary three-column formulation. In the right-hand column the therapist simply re-states the pattern of interaction within the family as described by Dorothy and Timmy. In the left-hand column the therapist lists predisposing factors that are relevant to the presenting problem and pertinent to the pattern of interaction within the family. In the middle column the therapist lists the maintaining cognitions and beliefs that link the predisposing factors to the pattern of interaction. An example of this type of formulation based on assessment information offered by Dorothy and Timmy is illustrated in figure 2. This preliminary formulation is presented to Timmy and Dorothy on completion of the assessment when a contract for treatment is being negotiated. At this time, their views are sought on its accuracy in describing the pattern of interaction they described, and the links hypothesised by the therapist between that interaction and predisposing factors combined with linking beliefs and cognitions. It is also an opportunity to present family members with a broader perspective on the important influences on family life and relationships based on the intricacies of how they behave as they interact with each other. This formulation should be discussed fully when presented in session and refined in response to feedback from family members. Once this formulation is agreed, it becomes the basis for inviting family members to brain-storm alternatives to the choices made in interactions as described in the formulation, that they can work towards implementing in their family life.
An essential compliment to the three column problem formulation that is helpful in facilitating families in generating alternatives, is to complete the same process of assessment and formulation concerning an exception to the problem. An exception to the problem is a time when the problem could potentially have happened but did not. In our case example this might reflect a time when Dorothy and Timmy did not fight but interacted in a manner that both of them found to be more positive. The session extract given below illustrates how the therapist continues the earlier conversation to glean information from Dorothy and Timmy in order to develop a three column formulation that accurately reflects an exception to their problematic interaction that supports Timmy’s anti-social and criminal behaviour (see figure 3). In subsequently reviewing the exception to the problem formulation when a contract for treatment is being negotiated, Dorothy and Timmy are invited to identify what was different in the way they thought, felt, and behaved, and to consider if setting themselves the goal of engaging in a similar way of thinking, feeling, and behaving in the future might help prevent a repeat of the problem behaviour.

**Therapist:** Okay, so that’s an example of a recent time when you fought. I wonder if you would tell me about a time when the opposite happened. By this I mean a time when you didn’t fight, didn’t avoid each other, but got on okay.

**Dorothy:** Do you mean a recent time?

**Therapist:** Yes, a recent time.

**Dorothy:** Hmm…can you think of a time?

**Timmy:** Dunno….last week maybe….that time when we had burgers for tea and watched the Simpsons.

**Dorothy:** Oh yeah.

**Therapist:** Good. Would you mind telling me about what happened?

**Dorothy:** We had burgers from the chipper [fast food shop] and watched tv. There was me, Timmy and the other kids.

**Therapist:** What day was this?

**Dorothy:** Let me think…was it Thursday?  Yeah, Thursday I think ‘cos I got paid on Thursday.
Therapist: Oh, was that a school day for you Timmy?

Timmy: Yeah.

Therapist: What kind of day was it in school?


Therapist: Does that mean you didn’t have any problems or worries in school last Thursday?

Timmy: Yeah.

Therapist: Can you think of why that was? Is Thursday different from other school days?

Timmy: Not really. I have double mechanical drawing which is deadly [very good].

Dorothy: He has Mr. McKiernan for mechanical drawing. He always does well in that class. He’s the only teacher in that school who’s any use.

Therapist: Did you get into any fights in school on Thursday?

Timmy: No.

Therapist: How did you manage that?

Timmy: Dunno. Just no one picked on me that’s all.

Therapist: So what kind of mood were you in when you got home?

Timmy: Good, I suppose.

Therapist: Did you go straight home from school, or did you do anything along the way?

Timmy: I met Razor. He was going to the shop for his Ma but I didn’t bother going with him.

Therapist: So what happened when you got home?

Timmy: Me Ma was there. She’s usually in a good mood on a Thursday ’cos its her night for going out. She told me to go to the chipper and get burgers and chips. So, I went and got them. When I came home we ate them in the kitchen. The Simpsons was on so we watched that. Me Ma thinks Mr. Cleary across the road looks like Ned Flanders.

Dorothy: No I don’t (laughs).

Timmy: She says “How-didily-doodily neighbour” whenever she sees him (laughs).

Therapist: What did you think when Timmy came home from school on Thursday?

Dorothy: Nothing really. I could see he was in a good mood. He’s good when he’s like that. He even helped me clear up afterwards. That’s what I don’t understand. He’s good when he wants to be. Like when he helps with the younger ones. And when he’s good, sometimes they’re good too.

Therapist: Why do you think that is?

Dorothy: They look up to him I suppose.
Therapist: Okay. That sounds like a nice evening. Thank you.

INSERT FIGURE 3 ABOUT HERE PLEASE

As mentioned previously, on completion of the assessment phase of intervention the next step in Carr’s model is to develop a contract for intervention. The three primary aims of intervention are to use the three column formulations to help the family move away from repeating the coercive style of interacting with one another, to increase the number of positive exchanges within the family, and to help the adolescent learn how to manage his behaviour so that he engages in a more socially acceptable manner. During the development of a contract for intervention practical arrangements concerning the number of sessions, their location and time should be clearly outlined. Suitable arrangements that will help prevent non-attendance should be put in place. These arrangements may include support from involved systems such as social services, the provision of transportation to appointments, or arranging to conduct sessions in the client’s home. As we have seen from the what works literature, the more chronic the adolescent’s anti-social and criminal behaviour the more intensive and long-term the functional family therapy that is likely to be required. These details may be put into a written contract that is signed by family members, the therapists, and other involved members of the family’s support network.

Intervention techniques

In the intervention phase a number of techniques can be implemented that will help to decrease coercive interactions, increase positive interactions, and facilitate parents in helping the young person to learn how to manage his behaviour. These include helping parents to monitor and understand the pattern of family interaction and its reflection of broader influences on behaviour in
a manner similar to that illustrated by the three column formulation process. Helping family members to positively reframe problem interactions can be achieved either by helping them to externalise the problem behaviour of the young person, rather than interpreting it as something intrinsically wrong with him, or by re-emphasising some positive element of the behaviour. Other techniques include planned special time, using reward systems to promote behavioural control, enhancing parenting skills, improving communication skills in family members, and improving problem solving skills. These and other approaches are described in detail in Carr (2000) and in other similar sources on clinical practice. In the remainder of this section we will describe three of these techniques in greater detail in order to give a picture of what the intervention process may be like.

**Planned special time**

In planned special time an attempt is made to break the coercive pattern of interaction between parent(s) and adolescent by scheduling positive time to be spent together. In doing so the parents and the adolescent plan and agree on a specific activity in which all parties can enjoy participating. The activities themselves do not have to be elaborate or incur any significant expense. With teenagers the special time might be as simple as going for a walk together once a week, or choosing a video to watch together and then having a conversation about it afterwards (however, generally speaking overly passive activities are less useful). The choice of activity for the planned special time should reflect the interests and resources of the family. There are a number of important aspects for therapists to emphasise in establishing this intervention. These include helping parents to develop positive attributions concerning the adolescent by asking parents to notice how much they enjoy spending time with their son. To improve the expression of boundaries and clear positive emotional statements within the family by asking parents to conclude the activity by
verbalising a review of what they have done together along with their positive feelings regarding the time spent together. Helping the development of parenting skills by asking parents to foresee and pre-empt rule breaking that could potentially occur related to the activity rather than allowing it to unfold.

Enhancing parenting skills

A key element of successful intervention is to enhance effective parenting skills. There are a number of parent training manuals, videos and programmes available that facilitate this goal. In this section we will describe a CD-ROM based intervention known as Parenting Adolescents Wisely that is well suited to this task. It combines instructional video clips on problems and possible solutions to the difficulty of parenting adolescents with disruptive and problematic behaviour, with educational instruction and content review quizzes. It was developed by Professor Donald Gordon in the US but has been implemented in a number of other countries including Ireland, the UK, and Australia. It was designed to specifically promote parenting practices the absence of which have been consistently linked to juvenile delinquency. In developing a CD-ROM based intervention Gordon was building on research evidence that demonstrates that video training is an effective way to improve parenting practices and knowledge, and is as successful in improving child behaviour problems as educational groups for parents or direct instruction from a therapist. It also has the advantage of offering a format that is low-cost and flexible for service providers as it does not require staff training and can be implemented in a family’s home through a laptop computer.

The format of Parenting Adolescent Wisely presents video clips illustrating nine parent-adolescent problem situations (including completing homework, sibling conflict, defiance, avoiding chores, disrespectful talk, associating with undesirable peers). At the conclusion of each video clip
illustrating the problem parents are given three strategies to choose from in response to the young person’s behaviour. The parent is invited to choose from three potential responses that best reflects the parenting approach that best reflects the way they would handle the situation. The parent’s choice of parenting strategy is then illustrated in another video clip that portrays the outcome of this approach. After the video clip is played a series of questions and answers appear on the screen which allow the parent to consider the positive and negative aspects of the choice of parenting strategy. If the response chosen by the parent is not the solution most reflective of good parenting principles the computer programme invites the respondent to select another option which is also illustrated in a video clip. When the optimal solution has been illustrated on video, the parent completes an on-screen quiz that facilitates a content review of the good parenting practices exemplified. Within the Parenting Adolescents Wisely programme a number of effective parenting behavioural management techniques are illustrated and reviewed. These include active listening, using “I statements” to express emotions, supervision, contracting with teenagers for positive behaviour, using appropriate discipline, and contingency management.

Gordon (2002) states that the goals of the Parenting Adolescent Wisely CD-ROM are five-fold. Firstly, to increase parents’ knowledge of the principles of good and successful approaches to parenting teenagers. Secondly, to improve their actual parenting behaviour in addition to knowledge gains. Thirdly, to facilitate the improvement of problematic behaviour among teenagers. Fourthly, to improve family functioning, and finally to enhance parents’ satisfaction with their ability to be effective in managing their children when they present with difficult behaviour. Gordon (2002) reviews evidence from six studies that indicate that the Parenting Adolescents Wisely programme effectively achieves these aims. In summary, these empirical studies attest to the effectiveness of the programme with teenagers and their families (a) referred from outpatient clinics and a residential centre for juvenile delinquents, (b) identified with problem
behaviours in a public school, (c) teenagers who are themselves parents of young children, (d) court referred juvenile delinquents from low income homes, (e) at-risk socially disadvantaged families, and, (f) in families identified in public schools where there is spousal conflict and family violence.

**Reward systems and behavioural control programmes**

Another key element of successful family intervention for adolescents with anti-social and criminal behaviour is to assist parents in directly promoting pro-social behaviour, and in directly discouraging anti-social behaviour, through the use of reward systems and behavioural control programmes without recourse to a coercive style of interaction. Reward systems provide an intervention well designed for the promotion of pro-social behaviour. They are an equivalent to approaches, such as star charts that are used with younger children, which are obviously unsuitable for adolescents. A format that is more acceptable to teenagers is for parents and the young person to agree to work on one or two positive behaviours that they would like to see the young person do more of (such as getting up at a certain time, speaking to family members in a regular voice, helping with a chore such as clearing up after a meal, doing homework at a set time). A pre-agreed number of points is offered for the successful completion of the specified task. A menu of rewards is also pre-agreed. It outlines benefits that can be claimed for an agreed number of reward points once they have been accumulated by the adolescent. Rewards are usually extra privileges (such as watching TV for an extra hour, staying up an extra half-an-hour, having a friend over to visit for two hours). There are some key elements that are helpful in successfully establishing this type of system. These include setting up the programme as one where the aim is not to control the adolescent’s behaviour, but to help him to consolidate habits that are more pro-social. Another useful approach is to begin the programme on a successful footing by including behaviours that are already within the teenagers repertoire at the outset. It is also important that the programme works
on small number of manageable goals rather than a large number of unmanageable ones, that parents are encouraged to engage in behaviours that positively models that encouraged in the adolescent, that there is consistency in the way the programme is implemented, that parents are encouraged to quickly offer praise and positive feedback to the young person when positive behaviours are displayed in addition to points rewards, and that all parties adopt an open minded approach to revising the system until one that works for the individual family is found.

An inescapable but infinitely more difficult aspect of the intervention concerns the use of behavioural control programmes. These are similar to reward programmes in that they aim to encourage positive pro-social behaviour, but differ in that they entail sanctions for engaging in negative behaviour and rule breaking. In establishing a behavioural control programme the primary care-giver(s) pick a small number of rules that they would like to promote (such as getting up at a certain time in the morning, speaking to family members in a calm non-aggressive manner, or returning home by a certain time in the evening). As before a system of reward points that can be accumulated and exchanged for pre-agreed privileges is established. However, an additional feature of the system is that points are deducted if the young person engages in rule breaking. The number of penalty points deducted within the system is also agreed in advance of the implementation of the programme. Engaging in this type of intervention is usually very stressful for families, particularly at the outset. A typical feature of their implementation is that the young person responds by escalating the intensity of their inappropriate behaviour. In the three-column problem formulation outlined for Timmy there are two instances where this happens (1. Timmy deliberately ignores Dorothy when she starts banging on his bedroom door. She becomes further frustrated and leaves. 2. Later Dorothy shouts at Timmy and Timmy responds by shouting back at her). Having these types of illustrations in the problem formulation helps prepare the family for what they should expect as they begin to implement a behavioural control programme as they are based on the real
life interactions of the family. They serve to highlight the coercive style of intra-family interaction, demonstrating how both Timmy and Dorothy use this approach as the default interaction technique within the family. They illustrate the outcome that when a parent tries to exert control, the adolescent continues to defy or escalates their defiance in response, and frustrated the parent gives up and both parties experience relief. During the intervention phase the aim is to help the parents introduce appropriate parental control and not repeat the unintentional rewarding of inappropriate behaviour. This would undoubtedly be a very difficult challenge for any parent. As part of preparing the family for this element of a functional family therapy intervention it is important to establish that all adults within the system implement the programme consistently, that adults are mutually supportive of the programme and have access to other forms of social support as appropriate, that the adults agree that in implementing the programme they will not engage in parenting towards the adolescent that is physically, emotionally or verbally punitive. In addition, this element of intervention is unlikely to meet with any success if it is not equally accompanied by the development of positive relationship interactions, positive reframing and problem solving skills. Given the initial resistance that will be elicited by this type of intervention it is very tempting for family members and therapists to repeat the usual outcome of intensified behavioural response by backing down. Consequently, appropriately maintaining the programme when initial resistance is encountered is very important.

**SUMMARY**

In summary, in this chapter we have seen that many theorists have acknowledged that more general criminal behaviour is a significant feature in a subset of those young people who engage in sexually abusive behaviour. A key aspect of the development of sexual and non-sexual criminal behaviour is theorised to be one of the significant outcomes of living in a family where interpersonal interaction
is characterised by a coercive and manipulative style. Turning to the empirical literature confirmed that non-sexual criminal behaviour is evident among many young people who sexually offend, and is particularly associated with those whose life-styles and offences are characterised by certain features such as sexual offending against peers/adults or against male victims. However, the exact extent of the problem of non-sexual criminal and anti-social behaviour among juveniles who sexually offend needs to be established through empirical investigation. Studies that have monitored development of young people who sexually abuse into adulthood clearly indicate that both sexual and non-sexual recidivism are issues that need to be assessed and addressed when offering therapeutic services. In this chapter we referred to the clear findings from the what works literature for children and adolescents regarding effective interventions for those who present with Conduct Disorder, as this diagnostic category incorporates many aspects of criminal and anti-social behaviour that the empirical literature indicates are features of the behaviour of some adolescents who sexually abuse others. Consistent with the hypothesised importance of coercive family interactions in the aetiology of sexual and non-sexual offending, the what works literature suggests comprehensive family based interventions as the most appropriate and most effective therapeutic response. Using a case example we concluded this chapter by outlining a model of functional family assessment, formulation and intervention conceptualised by Carr (1995, 2000). It is our hope that this chapter has high-lighted the importance of addressing other types of criminal and anti-social behaviours among a subset of adolescents who engage in sexually abusive behaviour. We also hope that it has presented an evidenced and practical introduction for practitioners who may wish to further consider addressing these needs within existing or developing services.
References


<table>
<thead>
<tr>
<th>Offence</th>
<th>Juvenile sexual offender group</th>
<th>Juvenile non-sexual offender group</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Rubenstein, Yeager, Goodstein &amp; Lewis (1993)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>First/second degree sexual offence</td>
<td>37%</td>
<td>10%</td>
</tr>
<tr>
<td>Violent non-sexual offence</td>
<td>89%</td>
<td>69%</td>
</tr>
<tr>
<td><strong>Sipe, Jensen &amp; Everett (1998)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual offence</td>
<td>9.7%</td>
<td>3.0%</td>
</tr>
<tr>
<td>Violent offence</td>
<td>5.6%</td>
<td>12.1%</td>
</tr>
<tr>
<td>Property offence</td>
<td>16.1%</td>
<td>32.6%</td>
</tr>
<tr>
<td>Other offence</td>
<td>15.3%</td>
<td>22.7%</td>
</tr>
<tr>
<td>Any arrest</td>
<td>32.3%</td>
<td>43.9%</td>
</tr>
</tbody>
</table>
Table 2. Diagnostic criteria for Conduct Disorder as outlined in DSM-IV and ICD 10 and adapted by Carr and Brosnan (2000). Reproduced with permission from the APA, WHO, and Routledge

<table>
<thead>
<tr>
<th>DSM IV</th>
<th>ICD 10</th>
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<tbody>
<tr>
<td>A. A repetitive and persistent pattern of behaviour in which the basic rights of others or major age appropriate societal norms or rules are violated as manifested by the presence of 3 or more of the following criteria in the past 12 months with at least one criterion present in the past 6 months:</td>
<td>Conduct disorders are characterised by a repetitive and persistent pattern of dissocial, aggressive or deviant conduct. Such behaviour, when at its most extreme for the individual should amount to major violations of age-appropriate social expectations, and is therefore more severe than ordinary childish mischief or adolescent rebelliousness.</td>
</tr>
<tr>
<td><strong>Aggression to people or animals</strong>&lt;br&gt;1. Often bullies, threatens or intimidates others&lt;br&gt;2. Often initiates physical fights&lt;br&gt;3. Has used a weapon that can cause serious physical harm to others&lt;br&gt;4. Has been physically cruel to people&lt;br&gt;5. Has been physically cruel to animals&lt;br&gt;6. Has stolen while confronting a victim&lt;br&gt;7. Has forced someone into sexual activity</td>
<td>Examples of the behaviours on which the diagnosis is based include the following: excessive levels of fighting or bullying; cruelty to animals or other people; severe destructiveness to property; fire-setting; stealing; repeated lying; truancy from school and running away from home; unusually frequent and severe temper tantrums; deviant provocative behaviour and persistent and severe disobedience. Any one of these categories, if marked, is sufficient for the diagnosis, but isolated dissocial acts are not.</td>
</tr>
<tr>
<td><strong>Destruction of property</strong>&lt;br&gt;8. Has deliberately engaged in fire-setting&lt;br&gt;9. Has deliberately destroyed others’ property</td>
<td>Exclusion criteria include serious underlying conditions such as schizophrenia, hyperkinetic disorder or depression.</td>
</tr>
<tr>
<td><strong>Deceitfulness or theft</strong>&lt;br&gt;10. Has broken into someone’s house&lt;br&gt;11. Often lies to obtain goods or favours or avoid obligations&lt;br&gt;12. Has stolen items without confronting the victim</td>
<td>The diagnosis is not made unless the duration of the behaviour is 6 months or longer.</td>
</tr>
<tr>
<td>Serious violation of rules&lt;br&gt;13. Often stays out late at night despite parental prohibitions (before 13 years of age)&lt;br&gt;14. Has run away from home overnight at least twice while living in parental home or once without returning for a lengthy period&lt;br&gt;15. Is often truant from school before the age of 13</td>
<td>Specify: Conduct Disorder confined to a family context where the symptoms are confined to the home</td>
</tr>
<tr>
<td>B. The disturbance in behaviour causes clinically significant impairment in social, academic or occupational functioning.</td>
<td>Unsocialised Conduct Disorder where there is a pervasive abnormality in peer relationships</td>
</tr>
<tr>
<td>C. In those over 18 years, the criteria for antisocial personality disorder are not met. Specify childhood onset (prior to 10 years) or adolescent onset. Specify severity (mild, moderate, or severe).</td>
<td>Socialised Conduct Disorder where the individual is well integrated into a peer group</td>
</tr>
</tbody>
</table>
Figure 1. A way to conceptualise the relationship between adolescent sexual offending, conduct disorder, and criminal behaviour of a sub-conduct disordered level – exact proportions of over-lap unknown.
Figure 2. Three column problem formulation for Timmy and Dorothy

Timmy has poor school attendance, a reading disability, and a poor relationship with teachers and classmates.

Timmy believes he should not have to go to school because he hates it.
Timmy believes no one understands how much he hates school.
Timmy has a long history of disruptive behaviour.

Dorothy believes there is something intrinsically wrong with Timmy.
Timmy comes home from school in a bad mood.
Timmy doesn't stop to talk to his mum, Dorothy.
Timmy isolates himself in his room.

The coercive style of interacting in the family means that there is a significant reduction of positive interaction between family members.

Dorothy believes Timmy is out of control.
Dorothy gives up (feels relieved).
Dorothy waits to see what T does.
Timmy doesn't return to school.
Dorothy shouts at Timmy.
Dorothy believes she must get Timmy to do as he is told.

A coercive pattern of interaction is the default relationship style within the family.
Alcohol abuse, marital and other violence have been a feature of family life.
Dorothy believes that when all else fails the best way to get Timmy to do as he is told is to threaten to get his father George to deal with him.

Dorothy and Timmy fight.
Dorothy threatens to tell George.

Rules and organisation are difficult to set and maintain within the family.
Timmy believes no one understands him and he is treated unfairly in the family.
Conflict within the family is defused through avoidance.

Dorothy tells Timmy to get out.
Timmy leaves and does not come home until after midnight.
Dorothy and Timmy experience relief.

Predisposing Factors
Maintaining Cognitive Factors
Pattern of Interaction
On good days in school Timmy can manage himself so he does not get into trouble.

Timmy thinks he is good at mechanical drawing.

Timmy thinks he is not being picked on.

One of the house rules that Timmy is supposed to follow is that he should go home after school.

Timmy has a good day at school.

Timmy does not go to the shop with Razor.

When the atmosphere at home is good family members spend more time together.

Timmy arrives home in a good mood.

Dorothy is in a good mood.

Timmy doesn’t isolate himself from the rest of the family.

Dorothy likes it when Timmy is in a good mood.

Dorothy thinks Timmy is in a good mood.

Dorothy recognises that Timmy is in a good mood and sends him to the shops for burgers and chips.

The family enjoy watching the Simpsons together.

The family sometimes organise meals together.

Timmy is sometimes prepared to help out at home.

Timmy thinks his mum needs help around the house.

Timmy’s younger siblings look up to him and sometimes follow his behaviour.

Timmy helps Dorothy clear up after tea.

Other kids in the family are well behaved.

Figure 3. Three column formulation for an exception to the problem for Timmy and Dorothy