7: Assessment And Treatment - For SABs: A General Overview

When we discuss assessment and treatment of Sexually Abusive Behaviours (SABs) we are talking about the process of working therapeutically with a client from the time they enter our service system to the time they leave us, in order to equip them to manage the behaviours. By *manage*, we mean that we aim – and strive to provide the young person with:

- Insight into why they engage in the behaviours,
- Insight that the behaviours cause harm,
- Alternate strategies to manage their issues that are healthy and societally appropriate, rather than SABs, and
- A model of appropriate sexual and relationship behaviours.

Assessment

Related Guides:
- 8: Risk Assessment: An Overview
- 9: Assessment: The ERASOR
- 10: Assessment: The J-SOAP-II
- 11: Assessment: Females Engaging in SABs

As a general rule, a practitioner should not commence treatment until a thorough assessment is completed. This is because, in general, the young person comes to the service with little understanding of the meaning and function of the SABs – why they did what they did. Assessment and treatment can be described as a process of investigating and awakening for the client what the behaviours' functions and meanings are. A therapist who commences treatment without first assessing what these may be is likely to have no sense of what treatment is trying to achieve.

At the conclusion of the assessment, the therapist should have identified the static and dynamic risk factors which have supported the development of and engagement in Sexually Abusive Behaviours by the client.

Focus of Treatment: Dynamic risk factors

The dynamic risk factors identified during assessment form the basis of the intervention. In other words, managing the dynamic risk factors becomes the focus of the intervention – assisting the youth to manage them through healthy/healthier ways (other than SABs) and strategies. Dynamic and static risk factors are not 'causal' in regards to SABs. In other words, background factors can be present and not result in sexual abuse occurring, however a number of these dynamic and static risk factors are present at significant rates amongst our clients.

Examples of the most prevalent risk factors we see during assessment are:

- Exposure and/or witness to family and domestic violence,
- History of sexual victimisation,
- The experience of long-term low-level neglect (i.e.: cumulative harm) and
- Being inappropriately exposed to sexual activity or pornography.

For a more comprehensive list of risk factors, see Rich, 2009, pages 128-129, 2011, page 121, 179-180.

Why might young people engage in SABs?

Potential reasons for engaging in SABs are many and varied. Some (but not all) potential reasons are:

- Using sexual contact for the management of uncomfortable internal states and emotions, including internalised anger, frustration, fear, and anxiety,
- Seeking revenge through sexual assault for perceived wrongs (generally trying to hurt someone other than the victim), through objectifying the victim. For example, sexually assaulting a younger step-brother or step-sister to 'punish' the parent that abandoned them for a new family,
- Sexual curiosity, paired with romantic and social awkwardness, and access to a vulnerable, generally younger child to target,
- Intellectual disability, autism-spectrum disorders, learning disorders and ADD and ADHD. Any of these may lead to a 'misreading' of the social nuances of the world, resulting in sexual behaviours that are generally uninvited and unwanted by others,
- The mistaken belief that sexual activity is a form of nurture and connection, due to a variety of reasons. For example the child exhibiting the behaviours believes that the act of sexual contact equates to love and/or connection,
- Re-enactment of their own sexual abuse, which may result from a lack of understanding of the 'wrongness' of their own abuse. Or in other cases, trying to understand or contextualise their own abuse by seeing the effect on others of similar behaviours.

Treatment under the Therapeutic Treatment Order legislation

The *Children, Youth & Families Act, 2005* (s.244) sets out the legislative framework regarding children and their families in need of a Therapeutic Treatment Order (TTO) legislative response. Whether a formal Order is required, or where the client and the family are attending voluntarily, ALL young people coming into your service for work regarding SABs should be considered to be clients under the legislation.

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Intervention network for children and young people displaying sexually abusive behavior

Until recently, there has been some confusion regarding the young people attending voluntarily versus those whose attendance was forced with a formal Therapeutic Treatment *Order*. Since 2007, when TTO legislation commenced, approximately 1000 youth per annum have been seen in therapeutic agencies across Victoria. Of these 1000, less than 25 individuals per annum have required formal Orders. Young people should only be placed on an order if they (or selected family members – generally parents) are *unable and/or unwilling* to attend treatment. **Your response and intervention should be the same for both formally ordered and voluntarily young people.**

If you are working with a young person voluntarily, and they cease attendance, or do not attend from commencement, or they attend but do not engage meaningfully (i.e.: attendance is not enough), then you should request that Child Protection apply for a TTO.

If you have a young person who is on a TTO, and is not attending, or is attending but not engaging, then consider (after attempting better engagement of course) requesting Child Protection to rescind the Order and return the matter to court, should charges be pending. TTOs do not have conditions – they are an "either-or" type Order. In other words – the child and family either is or is not doing what they need to do, and as such "*either there is compliance or we seek an order. If we have an order, either there is compliance, or we approach Child Protection to rescind the order and the matter returns to court".* If there are no charges pending, then the Order is still rescinded, and effectively, nothing else occurs, however, we report to CP and as such, inform the system.

Generally, the therapeutic service has 12 months to complete work under the legislation. There is potential for an extension of 12 months if the work is not completed.

The legislation is currently (as of February 2018) being amended to include youth aged 15 up to under 18 (17 years, 364 days). The amended legislation should provide the same protections to older youth as already provided in the under-15s in the current legislation.

The Treatment Model

The treatment model is somewhat *trauma-centric*, inasmuch as it assumes the behaviours are a response to trauma/s previously experienced by the youth engaging in SAB. Additionally it incorporates a *trauma-attachment-brain developmental* perspective. Therapists working within the TTO system should have, over and above their professional discipline training, solid knowledge of therapeutic principles regarding:

- Developmental trauma,
- Attachment,
- Brain development, and
- Child development (including sexual development).

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CEASE
Intervention network for children and young people displaying sexually abusive behavior

The treatment model is based on well-established trauma-treatment principles and could be called an *exposure-type model of trauma treatment*. The model is a 'four pillar' treatment model, in that it has four separate phases which are referred to as 'pillars' as they evenly 'support' treatment, with each being as important as the others. Here is the model:

- ***Affect regulation and emotional awareness***: clients learn to recognise emotion through discussion (cognitively based), role play, experiential exercises and games (all of which engage affective, internal processes), and, following the development of greater emotional awareness, to identify and manage their emotionally charged moments and issues. Through breathing, simple yoga style methods, and greater, meaningful connection to others who can assist them to be safe (initially the therapist and potentially caregivers/family).
- ***Good Way Bad Way***: uses narrative therapy techniques and sets up a dichotomous situation where clients can look at how their 'bad' side has been able to overcome their 'good' side. Allows clients to engage in difficult and potentially highly-charged affective situations without being overwhelmed by this. At the end of this section of the work, clients are then able to undertake 'offence-process' work, as they have a greater understanding of why the behaviours might have occurred, and have developed skills to manage their affective responses and can talk about their behaviours.
- ***Healthy sexuality***: If you take away something unhealthy, you must replace it with a healthy something. In this case, work focuses on healthy and legal models of sexuality, as well as healthy and respectful relationships, getting your needs met in respectful ways and consideration of the importance of others' needs as well.
- ***Future***: moving on from treatment – practice, and celebrating success. By this stage, most clients will have completed between one and two years of work. Families will also likely have been involved and worked hard as well. Shifts in thoughts, feelings and of course, behaviours should be evident.

Can I use my own therapeutic style?

The *four pillar* model gives you a framework on which to hang your own therapeutic techniques. It is not meant to be prescriptive in terms of how you do the work; rather it guides you as to what needs to be achieved along the way.

Family

Involvement with family is seen as important and logical. All effective treatment programs across Australia, New Zealand, the United Kingdom and the United States include family work in their treatment protocols. This is because the SAB is seen as a developmental issue, embedded within the family system.

Parents/carers must be included in the treatment unless they were known to be responsible for harm, or seen to be at risk of causing harm to the child.

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When a young person is in residential care, where possible and safe, family should still be approached and assessed for involvement. Where family involvement is contra-indicated (severe family violence, sexual abuse, lack of ability to engage etc) or not possible due to statutory orders, a staff member should be identified who can take on the parental/carer role in treatment. Someone in the residential unit (or within the broader community) *must* be able to assist the young person to take on the messages and strategies from treatment.

Aims of Therapy

The aims of therapy are to educate our clients and provide them, and their families, with strategies to manage the sexually abusive behaviours. It is not about challenging a client to admit to bad behaviour. It is not a process of investigation. It is a situation where a young person has deviated from a positive developmental pathway and it is our job to assist them back on track. For real change to occur, therapy needs to alter cognitive processes but has to also involve affective (emotional) processes for real, long term change to occur.

Finally…

Remember:

- The principles of 'RNR'; *Risk, Need, Responsivity* (Bonta & Andrews 2007). Your initial comprehensive assessment will assist you to provide the **right treatment** for the **right client** at the **right time**. Match risk with resources. A low risk clients get less of your resources than a moderate risk client. High risk clients get the most resources.

- Recidivism rates are extremely low for this client group. Caldwell's (2016) research found a 2.75% recidivism rate between 2000 and 2015. This gives us great hope that with effective treatment, the majority of our clients will not engage in these behaviours again.

You have a strong, clear role to play in your young clients' lives.

References and articles/books of interest

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