JUVENILE SEX OFFENDER TREATMENT OUTCOME AND CONDUCT DISORDER DIAGNOSIS

by

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Abstract

Using a descriptive design, this study investigated the differences in treatment outcomes between juvenile sex offenders who were diagnosed with Conduct Disorder (according to DSM-III-R (APA, 1987) classification system criteria) and those with a non-conduct disorder diagnosis. The clinical records of 100 juvenile males convicted with a sexual offense who were court ordered for a psychiatric/psychological/social assessment and treatment at Youth Court Services/Out-patient Clinic between January 1, 1989 and January 1, 1993 were studied. The results indicated that the youths diagnosed with Conduct Disorder displayed a significantly higher probability for unsuccessful treatment outcome as compared to those youths with a non-conduct disorder diagnosis. The findings suggest the juvenile sex offender who is diagnosed as conduct disordered may be a subtype who is at higher risk of unsuccessfully completing treatment, and may require a more specialized form of intervention. Furthermore, the findings suggest that there are limitations to the DSM-III-R classification system with this population.

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Acknowledgements

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CHAPTER ONE

INTRODUCTION

Statement of Purpose

The purpose of this thesis is to examine the association between the psychiatric diagnosis of Conduct Disorder and treatment outcomes of juvenile sex offenders. To achieve this purpose, the clinical records of a population of adolescent male sex offenders were studied to determine if the diagnosis has any impact on out-patient treatment outcomes. The juvenile sex offender diagnosed with Conduct Disorder possesses unique characteristics that discriminate him from other adolescent sex offenders. As such, the psychiatric diagnosis of Conduct Disorder may be one way of identifying a specific subtype of juvenile sex offender who is more likely to have unsuccessful treatment outcomes as compared to the offender who is not diagnosed with Conduct Disorder. Previous studies on possible discriminating dimensions for identifying subgroups within the sex offender group have been devoted to the adult population. The heterogeneity of adult sex offenders has been well documented and recent studies (eg. Knight & Prentky, 1990; Knight, 1992) have identified more

homogeneous subgroups for the purposes of improving prediction and enhancing dispositional accuracy. However, no comparable taxonomic studies have been undertaken for juvenile sex offenders (Knight & Prentky, 1993). Most of the empirical studies on juvenile sex offenders are limited to simple tallies of the frequencies of particular descriptive characteristics of these offenders and their offenses, such as, their ages, the history of their previous sexual and non-sexual offending, the types of sexual crimes they have committed, and the ages and sexes of their victims. The literature provides only weak speculations about the importance of particular discriminating dimensions.

Thesis Overview

This chapter will discuss some of the more significant dimensions that may act as starting points for classifying juvenile sex offenders into more homogenous subgroups. This provides a background to investigating Conduct Disorder diagnosis as a possible discriminating dimension for identifying a particular subtype of offender. The intention of this chapter is to introduce the background and problem area of this thesis. To accomplish this purpose, I shall,

first, define and describe the problem in terms of society's awareness and response to juvenile sexual assault. Second, I will offer a definition of juvenile sexual assault from the legal, as well as, the mental health perspective. Third, I will examine offense and offender characteristics in an attempt to demonstrate the heterogeneity of this population. In so doing, I will discuss certain typologies that may divide this heterogeneous population into meaningful subgroups. Finally, I will offer a preliminary discussion of the psychiatric diagnosis of *Conduct Disorder* as a subgroup classification and its relevance to the treatment outcomes of juvenile sex offenders.

Chapter two provides a review of the existing literature in terms of psychiatric diagnosis according to the various editions of the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association). In addition, chapter two provides a review of the literature on the diagnosis of Conduct Disorder and it's relevance to the assessment and treatment of adolescent sex offenders. Chapter three outlines the research design and Chapter four provides the results of this study. Chapter five discusses the research implications, limitations and conclusions.

The Juvenile Sex Offender's Impact on Society

Sexual assault is now recognized as one of the more severe problems in modern western society, ranking with nonsexual crime, poverty, environmental damage and substance abuse as a societal ill. The prevention of sexual assault will depend on the extent to which individuals can be stopped from committing these crimes. A large body of research has indicated that a very high percentage of adult sex offenders began their offending career as adolescents (Davis & Leitenberg, 1987; Groth, 1977; Groth, Longo & McFadin, 1982; Longo, 1983; Longo & Groth, 1983) and it is imperative to concentrate on juvenile offenders in order to detect the problem early and prevent or reduce later victimization. Ryan, Lane, Davis, and Isaac (1987) contend that early intervention is indicated both for the prevention of multiple victimizations and to interrupt the reinforcing nature of deviant sexual behaviours. Furthermore, several studies suggest that sex offenders may be more amenable to treatment during adolescence rather than during adulthood and that early intervention may have preventative value (Abel, Mittleman, & Becker, 1985; Groth, et al., 1982; Oliver, Nagayama Hall, & Neuhaus, 1993). Crime statistics indicate that a high

percentage of sexual offenses are committed by perpetrators under the age of 18 (Fehrenbach, Smith, Monastersky, & Deisher, 1986). In addition, a majority of adult sex offenders indicate that the onset of their deviant sexual behavior occurred in adolescence.

The Extent of the Problem

Prior to early 1980's, the predominant view of the sexual offenses committed by adolescents was that these were considered simply nuisance behaviours with a discounted estimate of the severity of the harm produced. These behaviours were not seen as assaultive, but more as examples of experimentation and therefore as innocent. As such, it was seen as the normal aggressiveness of sexually maturing adolescents. Some social scientists viewed this behaviour to be the result of the marginal status of the adolescent male and the consequent restrictions of his permitted sexual outlets (Finklehor, 1979; Gagnon, 1965; Maclay, 1960; Markey, 1950; Reiss, 1960; Roberts et al., 1973). Others saw it more as a reflection of a general problem of antisocial behaviour.

This tendency to minimize juvenile sex offending has reduced considerably over the last 15 years, mainly because

there is an increased awareness of the numbers of juvenile sex offenders. Twenty percent of all rapes and between 30% and 50% of all child molestations are perpetrated by adolescent males (Becker, Kaplan, Cunningham-Rathner, & Kavoussi, 1986; Brown, Flanagan, & McLeod, 1984; Deisher, Wenet, Paperney, Clark, & Fehrenbach, 1982; Groth, Longo, & McFadin, 1982). The U.S. 1986 arrest statistics report that approximately 20% of all sexually aggressive crimes are committed by males under 19 years of age (Federal Bureau of Investigation, 1987). Abel, Becker, Cunningham-Rathner, Rouleau, Kaplan, & Reich (1984) claim that the average adolescent sex offender will, without treatment, go on to commit 380 sexual crimes during his lifetime. Moreover, numerous studies suggest that approximately half of all adult sex offenders report sexually deviant behaviour in adolescence (Abel et al., 1985; Becker, Kaplan, Cunningham-Rathner, & Kavoussi, 1986; Longo & Groth, 1983; Longo & McFadin, 1981; McConaghy, Blaszczynski, Armstrong, & Kidson, 1989; Ryan, Lane, Davis, & Issac, 1987). Consequently, early intervention might be more efficacious than treating adults as the problem is treated in an individual before the behaviour becomes more entrenched in adulthood (Green, 1987; Stenson & Anderson, 1987)

The Juvenile Sex Offender and Offenses

Introduction

It is very difficult to establish a concise definition of the juvenile sex offender and his offenses. I will attempt to define these terms from both the legal and the medical perspectives, and conclude this section with a discussion of the limitations of these perspectives.

Legal Definition

The minimum age of juvenile court jurisdiction in North America varies from 6 to 12, with many U.S. states setting 10 as the lowest age of criminal responsibility; Canada has a minimum age of 12. Depending upon the state or province, the maximum age of juvenile court jurisdiction runs from 15 to 17. In Canada adulthood begins for criminal law purposes at the 18th birthday, with the reference date being the date of the commission of the alleged offense. Juveniles charged with more serious sexual offenses may be subject to transfer into the adult system for trial; if convicted there, they may face more severe adult sentences and can be incarcerated in adult facilities.

The legal definition of what constitutes a sexual offense

varies from one statute to another. Those seeking to invoke the criminal law in their work with adolescent sex offenders should be aware of the specific definitions in their jurisdictions and avoid relying simply on clinical or moralistic notions of what constitutes appropriate or inappropriate behavior.

In every jurisdiction, touching the genitalia of another person for a sexual purpose, whether or not this involves intercourse, is a criminal offense unless the other person freely consents. This would encompass such offenses as rape, sexual assault, and aggravated sexual assault. In some jurisdictions of the United States, there is a statutory minimum age for certain types of sexual offenses, such that a youth below a specified age, such as 14, is regarded as legally incapable of committing such an offense.

Every jurisdiction in North America has legislation that protects children and adolescents from sexual involvement with those who are legally regarded as being in a position to exploit the youthfulness of the victim. This legislation renders what would otherwise be consensual sexual relations a criminal offense. There is substantial variation in how such "statutory rape" provisions are drafted, and some

jurisdictions criminalize what other jurisdictions regard as legally acceptable. For example, it is an offense for a 15-year-old to be involved in a consensual sexual relationship with a 13-year-old in New York, but not in Canada. However, in Canada it is a criminal offense for a 16-year-old to be sexually involved with a 13-year-old.

Canadian Legal Definitions

Under the Canadian Criminal Code there are several types of sexual offenses. I will offer a brief overview of the most relevant types applicable to juvenile sex offenders.

Sexual interference. "Every person who, for sexual purpose, touches, directly or indirectly, with a part of the body or with an object, any part of the body of a person under the age of fourteen years..." (Martin's Criminal Code of Canada, 1994; p. CC/220).

Invitation to sexual touching. "Every person who, for sexual purpose, invites, counsels or incites a person under the age of fourteen years to touch, directly, or indirectly, with a part of the body or with an object, the body of any person, including the body of the person who so invites, counsels or incites and the body of the person under the age

of fourteen years..." (Martin's Criminal Code of Canada, 1994; p. CC/221).

Incest. "Every one commits incest who, knowing that another person is by blood relationship his or her parent, child, brother, sister, grandparent or grandchild, as the case may be, has sexual intercourse with that person" (Martin's Criminal Code of Canada, 1994, p.232).

Indecent acts. "Every one who wilfully does an indecent act (a) in a public place in the presence of one or more persons, or (b) in any place, with intent thereby to insult or offend any person... Every person who, in any place, for a sexual purpose, exposes his or her genital organs to a person who under the age of fourteen years...." (Martins Criminal Code of Canada, 1994; p. CC/245).

Sexual assault. "Sexual assault is an assault, which is commited in circumstances of a sexual nature such that the sexual integrity of the victim is violated...." (Martin's Criminal Code of Canada, 1994; p. CC/444).

Sexual assault with a weapon or causing bodiy harm. "Everyone who, in commiting sexual assault, (a) carries, uses or threatens to use a weapon or an imitation thereof, (b) threatens to cause bodily harm to a person other than the

complainant, (c) causes bodily harm to the complainant...." (Martins Criminal Code of Canada, 1994, p. CC/445).

Aggravated sexual assault. "...in commiting a sexual assault, wounds, maims, disfigures or endangers the life of the complainant" (Martin's Criminal Code of Canada, 1994, p. CC/447).

Meaning of "Consent"

"Consent means the voluntary agreement of the complainant to engage in the sexual activity in question. No consent is obtained where (a) the agreement is expressed by the words or conduct of a person other than the complainant; (b) the complainant is incapable of consenting to the activity; (c) the accused induces the complainant to engage in the activity by abusing a position of trust, power or authority; (d) the complainant expresses, by words or conduct, a lack of agreement to engage in the activity; or (e) the complainant, having consented to engage in sexual activity, expresses, by words or conduct, a lack of agreement to continue to engage in the activity." (Martin's Criminal Code, 1994; p. CC/448)

Consent no defence. Under section 150.1 of the Criminal

Code of Canada (1994) it states that when the offender is charged with a sexual offense and the victim is under the age of 14 it is not a defense that the victim consented. However, if the victim is 12 to 13 years of age it is not a defense that the victim consented unless the offender is: (a) 12 to 15 years old; (b) less than two years older than the victim; or (c) neither in a position of trust or authority towards the victim nor is the victim in a relationship of dependency with the offender.

In summary, it is apparent that the legal definition of what constitutes a sexual offense varies from one statute to another. Furthermore, the legal defintion alone is inadequate if the professional desires a clear understanding of juvenile sexual offending and the offender. As such, I will offer a medical definition that presents the psychiatric perspective of this problem.

Medical Definition

Paraphilia. "Paraphilia" is the medical or psychiatric term of choice for sexually deviant behaviour. The paraphilias described here include Exhibitionism, Fetishism, Frotteurism, Pedophilia, Sexual Sadism, Voyeurism, Transvestic

Fetishism, and Paraphilia Unspecified. The Diagnostic and Statistical of Mental Disorders (APA, 1994) describes the essential feature of the paraphilias as "recurrent intense sexual urges and sexually arousing fantasies generally involving either (1) nonhuman objects, (2) the suffering or humiliation of onself or one's partner, or (3) children or nonconsenting persons (p. 552)". Therefore, obviously, a significant number of sex offenders would be diagnosed a "paraphiliacs." According to Abel et al. (1985), 100% of adult child molesters can be diagnosed as "pedophiles." Pedophilia involves sexual activity with a prebuescent child (generally age 13 years or younger) and the individual diagnosed with Pedophilia must be age 16 years or older and at least 5 years older than the child (DSM-IV, APA, 1994). However, according to the DSM-IV (APA, 1994), "For individuals in late adolescence diagnosed with Pedophilia, no precise age difference is specified, and clinical judgement must be used; both the sexual maturity of the child and the age difference must be taken into account" (p. 527). As such, those perpetrators in early and middle adolescence who offend against small children do not qualify for this diagnosis. Moreover, one must rely on the professional's clinical

judgement when diagnosing those offenders in late adolescence.

The paraphiliac focus in Exhibitionism involves the exposure of one's genitals to a stranger and sometimes the individual masturbates while exposing himself. The paraphilic focus in Fetishism involves recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving the use of nonliving objects. Frotteurism involves touching and rubbing against a nonconsenting person. The individual rubs his genitals against the victim's thighs and buttocks or fondles her genitalia or breasts with his hands. The behavior usually occurs in crowded palces from which the individual can more easily escape arrest. Voyeurism involves the act of observing unsuspecting individuals, usually strangers, who are naked, in the process of disrobing, or engaging in sexual activity. Among rapists, diagnosis is not so straightforward. The only paraphilia presently listed in DSM-IV that relates to rape is Sexual Sadism, but it would apply only to those rapists who appear to gain sexual pleasure from the suffering of their victim.

As demonstrated, defining what constitutes sexual abuse with juvenile offenders is a complicated endeavour. The same

application as adult offenders is appropriate with respect to the degree of intrusiveness and amount of coercion used. However, the criterion of age difference between perpetrator and victim cannot be applied in a straightforward manner. The use of age differences is a reflection of the lack of adequate knowledge as to what constitutes "normal" adolescent sexual behaviour. It seems more constructive to examine the behaviours involved, particularllry in terms of the degree of coercion and the issue of consent than to rely on essentially arbitrary age-difference criteria (Barbaree, Marshall, & Hudson, 1993). As such, it may be that psychiatric diagnoses for the juvenile sex offender are being made based on the behaviours involved and not the strict age criteria as dictated by the Diagnostic and Statistical Manual of Mental Disorders.

Therefore, I will offer another definition of juvenile sexual assault in terms of behaviours, relationships, dynamics and impact. Second, I will offer a profile of the *modal* (or most commonly identified) juvenile sex offender. Third, I will present an analysis of particular discriminating features that do not fit with the modal profile, thus suggesting the heterogeneity of the juvenile sex offender population.

Finally, I will close with a preliminary discussion of the psychiatric diagnosis of *Conduct Disorder* as a subgroup classification and its relevance to treatment outcomes of juvenile sex offenders.

Juvenile Sexual Offense. As indicated previously, juvenile sexual offenses may be characterized by one or more of a wide array of behaviours, and more than one type of deviancy may be seen in a single individual. Molestation of younger children or peers may involve touching, rubbing, and/or penetrating behaviours. *Rape* may include any sexual act perpetrated with violence or force; legal definitions often include penetration. Penetration may be oral, anal, or vaginal and digital, penile, or objectile. *Hands-off* offenses include *exhibitionism*, *voyeurism*, *frottage*, *fetishism*, and *obscene communication* (such as obscene phone calls, and verbal or written sexual harassment).

In evaluating the sexual abuse of children by adults, age differential and behaviours are adequate to define the problem. However, when concerns arise regarding sexual interactions involving juveniles, age and behaviour identifiers are often inadequate and further assessment is required. Thus, in any sexual interaction, the factors that

are useful when assessing the presence or absence of exploitation are equality, consent, and coercion.

The issue of equality addresses differences in physical, cognitive, and emotional development, passivity and assertiveness, power and control, and authority. Although physical differences can be relatively easy to assess, cognitive and emotional differentials may be more reflective of life experience. That is, regardless of age differences, the act may be considered exploitive if the two parties are not developmentally equal. Similarly, power and control issues and passivity and assertiveness may be used to define the roles of two juveniles in an interaction in order to clarify the equality or inequality of the two in a particular situation. In addition, authority of one child over the other may exist. For example, in the case of an older child being put in charge of a younger in a babysitting relationship or when one child takes on the role of "parent" or "teacher" in a play situation. More subtle levels of authority may include the implications of family positions, popularity, competence, talents and success. The juvenile who feels inadequate may be victimized by a peer just as readily as a younger child may be victimized by an older adolescent.

The second factor in defining sexual exploitation is *consent.* Although arbitrary ages have been considered in the legal definition of the "age of consent", assessing consent demands more than a legal definition or an age identifier. The elements of consent have been defined as follows: Agreement including all of the following: (1) understanding what is proposed based on age, maturity, developmental level, functioning, and experience; (2) knowledge of societal standards for what is being proposed; (3) awareness of potential consequences and alternatives; (4) assumption that agreements or disagreements will be respected equally; (5) voluntary decision; and, (6) mental competence (National Task Force on Juvenile Sexual Offending, 1988).

The assessment of consent may cause confusion, particularly in terms of the distinctions between compliance, cooperation, and consent. Consent implies full knowledge, understanding, and choice; whereas, cooperation implies an active participation regardless of personal belief or desire and may occur without consent. Compliance may allow or passively engage the victim without resistance in spite of opposing beliefs or desires (Ryan, Lane, Davis, & Isaac, 1987).

Coercion, the third factor in defining exploitation in juvenile sexual interaction, refers to the pressures that deny the victim free choice. Once again, physical size and/or perceptions of power or authority are often exploited to coerce cooperation and compliance. Coercion can also involve secondary gains or losses. For example, the offender will use bribery in the form of money, treats, favours, or friendship in return for sexual involvements. Or, the offender may use more subtle and refined forms of coercion within the exploitive relationship that are based upon his manipulative use of caring and nurturance of the victim. As such, the victim will comply with the offender's wishes so as to avoid rejection or abandonment. Finally, the more blatant form of coercion lies in the use of threats and violence. Although acts of violence are used, threats of force or violence are more common. This form is particularly evident in the sexual abuse of children since a child is more easily coerced without resorting to violence as compared to sexual assaults against peers or adults.

The Modal Juvenile Sex Offender

With the legal and medical definitions in mind, the

juvenile sex offender is defined as a youth (age 12-17 in Canada) who commits any sexual act with a person of any age against the victim's will, without consent, or in an aggressive, exploitive, or threatening manner (Ryan & Lane, 1991). Although studies indicate that no one single profile can be applied to every juvenile sex offender, it is possible to present what Ryan and Lane (1991) call the *modal* (or most often identified) offender and offense as a composite. Using particular studies of juvenile sex offenders as reference, one is able to describe several features that are similar in most samples (Awad, Saunders, & Levene, 1984; Awad & Saunders, 1989; Becker, Kaplan, Cunningham-Rathner, Kavoussi, 1986; Davis & Leitenberg, 1987; Fehrenbach, Smith, Monastersky, & Deisher, 1986; Knight & Prentky, 1993; Ryan et al., 1987; Wasserman & Kappel, 1985; Wheeler, 1986)). As such, the modal juvenile sex offender is a fourteen year old white middle class male of average intelligence with some form of learning difficulty. He would have been living with two parents at the time of his offense. Although he has had no previous convictions for sexual assault, this is quite likely not his first offense or first victim. He will probably disclose that he has been a victim of sexual abuse by some one he knows,

such as a neighbour or relative. His victim is most likely a seven or eight year old female who is not related to the offender by blood or marriage. The assault is coercive involving genital touching, and quite often penetration. There is a 33% chance that he has been convicted of nonsexual delinquent behaviour prior to this arrest.

This brief thumbnail sketch suggests that juvenile sex offenders are an homogeneous group. However, the following discussion supports the contention that they are heterogeneous and present with a wide range of characteristics and dimensions. Moreover, it is argued that some of these characteristics may be discriminated to form more homogeneous subgroups. The dimensions featured in this discussion include: sociocultural factors; sexual adjustment; social competence; cognitive and academic ability; victim characteristics; level of aggression and violence; behavioral disturbances; and psychiatric diagnosis. Although all these factors can be linked to the assessment and treatment of juvenile sex offenders, the focus of this thesis is on the psychiatric diagnosis of Conduct Disorder and its related behavioral symptoms as they relate to treatment outcome. Furthermore, I shall suggest that Conduct Disorder may

facilitate the identification of a juvenile sex offender subtype who is less amenable to treatment, and may require a highly specialized intervention.

The Heterogeneity of Juvenile Sex Offenders

The study of the heterogeneity of juvenile sex offenders is in its infancy. Knight and Prentky (1993) offer three arguments to support the contention that juvenile offenders are at least as heterogeneous as sexually coercive adults. First, a significant portion of adult sex offenders have engaged in sexually coercive behaviour as juveniles suggests that the heterogeneity found among adult offenders may exist among juvenile offenders. Second, the low recidivism rates reported for juvenile offenders indicate that there may be a substantial subgroup of these offenders whose deviant behaviour does not persist into adulthood. Third, juvenile offender samples typically comprise both rapist and child molester subgroups. Although degree of aggression was determined in this study, rapist and child molester subgroups were not differentiated. Given that the subjects studied for this research were all out-patient adolescent males, most were determined to be less serious offenders, the majority being

child molesters.

As many as 50% of adult sex offenders report that their first sexual assault occurred during adolescence (eg., Abel, Mittleman, & Becker, 1985; Becker & Abel, 1985; Groth, Longo, & McFadin, 1982; Smith, 1984). This indicates that a large subsample of adult sex offenders were also juvenile sex offenders and, as such could provide evidence for the heterogeneity of juvenile sex offenders. Knight and Prentky (1993) in their study of 564 adult male sex offenders' clinical records compared the typological assignments of those men who were juvenile sex offenders and those who were not juvenile sex offenders. The juvenile sex offender group in this sample only included those males whose sexually coercive behaviour persisted into adulthood. The overall recidivism rates of juvenile offenders are reported substantially lower than those of adult offenders (Furby, Weinrott, & Blackshaw, 1989; Smith, 1984; Smith & Monastersky, 1986).

It appears that there is marked heterogeneity of the juvenile sex offender population, however, there is little concern for applying taxonomic specification among these offenders. Perhaps this lack of concern is simply a consequence of the mistaken view that adolescents commit few

sexual offenses of serious consequence. Furthermore, it may be a refection of the general reluctance of clinicians to apply deviant labels to children (Longo & Groth, 1983). Clinical labels can have some negative consequences. However by refraining from applying labels we may forfeit our chances of discerning causes, of designing intervention programs that address the more specific needs of subgroups, of identifying vulnerable individuals who might profit from primary prevention programs, and of improving our dispositional decisions about specific subgroups of offenders. The ability to gain an understanding of and make decisions about these young offenders depends on the reliability and the validity of the categorical structures that are generated and applied (Knight & Prentky, 1993).

As mentioned previously, most of the empirical studies on juvenile sex offenders are limited to tabulations of the frequencies of particular descriptive characteristics of these offenders and their offenses. To date only a few studies have actually compared juvenile sex offenders to delinquent or normal controls; however, several discriminating features are helpful for taxonomic purposes.

Sociocultural Factors

Juvenile sex offenders come from all racial, ethnic, religious, and geographic groups in approximate proportion to these characteristics in the general population. However, in studies from the United States that report race as a demographic variable, between 33% and 55% of the subjects were black, 21-32% were Hispanic and 12-46% were white (Becker, Cunningham-Rathner, et al., 1986; Becker, Kaplan, et al. 1986; Van Ness, 1984; Vinogradov, Dishotsky, Doty, & Tinklenberg, 1988). As such, these studies appear to indicate that non-white youth are over represented, particularly in terms of forcible rape (Brown, et al., 1984). However, arrest rates are biased against these racial subgroups and the apprehensions of non-whites are greater as compared to whites.

Although most juvenile sex offenders are living in two-parent homes at the time of discovery, over half report some parental loss such as divorce, illness, death of a parent, or permanent or temporary separations from the parents. Furthermore, family instability, frequent violence, high rates of disorganization, sexual and physical abuse have been commonly observed as prevalent in the histories of juvenile offenders (Awad et al., 1984; Awad & Saunders, 1989; Becker,

Kaplan, et al., 1986; Becker, Cunningham-Rathner, & Kaplan, 1986; Deisher et al., 1982; Fehrenbach et al., 1986, Lewis et al., 1979; Longo, 1982; Robertson, 1990; Smith, 1988; Van Ness, 1984). Reported rates range from 19% to 47% of adolescents in samples of sexual aggressors who were themselves the victims of sexual abuse (Becker, Kaplan, et al., 1986; Fehrenbach et al., 1986; Longo, 1982). In a study that included incarcerated adolescent homosexual pedophiles, 73% reported that they were sexually abused as children (Robertson, 1990). Moreover, Becker (1988) argued that the rates reported by juvenile sex offenders may actually underestimate the prevalence of sexual victimization in these samples, because the reporting of sexual abuse often emerges only after the adolescent has been in therapy. On the other hand, the estimates of the prevalence of this victimization is based on offenders' self-reports which may be interpreted as self-serving in the sense that they seem to attenuate the offenders' responsibility for their crimes.

Social Competence

Family dysfunction and related social factors have been linked to social competence as a significant variable in

differentiating juvenile sex offender subtypes. Marshall (1989a) has outlined the basis of a theory linking a lack of intimacy in peer relations to a proclivity to engage in offensive sexual behaviours. This study indicated that a sample of adult sex offenders more frequently failed to report intimacy in their lives and expressed greater feelings of loneliness than did nonoffender controls. As such, lack of assertiveness in social interaction, deficiencies in intimacy skills and social isolation have been identified in adolescent sex offenders (Becker & Abel, 1985; Fehrenbach et al., 1986). Attachment theorists argue that poor social relations are a function of inadequate bonds with parents during infancy and early childhood (Bowlby, 1973; Grossman & Grossman, 1990; Weiss, 1982). Awad et al. (1984) found that 88% of their sample of juvenile sex offenders had been separated from their parents for prolonged periods of time on at least one occasion. Furthermore, the parents of these boys lacked commitment to each other and had weak attachments to their children.

Fagan and Wexler (1988) found that 78% of the juvenile sex offenders in their sample were more socially isolated than chronically violent juveniles, and this isolation was more

apparent in their lack of relations with peer-aged females. Further studies have found that juvenile exhibitionists, who characteristically report their parents to have been rejecting, have considerable difficulties with intimacy and feel lonely and isolated from love relations (Marshall et al., 1991).

However, certain offender types may display a higher level of social competence than others. A recent study (Awad & Saunders, 1989) found significantly greater social isolation in a sample of court-referred adolescent child molesters, compared to other male delinquents matched for age, socioeconomic status, and time of referral. In addition, Saunders et al. (1986) found that while 60% of the exhibitionists and 72% of the child molesters had no close friends, only 32% of the rapists were so isolated (Saunders et al., 1986). Thus, it would appear that social competence may play an important role as a differentiator among subtypes of juvenile sex offenders.

Sexual Adjustment

At this writing, controlled studies of the patterns of sexual arousal and of sexual fantasies of adolescent sex

offenders have not been conducted. However, Becker (1988) proposed that there is a distinction between juvenile offenders with sexually deviant recurrent fantasies and a preference for sexually deviant activity and those for whom sexual aggression is simply a part of their impulsive behaviour. This distinction may be significant in terms of developing different offender subtypes.

Cognitive Factors and Academic Ability

The studies on IQ and cognitive abilities are somewhat inconsistent, offering contrasting results. Although Awad et al. (1984) found that their sample of adolescent sex offenders had significantly lower IQs than delinquent controls, Tarter, Hegedus, Alterman, and Katz-Garris (1983) found no differences between two similar groups. Although academic performance involves more variables than IQ level, it is significant to report that over 80% of the sex offenders in Awad et al.'s (1984) sample had experienced learning difficulties during some part of their school career; and 71% had required remedial education. A more recent study (Awad & Saunders, 1989) found a significantly greater degree of serious learning problems in a sample of court-referred adolescent child

molesters, compared to other male delinquents matched for age, socioeconomic status, and time of referral.

Lewis et al. (1981) have found cognitive differences between violent juvenile sex offenders and delinquents, but no differences on these dimensions between the sex offenders and violent, non-sex juvenile offenders. Results from these and other studies seem to suggest that the cognitive impairments may be more associated with violence in general rather than with sexual violence in particular. In fact, the hypothesis that juvenile sex offenders are characterized by a cluster of features that include cognitive impairment, below average IQ, and increased incidence of aggressive behaviour, may only be true of more violent sex offenders. In addition, one may suggest that the discrepancies across studies on cognitive abilities between juvenile sex offenders and nonsexual young offenders might be accounted for by the variations in the frequency of violent sex offenders in different samples.

Victim Characteristics

Fehrenbach et al. (1986) found that 62% of the victims of their sample of abusers were less than 12 years of age, with 44% less than 6. In both Deisher et al.'s (1982) and

Wasserman and Kappel's samples, 50-60% of the victims were under 10 years of age. The only exception seems to be with non-contact offenders, such as obscene phone callers and exhibitionists; whose victims are generally peer age or adults (Fehrenbach et al., 1986). As such, the victims are typically only 6-9 years of age, with male victims being younger than female victims (Awad & Saunders, 1989; Becker, Cunningham-Rathner, & Kaplan, 1986; Pierce & Pierce, 1987).

The majority (69-84%) of the victims of sexual assaults by juveniles are female, particularly with non-contact offenses (Awad et al., 1984; Groth, 1977; Fehrenbach et al., 1986; Longo, 1982; Van Ness, 1984; Wasserman & Kappel, 1985). However, studies seem to indicate that as the age of the victim decreases, the victim is more likely to be male, given that 45-63% of the child victims of adolescent offenders are male (Awad & Saunders, 1989; Shoor et al., 1966; Van Ness, 1984). Generally, the child molester knows his victims, either as relatives, children of friends of the parents, or children the offender had been babysitting (Awad & Saunders, 1989). In contrast, the adolescent rapist tends to victimize strangers (Vinogradov, et al., 1988). Therefore, there appear to be subgroups within the rapist and child molester

categories in terms of victim age and gender preference.

Level of Aggression and Violence

A wide range of coercion and violence has been reported in the sexual assaults committed by juveniles, ranging from no intimidation or threat, through threat, physical force, and extreme violence (Fehrenbach, et al., 1986; Groth, 1977; Lewis et al., 1981; Wasserman & Kappel,, 1985). In their study of the types of juvenile sex offender behaviour of 279 males, Fehrenbach et al. (1986) found the following figures: fondling, 59%; rape, 23%; exhibitionism, 11%; and other non-contact offenses, 7%. In a similar study of 161 male young offenders, Wasserman and Kappel (1985) found: 59% penetration, 31% intercourse, 12% oral-genital contact, 16% genital fondling and 12% non-contact offenses. It appears as the offender age increases rape and more violent sex offenses increases. Victims report higher levels of coercion than offenders, and younger victims seem to be subject to less force (Davis & Leitenberg, 1987). These studies indicate that one third of offenses perpetrated by adolescents result in physical injury. This variation suggests that level of violence may play a taxonomic role in juvenile sex offending.

Psychiatric Factors and Conduct Disorder

The most common indicators of behaviour disorder from the psychiatric perspective are taken to be a history of delinquency, prior arrests for both sexual and nonsexual crimes, and psychiatric diagnoses such as Conduct Disorder and Oppositional Defiant Disorder (France & Hudson, 1993). Adolescent sex offenders frequently have histories of other criminal activity (Saunders, et al., 1986). For example, a number of studies found that 28-50% of the subjects committed at least one prior nonsexual offense (Becker, Cunningham-Rathner, et al., 1986; Becker, Kaplan, et al., 1984; Becker, Kaplan et al., 1986; Fehrenbach et al., 1986). Several other related studies put these figures at 46-82% of the cases (Awad et al., 1984; Becker, Kaplan et al., 1986; Pierce & Pierce, 1987). Furthermore, aggressive acts and other antisocial behaviour were evident in 50-86% of cases (Awad & Saunders, 1989; Shoor et al., 1966; Van Ness, 1984). Consequently, the presence of other nonsexual behavioral disturbances suggests that the sexual offense is not necessarily a sex crime, but is simply one way of acting out (Davis & Leitenburg, 1987). On the other hand, a large group, particularly non-aggressive and

hands-off perpetrators do not engage in other antisocial behaviours. The range of rates for non-sexual offending found in these studies is partly explained by the type of sex offending. More serious and aggressive hands-on offending is associated with higher rates of non-sexual offending (Kavoussi et al., 1988; Lewis et al., 1979; Smith, 1988).

Although this study will not specifically address type of sex offending, it looks at the relevance of the issue of previous non-sexual offenses. That is, a history of non-sexual offenses may be one element of the Conduct Disorder subtype that has clinical relevance in terms of treatment outcome.

Although a more thorough and extensive discussion of psychiatric diagnosis will be discussed in the next chapter, it is necessary to briefly address this issue as it relates to exploring characteristics for classifying juvenile sex offenders. In so doing, a brief overview of the third revised edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R) (American Psychiatric Association, 1987) diagnosis of *Conduct Disorder* and its relevance to treatment will be offered as a transition to the next chapter.

A psychiatric diagnosis is frequently given to the

juvenile sex offender in 70-87% of this population (Awad & Saunders, 1989; Awad et al., 1984; Lewis et al., 1979). Moreover, prior psychiatric treatment had been required in 33% of young sex offenders (Awad & Saunders, 1989). The DSM-III-R (APA, 1987) classification of Conduct Disorder was given in 48% of young sex offenders, with rapists (75%) being more likely than child molesters (38%) to receive this diagnosis (Kavoussi, Kaplan, & Becker, 1988). The diagnosis of substance abuse was given in over 10% of a sample in Kavoussi et al.'s (1988) study of adolescent sex offenders. In addition, juvenile sex offenders appear to have exhibited high rates of emotional problems (Deisher et al, 1982; Groth, 1977; Shoor et al., 1966; Van Ness, 1984). Juvenile sex offenders displayed disturbed emotional functioning and disrupted peer relations. In addition, they displayed greater anxiety and estrangement and less emotional bonding to peers than seen in other juveniles (Blaske et al., 1989).

As alluded to earlier, several studies have sought to establish the rates of nonsexual disturbances of conduct in juvenile sex offenders by examining records of delinquency or through diagnoses of conduct disorder based on psychiatric assessment. These studies have established that approximately

half of juvenile sex offenders have a history of nonsexual arrests and that the majority of these can be described as conduct disordered (Awad & Saunders, 1989; Becker, Kaplan et al., 1986; Kavoussi et al., 1988). Therefore, it seems that the relationship between nonsexual disturbances of conduct and juvenile sex offending is relevant given that a significant number of juvenile sex offenders engage in other criminal acts and may be diagnosed as conduct disordered. Each condition shares several important distal causative and prognostic factors and there are similarities in the various attempts to subclassify both. Finally, the coexistence of conduct disorder and juvenile sex offending may have clinical significance in terms of identifying a discreet subtype of sex offender as well as for predicting treatment outcome.

CHAPTER TWO

PSYCHIATRIC DIAGNOSIS AND SEXUAL OFFENDING IN ADOLESCENTS

Introduction

The purpose of this chapter is to describe and evaluate the Diagnostic and Statistical Manual of Mental Disorders in general, and more specifically, assess the utility of psychiatric diagnosis as it relates to conduct disorder and the sexual offending behaviour of adolescents. Psychiatric diagnosis may be one way of identifying subtypes within the juvenile sex offender population. This chapter will look at the clinical relevance of the psychiatric diagnosis of conduct disorder, it's 13 behavioral symptoms, and history of non-sexual offending as elements for predicting treatment outcome.

The Diagnostic and Statistical Manual of Mental Disorders (DSM) has been described as a major advance in psychiatric classification since the publication of the first edition in 1952 (American Psychiatric Association, 1987). However, since that time and the recent publication of DSM-IV in 1994, the process has encountered criticism and created controversy from the non-psychiatric professionals, and in some instances, the medical profession as well.

First, a general review of the Diagnostic and Statistical Manual of Mental Disorders system and process will be offered from an historical perspective including the evolution of the multi-axial classification system. Second, a discussion of the strengths and limitations of the DSM classification system will be presented, addressing its utility for clinical practice; more specifically, in terms of youth diagnosed as conduct disordered. Third, the conduct disorder diagnosis will be described and analyzed in terms of its validity, reliability and utility in clinical practice. Fourth, an evaluation of the usefulness of this diagnosis as it relates to treatment outcomes of juvenile sex offenders will be presented. Finally, a discussion of the predictive validity of the diagnosis will conclude this chapter.

History of DSM Classification System

The clinician's desire to classify signs and symptoms of disease into discrete disorders has been an issue of contention for many years. This need to classify and label disorders has led to the creation, revision and demise of numerous classification systems (Reid & Wise, 1989). In the field of mental health there are currently two widely used classification systems: first, the International

Classification of Diseases (ICD) and; second, the Diagnostic and Statistical Manual of Mental Disorders (DSM). The ICD is a worldwide statistical disease classification system for all medical conditions, including mental disorders. The DSM, published by the American Psychiatric Association, consists of a series of Diagnostic and Statistical Manuals of Mental Disorders, the latest of which is the DSM-IV.

The official classification of mental disorders in North America was first attempted in the 1840 U.S. census when all mental illness was classified in a single category, "idiocy/lunacy". This was later expanded in the 1880 census to include eight different mental disorder categories (Williams, 1988). By the late 1920's, nearly every medical teaching facility used a different classification system for mental disorders. The result was a diverse nomenclature that typically lead to meaningless communications and arguments between mental health professionals. In an attempt to bring order to the terminology, the Standard Classified Nomenclature of Disease (SCND) was published in 1933. However, World War II caused a crisis in psychiatric terminology, as only 10% of the total cases seen by military psychiatrists could be classified using the SCND (American

Psychiatric Association, 1952). In addition, during the postwar period, three separate U.S. nomenclatures existed: the SCND, the Armed Forces nomenclature, and the Veterans Administration system. Moreover, none of these was consistent with the International Diagnostic Classification (IDC) system.

The confusion over terminology resulted in the Committee on Nomenclature and Statistics of the American Psychiatric Association proposal of a revised classification system. Subsequently, the first edition of the Diagnostic and Statistical Manual of Mental Disorders was published in 1952. When it became apparent that revisions would be needed, the manual later became known as DSM-I. DSM-II was the result of an international collaborative effort that also culminated in the mental disorders section in the Eighth Revision of the International Classification of Diseases (ICD-8). DSM-II and ICD-8 went into effect in 1968.

In anticipation of ICD-9's 1979 scheduled publication date, the development of DSM-III began in 1974. However, the lack of detail for research and clinical application in the mental disorders section proposed for ICD-9 resulted in the American Psychiatric Association Task Force on Nomenclature and Statistics development of a new classification system.

This development process included 14 advisory committees, consultants from associated fields, liaison committees with professional organizations, conferences, and field trials. DSM-III was seen as a dramatic deviation from it's predecessors. In their DSM training guide, Reid and Wise (1989) identify the major innovations of the DSM-III:

1) Definition of the term *mental disorder;*

2) Presentation of diagnostic criteria for each disorder;

3) Diagnosis according to a multi-axial evaluation system;

4) Redefinition of major disorders;

5) Addition of new diagnostic categories;

6) Hierarchical organization of diagnostic categories;

7) Systematic description of each disorder;

8) Decision trees for differential diagnosis;

9) Glossary of technical terms;

10) Annotated comparative listing of DSM-II and DSM-III;

11) Discussion of ICD-9 and ICD-9-CM;

12) Publication of reliability data from field trials;

13) Indices of diagnostic terms and symptoms (p. 5)

The development and goals of the DSM-III-R were similar

to those of DSM-III. Twenty-six advisory committees were formed, each with membership based on expertise in a particular area. In addition, the experience gained in using the DSM-III diagnostic criteria, particularly in certain research studies, played a significant role in proposed modifications. The following new appendices were added to DSM-III-R:

> Proposed diagnostic categories needing further study (eg. late luteal phase dysphoric disorder, sadistic personality disorder; and self-defeating personality disorder); an alphabetic listing of DSM-III-R diagnoses and codes; a numerical listing of DSM-III-R diagnoses and codes; an index of selected symptoms (Reid & Wise, 1989, p.5)

DSM-IV was first published in 1994 and demonstrated some significant changes as compared to it's predecessors. According to the DSM-IV Task Force, the threshold for making revisions in DSM-IV was set higher than that for DSM-III and DSM-III-R. In addition, in an effort to increase the clinical utility of DSM-IV, the criteria sets were simplified and

clarified. The American Psychiatric Association claimed commitment to "...historical tradition (as embodied in DSM-III and DSM-III-R), compatibility with ICD-10, evidence from reviews of the literature, analyses of unpublished data sets, results of field trials, and consensus of the field." (APA, 1994, p. xx). The APA further asserts that their reliance on data generated through scientific research promotes a transition from a descriptive classification system to an etiological classification system (Reid & Wise, 1989). This transition is further facilitated by the use of a multi-axial classification system.

Multi-axial Classification System

The multi-axial classification system was first introduced in DSM-III in 1980, and with particular modifications, remains as an integral component of DSM-IV. This system "...involves an assessment on several axes, each of which refers to a different domain of information that may help the clinician plan treatment and predict outcome" (APA, 1994, p. 25). The following is an overview of the five axes in DSM-IV:

Axis I Clinical Disorders

Other Conditions That May Be a Focus of Clinical Attention

Axis II	Personality Disorders
	Mental Retardation
Axis III	General Medical Conditions
Axis IV	Psychosocial and Environmental Problems
Axis V	Global Assessment of Functioning

Axis I and Axis II are used to describe the client's current condition. When necessary, multiple diagnoses, or diagnoses on both axes, are made. Axis I lists clinical syndromes present or if no mental disorder is present, reports the same. Axis II reports the Personality Disorders and Mental Retardation. Axis II can also be used to record prominent maladaptive personality features that do not meet the threshold for a Personality Disorder and any repetitive defense mechanisms that impair the client's ability to function.

Axis III is for reporting current general medical conditions that are relevant to the understanding or management of the individual's mental disorder. For example, the physical condition may be causative as in the case of

hypomanic or manic symptoms due to hyperthyroidism.

Axis IV is for the reporting of psychosocial and environmental problems that may affect the diagnosis, treatment, and prognosis of mental disorders. These problems are grouped together in nine separate categories; two examples being, "problems with primary support group" and "economic problems".

Axis V is for reporting the clinician's judgement of the individuals overall level of functioning on the Global Assessment of Functioning scale (GAF). The GAF Scale is a rating from 1 to 100 with respect only to psychological, social and occupational functioning. According to the DSM-IV commentary on the multi-axial system, the GAF Scale is useful in planning treatment and measuring its impact, and in predicting outcome (APA, 1994).

Evaluation of Multi-axial System

The DSM-III-R made substantial changes to the multi-axial system, such as the inclusion in Axis II, instead of Axis I, of Mental Retardation and Pervasive Developmental Disorders together with specific developmental disorders, for they represent enduring characteristics with onset during

childhood. Rutter and Shaffer (1980) severely criticized the DSM-III for having these disorders placed within Axis I because they did not perceive these as clinical disorders in need of attention. However, in the DSM-IV the developmental disorders have been relegated to Axis I because they are now considered to be a focus of clinical attention, whereas mental retardation has been maintained as an Axis II disorder. As such, Conduct Disorder is placed within Axis I as it is considered a clinical disorder in need of attention. This is also the case for any of the Paraphilias that a juvenile sex offender may be diagnosed with. Many juvenile sex offenders receive multiple diagnoses as they present with a myriad of problems requiring attention. For example, a 16 year old may be diagnosed with Pedophilia, Developmental Disorder (eg. learning disability), Attention Deficit Hyperactive Disorder and Conduct Disorder all on Axis I as conditions in need of attention. On occasion, a juvenile sex offender may also be diagnosed with Mental Retardation which will be entered on Axis II.

In terms of the use of Axis III and the reporting of current medical conditions relevant to the individual's mental disorder, youth diagnosed with Conduct Disorder or a

Paraphilia will on occasion receive a diagnosis on this Axis. For example, severe cases of acne may have impact on the youth's self-esteem and subsequent social competence. Other conditions, for example, may include diabetes or asthma, each of which can have impact on the young person's behaviour.

In DSM-III-R the clinician was asked to list and rate on Axis IV all the psychosocial stressors judged to have contributed to the development or exacerbation of the current disorder/s. Furthermore, it added the complication (not included in DSM-III) that the clinician should specify whether the stressors are "predominantly acute events" (less than six months) or "enduring circumstances" (duration of more than six months). Studies (Rey, Stewart, Plapp, Bashir & Richards, 1987; 1988) suggest that Axis IV ratings are unreliable; that identification of stressful events (particularly the milder ones) during an unstructured clinical interview is largely idiosyncratic, and that rating severity of stressors decreases reliability even more. As such, in DSM-IV the clinician is no longer required to rate or specify whether the psychosocial stressors are acute or enduring. In terms of juvenile sex offenders and youth diagnosed with Conduct Disorder, Axis IV is rarely if ever used.

Axis V, first introduced in DSM-III, had the clinician rate the highest level of adaptive functioning of the client. In DSM-III-R, this continuum became a completely new scale, the Global Assessment of Functioning Scale or GAF scale, to assess psychological, social and occupational functioning on a hypothetical continuum of mental health-illness. Clinicians are requested to rate their clients on a continuum from: "1. persistent danger of severely hurting self or others (eg. recurrent violence) OR persistent inability to maintain minimal personal hygiene OR serious suicidal act with clear expectation of death" to: "90. Absent or minimal symptoms (eg. mild anxiety before an exam), good functioning in all areas, interested and involved in wide range of activities, socially effective, generally satisfied with life..." (p.22). In DSM-IV the rating is now from 1 to 100, followed by the time period reflected in the rating in parentheses; for example, "(current)," "(highest level in past year)," "(at discharge)."

Little research has been published on the subject of assessment of functioning to warrant the dramatic changes on Axis V (Rey et al., 1988). The GAF scale in DSM-III-R has potential problems because its content is a mixture of symptom severity and/or social functioning, for example: "60. Moderate

symptoms (eg. flat affect and circumstantial speech, occasional panic attacks) OR moderate difficulty in social, occupational, or school functioning (eg. few friends, conflicts with co-workers)" which is likely to create circularity and spurious associations. DSM-IV has made an attempt to address these issues with the introduction of a proposed Social and Occupational Functioning Assessment Scale (SOFAS) in Appendix B (APA, 1994, p. 760). Although the psychosocial axes are considered invaluable within non-psychiatrist disciplines, very little research or clinical interest has been generated by the DSM Task Force (Williams, 1985; Williams, Spitzer, & Skodol, 1985).

Not one of the records of the subjects in this study included data on either Axis IV or V. Critics of the use of DSM see this as a significant omission and misuse of the multi-axial system.

Critical Analysis of DSM Revisions

Williams (1986) gives three reasons to justify the revisions in the DSM-III-R. First, it had become apparent that statements in the text and criteria were not clearly worded and were inconsistent with other statements in the

manual since the publication of DSM-III. Second, it was also suggested that a revision was necessary because new research had appeared with novel information which could be incorporated in the classification. This seems less understandable, for DSM-III was published in 1980 and the revision process was commenced in 1983. Since a research project typically takes about 3 to 4 years from the time of conception to the point of actual publication, it is apparent that the bulk of the research referring to the DSM-III classification could not have begun appearing until 1983 at the earliest. Thus, this justification does not appear to be well founded, particularly when in the introduction of the DSM-III-R (APA, 1987) it states:

> "...in attempting to evaluate proposals for revisions in the classification and criteria, or for adding new categories, the greatest weight was given to the presence of empirical support from well conducted research studies, though, for most proposals, data from empirical studies were lacking. Therefore, primary importance was usually given to some other consideration" (p.xxi).

Thirdly, with the DSM-IV having finally been published in

1994, after 14 years had elapsed between revisions, indicated a too long a period. Any classification takes time to permeate through the medical, research, administrative and teaching structures and practising clinicians need time to digest the changes and incorporate the ones that are considered useful into their practice.

Clinician Bias

Numerous studies have raised concerns regarding the scientific and empirical basis for some of the diagnoses and criteria sets that were proposed or included in DSM-III and DSM-III-R (Achenbach, 1980; Bayer & Spitzer, 1982; Caplan, 1987; Dell, 1988; Fenton, McGlashan, & Heinssen, 1988, Kaplan, 1983; Kendell, 1988a; Quay, 1986; Rey, 1988; Rutter & Shaffer, 1980; Schacht, 1985; Tyrer, 1988; Zimmerman, 1988). It has been suggested that some decisions reflected primarily the theoretical biases of the participant(s) or the specificity of the settings and experiences in which they practiced or researched (Gunderson, 1983; Kernberg, 1984; Michels, 1984; Millon, 1981). As such, it is felt that decisions depend upon the personnel and the personalities who are on a committee and the construction of the DSM could suffer from an unreliability

in its construction that is comparable to the unreliability of a clinical diagnosis. The diagnoses and criteria sets would reflect the committee membership rather than the clinical and empirical literature, just as unreliable clinical diagnoses reflect who is making the diagnosis rather than the syndromes being diagnosed. With each new DSM, new diagnoses and criteria would appear, changing with whomever has been given or has obtained the responsibility for making the decisions.

The clinical and research literature for the DSM process is not infallible and is often inadequate. Similarly, a clinician who ignores the DSM-III-R criteria may at times provide a more valid diagnosis than would be provided if the criteria were followed blindly, given the limitations and fallibility of any set of diagnostic criteria (Fenton, Mosher, & Mathews, 1981; Widiger et al., 1990). Research has indicated that a systematic assessment and adherence to the DSM-III-R criteria for the personality disorders can at times yield eight or more personality disorder diagnoses (Skodol, Rosnick, Kellman, Oldman, & Hyler, 1988; Widiger, Trull, Hurt, Clarkin, & Frances, 1987). Decision making in the DSM is considered by some to be an implicit process having insufficient empirical basis for particular decisions andthere

is often little documentation of the decision process to indicate otherwise (Achenbach, 1980; Caplan, 1987; Dell, 1988; Garfield, 1986; Garmezy, 1978; Kaplan, 1983; Kocsis & Frances, 1987; Taylor, 1983; Tyrer, 1988; Walker, 1987).

Strengths and Limitations of DSM

The use of the DSM is widespread among psychiatrists, psychologists, and social workers employed in a variety of settings. However, in a comprehensive survey of psychiatrists (Jampala, et al., 1986), 35% stated they would stop using the DSM if it were not required and fewer than 50% used three or more of the axes to record a diagnosis. The authors concluded that a significant proportion of psychiatrists are unenthusiastic about the DSM and that "...there is a danger that complex diagnostic systems, even if valid and reliable, might evolve in the course of time to be mere exercises on paper that are often praised but seldom practiced" (p.23).

Kutchins & Kirk (1988) in their study of the DSM-III and clinical social work offer several advantages and disadvantages to the system. They state that the DSM includes diagnostic criteria for each disorder, that these criteria increase diagnostic reliability, as well as facilitate

communication and enhance diagnostic skills. However, Kutchins & Kirk's (1988) conclude that the disadvantages far out weigh the advantages. First, they report that very little attention is given to all 5 axes. This was evident in this study as none of the records included reports on Axis IV or V. Second, there exists an overuse of certain diagnoses because of the theoretical orientation of the practitioner. This may be evident in the diagnosis of juvenile sex offenders who do not meet the diagnosis for Pedophilia given their relative age, particularly the youth in early adolescence. Third, it is not sensitive to racial and cultural differences. Fourth, the DSM classification system does not accurately reflect clients' problems and is more a management tool than a clinical tool. Finally, Kutchins & Kirk suggest it does not adequately reflect interactional problems.

Pathologizing Children

Kutchins & Kirk (1988) found that social workers rejected the medicalization of mental disorders and thought that DSM-III placed medical labels on psychosocial problems and in particular labelled too many problems of childhood as pathological. Furthermore, the DSM has increased the number

of childhood disorders to include many behaviours which are troublesome but not, in their opinion, pathological. However, society has a tendency to minimize and normalize childhood and adolescent sexual behaviour, which in fact may be sexual abuse and require specialized intervention. In the diagnostic criteria of Conduct Disorder the behaviours "often lies", "truancy", and "running away" qualify the individual to receive this diagnosis. In some circles these criteria may be perceived as normal acting out or rebellious adolescent behaviour. On the other hand, the diagnostic criteria may have clinical relevance in terms of predicting treatment outcomes as is hypothesized in this study. In their study, Kutchins & Kirk (1988) found that many psychiatrists approach diagnosis in an individual and unsystematic way and not in conformity with DSM criteria. Diagnosis should be intimately related to treatment but only 33% of the psychiatrists surveyed found DSM helpful in treatment planning and that it inhibits understanding of individual clients (Kutchins & Kirk, 1988).

In a similar study, psychologists found DSM-III as the least favourably endorsed diagnostic option and rejected the idea that mental disorder is a subset of medical disorder, and

concluded that too little effort had been made to promote alternatives to DSM-III (Smith & Kraft, 1983). They stated that the DSM labels clients and is not helpful in treatment planning (Raffoul & Holmes, 1986).

They go on to state that the threshold for making revisions in DSM-IV is much higher than was the case for DSM-III and DSM-III-R, utilizing: "comprehensive, systematic, and consensus reviews of the published literature; reanalysis of relevant collected data sets; and field trials (Francis et al., 1991). They also claim that it is more difficult to remove something that was already included in DSM-III-R than to introduce something new that has been suggested for DSM-IV (Frances et al., 1991) Of particular significance is this quote: "This is necessary to avoid frequent and arbitrary diagnostic changes that impede clinical discourse, training, and research. There has to be a fairly compelling reason to change the classification" (Frances et al., 1991, p. 172).

Changes in DSM Categories and Criteria

Hierarchical Structure

One of the main changes in the criteria for diagnosis refers to the hierarchical structure. Most of the

classifications actually in use in psychiatry have a hierarchical structure. That is, the different disorders are organized in levels in such a way that each level of pathology is allowed to exhibit the characteristic features of all lower levels but not any of a higher level. This approach makes possible the use of a single diagnosis despite the fact that multiple symptoms of different levels may appear at any given time. The DSM-III-R has largely done away with those principles which are maintained only in two areas: the organic mental disorders, which rule out a diagnosis of almost any other disorder, and schizophrenia which also preempts most other diagnoses. However, the hierarchical organization has been relaxed significantly. For example, a diagnosis of Anxiety Disorder or Major Depression can be made despite a concurrent diagnosis of Attention Deficit Hyperactivity Disorder or Conduct Disorder. These changes appear to be a response to criticisms of the exclusion criteria of DSM-III and of the hierarchical hypothesis on empirical grounds, and that correlations between diagnoses for which exclusion criteria were not used were sometimes stronger than when they were specified (Robbins & Helzer, 1986). Furthermore, the relaxation of the hierarchical structure has resulted in an

increase of the number of individuals with multiple diagnoses. However, results from several studies (eg. Loeber et al., 1994; Russo et al., 1994) support the hierarchal organization of disruptive behaviour disorders in children. That is, Conduct Disorder is perceived as an advanced and more severe form of Oppositional Defiant Disorder. This issue will be discussed in more depth in the following sections of this chapter.

Diagnostic Rules

Most of the specific diagnostic rules prescribed in DSM (i.e. minimum number of symptoms, minimum length of time during which symptom should be present, etc.) have never been tested empirically (Rutter & Shaffer, 1980; Eysenck, Wakefield, & Friedman, 1983). Moreover, the "Chinese menu system" (Klerman, 1978), in which symptoms are assorted into groups with the requirement that symptoms from all groups be present to be able to make a diagnosis, has been largely abandoned. Consequently, this has resulted in even longer lists of symptoms. These "laundry lists" (Klerman, Vaillant, Spitzer, & Michels, 1984) which make little sense, are impossible to remember, and which in many cases have become *de*

facto rating scales, but without having been subjected to psychometric analysis. An example of that is Conduct Disorder in the DSM-III-R with a list of 13 symptoms, 3 if which must be present to make a diagnosis. Ironically, the DSM-IV has responded to this issue by adding two more symptoms. In addition, as if to compromise, the 15 symptoms are now divided in 4 groups, however the 3 necessary criteria need not come from every group to make a diagnosis. As such, diagnostic criteria continue to seem more suited for use with standardised interview schedules and computer algorithisms, than for application in every day clinical practice.

DSM-III-R also expanded the description of severity, which is included in most diagnostic criteria. Clinicians are encouraged to make severity specifications: mild, moderate, severe, in partial remission and in full remission. This is particularly relevant for Conduct Disorder diagnosis, as the clinician is asked to make a distinction in the levels of severity. In fact, to present a new and empirically based perspective, the first version of the DSM-IV Options Book (APA, 1991) included an attempt to integrate Oppositional Defiant Disorder and Conduct Disorder in a single, alternative, disruptive behaviour syndrome with three levels

of severity: a modified oppositional disorder (MODD), and intermediate level of Conduct Disorder (ICD), and an advanced level of Conduct Disorder (ACD) (Russo, et al., 1994).

DSM-III-R and DSM-IV: More Empirical and Accessible

With the limitations in mind, the DSM-III-R and DSM-IV are more empirical and accessible than their predecessors because "a much broader, more representative array of diagnostic and research expertise was brought to bear on these versions of the *Diagnostic and Statistical Manual*" (Nathan, 1994, p. 103). Nathan goes on to state that "in their numbers, disciplinary bases, gender, racial diversity, and primary work settings, the several hundred mental health professionals who contributed to the development of DSM-IV were markedly different from those who developed the previous four editions" (p. 103). Only a small number of senior psychiatrists from the most prestigious departments of psychiatry were involved in the development of DSM-I and DSM-II in 1952 and 1968 respectively. However, a much larger number of psychiatrists with a broader scope of expertise, a psychologist, and a social worker worked on DSM-III which was published in 1980. According to Nathan (1994) this process of

broadening the base of contributors accelerated progressively during the development of the DSM-III-R and the subsequent development of the DSM-IV. The development of this current revision resulted in the involvement of a large and diverse group of mental health professionals that included three psychologists and a social worker joining the psychiatrists on the Task Force, a dozen or more psychologists and numerous mental health professionals of other disciplines on the Work Groups, and over 100 non-psychiatrists served as advisors. Furthermore, a substantial number of these individuals identified themselves as clinicians rather than university faculty. In addition, a significant number of women had previously, and quite conspicuously, been absent in the DSM development process.

Several studies indicate that negligible empirical data informed either the DSM-I or DSM-II processes (Garfield, 1986; Michels, 1984; Skodol et al. 1988; Widiger et al, 1990). Moreover, although both DSM-III and DSM-III-R were considered far more grounded in scientific research than their predecessors, in reality only parts of either classification system were the result of empirical research. Nathan (1994) contrasts this, stating that the criterion sets in nearly

every major diagnostic category in DSM-III-R and DSM-IV were influenced significantly by thorough literature reviews, and the results of both the analyses of existing data and extensive field trials. Furthermore, in contrast to previous editions where research findings were infrequently published, the results of Work Groups' analyses of existing data sets and field trials has been made easily accessible in the several volume's of DSM-IV *Sourcebooks* of published reports.

Several studies show that DSM-III was constructed through decisions based on expert consensus, as research on the diagnosis of mental disorders was often limited (Kendell, 1988b; Robins & Helzer, 1986; Spitzer, 1985). The development of DSM-IV benefits from the substantial increase in research and interest in diagnosis generated in part by DSM-III. The diagnosis of mental disorders prior to DSM-III was unreliable to the point that their validity was suspect (Blashfield & Draguns, 1976; Rosenhan, 1975; Spitzer & Fleiss, 1974). The major innovation of DSM-III with respect to the improvement of reliability was to provide explicit diagnostic criteria that made diagnosis more systematic and replicable (Spitzer et al., 1980).

The most recent studies state that the DSM-IV is much

better informed by empirical data than any of its predecessors and that not all diagnostic criteria have benefitted as fully from empirical findings as have others (Frances, Davis & Kline, 1994; Frances, Pincus, & Widiger, 1994; Pincus, Frances, Davis, Widiger, & First, 1994). For example, in the Disruptive Behaviour Disorders grouping, a number of overlapping criteria are shared by the various diagnoses and are less specific than other DSM diagnoses, such as Schizophrenia.

According to Nathan (1994) this dual emphasis on empirical findings and full accessibility of those findings clearly distinguishes the DSM-IV process from those of its predecessors. In addition, he states that this dual emphasis should ensure that the reliability, validity, and utility will be higher than in the previous instruments.

DSM Classification of Conduct Disorder

Disruptive Behaviour Disorders

The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV, APA, 1994) is the most widely used categorical diagnostic system of childhood disorders. Major Axis I diagnoses describing childhood and adolescent disturbances of

conduct are grouped as a subclass called Disruptive Behaviour Disorders. These disorders are characterized by socially disruptive behaviour that is of greater distress to others than to the diagnosed individual. The specific diagnostic syndromes are Attention-Deficit Hyperactivity Disorder, Oppositional Defiant Disorder, and Conduct Disorder.

The diagnostic term *Conduct Disorder* from the third revised edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R, American Psychiatric Association, 1987) includes the following set of behaviours listed in descending order of discriminating power:

(1) has stolen without confrontation of a victim on more than one occasion (including forgery)

(2) has run away from home overnight at least twice while living in parental or parental surrogate home

(3) often lies (other than to avoid physical or sexual abuse)

(4) has deliberately engaged in fire-setting

(5) is often truant from school

(6) has broken into someone else's house, building, or car

(7) has deliberately destroyed others' property

(8) has been physically cruel to animals

(9) has forced someone into sexual activity with him or her

(10) has used a weapon in more than one fight

(11) often initiates physical fights

(12) has stolen with confrontation of a victim

(13) has been physically cruel to people. (p. 58)

Conduct Disorder is considered the most severe of the Disruptive Behaviour disturbances, having as its essential feature "a repetitive and persistent pattern of behaviour in which the basic rights of others or major age-appropriate societal norms are violated" (APA, 1994, p.53). This essential feature is literally unchanged since DSM-III, other than the use of the additional term "repetitive" and the use of the word "behaviour" instead of "conduct" in the DSM-IV . This behaviour is typically observed to occur across situations (at home, at school, and in the community), across persons (parents, peers, and strangers), and across time. The DSM-III-R specifies a duration of at least six months, during which at least three of the of the behavioral symptoms are present. This symptom threshold was increased from only one

behavioral criteria as per the DSM-III to make a diagnosis. The DSM-IV changed the time threshold to state: "...the presence of three (or more) of the following criteria in the past 12 months, with at least one criterion present in the past six months" (APA, 1994, p.90). In addition, as mentioned earlier, the number of applicable diagnostic items have been increased from 13 to 15 discriminant behavioral items. These two new items are: "often bullies, threatens, or intimidates others", and "often stays out at night despite parental prohibitions, beginning before age 13 years" (APA, 1994, p. 90).

Stealing and physical aggression are primary to the diagnosis, although other behaviours such as running away from home and lying were reported to be high in discriminating power based on the results of a national field trial of DSM-III-R criteria (APA, 1987).

Evolution of Conduct Disorder (CD) Subtypes

It is clear to all who study antisocial behaviour in youths that CD is a heterogeneous diagnostic category (Farrington, 1987; Kazdin, 1987; Loeber, 1988). Therefore, subtypes have been proposed in an effort to capture

differences in behaviour, developmental trajectories, and assumed etiology. Subclassifications from earlier editions of the DSM have distinguished subtypes of CD on the basis of the capacity of the youth for maintaining social relationships, the presence or absence of aggression, age of onset, and the presence or absence of comorbid diagnosis.

Socialization and aggression. The distinction between socialized and under-socialized CD in DSM-III was based on a number of studies of psychiatric outpatients and incarcerated juvenile delinquents beginning with the pioneering studies of Jenkins (Jenkins & Hewitt, 1944; Jenkins and Glickman, 1947). These studies indicated that youths with under-socialized CD are more aggressive, adjust less well to juvenile detention facilities, are less likely to violate probation and be rearrested after release than youth with socialized CD (Henn et al., Quay, 1986b, 1987). However, explicit operational criteria is necessary in order to make a meaningful distinction between socialized and under-socialized CD.

The socialized and under-socialized subtypes of CD distinguished in DSM-III were each subdivided into aggressive and non-aggressive subtypes. There is evidence to support the belief that youths with CD who are physically aggressive

should be distinguished from those who are not (Olweus, 1979; Henn et al., 1980). Studies have shown that high levels of aggression as early as age 10 are highly predictive of persistent adult male criminality, especially violent and destructive crime (Henn et al., 1980; Stattin & Magnusson, 1989).

The symmetrical subtyping of CD in DSM-III along both the socialized-under-socialized and the aggressive-non-aggressive dimensions was dropped in DSM-III-R in favour of two subtypes that captured some aspects of these distinctions. A *solitary aggressive* type was distinguished, but no solitary non-aggressive subtype was provided on the assumption that few such cases of CD would be identified. The *group type* can include both aggressive and non-aggressive youths, but no distinction was made on the basis of aggression in this subtype. In support of this differentiation of subtypes, poor peer relationships have been demonstrated to be predictive of later maladjustment in this population (Roff & Wirt, 1984). It may be possible to differentiate subtypes within the juvenile sex offender population who are conduct disordered based on their level of aggression and socialization. That is, the more aggressive, under-socialized sex offender may be

one subtype of Conduct Disorder who is more likely to have poor treatment outcome. In the DSM-III-R, the juvenile sex offender diagnosed as "Conduct Disorder: solitary aggressive type" may fit into this category.

A study by Rogeness et al. (1983) is consistent with the DSM-III-R approach to subtypes of CD. Among 345 psychiatric inpatient children and adolescents given a DSM-III diagnosis of CD, 46% were given the diagnosis of socialized aggressive CD, and 38% were given the diagnosis of under-socialized aggressive CD. Fourteen percent received a diagnosis of socialized non-aggressive CD, but only 2% of the youths with CD received a diagnosis of under-socialized non-aggressive CD. However, these results are questionable because inpatient samples may not be representative of all clinic-referred youths with CD.

Age of onset. Certain studies have been able to distinguish between early and late onset forms of juvenile delinquency, in that late onset delinquents tend to be less severe in their offending, particulary in exhibiting less aggression, and have a better prognosis for desistance in offending (Farrington, 1987; Loeber, 1982, 1988). Similarly, Robins (1966) found that youths whose CD onset before age 11

were twice as likely to receive a diagnosis of Antisocial Personality Disorder (sociopathy) in adulthood as those with an onset after age 11. McGee et al. (1992) identified a very large group of male and female youths who exhibited DSM-III CD for the first time after age 11. Furthermore, this group were less likely to be aggressive, and exhibited higher verbal ability and reading scores.

An important goal of the DSM-IV field trials was to assess the utility of subtyping CD. Thus, the subgroups were compared to see if they differed in terms of impairment, family history, comorbidity, and other clinically important variables. Although a significant body of research suggests that meaningfully distinct subtypes of CD should be distinguished, DSM-IV field trials and related studies have determined that distinctions of socialization and aggression were redundant and identified the same subgroups of youths with CD (Frick et al., 1994; Loeber et al., 1993; Lahey et al., 1994). However, this same research determined that it was useful to distinguish between two developmentally staged levels of severity within CD. As such, DSM-IV offers two subtypes based on age of onset: "childhood-onset type: onset of at least one criterion characteristic of Conduct Disorder

prior to 10 years" and "adolescent-onset type: absence of any criteria characteristic of conduct disorder prior to age 10 years" (APA, 1994, p.91). Thus, it may be possible to identify subtypes of juvenile sex offenders diagnosed with Conduct Disorder based on age of onset. This would have clinical relevance in terms of predicting treatment outcome in that those juvenile sex offenders diagnosed with early onset Conduct Disorder are more likely to have poor treatment outcome.

Comorbidity. There is some evidence that youths with CD and comorbid Attention Deficit Hyperactive Disorder (ADHD) exhibit a more severe and persistent disorder than youths with CD alone (Offord et al, 1979; Schachar et al., 1981; Walker et al., 1987; Werry et al., 1987). Furthermore, they concluded that only the greater cognitive impairment associated with ADHD and the greater social impairment associated with Conduct Disorder differentiated the two groups across the majority of studies reviewed. However, given the previous research findings one would expect that those juvenile sex offenders with both CD and ADHD would have poorer treatment outcomes than those with a single diagnosis.

Evaluation of DSM Classification for Conduct Disorder

Three major criteria for the evaluation of classification systems were outlined by Quay (1986a). The first requires that features be operationally defined and covary. The second is related to the reliability of the observations. The rating scales commonly used in these investigations have been reported to have generally good interrater reliability (eg. between parents; Achenbach & Edelbrock, 1983). Finally, the classification must be valid. According to Baum (1989) dimensions defined by multivariate approaches are discriminable from each other and provide an empirical basis for investigating group differences in etiology, behavioral correlates, course, outcome, and response to treatment. However, the extensiveness of the behaviours assessed and the comparability of dimensions across studies are valid criticisms of these approaches (Quay, 1986a).

Using Quay's criteria (1986a) to evaluate the DSM-III-R, this revision appears to offer improvements over previous versions in the operationalization of diagnostic criteria by the use of specific descriptions of observable behaviours. However, clinical judgement is still required in terms of how frequently a behaviour must occur to meet the criteria.

Certain discriminating criteria of Conduct Disorder have been found to load on separate factors in multivariate research (Baum, 1989). For example, although "stealing without confrontation of a victim" is listed as highest in discriminating power and "stealing with confrontation" is 12th of the 13 DSM-III-R criteria (APA, p. 55), theft is commonly associated with the group type conduct disorder pattern and is rarely seen in the solitary aggressive type pattern.

Diagnostic Thresholds

The diagnostic thresholds for both ODD and CD were raised in DSM-III-R by eliminating the milder symptoms and increasing the number of symptoms required for each diagnosis, resulting in decreased prevalence of the two disorders (Lahey, et al., 1994). The changing criteria of DSM-III and DSM-III-R criteria for Conduct Disorder have been controversial for two main reasons. First, some researchers have challenged raising the diagnostic threshold for Conduct Disorder to three symptoms in DSM-III-R because some evidence suggests that even one or two conduct disorder symptoms in childhood predict adverse adult outcomes (Lahey, Loeber, Quay, Frick, & Grimm, 1992; Lahey Loeber, Quay, Frick, & Grimm, 1994; Robbins &

Price, 1991; Russo, Loeber, Lahey, & Canaan, 1994). Second, others have suggested that oppositional defiant disorder (ODD) is merely a milder form of Conduct Disorder and should not be considered as a separate disorder (Frick, Lahey, Applegate, Kerdyk, Ollendick, Hynd, Garfinkle, Greenhill, Biederman, Barkley, McBurnett, Newcorn, & Waldman, 1991; Lahey et al., 1994). Lahey et al. (1994) reviewed existing research in an attempt to evaluate the validity of the DSM approach to the diagnostic criteria for ODD and CD. These efforts provided consistent evidence of a strong developmental relationship between oppositional defiant disorder and conduct disorder. It appears that a high percentage of youths who meet criteria for conduct disorder before the age of puberty met criteria for Oppositional Defiant Disorder at an earlier age (Lahey et al., 1994).

Conduct Disorder Symptoms

There have been no research studies forthcoming to empirically distinguish between different severity levels within Conduct Disorder. Ongoing extensive research is needed to assess the utility of all potential diagnostic criteria for the disruptive behaviour disorders. Lahey et al. (1992) claim

that this can be done in three general ways. First, the conditional probability that if a youth exhibits symptom X the youth will also exhibit symptom Y may be so high that symptom Y is redundant and adds little or nothing to the diagnostic criteria. Thus, it may be possible to drop one or more redundant diagnostic criteria that simplify the diagnostic criteria without sacrificing diagnostic precision. Second, using a strategy developed by Loeber et al. (1993), the power of each symptom to predict the full diagnosis can be compared. This strategy may allow the elimination of some symptoms that are not clearly and specifically associated with the diagnosis. Third, when symptoms are identified for possible deletion in these ways, the prevalence, reliability, and validity of the diagnosis can be assessed before and after the deletion of the symptoms to be sure that they have not changed.

As mentioned earlier, previous evidence suggested that some of the more prevalent DSM-III and DSM-III-R symptoms of conduct disorder might more accurate symptoms of Conduct Disorder (CD) than of Oppositional Defiant Disorder (ODD). Therefore, a new alternative for the definition of oppositional defiant disorder and conduct disorder was

presented in the DSM-IV Options Book (APA, 1991). In this definition the symptoms of fighting, bullying, and lying would be moved from conduct disorder to oppositional defiant disorder. This option was rejected on the basis of reanalyses of existing data sets (Frick et al., 1994; Loeber, et al., 1993; Russo, et al., 1994) and symptom utility analyses of the field trials sample (APA, 1991).

Frick et al.'s (1994) analyses of CD symptoms in the DSM-IV revealed that the two symptoms not included in DSM-III-R criteria, "often bullies, threatens, or intimidates others" and "often stays out after dark without permission, beginning before 13 years of age" were highly predictive of the diagnosis. This study also indicated that altering the definitions of two symptoms increased their efficiency in predicting the diagnosis. When the definition of lying was altered to include only lying to "con others" ("often lies or breaks promises to obtain goods or favours") and the definition of truancy was altered to limit it to truancy beginning before age 13, the diagnostic efficiency of the symptoms was increased. As such, these alternative definitions of "lying" and "truancy" replaced the DSM-III-R versions of these CD symptoms. The decision to limit

"truancy" to youths in which the truancy began before the age of 13 was made to avoid misattributing this symptom to normal adolescents, in whom truancy is common. Given that these changes in the DSM have increased the predictive validity of Conduct Disorder diagnosis, one could speculate that these changes would also have significant clinical relevance in terms of predicting treatment outcomes for juvenile sex offenders receiving this diagnosis.

Treatment Outcome

There is wide agreement that juvenile sex offenders are extremely noncompliant and unmotivated toward treatment. As such, it is commonly felt that court-mandated treatment is necessary. However, even with the pressure of the criminal justice system many juvenile sex offenders fail to complete treatment successfully for a variety of reasons. For example, several of these reasons include: unmanageable due to behavioral disturbance; violation of agency rules; and/or, reoffense and incarceration. All these reasons reflect behaviours found in conduct disordered youth. However, are those juvenile sex offenders who are more resistant to treatment a discreet subtype who also meet the criteria for

Conduct Disorder. As such, one may speculate that those individuals diagnosed with Conduct Disorder would be more noncompliant and as a result more prone to not successfully completing treatment as compared to those with a non-conduct disordered diagnosis.

For this study, treatment outcome, was determined based on whether the youth successfully or unsuccessfully completed the out-patient treatment program. This was determined from the clinical record notes on file that included a discharge report written by the primary therapist. The youth was considered to have successful treatment outcome if he completed the program and received benefit from the program. In addition, the youth was considered unsuccessful if he was evaluated as at high risk to reoffend based on a phallometric measure of deviant arousal prior to discharge from the program. In summary, the treatment outcome variable was determined based on clinical judgement and the phallometric measure.

Phallometric assessment. In phallometric assessment, changes in penile tumescence are assessed while the subject is exposed to a variety of sexual and nonsexual stimuli (either slides or audiotapes). Cognitive-behaviorally oriented

researchers have relied heavily on phallometric assessment of sexual interest patterns, pointing out that self-report is often distorted and inconsistent with more objective measurement (Freund, 1981). There is a considerable body of literature on the use of phallometric assessment with adult offenders but there is sparse research on its use with a juvenile population. Studies have shown that adult child molesters can reliably be differentiated from non-sex offenders based on degree of response to stimuli depicting children and that high indexes of deviant arousal are associated with a greater level of sexual offending (i.e., more victims) (Barbaree & Marshall, 1989; Earls & Quinsey, 1985). It is estimated that over 175 juvenile sex offender treatment programs in the United States and Canada report using phallometric assessment with juveniles. In addition, a cognitive-behavioral model is the most frequently cited theoretical orientation of clinicians treating this population (Knopp, Freeman-Longo, & Stevenson, 1992).

Becker, Hunter, Goodwin, Kaplan, and Martinez (1992) assessed the test-retest reliability of audiotaped stimuli developed specifically for an adolescent sexual offender population. Statistically significant test-retest reliability

was demonstrated for 15 of the 19 audiotaped vignettes. The highest correlations were found for those sexual behaviours in which the adolescent had engaged, with significant correlations ranging from .48 to .83.

Schram, Milloy, and Rowe (1991) examined deviant sexual arousal in relationship to risk for recidivism. These investigators followed 197 male adolescent sexual offenders an average of 6.8 years following completion of treatment. Sexual recidivists were found to be more likely to have deviant sexual arousal patterns as well as a history of truancy, cognitive distortions, and a least one prior conviction for a sexual offense. No phallometric assessments were used. Instead, investigators relied on clinician assessments of deviant arousal and response to treatment.

Furthermore, empirical support for the reliability and validity of phallometric assessment of juvenile sexual offenders is growing. However, there is growing evidence that juveniles may be more global in their sexual interest and arousal patterns than adult offenders, and that phallometric data should not be interpreted in a manner parallel to that of adult offenders (Hunter & Becker, 1994).

Methodological Issues. The utility of the clinical

interview and psychological tests in the evaluation of juvenile sex offenders appears to be well established (Hunter & Becker, 1994). Although some studies have not been supportive (eg. Hanson, Steffy, & Gauthier, 1993; Rice, Quinsey, & Harris, 1991) of programs (such as the one in this study) of a multicomponent, cognitive-behavioral nature, many have produced promising results, especially with child molesters (see Marshall & Barbaree, 1990). It is important to note that some of these studies used more sophisticated evaluation methods, using designs that include comparison groups, adequate follow-up periods, and multiple outcome measures.

Marques, Day, Nelson, & West (1994) identify important methodological requirements for sound outcome research with sex offenders based on several previous studies (eg. Furby, Weinrott, and Blackshaw, 1989; Grossman, 1985). These requirements include comparison groups, recidivism measures, attrition, clinical judgement and statistical methods.

One of the most difficult obstacles in evaluating treatment programs for sex offenders is obtaining an adequate comparison or control group. It is virtually impossible to truly determine how effective treatment is without a

comparison group of similar offenders who did not receive the intervention. An ideal comparison group would be similar offenders randomly assigned to an untreated control group (Furby et al., 1989; Marshall & Barbaree, 1990). It has been argued that such designs are unethical because they require withholding treatment from offenders who may desire and/or need therapy (Becker & Hunter, 1992; Marshall & Barbaree, 1990; Marshall et al., 1991).

Although there is no consensus on the best criterion for treatment failure, most researchers use the recommission of a sex offense (e.g., Marshall & Barbaree, 1988), with some (e.g., Rice et al., 1991) considering other crimes against persons as well. However, there is also considerable variability across studies regarding the use of official data (such as records of arrest or convictions) and unofficial information (such as self-reports).

Officially reported numbers of sex offenses are widely recognized to be gross underestimates of the true number of crimes that have been committed (Repucci & Clingempeel, 1978; Russell, 1982). Marques et al. (1994) state that the types of legal charges and convictions that are recorded are a result not only of the acts committed but also of the policies and

practices of local law enforcement, prosecutors, and courts.

Self-reports by sex offenders are considered very unreliable given their high degree of denial and minimization of their offending behaviours. However, when absolute confidentiality is provided, offender self-reports have revealed large numbers of crimes that have not resulted in arrest (Abel et al., 1987; Weinrott & Saylor, 1991).

In terms of attrition, rates of treatment withdrawal and termination vary widely depending on a number of factors (eg. offender motivation, program requirements, legal consequences). In some studies (Maletzky, 1991), including this study, any offender who did not complete treatment was considered unsuccessful. However, other studies have excluded treatment dropouts (e.g., Abel et al., 1988; Marshall & Barbaree, 1990). In Abel et al.'s (1988) case, attrition was indeed a significant factor, with nearly 35% of those entering the program failing to complete it.

In terms of clinical judgement, Foa and Emmelkamp (1983) state that a treatment program's value is measured not only by the success of those who complete it but also by the number who refuse the interventions or drop out after beginning treatment. In evaluating treatment outcomes, schemes must be

devised to account for these offenders and determine their success and failure rates as well. This study accounted for treatment dropouts and failures and included them as unsuccessful subjects.

With respect to statistical methods, the usefulness of linear regression methods is limited, because the outcome to be predicted is often a binary variable, reoffense, which requires the use of nonlinear models (Aldrich & Nelson, 1984). The evaluation of treatment effectiveness with sex offenders requires the most rigorous and comprehensive research designs possible.

Although this study suffered from a lack of comparison groups, recidivism data and analytic methods that control for discrepant at-risk periods, it did include attrition factors, clinical judgement and statistical measures.

Research Purpose and Hypotheses

The overall purpose of this thesis is to examine the association between the psychiatric diagnosis of Conduct Disorder treatment outcomes of juvenile sex offenders. The uniqueness of this study lies with the fact that this

diagnosis has never been evaluated with this population in terms of treatment outcomes. However, as mentioned previously, there are certain limitations to the DSM classifications system and diagnostic process, particularly with this population.

Notwithstanding these limitations, this study attempts to demonstrate that juvenile sex offenders diagnosed with Conduct Disorder (according to DSM-III-R criteria) have a higher probability of unsuccessful treatment outcome and those not diagnosed with Conduct Disorder are more likely demonstrate successful treatment outcome in an out-patient treatment program.

Link to Hypotheses

As mentioned previously, the DSM states that "the essential feature of Conduct Disorder is a repetitive and persistent pattern of behaviour in which the basic rights of others or major age-appropriate societal norms or rules are violated" (APA, 1994, p. 85). Given this essential feature for diagnosis, one would find it difficult not to argue that all juvenile sex offenders are conduct disordered. However, the clinician must determine if the sexual misbehaviour is a

one time event, or "a repetitive and persistent pattern". A difficult task in a population renowned for it's high degree of denial and minimization.

Through the examination of records of delinquency and/or through the diagnoses of Conduct Disorder based on psychiatric assessment, studies have attempted to establish the rates of nonsexual disturbances of conduct in juvenile sex offenders with a view of diagnosing them as Conduct Disordered. Becker, Kaplan, Cunningham-Rathner, and Kavoussi (1986) found that 50% of their sample of juvenile male perpetrators had a record of previous non-sexual arrests, and that 63% of those available for psychiatric assessment could be diagnosed as Conduct Disordered. This rate of nonsexual arrests is higher than the self-reported rate (28%) among a more varied group of juvenile sex offenders studied by Becker et al. (1986), but is similar to figures for non-sexual delinquencies reported in other samples of juvenile sex offenders (Awad & Saunders, 1989; Awad, Saunders, & Levene, 1984; Fehrenbach, Smith, Monastersky, & Deishner, 1986; Kavoussi, Kaplan, & Becker, 1988; Pierce & Pierce, 1987). Adult sex offenders who were diagnosed with Antisocial Personality Disorder (considered the adult counterpart of Conduct Disorder) in conjunction with

their sexually abusive behaviours were more likely to reoffend both sexually and nonsexually (Bard, Carter, Cerce, Knight, Rosenberg, & Schneider, 1987; Hall, Mauiro, Vitaliano, & Proctor, 1986; Henn, Jerjanic, & Vanderpearl, 1976). Moreover, studies indicate that those offenders who fail to complete treatment are more likely to reoffend either sexually or nonsexually (Abel, Mittleman, & Becker, 1985; Marshall, Jones, Ward, Johnston, & Barbaree, 1991). Thus, it would make sense to speculate from these studies that youth diagnosed with Conduct Disorder would have poor treatment outcomes. However, given the questionable reliability and validity of the DSM process in general; and more specifically, the instability and continually changing diagnostic criteria and the debatable application of the Conduct Disorder diagnostic process, does this particular diagnosis have clinical relevance in the assessment and treatment of juvenile sex offenders. Conduct Disorder diagnosis in the DSM-III-R (APA, 1987) lacks precision and the presence of rather "soft" diagnostic behavioral criteria, such as "lying" and "truancy" may create the over-diagnosis of youth who are convicted of sexual offending. On the other hand, is it possible that assessment and treatment formulations for Conduct Disorder has

useful explanatory power for at least some types of juvenile sex offending.

France and Hudson (1993) suggest that a significant number of juvenile sex offenders engage in other criminal acts or may be diagnosed as conduct disordered and that the coexistence of disturbances of conduct and juvenile sex offending may be significant for predicting risk of reoffending. However, studies on the importance of Conduct Disorder as a prognostic indicator in juvenile sex offending are few and show conflicting results. Henderson, English, and MacKenzie (1988) stated that 50% of the youths in their treatment program, who had victim related criminal histories prior to the sex offense, continued to exhibit sexually assaultive behaviour after treatment. However, Smith and Monastersky (1986) found only a slight trend between a history of aggressive and destructive behaviour and the likelihood of reoffense.

At this writing, there appears to be only one study that compares the differentiating characteristics of juvenile sex offenders who successfully complete treatment to those who fail to complete treatment. Based on clinician assessment and subjective judgment, Joseph Randazzo (1992) found that

offenders who selected victims near in age to themselves, who blamed their acts on alcohol and/or drugs and who had school truancy problems were distinguished as being at highest risk of treatment drop-out or failure. Furthermore, Randazzo (1992) suggests that non-completers were perceived by their therapists to be more aggressive, more anti-social, and more dangerous than other subjects. This suggests that those juvenile sex offenders who failed to complete treatment displayed many of the behaviours found in Conduct Disorder and may have been so diagnosed.

Given the previous rationale, specific hypotheses regarding treatment outcome are stated as follows:

1) Juvenile sex offenders who have been given a psychiatric diagnosis of Conduct Disorder will have less successful treatment outcomes.

2) Juvenile sex offenders who meet the criteria according to the DSM-III-R classification of Conduct Disorder will have less successful treatment outcomes.

3) The psychiatric diagnosis of Conduct Disorder is associated with an alternate classification made according to the DSM-III-R criteria. This hypothesis was tested to determine if the subjects did indeed meet the full criteria

for Conduct Disorder. In addition, this hypothesis sought to test whether these youth were being over-diagnosed.

4) Conduct Disorder symptoms are associated with successful treatment outcome. As mentioned previously, studies have shown that single Conduct Disorder symptoms such as "lying" have predictive validity for the diagnosis. This hypotheses was tested to determine if single Conduct Disorder behaviours are associated with unsuccessful treatment outcome.

5) Adolescent sex offenders with previous non-sexual offenses will be less likely to successfully complete treatment.

6) Adolescent sex offenders with previous non-sexual offenses are more likely to be given a psychiatric diagnosis of Conduct Disorder.

7) Adolescent sex offenders with previous non-sexual offenses are more likely to meet the full DSM-III-R criteria for a diagnosis of Conduct Disorder.

CHAPTER THREE

RESEARCH DESIGN

Introduction

Using a descriptive/associative design, this study examined the clinical records of juvenile sex offenders to determine if those diagnosed with Conduct Disorder were more likely to be unsuccessful at completing treatment then those who were not diagnosed with Conduct Disorder. The outcome measure was the treatment completion status in a court-mandated out-patient juvenile sex offender treatment program as determined and recorded by the primary clinician. The primary clinician was either a psychiatrist, a psychologist, a social worker or a psychiatric nurse who was in charge of that particular subject's case. The discharge status was determined from multidisciplinary treatment team review of the subject's progress.

In addition, I attempted to provide an alternate diagnostic classification of each subject, independent of the psychiatric diagnosis given on the clinical record, in an effort to determine if the subject did indeed meet the full diagnostic criteria according to the DSM-III-R (APA, 1987).

Method

Subjects

Clinical records of one hundred adolescent males, aged 12-18 at the time of admission, who had completed a court-ordered psychosocial assessment and were admitted to the Adolescent Sex Offender Treatment Program at Youth Court Services/Outpatient Department, Burnaby, B.C. were picked randomly from the time frame between January 1, 1988 and December 31, 1992.

Mean subject age was 15 years, the youngest in the sample was 12 and the oldest was 18. Twenty-four percent of the subjects had a grade 7 education or less, 63% had between grade 8 and 10, whereas 13 percent achieved grade 11 or higher. Seventy-three percent of the subjects had Caucasian ethnic background, 23% were of First Nations heritage, and 4% were considered other. At the time of the offense 41% of the subjects lived with their natural mother and her partner, 8% lived with their natural mother and natural father, 9% lived with their natural father and his partner, 5% lived with adult relatives, 7% lived with adoptive parents, and 30% lived with foster parents or in a group home.

Measures

Diagnostic variable. The diagnostic (independent) variable was measured by the clinical diagnosis (PCD) provided by the assessing professional expert (psychiatrist/psychologist) on the written report to court. This diagnosis was made after a thorough multidisciplinary assessment was completed by a psychiatrist, a psychologist, a clinical social worker and a psychiatric nurse. This assessment includes: a face to face psychiatric interview with the youth; a full battery of psychological tests and an extensive social history that includes an interview with the young person's care givers, social workers, teachers, probation officers, extended family and any other significant people within his social environment.

Alternate diagnostic variable (ACD). This variable was measured independently by this researcher to assess if the subject did indeed meet the full criteria according to the DSM-III-R Classification Manual (APA, 1987). Clinical records were analyzed and coded to ensure that the clinical diagnosis on record met the minimum 3 behavioral criteria necessary

within the minimum 6 months time frame. The 13 behavioral symptoms of Conduct Disorder included the following items:

(1) has stolen without confrontation of a victim on more than one occasion (including forgery)

(2) has run away from home overnight at least twice while living in parental or parental surrogate home

(3) often lies (other than to avoid physical or sexual abuse)

(4) has deliberately engaged in fire-setting

(5) is often truant from school

(6) has broken into someone else's house, building, or car

(7) has deliberately destroyed others' property

(8) has been physically cruel to animals

(9) has forced someone into sexual activity with him or her

(10) has used a weapon in more than one fight

(11) often initiates physical fights

(12) has stolen with confrontation of a victim

(13) has been physically cruel to people.

(APA, 1987, p. 58)

If the clinical records indicated that the subject met the minimum 3 criteria in the minimum 6 month time frame he was given an Alternate Conduct Disorder (ACD) classification. However, if he met less than 3 criteria he was given an Alternate Non-conduct Disorder (AN-CD) classification. Then, a comparison was made between the two diagnostic variables: Alternate Conduct Disorder (ACD) and Psychiatric Conduct Disorder (PCD). The alternate conduct disorder diagnosis variable was then recoded to include the dichotomous variable: alternate conduct disorder (ACD); or, alternate non-conduct disorder (AN-CD).

Conduct Disorder symptom variable. A yes/no response was given for each of the 13 behavioral symptoms of Conduct Disorder according to the data on file. Furthermore, each of these items had to meet the DSM-III-R criteria in terms of the 6 month time frame.

Previous non-sexual offense variable. The previous non-sexual offense variable was determined from the clinical records which report all prior criminal charges and convictions of a sexual or non-sexual nature.

Treatment outcome variable. The treatment completion (dependent) variable was measured according to the clinical

records on file recorded by the primary therapists in charge of the subject's case. This variable was coded into four categories of completion status that included: terminated due to noncompliance with program rules and/or criminal charges; probation ended and declined further treatment; completed program successfully; and, completed program unsuccessfully. The treatment completion variable was then recoded to include the dichotomous categories: (1) terminated due to noncompliance with program rules and/or criminal charges, and completed program unsuccessfully; or, (2) successfully completed program. A differentiation was made between those youth who simply completed treatment and those who were considered successful treatment completers. That is, many juvenile sex offenders complete treatment, but were still considered to be of high risk to reoffend. Therefore, treatment completion may be more the result of a combination of pressure from the criminal justice system and other supervisory supports and the degree of compliance in the individual offender. The subject was determined successful, if the discharge report indicated that he received maximum benefit from the program and was considered at low risk to reoffend. The subject was determined unsuccessful if he had

zero to minimal benefit from the program and was considered at moderate to high risk to reoffend after completion of the program.

Reliability and Validity

Interrater reliability of the previous non-sexual offense variable, the treatment outcome variable and the 13 Conduct Disorder symptom variables was performed by the researcher and a Master of Social Work student at Youth Court Services who was instructed on the coding of variables and rating procedures. Twelve cases were picked randomly from the total sample. The degree of agreement on all 15 variables of 12 ratings between the two raters was 93%.

Validity was measured according to the DSM-III-R classification manual criteria and the extensive professional clinical notes on file. As part of the interrater reliability measure, for the alternate diagnosis (ACD) the contents of the notes were analyzed to determine which of the 13 Conduct Disorder criteria were met. Of the 12 clinical records picked randomly and analyzed, interrater reliability on these 13 items showed a 94% degree of agreement between the two raters.

Validity of the Psychiatric Diagnosis was augmented by multiple sources of information gathered by various members of the multi-disciplinary clinical team. The social worker and/or psychiatric nurse gathered information from the family, teachers, probation officers and other significant people, based on questions directly related to the presence or absence of the Conduct Disorder criteria. The psychiatrist assessed the youth based on a one-to-one psychiatric interview and subject self reports of the presence or absence of the Conduct Disorder behavioral criteria. The psychological assessment was based on full battery of psychometric testing and a one-to-one psychological assessment. These members then collaborated to determine DSM-III-R diagnostic classification. However, the psychiatrist, given his/her medical professional status, would have final determination to make the diagnosis.

Validity of outcome measures was obtained by a similar collaborative process to determine treatment status upon discharge from the program. The primary therapist would then complete a standardized discharge report indicating the subject's progress in treatment and treatment completion status based on benefit received, degree of deviant arousal, ability to suppress deviant arousal, and subsequent risk to

reoffend.

Data Analysis

Hypothesis 1. To test the hypothesis that in a population of juvenile sex offenders a psychiatric diagnosis of Conduct Disorder is associated with outcome of out-patient treatment, a chi-square and Phi were computed between these two variables.

Hypothesis 2. To test the hypothesis that in a population of juvenile sex offenders an alternate conduct disorder diagnosis (ACD) is associated with outcome of out-patient treatment, a Chi-square and Phi were computed between these two variables.

Hypothesis 3. To test the hypothesis that in a population of juvenile sex offenders a psychiatric diagnosis of Conduct Disorder (PCD) is associated with an alternate Conduct Disorder classification (ACD) a Chi-square and Phi were computed between these two variables.

Hypothesis 4. To test the hypothesis that a single Conduct Disorder behaviours is associated with treatment outcome a Chi-square and Phi were computed between these two variables.

Hypothesis 5. To test the hypothesis that previous non-sexual offenses are associated with treatment outcome in a population of juvenile sex offenders in out-patient treatment, a Chi-squre and Phi were computed between these two variables.

Hypothesis 6. A Chi-squre and Phi were computed to measure association between previous non-sexual and psychiatric diagnosis of Conduct Disorder (PCD).

Hypothesis 7. A Chi-square and Phi were computed to measure association between previous non-sexual offenses and Alternate Conduct Disorder classification (ACD).

CHAPTER FOUR

RESULTS

Treatment Outcome

Psychiatric Conduct Disorder (PCD)

Hypothesis 1. In the present sample of juvenile sex offenders 50% of subjects were diagnosed as conduct disordered by the psychiatrist (PCD). Tabulations of data revealed that 45% percent of subjects had successful treatment outcome. In assessing whether there was an association between PCD and successful treatment outcome a negative correlation was observed, [X^2 = 37.1, Phi = -.38, $p < .001$]. Psychiatric non-conduct disorder (PN-CD) adolescent sex offenders (71%) were significantly more likely to have successful treatment outcome than not (29%). In contrast, psychiatric conduct disorder (PCD) subjects (67%) were more likely to have unsuccessful treatment outcome that not (33%). Table 1 provides further results of the distributions of successful and unsuccessful outcomes with or without a psychiatric conduct disorder diagnosis (PCD).

Alternate Conduct Disorder (ACD)

Hypothesis 2. From the total sample of 100, a higher percentage (68%) of subjects were given an alternate conduct disorder diagnosis (ACD) when diagnosis was dependent upon the DSM-III-R criteria as compared to 50% for the psychiatric conduct disorder diagnosis (PCD). A negative association was observed between alternate conduct disorder diagnosis (ACD) and successful treatment outcome, [X^2 = 37.0, Phi = -.59, p < .001]. Similarly, alternate non-conduct disorder diagnosed (AC-ND) juvenile sex offenders (88%) were significantly more likely to have successful treatment outcome than not. In contrast, alternate conduct disorder diagnosis (ACD) subjects were significantly more likely to have unsuccessful treatment outcome (75%) than not (25%) (see the bottom half of Table 1 for full results of these distributions).

Table 1

Percentages of Conduct Disordered and Non-conduct Disordered Subjects With Successful and Unsuccessful Treatment Outcomes

	OUTCOME			
	Successful		Unsuccessful	
ASSESSMENT	n	%	n	%
Psychiatric				
Conduct Disorder (PCD)	13	26%	37	74%
Non-conduct Disorder (PN-CD)	32	64%	18	36%
Alternate				
Conduct Disorder (PCD)	17	25%	51	75%
Non-conduct Disorder (PN-CD)	28	88%	4	12%
Total	45	45%	55	55%

Alternate (ACD) and Psychiatric Diagnosis (PCD)

Hypothesis 3. The association between the psychiatric diagnosis and this researcher's alternative assessment was significant, [X^2 = 19.4, Phi = .43, $p < .0001$]. Eighty-eight percent of those subjects given a conduct disordered diagnosis by the psychiatrist were given the same classification by the alternate assessment. Although the total degree of agreement was 70%, 80% of the juveniles who were not diagnosed as conduct disordered by the psychiatrist were considered conduct disordered by the alternate assessment.

Conduct Disorder Behavioral Variables

Hypothesis 4. A Chi-square and Phi were computed to measure association between each of the 13 behavioral variables listed for DSM-III-R Conduct Disorder diagnosis and the dependent variable, successful treatment outcome. Table 2 shows the values for significant associations between successful completion of treatment and the several of the behavior variables.

Table 2

Individual Conduct Disorder Behaviours and Successful Treatment Outcome

Behaviour	Successful Outcome %	X^2
often lies	49	24.1
steals	59	15.4
truant	61	17.5
runs away	70	18.2
cruel to people	72	17.7
physical fights	74	15.1
property destruction	75	16.1
fire-setting	77	--
break and enter	82	--
cruel to animals	3	--
robbery	7	--
weapon use	5	--
forced sex	97	--

Note. "--" depicts insignificant values. $p < .001$ on all significant values.

Previous Non-sexual Offenses

Hypothesis 5. Fifty-four percent of subjects had previous non-sexual offenses. A significant association was observed between previous non-sexual charges and successful treatment outcome, [X^2 = 14.1, Phi = -.38, $p < .001$]. The juveniles with no previous non-sexual charges were somewhat more likely to have successful treatment outcome (67%). Table 3 provides the full results for distributions of successful and unsuccessful outcomes for those with and without previous non-sexual offenses.

Psychiatric Conduct Disorder (PCD)

Hypothesis 6. A significant association was observed between juveniles having previous non-sexual offenses and having a psychiatric conduct disorder diagnosis (PCD), [X^2 = 16.1, Phi = $p < .001$]. The juveniles with no previous non-sexual charges were more likely to not have a psychiatric conduct disorder diagnosis (72%). Table 3 provides full results of the distribution of previous non-sexual charges and psychiatric conduct disorder diagnosis.

Alternate Conduct Disorder (ACD)

Hypothesis 7. A positive correlation was observed between juveniles having previous non-sexual charges and having an alternate conduct disorder diagnosis (ACD), [X^2 = 32.6, Phi = .57, $p < .0001$]. Those juveniles with previous non-sexual charges were more likely to have an alternate conduct disorder diagnosis (74%) than not. Those juveniles with no previous non-sexual charges were more likely to not have an alternate conduct disorder diagnosis (88%). Table 3 shows full distributions of these results.

Table 3

Percentages of Conduct Disordered Subjects and Non-conduct Disordered Subjects With Previous Non-sexual Offenses

Assessment	Offenses		No offenses	
	n	%	n	%
Psychiatric				
Conduct Disorder (PCD)	37	74	13	26
Non-conduct Disorder (PN-CD)	17	34	33	66
Alternate				
Conduct Disorder (ACD)	50	74	18	26
Non-conduct Disorder (AN-CD)	4	12	28	88

CHAPTER FIVE

DISCUSSION

Implications

The overall purpose of this study was to examine and more clearly understand the relevance of Conduct Disorder diagnosis in the assessment and treatment of juvenile sex offenders in order to determine which variables might be useful in predicting treatment outcome. The following discussion of each of the seven hypotheses offers clinical implications related to the purpose of the study.

Hypothesis 1

The study suggests that in a population of juvenile sex offenders in out-patient treatment, those who are given a psychiatric diagnosis of Conduct Disorder are more likely to have unsuccessful treatment outcomes. Furthermore, those juvenile sex offenders who are not classified as Conduct Disorder are more likely to have successful treatment outcomes. Although this, in and of itself, may not be a revelation to most clinicians working with troubled adolescents (given the non-compliant, anti-social nature of

this population), it suggests that there may be a sub-group of juvenile sex offenders who are less amenable to treatment. At the same time, it suggests that juvenile sex offenders who are not considered conduct disordered may also be a sub-group with unique characteristics making them more amenable to treatment approaches.

Hypothesis 2

This study suggests that those juvenile sex offenders who meet the criteria for a diagnosis of Conduct Disorder, according to the DSM-III-R (APA, 1987), are significantly more likely to have unsuccessful treatment outcomes and those who do not meet the criteria are significantly more likely to have successful treatment outcomes. The results from this component of the study reinforces the suggestion that Conduct Disorder is associated with treatment outcome. Moreover, if given an accurate diagnosis of Conduct Disorder, there is even stronger association between juvenile out-patient treatment outcome and the diagnosis. The degree of agreement between the psychiatric assessment and the alternate assessment is higher than most previous comparative studies on psychiatric diagnosis. However, given that 80% of the subjects who were

not given a psychiatric diagnosis of Conduct Disorder were classified as such in the alternate assessment, one would have to consider this a rather low degree of agreement in terms of underdiagnosing. Thus, this study suggests that Conduct Disordered juvenile sex offenders are being under-diagnosed in this sample and this finding may be generalizable to the population from which this sample was taken.

Hypothesis 3

The findings suggest that the psychiatric assessment and alternate assessment were highly correlated. However, as mentioned in the previous paragraph, the variance in the two assessments suggests that the psychiatric assessment under-diagnoses this population in terms of giving a diagnosis of Conduct Disorder. Although the results show that juvenile sex offenders are being accurately diagnosed as conduct disordered, a significant percentage of those youth who do meet the DSM-III-R criteria are in fact not being diagnosed as conduct disordered by the assessing psychiatrist. Several possible explanations can be put forward here. One, the psychiatrist may not be diagnosing conduct disorder unless the youth blatantly demonstrates the diagnostic criteria. Two,

the youth may already be diagnosed with Paraphilia, Pedophilia, and Attention Deficit Hyperactive Disorder (and/or some other disorder) and there is a resistance to give multiple diagnoses. Thus, although the offender does meet the criteria of Conduct Disorder, the diagnosis is not given for fear of overdiagnosing. Or, three, the diagnosis is simply not reported on the psychiatric assessment. Another explanation may be that the clinician who works with this popultion exclusively, and over a long period of time, may become desensitized to the youth who presents with Conduct Disorder behaviors. That is, the youth may demonstrate all the behaviors necessary to meet the diagnosis, but the clinician may not perceive him as "that bad" relative to the youth who demonstrates the more aggressive and violent behaviours against others. In any event, the discrepancy between psychiatric diagnosis (PCD) and alternate diagnosis (ACD) in this study is minimal, with the alternate (ACD) findings being similar except somewhat stronger on most variables.

Hypothesis 4

An observation of the association between the individual

behaviours of conduct disorder and successful treatment outcome suggests that the discriminative utility of individual symptoms are significantly associated with successful treatment outcomes. Particulary, behaviours such as "often lies", "running away", "truancy", and "physical cruelty to humans" are associated with unsuccessful treatment outcome. That is, juvenile sex offenders in out-patient treatment who exhibit any of these behaviours and even more so these behaviours in combination are more likely to have unsuccessful treatment outcomes. However, each behaviour must be examined more fully to get a clearer understanding of it's relevance. "Often lies" may suggest that the individual exhibits a higher degree of denial than his counterparts and is unwilling to accept he has a problem and thus, be more resistant to treatment. The youth who is often "truant" from school may be more likely to also be truant from the treatment program. As such, he is expelled from the program for breaking the rule of compulsory attendance. The behaviour "physical cruelty to others" may suggest that this individual is a more serious offender and is more aggressive and engages in a higher level of offense severity. For example, the rapist or offender who uses physical force as compared to the offender who is not

aggressive or engages in hands-off offenses. As such, the more serious offender may be a more anti-social and/or a more aggressive conduct disordered juvenile sex offender, making him much less amenable to treatment.

Hypothesis 5

The findings show that in a population of juvenile sex offenders in out-patient treatment those who have previous non-sexual arrests are more likely to have unsuccessful treatment outcome as compared to those who have no history of non-sexual offenses. This suggests that these subjects may be a discreet subgroup who are more anti-social, more delinquent, and consequently more severely conduct disordered. Logically, this would make them less amenable to treatment.

Hypothesis 6 and 7

These findings show that a population of out-patient juvenile sex offenders with a history of non-sexual offenses are more likely to be diagnosed with Conduct Disorder than those with no history non-sexual offenses. Once again, these finding may suggest the existence of a discreet subgroup that is at higher risk of unsuccessful treatment outcome. On the

other hand, it may also suggest a discriminate subtype of juvenile sex offender who does not engage in typical delinquent antisocial behaviours. Furthermore, this may suggest discreet subtypes based on level of aggression.

However, the presence or absence of non-sexual offenses may simply be a broad indicator of the Conduct Disorder behaviours that are criminal acts. For example, the DSM-III-R Conduct Disorder non-sexual behaviours, such as "theft", "robbery", "fire-setting", "break and enter", "destruction of property", "physical fights", and "weapon use" are all criminal offenses. As such, non-sexual offenses simply increase the likelihood of the juvenile sex offender with a history of non-sexual arrest as being diagnosed as Conduct Disordered. Thus, once again, the question must be asked; is this a discriminate subtype of sex offender, or is "forced sex" just another behaviour of a Conduct Disordered juvenile. However, it is significant to report that the results of this study showed no significant difference in the findings when the Alternate Conduct Disorder (ACD) was assessed independent of the "forced sex" DSM behavioral item.

At the same time, how does the researcher define the behaviour "forced sex". If the juvenile sex offender is not

aggressive and uses no form of overt coercion, does he meet this behavioral criteria. The clinician must then make a judgment based on the issues discussed in the first chapter of this paper; such as, the level of equality, consent, coercion and aggression between the offender and the victim.

Taken together these findings suggest that there is a juvenile sex offender subtype that can be differentiated who is less amenable to out-patient treatment. This subtype is characterized by having a history of non-sexual offenses and by meeting the full criteria for Conduct Disorder diagnosis. Moreover, this subtype more likely demonstrates the following conduct disorder symptoms: often lies, runs away, is truant and is physically cruel to others. As such, the findings suggest that the more severe and aggressive Conduct Disordered juvenile sex offender is less amenable to treatment.

Limitations

This study suffered from several limitations. First, the data collection and compilation was based on the available clinical record documentation on file. As such, I relied on the premise that the clinicians' gathering and recording of

information was valid, reliable and accurate. Second, the population I sampled from were considered by the professional staff to be the more serious and resistant juvenile sex offenders receiving out-patient treatment in the province of B.C. That is, a significant percentage of the youth referred for treatment to the Youth Court Services/Out-patient Department in Burnaby, B.C. could not be treated as readily in the outlying areas of the province where there was a lack support services and professional clinicians specialized in the treatment of juvenile sex offenders. However, a significant percentage (89%) of the subjects in this study were housed in specialized residences for adolescent sex offenders, and were considered as more serious offenders. As such, this data then may not be representative of the typical out-patient juvenile sex offender who is usually considered as less serious an offender, as at less risk to reoffend, and as more amenable to treatment. There may be an over-representation of conduct disordered subjects relative to the general population of juvenile sex offenders receiving out-patient treatment. On the other hand, the findings of this study are consistent with previous studies on the incidence of Conduct Disorder for this population. Third, this study

lacked recidivism data. Although a juvenile sex offender may successfully complete treatment, there is no guarantee that he will not reoffend. Furthermore, although studies report that offenders who successfully complete treatment are at lower risk to reoffend, many offenders who complete treatment do in fact go on to reoffend. A fourth limitation, was that this study was descriptive in nature, summarizing frequencies and measures of association between variables. Although the findings were significant, they must be interpreted with caution. Without a control group, or at the very least a comparison sample of juvenile non-sexual offenders diagnosed with and without Conduct Disorder, one can only speculate on the significance of these findings. A fifth limitation was that although the frequencies of other diagnoses were examined, the implications of any diagnoses other than Conduct Disorder, and/or the impact of multiple diagnosis on treatment outcome was not examined. For example, many youth diagnosed with Conduct Disorder are also diagnosed with Attention Deficit Disorder (27% in this sample). This may have a serious impact on the individual's ability to successfully complete treatment. A final limitation, was the fact that this was a convenience/availability sample of existing

archival data. The data was collected entirely from client records and, as mentioned earlier, I relied completely on the various clinicians' accurate information gathering and recording of the data. A more robust study would have the researcher collect all data using a standardized diagnostic measures, such as the Diagnostic Interview Scale for Children (DISC-2) (Shaffer et al., 1992). This would involve extensive interviews with the youth, caregivers, and teachers, pre and post treatment. Such an endeavour with the same sample size would take approximately 2 years of concentrated effort on data collection alone.

Conclusions

This study's findings suggest that there is a Conduct Disorder subtype of juvenile sex offender who is less likely to have successful treatment outcome. At the same time, it suggests that there may be a subtype of juvenile sex offender who is not Conduct Disordered and who is more amenable to treatment. As such, it may be necessary to provide more specialized treatment for these subtypes based on this diagnostic assessment. For example, the Conduct Disorder juvenile sex offender may not be suited for the typical out-

patient cognitive-behavioral, didactic program. Perhaps a more intensive, process oriented approach in a closed setting would be more appropriate.

This study suggests that there are subtypes within the juvenile sex offender population that are less or more amenable to treatment based on Conduct Disorder diagnosis and its behavioral criteria. This may mean that certain behavioral indicators are indicative of poor prognosis in terms of successful treatment outcomes. With this in mind, studies comparing subgroups of juvenile sex offenders are needed, particularly with respect to Conduct Disorder and recidivism in response to specific treatment interventions.

This study also suggests that the psychiatric diagnosis of Conduct Disorder is underdiagnosed for this population. As such, more rigorous and exact diagnosing may enhance the classification of Conduct Disorder juveniel sexual offenders and subsequently, more accurately identify those youth who are more or less likely to be successful in treatment.

Factors such as level of intellectual functioning, presence of learning disabilities, degree of social skills, and level of impulse control must be considered when studying treatment outcomes with this population. This is especially

relevant, given that studies show that a signifiant number of adolescent sex offenders suffer from deficits in all these areas. Treatment success might be affected by the ability to learn that which is offered in therapy. This is important when considering that cognitive-behavioral therapy has a strong "teaching" component, as is the case for the program accessed for this study.

In outcome studies of juvenile sex offenders, numerous extenuating factors must be considered. The leverage of the criminal justice system in terms of the collaborative effort with the treatment team and caregivers is necessary to compel a very resistant population to engage in and remain in out-patient treatment for the duration. Furthermore, studies examining the efficacy of out-patient as compared to in-patient treatment particularly for the more resistant and unmanageable adolescent Conduct Disordered sex offender are necessary.

Finally, future studies are needed to address the issue of the increased reliability and validity of the DSM-IV as compared to it's predecessors. Of particular relevance is an analyses of the CD behaviors not included in the DSM-III-R criteria, "often bullies, threatens, or intimidates others"

and "often stays out after dark without permission, beginning before 13 years of age". These are highly predictive of CD diagnosis (eg. Frick, et al., 1994) and may have predictive utility for treatment and recidivism outcomes. Studies also indicate that altering the definition of lying to "cons others" and the definition of truancy to " truancy beginning before age 13" has increased the diagnostic efficiency of these behaviours, especially their positive predictive value (Frick, et al., 1994). In addition, the increase in the time window for DSM Conduct Disorder behaviors from 6 months to one year (APA, 1994) may enhance the diagnostic precision for the juvenile sex offender population. The significance of the presence of conduct disorder behaviours in juvenile sex offenders will depend on research that overcomes methodological and conceptual problems that were evident in this study and previous related research.

The clinician and researcher alike must contemplate what Kazdin (1989) states is the most important consideration in the diagnosis of Conduct Disorder: the stability, breadth, and intensity of the behaviours, rather than simply the presence of any particular behaviour. As such, careful consideration must be taken to determine if the significant behaviours have

been in evidence for the minimum 12 month time window. This is important, particularly when assessing the degree of severity of the disorder. Furthermore, the "age of onset" subtype criteria for Conduct Disorder (DSM-IV, APA, 1994) must be assessed carefully. This is particularly important in the evaluation of treatment outcome, given that early onset Conduct Disorder youth have been found to be much less amenable to intervention as compared to the late onset subtype.

Furthermore, there is a need for diagnosis to expand along different dimensions and sociocultural factors must be taken into consideration. Currently, the explicit orientation of clinical diagnosis is on the "problem of the child". The behaviour must be viewed in the context of alternative systems, particularly that of the family. The empirical literature consistently points to the family as a training ground for antisocial behaviour and as a predictor of long-term course (Kazdin, 1987). Thus, in the assessment of Conduct Disorder and in the making of predictions in terms of treatment outcome, family factors need to be taken into account.

Family dysfunction, parental psychopathology, and social

disadvantage are just some of the sociocultural dimensions that are relevant to the conduct disordered youth. To expand the model of diagnosis, multiple dimensions of functioning must be addressed. A more complete profile of antisocial youths and the environments from which they came would then be offered.

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APPENDICES

12 Summary of methodology and procedures. (Must be typewritten in this space). NOTE If your study involves deception, you must also complete page 8, the "Deception Form".

Data will be obtained from the medical records (archival data) at Youth Court Services/Out-Patient Treatment Program for adolescent sex offenders.

Subjects will be selected via individual medical files of out-patient adolescent males who completed a full court-ordered biopsychosocial assessment and who were recommended for and court-ordered to complete the treatment program.

All the subjects are males who were charged with sexual offences and consequently evaluated between Jan. 1/90 - Dec.31/92 will be included (n = 156) in this study. All files will be separated based on completers vs. non-completers according to psychology/psychiatric reports. Each record will be examined to determine diagnosis according to the DSM-III-R classification system and the related features of the diagnosis.

SCRIPTION OF POPULATION

13 How many subjects will be used? 156
How many in the control group? no control group

14 Who is being recruited and what are the criteria for their selection?

Medical/Clinical records of 156 juvenile sex offenders court-ordered for assessment and treatment at the Youth Court Services/Out-Patient Sex Offender Treatment Program at the Burnaby Clinic between Jan. 1/90 and Dec. 31/92.

15 What subjects will be excluded from participation?

Nil

16 How are the subjects being recruited? (If initial contact is by letter or if a recruitment notice is to be posted, attach a copy.) NOTE that UBC policy discourages initial contact by telephone. However, surveys which use random digit dialing may be allowed. If your study involves such contact, you must also complete page 9, the "Telephone Contact form".

Retrieval of medical/clinical records.

17 If a control group is involved, and if their selection and/or recruitment differs from the above, provide details.

No control group.

ROJECT DETAILS

18 Where will the project be conducted? (room or area)

Youth Court Services/Out-Patient Program Burnaby, B.C.

19 Who will actually conduct the study and what are their qualifications?

Michael J. Pond, RPN, BSW

20 Will the group of subjects have any problems giving informed consent on their own behalf? Consider physical or mental condition, age, language, or other barriers.

- Age 12 - 17 yrs. young offenders
- consent has been obtained through Youth Court Services - Clinical Director

21 If the subjects are not competent to give fully informed consent, who will consent on their behalf?

N/A

22 What is known about the risks and benefits of the proposed research? Do you have additional opinions on this issue?

Risks - None

Benefits - Assist in screening process of high risk offenders not completing treatment.

23 What discomfort or incapacity are the subjects likely to endure as a result of the experimental procedures?

None–confidentiality is ensured.

24 If monetary compensation is to be offered the subjects, provide details of amounts and payment schedules.

None

25 How much time will a subject have to dedicate to the project?

None

26 How much time will a member of the control group (if any) have to dedicate to the project?

None

TA

27 Who will have access to the data?

Researcher Only

28 How will confidentiality of the data be maintained?

-All files will remain on site.

-All files will be numerically coded to maintain confidentiality

29 What are the plans for future use of the raw data (beyond that described in this protocol)? How and when will the data be destroyed?

None

30 Will any data which identifies individuals be available to persons or agencies outside the University?

No individuals will be identified

31 Are there any plans for feedback to the subject?

NO

32 Will your project use: (check)

( ) Questionnaires (submit a copy)

( ) Interviews (submit a sample of questions)

(x) Observations (submit a brief description) - indirect observation of archival data in Medical Records.

( ) Tests (submit a brief description)

FORMED CONSENT

33 Who will consent? (check)

( ) Subject

( ) Parent/Guardian (Written parental consent is always required for research in the schools and an opportunity must be presented either verbally or in writing to the students to refuse to participate or withdraw. A copy of what is written or said to the students should be provided for review by the Committee.)

(x) Agency Official(s)

In the case of projects carried out at other institutions, the Committee requires written proof that agency consent has been received. Please specify below:

( ) Research carried out in a hospital - approval of hospital research or ethics committee.

( ) Research carried out in a school - approval of School Board and/or Principal. (Exact requirements depend on individual school boards: check with Faculty of Education Committee members for details.)

( ) Research carried out in a Provincial Health Agency - approval of Deputy Minister

(x) Other, specify: Dr. Roy O'Shaughnessy, Clinical Director
Youth Court Services/Out-Patient Department
Burnaby, B.C.

160

34 UBC Policy requires written subject consent in all cases other than questionnaires which are completed by the subject (see item #35 for consent requirements). Please check each item in the following list before submission of this form to ensure that the written consent form attached contains all necessary items. If your research involves initial contact by telephone, you need not fill out this section.

( ) Consent form must be prepared on UBC Department letterhead

(X) Title of project.

(X) Identification of investigators (including a telephone number). Research for a graduate thesis should be identified as such and the name and telephone number of the Faculty Advisor included.

(X) Brief but complete description IN LAY LANGUAGE of the purpose of the project and of all procedures to be carried out in which the subjects are involved. Indicate if the project involves a new or non-traditional procedure whose efficacy has not been proven in controlled studies.

(X) Assurance that identity of the subject will be kept confidential and description of how this will be accomplished.

(X) Statement of the total amount of time that will be required of a subject.

(X) Details of monetary compensation, if any, to be offered to subjects.

( ) An offer to answer any inquiries concerning the procedures to ensure that they are fully understood by the subject and to provide debriefing if appropriate.

( ) A statement of the subject's right to refuse to participate or withdraw at any time and a statement that withdrawal or refusal to participate will not jeopardize further treatment, medical care or influence class standing as applicable. NOTE: This statement must also appear on letters of initial contact. For research done in the schools, indicate what happens to children whose parents do not consent. Note: The procedure may be part of classroom work but the collection of data may be purely for research.

( ) A statement acknowledging that the subject has received a copy of the consent form including all attachments for their own records.

( ) A place for signature of subject CONSENTING to participate in the research project, investigation or study and a place for the date of the signature.

( ) Parental consent forms must contain a statement of choice providing an option for refusal to participate. (e.g. "I consent/I do not consent to my child's participation in this study." Also, verbal assent must be obtained from the child, if the parent has consented.

( ) If more than one page, number the pages of the consent, ie page 1 of 3, 2 of 3, 3 of 3 etc.

35 Questionnaires should contain an introductory paragraph which includes the following information. Please check each item in the following list before submission of this form to insure that the introduction contains all necessary items.

( ) UBC letterhead

( ) Title of project

( ) Identification of investigators (including a telephone number)

( ) A brief summary that indicates the purpose of the project

( ) The benefits to be derived

( ) A full description of the procedures to be carried out in which the subjects are involved

( ) A statement of the subject's right to refuse to participate or withdraw at any time without jeopardizing further treatment, medical care or class standing as applicable. Note: This statment must also appear on explanatory letters involving questionnaires

( ) The amount of time required of the subject must be stated

( ) The statement that if the questionnaire is completed it will be assumed that consent has been given

( ) Assurance that identity of the subject will be kept confidential and description of how this will be accomplished

( ) For surveys circulated by mail submit a copy of the explanatory letter as well as a copy of the questionnaire

TACHMENTS

36 Check items attached to this submission if applicable. Incomplete submissions will not be reviewed.

( ) Letter of initial contact (item 16)

( ) Advertisement for volunteer subjects (item 16)

( ) Subject consent form (item 34)

( ) Control group consent form (if different from above)

( ) Parent/guardian consent form (if different from above)

(X) Agency consent (item 33)

( ) Questionnaires, tests, interviews, etc. (item 32)

( ) Explanatory letter with questionnaire (item 35)

( ) Deception form (including a copy or transcript of written or verbal debriefing)

( ) Telephone Contact form

( ) Other, specify:

Deception undermines informed consent. Indicate (a) why you believe deception is necessary to achieve your research objectives, and (b) why you believe that the benefits of the research outweigh the cost to subjects.

N/A

Explain why you believe that there will be no permanent damage as a result of the deception.

N/A

Describe how you will debrief subjects at the end of the study.

N/A

1 Telephone contact makes it impossible for a signed record of consent to be kept. Indicate why you believe that such contact is necessary to achieve your research objectives.

N/A

2 Include a copy of the proposed "front end" of your telephone interview. Please check each item on the following list before submission of request for review to ensure that the front end covers as much as possible of the normal consent procedures.

( ) identification of fieldwork agency, if applicable

( ) identification of researcher

( ) basic purpose of project

( ) nature of questions to be asked, especially if sensitive questions to be asked

( ) guarantee of anonymity and confidentiality

( ) indication of right of refusal to answer any question

( ) an offer to answer any questions before proceeding [see below, item 3]

( ) a specific inquiry about willingness to proceed

3 Indicate how interviewers will be trained to answer respondents' questions. Investigators should prepare and submit "scripted replies", which may cover, but are not necessarily limited to:

(a) Means by which respondent was selected

(b) An indication of the estimated time to be required for the interview

(c) The means by which guarantees of anonymity and confidentiality will be achieved

(d) An offer to provide the name and telephone number of a person who can verify the authenticity of the research project. This person shall not be the Research Administration Officer or any person in the Office of Research Administration. (Note: Investigators should be prepared, should potential respondents request it, to provide the name of a person <u>outside</u> the research group, as required by Section 9 of the SSHRCC guidelines.)

4 <u>Sensitive Subject Matter</u>: Respondents' should be forwarned of such questions. It is not always practical to do so as part of the interview's front end. Warnings can be placed later in the interview and can take a naturalistic form as long as their content <u>specificially</u> refers to the sensitive matter. Indicate how you propose to deal with sensitive items, if any, in your interview.

Psychiatric Admission Assessment Worksheet

Name:

Residence:

Date of Birth:

Admission Date:

Duty Doctor's Signature:

CONFIDENTIALITY WARNINGS GIVEN Y: ❑ N: ❑

CHARGES	PLEA

PAST CHARGES	DISPOSITION

PENDING CHARGES

HISTORY OF CRIMINAL BEHAVIOUR

Medical History:

Functional Inquiry:

Alcohol and Drug Abuse:

Psychiatric History:

FAMILY HISTORY

I CRIMINAL BEHAVIOUR

F	Y: ☐ N: ☐
M	Y: ☐ N: ☐
Step P's.	Y: ☐ N: ☐
Sibs	Y: ☐ N: ☐

II PSYCHIATRIC HISTORY

F	Y: ☐ N: ☐
M	Y: ☐ N: ☐
Step P's	Y: ☐ N: ☐
Sibs	Y: ☐ N: ☐

III A & D HISTORY

F	Y: ☐ N: ☐
M	Y: ☐ N: ☐
Step P's	Y: ☐ N: ☐
Sibs	Y: ☐ N: ☐

M.S.E.

General Attitude:

Mood: *(sleep, appetite, energy, psychomotor)*

Suicide: *(thoughts, attempts)*

Suicide Risk: High: ❑ Moderate: ❑ Low: ❑

Anxiety: *(general, phobias, panic attacks)*

Thought: *(form and content)*

Delusions: Y: ❑ N: ❑

Hallucinations: Y: ❑ N: ❑

DIAGNOSIS

Axis I:

Axis II:

Axis III:

Axis IV:

Axis V:

Comments:

PRIMARY THERAPIST COMPLETES

SOCIAL HISTORY

Primary Therapist Signature:

Bio F:

Bio M:

Step P's:

Sibs:

Adoption: Y: ❑ N: ❑ Age:

Apprehension: Y: ❑ N: ❑ Reason:

Current Placement:

Past Placements:

DEVELOPMENT HISTORY

Birth: Normal ☐ Problems ☐ Don't Know ☐

Pre-School:

School History:

Current School:

Academic:

Behaviour: Susp: Y: ☐ N: ☐ Exp: Y: ☐ N: ☐

Occupational:

Peers: Gang Affiliation: Y: ☐ N: ☐ Delinquent Subculture: Y: ☐ N: ☐

ABUSE HISTORY

Physical Abuse: Y: ☐ N: ☐

Sexual Abuse: Y: ☐ N: ☐

If Abused:

Recurrent Dreams: Y: ☐ N: ☐ Memories: Y: ☐ N: ☐ Flashbacks: Y: ☐ N: ☐

Avoidance: Y: ☐ N: ☐ Memories: Y: ☐ N: ☐ Flashbacks: Y: ☐ N: ☐

Amnesia: Y: ☐ N: ☐ Detachment: Y: ☐ N: ☐ Restricted Affect: Y: ☐ N: ☐

Arousal:

Insomnia: Y: ☐ N: ☐
Irritability: Y: ☐ N: ☐
Startle: Y: ☐ N: ☐

Poor Concentration: Y: ☐ N: ☐
Panic Attacks: Y: ☐ N: ☐

ADHD

1.	Fidgeting in seat	Y: ❑ N: ❑
2.	Difficulty remaining seated	Y: ❑ N: ❑
3.	Easily distracted	Y: ❑ N: ❑
4.	Difficulty Awaiting Turn	Y: ❑ N: ❑
5.	Answers questions before asked	Y: ❑ N: ❑
6.	Fails to finish tasks	Y: ❑ N: ❑
7.	Difficulty sustaining attention	Y: ❑ N: ❑
8.	Shifts from uncompleted activities	Y: ❑ N: ❑
9.	Difficulty playing quietly	Y: ❑ N: ❑
10.	Talks excessively	Y: ❑ N: ❑
11.	Often interrupts	Y: ❑ N: ❑
12.	Doesn't listen (often)	Y: ❑ N: ❑
13.	Often loses necessary things	Y: ❑ N: ❑
14.	Engages in physically dangerous activities	Y: ❑ N: ❑

CONDUCT DISORDER CRITERIA

			Age of Onset		
			0-6 yrs.	6-12 yrs.	12-18 yrs.
1.	Stealing (more than once)	Y: ☐ N: ☐			
2.	Runaway overnight (at least twice)	Y: ☐ N: ☐			
3.	Frequent lying	Y: ☐ N: ☐			
4.	Firesetting	Y: ☐ N: ☐			
5.	Truancy	Y: ☐ N: ☐			
6.	B&E (house, car, or building)	Y: ☐ N: ☐			
7.	Vandalism	Y: ☐ N: ☐			
8.	Cruel to animals	Y: ☐ N: ☐			
9.	Sexual Assault	Y: ☐ N: ☐			
10.	Use of weapon (more than one fight)	Y: ☐ N: ☐			
11.	Frequent fighting	Y: ☐ N: ☐			
12.	Stealing with confrontation	Y: ☐ N: ☐			
13.	Physically cruel to people	Y: ☐ N: ☐			

1. Verbally Hostile: shouts angrily, yells mild insults, makes loud noises.

(age of onset _____) (age last _____)

0	2	3	4	5
Never	1/Week	2-4/Week	1/Day	> 1/Day

2. Verbally Aggressive: curses viciously, makes threats of violence toward self or others.

(age of onset _____) (age last _____)

0	2	3	4	5
Never	1/Week	2-4/Week	1/Day	> 1/Day

3. Aggressive Posturing, aggression against objects: slam doors, make a mess, throw objects, hit walls, break things.

(age of onset _____) (age last _____)

0	1	2	3	4	5
Never	1-2/Month	1/Week	2-4/Week	1/Day	> 1/Day

With Friends ☐ Siblings ☐ Teachers ☐
Peers ☐ Parents ☐ Strangers ☐ Total = _____ (AP)

4. Aggressive against self:mild, tantrum-like behaviour without serious injury, scratch, hit self, pull hair, throw self on floor

(age of onset _____) (age last _____)

0	1	2	3	4	5
Never	Once	2-3 Tims	4-6 Times	7-10 times	More Than 10 Times

With Friends ☐ Siblings ☐ Teachers ☐
Peers ☐ Parents ☐ Strangers ☐ Total = _____ (AS)

5. Violence against self: significant self-injury, self-mutilation - deep cuts, bites that bleed, fractures, burns.

(age of onset _____) (age last _____)

0	1	2	3	4	5
Never	Once	2-3 Tims	4-6 Times	7-10 times	More Than 10 Times

With Friends ☐ Siblings ☐ Teachers ☐
Peers ☐ Parents ☐ Strangers ☐ Total = _____ (VS)

6. Physical hostility toward others: mild physical aggression - threatening gestures, grab clothes, push, hit without serious injury.

(age of onset _____) (age last _____)

0	1	2	3	4	5
Never	1-2/Month	1/Week	2-4/Week	1/Day	> 1/Day

With Friends ☐ Siblings ☐ Teachers ☐
Peers ☐ Parents ☐ Strangers ☐ Total = _____ (PHO)

7. Physical violence toward others: attack others causing serious injury, heavy bruising, cuts, lacerations, fractures, internal injury

(age of onset _____) (age last _____)

0	1	2	3	4	5
Never	1-2/Month	1/Week	2-4/Week	1/Day	> 1/Day

With Friends ☐ Siblings ☐ Teachers ☐
Peers ☐ Parents ☐ Strangers ☐ Total = _____ (PVO)

8. Carry weapon:
gun Y: ☐ N: ☐
knife Y: ☐ N: ☐
other Y: ☐ N: ☐ _____

9. Use weapon:
gun Y: ☐ N: ☐
knife Y: ☐ N: ☐
other Y: ☐ N: ☐ _____

YOUTH SERVICES INFORMATION SYSTEM
Forensic Psychiatric Services Commission

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~~179~~

PROVISIONAL DIAGNOSES

ADMISSION DATA
(Psychiatry)

CLIENT NUMBER [__|__|__|__|__|__]

AGENCY: _____ **WARD/PROGRAM/UNIT** _____

CLIENT NAME _____

DIAGNOSES: **CODES**

Primary Diagnoses:	**DMSIII-R**	**ICD9-CM**
Secondary Diagnoses:		
Other Diagnoses:		

FORMULATION:

Signature _____ **Date (y/m/d):** _____/_____/_____

YOUTH SERVICES INFORMATION SYSTEM
Forensic Psychiatric Services Commission

MEDICAL AND BEHAVIORAL ALERTS

ADMISSION/ASSESSMENT DATA
DISPOSITION DATA
(Ward/Unit Supervisors)

CLIENT NUMBER [__|__|__|__|__|__|__]

AGENCY: _____ WARD/PROGRAM/UNIT _____

DATE (y/m/d): _____/_____/_____

CLIENT NAME _____

1. ADMISSION/ASSESSMENT DATA 2. DISPOSITION DATA

MEDICAL ALERTS:

Alcohol/Drug Abuse: _____ DATE (y/m/d): _____/_____/_____

Personal Background: _____ DATE (y/m/d): _____/_____/_____

Criminal Record: _____ DATE (y/m/d): _____/_____/_____

Med. Complications: _____ DATE (y/m/d): _____/_____/_____

Special Diets: _____ DATE (y/m/d): _____/_____/_____

Family Characteristics: _____ DATE (y/m/d): _____/_____/_____

Other: _____ DATE (y/m/d): _____/_____/_____

Other: _____ DATE (y/m/d): _____/_____/_____

Other: _____ DATE (y/m/d): _____/_____/_____

Other: _____ DATE (y/m/d): _____/_____/_____

BEHAVIORAL ALERTS (Table 42):

_____ DATE (y/m/d): _____/_____/_____

_____ DATE (y/m/d): _____/_____/_____

_____ DATE (y/m/d): _____/_____/_____

_____ DATE (y/m/d): _____/_____/_____

_____ DATE (y/m/d): _____/_____/_____

_____ DATE (y/m/d): _____/_____/_____

DESCRIBE SPECIFIC CIRCUMSTANCES:

Signature _____

RESPONSIBILITY OF INTAKE WORKER/CASE MANAGER
Complete and return for data entry within 24 hrs of admission. Copy of this form must be placed in the Client Clinical Chart within 48 hrs.

YOUTH SERVICES INFORMATION SYSTEM
Forensic Psychiatric Services Commission

ADMISSION DATA
(Intake Worker/Case Manager)

CLIENT NUMBER [__|__|__|__|__|__]
Old Client Number (if any)
[__|__|__|__|__|__]

AGENCY: _____ WARD/PROGRAM/UNIT _____

CLIENT NAME _____

ALSO KNOWN AS _____

_____

PERSONAL INFORMATION

Sex (1 = Male, 2 = Female): _____ Education (Table 28): _____

Eye Color: _____ Handicaps: _____

Hair Color: _____ Height (###.# cm): _____

Distinguishing Marks: _____ Weight (##.# kg): _____

Date of Birth (y/m/d): _____ Ethnic Group (Table 51): _____

Birthplace (Table 25): _____ P.H.N: _____

Country _____ M.S.P: _____

Citizenship (Table 26): _____ Name on Card: _____

NAME and ADDRESS — Phone #/Notify (Y/N) — RELATIONSHIP

CLIENT'S ADDRESS:

_____ _____ ___ _____

_____

_____

_____ Postal Code: _____

GUARDIAN OR PARENT:

_____ _____ ___ _____

_____

_____

_____ Postal Code: _____

EMERGENCY CONTACT:

_____ _____ ___ _____

_____

_____

_____ Postal Code: _____

_____ _____ ___ _____

_____

_____

_____ Postal Code: _____

YOUTH SERVICES INFORMATION SYSTEM
Forensic Psychiatric Services Commission

ADMISSION DATA
(Intake Worker)

CLIENT NUMBER |__|__|__|__|__|

AGENCY: _____ WARD/PROGRAM/UNIT _____

DATE (y/m/d): _____/_____/___

CLIENT NAME _____

LEGAL AND OTHER INFORMATION:

Legal Status (Table 38): _____
Effective Date (y/m/d): _____/___/___
Previous Convictions (Y/N): _____
Sex Offense (current) (Y/N): _____
Child Offense (current) (Y/N): _____
Probation (Y/N): _____
Probation Length (mo): _____
Sentence Expiry Date (y/m/d): _____/___/___

Probable Expiry Date (T/A) _____/___/___
Court Location: _____
Court Date (y/m/d): _____/___/___
Court Time (h:m): _____:_____
Stage of Proceedings (Table 56): _____
Region Code (Table 105): _____
Date of Legal Order (y/m/d): _____/___/___
O.I.C - Date Req'd (y/m/d): _____/___/___
Ward/Non-Ward (Table 54): _____

Criminal Charges (Table 53):

_____ _____ Code:_____ Date:_____/___/_
_____ Code:_____ Date:_____/___/_
_____ Code:_____ Date:_____/___/_

CERTIFYING DOCTOR (Name and Address):

_____ Phone: _____
_____ Certifying Date (y/m/d): _____/___/___
_____
_____ Postal Code: _____

CROWN COUNSEL (Name and Address):

_____ Phone: _____
_____
_____
_____ Postal Code: _____

LAWYER/DEFENCE COUNSEL (Name and Address):

_____ Phone: _____
_____
_____
_____ Postal Code: _____

PROBATION/BAIL OFFICER (Name and Address):

_____ Phone: _____
_____
_____
_____ Postal Code: _____

YOUTH SERVICES INFORMATION SYSTEM
Forensic Psychiatric Services Commission

ADMISSION DATA
(Intake Worker)

CLIENT NUMBER |__|__|__|__|__|__|

WARD/PROGRAM/UNIT _____

AGENCY: _____ FACILITY: _____

DATE (y/m/d): _____/_____/_____

CLIENT NAME _____

ADMISSION INFORMATION:

Referral Type (Table 57): _____

Referral Source (Table 37): _____

Date of Referral (y/m/d): _____/_____/_____

Date of Admission/Registration (y/m/d): _____/_____/_____

Time of Admission/Registration (24hr clock): _____:_____

Type of Admission (Inpatient/Outpatient/): _____

Assessment or Treatment: _____

Client Came With (Table 39): _____

Mode of Admission: _____

Projected Discharge Date (y/m/d): _____/_____/_____

Referred by (Name and address):

_____ Phone: _____

_____

_____

_____ Postal Code: _____

Region: _____ Code: _____

CASE ASSIGNMENT INFORMATION

Child Care Counsellor: _____ Phone # _____

Nurse: _____

Health Care Worker: _____

Social Worker: _____ Phone # _____

Psychiatrist (Tbl 104): _____ Primary (Y/N) _____

Psychologist (Tbl 104): _____ Primary (Y/N) _____

CLIENTS FAMILY PHYSICIAN:

_____ Phone: _____

_____

_____

_____ Postal Code: _____

YOUTH SERVICES INFORMATION SYSTEM
Forensic Psychiatric Services Commission

MEDICAL PROCEDURES/PSYCHOLOGICAL TESTS

DISPOSITION DATA
(Medicine/Psychiatry/Psychology)

CLIENT NUMBER [__|__|__|__|__|__]

AGENCY: YCS WARD/PROGRAM/UNIT IAU

CLIENT NAME _____

Procedures (Table 47)	Code	Date (y/m/d)
Hematology: Hemoglobin, WBC, ESR, Differential Morphology		
Platelets		
Chemistry #1: Routine, Bilirubin-total, AST (SGOT)		
LDH Random B/S		
Chemistry #2: Routine Thyroxine (T4RIA)		
Urinalysis: Routine		
Psychological Tests (Table 46)	**Code**	**Date (y/m/d)**
MMPI		
Jesness		
WISC-R/WAIS-R		
H.T.P. (House, Tree, Person Drawings)		
Sentence Completion		
Self-Adolescent Alcohol Involvement Scale		
Self-Drug Use Screening.		

Signature _____ Date (y/m/d): ____/____/____

SOCIAL HISTORY FORMAT
ASSESSMENT OF YOUNG OFFENDERS

Sources of Information should be outlined in opening paragraph. - interviews - reports - phone contacts.

1. Relatives: Both parents where possible, aunts, uncles or other significant relatives.

2. Guardians: Foster-parents, group home personnel.

3. Agencies: MHR social workers, Probation Officers, or other who have had significant contact with the young person. school counsellor

4. Written reports: Documents sent with the referral package, all other reports read or received. police reports school reports ... case held in confidence ☆

Reason for the Referral

1. As stated by Court Order.

2. As expressed by the Probation Officer, written or verbal.

3. As understood or interpreted by parents and guardian.

4. As understood by the writer of the Social History, plea ... given circumstances, Ct requested a psychiatric + psychological evaluation to be done to aid in the disposition of this matter.

History of Difficulty

This can include a précis of:

1. Previous charges, dispositions and other outcome.

2. Difficulties at home, school, and in the community. when parents thought it began.

3. Current problems and their relationship to the historical difficulties, (i.e., escalating, diminishing, new emphasis.)

Developmental History

A. Early Development: (Mothers give the best information) - location of father

1. Ante-natal information (some probing and jogging of memory is often necessary)

(a) Physical and emotional conditions of mother. Illness, medications taken, toxemia.
(b) Lifestyle habits - drinking, smoking, drugs.
(c) Pregnancy: duration.

. . .2

2. Delivery and Post-natal

(a) Type of birth: natural, breech, C-section, use of forceps, other complications.
(b) Condition of baby: blue, jaundiced, weight.
(c) Response of baby: contented vs agitated; colicky, eating and sleeping habits.

3. Birth to 2 years

(a) Milestones: walked, talked, toilet-trained (i.e., slow, fast, time).
(b) Traumas: illness, hospitalization, separations from parents.

4. 2 years to 5 years

(a) Health, social interaction with other children, speech development.
(b) Behavioural indicators, indicators of possible hyperactivity, aggression, WITHDRAWN

B. Education, Development during those years:

1. Elementary school.

(a) Academic performance, grades repeated, tests done by school, awards and recognition.
(b) Behaviour as perceived by teachers and peers; suspensions.
(c) Sports and other involvement.

2. High School.

(a) Academic performance, grades repeated, tests done by school, awards and recognition.
(b) Behaviour as perceived by teachers and peers; suspensions.
(c) Sports and other involvement.
(d) Peer relationship, and present grade.
(e) Ambitions and plans.

C. Other Concerns:

1. Health problems, falls, head injuries, etc. (e) substance abuse
2. Explore problems with
(a) enuresis, and somnambulism. encopresis
(b) fire-setting, cruelty to animals.
(c) aggressive behaviour, WITHDRAWN
(d) sexual abuse / physical abuse

Family Relationships - biological fx background

1. Parents: when marriage, strength of relationship. Inquire about:-
(a) Disagreements and fights between parents - causes.
(b) Alcohol or drug problems.
(c) If separated or divorced - cause of marriage breakdown.
(d) Work of parents or means of financial support.
(e) Relationship of patient to parents.

general fx patterns
- boundaries - hx mental illness
- affection - criminal activity
-

. . .3

2. Siblings: significant information about each. Patient's relationship with sibs. recent changes

3. Extended family: patient's relationship with family members.

4. Other important information about the family dynamics.

5. Friendships. Close friends of patient; duration of friendships; ability to make and keep friends. (young children)

Discipline and Control

1. Explore parents' methods and attitudes towards discipline. (examples

2. Child's earlier response to discipline.

3. Patient's present response to discipline and control.

4. Patient's involvement in discipline-forming organizations (e.g., Cadets, Demolay, the church or synagogue, sport clubs).

Future Plans

1. Parents' point of view as to what they would like to see happen with/for the patient. ... based on exp re ... ; ... in consultation re ...

2. Involved agencies' plans for patient.

3. Writer's impression of what might be helpful to patient based on information gathered. tx programs available

Summary and Evaluation

Summarize salient points of history, and interpret their psycho-social meaning based on the gathered information, as well as the affect and emphasis given to the facts by the parents and other sources of information.

Recommendations may be made subject to the psychiatric/psychological ~~findings~~ evaluation findings of this/her.

... I fully support + agree re the recommendations contained ...

Yours respectfully,
Respectfully submitted,

Thank you for your referral. Please contact us if you have any Q's regarding our assessment.

Signature of Writer
Title of Writer.

We trust that this info. will be useful to the Cts. Should there be any questions, please do not hesitate to contact any member of the assessment team.

YOUTH COURT SERVICES

NURSING ASSESSMENT GUIDELINES

1. IDENTIFYING DATA

Name:
D.o.b:
Age:
Status:

2. REASON FOR REFERRAL

Record legal status,including Young offenders Act and Criminal Code Section if known.Record offences.

3. LEGAL HISTORY

Enter for each crime or group of crimes.
(a) Date
(b) Type
(c) Disposition

4. MEDICAL HISTORY

Enter for each major illness,including operations and injuries

(a) Nature of illness(diagnosis if available)
(b) Place of treatment
(c) Attending phisician
(d) Nature of treatment
(e) Response to treatment

5. PAST MENTAL HEALTH (include inpatient,outpatient and private (psychiatrist.)

(a) Date
(b) Place of treatment
(c) Attending physician
(d) Symptoms or diagnosis
(e) Treatment
(f) Response to treatment

6. FAMILY HISTORY

(1) Parents; (2) Siblings; (3) Foster or adoptive parents.Record the following for each.
(a) Age
(b) Occupation
(c) Marital status
(d) Any major illness (physical and mental)
(e) Any history of alcohol,drugs,suicide attemps, diabetes,epilepsy,etc.

(f) If member deceased,record cause and age at death.
(g) Quality of relationship with patient.

7. PERSONAL HISTORY

(a) Date and place of birth
(b) Ethnicity
(c) Complication of pregnancy/delivery and birth weight.
(d) Early development,include history of aggressive behaviour.
(e) Home atmosphere: relationships in childwood with parents, siblings,quality of family life.
(f) Education:include grade level,grade failures,further education,reason for leaving school,special abilities, special problems,special/recreational/academic achievements,peer group relationships.
(g) Work history:include age started work,jobs in chronological order and length job held,reason for change, present job.
(h) Sexual History:Early sexual development,masturbation (including fantasy),sexual adequacy,present outlet and performance,sexual orientation,abnormal sexual interests.

8. LIFESTYLE PRIOR TO REFERRAL

(a) Social relationships/friends/school.
(b) Habits:illicit drugs/alcohol/,amount and frequency,effects on lifestyle.
(c) Religion:church attendance,moral values.
(d) Activities and interest.

9. CIRCUMSTANCES LEADING TO ARREST AND REFERRAL

(a) Record in detailsd and chronological order,patient's account of events (i.e.,subjective form).Psychiatrist may also include this information.However,a second opinion can be invaluable.

10. CURRENT MENTAL STATUS

(a) General behaviour and appearance/degree of cooperation. Contact with surrounding.

(b) CLINICAL TESTING OF SENSORIUM

(i) Orientation,time/date/month/year,place,person. Awareness of legal situation and charges. Understanding the nature and purpose of interview.

(ii) Attention and concentration (comment on person's ability to attend to relevant matters).Always include serial 7's or serial 3'. Month reversal.

(iii) Memory,recent and remote.Comment on person's ability

to recall events at the time of the alleged offence. Ask patient to give name and address,to repeat immediately and again in three minutes.

(iv) General information:Always include the following. Six large cities in Canada,Capital of Canada,Capital of England,Name of the Prime Minister,ruling political party (Provincial and Federal).

(v) Intelligence:make a general assessment based on the patient's education, general knowledge,use of language,understanding of concepts,etc.

(c) Mood- elevation,depression,flatness,incongruity, suspicion,perplexity,fear,anxiety,sleep,energy, libido,appetite.

(d) Thinking and Speech- spontaneity of conversation,rate, pressure,poverty,possession-(when a person's thinking is controlled from elsewhere).
Thought blocking-perseveration-(the ability to switch words or ideas),circumstantiality, interpretation-the interweaving of two or more thought sequences at one time),other thought disorder,ability to abstract-(record following responses ``stitch in time...'', ``out of a frying pan...'', ``people in glass houses....''.

(e) Perceptual disorders.
Hallucinations-visual,auditory,etc.
Derealisation/Depersonalisation.

(f) Special Information. (if fitness is required).
Pleas available to patient.
Nature of evidence
Meaning of Oath
Function of Judge,jury,prosecutor, defence lawyer.

(g) Insight and judgement.
Attitude to present situation, including court case,lawyer, offences,etc.
Understanding of illness(if present) and need for treatment,ability to plan ahead.

11. PROBLEM FORMULATION OR IMPRESSION.

S.O
Rev.-1992.03.05

PSYCHOLOGICAL INTERVIEW

DATE:

D.O.B.:

CHRONOLOGICAL AGE:

- Inform of limits of confidentiality

PRESENT CHARGE

- pled guilty
- current offense (with whom, when and where)
- justification
- family criminal history
- remorseful feeling

PREVIOUS CHARGE

- offense & sentences received
- outstanding charges

FAMILY CONSTELLATION

- relationship with mother
- relationship with father
- relationship with siblings
- relationship between mother and father

- problem in the family: alcoholism, drugs, separation, work problems

LIVING SITUATION

- presently living where
- history of foster placement
- history of running away

SCHOOL

- present school
- grade
- favorite subject
- like or dislike school
- grade failures
- suspension in school
- history of fighting
- numbers of schools attended since kindergarten

FRIENDS

- numbers of friends
- degree of intimacy and independence with friends
- types of activities enjoyed with friends
- best friends (how long this relationship has existed

ALCOHOL AND DRUG HISTORY

- onset of using alcohol and/or drugs

- what kinds of drugs
- quantity per day, week or month

SEXUAL HISTORY

- pubertal experience (including sex abuse, pornography, exposure to sexuality)
- first sexual experience and type
- numbers of sexual partners
- if charge is sexual in nature, the details of it
- sexual fantasy
- masturbation
- prostitution
- pregnancy

HEALTH

- hospitalizations
- high fever
- head injury
- health in general
- allergies

FUTURE PLANS

BEST MOMENT IN LIFE

WORST MOMENT IN LIFE

ANGER MANAGEMENT

- frustration tolerance
- sensitivity to criticism
- response to authority figures
- emotional control
- verbally abusive
- physically abusive
- abuse towards inanimate objects
- abuse towards animals or people
- self destruction tendencies

THREE WISHES

PSYCHOLOGICAL HISTORY

- therapists (how many, frequency, where, and when)

HISTORY OF SEXUAL ABUSE

HISTORY OF PHYSICAL ABUSE

MENTAL STATUS EXAMINATION

- general presentation (height, weight, color of hair, general appearance, dress)
- rapport
- verbal expression
- eye contact

- credibility
- cooperation
- behaviour during interview (aggressive, alert, apathetic, bizarre, hostile, flat, bland, passive)
- mood (1 to 10) at assessment time, in general: stable - labile
- affect (e.g., anxious, flat depressed, euphoric etc.)
- hallucination (auditory and/or visual)
- delusions
- insight and judgement
- eating disturbance
- recent loss of weight (general eating patterns)
- general eating patterns
- sleep disturbance
- initial insomnia
- intermittent insomnia
- terminal insomnia
- history of nightmares
- somatization
- paranoid ideation
- signs of depression
- low energy level
- crying spells
- withdrawal from regular activity

- apathy
- dysthymic tendencies
- signs of psychosis
- anxiety level

ADOLESCENT'S CHOICE OF DISPOSITION

IMPRESSIONS

RECOMMENDATIONS

Weschler Intelligence scale for Children - Revised (WISC-R)

The WISC-R is an intelligence test comprised of ten sub-scales which permits an evaluation of various cognitive abilities, including a number of both verbal and visual-spatial abilities. In addition to indicating how a child is functioning intellectually in comparison with same-age peers, the WISC-R also yields clues to the child's self-perception, frustration-tolerance, and a number of performance characteristics.

Projective Drawings Tests

Projective drawing tests (e.g. House-Tree-Person Test) permit an evaluation of a child's fine motor coordination and general developmental level, and also yield insight into the child's self-perception and view of his or her environment. In addition, they provide clues to the child's personality and emotional state.

Minnesota Multiphasic Personality Inventory (MMPI)

The MMPI is a self-referral questionnaire which is useful in assessing an individual's personality, affect, and interactive style. Essentially, it is an objective instrument used to identify the major personality characteristics which affect personal and social adjustment.

Jesness Personality Inventory

The Jesness is also a self-referral questionnaire, but it is specifically tailored to adolescents. It provides information regarding an adolescent's affective state, value orientation and social adjustment, as well as his or her personality and acting out potential.

Incomplete Sentences Blank Form

This test helps illuminate the individual's emotional state and attitudes, how he or she perceives the social environment, and what his or her hopes and fears are for the future.

Rorschach Inkblot Test

Individuals' perceptions of ambiguous stimuli (i.e. inkblots) reveal a great deal about their personality organization, interrelationships and areas of conflict. In addition, this test permits an evaluation of cognitive distortions and creative abilities.

Thematic Apperception Test (TAT)

The TAT requires the individual to create stories in response to pictures depicting ambiguous scenes. The ways in which the individual interprets the pictures yield clues to the ways in which he or she perceives his or her own social environment, and is often indicative of conflicts, stressors, relationships and other important features of the individual's life.

Province of
British Columbia

Ministry of
Health

JUVENILE SERVICES
TO THE COURTS

Forensic Psychiatric
Services Commission
3405 Willingdon Avenue
Burnaby
British Columbia
V5G 3H4
Telephone: (604) 660-5788

91.02.26

DOCUMENT FORENSIC PSYCHOLOGICAL REPORT

PRIVATE AND CONFIDENTIAL

His or Her Honour the Presiding Judge,
Youth Court of British Columbia,
c/o The Court Registry,
Then the address of the court.

Your Honour,

re: Name of the adolescent
Date of Birth

REASON FOR REFERRAL

Referred by Probation Officer/Court.
Also indicate where the adolescent has been seen and how many times.

SOURCE OF INFORMATION:

Psychiatrist progress note.
Social Worker progress note.
Nursing file.
PO - Youth Workers report.
Information from parents interview or telephone call and case conference.

BACKGROUND INFORMATION - SUMMARY

Summarize the most salient moment of the adolescent.
Longstanding history of delinquency.
Recent placement.
Attendance in school.
Brief summary of the family situation.
Number of times he appears before the court.

INTERVIEW WITH THE PATIENT

Information of limited confidentiality.

CRIMINAL HISTORY

Present charge/ past criminal history/outstanding charge.
Involvement with community hours.
Probation time done.
Rationale for the patient to explain misconduct.
Remorseful feeling, reaction towards victims.
Onset of misconduct behavior.

FAMILY HISTORY

Where is the child living at the time of the assessment.
Relationship with each member of the family including stepbrother, stepfather, and stepmother.
History of foster placement.
Problem at home.
Alcohol and drugs, separation, work problem, and financial problem.
Family consultation and number of siblings and step family involved.

SOCIAL ENVIRONMENT

Friends, doing crime or not doing crime.
Alcohol and drug abuse.

HEALTH

Injuries, allergies, and broken bones.
History of hospitalizations.

SEXUAL HISTORY

Onset of sexuality.
Homosexual tendencies.
Pregnancies.
Contact with pornographic material.
Promiscuous behavior.
Inappropriate dressing code.

SCHOOL

School performance.
History of school attendance.
History of fights at school.
Suspension from school.
Attitude toward school work.

Major problem in school.

TEST RESULTS

Psychological testing.
Behavioral testing.
Result from the testing.
  Cognitive abilities.
  Personality Inventory.
      Result from the MMPI.
      Result from the Jesness Personality Inventory.
      Result from the House-Tree-Person.
      Result from the Incomplete Sentences Blank.

MENTAL STATUS EXAMINATION

General description of the patient.
Style and appearance.
Rapport.
Affect.
Eating disturbance.
Sleeping disturbance.
Suicidal ideation - suicidal attempt - suicidal plan.
Hallucination: auditory or visual.
Verbal expression: amount, flow, and syntax.
Sign of depression.
Sign of psychosis.
Thought disorder.
Anxiety level and somatization.

IMPRESSION AND RECOMMENDATION

This section is extremely essential since most of the time this is the only part that the judge will read, before the kid appears in court. We, therefore, have to summarize the main point of the report even if it seems redundant to repeat them.

Summary: the age of the patient, intellectual functioning of the patient, his numbers of appearance before the court previous to this charge, his attitudes in the interview and in the testing.

The main D.S.M. - III diagnostic colon would be: conduct disorder, psychotic disorder, Clinical Affective Disorder, anxiety disorder, and Attention Deficit Disorder.

Prognosis and explanation of why we proceed the prognosis guarded or not.

Recommendations: time for probation, access to children, curfew, attendance in school, work placement, child care worker, and D.A.R.E. worker.

Treatment: group, individual, and follow-up of treatment.

CLOSING SUMMARY

1. Identifying Data:

   Name:
   D.O.B:
   Address:
   Status:

2. Reason for Activation:

   Record legal status, offences, and referring agency.

3. Reason for Termination:

   Record expiry of bail, probation, and rescindment of O.I.C. or termination by patient.

4. Mental State at Time of Termination:

   Briefly give patient's mental state, how stable he/she is.

5. Treatment Provided:

   Example - chemotherapy, supportive psychotherapy.

6. Medication:

   List all medication patient has been on and current medication.

7. Diagnosis:

   As per psychiatrist.

8. Recommendation:

   Any future treatment and management plan.

SO/cm

YOUTH SERVICES INFORMATION SYSTEM
Forensic Psychiatric Services Commission

DISCHARGE/DISPOSITION DIAGNOSES

ADMISSION DATA
(Psychiatry)

CLIENT NUMBER [__|__|__|__|__|__]

AGENCY: _____ WARD/PROGRAM/UNIT _____

CLIENT NAME _____

DIAGNOSES:

	CODES	
Primary Diagnoses:	DMSIII-R	ICD9-CM
_____	_____	_____
_____	_____	_____
Secondary Diagnoses:		
_____	_____	_____
_____	_____	_____
Other Diagnoses:		
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

FORMULATION:

Signature _____ Date (y/m/d): ____/____/____