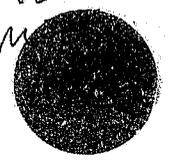


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# THE SEX OFFENDER:

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## A Review of the Literature

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October 1984

102607



Program Services Unit  
Division of Juvenile Rehabilitation

THE SEX OFFENDER:  
A REVIEW OF THE LITERATURE

102607

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October 1984

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## Preface

This paper presents both a synthesis and annotated review of recent literature on the assessment and treatment of sex offenders with an emphasis on the juvenile sex offender. The reader should note that many of the articles are based on adult sex offenders, reflecting the general lack of research on juvenile offenders. Caution should be used in applying these findings to juveniles.

This review is the first in a series to be produced by the Division of Juvenile Rehabilitation, Program Services Unit. All reviews issued will be periodically updated and reissued, with the intent of providing a useful resource to those involved in the treatment of juvenile offenders.

We would like to acknowledge the effort of Denise Lishner in developing this review.

## SYNTHESIS: SEXUAL OFFENDER LITERATURE REVIEW

Adolescent males comprise a large proportion of sexual offenders (Ageton, 1977; Groth, 1977; Groth and Lored, 1981; Longo, 1982). Juvenile crime statistics for 1973 indicate that 61 percent of apprehended rapists are under the age of 15 (Ageton, 1977). In 56 percent of cases of child molestation referred to the Child Sexual Abuse Victim Assistance Project in Washington, D.C., the offender was under 18 and 42 percent of a sample of 1000 child victims seen in two sexual assault centers had been assaulted by an adolescent. (Deisher, Wenet, Paperny, Clark and Fehrenback, 1982). In Washington State, 10 percent of youths committed to the Division of Juvenile Rehabilitation (DJR) have been adjudicated for sex offenses and one-third of young male offenders at DJR's Echo Glen Children's Center (EGCC) had a sex offense on their current or prior offense record (Lafond, Thomas, and Stark, 1981). A study of 137 convicted rapists and child molesters revealed that 47 percent had committed their first sexual assault between the ages of 8 and 18, with the modal age being 16 (Groth and Lored, 1981). Fifty-seven (57) percent of adolescents, sexual assaulters committed prior sexual offenses, indicating an ongoing problem (Deisher, Wenet, Paperny, Clark and Fehrenback, 1982).

Despite the large proportion of juveniles among the sexual offender population, little attention has been paid to the adolescent sexual offender (Longo, 1982; Ageton, 1977). Adolescent sex offenses are frequently underreported, not regarded as significant, and generally dismissed as normal curiosity or experimentation (Groth and Lored, 1981), courts are reluctant to prosecute juvenile sex offenders, and adult treatment centers frequently refuse to admit those under 16 (Groth, 1977). Juveniles held to be guilty of sex offenses often are not charged with sex conduct violation but are labeled euphemistically as ungovernable (Reiss, 1967).

The problem of adolescent sexual offenders is being taken more seriously, as statistics indicate that adult sexual offenders begin their criminal careers at an early age. Longo (1982) found that sexual offenders in a treatment center were about 17 at the age of conviction but 14 at the age of onset of sexual assaultiveness. Groth (1977) notes the continuity of sexual offenses over time, with offenses committed by adult offenders often identical to those committed by them earlier as juveniles. Sexually assaultive behavior in adolescents is often a prelude to adult sexual offenses (Fortune, 1983). Groth and Lored (1981) indicate that previous normative sexual experiences of offenders disprove the contention that the offenses are themselves experimental or due to curiosity. Groth (1977) stresses that adolescent sex offenses need to be regarded as symptoms of emotional disturbance warranting psychological assessment.

A number of researchers have described distinguishing characteristics of the adolescent sexual offender (Longo, 1982; Markey, 1950; Shoor, Speed and Bartelt, 1966) and have attempted to distinguish the profiles of various types of sexual offenders. Distinct characteristics have been found when comparing passive versus aggressive child molesters (Shoor, Speed and Bartelt, 1966) and when comparing rapists, pedophiles and exhibitionists

(Wright and Vera, 1980; Rader, 1977; Fortune, 1983). In a study comparing three groups of defendants -- those charged with acts of violence alone, those charged with acts of violence and sexuality, and those charged with purely sexual acts -- variables best discriminating offender types included age, history of mental health hospitalization, ability to abstract, psychosis, marital status, school record and job status (Vera, Barnard, Holtzen, and Vera, 1980). These same authors note similar traits between these three groups including high incidence of parental separation prior to offender age 16, substitute homes, incomplete high school and frequent previous criminal record prior to age 15. A study of expositors, rapists and assaulters indicated that all three groups were more deviant than the general population as measured by the MMPI (Rader, 1977).

Researchers have identified etiological factors associated with adolescent sexual offenses. It has frequently been demonstrated that sexual offenders were themselves sexually abused or traumatized as children (Groth, 1979; Groth and Longo, 1982; Powers and Chain, 1983; Wenet and Clarke, 1977) with estimates of sexual victimization ranging from 33 percent (Groth, 1979) to over 50 percent (Deisher, Wenet, Paperny, Clark and Fehrenbach, 1982). Groth (1979) suggests that sexual assaults frequently replicate the victimization of the assaulter, representing a maladaptive effort to solve or control unresolved early sexual trauma.

Rape and aggressive sexual offenses have been associated with rage, anger, and the desire for retaliation (Fortune, 1983). Sex is generally not viewed as the dominant issue; sexual offenses are seen as serving non-sexual needs revolving around conquest, control, or power (Groth, Burgess and Holmstrom, 1977).

Additional predictors or correlates of adolescent sexual offenses include poor social skills and undeveloped personal relationships (Deisher, Wenet, Paperny, Clark and Fehrenbach, 1982; Groth, Burgess and Holmstrom, 1977; Crawford, 1979; Powers and Chain, 1983), low self-esteem and feelings of sexual inadequacy (Fortune, 1983; Costell and Yalom, 1972), underachievement (Groth, 1977), a destructive family relationship (Fortune, 1983; Powers and Chain, 1983) and genetic and constitutional factors (Rader, 1978).

Assumptions about the causes of this problem have treatment implications. Blame models (Brodsky and Hobart, 1978) variously implicate the offender, the victim, the situation and society, suggesting different treatment responses. Similarly, treatment may vary depending on the type of offense, with secure institutional facilities reserved for the more assaultive, violent or untreatable offenders (Fortune, 1983; Shoor, Speed and Bartelt, 1966).

This suggests the importance of sensitive assessment procedures. Simmons, Richter and Moore (1982) have developed guidelines to distinguish the potentially dangerous adolescent sexual offender from normal or innocuous sexual activity. These indicators include the intensity, seriousness, age appropriateness, frequency and repetitiveness of the behavior. Groth and

Loredo (1981) have established eight criteria for evaluating the seriousness of inappropriate sexual behaviors, which can be used as guidelines in making a diagnosis. Some assessment tools utilized to differentiate sexual offense types or to measure seriousness and dangerousness of the offenders' behavior include the MMPI (Quinsey, Arnold, and Pruesse, 1980), social skills indicators (Abel, 1978) and physiological response measures (Quinsey and Carrigan, 1978; Abel, 1978).

Many treatment modalities have been employed, but only recently have specialized intervention and treatment programs been developed specifically for juvenile sexual offenders (Longo, 1982). Only two identified institutions work with adolescent sex offenders, with most special programs operative within juvenile agencies (Fortune, 1983). The state of the art of treatment is limited. Little evaluation data exist and few experimental studies have been conducted on treatment modalities (Quinsey, n.d.). There are limited data on the juvenile offender population due to lack of access, low conviction rates, infrequency of reporting voluntarily for treatment, and absence of controlled studies (Groth, 1977). Few cases of successful treatment for violent sexual offenders have been documented (Sadoff, 1975). Incarceration and punitive measures have been found insufficient to rehabilitate dangerous offenders (Groth, 1978).

Three basic treatment approaches used with sex offenders are physical, psychological and behavioral (Groth, 1978). Physiological techniques include medroxy progesterone acetate (Gagne, 1981) and Androgen-depletive hormone Depo-provera (Mohey, 1972) to reduce arousal and desire for deviant sexual behavior, as well as use of hormones, tranquilizers and depressants (Rader, 1978). Rada (1978) indicates that there is not drug treatment of choice. Since the exact mechanism of the action of aggressive behavior is unknown. Critics of these approaches assert that the problem is not merely excessive sexual arousal, and argue for more comprehensive treatment to modify attitudes, behaviors, and personality problems (Marshall and Barbaree, 1978; Carwford, 1979).

Sex offenders have generally been regarded as untreatable using traditional psychological therapeutic techniques, due to failure to cooperate, denial of guilt, lack of motivation for change and serious character disorders (Peters and Roether, 1972). Sex deviation is viewed as a symptom of a larger personality disorder requiring alterations in the character structure (Salzman, 1972). Variations of group therapy have been used with this population to achieve emotional release and resolve early trauma and to improve interpersonal relations (Peters and Roether, 1972; Costell and Yalom, 1972; Brancale, Vinocolo and Prendergast, 1972). A two-year follow-up of a program offering small group process to probational sex offenders demonstrated lower recidivism rates among treated subjects as compared to a comparison group (Peters and Roether, 1972).

Social skills training has been provided to sex offenders to remedy interpersonal skills deficits (Whitman and Quinsey, 1981). Quinsey (n.d.) found that rapists were less socially competent than community controls. Programs

offering social skills training to this population have demonstrated moderate success in improving social skills training, but have not determined whether these acquired skills are generalizable to real-life situations or to other areas (Becker, Abel, Blanchard, Murphy and Coleman, 1978; Whitman and Qunisey, 1981).

Finally, a variety of behavioral techniques have been implemented with sex offenders (Turner and VanHasselt, 1979; Abels, Blanchard and Becker, 1976). Early behavior therapists viewed treatment primarily as elimination or reduction of the deviant behavior (Marshall and Barbaree, 1978), but now advocate more comprehensive treatment (Crawford, 1979). Therapeutic techniques include systematic desensitization, assertive training modeling, aversive conditioning, covert sensitization and shame aversion therapy (Serber and Wolpe, 1972). Multiple behavioral strategies were used in treatment of a sexually aggressive adolescent with positive results (Turner and VanHallelt, 1979). Unfortunately, there have been few controlled studies of the effects of behavioral techniques on sex offenders (Serber and Wolpe, 1972; Turner and VanHasselt, 1979).

While recidivism among dangerous sexual offenders is generally reported to be low, there is increasing evidence to contradict this (Groth, Longo and McFadin, 1982). Abel (1978) found a recidivism rate of 22 to 36 percent five years after release from incarceration. Results of a study of 83 convicted rapists and 54 child molesters at a rehabilitation treatment center indicated that two-thirds of the rapists and two-fifths of the molesters had at least one prior conviction, that the combined sample averaged 5.2 rapes and 4.7 sexual assaults on children, and that offenders admitted two to five times as many sex crimes than those for which they were apprehended (Groth, Longo and McFadin, 1982). A follow-up study of untreated sex offenders (Soothill and Gibbens, 1978 in Quinsey, n.d.) showed that 48 percent had recidivated and 23 percent had committed a new violent or sexual offense. A study of 231 pedophiles, rapists and exhibitionists randomly assigned to therapy or probation failed to show significant differences in recidivism rates between the two groups (Joseph J. Peters Institute, 1980). The highest recidivism rate was found for exhibitionists (41%), confirming the finding that generally the less serious the offense, the more frequently it occurs (Quinsey, n.d.). Marital and school problems and age of arrest were significantly associated with differences in recidivism, and those with long histories of sexual offense had a higher probability of recidivism in spite of type of treatment used (Joseph J. Peters Institute, 1980). Quinsey (n.d.) found that variables predicting recidivism include prior sexual offense, excessive use of alcohol, unorthodox sexual values, grave difficulties establishing meaningful relationships with families and desire for children as objects.

Quinsey (n.d.) argues that evaluators should not rely on recidivism data to test program effects since reoffenses are relatively infrequent and may not be detected. Groth et al. (1982) concur that the use of recidivism as a measure of program effectiveness is unreliable.

## SEX OFFENDER REVIEW

### I. ETIOLOGY AND PREDICTORS

#### A. Articles specific to juvenile offenders.

1. Robert E. Longo, Sexual Learning and Experience Among Adolescent Sexual Offenders, International Journal of Offender Therapy and Comparative Criminology, 1982, 26/3, pp. 235-241. Only recently have specialized intervention and treatment programs been developed specifically for juvenile sexual offenders. In the past adolescent sexual offenses were written off as normative curiosity or experimentation (Groth and Lored, 1981): In Washington State at Echo Glen Children's Center, 10 percent of male youths have been adjudicated for sexual offenses and one-third of young male offenders had a sex offense in their current or prior offence history (Lafond, Thomas, and Stark, 1981) 17.6 percent of offenders arrested for sex related offenses in 1977 were under 18. Yet, little attention has been paid to adolescent sexual offenders.

A significant number of sex offenders have been victims of sexual abuse or sexual trauma usually prior to puberty (Groth, 1979; Prendergast, 1979; Groth and Longo, 1982). Unresolved trauma may prompt compulsive reenactment to control it.

Longo identified only two institutions working with adolescent sex offenders: The Juvenile Sexual Offender Program, University of Washington, Seattle and North Florida Evaluation and Treatment Center of Gainesville, Florida. Other special programs operate within juvenile agencies. A specific program has been developed by the author and his colleagues to work with this sub group. Adolescent sexual offenders have sexual concerns leading to poor self-concept and feelings of inadequacy as males and also have unconventional sexual development. A sample consists of 17 adolescent sexual offenders in the Florida program, ages 19 and under, convicted of sexual assault and in treatment at least eight months. Each subject was administered an anonymous questionnaire. A profile reveals offenders to be 17 at the age of conviction, but 14 at the age of onset of sexual assaultiveness. Sexual experiences begin at an early age (average age 9). Forty-seven percent reported sexual molestation in childhood. Forty-seven percent experienced some form of sexual dysfunction such as premature ejaculation or impotence due to anxiety. Sexual encounters are usually with older consenting partners and offenders often report feeling inadequate. Offenders own victimization or trauma may be a primary cause of sexually acting out and this needs to be addressed. Seriousness of this problem should not be underestimated and more research and treatment programs are needed to prevent adolescent sexual offenders from committing more serious sexual crimes.

2. Oscar T. Markey, A Study of Aggressive Sex Misbehavior in Adolescents Brought to Juvenile Court, American Journal of Ortho Psychiatry, 20, 1950, pp. 719-731. Examined 25 boys and 25 girls charged with some form of "immorality" at Cuyahoga County Juvenile Court who were compared with an equal number of boys and girls charged with other forms of delinquency and randomly selected to the study. The study found that personality stability was poor with sex symptoms reflecting poor personality integration. Most of the boys and girls referred for general delinquency had been sexually active in much the same manner as the other group. Sex activity was found to be a part of the general maladjustment inherent in the family picture.
3. Suzanne S. Ageton, Sexual Assault Among Adolescents: A National Study. Behavioral Research Institute Proposal, 1977. Proposed study would test model and factors associated with adolescent sex offenses. Offender population contains a large proportion of adolescent males (Amir, 1971; Curtis, 1974) yet there are little data on adolescent sexual offenders. Juvenile crime report statistics for 1973 indicate that 61 percent of apprehended rapists are under the age of 25. Proposed study would look at variables such as social integration and also at the relationship between adherence to sexual stereotypes and commission of sexual assaults. The study would also explore the relationship between sexual assault and other violent offenses and attitudinal structures supportive of violence which may allow a youth to participate in sexual assault by rationalizing inhibitions and guilt. Situational variables such as drug use and relationship to the victim may be mediating factors.
4. Marie Marshall Fortune, Sexual Violence, The Unmentionable Sin, 1983, New York: Pilgrim Press. Sex offenses are the sexual expression of power and anger and reflect personality difficulties such as lack of intimacy or trust. Three types of rapes are (a) power rape involving conquest and reaffirmation of masculinity, (b) anger rape involving brutal attack to humiliate, harm or avenge, and (c) sadistic rape involving gratification in tormenting the victim. Pedophiles are often heterosexual men seeking to control through highly repetitive compulsion, fixated or regressed. Incest offenders encompass 50 percent of sexual abuse of children and often reflect inadequacy, low self esteem, isolation, poor impulse control and rigid authoritarian natures. Many sexual abusers were themselves sexually abused as children leading to poor self-image, lack of trust, anger and unresolved early sexual trauma.

Teenage offenders represent significant proportions of all offenders. Sexually assaultive behavior is often a prelude to the adult sexual offenses. Adolescents often abuse someone known such as a younger sibling. Factors include alienation, destructive family relationship, lack of accurate information about sexuality, media and abuse. Offenders seldom tell the truth about their behavior or express remorse and are often repeat offenders.

State of the art of treatment is limited. Child offenders require long term behavioral oriented treatment. A major problem is the off setting of sexual gratification derived from the offense which acts as a reinforcer. Imprisonment does not facilitate or reduce recidivism but may be necessary for the untreatable.

5. John H. Gagnon and William Simon (editors), Sexual Deviants, 1977, New York: J & J Harper, Article by John H. Gagnon. Sexuality and Sexual Learning in the Child. Chapter assesses factors that control childhood sexuality and learning and the way this is linked to sexual values of adults. Entirety of sexual life permeated with sense of guilt and shame even when specific behaviors are prescribed. The salience of child's peer group may be greater in this area of learning than other areas due to lack of sexual information supplied in the home and prohibitions against talking about sex.

#### I. B. Articles Not Specific to Juveniles

1. A. Nicholas Groth, Sexual Trauma in the Life Histories of Rapists and Child Molesters, Victimology 4/1, 1979, pp. 10-16.  
Studies 348 men convicted of rape regarding incidents and types of sexual trauma experienced. About one-third had been sexually victimized as children as compared to a control group of 62 male policemen in which 3 percent experienced early sexual trauma. Child molesters tended to experience forcible sexual assault by non-family members resulting in fear and subsequently sensed that children are safer and less threatening than adults. Rapists were often pressured into sexual activity by family members leading to anger and a sense of being victimized by women. Sexual assaults often replicate the victimization of the assaulter and may represent a maladaptive effort to solve unresolved sexual trauma. Rape is the sexual expression of power and anger and has retaliatory and compensatory rather than sexual motives.
2. A. Nicholas Groth, A. W. Burgess and L. L. Holmstrom, Rape: Power, Anger and Sexuality, American Journal of Psychiatry, 1977, 134, pp. 1239-1243.  
Issues of power, anger and sexuality operate in every rape but the proportion varies and one issue dominates in each instance. In a random sample of 133 convicted rapists and 92 victims, offenses could be categorized as power or anger

A sharp distinction can be drawn between aggressive and passive child molesters. In the aggressive child molester physical violence and sexual expression are closely correlated. This type of offender needs correctional treatment, in a secure facility and external controls. The passive child molester tends to employ physical contact with cajoling and bribery but is easily dissuaded. Generally, the passive molester is sexually immature with low social and academic functioning and has oedipal problems. Passive cases can be properly managed in the community by psychiatric treatment and family consultations to manage the problem of self-control.

2. Judith Powers and Stephen Chain, The Adolescent Male Perpetrator in Child Sexual Abuse, Colorado's Children Volume 1, No. 2, Winter 1982-83.

Cases are frequently seen where the perpetrator is an adolescent male and victims are younger siblings or neighborhood children. The Arapahoe County Department of Social Services initiated a program providing clinical services to adolescent offenders in weekly psychotherapy groups. Intervention focuses on admission of the sexual abuse, understanding of the behavior and enhancement of self-esteem, establishment of positive peer relationships, development of appropriate avenues for meeting one's needs, and clarification of one's own sexuality issues. The program also includes educational components and family therapy.

Of six cases studied, interaction in the family was chaotic, violence was not uncommon, physical or sexual abuse of the adolescent recurred repeatedly, the family denied the seriousness of the boy's behavior, the family's boundaries were rigid or lacking, and alcohol or other drug abuse was a prominent factor. The boys were socially immature, had difficulties in relationships, were confused about their own sexuality, had a hard time expressing emotions, impersonalized their own bodies and lacked problem-solving techniques.

3. Richard Wright and D. J. West, Rape: A Comparison of Group Offenses and Lone Assaults, Medical Science and Law, 1981, Volume 21, No. 1, Great Britain, pp. 25-30.

Whereas some assaults by individual offenders may reflect personality propensities or pathologies, group rapes originate in the dynamics of youthful gangs. The sample comprised all incidents recorded by police as genuine rapes or attempted rapes in six English Counties from 1972-1976. 86.9 percent of the rapes were committed by single attacker. For group assaults, 65 percent of suspects were under the age of 21 compared with 27 percent of the suspects in individual assaults. Group attacks were much more prevalent among non-whites. Those committing group offenses were less

likely to have had a previous conviction for a sex crime or prior psychiatric treatment. Group assault suspects were more likely than individual suspects to be convicted of the charge arising from the incident and attracted more severe penalties. In both groups about one-third of the suspects had been drinking heavily beforehand.

4. A. Nicholas Groth, The Adolescent Sexual Offender and His Prey, International Journal of Offender Therapy and Comparative Criminology, 21, pp. 249-254, 1977. Little attention has been paid to the adolescent male who commits rape or child molestation, with emphasis on the adult offender. A reluctance of courts and agencies to view juvenile sexual offenses as significant or serious is evident. Only 26 of the 300 offenders examined at the treatment center were juveniles, reflecting the court's reluctance to prosecute juvenile sexual offenders and the reluctance of treatment centers to accept patients under the age of 16. These 26 offenders, aged 15 to 17, were examined between 1970 and 1975 at the Center for the Diagnosis of Sexually Dangerous Persons in Massachusetts. Fourteen were convicted of rape and 12 were convicted of child assault. 37 convicted adult sexual offenders with a history of juvenile rape or child assault were also included in the study.

The sample was divided into three groups on the basis of the age of the victims relative to the age of the offender. Data were collected through clinical interviews. A general profile emerged of a boy aged 16, white, of average intelligence, lone assault, and the victim being a younger white female. In three-quarters of the cases, offenders were likely to have committed prior sexual assaults but most cases were disposed of without commitment.

In differentiating between adolescent sexual offenders who rape and those who molest children, the data suggest that rapists fall within a narrower age range, there is a higher incidence of interracial assaults, victims are more likely to be strangers, more likely that a weapon was used and that sexual penetration was achieved, and assaulters scored somewhat higher on IQ tests. Child molesters were younger, there were a larger proportion of male victims, they were more likely to be at least casually acquainted with the victims, and did not attempt sexual penetration. Those who rape significantly older persons choose females more often, these offenders are usually black, the offense occurs indoors, there is greater drug or alcohol use, greater use of weapons, and actual or attempted intercourse. Peer age assaults show greater incidence of gang rape, male victims, familiarity between offender and victim, and out of door locale.

Continuity over time in regard to offenses is noted. Offenses of adult offenders are often identical to those they committed earlier as juveniles. Previous offenses of juveniles are identical to current offenses. There were often more incidents of anti-social sexual behavior than appeared on the offender's criminal record, which were typically dismissed as unimportant when they occurred during adolescence.

The dynamics of forcible sexual assault by adolescents are the same as those exhibited by adult offenders, a sexual expression of anger and/or power. Adolescent rapists like adult rapists tended to be loners with no skill in establishing close peer relationships, underachievers, suffering from dulled depression, impulsive, irritable, with low frustration tolerance and low coping skills.

Rape may represent symptoms of development defect in regard to the male's identity or self-esteem, with frustrations in achieving an adequate masculine image, and intolerable pressures to gain mastery over life. Adolescent sexual offenses need to be regarded as symptoms of emotional disturbance warranting psychological assessment. There is a need for secure treatment facilities for such young offenders.

5. James E. Simmons, Arthur B. Richter, and Gregory W. Moore. The Teenage Exhibitionist and Voyeur, Volume 16, I., January 1982 (incomplete cite).

It may be difficult to determine whether youngsters' sexual activity is normal and innocuous or suggestive of serious problems. The following guidelines may help to determine which adolescents are at risk for becoming adult sexual offenders. One should assess the intensity, seriousness, age appropriateness, frequency and repetitiveness of the behavior. One should look for other signs of maladjustment such as poor peer relations or school experiences, and evaluate the stability of family. Behaviors likely to be innocuous include streaking, peeping or exhibiting in groups, single events, acts accompanied by a fun and games mood, victim of the same age, evidence of complicity, offender feeling ashamed or embarrassed by the victim's response, no accompanying criminal act, stable home situation, and no other serious problems. Indicators of potential seriousness are solitary peeper or exhibitionist, act accompanied by high sexual excitement or masturbation, acts are repeated, exclusive or preferred method of achieving sexual pleasure, compulsive nature, victim is very young or a lot older, offender pleased or indifferent at having hurt the victim, act is accompanied by crime, and there are other definite personal and family problems.

6. A. Nicholas Groth and Carlos M. Lored, Juvenile Sexual Offenders: Guidelines for Assessment, 1981, International Journal of Offender Therapy and Comparative Criminology, 25, pages 31-59.

In 56 percent of cases of child molestation referred to the Child Sexual Abuse Victim Assistance Project in Washington, D.C., the offender was under 18, mostly age 14 through 16. A study by the Massachusetts Probation Commission showed that juvenile defendants ages 7 through 16 accounted for 7.4 percent of the total number of offenders arraigned for rape and rape related crimes between 1974 and 1978. A study of 137 convicted rapist and child molesters (Groth, Longo and McFadin) revealed that 47 percent had committed their first sexual assault between age 8 and 18 with the modal age being 16. Such offenses are underreported, regarded as not serious or not significant and generally dismissed as normal curiosity or experimentation.

Human service providers generally have not been trained to work with such clients. The behavior may be misdiagnosed as adolescent adjustment reaction. Sex offenders often do not self-refer due to legal and social consequences, self denial and fear of stigma.

It is important to determine whether a behavior is situationally determined or symptomatic, transitory or a deep rooted problem. In evaluating this eight issues need to be addressed:

- a. The age relationships between the persons involved. A greater age discrepancy reflects inappropriate sexual activity, especially if the victim is a prepuberty child or much older than the offender.
- b. What is the social relationship between the persons involved? Inappropriate especially with family member or total stranger.
- c. What type of sexual activity is being exhibited? Is it age or socially inappropriate or ritualistic?
- d. How does the sexual contact take place? Mutual agreement, deception, force? Is sex seen as a way of hurting, embarrassing, controlling, degrading, or punishing another individual?
- e. How persistent is the sexual activity? Is it an excessive preoccupation that predominates or is it compulsive?
- f. Is there any evidence of progression in the nature of the offense or frequency of the sexual activity? Any increase in aggression is ominous.

- g. What is the nature of the juvenile's fantasies that precede or accompany his behavior? These need to be assessed.
- h. Are there any distinguishing characteristics about the targets or victims?

Behavior must also be examined in regard to the offender's personality development and the context of current situation. What critical developmental events have predisposed him to act out sexually? Was he a victim of sexual assault or trauma? What stresses activate his offense? What are his family interrelationships and dynamics and the response of the family to his offense? What other serious psychological disorders exist and what are the primary problems?

Clinical experience with sexual offenders indicate previous normative sexual experiences, thus the offense can't be regarded as mere curiosity or experimentation. These experiences tend to be impersonal, an effort to cope with distress, a reenactment of psychological struggles reflecting a crisis state. Functioning and development of coping skills are undermined and the resulting stress prompts the offense.

- 7. Robert W. Deisher, Gary A. Wenet, David M. Paperny, Toni S. Clark, and Peter A. Fehrenbach. Adolescent Sexual Offense Behavior: The Role of the Physician. Journal of Adolescent Health Care 2, pages 279-286, 1982.

The physician needs to be aware of and recognize adolescent pathologic sexual behavior. The authors reviewed data from two programs serving child victims of sexual assault, the Children's Hospital in Washington, D.C., and the Sexual Assault Center in Seattle. Forty-two percent of the 1,000 child victims had been assaulted by an adolescent.

This study involves findings during the first three years of the Juvenile Sexual Offender Project at the University of Washington. Eighty-three male adolescents ages 12 to 17 received evaluation and treatment. Offenders were 64 percent white, from all social classes and were usually referred initially by juvenile courts or police.

The most common cases (37.3 percent) were indecent liberties against younger children, usually age 8 years or younger. Male teenage child molesters have long histories of underdeveloped peer relationships and social isolation, family scape-goating patterns, poor social skills, peer isolation, and conflicted family relationships. These lead to low self esteem and attraction to younger submissive children with whom they feel comfortable. Use of verbal threats are common. More than one-half of the teenage child molesters

were sexually abused themselves as children. Treatment for these offenders hinges on understanding the seriousness of the behavior and consequences for the child.

The teenager referred for rape or indecent liberties with an adult or peer is more likely to have used physical force or a weapon, shows little empathy for the victim, denies the seriousness of the behavior, blames the victims or justifies his own actions, usually is quite disturbed, manipulative, avoids therapy and often requires residential treatment. Without court-ordered therapy there is high attrition from outpatient treatment. Fifty-seven percent of the adolescent sexual offenders commit prior sexual offenses indicating an ongoing problem. This problem reflects conflicts or anger and a need to establish personal power.

The third category includes adolescent sexual offenders whose crimes do not involve physical contact with victims, such as exposing and peeping. This behavior suggests serious underlying emotional problems, feelings of inadequacy, and trouble dealing with anger and frustration.

The role of the physician is discussed in recognizing these problems and referring clients for tests and treatment.

8. Albert J. Reiss, Jr. Sex Offenses: The Marginal Status of the Adolescent in Gagnon and Simon, 1967.

Adolescents encounter biological capacities for sexual behaviors in the context of moral and legal sanctions against expression of that behavior. Intense biological imperatives exist, within an ambiguous sexual environment with no set of specific sanctions considered appropriate. Sanctions do not occur unless the behavior itself becomes visible or disturbing.

Differences in the kinds of sexual behavior acted out depend on gender and social class, due to different expectations and uneven enforcement of the law. The definition of juvenile sex offenders is unclear and varies such that any sexual act or conduct can be defined as a sexual offense. Juveniles held to be guilty of sex offenses often are not charged with specific sex conduct violations, but rather are considered ungovernable, etc. It is hard to secure accurate and reliable statistics on the violation of sexual morals. Sex may be defined as rape by parents of the girl, though the boy is not a rapist in any technical sense. Delinquent gangs often involve male prostitution. Author notes the failure to accord adolescents a distinct status and to institutionalize norms governing behavior.

## II. B. Articles Not Specific to Juveniles

1. Stanton Wheeler, Sex Offenses: A Sociological Critique (incomplete citation). Several criteria for definition and grading of sex offenders are described. These include moral condemnation in sex laws, conception that criminal law should punish socially dangerous acts, emphasis on degree of psychopathology, and enforceability. Legal versus psychiatric viewpoints suggest different responses. Little experimental research has been conducted on treatment results or predictors. Aggressive offenders (rape, assault) were compared to passive offenders (exhibitionists) and found to be normal by psychiatric diagnosis, less inhibited or emotionally disturbed, with less severe emotional deprivation in childhood, more non-sexual than sexual offenses, and more hostile than passive offenders (Ellis and Brancale, 1956). Offense may be viewed as part of a broader behavior system using force rather than resulting from highly specific and deviant sexual motivation.
2. Vernon L. Quinsey, Larry S. Arnold, and Manfred J. Pruesse, MMPI Profiles in Men Referred for a Pretrial Psychiatric Assessment as a Function of Offense Type, Journal of Clinical Psychology, 1980 (36), pp. 410-417. MMPI and demographic data were obtained on six groups of 25 men remanded by courts to a maximum security psychiatric hospital for pretrial assessment. Groups differed by offense type ranging from murder or attempted murder of a family member or girlfriend, of an unrelated victim, arson, rape, child molesting or property crime. MMPI profiles of the groups were remarkably similar. Best discriminators and predictors of recidivism were age on admission and whether in corrections before the current offense. The MMPI does not differentiate the offense types of mentally disordered offenders but does reflect the high level of psychopathology.
3. Herman Vera, George W. Barnard, Charles W. Holtzer III and Marie I. Vera, Violence and Sexuality: Three Types of Defendants, Criminal Justice and Behavior, 7(1) 9/80, pp. 243-255. Study compares profile of three groups of defendants (N=964):
  - a. Charged with acts of violence alone.
  - b. Charged with violence and sexuality.
  - c. Charged with a purely sexual act.Aim was to uncover differences and similarities in the three groups. The study showed that variables which best discriminate include age, history of mental health hospitalization, ability to abstract, psychosis, marital status, school record and job status. Non-sexually violent offenders were typically under 30, not married, had not completed high school, had record of school failure, previous criminal

record and job status. Non-sexually violent offenders were typically under 30, not married, had not completed high school, had record of school failure, previous criminal record, and had held a job over three months. The sexually violent offenders were generally over 30, not married, had not completed high school, had high rates of school failure, prior criminal record after age 15, less than honorable military discharge, and had held a job over six months. The sexually non-violent offender was usually over 30, white, married, had not completed high school, prior criminal record after age 15, honorary military discharge, and better job stability. Highest psychosis was found among non-sexually violent offenses. High association was found between alcohol and violent and sexual offenses. Similar traits between the three groups include high incidence of parental separation prior to offender age 16, substitute homes, incomplete high school, and frequent previous criminal record prior to age 15.

4. G. G. Abel, Behavioral Assessment of Rapists, from Research Into Violent Behavior, 1978, U.S. Congress House Committee on Science and Technology, Washington, D.C., 1978. Social skills deficits of rapists identified and recent findings from physiological recordings of rapists as compared to non-rapists are highlighted. It is important to understand how rapists differ from non-rapists on social and physiological response spheres. Rapists may have deficits in assertive skills, heterosocial skills, inadequate sexual information, and gender role confusion. Treatment should be directed toward reducing rapist erection responses to rape cues. Rapists consistently report less sexual arousal than recorded by physiological measurements. Verbal reports are a poor means of assessing progress in treatment. Physiological measurements allow exploration of possible motives and appropriate treatment.
5. Charles M. Rader, MMPI Profile Types of Exposers, Rapists and Assaulters in a Court Services Population, Journal of Consulting and Clinical Psychology, 1977, 45(1), pp. 61-69. The MMPI of 36 exposers, 47 rapists and 46 assaulters referred by court services were compared. Rapists were the most disturbed group and had mean raw scale scores significantly greater than other groups. Rapists showed more bizarre mentation, somatic concerns, depression, repression, denial, aggression, anger, acting out, hostility, and suspiciousness, projected blame, with fear of emotional involvement, poor social intelligence, conflicts about sexuality, and alcohol use. Exhibitionists scored within normal limits and were mildly conforming with minor run ins. Assaulters were rebellious, resentful, non-conforming, had limited frustration tolerance and were "typical" psychopaths. All three groups were more deviant than the general population.

6. Vernon L. Quinsey and Wayne F. Carrigan, Penile Responses to Visual Stimuli, Instructional Control With and Without Auditory Sexual Fantasy Correlates, Criminal Justice and Behavior, 5(4), 12/78, pp. 334-341.  
Article concerns validity regarding the ability of the Penile Transducer to evaluate sexual offenders. A study of nine non-deviants instructed to fake a deviant sexual preference during measurement of sexual arousal confirms that normals can fake arousal with the transducer. This supports the need for cautious interpretation of this measure.

### III. Recidivism

#### A. Articles Specific to Juvenile Sexual Offenders

1. Nicholas Groth, Robert E. Longo and J. Bradley McFadin, Undetected Recidivism Among Rapists and Child Molesters, Crime and Delinquency, July 1982, 28(3), pp. 450-458.  
Recidivism among dangerous sexual offenders is generally reported to be low but clinical experience contradicts this. Questionnaire was administered to 83 convicted rapists and 54 child molesters at a rehabilitation treatment center and maximum security prison. Results indicate that two-thirds of the rapists and two-fifths of the molesters had at least one prior conviction. The combined sample averaged 5.2 rapes and 4.7 sexual assaults on children. Offenders admitted two to five times as many sex crimes than those for which they were apprehended.

Dangerous sexual offenders usually commit their first assault during adolescence (modal age 16) and this persists but is often ignored and untreated. Juvenile records are often destroyed and so offenders' records may omit serious crimes. Article stresses need to detect problems earlier. The use of recidivism as a measure of program effectiveness is unreliable.

#### III. B. Articles Not Specific to Juveniles

1. Vernon L. Quinsey, Prediction of Recidivism and the Examination of Treatment Programs for Sex Offenders, n.d., Penetanguishere, Ontario.  
Sexual aggressives vary in dangerousness, frequency, type of victims, and personality. These must be taken into account in assessing treatment. Generally, the less serious the offense, the more frequently it occurs, and so the events we most want to predict are the rarest. A study of untreated offenders (Soothill and Gibbens, 1978) showed that 48 percent had recidivated and 23 percent had committed a new violent or sexual offense by the end of the 22 year follow up.

Programs seeking to rehabilitate serious sexual offenders must show a reduction in already low recidivism rates. Measurement techniques other than recidivism data are needed which are related to characteristics influencing recidivism (e.g., type and number of offenses), and which are sensitive to treatment intervention.

Variables predicting recidivism include prior sexual offense, excessive use of alcohol, unorthodox sexual values, grave difficulties establishing meaningful relationships with females, and desire for children as sex objects.

Clinical assessments rating dangerousness have low interrater reliability. The MMPI doesn't discriminate types of offenders.

Another predictive measure entails assessment of heterosocial skills, since rapists are much less socially competent than community controls. It is not known whether initial deficits are related to offense history or improvement predicts lower rates. Another measure is sexual arousal patterns. Post treatment sexual arousal data are related to recidivism in the short but not the long term (Quinsey, Chaplin and Carrigan, 1980).

There are little evaluation data or experimental studies on treatment modalities.

2. Joseph J. Peters Institute (Abstract), A Ten Year Follow Up of Sex Offender Recidivism, Philadelphia, PA, 1980. Study involves a random sample of 231 sexual offenders remanded either to therapy or probation, to assess differential effects on recidivism. Fifty-seven percent were rearrested, 11.3 percent on a sex charge. The highest recidivism rate was for exhibitionists (41 percent). Rapists and assaulters accounted for 64.9 percent of rearrests, and 44 percent of pedophiles were rearrested.

The assault population committed offenses at an earlier age than pedophiles and exhibitionists and began careers earlier. Sixty percent of the sex arrests of the treatment group occurred by the age of 26. Treatment versus probation was not significantly associated with recidivism. Fifty-five percent of the treatment group and 60 percent of the probation group has at least one arrest post intervention. Marital and school problems and age of arrest were significantly associated with differences in recidivism. Those with long histories of sexual offense had a higher probability of recidivism in spite of type of treatment used.

#### IV. Treatment Approaches

##### A. Articles Specific to Juvenile Offenders

None included

##### B. Articles Not Specific to Juveniles

1. William P. Whitman and Vernon L. Quinsey, Heterosocial Skills Training for Institutionalized Rapists and Child Molesters, Canadian Journal of Behavioral Science Rev. 13(2), 1981, pp. 105-114.  
Heterosocial deficits have commonly been observed among sex offenders though it is unclear if there is an etiological role. Eleven child molesters and six rapists were given heterosocial skills training and sex education. Sex education was a comparison condition. Assessment of social skills was made before, during and after training by blind raters. Social skills ratings showed no improvement as a result of sex education but showed improvement as a result of social skill training. Effects of social skills training on ratings of videotaped role plays were significant when administered before sex education but not after. Social skills ratings made of subject responses to interrupted audiotaped interactions showed larger effects of social skills training than videotaped role plays and were significant for both orders of treatment. Subjects' ratings of social skills showed significant improvement over the course of the study but this was unrelated to the type of training received. The extent to which their newly acquired skills are generalizable to real life situations is unknown.
2. Judith V. Becker, Gene G. Abel, Edward B. Blanchard, William D. Murphy and Emily Coleman, Evaluating Social Skills of Sexual Aggressives, Criminal Justice and Behavior, 5(4), December 1978, pp. 357-367.  
Self-report measures confirm that some sexual aggressives are unable to maintain an adequate social interaction with adult females, or to assert themselves appropriately. Some are cold and indifferent to others' feelings. Article describes an objective assessment tool for assessing social skills and discusses the impact of skills training on sexual aggressives.

Treatment consists of behaviorial rehearsal, modeling, social reinforcement, videotaped feedback, assertiveness training, assessing and teaching empathy skills. Patients can be trained in a short period of time to acquire various interpersonal skills and these skill deficits can be objectively assessed but treatment in one skill area does not generalize into other areas.

3. Richard T. Rada, Legal Aspects in Treating Rapists, Criminal Justice and Behavior, 5(4), December 1978, pp. 369-377.  
New evaluation and treatment methods for rapists and child molesters have resulted in unique legal and ethical problems. Greater care is needed to protect the client, therapist, staff and potential victims from assault. It is important to understand the sexual offenders' history, current behavior, response to treatment, and current ability to control behavior.
4. A. N. Groth, Treatment of Offenders in Research Into Violent Behavior - W. E. Wolfgang, U.S. Congress House Committee on Science and Technology, Washington, D.C., 1978 (Abstract).  
Types of treatment or rehabilitation used for convicted rapists or child molesters are assessed. Generally, mental health agencies have let the criminal justice system deal with the dangerous offender. Treatment usually involves penalties, which are insufficient to rehabilitate dangerous offenders. It is difficult to determine effective treatment since we don't understand causal factors. Three basic treatment categories are physical, psychological and behavioral.
5. Robert M. Sadoff, Treatment of Violent Sex Offenders, International Journal of Offender Therapy and Comparative Criminology, 19(1), 1975, pp. 75-80.  
Treatment for violent sexual offenders includes individual and group psychotherapy, behavior therapy, negative reinforcement techniques, and physiological techniques. Violent sexual offenders themselves differ considerably (e.g., episodic versus patterned) so different treatment may be required. Few cases of successful treatment for violent sex offenders have been demonstrated.
6. Samuel M. Turner and Vincent B. VanHasselt, Multiple Behavioral Treatment in a Sexually Aggressive Male, Journal of Behavioral Therapy and Exp Psychiatry, 1979, 10(4), pp. 343-348.  
Multiple behavioral strategies were used in treatment of a sexually aggressive 17 year old male including thought stopping, monitoring, systematic desensitization, and social skill training. Self-monitoring reduced obsessive thoughts revolving around poor social relations and sexual aggressiveness. Ratings were based on behavioral assessments and videotapes. Findings indicated a decline in duration and frequency of distressing thoughts, an urge to hurt others, and also showed more eye contact and positive statements. While a variety of behavioral approaches have been used recently with rapists (Abels, Blanchard and Becker, 1976; Barlow, 1974) there are little experimental data on comprehensive treatment including social skill training.

7. W. L. Marshall and H. E. Barbaree, The Reduction of Deviant Arousal - Satiation Treatment for Sexual Aggressives, Criminal Justice and Behavior, 5(4), December 1978, pp. 294-303.

The problem is not just excessive sexual arousal but patterns of sexual arousal for deviants. Early behavior therapists viewed treatment as elimination or reduction of the deviant behavior but now argue for more comprehensive treatment that includes attempts to decrease deviant arousal, increase appropriate arousal, and provide skills to act on changed patterns. Procedures include aversive therapy, punishment procedure, classical conditioning, shame aversion therapy (Serber, 1970), and covert sensitization (Barlow et al., 1969). Most sex offenders have low self-esteem (Dingman and Frisbee, 1968; Marshall, Christie and Lanthier, 1977). Authors developed a procedure to associate boredom with patients' deviant fantasies, called satiation treatment.

8. David A. Crawford, Modification of Deviant Sexual Behavior: The Need for a Comprehensive Approach, British Journal of Medical Psychology, 1979, 52, pp. 151-156.

Sexual offenders have difficulties in many areas of their lives, including poor impulse control and acting out (Howells and Wright, 1978), poor capacity to establish satisfactory relationships with mature persons of the opposite sex (Pacht and Cowden, 1974), broken homes with parental friction, limited sex experiences, unhappy marriages and alcoholism (Gebhard et al., 1965). Comprehensive treatment programs should address sexual dysfunction, anxiety, deficient social skills, inadequate sexual knowledge, poor self-control, lack of non-deviant sexual arousal and presence of deviant sexual arousal.

Aversion therapy is inadequate for successful long term modification of deviant sexual behavior since problems exist in many areas and are not just physiological. It is necessary to modify attitudes, behaviors and arousal to non-deviant stimuli and to deal with general personality problems.

9. Pierre Gagne, Treatment of Sex Offenders with Medroxyprogesterone Acetate, American Journal of Psychiatry, 138, (5), May 1981, pp. 644-646.

Forty-eight male patients with long histories of deviant sexual behavior received M.A. and milieu therapy for up to 12 months. Forty responded positively within three weeks with diminished sexual fantasies and arousal, decreased desire for deviant sexual behavior, increased control over sexual urges and improvement in psychosocial functioning. Improvement in deviant sexual behavior and psychosocial functioning was maintained after treatment was over (time frame not specified). Twenty-six of the 48 patients had been introduced to sexual activity by an adult before they reached puberty.

10. G. Abel (Abstract), Evaluating and Treating Rapists and Child Molesters Current Status from Research into Violent Behavior, 1978, M. E. Wolfgang, U.S. Congress House Committee on Science and Technology, Washington, D.C.  
Notes major advances in treatment of rapists and molesters as well as impediments to treatment. Recidivism rate is high when incarceration follows conviction (22-36 percent five years after release). Rapes are committed by heterogeneous group and may result from sociocultural factors or psychological conflict. Physiological means are used to evaluate erotic preferences of rapists, and are capable of providing information regarding tendencies.
11. R. T. Rada, Biological Aspects and Organic Treatment of the Rapist, from R. T. Rada, Clinical Aspects of the Rapist, 1978, Grove and Sutton, Inc.  
Biological aspects and organic methods of treatment are described. Genetic and constitutional factors may predispose a person to sociopathy and criminality. Epilepsy and tumors have been associated with abnormal sexual behavior. Studies report relationship between testosterone and aggressive behavior, mediated by other factors. Drugs used for treatment include hormones, tranquilizers, and depressants but there is no specific drug treatment of choice for violent offenders, since the exact mechanism of the action of aggressive behavior is unknown.
12. H. L. P. Resnik and Marvin E. Wolfgang (Eds), Treatment of the Sex Offender, Boston. Little, Brown and Co., 1972.
  - a. Seymour Halleck, The Therapeutic Encounter.  
Factors determining treatment are mental illness, dangerousness and treatability. Sex offender psychiatric institutions provide only a few hours of counseling weekly to non-voluntary patients, and outpatient treatment is too hard for sex offenders to obtain.
  - b. Leon Salzman, The Psychodynamic Approach to Sex Deviants.  
Same procedures used in psychotherapy of neurotic disorders are applicable for sex deviants. Sex deviation is not seen as a separate disease but as a symptom of larger personality disorder. Orgins include primary genital phobias, fixating experiences, and early activities related to genitals. Therapy involves analysis of character structure.

- c. Michael Serber and Joseph Wolpe, Behavior Therapy Techniques.

Sex offender is one who habitually performs sexually deviant acts that render him liable to prosecution. These may be triggered by emotional states, external stimuli or both. Therapeutic techniques include systematic desensitization, assertive training, modeling, aversive conditioning, covert sensitization, and shame aversion therapy. Physiological measures may be used for monitoring. No controlled studies demonstrate effectiveness of aversive conditioning in the treatment of sexual deviance.

- d. Joseph J. Peters and Hermann A. Roether, Group Psychotherapy for Probational Sex Offenders.

Small group process is used to treat sex offenders at outpatient clinic. Sex offenders usually regarded as untreatable by most psychotherapists due to failure to cooperate, denial of guilt, character disorder, and lack of motivation for change. Small group approach can build cohesiveness, bridge gap between patient and therapist, work on denial process, feelings of inadequacy, interaction, support, and stress rights of others.

A two year follow up compared rearrests and attitude change in 92 treated offenders with matched subjects on probation supervision. The treated group initially had higher prior sex offenses. At follow up, comparison group had 27 percent as opposed to 3 percent (experimental group) rearrests for all new crimes, and 8 percent versus 1 percent rearrests for sex offenses.

- e. Ronald Costell and Irvin Yalom, Institutional Group Therapy.

Sex offenders have severe interpersonal pathology and impaired ability to establish mature interpersonal relationships. Describes two state hospital programs (Patuxent in MD; Atascadero in Calif.). Group process works against maladaptive interpersonal behavior towards corrective emotional experiences by exposing patient, under more favorable circumstances, to traumatic emotional situations he could not handle in the past. Pedophilia may reflect fear of masculine competition. Exhibitionism is associated with castration anxiety, low self-esteem and low tolerance for frustration. Aggressive sexuality may result from mistreatment by female figures in childhood. Goal of therapy is alteration in character structure.

- f. Ralph Brancale, Alfred Vinocolo and William E. Prendergast, Jr., New Jersey Program for Sex Offenders. Program consists of group therapy, directive treatment and sex education. Sex offenses are seen as symptoms requiring "whole man" treatment and emotional release.
- g. John Mohey, The Therapeutic Use of Androgen-depletive Hormone. Depo-provera lowers testosterone levels, reduces potency and ejaculation and sexual urge.

Juvenile Male Sexual Assaulters. Dorothy O. Lewis, Shelly S. Shankok, and Jonathan H. Pincus. American Journal of Psychiatry. 136:9 September 1979, 1194-1196.

Purpose of study was to determine whether violent juvenile sexual assaulters differed psychiatrically, neurologically, or psychoeducationally from other violent juveniles who had not committed sexual offenses. Especially violent incarcerated male delinquents showed more neurological and psychiatric signs than less aggressive peers and were more likely to have been severely abused by family members (Lewis, Shankok, Pincus et al., in press).

Sample consisted of all boys committed to secure unit for violent offenders over 18 month period and found guilty of sexual assault (N = 17). Comparison sample consisted of 61 boys incarcerated on secure unit same period for serious violent acts other than sexual assault. Average age for both samples was 15. Subjects evaluated by a child psychiatrist and neurologist. Diagnosis criteria included psychiatric symptomatology, neurological abnormalities, psychological tests, educational assessments, history of abuse.

#### Findings

Sexually assaultive children had been behaving in a variety of violently antisocial ways since early childhood. Childhood was characterized by general rather than sexual violence, including threats, fights, records of juvenile offenses other than sexual acts. Their behaviors closely resembled that of the violently nonsexually assaultive boys. Average age at which deviance was first documented was six years. When comparing psychiatric, neurological, psychological and educational factors, no outstanding differences were found between the two groups. Strikingly similar was presence of depressive symptoms; auditory and other hallucinations; paranoid symptoms; loos, rambling, illogical thought processes; and grossly abnormal EEG's or grand mal seizures. Both groups functioned far below reading grade expectancies. Sexual and physical abuse were prevalent among both groups.

Findings contradict prevailing assumptions that sexual assaults by juveniles are rare occurrences and that juvenile sex offenders have a lower rate of recidivism than other delinquents. Study also calls into question the distinction made between sexual and aggressive drives. Violence and sexual violence may reflect similar etiologic vulnerabilities.

Cognitive Capacities of Juvenile Violent, Nonviolent and Sexual Offenders. Ralph E. Tarter, Andrea M. Hegedns, Arthy I. Alterman and Lynda Katz-Gavins.

Research focusing on environmental, personality and early child development has not to date identified any specific characteristics which are intrinsic to a violent behavioral disposition. Several studies have been reported in which cerebral dysfunction was underlying factor in adolescent antisocial disturbance. Violent juveniles have been differentiated from non-violent offenders but separate data on sexual offenders were not presented. This report presents result of a comprehensive neuropsychological, intellectual and educational evaluation conducted on three groups of male adolescent offenders - sexual, violent and non-violent. Question is whether these groups can be differentiated in above three areas of cognitive functions, and what is strength of association between degree of violent behavior and cognitive functioning.

Sample consisted of 73 males referred to clinic from court for comprehensive neuropsychiatric evaluation. None has EEG abnormalities or were long term institutional residents. A battery of tests were administered. Only one statistically significant difference between the three groups was revealed out of 47 variables. Three groups did not differ from each other on broad range of intellectual, psychoeducational and neuropsychological abilities. Little relationship was found between cognitive performance and rating of the delinquent's most violent act. Cognitive impairment or cerebral dysfunction is not generalizable to the total population of delinquent adolescents.

Note: Study does not compare data for cognitive functioning of normal non-offender group.