Young Boys Who Commit Serious Sexual Offenses: Demographics, Psychometrics, and Phenomenology

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This study reports on a population of early adolescent male sexual offenders 9 to 14 years of age compared with a clinic control group matched for age, sex, ethnic status, and the presence of a DSM-III-R conduct disorder. The sex offenders were found to exhibit a significant history of nonsexual antisocial behavior, physical and sexual abuse, and psychiatric comorbidity. The two groups did not differ in number and category of comorbid psychiatric diagnoses, the number of nonsexual aggressive and nonaggressive symptoms of conduct disorder, symptoms of major depressive disorder or dysthymia, and symptoms of anxiety disorders. The EGTC group demonstrated significantly lower mathematic achievement. There is evidence that sexual offending behavior in this population is one aspect of a pattern of antisocial behavior. Sixty-five percent of the index group had a history of early sexual victimization.

Sexual offending behavior is not a rare happening in the male adolescent population. A survey of a national probability sample of 863 male adolescents 13 to 19 years of age indicated that the rate of sexual assault per 100,000 adolescent males ranged from 5,000 to 16,000.[1] Studies of adult sex offenders suggest that the majority have the onset of sexual offending behavior before 18 years of age.[2,3]

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Twenty percent of all rapes and 30 to 50 percent of child molestations are carried out by adolescents.[4] A survey of 305 adolescent sex offenders revealed that 42.3 percent of the offenders were under 15 years of age,[5] and the majority of adolescent sex offenders commit their first sexual offense before 15 years of age.[5,6]

The adolescent sexual offending population is a heterogenous group. One of the most important findings to have emerged in psychiatry and child/adolescent psychiatry in recent years is the discovery that psychiatric comorbidity is more often the rule than the exception.

Deviant sexual behavior is often associated with a matrix of behavioral, emotional, and developmental problems. Several authors have examined adolescent sexual offenders in an effort to explicate the spectrum of psychopathology.[7-9] The findings are understandably affected by choice of sample selection, i.e., inpatient/outpatient, severity of offending behavior, and assessment and evaluative approaches.

Lewis *et al.*[7] found little differences between violent sexual offenders and violent nonsexual delinquents on measures such as depressive and paranoid symptoms, hallucinations, illogical thought processes, history of violent nonsexual behavior, major and minor neurological abnormalities. Becker[8] has suggested that the spectrum of adolescent sex offenders includes true paraphiliacs and those whose impulse control is compromised by concurrent conduct disorder and other psychiatric diagnoses and those whose impaired social and interpersonal skills result in their turning to younger children for sexual gratification unavailable from their peer groups. More recently, a study of an outpatient population of 58 male adolescent sex offenders 13 to 18 years of age was the first report using standardized structured psychiatric interviews.[9] Eighty-one percent were reported to have a psychiatric diagnosis using DSM-III criteria. Forty-eight percent met criteria for conduct disorder, 18.9 percent for substance abuse, 8.6 percent for adjustment disorder with depressed mood (ADDM), 6.9 percent attention deficit disorder (ADD), and 5.2 percent for social phobia. None of the subjects were reported to meet full criteria for mood disorders.

Not surprisingly then, these studies suggest that a substantial proportion of young boys who commit sexual offenses exhibit psychiatric disorders, particularly conduct disorder. It is important, therefore, that the nature of the association between adolescent sexual offending and psychiatric disorder be explicated fully to clarify the role to be played by child and adolescent psychiatry in dealing with this important social problem. This paper will report on a study of the phenomenology and psychiatric diagnoses of a population of early adolescent male sexual offenders who have been admitted to a residential treatment center for long-term treatment.

Method

Subjects Subjects were the first 26 boys, 9 to 14 years of age, admitted to the Elaine Gordon Treatment Center (EGTC) since its reopening on November 19, 1990, at the South Florida State Hospital under the direction of the Division of Child and Adolescent Psychiatry of the University of Miami School of Medicine. The majority of the boys (17) were admitted for at least one felony sex offense, while the others were referred from state social service agencies. It is important to note these 26 youths do not represent the total number of cases referred to EGTC or a random sample of youths referred for sex offenses. Rather, youths were accepted by EGTC on the basis of admission of sexual offense, IQ > 70, the absence of psychosis,

and evident neurological substrate disability.

A matched comparison group was drawn from the DSM-IV Field Trials for the Disruptive Behavior Disorders.[10] The field trials sample was drawn from a variety of psychiatric, psychological, and pediatric clinics, and from one correctional facility in cities across the United States. The boys in the comparison group were chosen to be comparable to the EGTC youths, who were in a psychiatric facility, but who had been remanded because of their criminal behavior. The comparison group was selected from the Field Trials sample without knowledge of any dependent variable. They were the 26 subjects who exactly matched the EGTC group in terms of sex and the presence of a diagnosis of DSM-III-R conduct disorder (CD), and who matched the EGTC group as closely as possible on age and ethnic status. However, boys were excluded from the comparison group if either informant reported that they had forced someone into sexual activity. The 26 boys who were selected for the comparison group in this way had been referred to child psychiatry outpatient clinics (n = 9), a child psychology outpatient clinic (n = 1), child psychiatry inpatient clinics (n = 8), or to a juvenile detention center (n = 8). As shown in Table 1, the boys in both groups ranged in age from 9 to 15 years, with mean ages of approximately 13 years. The groups were also very similar in ethnic composition, with the slight differences between the two groups in age and ethnic composition not approaching statistical significance. When compared with the psychiatric comparison group that was matched on sex, ethnic status, age, and diagnosis of CD, the groups did not differ in intelligence or reading achievement, but the groups differed statistically in mathematics achievement.

Table 1
Demographic Characteristics of Adolescents Remanded to EGTC for Sex Offenses to Matched Psychiatric Controls

	EGTC (N = 26)	Comparison Group (N = 26)
Mean age in years	13.1	12.6
Ethnic composition		
Anglo-Caucasian	13 (50%)	17 (65%)
Hispanic	1 (4%)	1 (4%)
African-American	12 (46%)	8 (31%)
WISC-R Intelligence	91.3	96.9
WRAT-R Reading	87.5	89.0
WRAT-R Math*	76.4	89.1

* Significantly different, $t(40.0) = 2.44$, $p < .02$.

Each boy on admission was interviewed regarding his sexual offending behavior, medical, criminal, sexual, and psychosocial history. Each youth and a knowledgeable adult informant were interviewed separately using the DSM-IV Field Trials version of the NIMH Diagnostic Interview Schedule for Children (DISC-2).[11] This version of the DISC-2 provides standard queries of all DSM-III-R, ICD-10, and Draft DSM-IV criteria for a range of disorders. The DISC-2 allows diagnoses of conduct disorder, attention-deficit hyperactivity disorder, oppositional defiant disorder, overanxious disorder, separation anxiety disorder, avoidant disorder, simple phobia, social phobia, agoraphobia, generalized anxiety disorder, panic disorder, posttraumatic stress disorder, major depres-

sive disorder, dysthymia, and manic episodes. Algorithm-based diagnoses from the DISC-2 have been shown to exhibit acceptable test-retest reliability and to agree substantially with clinical diagnoses for the disruptive behavior disorders, anxiety disorders, and depression in a clinic-referred sample.[12]

In eight of the EGTC cases and all of the 26 comparison cases, a biological or foster parent of the youth completed the parent DISC-2. For the remaining 18 EGTC cases, parents could not be interviewed either because they were not available or because the youth had been in detention or inpatient treatment for more than six months prior to admission to EGTC. In these cases, interviews of the youth's primary case worker using the parent DISC-2 were conducted after the youth had been a resident of EGTC for at least six months. However, because of the lack of reliable information in these cases about the age of onset of attention-deficit hyperactivity disorder, the diagnoses of ADHD were omitted.

Following Leaf *et al.*,[12] information from the parent and child versions of the DISC-2 was combined for the purpose of making computer-generated cross-informant diagnoses. Symptoms and other diagnostic criteria were considered to be present if all requirements were met (duration, frequency, age of onset, etc.) as reported by either informant. However, because actual parent informants were not available for most of the EGTC boys, we also made comparisons using reports of symptoms from the child DISC-2 separately.

Psychometric Measures All boys at EGTC were administered the Wechsler Intelligence Scale for Children, Revised (WISC-R) and the Revised Wide Range Achievement Test (WRAT-R). The WISC-R was also administered to 19 of the 26 comparison group and the WRAT-R was administered to 16 of the comparison youths.

Results

Primary sex offenses committed by the EGTC group leading to placement were rape (10), anal sodomy (9), and history of fondling, fellatio, and cunnilingus (6). It is significant that considerable coercion and force was a characteristic feature of the sex offending behavior: 54 percent (14) physical force, 35 percent (9) physical threats, 73 percent (19) Bribery/manipulation, and 4 percent (2) used weapons.

In a manner comparable to adult sex offenders, the boys demonstrated a proclivity to commit diverse and multiple sex offenses, rarely demonstrating a specific pathway of sexual gratification. The number of sexual offenses committed ranged from 1 to 40 per child with the average number of offenses committed per child was 9.0 (Table 2). The average age of the first sexual offense was 9.3 years. The children victimized ranged in age from 6 months to 15 years with a mean age 7.3 years, median age 7.

Prior nonsexual criminal behavior was noted in 17 (65.4 percent) of the EGTC youths. There was a considerable range of criminal behavior with marked individual differences in the frequency and diversity of committed offenses (Table 3). Twenty of the EGTC boys

Table 2
Sexual Offenses

Type of Offense	Number of Offenders	Number of Offenses	Number per Resident
Rape	14	24	1.7
Active fellatio	6	26	4.3
Receptive fellatio	11	32	2.9
Sodomy (anal intercourse)	11	72	7.0
Cunnilingus	4	4	1.0
Fondling	16	41	2.6
Stealing Underwear	2	2	1.0
Frottage	10	15	1.5
Exposure	11	19	1.7
Total	26	233	9.0

N = 25; boys 9–14 years; mean 12.6 years.

Table 3
Nonsexual Offenses

	Documented		Self-Report
	Residents	Offenses	Residents
Assault and battery	5	5	9
Criminal mischief	1	1	2
Theft (retail)	3	4	9
Larceny	2	2	0
Burglary	3	7	1
Auto	2	2	5
Petty theft	2	2	5
Loitering and prowling	1	1	7
Breaking and entering	1	1	2
Strong armed robbery	2	2	3
Cruelty to animals	1	1	0
Total	9	28	17

reported a history of physical abuse, 17 a history of sexual abuse, with 14 being the victims of sexual and physical abuse. The 17 who had been the victims of sexual abuse reported the average age of the initial victimization to be 5.7 years, median age 5 (range 3 to 14 years). Fourteen were victimized by males and three by females.

As shown in Table 4, 21 of the 26 young sexual offenders met criteria for DSM-III-R CD. In addition, two other youths exhibited two symptoms of CD and fell just below threshold for a third symptom of CD in each case. Thus, it is clear that sexual offending, which is a symptom of CD in DSM-III-R, is closely linked to the diagnosis of CD. The young sexual offenders also exhibited substantial frequencies of other psychiatric disorders: an anxiety disorder was present in (13) 50 percent, major depression or dysthymia (9) 35 percent, and post-traumatic stress disorder (3) 12 percent.

The groups did not differ in the proportion of youths with an anxiety disorder, a depressive disorder, or with any specific anxiety or depressive diagnosis

Table 4
Comparison of EGTC Boys with CD to Matched Comparison Group on DSM-III-R Diagnoses Based on Parent and Child DISC-2 Reports

	EGTC (N = 26)	Comparison Group (N = 26)
Conduct disorder[a]	21 (81%)	21 (81%)
Any anxiety disorder	13 (50%)	15 (58%)
Simple phobia	8 (31%)	7 (27%)
Social phobia	7 (27%)	8 (31%)
Agoraphobia	2 (8%)	6 (23%)
Avoidant disorder	1 (4%)	0
Overanxious disorder	7 (27%)	6 (23%)
Generalized anxiety disorder	1 (4%)	2 (8%)
Separation anxiety disorder	4 (15%)	4 (15%)
PTSD	3 (12%)	Not known
Panic disorder	0	0
Any depressive disorder	9 (35%)	10 (38%)
Major depression	2 (8%)	7 (27%)
Dysthymia	7 (27%)	9 (35%)
Manic episode	0	1 (4%)

[a] EGTC and Comparison Group matched on the number of diagnoses of CD.

according to DSM-III-R criteria. There was a nonsignificant trend toward lower proportion of MDD in EGTC group than in the matched nonoffender comparison group, Fisher's exact test (two-tailed), $p = .14$. PTSD was not measured in the comparison sample.

The fact that parents of the EGTC youths were not available in most cases for DISC-2 interview raises concern about the completeness of diagnostic information on the EGTC boys. For this reason, we also compared the groups on the number of symptoms reported by the youths alone on the DISC-2. As shown in Table 5, the youths did not differ in the number of symptoms of CD involving aggression against persons, the number of nonaggressive symptoms of CD, the number of symptoms of all anxiety disorders, or the number of symptoms of dysthymia and major depression. To avoid confounding, the aggressive CD symptom of forced sexual activity was not included in the number of aggressive CD symptoms, since the matched comparison group was selected in part on the basis of the absence of reported forced sex. However, when known aggressive sexual offenses were added to the list of aggressive CD symptoms, the EGTC boys exhibited significantly greater aggression, $t\ (50) = 2.91$, $p = .005$.

Table 5
Comparison of EGTC Boys with CD to Matched Comparison Group on Number of DSM-III-R Symptoms of CD, Anxiety, and Depression Reported by Child on DISC-2

Number of Symptoms	EGTC (N = 26)	Comparison Group (N = 26)
Aggressive CD[a]	1.00	0.75
Nonaggressive CD	2.54	2.17
Total CD[a]	3.54	2.92
Anxiety	2.54	2.46
Depression	4.08	3.71

[a] Symptom of forced sex not included.
No differences significant at the .10 level.

Discussion

A number of studies have confirmed the spectrum of psychosocial adversity, psychopathology, and the history of sexual and physical abuse in the incarcerated adolescent sex offender (Table 6). This is the first study to focus on the incarcerated early adolescent male sex offender population. Our findings have to be interpreted within the specific parameters of a group of sex offenders who are incarcerated, manifesting moderately severe and repetitive sexual offending behavior, and who have been selected for admission relative to specific inclusion and exclusionary criteria.

The results confirmed the general findings in the literature that the majority of the adolescent offenders had engaged in pedophilia. Somewhat surprising relative to the young age of this sample was the high frequency of committed sexual offenses, frequency and

Table 6
Adolescent Sex Offenders

	Males (n)	Age Range (yr)	Setting	Sexual Abuse (%)
Longo[17]	17	16–19	IP	47
Becker *et al.*[8]	139	12–19	OP	19
Becker *et al.*[15]	22	13–18	OP	23
Fehrenbach *et al.*[5]	286	11–17	OP	18
This study	26	9–14	IP	65

IP = residential or correctional facility; OP = outpatient facility.

diversity of sexual offenses, which began at an early age. The average age of the first sexual offense was 9.3 years and the average age of the victim was 7.3 years.

A particularly interesting finding was the high prevalence of sexual abuse in the history of these boys (65 percent), which stands in contrast to most other reported studies.

Seghorn *et al.*[13] studied an adult population 18 to 68 years of age and found that child molesters (victims under 16 years of age) were twice as likely (57 percent) to have a history of sexual victimization than rapists (23 percent) whose victims were over 16 years. There is a suggestion that the greater frequency of sexual abuse in our sample indicates that early and frequent sexual victimization may be an important determinant of early onset of sexual offending behavior and may contribute to severity. Clearly, this is a question that requires further study. Lewis[14] suggests that early physical abuse frequently results in the modeling of aggression, brain injury, and delayed verbal skills and may engender hypervigilence, rage, paranoia, and dissociative experiences associated with the lack of recognition of feelings in the self and others. This is thought to lead to irritability, impulsivity, impaired verbal competence, poor social skills and judgment, resulting in paranoid misinterpretations and a readiness to turn to aggression as a way of resolving conflict.

There is evidence that a history of sexual abuse is not sufficient to produce a pattern of deviant sexual behavior. A number of other risk factors are generally present in addition to the history of sexual abuse, i.e., impulse control problems, limited cognitive abilities, physical abuse as well as family variables to include a history of coercive parental sexual behavior, which is supportive of coercive sexual behavior and a family system characterized by lack of empathy and impaired interpersonal and social skills.[5,8,15]

It is of interest that the EGTC group was significantly different from the CD group on mathematics achievement, which may suggest either a highly specific cognitive limitation associated with a number of possible mediators or a failure to benefit from educational experiences. This finding stands in contrast to that reported by Lewis *et al.*,[7] who found that the adolescent sex offenders were significantly more impaired in reading achievement than in math when compared with other nonsexual violent delinquents.

While exhibiting a high prevalence of conduct disorder, the EGTC group also manifested a number of internalizing disorders. Social phobia was the most frequent diagnosis followed by that of overanxious disorder. Only two cases of MDD were found in the EGTC group compared with seven in the CD group. It is possible that the low prevalence of MDD in this group may relate to the relative good adjustment of these boys to the residential treatment center with its generally supportive ambience compared with the family and psychosocial environs of origin such that they failed to meet severity level and the two-week criteria. In contrast the relatively significant (27 percent) prevalence of DD re-

flects the longer time frame of one year and its less incapacitating symptomatology.

We have found a higher prevalence of conduct disorder and history of prior nonsexual crimes than was reported by Kavoussi *et al.*,[9] who administered the SCID and the Kiddie SADS-E (Children's Schedule for Affective Disorders and Schizophrenia-Epidemiological Version) to a group of nonincarcerated adolescent sex offenders. This would be expected regarding the differences in severity and the higher frequency of sexual offending behavior in our incarcerated group.

A number of studies have compared sexual offenders with other juvenile offenders. Lewis *et al.*[7] compared 17 incarcerated adolescent sex offenders with 61 violent juveniles and found few differences, both the sexual offenders and the violent juveniles manifested an ongoing pattern of antisocial and aggressive behavior since early childhood. Tarter *et al.*[16] compared juvenile violent, nonviolent, and sexual offenders across a broad range of intellectual, neuropsychological, and psychoeducational measures and found no systematic differences between the groups.

Our findings suggest that sexual offending behavior is strongly linked to conduct disorder and that youths who force sex may not differ from other youths with conduct disorder. If one excludes sexual aggressive (offending) behavior, the number of aggressive symptoms are comparable between the two groups. The majority of the EGTC group have a long established history of aggressive, antisocial, and criminal behavior.

The propensity for minimization, denial, and lying of boys with conduct disorder suggests that antisocial behavior is underreported in this group. It appears that the sexual offending behavior is but an interesting variation on a well-established matrix of antisocial and aggressive behavior. It is possible the experience of sexual victimization in the history of these youth consolidates sexual offending as an additional pathway for the expression of antisocial behavior. Further investigation will be required to separate out the confounds of sexual and physical abuse, family dysfunction, and psychosocial adversity that often precede and accompany the history of sexual victimization. Would these youths have been similar to more typical youths with conduct disorders if there had not been the history of sexual victimization?

These findings add credence to the increasing recognition that while adolescent sex offenders are a heterogeneous group the severest forms of early adolescent sex offenders have a central antisocial core. Treatment strategies must recognize the psychiatric comorbidity associated with sexual offending behavior. Residential treatment programs have to increasingly support a multimodal, multidimensional, and multidisciplinary approach that is sensitive to the complexity of psychological symptoms and well-established patterns of maladaptive behavior. The current emphasis on the use of cognitive-behavioral interventions must also be accompanied by other approaches to include a strong

behavior management program, family interventions, and peer-related group and individual therapy. Individual therapy is particularly useful in facilitating the working through of the experiences of traumatic abuse and promoting a therapeutic alliance within the milieu. It is also apparent that a subset of these boys are not treatable within the limited therapeutic armamentarium commonly available.

This preliminary report is designed to stimulate research on youths who commit sexual offenses. Because of the relatively small number of subjects available for these analyses, some failures to detect statistically significant differences may represent type II errors because of insufficient statistical power. For this reason, we will continue to collect data on newly admitted youths at EGTC and will repeat the comparisons reported in this paper at a later date. However, although a few of the statistical comparisons might have reached conventional statistical significance if relative differences had been maintained in larger samples (e.g., the lower proportion of EGTC youths with major depression), most comparisons failed to reach statistical significance by a wide margin. Moreover, perhaps the greater concern should be that the large number of statistical comparisons may have led to the few significant differences on a chance basis. Because of both concerns, replication in larger samples is greatly needed.

It is also important to note that the EGTC and comparison groups probably differed in terms of inpatient hospitalization and/or incarceration. Most of the boys at EGTC had been residents of the institution for at least six months at the time of the assessment, and many of them had been in other psychiatric or penal institutions for considerable periods prior to placement at EGTC. In contrast, 10 of the 26 comparison cases were not residents of either inpatient or correctional facilities. Because incarceration eliminates the opportunity for some symptoms of CD (e.g., running away from home) and probably reduces the opportunity for most other symptoms of CD, this raises the possibility that had we been able to match the EGTC subjects by only using youths who were in locked facilities that greater differences in the number of symptoms of CD may have emerged. It is also possible that this difference in facilities between the two groups may have influenced the number of symptoms of anxiety and depression as well. Again, this limitation also suggests the need for additional research on this important population.

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