

JCPP Practitioner Review

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**Title:**

*Practitioner review. The victims and juvenile perpetrators of child sexual abuse: Assessment and Intervention.*

**Abstract (word count = 296)**

**Background:**

The assessment of victims of child sexual abuse (CSA) is now a recognized aspect of clinical work for both CAMH and adult services. Since juvenile perpetrators of CSA are responsible for a significant minority of the sexual assaults on other children, CAMH services are increasingly approached to assess these over-sexualised younger children or sexually abusive adolescents. A developmental approach to assessment and treatment intervention is essential in all these cases.

**Method:**

This paper examines research on the characteristics of child victims and perpetrators of CSA. It describes evidence based approaches to assessment and treatment of both groups of children. A selective review of MEDLINE, Psycinfo, Cochrane Library and other databases was undertaken. Recommendations are made for clinical practice and future research.

**Results:**

The characteristics of CSA victims are well known and those of juvenile perpetrators of sexual abuse are becoming recognized. Assessment approaches for both groups of children should be delivered within a safeguarding context where risk to victims is minimized. Risk assessment instruments should be used only as adjuncts to a full clinical assessment. Given high levels of psychiatric co-morbidity, assessment, treatment and other interventions should be undertaken by mental health trained staff.

**Conclusions:**

Victims and perpetrators of CSA present challenges and opportunities for professional intervention. Their complex presentations mean that their needs should be met by highly trained staff. However, their youth and developmental

immaturity also give an opportunity to nip problem symptoms and behaviours in the bud. The key is in the earliest possible intervention with both groups. Future research should focus on long term adult outcomes for both child victims and children who perpetrate CSA. Adult outcomes of treated children could identify problems and/or strengths in parenting the next generation and also the persistence and/or desistence of sexualized or abusive behavior.

**Keywords:** Child Sexual Abuse (CSA); Victims; Juvenile Perpetrators; Characteristics; Assessment; Intervention; Treatment

## Introduction

### Prevalence of child sexual abuse (CSA) victimisation:

Sexual abuse of children is defined as '*Sexually interfering with or assaulting a child*' (Royal College of Psychiatrists, 2012). A 'child' is defined as a person under 18 years old (Children Act, 1989). For the purposes of this review, 'children and young people' are defined as individuals under the age of 21 years old.

Sexually abusive acts range from indecent touching of a child on private parts to penetrative sexual assaults and include the grooming and sexual abuse of children via technology and the internet (For further information see CEOP, 2010; Byron, 2010; Livingstone, Haddon, Gorzig & Olafsson, 2010). Many definitional and methodological differences between studies mean that reliable estimates of prevalence are difficult to establish. Reliance on official records means that most cases of sexual abuse of children are not captured since the majority of sexually abusive incidents are neither disclosed nor reported for many years (Anderson, Martin, Mullen, Romans & Herbison 1993; Allnock et al., 2009). Given these difficulties it is likely that published statistics on the prevalence of CSA are underestimates of the true rate of occurrence of the problem.

Finklehor's (1979) survey of 796 New England, white College students under age 21 years old, showed that 19.2% of female and 8.6% of males had been sexually victimized, results replicated in other retrospective studies (Finklehor, 1979; Russell, 1983; Baker & Duncan, 1985). In a recent meta-analysis of 217 publications between 1980 and 2008, comprising 9M subjects, the overall estimated CSA prevalence was 127/1000 in self-report studies and 4/1000 in informant studies (Stoltenborgh, Van Ijzendoorn, Euser & Bakermans-Kranenburg, 2011). These results are in line with those from studies thirty years earlier (Finklehor, 1979; Russell, 1983; Baker & Duncan 1985). The rates of self-reported prevalence varied widely across different countries due to methodological differences in the studies reported and not for cultural or religious reasons (Stoltenborgh et al., 2011).

In a recent national study of prevalence of child maltreatment in the UK, contact sexual abuse, as defined by the criminal law, was noted in 11.3% of young people aged 18-24 years old (5.1% males; 17.8% females) and in 4.8% of children aged

11-17 years old (2.6% males; 7.0% females) (Radford et al., 2011). However, 16.5% of 11-17 year olds and 24.1% of 18-24 year olds had experienced sexual abuse including non-contact offences by an adult or peer. Overall, in 34% of cases of sexual assault by an adult and in 82.7% of cases of sexual assault by a peer, nobody knew about these offences (Radford et al., 2011). This adds weight to the well established finding that recorded statistics on sexual assaults of all kinds are likely to be a significant underestimate (Anderson et al., 1993; Allnock et al., 2009).

Recent evidence from the USA and the UK suggests that the prevalence of various forms of child maltreatment including sexual abuse has declined in recent years. Between 1993 and 2004, an overall reduction of between 40-70% of all forms of child maltreatment, child homicide, and non-sexual criminal assaults on children has been noted (Finklehor & Jones, 2006). A reduction of 49% in substantiated cases of CSA was also noted between 1990 and 2004 in the USA (Finklehor & Jones, 2006). A recent NSPCC survey of the prevalence of child abuse and neglect in the UK gives some indications of a reduction in CSA echoing the decline in official registrations for both sexual and physical abuse (Radford et al., 2011; DH 2003; DH 2007). Skeptical challenges to this decline in reported cases of sexual abuse have been refuted by Finklehor & Jones (2006) on the basis that multiple, independent, international sources of data on the prevalence of violent crimes against children all show an overall decline so the decline in sexual abuse cases is likely to be a real one.

Even if it is accepted that the actual numbers of children being sexually abused has recently declined, current evidence still shows that a significant minority of both boys and girls have suffered some form of unwanted sexual contact in their childhoods (Radford et al., 2011).

#### Prevalence of sexually abusive behavior by children and young people:

It is known that young people are more likely to generally offend than adults (Budd, Sharp & Mayhew, 2005; Ministry of Justice (MoJ) 2011). A recent Home Office research report showed that young people aged 10 to 17 years old were responsible for 23% of police recorded crime in 2009/10, which is equivalent to 1.01 Million crimes (Cooper & Roe, 2012). Furthermore, 20% of these crimes were sexual and were likely to involve co-offending (Cooper & Roe, 2012). It is also known from victim surveys, meta-analyses and official reports that the prevalence of sexually abusive behaviour by children and young people is between 20-50% of all CSA (Davis & Leitenberg, 1987; Vizard, Monck & Misch, 1995; Lovell, 2002; Home Office 2003; Brooks-Gordon, Bilby & Wells, 2006).

The majority of these young sexual perpetrators are male (19%) compared with girls (1%) (Cooper & Roe, 2012). Many are siblings, extended family members or peers of the perpetrator (Anderson et al., 1993; Richardson, Graham, Bhate & Kelly 1995; Vizard et al., 1995; Halperin et al., 1996; Radford et al., 2011).

It remains unclear whether those who perpetrate juvenile sexually abusive behaviour are, at least in part, a distinct subgroup of anti-social juveniles, or

whether such behaviour can be construed as part of anti-social behaviour in general. This debate centres on whether juvenile sexual abusers are on a developmental trajectory towards becoming adult sex offenders, or whether they will desist from the behaviour in adulthood. Studies comparing sexual and non sexual recidivism rates in adulthood noted lower sexual re-conviction rates (9% to 37%) but much higher levels of non-sexual re-conviction rates (37% to 89%) (Nisbet, Wilson & Smallbone, 2004; Rubinstein, Yeager, Goodstein & Lewis, 1993; Sipe, Jensen & Everett, 1998; Worling & Curwen, 2000; Caldwell, 2002). It is worth noting that sexual recidivism rates are probably an underestimate of the true rates of undetected sexual offending, since these crimes are notoriously difficult to detect and prosecute.

However, it has been suggested that early onset sexually abusive behaviour (i.e. before the age of 10) may represent a behavioural risk marker for a maladaptive trajectory and generic offending (McCrary, Hickey, Farmer & Vizard, 2008). Consistent with this suggestion is a general consensus that early onset conduct problems in general is associated with more serious and enduring patterns of offending (Utting, Monteiro & Gbate, 2007; Farrington, 1995; Hodgins, 2007; Moffitt et al., 2008).

It has been known for several decades that children, particularly adolescents, could have sex with other children but this was not always construed as sexually abusive and may have been described as 'sexual experiences' or as 'sibling incest'. Finklehor's (1979) study of College students noted that brother-sister incest was far more common than father-daughter incest (4% of the girls' experiences) with 39% of the incest reported by girls and 21% reported by boys being brother-sister. Furthermore, 5.7% of girls and 2.3% of boys reported sexual experiences with adolescent partners 5 years older than them but it was not clear if these partners included relatives or other family members such as cousins (Finklehor, 1979).

After decades of research into victimization by adults, it is now accepted that the risks posed to victims of sexual abuse by adolescent or child perpetrators must be recognized. The recent NSPCC prevalence study on child maltreatment in the UK found that 57.5 % of contact sexual abuse of children up to age 17 years old, was perpetrated by children and young people, 34.1% by adults and 8.4% by both adults and children or young people. These findings indicate that sexually abusive behavior by children and young people is nearly twice as common as sexual abuse by adults but it may also be far less commonly disclosed (Radford et al, 2011).

#### Characteristics of CSA victims:

Awareness of the sequelae of CSA victimization has increased steadily over the last three decades but the core problems remain similar to those described by Freidrich (1986).

Some children may never tell about their abuse or may wait years before doing so. In the NSPCC Prevalence study, in 34% of cases of sexual assault by an adult

and in 82.7% of assaults by a peer, no one knew about these assaults (Radford et al., 2011). A delay in disclosure of CSA by many victims has been noted by researchers for decades (Finklehor, Hotaling, Lewis & Smith, 1990; Lippert, Cross, Jones & Walsh, 2009).

Many children who have been sexually abused subsequently develop mental health problems, contributing to the over-representation of CSA victims and survivors in adult mental health services (Ruggiero, McLeer & Dixon, 2000; Stovall-McClough & Cloitre, 2006). In a study to determine the rate and risk of clinical and personality disorders in adults sexually abused as children, the forensic medical records of 2,759 sexually abused children assessed between 1964 and 1995, were examined and compared with controls. Sexually abused individuals had a three times higher rate (23.3%) of lifetime contact with public mental health services compared with the controls (7.7%) (Cutajar et al., 2010).

A substantial range of psychological problems can be seen throughout the lives of sexual abuse victims, including depression, anxiety, psychosis, posttraumatic stress disorder (PTSD), guilt, fear, sexual dysfunction, substance abuse and acting out. (Mullen, Martin, Anderson, Romans & Herbison, 1996; Mullen, Martin, Anderson, Romans & Herbison, 1993; Banyard, Williams & Siegal, 2001; Cutajar et al., 2010).

In a study designed to examine predictors of psychopathology in non-clinically referred, sexually abused children aged from six to sixteen years old, abuse-related factors and demographic variables accurately predicted PTSD status for 86% of the participants. Reviewing other studies, the authors conclude that *'symptoms of PTSD are the most prevalent correlates'* (of having been sexually abused) (Ruggiero et al., 2000, p. 951). Victims who suffered penetrative abuse were more likely than non-penetrated victims to have contact with mental health services and to have psychosis or alcohol abuse whilst victims abused by more than one perpetrator were 1.6 times more likely to have contacted mental health services (Cutajar et al., 2010).

However, the strongest indications of a past history of sexual abuse are said to be inappropriate sexual knowledge, sexual interest and sexual acting out (American Psychological Association, 2007). An early age of onset of being sexually abused has been shown to predict hypersexual, exposing and victimizing sexual behaviors (McClelland et al., 1996; Vizard, Hickey & McCrory, 2007b).

A developmental perspective on any symptoms shown by children who have been sexually abused is important since different behavioural patterns or bodily symptoms may emerge in different age groups (Macdonald, Higgins, & Ramchandani, 2009). A study using longitudinal data from a national probability sample of 1,467 children aged two to seventeen examined the effects of child internalizing and externalizing symptoms at different ages on increases in victimization over a one year period (Turner, Finklehor & Ormrod, 2010). Although the relationship of symptoms to subsequent victimization varied across developmental stages, children with mental health problems were at higher risk of peer victimization, maltreatment and sexual victimization. In particular,

school age children with internalizing and externalizing symptoms (dysregulated behavior) on school entry were at risk of victimization because of exposure to a wider range of peers and opportunities for interaction (Turner et al., 2010).

In earlier waves of the same DVS study, Finklehor and colleagues proposed a conceptual model suggesting four different pathways to *'poly-victimization'* as follows: (a) residing in a dangerous community (b) living in a dangerous family (c) having a chaotic, multiproblem family environment (c) having emotional problems that increase risk behavior, engender antagonism, and compromise the capacity to protect oneself (Finkelhor, Ormrod, Turner & Holt, 2009).

Hence, the effects of a seriously deprived and abusive family context on the developing, victimized child should be a vital consideration in deciding on case management, assessment and treatment of victims of child abuse. As Mullen has noted *'The message for therapists is that when evaluating the relevance of childhood abuse to beware an exclusive, and potentially exaggerated focus on the traumas of sexual abuse which may obscure both the relevance of other forms of abuse and the unfolding of other damaging developmental influences'* (Mullen et al., 1996, p. 20)

#### Characteristics of juvenile perpetrators of CSA:

Many of the characteristics described above in relation to CSA victims are also found in juvenile perpetrators of sexual abuse. This is particularly true in relation to past experiences of victimization and polyvictimisation where the same symptoms and behaviours can be noted in juvenile perpetrators of sexual abuse as those seen in CSA victims (Finklehor et al., 2009). Dissociative phenomena were also been noted in 10 out of a sample of 70 adolescent sex offenders compared with 2 of the comparison group of 47 psychiatric inpatients (Freidrich et al., 2001).

Childhood developmental factors are now accepted as having a contributory role in the pathways to offending in adult life (Roberts, Zhang, Yang & Coid, 2008). A study comparing adult rapists with child molesters across a range of static measures and developmental variables, provided a risk prediction model aimed at distinguishing between sex offenders at highest risk of community treatment failure from those most likely to succeed in treatment. The key risk factors or developmental variables included: *child maltreatment (sexual, physical and emotional abuse), childhood emotional/behavioural difficulties and secure attachments to primary caregivers* (Craissati & Beech, 2006, p.335).

A descriptive study of 280 juvenile sexual perpetrators referred to a national forensic CAMH service found that 71% of the sample had been sexually abused, 66% had been physically abused, 74% had suffered physical neglect, 49% had been exposed to domestic violence and 25% had experienced all five forms of abuse (Vizard, Hickey, French & McCrory, 2007a). The sample also suffered from general educational and cognitive difficulties with 25% being learning disabled with an IQ of < 70 and 45% having a statement of educational need. The sample had high levels of developmental, behavioural and mental health problems.

Developmental delays in walking or talking were noted in 39%, physical aggression in 70% whilst the commonest psychiatric diagnoses were conduct disorder (50%) and PTSD (29%) (Vizard et al., 2007a). The overall picture from this research on a high risk sample was that children starting their sexually abusive behaviour early in childhood were raised in an environment characterized by a matrix of adverse developmental, traumagenic and family factors putting some of them at risk of the emergence of mental health problems in general, and severe personality disorder traits in particular.

In a subsequent study comparing the developmental and behavioural characteristics of female and male juveniles presenting with sexually abusive behavior, it was suggested that they may follow different pathways towards abuse of others. There was a statistically significantly higher rate of sexual abuse in the females (95.5%) compared with the males (69.9%) but no other significant differences in rates of physical, emotional or neglectful abuse (Hickey, McCrory, Farmer & Vizard, 2008). However, the males had experienced more exposure to family violence, i.e. domestic violence (49.2% not significant) than females (36.4%) (Hickey et al., 2008). This may be relevant since other research has also highlighted the role of witnessing or participating in domestic violence as a risk factor for later perpetration of sexual abuse by boys (Skuse et al., 1998; Salter et al., 2003).

#### Links between sexual victimization in childhood and later sexual perpetration:

Despite the many traumagenic features, including sexual victimization, in the backgrounds of juveniles who sexually abuse, a simple causal link between being abused and going on to abuse others has not been borne out in the literature (Watkins & Bentovim, 1992; Skuse et al., 1998; Salter et al., 2003).

In a retrospective file review of a large sample of males (N = 747) attending a specialist forensic psychotherapy service over a period of 6 years, 35% of those men who were perpetrators of sexual abuse had been victims of sexual abuse compared with 11% of victims amongst the non perpetrators (Glasser, Kolvin, Campbell et al, 2001, p. 482). The authors concluded that *'The data support the notion of a victim to victimizer cycle in a minority of male perpetrators....'* (Ibid, p. 482). However, in two somewhat critical invited commentaries on this study, the 'perils of prediction' are noted, the limits of extrapolating from a highly specialist service are discussed, the need for complex causal models and the concept of 'developmental pathways' are stressed, rather than the perceived simplicity of a victim to abuser cycle (Cannon, 2001, pps 495 & 496; Bailey, 2001, p. 497).

In a longitudinal study (7-19 years duration) of 224 former male victims of sexual abuse, it was found that 26 (12%) of them had subsequently committed sexual offences (Salter et al., 2003). However, the authors acknowledge that there could have been some misclassification of perpetrator status, given that the data sources used (criminal records, social services files and clinical records) were likely to have been incomplete (Salter et al., 2003). Even so this study shows that sexual victimisation on its own cannot be taken as a definite risk factor for later sexually abusive behaviour. The same study looked at protective

factors which would have an effect on outcome at high levels of risk and found that none of the individual protective factors identified (e.g. good relationships with adults, siblings or peers, years spent in foster care, non-abusive carers, etc) interacted significantly to reduce the level of risk of paedophilic behavior (Salter et al, 2003, pps 471 & 474).

In a study of 280 high risk juvenile sexual abusers, only 71% of the sample had been sexually abused meaning that a different explanation needs to be sought for the behaviour of the 29% of non sexually abused children. A limitation of this study was the lack of longer term follow up to measure rates of sexual re-offending by the sexually abused and non sexually abused children (Vizard et al., 2007a).

An additional indicator of risk of perpetration of sexual abuse by juveniles seems to relate to 'exposure to a climate of intrafamilial violence', particularly witnessing and experiencing physical violence including domestic violence (Skuse et al., 1998, p. 175; Bentovim & Williams, 1998; Hickey et al., 2008). It is possible that these experiences of physical violence and the breaching of personal boundaries by assault may in some way give permission for the young person to go on to inflict sexual violence on another child.

Overall, the research shows that only a minority (12%) of sexually abused children go on to sexually abuse others and that around 50% of juvenile perpetrators of sexual abuse have themselves been sexually abused (Salter et al, 2003; Bentovim & Williams, 1998, pps. 101 & 103). Furthermore, although a significant minority of adult sexual abusers have been sexually abused themselves, many have not suffered sexual abuse but may have experienced other forms of child abuse and significant loss in childhood (Glasser et al, 2001).

Hence, sexually abused and non sexually abused juvenile perpetrators need careful assessment and treatment to encompass their victimization needs and many risk factors whilst not losing focus on their offending behaviour. However, there is no clear support in the literature for a simple victim to abuser link (Skuse et al, 1998; Salter et al, 2003).

### Common assessment approaches for victims and perpetrators of CSA

Good practice suggests that a full multi-disciplinary and developmentally informed clinical assessment of victims and perpetrators of CSA will always be needed (Vizard, 1993; Worling, 2002; Calder, 1997; Vizard, 2004). This approach reflects existing good practice in relation to the assessment of all children attending CAMH services (Bruce & Evans, 2011). Given the serious child protection concerns involved in these cases, assessment of CSA victims and perpetrators needs to be undertaken within a systemic, multi-disciplinary and safeguarding context in line with government guidance on the subject (Jones & Ramchandani, 1999; Department of Health, Department for Education and Employment, Home Office, 2000; DH, 2003). The elements of the DH assessment framework are encapsulated within the so called 'Assessment Triangle', which requires data to be collected, analysed and acted upon within the three domains

identified in the sides of the triangle as follows: 1. *Child's developmental needs* 2. *Parenting capacity* & 3. *Family & Environmental Factors*. For both victims and juvenile perpetrators of sexual abuse all three sides of the assessment triangle and the domains within them are necessary for a full assessment.

A practical approach to assessing children's needs is outlined by Cox, Bingley Miller and Pizzey (2009) in seven steps as follows:

Step 1. Consider the referral, the safety of the child and the aims of the assessment; Step 2. Gather additional information; Step 3. Categorize available information and organize it within the Assessment Framework triangle: what is known and not yet known; Step 4. Analyze the processes influencing the child's health and development; Step 5. Predict the likely outcome for the child; Step 6. Plan interventions; Step 7. Identify outcomes and measures which would indicate whether interventions are successful (Cox et al., 2009, p. 75-105).

The DH 2000 assessment framework was extended within the Common Assessment Framework (CAF) to help identify a child's needs and to request services (DH et al., 2000; Department for Education, 2005). However, despite all this guidance over the last decade, a recent review of social work assessments has noted: *'The evidence shows that on occasion, practice has fallen short of the standard required. Poor quality, incomplete or non-existent assessments have been of particular concern.'* (Turney, Platt, Selwyn & Farmer, 2011, p. 1).

Rutter & Taylor have stressed the need to strike a balance between the generally recommended use of focused questioning in standardized interviews and the possible *'dangers in the restriction of assessment to such diagnostic instruments'* (Rutter & Taylor, 2008, p. 46). The onus is therefore on the clinician to select risk assessment instruments which match his or her clinical population (See Calder (1997) for a selection of relevant instruments). Victims and perpetrators of CSA tend to be co-morbid for several psychiatric disorders, to have more than one developmental disorder and to have a number of sub-threshold symptoms, traits or behaviours which cause problems but are difficult to classify (Bladon, Vizard, French & Tranah, 2005; Vizard et al., 2007b). Therefore a 'tick box' approach to assessment of these children is not sufficient to identify all their needs, no matter how well validated the psychometric measure or risk assessment instrument, so a clinical assessment by a trained mental health professional and a diagnostic formulation will also be needed.

A recent study looking at the effectiveness of training and consultation on social workers' ability to identify and respond to emotional abuse, suggested that more systematic training of social workers in assessment techniques, with a tiered method being used for the gathering of risk factors rather than a tick box approach, resulted in significantly more reporting of emotional abuse following training (Glaser, Prior, Auty & Tilki, 2012).

### Specific assessment approaches for juvenile perpetrators of CSA

Vizard (2007) has modified the DH assessment triangle specifically for juvenile perpetrators of sexual abuse using evidence based risk factors for the three sides of the triangle to guide practitioners in assessing risk.

As mentioned earlier, a full clinical assessment of the child by a trained mental health professional and a diagnostic formulation will be needed in addition to any risk assessment measures. This is primarily because victims and perpetrators of CSA tend to be co-morbid for several psychiatric disorders, to have more than one developmental disorder and to have a number of sub-threshold symptoms, traits or behaviours which cause problems but are difficult to classify (Bladon et al., 2005; Vizard et al., 2007b).

No one risk assessment instrument can cover all possible risk indicators (Hanson & Thornton, 2000; Worling, 2002). Furthermore, some may be biased towards higher or lower risk populations, they may focus on so called 'static' and unchangeable variables (such as historical events in childhood) without emphasis on 'dynamic' or changeable variables (such as attitudes towards women or children). For instance, once assessed as 'high risk' on 'static' variables, an offender will always remain at 'high risk' since this is an unchanging variable. This means that, valid as the particular instrument may have been during research trials with one type of population (community or incarcerated), it may be the wrong instrument to use in other clinical populations.

The Estimate of Risk of Adolescent Sexual Offence Recidivism (ERASOR), is a risk assessment instrument devised to predict the risk of sexual reoffending in adolescents was based on a young person's subsequent involvement in the criminal justice system (Worling & Curwen, 2001). This is a limitation acknowledged by the authors, since reliance on recidivism statistics needs to take into account the distinction between actual reoffending (higher) and documented conviction and recidivism (lower). Risk factors were categorized as: well supported; promising; possible and unlikely, with a breakdown of static and dynamic factors given for each (Worling, 2002). Hence, the ERASOR risk assessment instrument appears to balance static and dynamic risk factors, clinical and psychometric assessment elements with the need to formulate the risk estimate in an informed and defensible way (Worling, 2002). The Juvenile Sex Offender Assessment Protocol-II (J-SOAP-II) also used with adolescent sex offenders clearly states: *'Decisions about re-offense risk should not be based exclusively on the results from J-SOAP-II. J-SOAP-II should always be used as part of a comprehensive risk assessment...scores from J-SOAP-II should not be used in isolation when assessing risk'* (Prentky & Righthand, 2003, p. 1).

Certain psychometric measures can assist the final diagnostic formulation of children with sexually abusive behaviour when they include measures of sexual behavior (Friedrich et al., 1992). In a comparative study of children aged 2-12 years old (880 normative children and 276 sexually abused children), a 35 item behavior checklist, the Child Sexual Behavior Checklist (CSBI) sexual behaviors between the two groups were compared. The study showed a strong correlation between sexual behaviors and having been sexually abused and the CSBI was found to be reliable and valid with the authors concluding that *'.....sexual behavior is evident at greater levels in sexually abused than in non abused children, and sexual abuse provides a precocious introduction to adult sexual behavior'* (Friedrich et al., 1992, p. 310).

However, as discussed earlier, a straightforward CSA victim to sexualized behavior link is not borne out by more recent research so other background factors also need to be considered in assessment (Skuse et al., 1998; Salter et al., 2003; Vizard et al., 2007a; Vizard, 2007).

In summary, an holistic, clinical approach to the assessment of victims and perpetrators, combined with the use of appropriate psychometric measures is essential in complex cases where serious psychopathology and issues of risk are likely to be present (Vizard, 2007). This is particularly so when dealing with adolescent sex offenders who may show callous-unemotional traits, often associated with the later development of psychopathy (Hodgins, 2007; Viding, Frick & Plomin, 2007; Vizard, 2008).

#### Types of treatment available for CSA victims:

Many research studies and reviews have claimed that effective treatment of the traumatic effects of CSA is best delivered within a cognitive-behavioural framework (Cohen, Mannarino, & Deblinger, 2006; Child Welfare Information Gateway, 2007; Macdonald et al., 2009). However, the way in which child patients are selected for either dynamic therapy or CBT may also be relevant and may depend on certain child specific characteristics.

In an RCT with 291 adult in-patients, it was found that systematic selection resulted in a better long term outcome for psychodynamic therapy (PDT) but not for those receiving CBT (Watzke et al., 2010). This result is said to be in line with the requirement to select patients more carefully for PDT, ensuring that they have the ability to reflect or that they are psychologically minded (Watzke et al., 2010). Commenting on these findings, Fonagy (2010) has noted that Watzke et al.'s (2010) study offers apparent validation for the role of clinical judgement in assessing suitability for PDT. The question remains as to how much (if at all) these findings from studies with adults can be extrapolated to selecting an appropriate type of therapy for work with children.

An example of a CBT approach to work with children is Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) developed by Cohen and colleagues in the University of Carolina in collaboration with the National Child Traumatic Stress Network (Cohen et al., 2006). TF-CBT involves the delivery of individual sessions to both child and to non-offending caregiver as well as joint caregiver/child sessions.

The key components of TF-CBT are summarized by the Acronym PPRACTICE: Psycho-education; Parenting skills; Relaxation; Affective modulation; Cognitive coping and processing; Trauma narrative; In vivo mastery of trauma reminders; Conjoint child-parent sessions; Enhancing future safety and development (Cohen, Deblinger & Mannarino, 2005). Hence the TF-CBT approach uses a multi-modal approach to mastery of intrusive PTSD symptoms which includes direct child CBT as well as the support and reinforcement of the non-abusing caregiver.

Six randomized controlled trials (RCTs) of TF-CBT with other active treatments have shown that significantly greater improvements in a range of symptoms up to two years post treatment (Cohen et al., 2006). In a follow-up study of a multisite, randomized, controlled trial for children with sexual abuse-related PTSD symptoms, 183 children aged eight to fourteen years old and their primary caregivers were assessed six and twelve months after posttreatment evaluations (Deblinger, Mannarino, Cohen & Steer, 2006). It was found that children treated with TF-CBT as opposed to Child Centered Therapy (CCT) had significantly fewer symptoms of PTSD, showed less shame and had fewer symptoms of abuse-specific parental distress at both six and twelve months than the children who had been treated with CCT (Deblinger et al., 2006).

However, in a Cochrane review of ten randomized and quasi-randomized studies, criticism is made of selective reporting of trauma related data in the Cohen et al studies included in the review (Macdonald et al., 2009). Such criticism is relevant since many research studies commonly use PTSD related symptoms as indicators of treatment outcome.

A more recent RCT (N = 64) with three groups of very young children (aged three to six years old) traumatized from either acute single blow trauma, from witnessing domestic violence and from being victims of Hurricane Katrina compared treatment with TF-CBT and waiting list assignment (Scheeringa, Weems, Cohen, Amaya-Jackson, & Guthrie, 2011). The findings suggested that TF-CBT was indeed feasible and effective with very young children, showing greater effect sizes for PTSD than for co-morbid disorders (Scheeringa et al., 2011). This study and other studies with older children suggest that TF-CBT can be a good treatment method for children of all ages suffering from a range of trauma induced PTSD symptoms and not just for CSA victims.

A Cochrane Library Review investigating the efficacy of CBT on CSA victims up to eighteen years of age in ten studies found that, although CBT may have a positive impact on the sequelae of CSA, most results were statistically insignificant. The review authors urge caution in the interpretation of results from trials with CSA victims, having noted methodological problems in certain studies including selective reporting of data and serious weaknesses in implementation and data analyses (Macdonald et al., 2009). Nevertheless the review concludes that *'There is nothing in this review to detract from the general consensus that cognitive-behavioral approaches, particularly those that are trauma-focused, merit consideration as a treatment of choice for sexually abused children who are experiencing adverse consequences of that abuse'* (Macdonald et al., 2009, p. 10).

#### Types of treatment available for juvenile perpetrators of CSA:

##### *CBT*

Meta-analyses and reviews of treatment approaches for adult sex offenders have generally concluded that men who complete treatment, from late adolescence onwards show less recidivism than controls and that cognitive behavioural

treatment (CBT) approaches show more robust effects than non behavioral approaches (Losel & Schmucker, 2005; Brooks-Gordon et al., 2006).

Taken together, the results of several meta-analyses and follow up of randomized control trials (RCTs) with children and young people showing sexually harmful behavior, support short term, sexually abusive behavior focused CBT interventions, particularly those such as MST, which also include substantive input to caregivers (Walker, McGovern, Poey & Otis, 2004; Carpentier, Silovsky & Chaffin, 2006; Letourneau, Chapman & Schoenwald, 2008; Borduin, Schaeffer & Heiblum, 2009).

Younger age in the children receiving help may be important in achieving good outcomes. A ten year prospective follow up RCT of 135 children aged five to twelve years old with sexual behavior problems compared those who were given a twelve session group cognitive behavioural intervention with those given group play sessions and a control group of non-sexual behaviour children. The CBT group had fewer future sexual offences than the play therapy group (2% vs 10%) but did not differ from the control group (3%). The authors concluded that the results support the use of short term CBT for younger oversexualised children and also that the low rate of future offences on ten year follow up did not support the notion that children with sexual behavior problems would grow up to be adolescent or adult sex offenders (Carpentier et al., 2006).

A meta-analysis of nine studies describing treatment (including MST, CBT and Treatment as Usual) for juvenile sexual offenders showed that treatment had a statistically significant effect in reducing sexual recidivism a finding supported by many other treatment outcome studies (Reitzel & Carbonell, 2006; Carpentier et al., 2006; Borduin et al., 2009). However, the point has also been made that prior assessment should distinguish between generalist and specialist sex offenders since the latter may have unique risk and aetiological factors requiring a targeted treatment approach (Pullman & Seto, 2002).

Pragmatic and safeguarding considerations are also essential in providing CBT (and other therapies) whether individual or group based, in a community context. Clinical experience has shown the value of providing concurrent support work for carers of the children in treatment since these adults will be expected to reinforce the new thinking proposed in the CBT sessions and to deal with any acting out behaviours during treatment (Griffin, Williams, Hawkes & Vizard, 1997). A structured and holistic approach to CBT in a community based setting has also emphasized the need for trained staff to have carers actively involved in the treatment process and qualified supervisors to support delivery of the manualised programme (McCrorry et al., 2011).

### *Multi-systemic therapy (MST)*

MST is a well established, home based intervention approach, using a family rehabilitation approach for young people aged 12-18 years old with general psychosocial and behavioural problems (Henggeler et al., 1986). A recent 21.9 year follow up to an RCT with serious and violent juvenile offenders showed that

recidivism rates were significantly lower for MST compared with Individual Therapy (IT) participants ( 34.8% vs 54.8%) (Sawyer & Borduin, 2011). An earlier Cochrane review of eight randomized controlled trials of MST for non-sexual, social, emotional and behavioural problems in the USA, Canada and Norway warned that caution was needed stating that: *'it is premature to draw conclusions about the effectiveness of MST compared with other services'* (Littell, Campbell, Green & Toews, 2005). However overall, the research outcomes from MST for general antisocial behavior problems are good with cost benefits claimed from reduced offending by youth (Borduin et al 2009, p. 651).

There are currently thirteen adaptations of MST to other problems being considered with four in the later stages of development - (Child Abuse & Neglect; Psychiatric; Substance Abuse; Problem Sexual Behavior (PSB) (MST Services 2012). A one year follow up of an effectiveness trial for MST-PSB, randomized juvenile sexual offenders to MST-PSB or to treatment as usual (TAU). The results showed *'significant reductions in sexual behavior problems, delinquency, substance abuse, externalizing symptoms and out-of-home-placements'*. The authors conclude that MST-PSB holds considerable promise in meeting the needs of juvenile sexual offenders (Letourneau et al., 2009, p. 1).

The first UK based MST-PSB adaptation is currently underway in the Brandon Centre in London, dealing with young people between ten to seventeen years old with PSB including sexual offending. Over a period of five to seven months, the MST-PSB programme will provide intensive, in-home family work and individual work (including CBT) which aims to reduce denial and increase youth accountability for problem sexual behavior (Brandon Centre, 2012).

### | *Dynamic Therapy*

In contrast to victims of sexual abuse, there is a sparse literature on the use of dynamic or psychoanalytical therapies with young people who sexually abuse. One reason for this may be that working only with the historical risk factors (e.g. child abuse) which contributed to the young person's behaviour, does not allow for safe practice in the here and now with the sexually abusive behaviour which has harmed victims and brought the young person to therapy.

It has been noted that: *'In treating juvenile sexual offenders, deeply abstract and delving psychodynamic therapy is of little practical use. If the goals are self awareness and insight and subsequent cognitive and behavioral change, more pragmatic versions of psychodynamic therapy are called for'* (Rich, 2011, p. 291). The author goes on to suggest that psychodynamic therapy with this client group will need to be interpersonal, build the therapeutic relationship and operate within a more concrete and less abstract framework which can focus on improved self-awareness and personal development (Rich, 2011).

Clinical experience with higher risk young people showing sexually harmful behavior shows that only a minority of very carefully assessed and supervised individuals can deal with the demands of intensive, dynamic therapy in a non-residential setting. Furthermore, close inter-agency supervision of the young

person in the community is needed to minimize risk and to ensure public protection during dynamic therapy which can raise arousal and acting out (Vizard & Usiskin, 1999).

A study of treatment outcome for male and female adolescents with sexually inappropriate and aggressive behaviours in a residential psychiatric facility used a multimodal/holistic approach within a therapeutic milieu to tackle distorted attitudes and beliefs (Jones, Chancey, Lowe & Risler, 2010). The results showed a decrease in deviant sexual interest scores from intake to discharge, particularly in those with an existing interest in sexual violence. The authors speculate that these findings suggest that some youth who sexually abuse may be motivated to do so by anger rather than by deviant sexual interests (Jones et al., 2010).

A related review looking at the clinical implications of working with sexually abusive adolescents in secure settings concluded that specialized treatment programs result in lower recidivism rates with the role of supportive work for family and caregivers emphasized (Worling & Langton, 2012).

The overall conclusion from the literature appears to be that well organized treatment approaches of all types, delivered by trained and supervised staff, for adolescents showing sexually harmful behavior appear to have good outcomes. In a meta-analysis of ten studies it was noted that *'the results were surprisingly encouraging, suggesting that treatments for male adolescent sex offenders appear generally effective (r = .37)'* (Walker et al., 2004, p.281).

### Conclusions

Research shows that 16.5% of 11-17 year olds have experienced either contact or non-contact sexual abuse by an adult or peer and that 57.5% of the contact sexual abuse was perpetrated by children or young people themselves, nearly twice as frequent as that perpetrated by adults (34.1%) (Radford et al, 2011). Since being sexually abused or perpetrating the abuse is associated with increased psychopathology and involvement in the criminal justice system, significant costs for the public purse are incurred across the lifespan of both victims and perpetrators (Welch, 2003; Utting et al., 2007).

Assessment of child victims of sexual abuse is now generally accepted as a core function of CAMHS (Child and Adolescent Mental Health Services), probably because so many children presenting to CAMHS with other problems turn out to have been sexually victimised.

However, in contrast, there is widespread reluctance within CAMHS to undertake direct clinical assessments of children who sexually abuse, for reasons which remain unclear. They may fail to appreciate that sexually harmful behaviour in younger children can be a marker for later mental health problems including poor emotional and behavioural regulation with an increased risk of poor adult outcomes (McCorry et al., 2008).

The author's clinical experience in this field over several decades suggests that professionals are also disconcerted by the combination of aggression and vulnerability so often seen in juvenile perpetrators of sexual abuse. Practitioners may also be fearful of interviewing these children and confronting a possible aggressive response as well as a likely denial of responsibility for the sexually abusive behaviour. They may also be reluctant to prepare reports or to give evidence in contested Court proceedings in these cases.

Hence, a more 'forensic' professional stance is needed in relation to working with children and older young people such that their simultaneously vulnerable and potentially dangerous presentations can be observed, assessed and reported upon in a neutral manner. This stance should be acquired through training and rigorous supervision of clinical work.

Since children who have been sexually abused have been recognized by professionals for longer than those who perpetrate abuse, it is not surprising that treatment programmes for the needs of victims are far better established in the UK than those for child perpetrators (Allnock et al., 2009).

The burden of psychopathology, poor parenting and possible criminality associated with untreated CSA victims and their juvenile perpetrators has major personal and financial implications for the children concerned and for society as a whole (Welch, 2003; Utting et al., 2007). It follows that effective early intervention with both victimized and over-sexualised children will reap major benefits in terms of preventing sexual abuse and its' long term sequelae.

***Key Practitioner Messages for work with victims & juvenile perpetrators of CSA***

<b>Earliest possible intervention with both groups</b>	Although maltreatment and adversity may negatively affect a child's developing brain and general wellbeing, recovery is possible when effective interventions are delivered as early as possible.
	Professionals should always act when there is reasonable suspicion of abuse or abusive behavior, as child victims and perpetrators will become more damaged if left unassisted in abusive situations.
<b>The Role of Practitioners</b>	The impact of this disturbing work on the practitioners should be remembered by supervisors and managers. Practitioners should have regular supervision (not just line management) by fully trained, registered and experienced clinicians, plus external staff support or consultation if necessary.
	Failure of professionals to act on reasonable suspicion of abuse or abusive behaviour colludes with the forces of denial always present in the systems around these children.
	No practitioner should find him/herself working 'solo' with a child victim or perpetrator in a situation where no other individuals or agencies are involved.

	A systemic, interagency approach is needed, for safeguarding reasons, and to handle the new disclosures of abuse that regularly occur with this client group.
<b>Appropriate Training</b>	Live supervision of clinical assessments and treatment should be provided during training where possible.
	Complex cases should be seen by more senior practitioners, who should have specialist training and experience.
	Expert witness training is necessary for practitioners who will give evidence in child victim or perpetrator cases in family or criminal court contexts.
<b>Assessment Issues</b>	A different, more 'forensic' mindset is needed when working with juvenile perpetrators, as opposed to victims. Difficult questions about sexually abusive behavior, criminal responsibility, empathy, insight and remorse will need to be asked of young people in full or partial denial. The case has probably been sent to the team for these questions to be asked, so training and support for practitioners will be needed.
<b>Victim-Perpetrator Cases</b>	Many but not all juvenile sexual perpetrators have been sexually abused. Possible re-enactment of the child's own sexual abuse in subsequent perpetration should be noted. PTSD flashbacks to the sexual abuse experience may be both arousing and distressing for the child perpetrator. Assessment of many other risk, protective and mental health factors is needed for both victimized and non victimized sexual perpetrators.
<b>Treatment Issues</b>	A plan for treatment is needed before starting. Pre-treatment assessment should identify whether any treatment is appropriate, and if so the model, treatment duration and whether there should be a subsequent treatment input or a psychosocial intervention.
	Manualised treatment programmes can be a great thing. However, individual children's needs may vary slightly or very considerably from what is recommended in the manual! Some children may need specially adapted programmes to cater for their complex impairments.
	Post treatment review meetings should help the client and carers reinforce learning from treatment, reduce psychiatric symptoms and recidivism. Importantly, these reviews will show that someone cares.
<b>Future Research</b>	Future research should investigate long-term adult outcomes of victims and perpetrators of SHB who: <ol style="list-style-type: none"> <li>1. Have an early onset of SHB (under 10 years old) to track any life course persistent developmental pathways towards adult offending</li> <li>2. Have received treatment, to inform on persistence and/or desistence of sexualized or abusive behavior post treatment</li> <li>3. Have evidence of callous-unemotional (CU) traits to track emergence of any adult psychopathy</li> </ol>

	<p>MST is effective for general delinquency. CBT is effective for victimized children and for sexually harmful behaviour.</p> <p>Future research should investigate whether MST-PSB or CBT-PSB is more effective with sexually harmful behaviour.</p> <p>Parenting interventions for very disturbed younger children with SHB and CU traits should be developed to try to maintain a home placement and to avoid reception into care.</p>
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