

Psychiatric Diagnoses in Adolescent Sex Offenders

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Abstract. Crime statistics indicate that a high percentage of rapes and child molestations are committed by sexual perpetrators under the age of 18. To determine the psychiatric characteristics of this population, 58 outpatient male adolescent sex offenders were interviewed with structured instruments. Conduct Disorder was the most common diagnosis, while rates of other disorders were much lower than in earlier studies. Implications of these findings for future research in the evaluation and treatment of adolescent sex offenders are discussed. *J. Am. Acad. Child Adolesc. Psychiatry*, 1988, 27, 2:241-243. **Key Words:** adolescents, Conduct Disorder, sex offenders.

Crime statistics indicate that as many as 30% of rapes and 56% of child molestations are committed by sexual perpetrators under the age of 18 (Fehrenbach et al., 1986). In addition, a majority of adult sex offenders indicate that the onset of their deviant sexual arousal and behavior occurred before the age of 18 (Abel et al., 1985). Yet, little is known about the characteristics of this population, and there have been few studies of psychopathology in this group. Available studies suggest that there is a high prevalence of neuropsychiatric disorder in juvenile sex offenders. Lewis et al. (1979) studied 17 male adolescents incarcerated in a secure unit because of violent sexual assaults. They compared these boys to 61 boys incarcerated for violent nonsexual acts and found that both groups had a high prevalence of psychiatric symptoms, depression, auditory hallucinations, paranoia, and thought disorder, and that the sexual assaulters had a prior history of violent nonsexual behavior. Using the Schedule for Affective Disorders and Schizophrenia (SADS) (Spitzer and Endicott, 1978) McManus et al. (1984) studied 40 incarcerated, serious delinquent males, six of whom had committed sexual assaults. They found high prevalences of psychiatric disorders in the whole sample—especially Conduct Disorder, substance abuse and alcoholism, affective disorders, and Personality Disorders (particularly borderline). All 40 of the boys in McManus et al.'s sample had multiple diagnoses.

Packard and Rosner (1985) retrospectively reviewed psychiatric diagnoses in the records of 95 outpatient adult sex offenders attending a forensic clinic. They found 18% to be psychotic, 2% to have affective illness, 43% to have Personality Disorders (of note is that few of the sample were borderline), and 4.2% to be substance abusers.

It is important to note that the above studies of adolescent sex offenders were conducted on incarcerated juvenile offenders. A large percentage of boys who engage in sexually inappropriate behavior are not confined or are confined only for brief periods. Although these adolescents are often referred for outpatient treatment, to the authors' knowledge, there have been no studies of psychopathology in this group.

In addition, there has been little attempt to determine

whether different types of offenders (e.g., rapists vs. child molesters, incarcerated vs. nonincarcerated) have different degrees of psychiatric illness.

This paper describes a study of psychiatric diagnoses in a population of outpatient male adolescent sex offenders. Whether adolescents who had raped, or attempted to rape, adults differed from those involved with other sexually inappropriate behavior in terms of prevalence of psychiatric disorders was also examined. It was hypothesized that rapists would show more evidence of psychopathology and disordered impulse control in comparison with nonrapists.

Method

The subjects were 58 male adolescents, aged 13 to 18, referred to an outpatient evaluation and treatment program, from either the criminal justice system or social service agencies. All had admitted to or had been found guilty of a sexual crime that had been reported to the authorities.

Informed consent was obtained from each adolescent and his legal guardian. All subjects were first interviewed about their sexual behavior by one of the investigators (M. K. or J. B.). A different investigator (R. K.) then interviewed each boy using two semistructured interviews. The SCID (Structured Clinical Interview for DSM-III) (Spitzer and Williams, 1984) was used to probe for diagnoses of affective disorders, psychotic disorders, Anxiety Disorders, and substance abuse. The Kiddie SADS-E (Children's Schedule for Affective Disorders and Schizophrenia—epidemiologic version) (Puig-Antich and Chambers, 1978) was used to probe for diagnoses of Conduct Disorder and Attention Deficit Disorder. Evidence for the reliability and validity of these instruments has been reported elsewhere (Hodges et al., 1987; Riskind et al., 1987). All diagnoses were made by R. K., who was blind to the actual problematic sexual behavior in which each boy had engaged. Diagnoses were made according to DSM-III criteria based on information obtained from the interviews as well as information obtained from the subjects' families and referral source. 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.

Results

The mean age of the 58 subjects was 15.3 years, ranging from 13 to 18. Eleven percent of the subjects were Caucasian, 61% were black, and 28% were Hispanic. At the time of the interviews, 43% were on probation, 25% were awaiting sentencing, 5% were on parole, 12% were living in the Division for Youth facilities, and 15% were either on PINS (persons in need of supervision) petitions or had been reported to the Bureau of Child Welfare.

Accepted November 25, 1987.

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This research was supported in part by New York State Division of Criminal Justice Services, grant No. 3102.

This paper was presented in part at the American Psychiatric Association Annual Meeting, Chicago, Illinois, May 14, 1987.

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0890-8567/88/2702-0241\$02.00/0© 1988 by the American Academy of Child and Adolescent Psychiatry.

Twenty-three of the 58 subjects had been sexually involved with young girls (under age 11); 10 of these boys had been involved with female relatives, usually sisters or cousins. Fourteen of the 58 subjects had been involved with young boys under age 11; of these, three were cases of incest. Sixteen of the subjects had raped or attempted to rape adult women. There were five boys who had other types of inappropriate sexual behavior (e.g., frotteurism and voyeurism).

Fifty-two of the subjects had no prior arrests for sexual crimes. Five had been arrested once before, and one had two previous arrests for sexual crimes. Forty-four subjects had no prior arrests for any nonsexual crime. Eight had one previous arrest, three had two prior arrests, and one subject had been arrested five times for nonsexual crimes. These crimes included burglary, robbery, petty theft, trespassing, and drug charges.

Table 1 shows the frequency of full psychiatric syndromes (i.e., meeting all DSM-III criteria) in the 58 subjects. By far, the most common diagnosis in the group was Conduct Disorder (48%). The majority of boys with Conduct Disorder 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, Dysthymia, or Psychotic Disorder. Nineteen percent of the adolescents had no DSM-III diagnosis.

Because it may be argued that many more of these boys had severe psychopathology that did not meet full criteria for a psychiatric disorder, the frequency of the presence of any criteria for the psychiatric syndromes was examined (Table 2). One subject reported auditory hallucinations. The prevalence of major depressive and dysthymic symptoms was low; however, 20% of the boys had some symptoms of Adjustment Disorder with depressed mood (usually as a result of being arrested).

Also investigated was the prevalence of Conduct Disorder in offenders who had raped adult women as opposed to those who had been involved in other sexually-deviant behavior (Table 3). A significantly higher percentage of adolescents who had raped or attempted rape of adult women (75%) fit the criteria for Conduct Disorder; only 38% of the other boys in the sample met criteria for Conduct Disorder.

Discussion

Previous studies have demonstrated high degrees of psychopathology in incarcerated adolescent sex offenders. Although

TABLE 1. No. of Adolescents Who Met Full DSM-III Criteria for Diagnosis

Diagnosis	N	%
Conduct Disorder	28	48.3
Socialized	23	
Nonaggressive	18	
Marijuana abuse	6	10.3
Alcohol abuse	5	8.6
Adjustment Disorder/depressed mood	5	8.6
Attention Deficit Disorder	4	6.9
Social phobia	3	5.2
No diagnosis	11	19.0

TABLE 2. No. of Adolescents Who Met Any DSM-III Criteria for Diagnosis

Diagnosis	N	%
Conduct Disorder	39	67.2
Attention Deficit Disorder	20	34.5
Adjustment Disorder/depressed mood	12	20.7
Marijuana abuse	9	15.5
Alcohol abuse	7	12.1
Social phobia	6	10.3
Dysthymia	5	8.6
Obsessive compulsive	4	6.9
Major Depression	3	5.2
Panic Disorder	2	3.4
Cocaine abuse	1	1.7
Hallucinogen abuse	1	1.7
Schizophreniform	1	1.7

TABLE 3. Conduct Disorder in Juvenile Rapists and Nonrapists

	Conduct Disorder	No Conduct Disorder	Total
Rapist	12 (75%)	4 (25%)	16
Nonrapist Sex Offender	16 (38%)	26 (62%)	42
Total*	28	30	58

* $\chi^2 = 4.93, p < 0.05$.

psychopathology was present in this sample, the prevalence of psychiatric disorders was much lower than that described in earlier studies. It is important to note that the adolescents in those studies were inpatients, had committed violent sexual assaults, and had a history of recurrent violent behavior in nonsexual areas. In contrast, all of the adolescents in this sample were deemed fit to be treated as outpatients by the courts or were allowed to be free on bail pending sentence. The vast majority had no prior arrests for any crimes, sexual or nonsexual. These findings serve to emphasize that adolescent sex offenders are a heterogeneous group and that it is not always possible to extend the findings in one subset of this population to all juvenile sex offenders.

One reason for the lack of more severe psychopathology (e.g., psychotic disorders, Major Affective Disorder) in our sample may be that adolescent offenders with more serious psychiatric problems are not referred for the type of outpatient assessment and treatment offered in our program but rather are placed in hospital or residential settings. Again, this suggests that it is important to define the specific population of adolescent offenders in any investigation of characteristics and when setting up programs for evaluation and treatment.

It may be argued that the subjects in this study minimized revealing psychopathology or more serious drug use because they were outpatients and did not want to jeopardize their status. However, all sources of information available were used in making diagnoses—parents, court records, prior psychiatric or psychological evaluations, and probation or parole officers. In addition, 60% of the adolescents had already been sentenced and mandated to receive treatment in the study site clinic, giving them little reason to hide psychiatric problems. In fact, boys were occasionally encountered who admitted

that they had made up or magnified psychiatric problems to previous interviewers in order to gain sympathy.

It is important to note that, in this study, personality diagnoses were not made, because of limitations of the diagnostic instruments used. In order to evaluate the role of personality in adolescent sex offenders, future studies should address this issue using structured, valid, and reliable measurements of personality traits in adolescents.

This study did not have a comparison group in which to study psychiatric diagnoses. Most of the sample subjects were inner city minority boys. This probably reflects our referral sources rather than a characteristic of the population. Future studies of this population should include control groups of watched normal adolescents from the inner city and nonsexual juvenile offenders.

The high incidence of Conduct Disorder in this sample (48%) suggests that many sex offenses committed by adolescents are part of a pattern of poor impulse control and antisocial behaviors. This seems particularly true in the case of the rapists in our sample, three quarters of whom had full Conduct Disorder. The fact that nonrapists had a much lower incidence of Conduct Disorder suggests that, for many of these boys, there may be other factors that led them to engage in inappropriate sexual behavior. For example, although only four of the subjects met full criteria for Attention Deficit Disorder, it is important to note that 34.5% of the adolescents had some evidence of the syndrome.

Recent studies have suggested that deviant sexual behavior among adolescents is not experimental in nature and can lead to a pattern of repeated sexual offenses (Becker et al., 1987). It is therefore important to intercede at an early point to prevent recidivism. Various treatment programs have been suggested for use with adolescent sex offenders: family therapy, especially for incest offenders (Giarretto et al., 1978); group therapy and individual psychotherapy (Knopp, 1986); behavior therapy (Becker et al., in press). This study stresses the heterogeneous nature of the adolescent sex offender group and suggests that no single treatment regimen will be effective in all cases, e.g., adolescent offenders who have evidence of psychosis or affective disorders should be specifically treated for those disorders (with antipsychotics, lithium, antidepressants, etc.) as clinically indicated and then reevaluated for sexual acting-out potential. Similarly, those boys with evidence of general impulse control problems (e.g., Conduct Disorder or ADD) may preferentially respond to treatments aimed at reducing their impulsivity (e.g., social skills training, anger management training, stimulants, lithium, etc.). Those

boys with no evidence of DSM-III psychopathology may have psychodynamic, behavioral, and/or family systems factors underlying their sexual acting-out and thus require specific interventions in each of these areas.

In order to help these boys develop control over their sexual behavior and prevent future sexual victimization, we must develop treatments tailored to the needs of the individual offender. Future studies will need to compare subgroups of adolescent sex offenders with respect to long-term recidivism in response to specific treatment interventions.

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