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ADOLESCENT SEXUAL OFFENDERS:
SOCIAL ISOLATION, SOCIAL COMPETENCY SKILLS
AND IDENTIFIED PROBLEM BEHAVIOURS

by

Catherine M. Rowe-Lonczynski
M.A., University of Windsor, 1984

A Dissertation
Submitted to the Faculty of Graduate Studies
through the Department of Psychology
in Partial Fulfillment of the
Requirements for the Degree
of Doctor of Philosophy at the
University of Windsor

Windsor, Ontario, Canada

1989

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Dedication

This dissertation and its significance is dedicated to my parents, Bill and Marion Rowe, to show my appreciation for their constant love, support and encouragement throughout my schooling. Their firm belief in the importance of knowledge and education has always been an inspiration to me.

ABSTRACT

The purpose of this study was to examine social isolation, social competency skills and areas of problem behaviours in non-incarcerated adolescent males who have committed sexual offenses against children and compare them to two groups of non-offending adolescent males. The comparison groups were made up of: 1. Boys in outpatient treatment for a variety of emotional and behavioural difficulties and 2. Boys from two large community churches with no history of outpatient psychological treatment.

Adolescent sexual offenders and clinic treatment participants reported a higher incidence of emotional and behavioural difficulties than the community control group. Included in this were reports of academic and behavioural difficulties in school and a large number of special education placements in the two groups. In comparison to the clinic treatment group, sexual offenders were also found to have significantly higher rates of actual or suspected physical and/or sexual victimization.

Although overall measures of social isolation and social competency skills did not reveal significant differences between the sexual offenders and the two comparison groups, specific item analyses did indicate some significant signs of isolation and withdrawal in the offender group. Item analyses also provided evidence that problem behaviours are likely underreported by sexual offenders on self-report measures due to apparent

defensiveness and denial in these individuals. Overall, the sexual offender and clinic treatment groups scored more similarly on the measures of problem behaviours than either group did with the community group.

An additional finding in the study was that of large differences between groups in parental involvement in the study. Thirty-five percent of the parents in the sexual offender group failed to return the questionnaires after agreeing to participate in the study. Two trends were found in families who failed to complete the study: disbelief or denial of the child's guilt in committing the offense and a history of incestuous relationships in the child's home. Further investigation of these elements could provide more evidence in regard to the importance of parental commitment and cooperation in treating adolescent sexual offenders and the implications for treatment success.

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CHAPTER I
INTRODUCTION

The investigation of sexual abuse and the victimization of children and adolescents has elicited much interest in recent years. This research has generally focused on the victim in regard to the emotional impact of the abuse and methods of therapeutic intervention (Burgess, 1978; Burgess & Holmstrom, 1979; Nadelson, 1982). Investigations of sexual offenders have tended to concentrate on the adult perpetrator. An area receiving comparatively little attention is that of the adolescent sexual offender. However, information gathered from arrest statistics and victim surveys indicate that about 20% of all rapes and 30-50% of all incidents of sexual abuse involve adolescent offenders (Deisher, Wenet, Paperny, Clark & Fehrenbach, 1982; Davis and Leitenberg, 1987). Given the evidence that the child offender is the forerunner of the adult perpetrator (Atcheson & Williams, 1954; Groth, Hobson, Lucey & St. Pierre, 1981; Longo & McFadin, 1981; Groth, Longo & McFadin, 1982; Longo & Groth, 1983; Davis & Leitenberg, 1987), the need for

research attention to juvenile offenders becomes obvious. The average adolescent sexual offender may be expected to commit 380 sex crimes during his lifetime (Abel, Becker, Cunningham-Rathner, Rouleau, Kaplan & Reich, 1983). Comprehensive studies aimed at early detection, increased understanding of etiology and pathology, and successful treatment modalities for adolescent sexual offenders should reduce the number of adult perpetrators as well.

The purpose of this study is to compare social competency and patterns of social isolation in male adolescent sexual offenders with two groups of non-offending adolescents. Do adolescent sexual offenders differ significantly from non-offending adolescents on these measures and, if so, how do they differ? Are there qualitative and/or quantitative differences which point to unique patterns of social isolation and/or poor social skills in juvenile sex offenders. Detection of such differences would aid in early detection and treatment strategies of potential sex offenders especially when other risk factors (i.e., victim of sexual abuse, family dysfunction, physical aggression) are present.

Clinical observations have indicated that the juvenile sex offender is generally male and a loner, having little contact with peers of either sex (Groth, 1977; Fehrenbach, Smith, Monastersky & Deisher, 1986; Shoor, Speed, & Bertelt, 1966). Social skills may be limited and play generally restricted to play with children younger than

himself. The juvenile offender has also been found to demonstrate little skill in developing close and meaningful relationships with peers (Groth, 1979) as he appears to lack the type of negotiation skills and self-control which is necessary in relationships between children (Van Ness, 1984). In a state-funded study of 305 sex offenders under the age of 18 and referred to the Adolescent Clinic at the University of Washington, Fehrenbach et al., (1986) noted that 65% showed evidence of severe social isolation. This finding was even more striking in youths who committed rape, with 73.9% indicating that they had no close friends. In a study 20 years previously, Shoor et al., (1966) also reported that nearly all of their sample of adolescent offenders were socially isolated. It is important to note that sexual offenders have also been found to be personable and likeable, some with histories of outwardly normal adolescent peer relationships and dating behaviours (Davis & Leitenberg, 1987; Margolin, 1983; Cohen et al, 1969). The authors of these studies, however, tend to question the sincerity of these qualities with the suggestion that such qualities place the offender more readily into positions of power and control.

No empirical studies have compared adolescent sexual offenders with other adolescents on measures of social isolation and social competency. Until this type of comparison is made, judgments surrounding social skill

deficits in adolescent sexual offenders may be difficult (Deisher & Leitenberg, 1987). Further investigation of these deficits could lead to intervention strategies aimed at reducing such difficulties and aid in early detection of potential adolescent offenders. According to O'Brien and Bera (1986), "The best way to minimize the number of sex offenses and their corresponding harmful effects is to intervene at the beginning or before the abuse pattern is established" (p.2). Early therapeutic intervention is essential in that deviant patterns and distorted thinking processes are less deeply ingrained and, therefore, easier to redirect or extinguish. In addition, young offenders are better candidates for learning and implementing new social skills (Knopp, 1987).

The first comparison group in the present study consists of adolescent boys being seen in a Community Mental Health clinic for a variety of emotional and behavioural disturbances. The second group is comprised of adolescent boys from two Detroit area church youth groups with no reported history of severe emotional or behavioural difficulties. This group serves as a comparison group of adolescent boys who currently are not receiving therapeutic treatment in a mental health setting. The first group was chosen as a comparison group because many of the presenting problems precipitating the need for outpatient treatment (i.e., aggressiveness, truancy, lying, severe family dysfunction, depression,

academic difficulties) are commonly found in adolescent sexual offenders. Although the clinic group is somewhat heterogenous in terms of presenting difficulties, it is similar to the offender group in that their behaviours were seen as serious enough to initiate referral for therapeutic intervention in an outpatient setting. In addition to measures of social competency and social isolation, parental and self-report measures of common behaviour problems are also compared to discern similarities and/or differences between the groups. This type of comparison may yield information which would aid in differentiating between emotionally troubled youths who act out sexually with those who do not. This may also assist in identifying offending youths who have been referred to the mental health system for other difficulties but have not been identified as sexual offenders.

An alternative comparison group in this type of study would be one of non-sexual juvenile offenders. This type of comparison has been used in research examining characteristics of adult offenders and has yielded significant differences as well as similarities between groups (Fisher & Rivlin, 1971; Perdue & Lester, 1972; Segal & Marshall, 1985; Lipton, McDonel & McFall, 1987). All of these studies, however, have examined incarcerated sexual and non-sexual offenders, indicating that their offenses were serious enough to warrant prison terms. The

focus of this study is on juvenile offenders whose offenses have warranted the parent, court or other social system to require therapeutic treatment on an outpatient basis. The mental health clinic group was chosen for this study as it contained a number of youths who have displayed aggressive and anti-social behaviours which could warrant police intervention. In response to these difficulties, these youths were referred by family or social services to outpatient treatment. Although it can be argued that most non-sexual juvenile offenders demonstrate emotional difficulties severe enough to warrant treatment, the majority are not referred to outpatient facilities when they are adjudicated. Future research might focus on the similarities and/or differences of sexual and non-sexual juvenile offenders at the time of the offense or adjudication.

Social Learning Theory

Social learning theory is based on the assumption that individuals are neither driven by inner forces or powerless agents of environmental forces. According to Bandura (1971) "psychological functioning is best understood in terms of a continuous reciprocal interaction between behaviour and its controlling conditions" (p.264). Factors such as cognitive processes, past experiences, and personal and social context play an important role in the development of individual characteristics. Social

learning theory suggests that people learn through direct, as well as vicarious, experiences. This model proposes that sexual aggression is not inborn, but results from learned behaviours. Sexual offenders may have viewed aggressive behaviours within the family, peer group, or figures observed in the mass media. From this view, the rapist who acts out of anger and displays characteristics indicative of a more generalized pattern of antisocial behaviour, likely experienced early environmental factors somewhat different from that of the non-aggressive fixated child molester who chooses sexual relations with a child because it is safe and comfortable. Numerous personal and social factors play a role in the development of all deviant behaviours including sexual assaultiveness. Although there have been studies which have examined the role of particular family characteristics in the development of sexual deviancy (Deisher, Wenet, Paperny, Clark & Fehrenbach, 1982; McCord, McCord & Verden, 1962; Maclay, 1960; Waggoner & Boyd, 1941), no clear-cut relationships have been established. Included in this area is the evidence of sexual abuse or sexual trauma in the histories of a large number of sexual offenders (Longo, 1982; Deisher et al., 1982; Margolin, 1983; Becker & Abel, 1984; Fehrenbach, Smith, Monastersky & Deisher, 1986; Smith & Monastersky, 1986; Davis & Leitenberg, 1987). The sexual abuse, which may have lasted over a number of years, does not have to be chronic in nature. Much of the

deviant learning may take place after the sexual experience in that the act later supplies a fantasy for masturbation. Subsequent masturbation to the fantasy serves to strengthen the connection between the deviancy and sexual pleasure. Because the perverse sexual act is likely the first sexual experience, it may make a strong impression on the child (Becker & Abel, 1984; McGuire, Carlisle & Young, 1965).

Another feature is the individual's ability to establish quality relationships with others. Families that do not provide good role models for demonstrating adequate social and assertive behaviours may produce adolescents who do not know how to relate effectively and may possibly be isolated and rejected by peers. This may result in the adolescent socializing with younger children which may, in turn, become eroticized or lead to the use of aggression in obtaining sexual contact with a peer.

An important feature of social learning theory is the emphasis on the individual's social environment. Individuals are subject to wide variations in environmental influences. Social attitudes pertaining to aggressiveness towards women and children may play an important role in the etiology of sexual assaultiveness.

Feminist Theory

Feminist theories of sexual deviancy are based primarily on the tenets of social learning theory.

According to Medea and Thompson (1974) "rape is not a special, isolated act ... Rape is simply at the end of the continuum of male-aggressive, female-passive patterns, and an arbitrary line has been drawn to mark it off from the rest of such relationships" (p.76). Rada (1978) points out that the "use of violence, the subjugation of women, and coercive sexual practices are not only widespread and tolerated but are encouraged and rewarded in a variety of ways (notably the high probability of success and the low risk involved)" (p.73). Check & Malamuth (1985) also report that forced sexuality and rape are prevalent and often unquestioned in North American society. In their study, they found that acceptance of rape myths (i.e., women really want and like to be raped) are correlated with acts of aggression against women and that mass media representations of sexual violence play an important role in fostering beliefs in rape myths. Check (1984) (cited in Malamuth & Briere, 1986) reported that repeated exposure to pornography resulted in increased acceptance of violence towards women and rape myths. Linz (1985) (cited in Malamuth & Briere, 1986) also found that when males were exposed to a number of sexually violent films they became less sympathetic to rape victims. Malamuth and Briere (1986) conclude that portrayals of sexual violence by the mass media, in combination with personality characteristics acquired through "adversive childhood experiences", may result in sexual

aggressiveness while dating. If reinforced (i.e., offense not reported, peer support), it may create a "further alteration in attitudes and perceptions that could attract the individual to a peer network supportive of sexual assault. These peers, themselves the product of originating and intermediate variables, might then provide greater support and approval for further sexual aggression" (p.79). Ageton (1983) also reported on the importance of peer group encouragement as an impetus for sexually aggressive behaviour.

In contrast to the psychiatric model of the rapist who is a sexual deviate and must be treated to be more like "normal" men, feminist theorists state that rapists and normal men are more similar than different, with behaviour which differs only in the degree of coercion (Check & Malamuth, 1985). Although this is an extreme statement, in support of their argument, the authors point out that gross differences in pathology are rarely found between rapists and nonrapists with only about 5% of rapists found to be psychotic during the rape offense. Psychopathology may be better judged by the tendency to be caught and convicted of the rape offense. Smithyman (1978) (cited in Check & Malamuth, 1985) reported that "self-admitted" rapists who were not reported for the offenses were very different from convicted rapists (i.e., 50% of the self-admitted rapists had college educations).

Check and Malamuth (1985) also report that sex-role

stereotyping had a significant effect on subjects' reactions to rape depictions. Respondents who were rated high in sex-role stereotyping were found to rate the victim's experience of the rape as being more positive than those rated low in stereotyping, and to admit a greater likelihood that they might commit a similar offense. Kirkpatrick and Kanin (1957), Kanin and Parcell (1977) and Byers and Eastman (1981) report findings which suggest that 38-50% of college women have been victims of some type of sexually aggressive behaviour during the previous year. These data point to the prevalence of sexual aggression in today's society.

Many other factors have been proposed to play an important role in the etiology of sexually offensive behaviours. These include many of the issues and characteristics described in later sections of this paper such as chronic feelings of inadequacy, insufficient ego development, lack of emotional support and parental characteristics of hostility, overprotectiveness, or uninvolvedness. In addition, social isolation and poor social skills have been noted throughout the literature as common characteristics of both adolescent and adult offenders. Further investigations in research and clinical work need to focus specifically on these areas to discern patterns of distinctive characteristics which may lead to earlier identification and treatment of youths who offend sexually.

Social Isolation and Social Skills Deficits

Given the common clinical observance of poor social relationships and feelings of low self-esteem in adolescent sexual offenders, a review of the literature on the possible ramifications of poorly developed social skills and social isolation may help in our understanding of these youths. Research has shown that childhood friendships provide experiences which facilitate cognitive, social, and emotional growth (Asher, Renshaw & Geraci, 1980). According to Fine (1981), friendships give children the opportunity to learn how to manage aggressive feelings and sexual relationships, as well as providing a context for the growth of the child's social self-awareness and self-image. Emotional development is also enhanced by childhood friendships which engender feelings of security and well-being. Approximately eight percent of the children in the United States report feeling "very lonely", with many of these children reporting that they have no friends (Asher et al., 1980). Hymel and Asher (1977) found that 5 to 10 percent of elementary school aged children are not selected as friends by their classmates.

Evidence of problematic behaviour in youths who have low peer acceptance is found throughout the literature. Ullmann (1957) found that socially isolated children are more likely to drop out of school. In addition, these

children have been found to be low achievers (Bonney, 1971; Davis & Leitenberg, 1987), and to experience learning difficulties (Amidon & Hoffman, 1965). In a longitudinal study over 11 years, Cowen, Pederson, Babigian, Izzo and Trost (1973) used IQ scores, grade point averages, scholastic achievement, teacher ratings, and peer ratings to predict later emotional difficulties. The authors found peer ratings to be the best predictor; children who were least liked by their peers were more likely to have sought mental health treatment eleven years later.

In a review of the literature, Asher, Oden and Gottman (1977) identified numerous reasons for reduced peer acceptance. Simple characteristics such as one's physical appearance, name, race and sex were found to influence peer acceptance and selection of friends. Situational factors in the child's environment, as well as the types of accessible activities and opportunities to participate can all affect friendship selection. In addition, many socially isolated children have been found to lack specific social skills which are necessary for developing close relationships. Asher et al. (1980) reported that popular and unpopular children differed in strategies selected for a variety of social situations presented. Compared to popular children, unpopular children consistently selected strategies which were ineffective in solving problems and less likely to enhance

relationships.

Based on the social learning theory, the development of social skills necessary for handling the give and take of close relationships is, to a large extent, dependent upon interactions with peers. Unlike relationships with adults, peer relationships center around mutuality and consent (Margolin, 1983). In addition, Margolin points out that role taking skills appear to develop during interactions with peers. These skills enable the individual to understand another's point of view and see themselves through someone else's eyes. As a result, the child learns empathic and cooperative behaviour as well as assertiveness and other skills which promote positive self-esteem. Social skills deficits have also been found to be significantly correlated with depression (Lewinsohn, 1974; Zemore & Dell, 1983; Wierzbicki, 1984). Research suggests that social skills training can be effective in reducing mild to moderate depression although it is still uncertain whether this type of training can prevent future episodes of depression (Wierzbicki, 1984).

Adolescent Sexual Offenders

Adolescents account for a large percentage of the sexual offenses committed in North America. A high percentage of victims in assaults by adolescents are family members, friends or acquaintances of the juvenile

offender (Fritz, Stoll & Wagner, 1981; Fehrenbach, Smith, Monastersky & Deisher, 1986; Davis & Leitenberg, 1987). According to Justice and Justice (1979), sibling incestuous relationships are five times as prevalent as those involving father and daughter. Typically, adolescent sexual offenders are males (Fritz et al., 1981; Davis & Leitenberg, 1987). Although there have been cases of adolescent females committing sexual offenses (Atcheson & Williams, 1954), it is uncommon to find reports of female perpetrators in the literature. Again, research and clinical observations indicate that the juvenile sex offender is severely limited in his abilities to establish close relations with others. Frequently, he is an underachiever who has had few positive experiences and accomplishments in his life (Loss & Doss, 1985). Commonly, he is quite sexually immature and there is a clear need for appropriate sex education. Feelings of inferiority, inadequacy, and insecurity in his sense of sexual identity are notable (Shoor, Speed & Bertelt, 1966; Groth & Loreda, 1981). These factors lead to feelings of anger and depression and patterns of maladjustment are common. Family constellations are often dysfunctional and provide poor role models (Waggoner & Boyd, 1941; Maclay, 1960; McCord, McCord & Verden, 1962; Shoor et al., 1966; Deisher, Wenet, Paperny, Clark & Fehrenbach, 1982). In response to these difficulties, the juvenile sex offender withdraws into a world of fantasy or becomes restless and

overactive. Subsequently, the juvenile doesn't acquire the skills necessary for handling everyday problems and the resulting distress spurs him into committing a sexual offense (Groth & Lored, 1981). Sexual assaults by adolescents are not motivated by sexual problems and are more accurately described as sex-superficial styles of behaviour. Such behaviour is initiated by feelings of anxiety, self-reproach and guilt rather than desires for pleasure and gratification. Groth and Lored (1981) point out that in an effort to alleviate overwhelming feelings of distress, the juvenile offender tends to use the assault as a "masturbatory ritual using the victim as a prop and constituting a re-enactment of unresolved developmental issues and psychological struggles" (p.38). The offense represents a "crisis state in the offender, a struggle for control, a quest for identity, and a discharge of emotion" (p.38).

Classification of Adolescent Sexual Offenders

Adolescent sexual offenders can be classified into distinct groups. The largest group consists of those juveniles whose offenses are directed towards children substantially (usually at least five years) younger than themselves (Deisher, Wenet, Paperny, Clark & Fehrenbach, 1982; Smith & Monastersky, 1986; Fehrenbach, Smith, Monastersky & Deisher, 1986; Davis & Leitenberg, 1987). Due to their limited social involvement with peers and

apparent naturalness with young children, they are often selected as babysitters. Many offenses occur while the offender is in a temporary position of power as a babysitter. These offenses are primarily ones of "indecent liberties" (i.e., forced mutual fondling of genitals or other types of sexual contact just short of penetration) and are generally directed towards family members or acquaintances. Wasserman and Kappel (1985) (cited in Davis & Leitenberg, 1987) reported that 91% of the child victims in their study were known to the adolescent offender at the time of the offense. A majority of victims are under the age of ten (Fehrenbach et al., 1986; Davis & Leitenberg, 1987). Physical force is rarely involved in committing the assault. Verbal threats appear to be the most commonly used method of coercion with young children (Davis & Leitenberg, 1987).

The next largest group of offenders are those who rape. This type of offender is usually somewhat older than the first group and the offense is most often committed against same-age peers or older victims. According to Deisher et al., (1982), on the surface, these youths may be performing acceptably in school and demonstrate some peer involvement. The authors point out, however, that "these teenagers are usually quite disturbed, which is in part evidenced by their severely limited ability to empathize with the victim and in their total unwillingness to see their behaviour as problematic"

(p.282). Adult victims are likely to be strangers and the use of physical force is common during the assault (Groth, 1979; Fehrenbach et al., 1986). According to Groth (1979), "the act of rape may represent a symptom of a developmental defect; a failure to achieve an adequate sense of self-identity, the consequences of which become especially acute in adolescence" (p.184). The author goes on to point out that difficulties in self-esteem are "exhibited in the frustrations he experiences in his efforts to achieve an adequate masculine image ... and his desire to gain mastery over his life in an active and assertive way" (p.184). Violent assaultive offenders commonly show very little empathy for the victim and downplay the seriousness of their offensive behaviours. The violent offender is often very manipulative and is deceptively clever and well-spoken. Frequently, there are available sex partners, indicating that the rape has little to do with sexual needs. Instead, the offense appears to be an outlet for aggression which cannot be appropriately expressed, as well as an effort to establish a sense of control. The offender is concerned with presenting himself to others as a "good boy", but this image appears planned and insincere (Margolin, 1983). According to Margolin, "the outward show of cooperation is often saccharine, too sweet, too perfect, reflecting the fact that the youth is more concerned with controlling others' responses than in expressing goodwill and caring"

(p.2). The need to control is apparent in all areas of the offender's life which is demonstrated in his propensity to lie. Court ordered outpatient treatment or residential placement is often required to keep the offender involved in treatment. Also included in this category are offenders who engage in "date rape". Although this type of offense is a serious problem, reported offenses appear to be low. Adolescent female victims are frequently reluctant to report such offenses for fear of reactions and reprisals of parents and peers (Deisher et al., 1982; Fehrenbach, et al., 1986) as well as feelings that, in some manner, she is responsible for the assault. Deisher et al., (1982) report that in an unpublished study, Zellman, et al. found that more than half of adolescent males surveyed indicated that it was "acceptable for a boy to force a girl to have sexual intercourse under certain circumstances, that is, when the girl sexually excited the boy, or when the girl agreed to have sex but later changed her mind" (p.285). In a review of the literature, Davis & Leitenberg (1987) report that less than half of all rapes are ever reported, with the percentage of reported rapes involving adolescent offenders being even lower.

Adolescents who engage in what has been termed "nuisance" or "hands-off" offenses (i.e., exhibitionism, voyeurism, fetishism, obscene phone calls, transvestism, and zoophilia) constitute a third group of young sexual

offenders. This type of adolescent offender is overwhelmed by a sense of inadequacy; few report initiation of age-appropriate dating behaviours. Victims, in these types of offenses, are generally strangers, female, and similar in age or older than the offender (Davis & Leitenberg, 1987). Feelings of anger and frustration are expressed through the offense. These types of offenses are frequently unreported and go untreated even though recidivism is high. Exhibitionism has the highest rate of recidivism of all the sexual offenses (Longo & McFadin, 1981; Fehrenbach et al., 1986). Exhibitionist offenders tend to commit the same offense over and over as they are allowed to remain in society with little pressure to obtain treatment. It is not unusual for an offender to admit that these early behaviours, which were initially satisfying, no longer satiated his needs, and subsequently progressed to more serious offenses of rape or child molestation (Longo & McFadin, 1981; Longo & Groth, 1983). The juvenile's early minor sexual offense most often leads to placement on probation with little or no psychological intervention. Labels of adolescent adjustment disorder or anxiety reaction may be applied and associated mental health attention is frequently minimal. Exhibitionist offenders are unlikely to be viewed as serious offenders and their potential to repeat the offense or commit a more serious offense goes unrecognized.

Psychological and Behavioural Difficulties

Research indicates that low self-esteem and an inadequate sense of masculinity which result in feelings of powerlessness, depression and fear of close interpersonal relationships are common in adolescent sexual offenders (Davis & Leitenberg, 1987). Anger, poor frustration tolerance and a belief in sex role stereotypes of women often result in sexual acting out. Van Ness (1984) found that 90% of her sample of youth rapists reported having a fight or argument, which they found disturbing, between two to six hours before the assault. In each case, the victim was not the individual the offender had argued with. In addition, 86% of the offenders indicated knowing that the rape would take place, suggesting a premeditated offense. Van Ness reported that compared to non-sexual offenders, sexual offenders were less skilled in controlling anger.

Physical aggression also appears common in other aspects of the adolescent offender's life. Aggressive non-sexual assaults are found in the records of many of the offenders (Shoor et al., 1966; Van Ness, 1984; Smith & Monastersky, 1986; Davis & Leitenberg, 1987). Lewis, Shankok and Pincus (1979) reported that offenders' behaviours throughout childhood and adolescence were similar to those of non-sexual violent assault offenders. Problematic school behaviours and a history of academic failure were found to be similar to those of other

non-sexually delinquent youths (Davis & Leitenberg, 1987). Fehrenbach et al. (1986) report that only 55% of a sample of adolescent offenders were on schedule in terms of grade placement, despite an average range of intelligence. Tarter, Hegedus, Alterman, & Katz-Garris (1983) reported no significant differences between groups of sexual, violent, and non-violent juvenile offenders on a range of intellectual, educational and neuropsychological measures. Margolin (1983) found "hands on" sexual offenders to be less impulsive, less disruptive, and not as outwardly rebellious as youths assigned diagnoses of conduct disorder. Rada (1978) reported that although some sexual offenders showed no severe signs of sociopathic behaviour, others demonstrated antisocial behaviours such as chronic running away from home, petty larceny, illicit drug use and fighting. Gomes-Schwartz (1984) (cited in Davis & Leitenberg, 1987) found that 80% of a sample of adolescent sexual offenders scored below age appropriate levels on the Loevinger Ego Development Scale. According to the author, this finding suggests that juvenile sex offenders experience difficulty conforming to the expectations of society due to a lack of ability to discern between right and wrong behaviours. Gratification of personal needs appears to be of utmost importance for these adolescents.

Reports on the usage of drugs and alcohol by the juvenile offender are conflicting. Fehrenbach et al. (1986) and Davis and Leitenberg (1987) both report a low

incidence of alcohol or drug abuse at the time of the offense. However, Amir (1971) reported that alcohol was involved in 34% of 646 rape cases studied and Van Ness (1984) found that 55% of a sample of offenders reported alcohol or drug use prior to the offense. The author points out that caution must be used in interpreting these results in that many of the offenders, when caught, use a variety of excuses including substance abuse to avoid accepting responsibility for the assault. Fifty two percent of the sample, however, reportedly had a chemical abuse problem.

Family History

A number of studies in the literature discuss the important role the dysfunctional family environment also plays in the formation of sexually assaultive behaviour in adolescence. Factors such as violent homes, neglect, physical and sexual abuse, as well as inconsistent emotional support and inappropriate relations appear to be related to offensive behaviour. Maclay (1960) reported that assaultive behaviour was positively correlated with "poor emotional adjustment", feelings of insecurity, and emotional impoverishment in the home. McCord, McCord, & Verden (1962) concluded from their research that the adolescent offender's behaviours are directly influenced by occurrences within the home. Deisher et al. (1982) noted the commonality of "distorted family relations" in

studying adolescent offenders. In addition, Van Ness (1984) discusses the necessity of early socialization in learning how to adequately control anger.

In an examination of individual cases of juvenile sex offenders, Waggoner and Boyd (1941) discussed two trends in the characteristics of home environments. One group of boys were similar in that they grew up in homes with dominant, overprotective mothers and maternal relationships centered around the mother's need for control. Personal needs of the mother tended to create an unhealthy model of mutual relationships for the child, creating conflict and confusion with the approach of physical maturity. Shoor et al. (1966) describe many of these mothers as being "overtly and covertly seductive" in their behaviour towards their sons. Boys in this group tended to be emotionally immature, dependent individuals who very rarely made important decisions on their own. Many were physically small and/or displayed effeminate features. Sexual urges during puberty tended to cause confusion, as it was unclear how they should be handled to gain relief yet not disrupt parental mores.

In contrast to the first group, the second group in the study included children from homes marked by parental rejection. Feelings of inferiority and inadequacy were common. Offenders from this group tended to be immature individuals who sexually acted out in a childish manner. In some cases, the parents themselves demonstrated acts of

violence and immorality which provided unhealthy models of behaviour (Waggoner & Boyd, 1941).

McCord et al. (1962) found that a group of sexually assaultive boys differed significantly from a control group with respect to family characteristics. Families of assaultive boys were characterized by an authoritarian and sexually anxious mother who pushed the child into emotional dependence, a physically punitive father, and intense parental conflict.

History of Abuse and Sexual Experimentation

A notable number of juvenile sex offenders have been found to be victims of sexual assault or have experienced a "sexual trauma" before reaching puberty (Longo, 1982; Deisher et al., 1982; Margolin, 1983; Fehrenbach et al., 1986; Smith & Monastersky, 1986; Davis & Leitenberg, 1987). Glueck (1965) (cited in Ellerstein & Canavan, 1980) suggested that almost one half of all pedophiliacs were victims of sexual abuse as young boys. Early exposure to such events may affect the child's impression of sexual behaviour and subsequent trauma may cause the child to attempt to re-enact the episode in an effort to gain control over it (Knopp, 1987; Longo, 1982; Waggoner, 1941). Facts about the individual's own molestation as a child have many times gone unreported until the offender is apprehended for his sexual assault on another. Unresolved feelings about his own trauma are only then

brought out into the open to be dealt with appropriately.

Consequences of sexual victimization have received much attention in research over the past decade. Common effects of sexual abuse include lowered self-esteem, isolation from peers, fear and anxiety, concentration problems in school, betrayal of trust, and signs of clinical depression (i.e., sleep and appetite disturbance, suicidal ideations). According to Friedrich, Urquiza and Beilke (1986), "The more invasive the sexual act and the longer and more frequently these acts were committed by someone close to the child constitute greater severity and are related to corresponding increases in a variety of behavior problems" (p.55). The child who is victimized may run away if the abuse is a chronic occurrence in the home, or may turn to alcohol and/or drugs. Long-term effects include increased isolation, chronic low self-esteem, and sexual dysfunction which causes the child to associate sex with negative feelings. In some cases the child may become sexually promiscuous and in other cases the child/adolescent may, in turn, abuse others. In a comparison study of young boys, those who had been sexually abused were found to be significantly more sexualized on the Child Behavior Checklist than a comparison group of non-sexually abused boys (Friedrich, Beilke & Urquiza (Under review)). According to the authors, parents often rated these boys as "masturbating too much and, in particular, reported that they were

preoccupied with sex" (p.7).

In most cases, sexual assault is not the initial sexual experience for the juvenile offender (Becker, Cunningham-Rathner & Kaplan, 1986; Longo, 1982; Rada, 1978; Groth, 1977; McCord et al., 1962). A majority of offenders have had preceding, mutually agreed upon, sexual experiences. Estimates from research reports suggest that the median age for an offender's first sexual experience is about 9.1 years (Longo, 1982). In his study, Longo found that sexual offenders not only experienced sexual molestation at an earlier age than non-offenders, but they also experienced a higher frequency of "mutually consenting" sexual contacts with adult partners, both male and female. The actual capability of children to "consent" to sexual acts with adults is highly questionable however. Finkelhor (1979) points out that children do not possess the knowledge to make an "informed" decision on such matters and suggests that children do not really have the freedom to say yes or no. Reports of sexual experimentation with older partners were frequently described as negative experiences by juvenile offenders. Included in this was a sense of insecurity over sexual performance resulting in feelings of inferiority and sexual inadequacy.

In addition to sexual abuse, physical abuse has also been found to be prevalent in the histories of a number of juvenile sex offenders. Lewis et. al. (1981) reported

that 75% of incarcerated sexual offenders had been physically abused compared to 29% of non-sexually assaultive inmates. In addition, 79% had witnessed violence within the family compared to 20% of the compared group. Van Ness (1984) found that 41% of the offenders examined reported a history of neglect or physical abuse.

Adult Sex Offenders

A review of the literature on adult sexual offenders is also warranted in that a majority of the current research focuses on adult offenders. In addition, up to 50% of adult offenders report initial offenses having occurred during adolescence (Groth et al., 1982; Smith & Monastersky, 1986). Although much of the literature on sexual offenders suggests the continuity of juvenile offenders becoming adult offenders, no research addresses this specifically. It is plausible that personality factors leading to dysfunctional patterns of handling emotional distress would persist, if left untreated, and similar offending behaviours would continue into adulthood.

Contrary to the longstanding myth about the adult sex offender who was believed to be psychotic, retarded or have a high sexual drive with limited outlets, research has uncovered a heterogeneous group of men who have serious difficulties in interpersonal relationships with members of both sexes and who respond to stress in a sexually

aggressive manner (Cohen, Seghorn & Calmas, 1969; Groth, 1979; Bradmiller & Walters, 1985). These studies stressed the offender's relative deficits in many of the basic social skills necessary in relating to others. Although these deficits are pronounced in all adult male sexual offenders, the social deficits differ in nature and intensity and subclasses can be discriminated within the group. Groth and Burgess (1977) define sexual deviations as "any pattern of persistent or preferential sexual activity which is primarily directed toward the satisfaction of needs that are not basically or essentially sexual" (p.255). The authors point out that sex offenses, for most of these men, represent a temporary and inappropriate attempt to establish some type of interpersonal relationship.

One dichotomy that is apparent is that offenders who offend against adults tend to re-offend against adults, whereas those whose offenses are aimed towards children tend to re-offend against children (Hall and Proctor, 1987). In contrast to child offenders, adult rapists also tend to have a history of nonsexual criminal activity which suggests that adult rape may be indicative of a generalized pattern of antisocial behaviour (Fisher and Rivlin, 1971; Hall and Proctor, 1987). Sexual offenses directed towards children generally occur under conditions of less severe force and threat of bodily harm due to the child's weakness and naivete and the offender's use of

authority, persuasion and misrepresentation (Finkelhor, 1980). Even so, 55% of Finkelhor's sample of 796 college students who report early victimization indicate that some type of force had been used to obtain their compliance.

In the following sections, adult sex offenses will be broken down into the two major categories of adult rape and child molestation. A review of the literature on both types of offenses will be included. Exhibitionism, a non-contact offense, will also be discussed.

Adult Rape

Sexual violence against women is a serious and widespread problem in today's society. Statistics indicate that about 25% of North American women have been the victim of rape or other types of sexual assault (Malamuth & Briere, 1986). Kanin and Parcell (1977) reported that 50% of a group of college females reported experiencing some type of male sexual aggression during the previous year.

One of the most basic statements that can be made about rapists is that they are not a homogeneous group. Offenses which are similar in context may be satisfying different needs in offenders and offenses which bear little resemblance to one another, outside of the inappropriate expression of sexuality, may serve the same purpose in different offenders. Despite these differences, however, the act of rape appears to serve

nonsexual needs (Groth, 1979). According to Groth, rape is the "sexual expression of power and anger. It is a pseudosexual act, complex and multidetermined, but addressing issues of hostility (anger) and control (power) more than passion (sexuality)" (p. 5). Groth also states "Rape is always a symptom of some psychological dysfunction, either temporary and transient or chronic and repetitive. It is usually a desperate act which results from an emotionally weak and insecure individual's inability to handle the stresses and demands of his life" (p. 5).

The rape victim is a symbol, who most frequently represents something or someone else. Emotional involvement is minimal and the act of intercourse appears to be the least important element of the rape episode (Rada, 1978). Rada reviewed several studies which have found that 30 to 40% of all rapists are married at the time of the rape offense and many of the unmarried offenders were dating women with whom they had an active sexual relationship. These reports suggest that appropriate sexual outlets are available for many rapists at the time of the offense. However, the absence of a healthy, emotionally intimate marital relationship is common among rapists, as they lack many of the characteristics (i.e., warmth, affection, empathy, trust) necessary to maintain close relations (Rada, 1978; Groth, 1979). Established relationships with males and females

tend to be characterized by the use of manipulation and exploitation by the rapist, who fails to recognize or care about the needs of others. Consequently, the rapist tends to remain psychologically distanced from others, with very few friends, and lacks confidence in all areas of his life, both sexual and non-sexual. Frustration and anger result, as feelings of inadequacy and powerlessness permit little sense of personal control over his life. For the rapist, sex may represent the highest source of personal control a woman has. The sexual assault is a means by which the victim is forced to give up this control and relinquish it to him. According to Rada, "Rape is a crime of control, power, and dominance. The primary motive in the rapist is the desire to control the victim in the specific instance of rape and, by extension, all women" (p. 24). He goes on to point out that this becomes a paradox, in that the act of submission by the victim, in turn, reduces the rapist's own sense of control.

Chronic rapists also demonstrate a number of other similarities. Numerous studies have indicated that most rapists have at least average intelligence but demonstrate poor judgment, especially when under stress or aroused emotionally (Groth, 1979; Rada, 1978; Groth, Burgess & Holstrom, 1977; Fisher & Rivlin, 1971). Gebhard, Gagnon, Pomeroy & Christenson (1965), however, report 4.4% of adult rapists were found to have IQ's below 70, indicating the importance of intellectual assessment to aid in

treatment considerations.

Reports on sexual dysfunctions in rapists are contradictory. Groth (1979) indicated that one out of three offenders reported some type of sexual difficulty during their assault. Rada (1978) reports that rapists appear to have fewer difficulties than other types of sex offenders such as pedophiles and exhibitionists. He points out that when impotence does occur during the rape it may be due to anxiety over sexual adequacy or may "serve as a defense against excessive hostility" (p.46). According to Rada, voluntary sex partners of rapists report few incidents of impotence. The author also points out that although physical aggression is common, sexual aggression is not a common occurrence in marital relationships. In another study, however, Hitchens (1972) reports that in conjoint therapy with rapists and their wives, denial, especially surrounding sexual problems, appears to be a common theme.

Rapists, on the whole, have been found to be generally young in age. A number of studies indicate that the average age of the adult offender is usually under 30 (Petrovich & Templer, 1984; Fisher & Rivlin, 1971; Revitch & Weiss, 1962; Groth, 1979). Groth (1979) points out that it is uncommon to find rapists who are older than their late forties and that compared to other violent criminals, rapists generally "burn out with time" (p.152).

Alcohol and/or drug abuse has been identified as a

common problem among adult sexual offenders (Malamuth & Briere, 1986; Giannini & Fellows, 1986; Wormith, 1984; Groth, 1979). These studies report that up to 76% of all incidents of sexual assault involve the use of alcohol or drugs. The actual incidence of substance abuse is difficult to determine, however, as "being under the influence" is often used in an attempt to avoid taking responsibility for the offense. In the literature, alcohol and/or drug abuse is generally not considered a causal factor, but an associated secondary disorder.

Studies comparing rapists with incarcerated non-sexual offenders on a number of measures have reported differences, as well as similarities between groups. Fisher and Rivlin (1971) found that, on the whole, rapists tend to be "less achievement oriented, less self-assured and aggressive, less independent and self-directed... a greater self-criticism and a greater need to nurture others and to be dependent upon others" (p.183). In a comparison of Rorschach protocols, Perdue and Lester (1972) found no significant difference between responses of rapists' and those of men convicted of aggressive non-sexual crimes. Segal and Marshall (1985) compared social skills in incarcerated groups of rapists, child molesters and aggressive non-sexual offenders with those of two control groups made up of low SES and high SES men from the community. Their results indicated that all three of the prison groups could be viewed as being less

socially skilled than the two groups of controls. In addition, they found that rapists demonstrated higher physiological signs of anxiety while role-playing incidents requiring assertive behaviours.

Child Molestation

Like adult rapists, sexual offenders whose victims are children cannot be considered a homogeneous group. One group of offenders' sexual interest is almost exclusively directed toward prepubescent or pubescent children (fixated pedophiles) whereas a second group turns to a child under stress over marital or sexual difficulties (regressed pedophiles) (Cohen, Seghorn & Calmas, 1969; Groth & Birnbaum, 1978). A third category is termed by Cohen et al., (1969) as the Pedophile-Aggressive type. These offenders are characterized by an aggressive and sexual approach to a child. Groth and Burgess (1977) divide this group further into exploitive assaults and sadistic assaults. In the exploitive assault, the offender forces himself sexually on the child through the use of physical force, intimidation, and threats. Sexuality appears to be based on a need for power. Children are selected as easy prey to overcome and control. Although offenders demonstrate little concern for the child, aggression is only used to force compliance in the child. This is not true in sadistic assaults which are similar to those committed on adults, with eroticized

aggression. The child becomes a target of hostility and rage who is tortured and sexually abused. According to Groth and Burgess, "at some level the child symbolizes everything the offender hates about himself and, thereby, becomes an object of punishment" (p.261).

In contrast, fixated pedophiles tend to engage in behaviours such as touching, stroking, and fondling the child. This type of offender is uneasy in social relationships with adults and has a history of isolation from peers since adolescence (Cohen et al., 1969). Groth and Birnbaum (1978) report that in a group of 85 fixated offenders, 88% had never married. Sexual intercourse is unusual in this type of offense. For the fixated offender, sexuality appears to satisfy unmet needs for physical contact and affection as well as acknowledgement and acceptance. Affiliations with children are sought out as they represent something comfortable and safe. The eventual goal of these relationships is one of sexual control, which is usually accomplished with the consent of the child, as the relationship is established in a skillful and charming manner. In the majority of cases, the child is male, below the age of 12, and either a complete stranger or casual acquaintance of the offender (Groth & Birnbaum, 1978).

In the regressed offender, there is a history of outwardly normal adolescence with good peer relations and dating behaviour. This type of offender experiences

overwhelming feelings of inadequacy in both sexual and nonsexual areas of his life (Cohen et al, 1969). Difficulties in adjustment to work and marriage are evident and there is a history of ineffectiveness in handling everyday stress. Incestuous child molesters, included in this group, are situational offenders whose family dynamics and opportunities play an important role in the commission of the offense (Quinsey, 1977). Swanson (1968) reports that 75% of the regressed offenders studied had unstable heterosexual relations and 50% had experienced severe marital difficulties resulting in the loss of a sexual partner. In almost all cases of regressed pedophilia, the victim is a female child (Cohen et al., 1969; Quinsey, 1977).

Like adult rapists, child molesters are relatively young in age and generally have at least average intelligence (Swanson, 1968; Groth, 1979). An excessive use of alcohol during offenses appears to be common (Peters, 1976; Swanson, 1968; Cohen et al., 1969; Quinsey, 1977). In comparing groups of pedophiles with rapists on a number of psychological measures, Peters (1976) found evidence of a large number of somatic complaints in the pedophile group but fewer signs of emotional problems suggesting a "strong tendency on their part to somatize affective problems and consequently to view themselves as inferior" (p.409). In addition, compared to rapists, pedophiles also show fewer indications of poor judgment,

less impulsiveness, and less confusion over sexual role identification. Pedophiles were also found to be more passive and submissive with a tendency to withdraw and become socially isolated when under stress.

As in the case of adult rapes, sexuality is not the core issue in pedophilia. Child offenders tend to be very specific in their choice of victim (i.e., female or male) and the type of assault they commit (Groth & Birnbaum, 1978). The authors point out that this suggests that "the sexual attraction to children has particular and specific psychological dynamics underlying it rather than being the result of either situational opportunity or an indiscriminate, unorganized, polymorphous sexual desire" (p.179). Throughout the literature, child molesters are described as emotionally immature, timid, and passive individuals who are overwhelmed with feelings of sexual inadequacy. Sexual assaults on children represent an attempt to exorcise doubts surrounding masculinity with a relatively safe, non-threatening and non-judgmental victim.

Exhibitionism

Currently, there is much controversy over the relationship between exhibitionism and the more aggressive assaults of adult rape and child molestation. Rooth (1973), in his discussion on exhibitionism, points out that disagreement between researchers may result from the

tendency to consider such offenders as a homogeneous group. Exhibitionistic behaviour appears to begin at a young age, between 15 and 20 years (Rooth, 1973). Many rapists and child molesters have been found to have a history of exhibitionistic behaviour beginning in adolescence which progressed to rape or child molestation or may be continued along with it (Swanson, 1968; Rada, 1978). In his study, however, Rooth found that "persistent" exhibitionists show a general lack of aggressive behaviour and a low incidence of force used during offenses. They are characterized as extremely timid individuals who have difficulty expressing aggressive feelings. More specific differences between the groups are difficult to determine as apprehension and conviction for exhibitionism is rare and those who are caught are seldom evaluated for risk of more serious offenses.

Recidivism

According to Groth & Loredó (1981), a notable percentage of adult sexual offenders committed their initial sexual assault before the age of 18, with a modal age of 16. Unfortunately, juvenile sexual offenses are frequently dismissed by parents, mental health professionals, and the criminal justice system as simply being adolescent sexual "curiosity" or experimentation (Groth, 1977; Groth & Loredó, 1981; Longo & McFadin, 1981;

Groth et al., 1982). There is a general tendency to dismiss the seriousness of the offense. As a result, these difficulties escape detection and subsequently, offenders receive no therapeutic attention until they reach adult status and repeat the same or similar offense. Appropriate intervention does not begin at an early stage in the development of abnormal sexual behaviour but tends to be initiated only after it has become more of an ingrained pattern of behaviour. As a result, it has been found that sexual offenders have a history of repeated offenses (Becker, Kaplan, Cunningham-Rathner & Kavoussi, 1986; Groth et al., 1982). This is difficult to substantiate because of the reluctance of the courts to prosecute adolescents for sexual acting-out. In their study, Groth et al. (1982) found that the offenders questioned reported actually committing "two to five times" the number of offenses which resulted in arrest and detention. Individuals who have committed serious sexual offenses such as rape and child molestation have been found to have a high rate of recidivism, but this is not apparent by examining arrest records (Groth et al., 1982). Estimates of recidivism are likely quite low and cannot be accurately estimated by the number of individual offender arrests. The authors point out that the high rates of recidivism help to substantiate the belief that sexual offenses are psychologically rather than situationally determined. An emphasis is placed on the need for more

focused attention on the juvenile sexual offender because "if we are to deal effectively and meaningfully with the problem of sexual assault, we must recognize it as a repetitive pattern of behaviour, most of which is undetected" (p.458).

In summary, available research indicates that many juvenile sex offenders lack confidence in their abilities and tend to feel an overwhelming sense of inadequacy. They are viewed as immature and many experience difficulty in establishing and maintaining interpersonal relationships. As a result, they tend to remain socially isolated from peers and lack the appropriate skills needed to deal with developing sexuality and aggression. The juvenile's own possible sexual victimization and/or traumatization creates a sense of little control and the young offender may attempt to re-enact the episode in an effort to regain that control. Defects in personality structure appear to be related to unhealthy parent-child relationships and inappropriate discipline techniques. In addition, sexually assaultive behaviour appears to be directly related to the more usual and familiar types of juvenile behaviour problems and may be another expression of a youth's delinquency pattern which is established during a defective upbringing. Becker et al., (1986) found that a high percentage of their sample met the DSM-III criteria for conduct disorder.

Research Implications

Few clinical and data-based studies on adolescents who commit sexual offenses are found in the research literature. Most of the available information on adolescent sexual offenders is based on clinical impressions and judgments made during the course of interviews, psychotherapy or gathered from clinical records (Markey, 1950; Cohen et al., 1969; Fehrenbach et al., 1986). These types of methods may be somewhat unreliable as they are often unstandardized and fail to identify examiner bias promoted through knowledge of group membership (Bailey, 1978). Included in this area are reports of poor social skills and social isolation of adolescent offenders. Although heterosocial skills have been empirically examined in adult sexual offenders (Lipton, McDonel & McFall, 1987; Overholser & Beck, 1986; Segal & Marshall, 1985), no studies have systematically compared social skills, peer relationships, and social isolation of adolescent sexual offenders with non-offenders. Therefore, unique differences which may exist between the groups in these areas have not been established.

Clinically based research has shown that adolescent sexual offending is broad in scope. Variables such as age of victim, hands-on versus hands-off offenses and the relationship of the victim lend support for the rationale of a system of classification of juvenile offenders

(Fehrenbach et al., 1986). According to Smith and Monastersky (1986), different personality factors are associated with different types of offenses yet, most of the group studies on sexual offenders include subjects who have committed different types of offenses. In addition, there is frequently an absence of adequate comparison groups (Overholser & Beck, 1986). As a result, little is known about the different types of adolescent offenders.

Another major methodological difficulty, which confounds all research on offenders, lies in the evidence that juvenile sexual offenders are underreported and recidivism rates are low. Once detected, adolescent sexual offenders frequently avoid placement in treatment. Those that end up in treatment constitute a small proportion of all adolescent offenders. As a result, we do not have a clear sense of the actual prevalence of juvenile sexually offensive behaviours. Another concern is that research done on adolescent offenders who end up in treatment programs or facilities may not be applicable to juvenile sex offenders in general. Those who have been caught and forced into a treatment situation may be different not only from those who go undetected but also from those who are caught but not made to seek treatment. Some of the available research on sex offenders has been done on incarcerated samples (Lipton et al., 1987; Baxter, Barbaree & Marshall, 1986; Barlow, Abel, Blanchard, Bristow & Young, 1977). This presents a question

concerning the possible effects imprisonment itself may have on the offender. Incarcerated sex offenders and non-offenders have shown poorer social skills than non-incarcerated control subjects (Overholser & Beck, 1986; Segal and Marshall, 1985). Studies using non-incarcerated offenders may be somewhat more representative of offenders who remain undetected.

Purpose of the Present Study

The purpose of this study is to examine patterns of social isolation and social competency in non-incarcerated adolescent males who have committed sexual offenses against children. Although clinical observations indicate that the adolescent sexual offender demonstrates difficulties in both of these areas, no available research has examined the characteristics and severity of these problems. Are there quantitative and/or qualitative differences in adolescent sex offenders in terms of social isolation and social competency compared to adolescents who have not committed sexual offenses? What of other problem behaviour areas? Adolescent sex offenders are described as utilizing dysfunctional coping techniques for handling distress. How do these offenders compare in areas of common complaints for non-offending adolescents experiencing emotional problems (i.e., depression, somatic complaints, aggressiveness, delinquency, and anxiety)? Identifying areas of concern which may constitute risk

factors is an important step in developing adequate treatment and prevention strategies.

Hypotheses

This study will compare male adolescent sexual offenders in an outpatient treatment program with non-offending adolescent boys from a mental health clinic population and a community comparison group of adolescent boys who have no history of emotional difficulties. Differences and/or similarities on demographic variables as well as measures of emotional and behavioural difficulties and social competency and isolation will be assessed.

Hypothesis 1: Adolescent sex offenders will score significantly higher than the clinic population and community comparison group on a measure of social isolation and significantly lower on a measure of social competency.

Hypothesis 2: Adolescent boys in a mental health clinic population will score significantly higher than the community comparison group on measures of social isolation and significantly lower on a measure of social competency.

Hypothesis 3: Adolescent sex offenders will score significantly higher than the community comparison group on the CBCL and YSR scales Depression, Somatic Complaints, Somatic Concerns, Thought Disorder, Immaturity,

Unpopularity, Uncommunicativeness, Hostility/Withdrawal, Hyperactivity, Aggressiveness and Delinquency.

Hypothesis 4: Adolescent boys in a mental health clinic population will score significantly higher than the community comparison group on the CBCL and YSR scales of Depression, Somatic Complaints, Somatic Concerns, Thought Disorder, Immaturity, Schizoid, Uncommunicativeness, Hostility/Withdrawal, Hyperactivity, Aggressiveness and Delinquency

Hypothesis 5: Adolescent sex offenders will score significantly higher than the clinic group on the CBCL and YSR scales of Hostility/Withdrawal and Unpopularity.

Hypothesis 6: Social isolation and low levels of social competency will correlate significantly with the YSR scale of Depression.

Hypothesis 7: Parent and self-reports of behaviour problems will show greater disparity in the clinic groups than in the community comparison group.

CHAPTER II

METHOD

Subjects

Participants in this study represented two clinical samples: Group I: 20 adolescent boys from the Adolescent Sexual Abuser Program (ASAP), an outpatient adolescent sexual offender treatment program at the Children's Center of Wayne County in Detroit, Michigan, and Group II: 16 adolescent boys from two Detroit area Community Mental Health agencies (Children's Center and Northeast Guidance Clinic) in outpatient treatment for a variety of emotional and behavioural difficulties with no history of sexual offense. Group III was made up of 19 adolescent boys from two Detroit area church youth groups who had no reported history of mental health treatment. The following criteria were established for inclusion in the experimental groups: (1) participants must be males between the ages of 12 to 16 years, (2) Group I participants must have molested a child younger than himself and have been involved in treatment for less than

one year, and (3) Group II participants were screened to insure there was no history of sexually offensive behaviour.

Measures

Three dependent measures with established norms were utilized in this study. Two of these, the Youth Self-Report (YSR) and the Adolescent Alienation Index (AAI), were administered to the youths while the Child Behavior Checklist (CBCL) was filled out by the primary caregiver, most often the mother. Demographic information and family living situations were also obtained. Histories of early sexual and physical abuse were obtained from the youth's clinical records.

The Child Behavior Checklist (Achenbach & Edelbrock, 1983) is a questionnaire designed to provide information on two basic scales: (1) Social Competence, and (2) Behavior Problems in children ages 4 through 16. Twenty social competence items obtain parents' reports on the amount and quality of participation in a variety of activities (i.e., sports, hobbies, games, organization involvements, jobs and household chores, friendships and school functioning). The parent is asked to (1) list the child's activities, organization involvements and chores; (2) indicate, by comparison to same-aged children, the amount of time spent at these activities; and (3) for sporting activities and hobbies, compare the child's skill

to other children. Based on these responses, a Social Competence Profile is derived made up of three scores: (1) Activities, (2) Social, and (3) School.

The Behavior Problems scale consists of 118 items which are answered according to a 3-step response scale (0=not true, 1=somewhat or sometimes true, and 2=very true or often true) based on the child's behaviour over the past six months. Factor analysis yielded nine factors for males in the criterion age group (Achenbach & Edelbrock, 1983). The resulting behaviour problem scales include Schizoid or Anxious, Depressed, Uncommunicative, Obsessive-Compulsive, Somatic Complaints, Hostility/Withdrawal, Hyperactive, Aggressive, and Delinquent. Total raw scores for each of the behaviour problem scales are marked on a graph which indicates the percentiles based on normal children and the corresponding T score. Normalized T scores have been based entirely on percentiles up to a T score of 70 (98th percentile). Reliability of the CBCL was assessed using test-retest, inter-rater agreement, and longer-term stability measures. Intraclass correlations (ICCs) for individual items scored were in the .90's. Test-retest correlations for inpatients' scores over a 3-month period averaged .74 for parent's ratings and .73 for child care worker's ratings of behaviour problems. Test-retest correlations for outpatients' scores over a 6-month period were in the .60s for both behaviour problems and competence scores

(Achenbach & Edelbrock, 1983).

The Youth Self-Report (Achenbach & Edelbrock, 1987) was designed to obtain 11- to 18-year olds' reports of their own competencies and problems in a standardized format. Many of the same items on the Child Behavior Checklist (CBCL) are included in the questionnaire. This allows for comparisons to be made between the results of the two questionnaires. Discrepancy between the reports may indicate that the child behaves differently in front of the parent or simply differences in the standards of judgment between the two. As in the CBCL, participants answered items pertaining to social competence and behaviour difficulties. The Social Competence Profile of the YSR is derived by two scores (1) Activities, and (2) Social. The Behavior Problems Profile consists of scores on seven scales: Depressed, Unpopular, Somatic Complaints, Self-Destructive/Identity Problems, Thought Disorder, Delinquent, and Aggressive. Test-retest reliability for the YSR after 1-week was .81 for nonreferred adolescents. Self-ratings after an 8-month period showed a test-retest reliability of .51 (Achenbach & Edelbrock, 1987).

The Adolescent Alienation Index (AAI) (Heussenstamm, 1971), was developed to measure the existence and extent of alienation as manifested by in-school adolescents. There are 41 items and subjects are asked to choose between two statements which best describe how they feel.

Raw scores as well as a corresponding designated score of alienation (1 = minimal alienation; 2 = little alienation; 3 = typical alienation; 4 = moderate alienation; 5 = extreme alienation). A reliability coefficient for the AAI of .78 was obtained using the Kuder-Richardson Formula 20. The correlation between the AAI and the Rotter I-E Scale, a measurement used to assess concurrent validity, was .61 (Heussenstamm, 1971).

Procedure

Participants in both clinical groups were initially approached to participate in the study by their individual or group therapist. All of the therapists involved had been informed of the study during group supervisory meetings. The purpose of the research was discussed and the therapists who had clients matching the criteria were asked to approach the youth and family about participating. A letter of explanation was provided (See Appendix A) with a brief description of the study and an assurance of confidentiality. Parents, in these groups, were approached either by the child's therapist or by a letter of explanation in the mail. They were informed that the results of the questionnaire would be used for research but also shared with the child's therapist to provide aid in treatment planning. Both the child and parent signed a consent form to participate in the study. All of the youths in the clinical groups filled out the

questionnaires before or after their scheduled therapy sessions. Many of the parents of the youths in Group II accompanied their children to therapy sessions and completed the questionnaire at that time. To insure attendance, youths in the offender group are picked up for scheduled group therapy by a clinic van but their parents do not accompany them. As a result, other parents, including most of the parents in the offender group, were mailed the CBCL with an explanatory letter (See Appendix B) and provided with a stamped self-addressed envelope in which to return it. If the questionnaire was not returned within two weeks, a reminder was mailed out indicating that a new questionnaire would be provided if the original was lost. Finally, the child's therapist made follow up calls two weeks after the reminder was mailed to encourage the parent to return the questionnaire promptly.

Participants in Group III were recruited by two Children's Center employees who were actively involved in two large Detroit area churches. This group was selected as a comparison group with the viewpoint that they would be close in approximation to the clinic groups in terms of race and socioeconomic status. Youths and parents were approached by these employees and asked to become involved in a research project involving teenage boys. A letter of explanation was provided (See Appendix C) as well as a stamped self-addressed envelope to return the questionnaires in. Forty packets were handed out and 19

were returned. These youths had no reported histories of outpatient treatment for emotional or behavioural difficulties. Histories of sexual and/or physical victimization were not collected as questions concerning these areas have been found to be disturbing to parents. Becker and Abel (1984) report that most school systems and adults in our society are uncomfortable with the notion of childhood and adolescent sexuality. In fact, none of the parents initially approached agreed to participate in the study when the topic of sexual victimization was brought up. As a consequence, it was decided to compare only the two clinic groups in these areas as the information could be gathered from the clinical records or by questioning the therapist.

Missing Data

The issue of missing data in the present study needs to be addressed as it is felt that it has made an impact on the results of the study. Due to small group numbers, participants with missing data were still included in the study. Missing data, however, often resulted in the participant being excluded from certain statistical analyses. Most notable was the number of missing parent questionnaires, the Child Behavior Checklist. Only forty four (80%) of the participants had completed CBCLs. Most remarkable is the fact that nine (45%) of the 20 parents or guardians in the sexual offender group, who had

originally agreed to participate in the study, did not return the questionnaire despite numerous reminders by mail, telephone calls and personal contacts made by the child's therapist and/or the interviewer. In contrast, only one parent out of 16 in the clinic treatment group and one parent out of 19 in the community comparison group failed to return the questionnaire. Clinically, these findings are notable and interpretations will be offered in the final section of this paper.

In addition, participants and parents in all three groups left some items blank on the YSR and CBCL. The social competency scores were affected most dramatically by this due to an inability to calculate these scores because of item deletion. Also, four participants from the community group did not include the AAI or the family living situation data form when they returned the questionnaires.

Sample Demographics

The final sample consisted of 55 adolescent males, 47 of whom (85%) were black and eight of whom (15%) were white. The average age of the participants was 14.3 years and mean grade level was 8.5. A family living situation question was included to obtain information on the marital relationship of the natural parents. Nine categories were

included: Married, legal (n=27 or 49%); Married, common law (0); Separated (n=5 or 9%); Divorced (n=5 or 9%); Widowed (n=3 or 5%); Never Married (n=7 or 13%); Divorced, mother remarried (n=2 or 4%); Divorced, father remarried (n=2 or 4%); and Divorced, both parents remarried (n=4 or 7%). The average number of siblings for the sample was four. Thirty six percent of the sample (n=20) are presently in special education classes (learning disabled or emotionally impaired).

For the completed CBCLs, thirty five (85%) were filled out by the child's natural mother and three (7%) were filled out by the natural father. Of the remaining six, five (11%) were completed by a female relative who was the child's primary caretaker and one (2%) was completed by the child's foster mother.

CHAPTER III

RESULTS

The results of the study are presented in two sections. The first section contains a synopsis of selected demographic characteristics of the sample including academic difficulties and special education placements as well as histories of physical and sexual victimization. The second section addresses each of the seven hypotheses presented in Chapter I. All analyses were conducted using the statistical Package for the Social Sciences (SPSS) (Nie, Hull, Jenkins, Steinbrenner & Bent, 1975).

Sample Demographics

According to reports from the CBCL and the medical records of the two clinic groups, 62% of the youths in the entire sample (n=13 for Group I and n=14 for Group II) are presently exhibiting academic and/or behavioural difficulties in school. In addition, 36% of the sample (n=20) are presently in special education classes (learning disabled or emotionally impaired).

Histories of past sexual and/or physical victimization

were also gathered on participants in the offender (Group I) and clinic (Group II) groups. Four youths (13%), all from the sexual offender group, had positive histories for past sexual victimization. An additional six participants (19%), again all from the offender group, had histories strongly suggesting the possibility of past sexual victimization, but the youth had not yet made such a disclosure. Seven of the participants (23%) had positive histories of past physical abuse. Four additional youths (13%), two from each group, were found to have histories strongly suggesting the possibility of physical abuse, but again the child had never substantiated these suspicions.

Table 1 summarizes the selected demographic variables of age, race, grade family living situation, number of siblings, and also enrollment in special education and the presence of academic and/or behavioural difficulties in school for each of the three groups: Group I = adolescent sexual offenders (n=20); Group II = clinic treatment group (n=16); Group III = community group (n=19). The groups did not differ significantly in terms of age, grade and number of siblings. An examination of racial distribution between groups using a chi-square analysis with the Yates correction for low cell frequencies did not yield significant results ($\chi^2(2, N=55)=5.13, n.s.$), indicating that the groups did not differ significantly in terms of race. Chi-square analyses were also done to determine

Table 1

Summary of Demographic and Other Variables

<u>Variable</u>	<u>Group I</u>		<u>Group II</u>		<u>Group III</u>	
	(n=20)		(n=16)		(n=19)	
	<u>F</u>	<u>%</u>	<u>F</u>	<u>%</u>	<u>F</u>	<u>%</u>
Age						
12	1	5	1	6	5	26
13	2	10	4	25	3	16
14	9	45	2	13	3	16
15	6	30	5	31	2	11
16	2	10	4	25	6	31
Race						
White	3	15	5	31	0	
Black	17	85	11	69	19	100
Grade						
6th and 7th	6	30	4	25	5	26
8th and 9th	11	55	8	50	7	37
10th and 11th	2	10	4	25	6	32
Dropped Out	1	5	0		1	5
Family Living Situation						
Married	8	40	6	38	13	68
Separated	2	10	1	6	2	11
Divorced	6	30	3	19	0	
Widowed	1	5	2	13	0	
Never Married	3	15	4	25	0	
Missing Data	0		0		4	21
Number of Siblings						
0-2	8	40	6	38	8	42
3-4	8	40	5	31	3	16
5 or more	4	20	5	31	4	21
Missing Data	0		0		4	21
Academic and/or Behavior Problems at School						
Yes	13	65	14	88	7	37
No	4	20	2	12	11	58
Missing Data	3	15	0		1	5
Special Education						
Yes	9	45	11	69	0	
No	9	45	5	31	18	95
Missing Data	2	10	0		1	5

whether the three groups differed on categorical demographic data. Results indicate that two variables, special education and academic/behavioural difficulties, yielded significant chi-square values. Sexual offenders and the clinic treatment participants were more likely than the community comparison participants to be found in a special education classroom, $\chi^2(2, N=52)=18.46, p < .0001$, and to be experiencing academic and/or behavioural difficulties at school, $\chi^2(2, N=51)=10.11, p < .01$.

Histories of past sexual and physical victimization are reported for Groups I and II in Table 2. Chi-square analyses were utilized to determine whether the groups differed on these variables. In order to obtain acceptable cell frequencies for chi-square analyses, youths who had positive histories for victimization were combined with those who had histories strongly suggesting that victimization had occurred. Results indicated that, compared to the clinic treatment group, sexual offenders had a higher frequency of reported or suspected past sexual victimization, $\chi^2(2, N=32)=12.83, p < .01$, and physical victimization, $\chi^2(2, N=30)=9.58, p < .01$.

Social Isolation and Social Competency

Hypothesis one predicted that adolescent sexual offenders (Group I) would score higher than the clinic treatment and control groups (Groups II and III) on a measure of social isolation. Hypothesis two predicted

Table 2

Frequency and Percentages of Physical and Sexual
Victimization Histories for Groups I and II

<u>Variable</u>	<u>Group I</u>		<u>Group II</u>	
	(n=20)		(n=16)	
	<u>E</u>	<u>%</u>	<u>E</u>	<u>%</u>
Physical Victimization				
Yes	7	35	0	0
No	6	30	13	81
Possible	2	10	2	13
Unknown	5	15	1	6
Sexual Victimization				
Yes	4	20	0	0
No	7	35	15	94
Possible	6	30	0	0
Unknown	3	15	1	6

that adolescents in the clinic treatment group (Group II) would score higher on a measure of social isolation than the community group (Group III). The Adolescent Alienation Index (AAI) was selected for the present study to measure social isolation. Raw scores as well as a corresponding designated score of alienation. Hypothesis one also stated that sexual offenders would score lower on measures of social competency than both the clinic treatment and community groups. Hypothesis two predicted that the clinic treatment group would score lower than the community group on measures of social competency. The social competency sections of the CBCL and the Youth Self-Report (YSR) were utilized as measures for the present study. In the CBCL, social competency is divided into three categories: Activities, Socialization, and School. In the YSR, there are two categories of social competency: Activities and Socialization. T-scores are calculated for each of these categories and are also combined into a Total Competency Score for each questionnaire.

The primary purpose of discriminant function analysis is to find dimensions along which groups are maximally different and then to predict group membership based upon these dimensions (Tabachnick & Fidell, 1983). Six predictor variables were used in the analysis (AAI raw score and the five CBCL and YSR social competency scores). On the basis of these variables, it was not possible to

maximally separate the three groups. Unfortunately, as reported earlier, because the questionnaires were mailed, eleven subjects did not have a CBCL completed on them and another four were missing the AAI. In addition, subjects with any missing data are excluded from the analysis. For instance, if the parent or child did not answer all items in the social competency section, scores could not be calculated and the subject could not be included in the analysis. As a result, due mainly to missing CBCL and AAI data, only 24 of the 55 subjects were included in the analysis, resulting in a small subject to variable ratio. In an effort to control for missing data, another discriminant function analysis was performed using only the two YSR social competency scales as predictors. Fifty four of the subjects were included in this analysis. The analysis, however, did not predict group membership.

One-way analyses of variance on the eight predictor variables (the CBCL and YSR Total Competency scores in addition to the previous six scores mentioned) revealed significant differences between the three groups. As Table 3 indicates, a highly significant finding was obtained on the CBCL Social Competency-School category, $F(2,36) = 7.98$, $p < .001$, and the CBCL Total Social Competency scale, $F(2,36) = 3.35$, $p < .05$. Post hoc (Tukey) comparisons between the groups yielded significant differences ($p < .05$) between the clinic treatment and community groups on the two scales. These results suggest

Table 3

Results of Analyses of Variance of CBCL and YSR Social
Competency and AAI Social Isolation Scales

Scale	Range	Group I		Group II		Group III		F
		n=20		n=16		n=19		
		X	s.d.	X	s.d.	X	s.d.	
CBCL S.C.- Activities	10-55	47.6	5.89	39.7	12.98	43.3	14.69	1.22
CBCL S.C.- Social	15-55	42.3	10.74	40.3	9.60	43.6	12.60	.23
CBCL S.C.- School	18-55	39.2	11.80	34.0	8.92	48.4	9.06	7.98**
CBCL S.C.- Total	20-61	40.9	10.59	31.7	11.15	45.9	11.40	3.35*
YSR S.C.- Activities	10-55	42.3	13.50	44.3	11.61	44.3	11.87	.16
YSR S.C.- Social	10-55	48.4	7.14	43.1	11.59	46.7	11.01	1.27
YSR S.C.- Total	10-74	47.0	12.07	42.9	8.93	46.6	16.60	.50
AAI (Raw)	4-31	10.7	5.77	14.3	8.35	12.7	6.81	1.17

* $p < .05$
** $p < .001$

that the clinic treatment group demonstrates lower levels of social competency than the community group, with significant difficulties in competency at school. Consequently, hypothesis two was partially supported. Post hoc comparisons indicated no significant differences between the sexual offender group and clinic treatment or community groups on these measures. Hypothesis one was, therefore, not supported by these measures

Behaviour Problem Scales

Hypothesis three stated that adolescent sex offenders (Group I) would score significantly higher than the community comparison group (Group III) on selected CBCL and YSR behaviour problem scales. Hypothesis four stated that adolescent boys from a mental health clinic (Group II) would also score significantly higher than the community group (Group III) on the same selected behaviour problem scales. Analyses of variance were performed using the CBCL and YSR scales of Depression, Immaturity, Somatic Complaints, Thought Disorder, Unpopularity, Uncommunicativeness, Somatic Concerns, Schizoid, Hostility/Withdrawal, Hyperactivity, Aggressiveness and Delinquency. Results of the analyses, presented in Table 4, demonstrate significant differences on the CBCL Schizoid scale, $F(2,40) = 4.84, p < .01$, Somatic Concerns scale, $F(2,40) = 3.92, p < .05$, and Immaturity scale, $F(2,40) = 3.81, p < .05$. Reliable differences were also

Table 4

Results of Analyses of Variance of Selected CBCL and YSR
Behavior Problem Scales

Scale	Range	Group I		Group II		Group III		F
		n=20		n=16		n=19		
		X	s.d.	X	s.d.	X	s.d.	
Depression	55-88	59.6	8.39	61.3	10.58	55.2	.69	3.11
Immaturity	55-85	64.6	8.44	70.0	10.20	61.7	6.84	3.81*
CBCL Somatic Concerns	55-79	60.8	8.12	66.6	7.14	59.4	7.25	3.92*
YSR Somatic Complaints	55-82	62.1	8.27	60.9	7.05	55.4	.96	6.10**
Schizoid	55-80	59.1	5.36	66.0	8.14	59.1	6.54	4.84**
Thought Disorder	55-92	64.5	9.73	64.6	10.33	57.37	4.50	4.40**
Unpopularity	55-83	59.2	7.06	60.4	9.33	55.9	2.18	2.21
Uncommunicativeness	55-82	61.1	9.32	63.9	6.92	58.2	5.19	2.58
Hostility/Withdrawal	55-89	64.1	10.52	68.7	9.35	61.2	6.86	2.91
Hyperactivity	55-86	65.5	10.62	67.9	8.00	63.3	8.37	1.06
CBCL Aggressiveness	55-91	63.6	11.23	64.9	7.72	60.1	5.69	1.50
YSR Aggressiveness	55-79	57.2	5.06	59.6	6.22	55.5	1.50	3.43*
CBCL Delinquency	55-79	61.5	4.78	66.6	7.22	63.3	8.05	1.71
YSR Delinquency	55-71	57.5	5.01	59.0	5.98	57.0	3.70	1.04

* $p < .05$ ** $p < .01$

found between groups on the YSR scales of Thought Disorder, $F(2,52) = 4.40$, $p < .01$, Aggressiveness, $F(2,52) = 3.43$, $p < .05$ and Somatic Complaints, $F(2,52) = 6.10$, $p < .01$. Post hoc (Tukey) tests ($p < .05$) confirmed that the clinic treatment group scored significantly higher than the community group on the CBCL Schizoid, Somatic Concerns and Immaturity scales, as well as the YSR scales of Thought Disorder and Aggressiveness. Sexual offenders also scored significantly higher than the community group on the YSR Thought Disorder scale. Post hoc comparisons also indicated that both the adolescent offender and clinic treatment groups scored significantly higher on the YSR Somatic Complaints scale than the community comparison group ($p < .05$). However, as shown in Table 4, the groups differed in terms of homogeneity of variance on this scale, with Group III demonstrating very little variance compared to Groups I and II. Because violation of the assumption of homogeneity of variance, particularly with unequal cell sizes, may have affected these results a test not sensitive to variance differences was carried out. A Kruskal-Wallis nonparametric test indicated a significant effect $\chi^2(2, N=55)=9.31$, $p < .01$.

In an effort to determine possible areas of significant differences which might have been concealed by inclusive scale comparisons, frequencies of endorsement for each of the YSR items were compared among all three groups. Forty eight of the 113 YSR items revealed notable

frequency differences between groups. Chi-square analyses were performed on these items to reveal significant differences. Two items: "I have a hot temper" and "I have nightmares" were endorsed more frequently by the sexual offenders and demonstrated highly significant differences between only the offenders and the community control group, $\chi^2(2, N=55)=16.16, p < .001$ and $\chi^2(2, N=55)=8.48, p < .01$ respectively. The item "I have nightmares" is one of 12 items comprising the Thought Disorder scale. This item is likely a major contributor to the overall scale difference which was found between the sexual offender and community comparison groups. Although the clinic treatment group also differed significantly from the community group on the Thought Disorder scale, the distinction between the groups on this particular item was not significant, indicating that other items contributed to the difference. The item "I have a hot temper" is one of 17 items comprising the Aggressive scale. Although the sexual offenders did not differ significantly from the community group overall on the Aggressive scale, they differed significantly on this particular descriptor indicating some difficulty with anger control. The effect of this item on the total score was perhaps not significant due to the large number of items comprising the scale.

Three additional YSR items: "I like to be alone", "I daydream a lot" and "I have aches and pains without known

medical causes" were also endorsed more often by the sexual offenders than the community group only, $\chi^2(2, N=55)=7.67, p < .05$, $\chi^2(2, N=55)=6.64, p < .05$ and $\chi^2(2, N=55)=6.17, p < .05$, respectively. The items "I like to be alone" and "I daydream a lot" are two of 20 items making up the Depression scale. Though the groups did not differ overall on the Depression scale, they did differ significantly on these two items. Whereas the differences were not large enough to affect the entire scale, they do give evidence to the presence of some depressive, isolative type behaviours in this sample of adolescent sexual offenders. The final item "I have aches and pains without known medical cause" is one of twelve items on the Somatic Complaints scale. This item also likely contributed considerably to the overall scale differences between the sexual offenders and the community comparison group. While these three items did not provide as high a level of confidence as did the previous two, they are noteworthy as previous research and clinical observations have indicated similar behaviours and complaints in adolescent sexual offenders. It must be remembered, however, that whenever a number of analyses are performed, caution must be taken in interpreting the results because of the risk of reporting results which are significant simply due to chance.

Item analyses also demonstrated significant differences between the clinic treatment and community

groups with clinic treatment participants showing a higher frequency of endorsement on four items. Highly significant differences were found on the items: "I threaten to hurt people" ($\chi^2(2, N=55)=8.96, p < .01$), "I am secretive or keep things to myself" ($\chi^2(2, N=55)=11.21, p < .01$), "I think about sex too much" ($\chi^2(2, N=55)=8.32, p < .01$), and "I swear or use dirty language" ($\chi^2(2, N=55)=10.95, p < .01$). Items "I think about sex too much" and "I swear or use dirty language" are two of 17 items on the Aggressive scale, one of the scales where the two groups differed significantly. The item "I threaten to hurt people" is one of 22 comprising the Delinquent scale. Although the two groups did not differ overall on this scale, again possibly due to the large number of items, the results indicate evidence of aggressive and offensive behaviours being reported more frequently by the clinic treatment group. The final item "I am secretive or keep things to myself" is one of 20 items on the Depression scale, another scale where the groups did not show overall significant differences. These results are interesting in that, given the nature of their offenses, one would have expected to have seen the sexual offenders endorsing these items more than either the clinic treatment or community comparison groups. Implications of denial and defensiveness in the sexual offender group will be discussed in the next section. Hypotheses three and four were both partially upheld by these results.

Hypothesis five stated that adolescent sexual offenders (Group I) would score significantly higher than the clinic group (Group II) on the CBCL and YSR scales of Hostility/Withdrawal and Unpopularity. One-way analyses of variance indicated no significant differences between the three groups on these measures. Item analyses also indicated no significant differences between the sexual offenders and the clinic treatment participants on items comprising these scales. Hypothesis five was, therefore, not supported.

Hypothesis six stated that social isolation and low levels of social competency would correlate significantly with self-reports of depression on the YSR Depression scale. Correlations between the YSR Depression scale and the eight measures of social competency and social isolation failed to demonstrate significant relationships. This hypothesis was also not supported.

Correlations of the CBCL and YSR

Hypothesis seven stated that the parent (CBCL) and child (YSR) reports of social competency and behaviour difficulties would show greater disparity in the offender and clinic groups (Groups I and II) than in the community comparison group (Group III). The CBCL and YSR scales of Total Social Competency, Aggressiveness and Delinquency as well as scores on an Internalizing-Externalizing dichotomy were selected for comparison. The Internalization and

Externalization scores of the CBCL and YSR are derived from the items comprising the behaviour problem scales. Although the two questionnaires contain many of the same items, some of the scales have been categorized somewhat differently. The Internalization and Externalization scores along with the three other identical scales were thus chosen as the best means of comparison for the two questionnaires.

Correlations between the five CBCL and YSR scores for each of the three groups are presented in Table 5. Groups I and II demonstrated no significant correlations on any of the five comparison scores. Correlations for Group III were significant on four of the five scores including: Total Social Competency ($r = .83, p < .01$); Aggressiveness ($r = .50, p < .05$); Delinquency ($r = .48, p < .05$); and Externalization ($r = .43, p < .01$). Tests of significance of the differences between the Pearson r 's for all three groups failed to demonstrate significant differences between the groups. Although there appeared to be a tendency for the parent and youth to report more similar behaviours in the community group, it was not significantly different than the parent and youth reports in Groups I and II. However, due to missing CBCLs, group sizes were reduced substantially and were likely inadequate to demonstrate significant differences. Hypothesis seven was therefore not fully supported.

Post Hoc Archival Survey

Table 5

Correlations Between CBCL and YSR Scales

<u>Scale</u>	<u>Group I</u>		<u>Group II</u>		<u>Group III</u>	
	<u>r</u>	<u>n</u>	<u>r</u>	<u>n</u>	<u>r</u>	<u>n</u>
Total Social Competency	.73	6	.49	6	.83**	9
Aggressiveness	-.11	11	.13	14	.50*	18
Delinquency	.32	11	.17	14	.48*	18
Internalization	.19	11	.31	14	.43	18
Externalization	.48	11	.27	14	.65**	18

*p < .05

**p < .01

A post hoc examination of the medical records of participants in the sexual offender group was conducted in an attempt to discern differences between offenders whose parents responded to the study with those who did not. Social histories taken during the initial intake interview for all of the sexual offender participants indicated that the parents or guardians presented as motivated and committed to the child's treatment. As reported earlier, nine parents or legal guardians out of 20 in the sexual offender group did not follow through with returning the CBCL even though they had initially agreed to participate. In one case, the youth was a temporary court ward living in a residential setting whose primary social worker had originally agreed to fill out the questionnaire but then decided that it might be inappropriate due to confidentiality issues. In another case, the CBCL was not included because it was returned by the youth's social worker well after the sample's analyses had been run. In both cases, the youth's parents had been unavailable and the social worker had indicated knowing the child well. A third case involved a youth whose older brother was also in the program and the present study. The adoptive mother had filled out the CBCL on the brother, whose offense had been more serious, but not on the younger child. In three of the remaining six cases, there was strong evidence that the parent or families did not believe that their child had committed the offense. For example, one mother

refused to believe that her son had molested a younger girl because the girl had returned to their home to visit after the offense was said to have occurred. In two other cases, the social histories indicated severe incestuous relationships occurring within the home. In one case, the father had been convicted of rape and had been implicated in the rape and murder of a prostitute. The son, who participated in the study, had been sexually molested by numerous cousins while growing up. In the final case, the mother appeared to be extremely embarrassed over her son's offensive behaviour to the extent that she refused to sign a routine release for school records fearing that someone might find out. In comparison, during the initial intake interview of all of the participants whose parents or guardians returned the questionnaire, there was no evidence of denial on the part of the parent towards the child's offensive behaviour and although some of these youths had been sexually abused, none were reported to be cases of incest. Implications of these findings will be discussed in the next section.

CHAPTER IV

DISCUSSION

The primary purpose of this study was to compare adolescent sexual offenders in outpatient treatment with non-offending adolescents in outpatient treatment and youths from the community receiving no treatment on measures of social isolation, social competency and selected areas of behaviour problems. This comparison was done in several ways and an interpretation of the results is offered in this section.

Demographic Differences Between Groups

The three groups did not differ significantly in terms of age, grade level, number of siblings and family living situation. Although the present sample represents a high ratio of black to white youths (85% to 15%), it does not signify that sexual offending is more predominant in black than white youths. Previous studies addressing racial differences point out the difficulties in making such comparisons due to factors such as socioeconomic conditions and the effects of racism in reporting such offenses (Davis & Leitenberg, 1987). The current sample

more accurately reflects the proportion of blacks represented within the city of Detroit, similar to many large cities in the United States.

Participants from both the sexual offender group and from the clinic treatment group were found to have more reported academic and/or behaviour problems in school than the community comparison group. Problematic school behaviours and academic difficulties were also reported by Davis and Leitenberg (1987) for both sexual offenders and non-sexually delinquent youths and by Fehrenbach et al. (1986) for adolescent sexual offenders. In addition, in the current study, both sexual offenders and youths in the clinic treatment group were more often referred and placed in both emotionally impaired and learning disabled special education classrooms. This suggests that these youths experience chronic and significant academic and behavioural difficulties.

Adolescent sexual offenders in this study were found to have a significantly higher incidence of actual or suspected early sexual victimization compared to the clinic treatment group. A number of previous studies have also reported that sexual offenders were frequently sexually abused as children (Longo, 1982; Deisher et al., 1982; Margolin, 1983; Fehrenbach et al., 1986; Smith & Monastersky, 1986; Davis & Leitenberg, 1987). Early exposure to this type of victimization can often lead to chronic emotional and behavioural disturbances including

the sexual abuse of others. Sexual offenders in the present study also experienced significantly more physical abuse as children than the clinic treatment group participants. This finding is also consistent with other studies comparing sexual and non-sexual offenders (Lewis et al., 1981; Van Ness, 1984).

Social Isolation and Social Competency

Overall, contrary to prediction, there were no significant differences on measures of social isolation and social competency between the sexual offenders and the clinic treatment group or the community comparison participants. Sexual offenders tended to report about the same number of close friends as the community group. Considerations over the lack of findings will be presented later in this section.

In contrast, comparisons of the clinic treatment group with the community group on the same measures of social isolation and social competency revealed notable differences between the groups. According to parental reports, participants in the clinic treatment group were found to be significantly less competent overall with considerable difficulties in competency at school. When one considers the number of reported behaviour and academic difficulties at school as well as the number of special education placements found in the clinic treatment group, this finding is not surprising. Although the sexual offenders were similar to the clinic treatment

group on these measures, due to missing CBCLs, this information was gathered from social histories rather than the parents' reports and was not utilized in the overall social competency score.

Differences on Behavior Problem Scales

Comparisons of the three groups on selected behaviour problem scales of the CBCL and YSR revealed significant differences between groups. The sexual offenders scored significantly higher than the community group on the YSR scale of Thought Disorder. Participants in the sexual offender group endorsed more items tapping unusual thoughts and behaviours such as "I have nightmares" and "I hear things that nobody else seems able to hear". Lewis et al. (1979) reported that almost 47% of a sample of sexually assaultive juvenile offenders indicated experiencing auditory hallucinations and 70% displayed "loose, rambling, illogical thought processes" (p. 1196). In the present study, sexual offenders also scored significantly higher than the community group on the YSR scale of Somatic Complaints indicating that they frequently acknowledged experiencing a number of physical disturbances. This suggests that psychological disturbance may be manifesting itself in physical symptomatology. Similar findings were reported by Peters (1976) who found a high number of somatic complaints in male pedophiles.

Individual Youth Self-Report item analyses also

revealed significant differences between the sexual offenders and the community comparison group.

Participants in the sexual offender group endorsed a number of statements significantly more frequently than did participants in the community group. Included in this were the items: "I have a hot temper", "I have nightmares", "I like to be alone", "I daydream a lot" and "I have aches and pains without known medical causes".

Self-reports of having a "hot temper", an item from the Aggressive scale, support other indications that the adolescent sexual offender possesses poor anger control and tends to utilize aggression as a means of problem solving. According to Deisher et al. (1982), juvenile offenders often lack basic problem solving skills and will act out when feeling stressed. Anderson, Kuncie and Rich (1979) also point out that a number of offenders will act out in a manner which often proves to be self-defeating.

A number of studies have found strong evidence of extreme family dysfunction in the lives and histories of sexual offenders (Markey, 1950; Maclay, 1960; Deisher et al., 1982; Van Ness, 1984). Consistent with previous literature, sexual offenders in the present study experienced significantly more physical and sexual abuse than those in the comparison clinical group. The presence of nightmares in sexual offenders may be one indication of the trauma experienced by these youths from severe family violence, neglect and/or abuse.

Although the sexual offenders did not differ significantly from the community group overall on the Depression scale, they did endorse two items from the scale, "I daydream a lot" and "I like to be alone" significantly more than the community. This suggests that offenders in the present study display behaviours of isolation and withdrawal, symptoms commonly indicative of depression.

Participants in the clinic treatment group scored significantly higher than the community group on the CBCL Schizoid, Somatic Concerns, and Immaturity scales. This suggests that, according to parent or guardian reports, the clinic treatment group demonstrated more unusual thoughts and behaviours, physical complaints and child-like behaviours. On the YSR, clinic treatment participants also scored higher than the community group on the scales Thought Disorder, Somatic Complaints and Aggressiveness. This indicates that youths in the clinic treatment group, like the sexual offenders, were more likely to admit to experiencing unusual thoughts and behaviours and several physical difficulties. In addition, participants in the clinic treatment group were more likely than the community group to engage in aggressive and acting out behaviours. Item analyses demonstrated significant differences between the clinic treatment and community comparison groups on the statements: "I threaten to hurt people", "I think about

sex too much", "I swear or use dirty language", and "I am secretive or keep things to myself", indicating behaviours in clinic treatment participants suggestive of a conduct disorder. It is interesting to note that although one would expect the sexual offender group to endorse statements of this nature, they did not differ significantly from the community group on these items. These statements are clearly more transparent than others in terms of tapping anti-social behaviours. The reluctance of sexual offenders to endorse such items hints at the presence of denial and defensiveness in this group as well as evidence that disturbances may be underreported by sexual offenders in self-report measures. These and other methodological concerns will be discussed in the following section.

Considerations of the Findings

The results from the present study raise some issues which must be pondered. Foremost is the question of whether or not these groups actually differ on the variables studied. The results indicate that there are no significant differences between adolescent sexual offenders and clinic treatment participants or non-treatment participants from the community on measures of social competency and social isolation. Few differences were found between the sexual offenders and the non-treatment adolescents from the community in areas

of common behaviour problems. No significant differences were found between the sexual offenders and the clinic treatment group on any of the behaviour problem scales or item analyses. Questions arise over whether or not there are distinguishable differences, other than the sexual offense itself, between adolescents who sexually offend with those who do not. Sexual offenders and clinic treatment participants did score more similarly than either group did to the community comparison group. Are these groups, therefore, related more closely due to personality characteristics and surrounding circumstances which may have led to the referral for outpatient mental health treatment or the simple fact that they presently are in treatment and perhaps, more willing to disclose. If there are no distinguishing characteristics for adolescent sexual offenders, differentiating and diagnosing sexual offending youths from those who are not sexually offending becomes a dilemma. A difficult goal of the clinician is to differentiate between diagnosable offenders and youths who may be engaging in exploratory sexual behaviour. The goal of research with adolescent offenders is to help define normative adolescent sexual behaviour and to uncover the variables which may predispose the youth to develop a pattern of deviant sexual interest (Becker and Abel, 1984). Previous research has stressed the heterogeneity of adult sexual offenders and suggests that a number of personality types

may be indicated in offending behaviours (Markey, 1950; Perdue & Lester, 1972; Anderson et al., 1979). Future research might investigate possible clusters of personality types for adolescent offenders as well.

An alternative interpretation of the findings of the present study suggests that there are actual differences between the groups but that methodological confounds may have masked these differences. Although efforts were made at the beginning of the study to control for many of the following factors, circumstances surrounding the gathering of the data made it difficult to completely control them. The first factor was small group sizes in the study. Outpatient treatment programs aimed specifically at treating adolescent sexual offenders are scarce in this area. Although the Adolescent Sexual Abuser Program at Children's Center had been established for more than a year, at the time of the data collection the program was disrupted by the departure of the director and three therapists. As a consequence, data collection for the sexual offender group was held up for almost seven months. The remaining over-worked therapists were concerned over large client loads, long waiting lists (whom the examiner was asked not to contact), and keeping the program running. The examiner also appeared to be viewed as an "outsider" by the ASAP therapists, and was put off due to their perception that the data collection would be disruptive. Future studies with adolescent sexual

offenders would benefit from using clients from more than one outpatient program, as well as, larger, more established treatment programs with therapists who are in a position to be supportive and interested in research.

Another variable to be considered is the length and type of treatment of the two clinic treatment groups. Although all of the sexual offenders were screened to insure that they had not been in treatment for over one year, the non-offending clinic group was not. Questions arise over effects resulting from differing lengths of therapeutic treatment, as well as the type of treatment the youth is in. The sexual offenders in the present study were involved in group, as well as individual therapy. One of the intentions of group therapy for offenders is to improve their interaction skills with others. Most of the non-offending clinic group were not involved in group treatment and received individual therapy only. Future research could avoid such confounds by using outpatient clinic clients when they are initially referred to a therapist or on a waiting list for treatment.

Reporting bias is another factor which must be considered in the present study. Although the findings in the present study did not indicate distinct differences between sexual offenders and the other groups, they may be misleading in that the selected self-report measures did not account for defensiveness or an intentional attempt to

make oneself look good. Although there was an attempt on the examiner's part to control for this by assuring confidentiality, for the purpose of gaining parental participation it was also made clear that the therapist would have access to the results to aid in treatment planning. In hindsight, when one considers that these youths may have been adjudicated or at least made to attend outpatient treatment, an attempt to look good would be relatively easy and may be seen as a way of convincing the therapist that therapy has "worked" or is unnecessary and may be discontinued. Many of these offenders have denied the charges brought against them and continue to deny the offensive behaviour in therapy. Although total anonymity might have somewhat controlled for the need to present oneself as problem free, given the amount of denial and defensiveness experienced by these youths, one wonders if an accurate picture of the offender is possible with this type of questionnaire. Future research may investigate social competency and isolation more adequately by means of gathering observational data from sources other than the offender and close family members.

Another factor to be considered is the apparent parental ambivalence and subsequent missing data in the offender group. Although it was made very clear by both the examiner and the child's therapist that the results of the questionnaire could aid the child in therapy and despite numerous reminders, 45% of the parents or legal

guardians did not return the questionnaire. Given the low social desirability of the type of offense their child has committed and the evidence that many adolescent offenders were themselves the victims of sexual and/or physical abuse, the significance of defensiveness and denial on the part of the family should not be overlooked. In the present study, denial of the child's guilt as well as evidence of sexual acting out and previous incestuous relationships in the family appeared to affect the parent's willingness to participate in the study. Questions arise over how these parents view sexual abuse and, in turn, view their own child's offense. Is the child's offense taken seriously or is it viewed as a minor transgression "typical" of most boys? Are these parents still concerned and motivated to be involved in their child's treatment or do they view it as an unnecessary waste of time? Future research should examine more closely the relationship between parental views on sexual abuse and the level of involvement in the child's treatment as well as the relationship between parent opinions on sexual abuse and treatment outcome for the child.

Another methodological problem surrounds the selected community comparison group. Due to the sensitive nature of questions surrounding sexual offense and sexual and physical victimization, histories on these variables were not collected for this group. In addition, all of the

participants in the group were black, compared to 85% and 65% in the two clinic groups. Effects due to possible racial differences in social skills, as well as a willingness to answer openly cannot be ruled out. Matching comparison groups in terms of race and other demographic variables, such as SES, more closely and collecting thorough histories of possible offending behaviours and sexual and physical victimization would help eliminate these problems.

As in many studies, sample representativeness must be kept in mind in the interpretation of all findings. This is especially true when examining adolescent sexual offenders. Law agencies, social service agencies, the courts and the offender's family and friends often view the offense as an isolated incident which need not be reported, require mental health intervention or remain in the youth's records. Consequently, a large number of offenders are never even charged with the offense and subsequently do not receive mental health attention. Offenders who have thus far escaped detection must also be considered. One cannot rule out that these offenders may in some way differ from those who have been caught or charged and adjudicated. In addition, this study did not account for the more violent offenders who were incarcerated for their offensive behaviour. Participants in the present study are also largely of lower socioeconomic status. Treatment in the Adolescent Sexual

Abuser Program is provided free of charge so that it may be accessed by individuals with few monetary resources. The sample, therefore, does not include offenders whose families have the resources to provide private psychological treatment. Again, one cannot assume that these youths do not differ from the offenders who participated in the present study.

Clinical observations of adolescent sexual offenders in the literature have consistently noted the presence of limited social skills and poor or superficial peer relationships. Although the results in the present study did not show significant differences between juvenile sexual offenders and non-offending youths on measures of social competency and social isolation, the variables selected may not be sensitive measures for sexually offending youths. Future research to more closely examine the peer relationships of adolescent offenders would be beneficial in answering specific questions about the quality of these relationships. Reports by those who are familiar with the adolescent outside of the family, for instance the youth's teacher, may help validate specific problems in this area. Surveying adolescent offenders on topics such as views on sex and women, the negative impact of sexual victimization on children and the ability of children to consent to sexual activity would also give important information about common distortions held by offenders. Finally, due to the potential effects of bias

and defensiveness in self-report measures, social skills may be examined more thoroughly by observing interactions in structured scenarios with confederates.

APPENDIX A

EXPLANATORY LETTER/CONSENT FORM FOR CLINIC GROUPS

the
CHILDREN'S
Center

I _____ agree to participate in a research project through the University of Windsor and Children's Center of Wayne County. I understand that I will fill out two questionnaires (student) or one questionnaire (parent) which will look at how I (my child) feel(s) about a number of topics including school. This will only take about 45 minutes. I also understand that all of my answers will be kept in strict confidence and only discussed with my therapist to aid in treatment planning. If I choose, I may withdraw from the study at any time.

Student

Date

Parent

Witness

APPENDIX B

EXPLANATORY LETTER MAILED TO PARENTS OF CLINIC GROUPS

APPENDIX C

EXPLANATORY LETTER FOR CHURCH CONTROL GROUP

APPENDIX D

RAW DATA

RAW DATA COLUMN IDENTIFICATION

Column	Variable
1-3	Respondent ID#
4-5	Age
6-7	Grade
8	Family Living Situation
9-10	Number of Siblings
11	Special Education
12	Academic/Behaviour Problems
13	History of Sexual Abuse
14	History of Physical Abuse
15-16	CBCL Social Competency-Activities
17-18	CBCL Social Competency-Social
19-20	CBCL Social Competency-School
21-22	CBCL Social Competency-Total
23-24	CBCL Somatic Complaints
25-26	CBCL Schizoid
27-28	CBCL Uncommunicative
29-30	CBCL Immature
31-32	CBCL Obsessive-Compulsive
33-34	CBCL Hostile/Withdrawal
35-36	CBCL Delinquent
37-38	CBCL Aggressive
39-40	CBCL Hyperactive
41-42	CBCL Internalization Total
43-44	CBCL Externalization Total
45-46	YSR Social Competency-Activities
47-48	YSR Social Competency-Social
49-50	YSR Social Competency-Total
51-52	YSR Depressed
53-54	YSR Unpopular
55-56	YSR Somatic Concerns
57-58	YSR Self-Destruct./Identity Prob.
59-60	YSR Thought Disorder
61-62	YSR Delinquent
63-64	YSR Aggressive
65-66	YSR Internalization Total
67-68	YSR Externalization Total
69-70	AAI Raw Score
71	AAI Assigned Score

APPENDIX E

FAMILY/LIVING SITUATION DATA FORM

FAMILY / LIVING SITUATION

NATURAL PARENTS ARE/WERE (PLEASE CHECK)

MARRIED, LEGAL	_____
MARRIED, COMMON LAW	_____
SEPARATED	_____
DIVORCED	_____
WIDOWED	_____
NEVER MARRIED	_____
DIVORCED, MOTHER REMARRIED	_____
DIVORCED, FATHER REMARRIED	_____
DIVORCED, BOTH REMARRIED	_____
OTHER (SPECIFY) _____	_____

SIBLINGS

HOW MANY OLDER BROTHERS DO YOU HAVE?	_____
OLDER SISTERS	_____
YOUNGER BROTHERS	_____
YOUNGER SISTERS	_____
STEPBROTHERS/HALF BROTHERS	_____
STEPSISTERS/HALF SISTERS	_____

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