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Editorial

Juvenile Sexual Offenders
Assessment Issues

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This editorial describes the ethical and systemic issues relevant to work with young sexual offenders against other children and outlines a proposed model for assessment.

The need for assessment and treatment provisions for children who sexually abuse other children has become increasingly apparent with greater understanding about the extent of sexual abuse carried out by juveniles (NCH, 1992). The picture from clinical work and from research studies suggests that the earliest possible intervention with abusing behaviour is needed to prevent escalation of the problem (Vizard, 1995).

A semi-structured interview format has been designed to assist clinicians in the task of assessing risk, dangerousness and the treatability of juveniles who sexually abuse other children and young people. Active techniques have been developed to help overcome resistance and denial in young sexual offenders and to map patterns of sexual arousal. This model was developed from the psychiatric assessment of 80 young abusers between the age of 8–21 years (mean age 14.7 years) who were referred to a specialist out-patient unit.

Ethical issues

Many professionals are reluctant to have labels such as 'sex offender', 'abuser' or 'perpetrator' attached to their child clients. Such important ethical considerations are closely connected to the major definitional issues surrounding work with young sexual abusers of children (Vizard *et al*, 1995). The crux of the debate about definitional and ethical issues is whether it is the child who is being labelled or the behaviour. The behaviour itself may cross various perceived boundaries and be difficult to categorise. However, most research studies looking at the characteristics of young abusers (Becker *et al*, 1986), and clinicians working in the field (Bremer, 1993), agree that some degree of coercion, force or persuasion coupled with unusually high levels of sexual arousal help to differentiate ordinary childhood interest in sexuality from the preoccupation with sex which can characterise even the very young abuser. In addition, the age, developmental status, physical, emotional and cognitive development of the child will all play a part in determining the extent to which the child understands the implications of his or her abusing behaviour towards other children. Work with dangerous but needy young abusers appears to challenge certain assumptions of the Children Act such as taking into account the 'wishes and feelings' of the child or young person, something which is ethically impossible when the young person concerned has 'wishes and feelings' directed towards abusing others.

Systemic issues

Difficulties in clinical work with the young abuser can be avoided in certain ways. First, a multidisciplinary team offers the best way of ensuring thoughtful and ethical work with such difficult cases. Second, the assessment should address all aspects of the young person's life and should be directed in a positive way towards the possibility of treatment. Third, the referring agency should be actively involved in the assessment process so that anxieties about labelling are resolved at the outset. It is vital to create a full inter-agency, systemic context around each referred case of a child as a young abuser since there is then a better chance that the (inevitable) inter-agency conflicts will be survived and a supportive network emerge.

Working Together (Home Office 1991, 5.24, p. 37) does point out that young abusers are themselves in need of services and suggests (5.24.3) '. . . there should be a child protection conference in respect of the alleged abuser. . . .' It is made clear that such a conference should be set up and handled in exactly the same way as any other child protection conference.

Assessment model

The assessment model includes four components: professionals meeting; psychiatric assessment interviews; psychological assessment; a comprehensive report.

Professionals meeting

The areas upon which referrers most commonly seek an opinion are:

(a) The risk of significant harm from sexual abuse posed by the referred young abuser to other children and occasionally to adult women, and the risk of significant harm from sexual abuse posed to the referred young abuser by other young people or adults
(b) A psychiatric assessment of state of mind of the young abuser
(c) Assessment of treatability
(d) Consultation on locally based treatment programmes
(e) Advice on placement.

The specialist team is often expected to take the responsibility for deciding about complex child protection matters, rather than advising on levels of disturbance, arousal and risk. The first task of the meeting should therefore be a clarification of roles.

Psychiatric assessment interviews with a multidisciplinary team

Assessments should ideally be carried out by a team of four; two professionals who work in the interview room (preferably a man and a woman) and two others observing and videotaping proceedings from an adjoining room. Interviews are semi-structured and each last for around two hours. Second or third interviews may be used to continue to explore the young person's attitudes and capacity for change, and may involve members of the natural or foster family depending upon placement. Assessment interviews can be divided into three stages: clarification and rapport building; mapping the abuse: the fantasies, strategies and behaviours; the future: placement, treatment and personal change.

Stage 1: Clarification and rapport building

The referring professional begins by explaining in plain words the reason why the young person has been brought for assessment and gives a list of the behaviours which have caused professional concern including offence related details.

The young person is then given an opportunity to respond, add to or disagree with what has been said. No attempt is made to challenge the young person on any inconsistencies in his/her story at this time. Efforts should be made to create a positive rapport with the young person who is often extremely anxious, angry or avoidant about the issues being discussed. A clear statement should be made by the team that their role is to explore difficult issues to do with sexual abuse, in order to try to find a way to help the young abuser and not to find fault or to be critical. A short break is taken to consult with observing colleagues and the referrer then joins the supervising team.

Stage 2: Mapping the abuse: the fantasies, strategies and behaviours

At this stage in the process of mapping or describing the fantasies, strategies and behaviour, it is often timely for the interviewers to challenge any discrepancy in the description of events given by the young abuser. The response will determine whether it is possible to go directly on to examine current sexual thoughts experienced by the young abuser or whether a less direct approach may be necessary to approach these areas of conflict. If a young child or an older learning disabled child is being assessed, drawings, play with model figures or dolls, etc. will be necessary to facilitate communication.

A useful assessment technique for children of all ages is the ideation of a pictorial representation of the young person's 'abuse cycle', i.e. his/her pattern of repetitive abusing behaviour. The method used in the Young Abusers Project is called *The Integrated Abuse Cycle* (Fig. 1) and is developed from earlier work with adult sex offenders (Mezey *et al*, 1990) and juvenile abusers (Lane, 1978). Such abuse cycles are based on a cognitive model of sexual offending in which the urge to sexually offend is triggered by external cues, such as the sight of a targeted child with the desired physical qualities, and where the fantasies then created are rehearsed and elaborated in patterns of masturbation which become compulsive and eventually require an outlet in acts of abuse against a child.

However, a purely cognitive–behavioural approach to eliciting cognitive distortions fails to address very important emotional reactions, relationship dynamics and memories of past trauma which can have a direct bearing on the young person's current masturbatory fantasies and on all current and future emotional relationships. The integrated abuse cycle includes an internal cycle of abusive fantasies and feelings and a concentric external cycle of abusive actions. In this way, the two concentric cycles allow the creation by the young abuser and the assessing team, of a dynamic diagram where external actions (including relevant childhood historical events) are mapped out and linked through lines drawn on the diagram with internal fantasies and feelings.

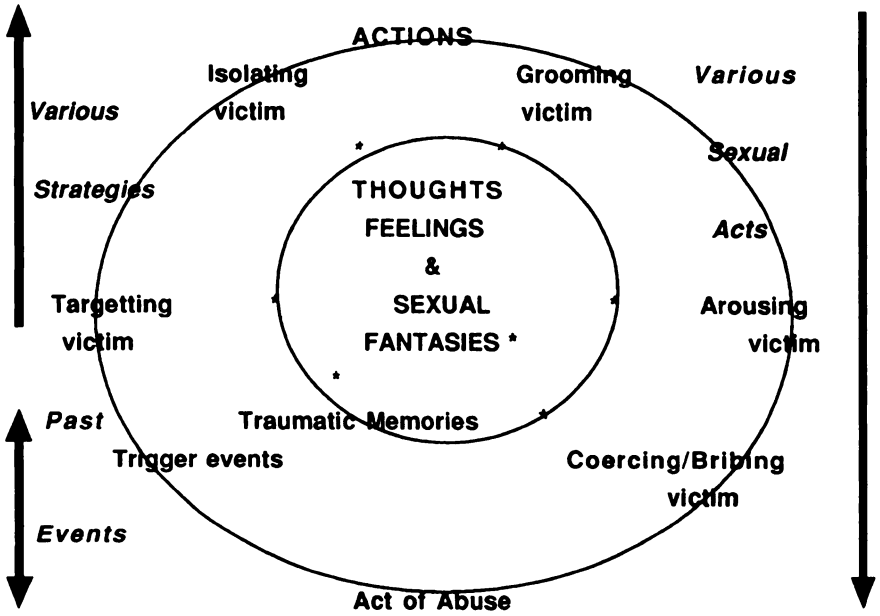

Fig. 1 Integrated abuse cycle: actions and thoughts.

This method of mapping the fantasies, strategies and behaviours helps to side-step major issues of denial and evasion which are typical of verbal exchanges (even with young abusers) while enhancing rapport. The young person himself will usually become engrossed in the task of completing the abuse cycle, and will often volunteer considerably more family, school and relationship material than can be written on the diagram. The positive rapport created will avoid a polarised, static confrontation in which the young person occupies a defensive or victim position from which exploration of more powerful, sadistic thoughts and actions become difficult or impossible. When sufficient information has been elicited, a short break is taken to consult with the supervising team after which the interviewers return for the last part of the session.

Stage 3: The future: placement, treatment and personal change

Treatment possibilities including group, individual and family work will be explained to the young person and his views about therapy will be explored. Placement problems relating to the risk of significant harm to other children at home or in foster care, for instance, will be discussed. An attempt will be made to engage the young person in a discussion of his future in terms of any wish for changes in personal attitudes, relationships and placement. A formal psychiatric examination of the young person's mental state is carried out with appropriate enquiry made about psychiatric disorder. The assessment does not, however, focus exclusively on sexual offending but does range widely over all relevant developmental and emotional issues.

Psychological assessment by a clinical psychologist

The psychological assessment of the child or young person forms an integral part of the overall assessment of the child's needs and a summary is included in the psychiatric report produced at the end of the assessment process.

A comprehensive report

The report produced at the end of the assessment is a structured, coherent account of the issues addressed in the assessment with a concise formulation of the child or young person's difficulties and a list of recommendations.

The report is intended to inform and is written bearing in mind that referrers, courts, parents and older children or young people may be able to read the contents. This latter consideration means that

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extra care must be taken in the way in which sexual arousal, sexual behaviours and the future prognosis for the young person are described. Good practice would suggest that there is the opportunity for any parent, child or young person to be taken through the contents of the assessment report by someone trained to explain and to deal with any reactions.

Discussion

Professional resistance

Professional resistance to work with young sexual abusers tends to be high. Colleagues may feel that resources are better directed towards victims rather than perpetrators. In addition the perverse sexual material involved may stir up very mixed feelings of disgust, arousal and anger which professionals may fear to confront. Supervision of both assessment and treatment work is essential.

Good assessment

A thorough assessment should not be seen as being 'unkind' or asking embarrassing questions but should establish an acceptable language with which to discuss unacceptable behaviour towards other children. Assessment should pave the way for treatment and should in itself have some therapeutic elements.

Psychiatric disorder

There is no diagnostic category for paedophilia for those under 16 years of age, within either DSM–IV (American Psychiatric Association, 1994) or ICD–10 (World Health Organization 1992), at present. This suggests that psychiatrists do not accept that young people under the age of 16 years can have a significant disorder of sexual arousal to other children. Nevertheless, the research literature (Vizard *et al*, 1995) in relation to juvenile sex perpetrators shows that the majority of adult sexual abusers of children begin to abuse child victims in their own adolescence. It is suggested that the creation of a new disorder *Sexual Arousal Disorder of Childhood* would help to identify vulnerable sexually aroused children and target resources towards early prevention of abuser behaviours.

Policy implications

Since the problem of sexual arousal towards children often starts in adolescence or earlier, it follows that young, sexually aroused boy victims need to be stopped from moving into abusing behaviour with early preventative input. The implications for policy are contentious suggesting that scarce resources may need to be shifted from work with older girl victims to work with young boy victim/abusers.

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