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THE ASSESSMENT OF ADOLESCENT SEXUAL OFFENDERS

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ABSTRACT

This chapter gives an overview of the problem of sexual assaults committed by adolescents. It includes theories to explain the causes of sexually aggressive behavior as well as the identification of sex offenders. The authors propose a model to explain the development of deviant sexual interests which includes individual, family and social-environmental variables. The authors describe assessment procedures including clinical interview, psychiatric interview, psychophysiologic measurement, and psychometric testing. A specific treatment program is described. Recommendations for future research are suggested.

INTRODUCTION

Overview of the Problem

The problem of sexual assaults by adolescents is serious and has been largely neglected to date. Although the exact incidence of sexual offenses committed by adolescents is unknown, data available from victim surveys, such as the National

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Crime Survey, and arrest records, such as the Uniform Crime Report, indicate that 20% of rape and approximately 40% of child sexual abuse cases are committed by adolescents.

In a study of adult sexual offenders seen on an outpatient basis, the 411 sex offenders reported that they had completed 218,900 sexual crimes (Abel, Mittelman, & Becker, 1985). The total number of victims was 138,137. On the average, each offender attempted 581 crimes, completed 533 crimes, and had 336 victims. Furthermore, 58% of the adults began their deviant sexual behavior during their adolescence.

Two recent studies have described populations of adolescent sexual offenders (Fehrenbach, Smith, Monastersky, & Deisher, 1986; Becker, Cunningham-Rathner, & Kaplan, 1986). Fehrenbach et al. (1986) evaluated 305 adolescent sexual offenders. More than 60% of the adolescent offenders had sexually victimized a child younger than 12 years of age.

Becker et al. (1986) reported that 61% of a group of 80 adolescent sexual offenders (mean age of 15 years) seen on an outpatient basis for evaluation or treatment had engaged in sexual behavior with children. The majority of victims were unrelated to the offenders and younger than 8 years of age. The 49 adolescents who involved themselves with young children had completed a total of 70 deviant sexual acts involving a total of 60 victims. For the majority of adolescents, however, the official records noted only 1 offense per adolescent. The next largest category of offenders were rapists (16 had raped females, and 5 had raped males). These 21 adolescents had completed 42 rapes involving 16 victims and had attempted 14 rapes involving 14 victims. The rapists who raped female victims used (on the average) more physical coercion than necessary to commit the crime and more aggression than the other diagnostic groups.

Defining the Problem

Why adolescents commit sexual crimes as well as how their deviant sexual interest patterns are maintained is unknown. A variety of theories have been proposed to explain the causes of sexually aggressive behavior and the nature of sexual violence (Ford & Beach, 1955; Freud, 1938; Gagnon & Simon, 1967; Groth & Birnbaum, 1979; Langevin, 1983; Malamuth, Feshbach, & Jaffe, 1977; Mohr, Turner, & Jerry, 1964). However, to date there is no empirically derived and tested model to explain why adolescents commit sexual crimes.

Much confusion surrounds the identification of juvenile sex offenders. Several researchers have found indications that a significant number of sexual offenders have the onset of their deviant sexual interest pattern soon after puberty (Abel, Mittelman, & Becker, 1985; Awad, Saunders, & Levene, 1979; Groth & Birnbaum, 1979; Longo & Groth, 1983). Some researchers have suggested that the early onset of deviant behavior in male adolescents may have simply been a matter of innocent sex play and experimentation, or that the sexual offenses were

due to the normal aggressiveness of the sexually maturing adolescent (Finkelhor, 1979; Gagnon, 1965; Reiss, 1960; Roberts, Abrahams, & Finch, 1973). Chatz (1972) suggested that these adolescent offenses are mostly minor and non-dangerous offenses and that they rarely repeat their behaviors. Recent research has suggested otherwise. Groth (1977) described the characteristics of 26 convicted adolescent sexual offenders. The majority (86%) had previous interpersonal sexual experiences prior to the sexual assault.

Becker, Cunningham-Rathner, and Kaplan (1986) reported that the adolescent offenders surveyed had engaged in nondeviant genital sexual behaviors beginning at ages ranging from 6 to 16; 41% reported never having engaged in nondeviant genital sex relationships. In a separate study of 22 adolescent incest offenders (Becker, Kaplan, & Cunningham-Rathner, 1986), it was found that they had begun engaging in nondeviant sexual behaviors prior to engaging in incestuous behavior. These findings seem to challenge the assumption that adolescents are mainly experimenting with sexuality when they engage in deviant sexual behaviors.

Model of Deviant Sexual Behavior

As noted previously, there is not at the present time an empirically validated model that explains the development of deviant sexual interest patterns in adolescents. The authors have developed a model by which deviant sexual behavior might be explained. Future research will attempt to test the model. This model incorporates individual characteristics, family variables, and social environmental variables as possible precursors to the commission of the adolescent's first deviant sexual act. Following the first sexual offense, we believe that there are three paths an adolescent might follow: (1) the Dead End Path, in which an adolescent never commits any further deviant sexual behavior. These adolescents are likely to be the ones who suffer the most negative consequences for their behavior, or for whom the behavior may have been exploratory in nature, lacking in violence and related to the lack of a peer partner or as a copy cat offense (modeling). (2) The Delinquency Path, in which an adolescent may commit further deviant sexual acts as part of general antisocial personality pattern. For example, some adolescents commit sexual crimes during the course of committing other delinquent acts, for example, during a burglary, or they have engaged in peer bonding with delinquent youths and commit other deviant sexual acts with their peers, for example, gang rape. (3) The Sexual Interest Pattern Path, in which an adolescent commits further sexual crimes and develops a paraphilic arousal pattern. These adolescents are likely to be those who (a) found the behavior to be very pleasurable, (b) experienced no or minimal consequences in relation to commission of the sexual crime, (c) experienced reinforcement of the deviant sexual behavior through masturbation activities and fantasies, and (d) are deficit in their ability to relate to age appropriate peers.

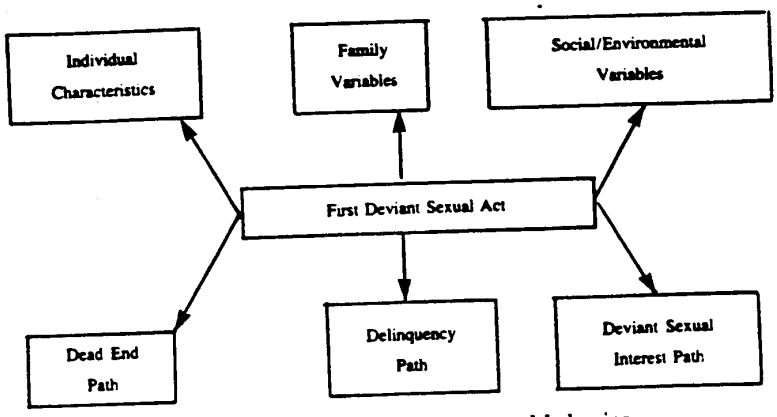

Figure 1. A model of deviant sexual behavior.

REVIEW OF ASSESSMENT MODELS

Evaluation of Adolescent Sexual Offenders

The evaluation of the adolescent sexual offender forms the basis for the treatment plan. The evaluation must include a specialized battery to focus on the sexual offense and a general assessment to profile the adolescent.

The first step in the evaluation is to gather information from the offender and outside sources such as referral sources, court reports, victims' reports, parents and other relatives. It is important to identify risk factors associated with individual, familial and social/environmental variables that may predispose an adolescent to commit a sexual crime.

Specific individual variables include deviant and nondeviant sexual behaviors and fantasies (deviant and nondeviant), victimization history, psychopathology, personality traits, beliefs in rape myths, distorted beliefs about appropriate sexual behavior, sex and knowledge, values and attitudes, history of delinquency, academic performance, gender role conflicts and future time perspective. Family risk factors may include intra-family violence, poor parent management techniques, and criminal behavior by family members. Social environmental risk factors may include bonding with delinquent peers and inappropriate role models.

A review of the clinical literature suggests that the likelihood of an adolescent offender's recommitting the crime can be predicted by (1) availability of a victim, (2) the offender's limited sexual knowledge, (3) cognitions or attitudes that sustain paraphiliac behaviors, (4) a history of substance abuse, (5) lack of empathy with the victim, (6) denial of the compulsive quality of his offense, (7)

absence of a strategy to control his paraphilic behavior, (8) limited understanding of sexual values, and (9) whether he was victimized as a child himself. Unfortunately, none of these factors have been validated in control studies to substantiate their predictive value.

A major task for the clinician is to determine whether the adolescent has engaged in a sexual behavior that is norm violating or sexually assaultive in nature. Some basic guidelines are: (a) the age difference between the adolescent and the victim, (b) whether force was used, (c) the relationship between the adolescent and the victim (relative vs. nonrelative), and (d) the type of sexual activity that was involved.

Below are two examples of adolescent sexual offenders seen at the Sexual Behavior Clinic.

John is a 16-year-old adolescent who resides with his mother, stepfather, and four siblings. John was arrested for having a 5-year-old neighborhood boy "lick his penis." John denies having used verbal or physical coercion to gain the compliance of the victim. The victim responded to John's request. John has little understanding as to why he engaged in the inappropriate sexual act. He denies having been sexually victimized as a child or observing an older person engage in sexual behavior with a child. John was placed on probation as a consequence of the inappropriate sexual behavior and mandated to receive treatment.

Peter is an 18-year-old adolescent who was referred to our clinic from a psychiatric hospital because he had repeatedly (more than 230 occurrences) forced anal intercourse on his two prepubescent brothers (8 years of age) and his prepubescent sister (9 years of age). Peter had presented as a voluntary admission because he was suicidal regarding his deviant sexual behavior. Peter had been sodomized at the age of 10 by a 15-year-old adolescent. This assault occurred while Peter was in a residential facility for conduct disordered children.

The Psychiatric Interview

A major question relates to whether adolescents who commit sexual crimes are characterized by an overall pattern of delinquency, conduct disturbance or other psychopathology. Yet, little is known about the characteristics of this population because there have been few studies of psychopathology in this group.

Lewis, Shankok, and Pincus (1979) compared 17 adolescent males incarcerated in a secure unit for violent sexual assaults to 61 boys incarcerated for violent nonsexual acts. She found that both groups had a high presence of psychiatric symptoms including depression, auditory hallucinations, paranoia, and thought disorders and that the sexual offenders had a prior history of violent nonsexual behavior.

McManus, Allessi, and Grapentine (1984) administered the SADS to 40 adolescent males who were incarcerated for serious delinquent behaviors, 6 of whom had committed sexual assaults. They found a high prevalence of psychiatric

disorders in the whole sample including conduct disorder, substance abuse and alcoholism, affective disorders and personality disorders. All 40 boys in this sample had multiple psychiatric diagnoses.

The above cited studies are limited because they have been conducted with incarcerated juvenile offenders and have not attempted to differentiate between types of offenders (i.e., rapists vs. child molesters). However, it is important to determine the role that psychiatric status plays in the commission of a sexual crime.

A comprehensive psychiatric evaluation should include a psychiatric history, a mental status examination, and a medical and family history (MacKinnon & Yudofsky, 1986). Psychological tests and psychiatric ratings scales are widely used for a variety of clinical assessments such as intelligence tests, brain disorder tests, and cognitive functioning tests.

Two psychiatric ratings scales that have been used with adolescent sexual offenders are the Kiddie-SADS-L (Chambers, Puig-Antich, Hirsch, Paez, Ambrosini, Tabrizi, & Davies, 1985) and the Structured Clinical Interview for DSM III (Spitzer & Williams, 1984).

A recent study conducted by Kavoussi, Kaplan, and Becker (1988) at the Sexual Behavior Clinic looked at whether an outpatient sample of juvenile sex offenders who had raped or attempted to rape adults differed from those involved in other sexually inappropriate behaviors with respect to prevalence of psychiatric disorders. Fifty-eight male adolescents accused of sexual crimes, aged 13 to 18, were interviewed using the SCID and the Kiddie SADS-E (Children's Schedule for Affective Disorders and Schizophrenia-Epidemiologic Version), 2 semistructured psychiatric interviews. Diagnoses were made according to DSM III criteria. In order to assess the degree of impulse control problems in these boys in nonsexual areas, the diagnosis of conduct disorder was made independent of the subject's sexual behavior.

Forty-four of the subjects had no prior arrests for any nonsexual crimes. The most common diagnosis in the group was conduct disorder (48%). The majority of the boys who met criteria for this diagnosis could be classified as socialized, nonaggressive. Substance abuse (marijuana, alcohol) was the only other diagnosis found in more than 10% of the sample. None of the subjects met full criteria for major affective disorder, dysthimia or psychotic disturbance, and 19% had no DSM-III diagnosis.

The Kavoussi et al. (1988) study found a lower prevalence of psychiatric disorders in juvenile sex offenders than in other studies (Lewis et al., 1979; McManus et al., 1984). Unlike the other studies, the Kavoussi et al. (1987) study focused on a nonincarcerated sample and also differentiated between types of sexual offenders. The findings underscore the heterogeneous nature of adolescents who engage in sexually inappropriate behavior. The fact that half of the sample did not meet the criteria for conduct disorder indicates that inappropriate

sexual behavior is not in all cases part of a pattern of antisocial behavior. Even for those adolescents who did meet the criteria for conduct disorder, one cannot assume that the commission of a sexual crime was solely the manifestation of conduct disorder. It may be the case that for certain adolescents who have been exposed to other variables including a violent home, sexual victimization, or poor parent monitoring, the presence of a conduct disorder facilitates the development of a deviant sexual interest pattern.

Further Assessment

Individual Risk Factors

Researchers have investigated the question of whether violence stems from individual characteristics. Tarter, Hegedus, Alterman, & Katz-Garris (1983) found no systematic group differences between violent adolescents and sex offenders on intellectual, neuropsychological and psychoeducational measures. The failure to find differences in all probability is related to the assessment battery utilized which was confined to psychiatric and neurological testing and did not access other variables that have been identified as contributory factors to the development of sexually deviant and delinquent behaviors.

Rutter and Giller (1983) found that a very small percentage of delinquents had "brain damage" and that it is likely not important in the etiology of delinquent behavior. They also conducted a study of IQ and conduct disturbance in delinquent youth and found that delinquency was significantly and negatively correlated with IQ. Loeber and Dishion (1983) have proposed that temperament plays a part in delinquency, and they have proposed a portrait of the "aggressive daring" adolescent. Several studies point to early childhood as an influence on later adolescent delinquency.

Early childhood has been observed to be an influence on later adolescent delinquency. Patterson (1981) described behaviors in 6- to 9-year-old males that were early manifestations of criminal behavior, such as taking belongings from siblings and parents, stealing from neighbors and shoplifting. Both Patterson (1981) and Loeber (1982) concluded that the redundant patterns of this early delinquent behavior, and not just isolated events, is predictive of later criminal behavior. Other researchers have noted poor school functioning (Farrington, Ohlin, & Wilson, 1986; Tarter et al., 1983), drug and alcohol abuse (Blumstein, Cohen, Roth, & Vishner, 1986), and aggressive childhood behavior (Farrington, 1981) as predictors of delinquent behavior.

Not all of the above cited findings can be generalized to adolescent sexual offenders nor to all delinquent offenders. However, they are important in guiding us to some of the variables that may predispose an adolescent to commit a sexual crime.

Family Variables

Family environment and management practices have been implicated in the development of sexually delinquent behavior. Previous research studies of families have attempted to predict children's adjustment from home environment variables and family interactions (Mink, Nihira, & Meyers, 1983; Oliveri & Reiss, 1982). Attempts to specify family patterns have been made from data collected on deviant youth (Giovanni & Billingsley, 1970). Deykin (1972) assessed family life functioning and found a relationship between the type of antisocial behaviors seen in delinquent children and the way the family functions as a unit. A search for patterns has been made on problem and nonproblem families (Moos & Moos, 1976), and researchers have defined a number of dimensions for distinguishing among families.

A review of the adolescent sex offender literature indicates that exposure to family violence, neglect or physical abuse may be implicated in the etiology of sexually delinquent behavior. Van Ness (1984) reported that 41% of the adolescent sex offenders in his sample had experienced intra-familial violence or neglect during childhood. By comparison, only 15% of the nonsex offender sample reported histories of abuse or neglect.

Lewis, Shankok, and Pincus (1979) and Glaser (1978) compiled data on neuropsychiatric, intellectual and educational status of extremely violent and less violent incarcerated boys. A history of physical abuse distinguished the more violent from the less violent children. Of the more violent children, 79% were known to have witnessed extreme violence directed at others, mostly in their homes, compared with 20% of the less violent children.

Further research is needed to confirm whether various aspects of the family environment differ for adolescent sex offenders as compared to nonsex offenders, delinquents, and nonoffenders. Davis and Leitenberg (in press), in a review article on adolescent sex offenders, argue that even if differences were confirmed, "the question remains as to how this influences the adolescent to commit a sexual offense."

These authors point out a number of plausible explanations: (1) when physical aggression and marital violence are tolerated, the adolescent learns that this is acceptable behavior, (2) neglect and abuse may predispose the adolescent to seek revenge on substitute targets, (3) parental abuse may lower self-esteem and the sexual offense may be a way of restoring self-worth, and (4) parental abuse may sensitize the child to more intimate relationships with peers, and consequently, he may socialize and then sexualize relationships with much younger children (Davis & Leitenberg, in press).

It is our belief that abuse behavior within the home in most cases is not sufficient to produce a deviant sexual interest pattern, but this behavior in combination with other aspects of family upbringing and other variables may be one pathway by which a deviant sexual interest pattern develops. In our clinic, the

specific family variables used for assessment include structural and functional histories; parent psychopathology; parent victimization; parent discipline and monitoring; parent criminal history; parental sexual knowledge, values, and attitudes; family adaptability; family communication; parental personality traits; parental beliefs in rape myths and beliefs about inappropriate sexual behaviors.

Social-Environment Variables

The assessment of the adolescent sex offender should include social-environment variables such as peer bonding, social and assertiveness skills of parents and adolescents, adolescent's means of dealing with anger control and other social situations, and history of delinquency.

Environmental Factors

Wolfgang, Figlio, and Sellin (1972) found that a significant number of children who became delinquents lived in "high crime areas" characterized by low income, low employment, high minority, overcrowding and a high proportion of children and adolescents relative to adults. Other researchers have also found a "subculture of violence," where the use of violence is either tolerated, permitted or encouraged. These researchers believe that violence is learned behavior that is culturally transmitted (Shamsie, 1985). Peer influence is also cited as a factor in the onset of delinquent behavior related to neighborhood role models. Research has shown that peer activities and having delinquent friends are associated with delinquent behavior (Hartstone & Hanson, 1984; Weis & Sederstrom, 1981).

Social Skills

In reviewing the literature on adolescent sex offenders and social adjustment, Davis and Leitenberg (in press) found that adolescent sex offenders have little skills in establishing and maintaining close friendships. A reason for this may be that sex offending youths lack assertive and social skills, which may cause them to fear rejection. A study by Fehrenback, Smith, Monastersky, and Deisher (1986) showed that 65% of adolescent sex offenders evidenced serious social isolation. No studies were found that compared adolescent sexual offenders with other adolescents on any battery of measures of social competence. Until such comparisons are made, differential judgments about social skills among adolescent sex offenders are problematic. However, the absolute level of maladjustment is still pertinent even without a comparison group.

Studies with adult offenders have reported mixed results in terms of social skills deficits. These studies could find little difference between adult sex offenders and other prison samples on roleplay assessments of interactions with female and male confederates. The sex offenders scored significantly lower than nonprison controls (Davis & Leitenberg, in press). Overholser and Beck (1986)

studied social skills in rapists, child molesters, nonsex offender prisoners, and two groups of nonprison controls. Overall, heterosocial skills deficits were found in child molesters and rapists in comparison to the control groups.

TREATMENT MODELS

In recent years, many specialized programs have been developed in order to assess and treat the adolescent sexual offender (Knopp, 1982). However, many different treatment modalities are being utilized with little systematic development and testing of approaches and outcomes (Knopp, 1986). For most of these programs, education is the predominant program mode. Group and individual therapy include roleplay, psychodrama, Gestalt therapy, transactional analysis, rational emotive therapy, guided interaction therapy, and family therapy. Some programs emphasize one type of therapy, and some combine treatment modes depending on the model used to assess the adolescent; several of these models will be discussed here.

We recently surveyed 5 adolescent sex offender treatment programs in the United States (the PHASE Program in Minnesota; the Sexual Offender Treatment Program at the University of Minnesota Medical School; the Sexual Offender Program at the Philadelphia Child Guidance Clinic; NEXUS Adolescent Program in Minnesota; and the Juvenile Sex Offender Program, Division of Adolescent Medicine, the University of Washington, Seattle, Washington.) All of these programs see the family as a major focus of treatment. However, to our knowledge, none of the programs has attempted to empirically demonstrate that the family is instrumental in the development or maintenance of deviant sexual interest patterns in adolescents. On a clinical level, the programs stress the need for family involvement in the treatment of the adolescent sexual offender since they postulate that family interactions and environments are contributory factors to the adolescent's sexually deviant behaviors.

Of the 300 juvenile adolescent treatment programs reviewed in a recent report (Knopp, 1986), 86% use group therapy as the core treatment approach, 90% include family therapy, and 52% use some form of behavioral treatment. Only 14% use individual therapy exclusively.

A COGNITIVE BEHAVIORAL ASSESSMENT MODEL

The following section will describe a cognitive-behavioral assessment model which we have used in treating adult offenders and recently modified for the assessment of adolescent sexual offenders.

Obtaining Consent

All adolescents seen at the Sexual Behavior Clinic are clients as well as research subjects. Since adolescents have the role of research subjects, it is imperative that the adolescent and parent(s) give consent for participation.

The majority of adolescents seen are referred by the criminal justice system. Data on the first 80 adolescents seen indicated that 33.8% were referred by Probation, 17.5% by the courts, 17.5% by the Division for Youth Services, 11.3% by Legal Aid Society, 2.5% by Parole, 1.3% by District Attorneys, and 16.3% by other sources such as doctors, Special Services for Children, families and counselors.

The legal status at the time of referral was as follows: 40% were on probation, 26.3% were presentence, 11.3% were in Division for Youth facilities, 6.3% were on parole, 3.8% were adjudicated contemplating dismissal (A.C.D.), 3.8% were PINS (Persons in Need of Supervision) Petitions, and 8.8% had not been officially charged but their crimes were known to the criminal justice system.

Although the majority of adolescents had been referred by the criminal justice system and had been adjudicated, they were not forthcoming in admitting their crimes. Of the first 80 adolescents seen, 26.3% admitted fully to committing the sexual crimes for which they were referred, 40% admitted to parts of the crime and denied others (e.g., level of aggression used, number of completions, etc.), and 32.8% totally denied any involvement in the sexual crimes for which they were referred. Some adolescents, because of embarrassment and fear of further reprisal, tended to minimize or deny the extent of their criminal activities.

Because evaluation and treatment records are subject to criminal subpoena, it is crucial that the adolescent be informed of all issues to undergoing an assessment, including benefits and risks.

If the adolescent and parent(s) are able to give informed consent, the consent form is read to the adolescent and his parent(s). They are then asked to read it again and sign it. An adult version of the form has been presented elsewhere (Becker & Abel, 1981). The consent form is divided into seven sections described below.

Section One provides a detailed description of what the assessment consists of and its potential risks (i.e., becoming anxious, depressed, nervous or angry). Section Two describes the potential impact that interviewing the parent(s) may have on the adolescent and an agreement between the adolescent and the therapist as to what will be shared with parents.

The benefits of the assessment to the adolescent are outlined in Section Three. The adolescent is informed that if he is uncomfortable with the psychophysiologic assessment, he may elect not to participate in erection measurement. The adolescent is informed in Section Four of the consent form that if he signs a release of information, that material regarding his evaluation can be accessed by members of the Criminal Justice System.

Since concern was expressed by hospital staff about possible risks involved in having offenders on the premises, a system was established regarding entrance and exit from the hospital. This is addressed in Section Five.

Section Six outlines the therapist's responsibilities, and Section Seven outlines what services will and will not be covered by the institution. The remainder of the consent form is for questions that the client may have and for the signatures

of the adolescent, parent(s), and therapist. Although the consent was designed for a clinical research project, we recommend one be used for evaluation of adolescents regardless of the setting.

Clinical Interview of the Adolescent

The interview time is approximately one and a half hours. The interview starts with nonthreatening questions such as family, school and demographic history which gives the clinician time to build rapport with the subject.

Because sexuality in general is a sensitive and personal subject, sexual topics are brought up slowly. Three questions are asked about the sexual offense indirectly in order to bring up the topic in a nonthreatening manner. Here are the questions:

Do you

1. Agree totally with the police report of these sexual acts?
2. Agree with most of the police report of these acts?
3. Agree with some of the police report of these acts?
4. Disagree with all of the police report about these sexual acts?
9. Does not apply to me.

Concerning the alleged sexual crime you were charged with:

1. The alleged victim initiated the involvement.
2. Involvement was by mutual consent.
3. I initiated the involvement, but the victim went along with it without resistance.
4. I initiated, and the victim resisted.
5. I initiated, the victim resisted, and I had to use force to commit the crime.
6. I was not present at the alleged crime.
9. None of these apply to me.

Concerning the alleged sexual crime you were charged with:

1. I was involved just the way it was described in court.
2. I was involved but wasn't responsible because I was under the influence of alcohol or drugs.
3. I was present at the scene but committed no sexual offense.
4. I was not present, but I knew the victim.
5. I was not present, and I did not know the victim.
9. Does not apply to me.

It is essential that the interviewer be comfortable with asking sexually explicit questions, and that they be asked in a casual manner. If an adolescent refuses to answer a question, we do not press him but instead go on to the next question and ask again later.

Following the questions about the offense, we take a history of sexual and physical abuse. Preliminary data from the Sexual Behavior Clinic indicates that 15% of the subjects reported being physically abused as children. All abusers were related to the subjects. Childhood sexual abuse was reported by 17.5% of the subjects. All but two of the cases were sexually abused by persons known to the subjects. These abuse rates are considerably lower than reported for adult sexual offenders. We believe this is due to several factors: (1) the information was obtained during an initial interview, when subjects were uncomfortable disclosing any type of information; (2) adolescents may be fearful of disclosing information on abuse because the abusers are known to them, and they may feel that there will be some consequences to the abuser if they are exposed (family members in particular); and (3) it may be more difficult for an adolescent than an adult to talk about his abuse because the abuse is more recent and therefore more emotionally disturbing.

The clinical interview then shifts to nondeviant sexual behavior with peers. Questions include ages of first nongenital and genital sexual experiences, number of sexual partners, Kinsey ratings of sexual orientation, frequency of masturbation, sexual fantasies, and effect of alcohol, drugs and pornography on sexual behavior.

The interview then moves to the area of deviant sexual behavior. The interviewer begins by surveying the frequency of many paraphilias including bestiality, coprophilia, exhibitionism, fetishism, frottage, odors, pedophilia, masturbation (public), rape, sadism, masochism, mooning, necrophilia, obscene phone calls, obscene letters, transsexual, transvestism, urolognia, and voyeurism.

The adolescent's paraphilias are listed and a chronological sexually deviant lifeline is constructed. For each paraphilia, the following information is obtained: (1) age of victim; (2) sex of victim; (3) relationship (known, stranger, relative); (4) if a relative, the precise relationship; (5) self-reported number of acts; (6) deviant behavior (specifically), (7) aggression used; (8) where crime occurred, (9) deviant fantasies; (10) age when deviant fantasies began; (11) current self-control (from 0–100 percent); (12) if subject masturbates to the deviant fantasy, (13) number of fantasies per week; and (14) whether subject denies or admits to the deviant behavior as described by the referral source.

It is important to ask about every possible paraphilia because our clinical experience indicates that if the adolescent is not asked about it specifically, he will not talk about it. If an adolescent denies committing the crime, we do not press him during the initial clinical interview. At the end of the evaluation, we talk about the referral report and things he may have "forgotten" to mention.

Clinical Interview of the Parent

The Parent Clinical Interview is a 100-item questionnaire developed by the investigators to (1) assess the parent's knowledge of their child's sexual interests (both consensual and deviant), (2) assess the parent's sexual interests and behaviors, (3) determine history of any prior physical or sexual abuse, (4) assess the parent's knowledge of their son's friends and social activities, (5) develop a structural family lifeline, and (6) determine demographic variables.

The parental interview should be administered separately to both parents if they are available. The parental interview follows closely the adolescent interview to facilitate detection of discrepancies. In addition, parents are asked in a nonthreatening manner about their son's offense. For example, they are asked questions such as "What is your son currently charged with?" or "Do you believe your son committed the offense?" or "Is your son in need of treatment for the offense?" The interviewer inquires about physical and sexual abuse of the parent as well as the adolescent.

Parents are asked to indicate the degree to which they agree or disagree with the following statements (1 = strongly agree, 3 = neutral, 5 = strongly disagree):

- Any sexual contact between an adolescent over 13 years of age and a child is sexual abuse even is the child is willing.
- Any sexual contact involving incest is sexual abuse even if the child is willing.
- Any sexual contact between an adult and a child is sexual abuse even if the child is willing.

The parental interview is more open-ended than the adolescent interview and usually takes a minimum of two hours to complete. The parents are given an opportunity to talk about why their son may have committed a sexual offense, and to give explanations if their knowledge is inconsistent with the referral report. Often parents are distressed and anxious, and need to be reassured.

At times, parents may continue to minimize or deny the problem. It is critical that the parents see the deviant sexual behavior as problematic and be supportive of their son receiving treatment, otherwise denial and minimization on the part of the parents only serves to reinforce the problem.

Self-Report Measures

The assessment instruments selected to evaluate the adolescents target behavioral deficits, excesses and assets. Many of the instruments we use with adolescents are modifications of the instruments that were developed for an adult sex offender population.

The Adolescent Sexual Interest Cardsort (ASIC) is a 64-item self-report mea-

sure of sexual interest developed by staff at the Sexual Behavior Clinic to determine the presence of deviant sexual interests. Very often patients have difficulty being honest and disclosing their deviant sexual interest patterns in a face-to-face interview. A cardsort gives the patient the opportunity to indicate deviant sexual interest patterns without having to verbally disclose them to the interviewer. The cardsort that we developed is based on a revision by one developed by Abel (1979). The ASIC consists of a series of sexual vignettes that the adolescent rates on a 3-point scale indicating whether he is aroused by the thought of engaging in that behavior. Examples of items on the cardsort are as follows: "My penis is moving in and out of a 5-year-old girl's mouth. It feels very good." An example of a forced sexual act with a peer with be: "I am holding a 12-year-old down. She is helpless as I rub my penis between her legs." Test-retest reliability was shown to be poor, but we believe this is related to the fact that, ethically, we are required to give feedback following the initial assessment regarding the inappropriateness of certain sexual acts. Consequently, that feedback appears to be reactive.

The Adolescent Cognition Scale (ACS) is a 32-item true-false test developed by the staff at the Sexual Behavior Clinic to determine if the subject has any distorted cognitions regarding sexual behaviors. Test-retest reliability on the first 11 subjects who completed the revised version of the Cognition Scale showed high test-retest reliability (Chi-Square = 49.8, $p < .001$). The ACS is a modification of a scale devised by Abel and Becker (1984). Our research with adult and adolescent offenders has pointed to belief systems that support engagement in deviant sexual activity. An example of some statements that the adolescents are asked to rate are as follows: "If a young child does not tell others about having sex with me, it means they really like it and want to keep doing it." An example of a distorted cognition regarding rape would be: "Some people are shy about asking for sex so they really want you to force them." Distorted belief systems about forcing rape on peers are very common in a group of adolescent sexual offenders that we have seen to date.

To assess the adolescent's sexual knowledge, we administer the Math Tech Sex Test (Kirby, 1984), which is divided into two parts: (1) sexual knowledge and (2) attitudes and values. For the adolescent, it contains 34 knowledge questions and 70 values and attitudes questions. One score is obtained for the knowledge section, and 14 scores are determined for the values and attitudes section. Norms are available for this instrument on a variety of populations including inner city youth.

Even though adolescents are provided sex education in the school system, they are still grossly misinformed about human sexuality. The adolescents that we have seen are a very sexually active group and are also unable to communicate their feelings about sexuality effectively with consenting peer partners. For the most part, they feel that it is the female's responsibility to insure that birth control methods are being used. Also, for the most part, they fail to consider that

their partners may have venereal diseases or that they may transmit such diseases. Consequently, it is important to assess the adolescents' knowledge and attitudes regarding sexuality.

It is not infrequent that adolescents will socialize and then sexualize their relationships with younger children because of deficits in the requisite skills to relate to peers. In order to assess social skills, we administer the Matson Evaluation of Social Skills in Youngsters (MESSY) (Matson, Esveldt-Dawson, & Kazdin, 1983), which is an evaluation instrument designed to assess the social and assertive skills of adolescents. The MESSY is a 62-item self-report measure that assesses five factors: (1) appropriate social skills, (2) inappropriate assertiveness, (3) impulsive-recalceitrant traits, (4) overconfidence, and (5) jealousy withdrawal.

Psychophysiologic Assessment of Sexual Interest Patterns

The direct assessment of sexual arousal in the male via erection measurement appears to be the most reliable index of sexual arousal (Abel & Blanchard, 1976; Barlow, 1977; Zuckerman, 1971). For further reading on the current state of technology of sexual arousal patterns, the reader is referred to Earls and Marshall (1983). A detailed description of how to build and operate a behavioral laboratory to evaluate and treat sexual deviance has been described by Laws and Osbourne (1983).

Physiologic assessment of sexual arousal is conducted to objectively evaluate the sexual interest patterns of the adolescent sex offenders. The psychophysiologic assessment is conducted in the laboratory at the Sexual Behavior Clinic. Penile tumescence is measured by means of a mercury in rubber strain gauge (D. N. Davis Incorporated). This device reflects changes in penile circumference as a linear function of resistance changes in a mercury column contained in the silicon rubber tubing. The output of this device is amplified and recorded on a Grass 78 Polygraph. The laboratory also contains a computer that provides a printout of each laboratory assessment. Communication between the client and technician is facilitated via an intercom. The client sits in a sound attenuated room approximately 10 feet by 10 feet. He places the strain gauge midway down the penile shaft to record tumescence. He then places a pair of light weight headphones on his head in order to hear the audiotaped stimuli. The stimuli consists of 19 audiotaped passages each lasting 2 minutes recorded by an adult male.

The tapes, narrated in the second person, consist of descriptions of sexual activity with a variety of targets. Each passage describes the age of the target, sex of target, and an interaction scene. Two of the tapes describe a nonsexual social interaction among a group of adolescents (neutral).

To insure cooperation from the client, the laboratory technician provides a clear rationale and concrete instructions. When the adolescent is brought into the

Table 1. Stimulus Characteristics of Audiotaped Passages for Assessment of Adolescent Sexual Arousal

Passage #	Victim		Degree of Coercion	Behavior
	Gender	Age		
1	F	<8	Verbal	Penetration
2	F	9–12	Consensual	Penetration
3	F	9–12	Physical	Penetration
4	F	13–18	Consensual	Penetration
5	F	13–18	Physical	Penetration
6	F (Incest)	<8–18	Verbal	Penetration
7	F	>18	Physical	Penetration
8	M	<8	Verbal	Penetration
9	M	9–12	Consensual	Penetration
10	M	9–12	Physical	Penetration
11	M	13–18	Consensual	Penetration
12	M	13–18	Physical	Penetration
13	M (Incest)	<8–18	Verbal	Penetration
14	F	Peer	Physical	Assault/No Sex
15	M	Peer	Physical	Assault/No Sex
16	F	>18	N/A	Voyeur
17	F	>18	N/A	Frottage
18	F	>18	N/A	Exhibition
19	Social Group			Neutral/No Sex

Note. These tapes describe a sexual encounter in the second person with or without force. Settings include baby-sitting and being at home. Penetration is generically described with no references to specific acts

laboratory, the technician explains that the purpose of the procedure is "to find out the different kinds of things that you are sexually interested in." In explaining the strain gauge, the technician says:

> You will be wearing this gauge during the laboratory run. The gauge is made out of rubber with mercury inside, just like on a thermometer. You will be putting the gauge around your penis in private. I will not be watching you. (The technician then demonstrates by placing the gauge around his finger.) "As you know, when you get sexually excited or aroused, your penis gets bigger. When it gets bigger, the gauge will stretch (the technician then shows the client that when the gauge is stretched, the pen on the polygraph is deflected upwards). After the lab run, I will show you what you got aroused to. I will be talking to you through this intercom (the technician then leads the client back into the sound attenuated room). You will be sitting here. After I leave the room, you pull your pants and your underwear down to about your knees and sit down on the chair and put the headphones on. You will be listening to tapes that talk about sexual activity. There will be 19 tapes, each 2 minutes long. The tapes will describe sexual activity with all kinds of people—men, boys, and girls. You may like some of

the tapes, and you may not like some of the tapes. I will be asking you if you like them, if you feel sexually interested in them in your mind, and if you got an erection while listening to them. The door to your room is never locked. I will be sitting right outside, and I will be talking to you during the run. If you want to take a rest or go to the bathroom, just let me know, or if you have any questions.

A dim light is left on in the testing room during the evaluation because some of the clients are afraid of the dark. Once the adolescent puts on the strain gauge, a steady baseline level is established for 3 minutes before the first passage is presented. The client is instructed to pretend that he is in the described scene and to imagine that he is doing what the man is saying on the tape.

If the client gets an erection response to any tapes, that response must return to no higher than 10% of the baseline before the next tape is presented. The entire procedure usually takes between 45 and 70 minutes. Following the last passage, the client is instructed to masturbate to a full erection in the laboratory with the gauge still on. This full erection measurement is used to compute percentage of erection response for each stimulus passage.

Following each laboratory session, the gauge is sterilized in Cidex 7 Solution. Every effort is made to discourage the client from faking erection responses or otherwise manipulating his response in the lab. During the procedure, the technician spot checks the client by asking him to describe what he heard on the tape. If the client takes the gauge off, puts it on his thumb and moves it in any way with his finger, this can be detected very easily on the polygraph by the technician.

The following cases illustrate the use of psychophysiological data for 2 adolescent sex offenders that we saw at the clinic. Case One: Bob is a 16-year-old male who was arrested for molesting a 6-year-old female while he was baby-sitting. The victim indicated that Bob did not penetrate her. Physical examination indicated that her hymen was intact. However, the medical report indicated that both Bob and the victim had gonorrhea. The victim indicated that Bob had verbally coerced her into allowing him to rub his penis against her vagina. Bob showed mild feminine gender motor behavior during the clinical interview. His self-reported Kinsey score was zero, reflecting that his sexual fantasies were of peer aged females, and that he was interested only in sexual behavior with peer aged females.

The psychophysiologic assessment indicated that Bob achieved the greatest degree of erection response (72%) to the passage describing forced sex with females aged 9 to 12. He also achieved a 72% erection response to the incest cue, a 6% response to female children younger than 8 years of age, and 67% for consensual sex with a girl age 9 to 12. Bob's erection response to the neutral cue was 11% indicating that his arousal was specific to the sexual cues. It is interesting to note that Bob achieved only 33% of an erection response to a cue of consensual sex with females around his own age (13 to 18 years old), which he had reported was his only interest. He achieved only minimum erection response

to all of the male pedophile cues and pure assault cues. Surprisingly, Bob generated 56% of an erection response to engaging in consensual sex with a male peer, despite denying sexual interest in males his own age.

Case Two: Sam is an 18-year-old adolescent who molested his brother from the time he was about 4 years of age until he was 12. Sam forced sex on his brother a total of 230 times, and used verbal coercion to complete anal penetration. He also indicated that when he was 14, he annally penetrated his 6-year-old sister on 8 different occasions. At age 18, Sam molested a 13-year-old male, and then he physically coerced the victim into masturbating him. Sam reported that when he was 10 and a resident of a children's shelter, he was molested by a 15-year-old boy.

Sam's Kinsey self-rating was four, indicating that he is bisexual leading towards homosexuality. The laboratory assessment was valid, given that Sam obtained no erection response to the neutral cue and clear sexual arousal to forcing male and female children younger than 12 years of age into engaging in sexual behaviors with him. His greatest erection was 100% of a full erection for forcing children younger than 8 years of age. His next highest response (84%) was to forcing female children 9 to 12 years of age into sexual activity. His third highest response (74%) was to forcing male children 9 to 12 years of age into being sexual with him. His arousal to consensual sex with male peers and female peers was 20%.

Both adolescents showed a higher erection response to the deviant cues than to the nondeviant cues. This is reflective of the presence of a deviant sexual interest pattern and the need for treatment to reduce that interest pattern.

Treatment Plan

Designing an individual treatment plan for the adolescent sexual offender is based on his assessed deficits, excesses and assets. A multi-component treatment is utilized at the Sexual Behavior Clinic. A first step is to impress upon the parent(s) the seriousness of their son's behavior and to seek their cooperation in motivating their child to attend therapy sessions.

The clinical interview, psychophysiologic assessment, as well as the Sexual Interest Card Sort inform us which sexual behaviors the adolescent is aroused to. Two behavioral techniques are utilized to teach the adolescent control over his deviant sexual interest pattern(s), covert sensitization and satiation.

Those adolescents who have inappropriate beliefs as measured by The Cognition Scale are in need of cognitive restructuring to alter their inappropriate beliefs. Deficits in sexual knowledge and/or inappropriate sexual values as measured by The Math Tech Sex Test are treated in the Sex Education-Sex Values clarification component of therapy.

Social skills' deficits as measured by the MESSY and self-reported or parent reported difficulty in handling anger are treated by Social Skills and Anger

Control Therapy. For those adolescents who have substance abuse problems, it is recommended that they participate in substance abuse treatment programs while they continue in our program.

Family and or marital therapy is recommended for those parents where dysfunctions exist. Although the focus of our own program is the adolescent, we do address the "family" and make referrals for treatment when marital or family problems exist.

CONCLUSION

Although a body of scientific data has been amassed in the evaluation and treatment of adult sexual offenders, the assessment of adolescent sexual offenders is in the early stages. Lacking in the studies reported to date have been matched comparison groups. Future research should focus on whether adolescent sexual offenders differ from "normal" adolescents on a host of variables including individual, social, environmental and family variables. Such data could allow us to speak to etiology and then prevention.

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