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Chapter Six

The Clinical Assessment of Young People with Sexually Abusive Behaviour.

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INTRODUCTION

This chapter outlines some basic ideas that can be used to plan and conduct a clinical assessment for a young person referred for problems with sexually abusive behaviour. It begins by considering key characteristics that reflect a good approach to clinical assessment with this population. It then considers aspects of motivation that are important in planning such assessments. It will outline the main areas usually covered during a clinical assessment and concludes with ideas on formulating information from the assessment, report writing, and contracting for intervention. We use fictional case material to illustrate key points made regarding assessment throughout. The ideas contained in this chapter are drawn from a variety of sources including Beckett (1994), Graham, Richardson and Bhate (1997), Becker, (1998), APA Task Force (1999), Will (1999), and Sheerin and O’ Reilly (2000), and O’ Reilly (2001). Each of these authors provide useful information and ideas on conducting clinical assessments with young people who sexually abuse.

CHARACTERISTICS OF A GOOD ASSESSMENT

Beckett, (1994) starts his consideration of completing an assessment with adults who have committed sexual offences by outlining what he considers to be four characteristics of a good assessment. O’ Reilly (2001) takes up this idea in relation to adolescents and suggests the following as key characteristics of a good clinical assessment:
1. It allows for the fact that the young person and his family can be at various points along a continuum from complete denial to acknowledgement of sexually abusive behaviour.
2. It is guided by clear theoretical models and research findings.
3. It aims to build a holistic understanding of the young person’s life and therapeutic needs.
4. The assessment team strive to create a non-collusive collaborative relationship with the young person and his family.
5. The assessment team adopt therapist features that are linked with positive outcome. Marshall, Anderson and Fernandez (1999) have identified a number of these and they are listed in the table 6-1 below.
6. It incorporates strategies to motivate engagement in assessment and intervention.
7. It makes a distinction between the young person’s unacceptable and harmful behaviours and the young person’s underlying personality.
8. It conveys to the young person and his family that the crises and dilemmas they face are understood by the assessment team.
9. It offers hope when appropriate.
10. It assumes that most young people with sexually abusive behaviour will not be motivated to disclose full details of their offending behaviour during the assessment.
11. Strategies for the detection of the presentation of misleading information by the young person are appropriately incorporated into the assessment.
12. It has access to third party information such as victim statements to police, courts, and social services.
13. Psychological testing is included as an integral part of the assessment.
14. It attempts a formulation of the strengths and weaknesses of the young person and his family that can be used to support them in rebuilding their lives in an abuse free way.
15. It formulates a considered opinion of the degree of future risk of re-offending posed by the young person.
16. It concludes with feedback to the young person and his care-givers on the formulations reached as an outcome of the assessment and any recommendations for intervention that logically follow.
17. It concludes with the offer of a contract for intervention if this is the recommendation of the assessment team.
18. It shares information from the assessment with the child protection network and the judicial system.
UNDERSTANDING THE YOUNG PERSON’S CURRENT STAGE OF MOTIVATION FOR PARTICIPATION IN AN ASSESSMENT

O’Reilly, Morrison, Sheerin, and Carr (2001) consider the usefulness of the Prochaska and DiClemente Transtheoretical Model of Motivation (Prochaska and DiClemente, 1983, 1986) for developing intervention techniques with young people who engage in sexually abusive behaviour. This model is also particularly helpful in understanding the level of motivation of young people as they attend for assessment. Prochaska and DiClemente’s model simply describes a person’s motivation to tackle problematic behaviour as consisting of five potential stages. These are:

1. A Pre-contemplative Stage of Motivation, where the person has not yet acknowledged that he has a problem that needs to be addressed. This lack of acknowledgement of a problem may reflect a variety of influences including denial of his offending behaviour, distorted thinking about the impact of the behaviour on those victimised, fear of the consequences of admitting to his behaviour, and shame. DiClemente (1991) subdivides this stage into four subtypes of pre-contemplation based on individual characteristics of reluctance, rebelliousness, resignation, and rationalisation.

2. A Contemplative Stage of Motivation, where the young person acknowledges that he has a problem with sexually abusive behaviour and is in a position to think about the possibility of change. While such a person may be open to a consideration that change may be required this is not to say that they will necessarily view change as a positive thing. Instead their consideration of change may be such that they conclude that they do not wish to move in a direction where they will instigate change.

3. A Determination Stage of Motivation, reflects a point where a young person has considered the need for change and has decided that change is indeed required. However, their determination to change does not mean that change will automatically follow, that the most appropriate form of change will be chosen, that positive changes will be maintained in the long-run, or that the young person will lose their ambivalence about change. Commitment to change in the determination stage may benefit from support.

4. An Action Stage of Motivation, where a young person embarks on the implementation of his plans for changing his behaviour in a positive manner. In essence this may reflect a point in time where a young person seriously commits and begins to implement new behaviours, ways of thinking and ways of expressing his emotions that are opened up to him by a good intervention programme in conjunction with support from significant people in his life.

5. A Maintenance Stage of Motivation, where the person is concerned with the continuation of changes that have successfully been made to address his problematic behaviour.
relation to addressing sexually abusive behaviour this can be equated to a relapse prevention stage of change.

It is our experience that young people present for assessment at intervention programmes at various points along this continuum of change. A key part of the assessment process is the formulation of ideas on where each individual lies along this model. If we can recognise where a young person is with regard to their readiness for change we can allow this to positively influence our thinking on how to approach him during the course of the assessment in a way that will facilitate him in moving from his presenting stage of motivation for change to the next. Di Clemente (1991) provides suggestions on how we might orientate our conversations with people at different stages of change in a way that will be more likely to be productive which are included in table 6-2 below.

**INSERT TABLE 6-2 ABOUT HERE**

**THE STRUCTURE AND CONTENT OF ASSESSMENT**

Graham, Richardson and Bhaté (1997) indicate that care needs to be given to structuring an assessment as this can play a vital role in ensuring that the young person can begin to view the process as positive and potentially helpful to him. In line with their ideas of we have found that completing assessments across a number of sessions, including various combinations of involved individuals, the inclusion of psychometric testing, and contracting from the outset for feedback and potential intervention provides a good structure around which a comprehensive assessment can be planned. The remainder of this chapter will outline the main features that can be used in such an assessment.

With regard to the content of an assessment with a young person who has sexually abused the American Psychiatric Association Task Force (APA Task Force, 1999) outline the contents of what they regard as constituting a comprehensive assessment. Table 6-3 summarises the main areas they recommend for coverage by the assessment team. The questions outlined later in this chapter should be used to elicit information pertaining to each of these areas as appropriate for the individual concerned.

**INSERT TABLE 6-3 ABOUT HERE**
Assessment session 1:
Meeting with the young person and primary care-giver(s)

The initial task in completing an assessment is to ensure that you contract with the young person and his parents or legal guardians for permission to complete the assessment. This allows an opportunity to outline and agree the content of the material to be covered during the course of the assessment and to ensure that all involved are clear and consent to the process. It also allows the clinical team completing the assessment to state clearly that their purpose in conducting the assessment is to reach a concluding point where there is a clear formulation of the young person’s sexually abusive behaviour that suggests an appropriate plan for intervention.

As suggested by Graham, Richardson and Bha (1997) taking a developmental history can be useful to begin the information gathering stage of an assessment for a number of reasons. Firstly, it is usually reassuring and less threatening for the young person and his family not to be directly asked about the sexually abusive behaviour during the first appointment. It can be very helpful to inform participants of this at the outset of the session. We usually begin by asking the young person directly how they felt about attending for the appointment. This usually elicits a variety of responses from ‘didn’t mind coming’ to ‘didn’t want to come’.

Therapist: ‘Peter, do you mind if I ask you about how you felt about coming to the centre today for this assessment?’
Peter: ‘Eh… didn’t want to come.’
Therapist: ‘What do you think today is going to be about?’
Peter: ‘About what happened with Eleanor……. Its over and won’t happen again so I just want to get on with things.’
Therapist: ‘Ok. Well, you are right, coming to the centre for this assessment is about what happened with Eleanor. Many of the young people who come to see us attend for similar reasons. We have learnt from them that most people feel like you seem to when they first come here. From what you have said already it sounds like you acknowledge what happened and have a clear idea that you do not want something similar to happen again. I think that is very good. Like you, most young people we have met who have had similar difficulties will tell us when they first come here that they do not need any help. What we would like to do over the course of four or five meetings is to meet with you and important people in your life to try and understand from you what happened, and to try and understand how you are able to be so clear that it is not a problem that is going to recur for you. During the course of the assessment we hope to work chiefly on these two things understanding what happened and understanding the strengths you have or are beginning to develop that will help you and those people who support you to ensure that you have clear plans and strategies to avoid problems with sexually abusive behaviour in the future. Perhaps at the end of the assessment we will come to agree with you that you have a clear understanding of what happened and have clear plans about how to avoid repeating the
behaviour again in the future. Perhaps we will find that there are areas of your understanding of what happened that it would be helpful for you to work some more on. If that’s the case then we might be able to help you with this. Perhaps there will be things that other people in a similar situation to you have found helpful that you have not yet thought about. If this is the case then we would be happy to help you to learn about them. Does this sound okay to you?’

Peter: ‘I suppose.’

Therapist: ‘Good. Then today we would like to start by asking you and the other people here about your experiences growing up. This helps us to get to know you and them a little better. Some of the things we will ask about concern when you were a baby so you probably do not remember them. Other questions will be about what things have been like as you have grown up. These will be things like what going to school was like, what type of things you enjoy doing and who are the most important people in your life. Do you think you will be able to help us with this type of stuff?’

Peter: ‘Suppose so.’

Therapist: ‘Good. It also means that we will not be asking you directly about what happened with Eleanor today. We will ask you about this later on when you have had the chance to get to know us a little better. Does this sound okay to you?’

Peter: ‘Yeah.’

In introducing the assessment in this way a number of important things can be accomplished:

- An attempt is made to establish a co-operative and respectful working relationship with the young person that is characteristic of a cognitive behavioural model of practice.
- An attempt is made to establish a contract where the young person is an active participant in the assessment while receiving support from significant others. This establishes the format that will be aimed for in intervention when the young person will be an active participant in the programme while receiving support from significant others.
- The young person’s perspective is acknowledged and used as a starting point for contracting for the assessment: ‘From what you said already it sounds like you acknowledge what happened and have a clear idea that you do not want something similar to happen again. I think that is very good. Like you, most young people we have met’.
- The young person is informed that others have faced similar difficulties and have received help from the assessment and intervention service.
- The young person is provided with positive reinforcement for his responses from the therapist: ‘Good’, ‘You are right’, ‘I think that is very good’.
- An attempt is made to put the young person at ease by informing him that his abusive behaviour will not be addressed directly during the first appointment. This avoids eliciting the young person’s strongest resistance to talking to the assessment team on their first meeting and allows the assessment to begin with topics which are usually less threatening for the young person and his family to discuss.
• The young person and his family are given a clear message that the assessment team wish to understand the young person in a broad way and are not solely interested in the abusive behaviour or in finding people to blame for what has happened.
• The content of the assessment is outlined.
• A number of potential outcomes to the assessment are signalled starting from the feedback meeting. These range from no further contact with the service to working on developing a better understanding of the build-up to the abusive behaviour to developing relapse prevention plans and skills.

A number of authors (Carr, 1999, Gilberg, 1995, Sheerin & O’ Reilly, 2000) describe the main areas that are usually covered while completing a developmental history. Broadly speaking the aim of collecting developmental information is to gain an understanding of the developmental pathway that has been followed by an individual so we can begin to construct a formulation of potential predisposing, precipitating, and maintaining factors that provide a context to the young person’s sexually abusive behaviour. It should also identify individual strengths that may be important in planning for the prevention of further sexually abusive behaviour. The main areas that are usually enquired about during a developmental interview are outlined in table 6-4.

**INSERT TABLE 6-4 ABOUT HERE**

**Assessment session two:**
**Meeting with primary care-giver(s)**

The second session can usefully be used to meet with the young person’s primary care-giver(s). There are a number of potential advantages to having such an appointment. These include the following:
• It allows the primary care-giver(s) an opportunity to talk about any important issues that they may feel uncomfortable discussing in the presence of the young person.
• It introduces or confirms the idea that a key part of successful assessment and intervention that aims to support a young person in refraining from further sexually abusive behaviour is contributed by the care-giver(s), and that the assessment and intervention team would like to support them in this.
• It provides an opportunity for the identification of care-giver resources that may be supportive
of the young person in his efforts to effectively deal with his sexually abusive behaviour.

- It provides an opportunity to assess the primary care-giver(s) readiness to support the young person in addressing and preventing their sexually abusive behaviour.
- It allows an opportunity for the assessment team to further cement their working alliance with the primary care-giver(s).
- It allows an opportunity to explore in more detail whether family dynamics such as a coercive style of interaction as identified by the Barbaree, Marshall and McCormick (1998) model have been a part of the young person’s experience and need to be integrated into the intervention plan.

The main content areas that can be covered in this part of the assessment are outlined in table 6-5.

**INSERT TABLE 6-5 ABOUT HERE**

In conducting this type of interview the assessment team need to exercise sensitivity and good judgement in discussing difficult life experiences for the family at a level and a pace that is set by the young person’s primary care-givers. An important balance needs to be struck between respectfully identifying difficult areas in a family’s experience while also identifying strengths and coping mechanisms that have been utilised by the family. At the end of this part of the assessment it is helpful to draw the discussion to a conclusion by considering what the primary care-givers regard as a positive future developmental pathway for the young person. This can help to conclude the meeting on a positive note and also to begin to co-construct a concrete expression of clear and healthy goals for the young person. Questions such as ‘Given all we have discussed so far in the assessment if you had three positive goals or wishes for Peter for his future what would they be?’ can facilitate a useful concluding discussion for the meeting.

**Assessment session three:**

**Individual meeting with the young person**

The third session of the assessment allows an opportunity for the young person to be seen individually. There are a number of tasks that can be completed during this meeting. Further efforts can be made to build on whatever level of working relationship established during the first appointment. It also allows for the assessment of individual strengths and difficulties (acknowledgement of abusive behaviour, readiness for change, low mood, conduct problems, or
attention and concentration problems. It also allows for the introduction of a discussion of sexual behaviour, experiences and attitudes separate from the young person’s abusive behaviour. This allows the assessment team to begin to understand the developmental pathway that the young person’s sexuality has been following. It further provides an opportunity for the young person to disclose any negative or abusive sexual experiences that they have had in the past in the context of a discussion other than one concerning their own abusive behaviour. Finally, a discussion on sexuality at this point prepares the ground for the assessment of the young person’s sexually abusive behaviour during the fourth and final appointment.

Table 6-6 outlines the main content areas that can be covered during the course of assessment session three. It begins with a gradual discussion of interests and activities. The questions on sexuality and sexual development are those suggested by Becker (1998) as constituting a comprehensive sexual development history. In approaching this part of the interview Becker makes a number of sensible and helpful recommendations to make the discussion less embarrassing for the young person and include: (1) Inform the young person that as part of your work you have completed many similar assessments in the past (if this is the case) and that there is nothing to be embarrassed about. (2) Remind the young person that the purpose of the assessment is gain a good understanding of him and the type of assistance that it will be most helpful for him to receive. (3) Be aware of your body language and responses given to the content of what the young person may say to ensure that this does not provide negative feedback to the young person. In asking about past sexual experiences Becker suggests that presenting questions to the young person in a neutral fashion such as ‘When was the first time you touched someone in a sexual way?’ or ‘When was the first time someone touched you in a sexual way?’ allows the interviewee to disclose normative experiences but also to disclose information on non-normative or abusive experiences without being directly prompted to do so.

**INSERT TABLE 6-6 ABOUT HERE**

**Assessment session four:**

**Individual meeting with the young person**

In the final assessment interview meeting the primary objective is to gain an understanding of the specifics of the young person’s sexually abusive behaviour that will allow us to construct a formulation of his difficulties and so suggest an appropriate plan for intervention. This is
potentially the most difficult of the assessment meetings for the young person and every effort should be made to facilitate him in as full a participation as is possible for him. Each of the characteristics of a good assessment outlined at the start of this chapter have a particular relevance at this point. In beginning this appointment it can be helpful to remind the young person of some important facts that established the basis for the contract for the assessment including that the purpose of the assessment is not to make judgements about him and his abusive behaviour, to chastise him for his behaviour, or to cause him embarrassment. Instead the purpose is to work with the young person to build up an understanding of what has happened and to develop a strategy to support him in developing clear plans and skills that will make his behaviour safe in the future.

In asking the young person about his sexually abusive behaviour the assessment team need to exercise good judgement with regard to how many offences they discuss in detail if the young person has more than one known offence. In general it can be useful to establish how many offences the young person has perpetrated and to discuss in detail the most recent offence. It should be established if this represents a typical incidence, if not detail about a typical incident should be included in the assessment. It is usually also instructive to ask for detail about the first offence.

Table 6-7 outlines the main areas that can be covered during assessment interview four. It is designed to facilitate the construction of a formulation of the young person’s abusive behaviour that informs the planning of appropriate interventions using cognitive behavioural and relapse prevention models. It is also informed by Lane’s cycle of offending model (Lane, 1997). Consequently it attempts to elaborate a comprehensive picture of the offence by detailing antecedent factors, abusive behaviour related factors, and consequential factors following on from the abusive behaviour. Questioning concentrates on inviting the young person to discuss situations, thoughts, feelings, and behaviours.

On concluding assessment session four it can be helpful to provide the young person with positive feedback that reinforces his participation to date that may help to encourage his continued involvement with the team as they work towards establishing a contract for intervention if this is to be the outcome of the assessment. This positive feedback should be encouraging but realistically reflect the level of participation that the young person has been able to provide. A client who has struggled to co-operate with the assessment might appropriately receive feedback that provides
encouragement by acknowledging his level of involvement with the process to date, his struggle with achieving a fuller level of participation but also sign-posts the potential benefits of participation in intervention from his current position:

**Therapist:** Thank you Peter for coming to meet us today and for the other times when you came to see us recently. We are glad that you did this. We understand that this is a difficult assessment to take part in so well done on seeing it through to completion. It’s been clear to us that today was more difficult for you than our other meetings. It seems you have found it a struggle to understand and tell us about your understanding of your sexually abusive behaviour difficulties. A thought that occurs to me at this point is that if you were offered a place on an intervention programme an important area the team could try to help you with is developing your understanding of what happened. You could then use this understanding to help you further with the goal that you have set yourself of avoiding problems with sexually abusive behaviour in the future. I know they have been able to help people in this way before. What do you think about this approach might be helpful to you if it is available?’

In contrast a young person who has been better able to co-operate with the assessment and has expressed clearly a reasonable first account of his abusive behaviour and states a wish to participate in intervention might be given feedback that not only provides him with encouragement but introduces him to some of the tasks he will complete during intervention:

**Therapist:** Thanks Peter for the way you have taken part in the assessment. Understanding and admitting what happened is an important part in reaching your goal of not repeating your abusive behaviour. The treatment team have a lot of experience in helping people further develop their understanding of their abusive behaviour. I am confident that they will also be able to help you with this. There are also other positive skills that they can teach you that will help you to keep clear of problems with sexually abusive behaviour in the future. These include helping you with your understanding of the harmful impact of your abusive behaviour on the person you assaulted, on her family, your family and on you. They can also help you to build up what’s called a Relapse Prevention Plan. This is a personal plan and a collection of useful practical skills, like anger management skills, that the team help you develop that you can use to avoid further problems with sexually abusive behaviour. If there is a place available on the intervention programme for you I think you can do very well there.

**Case example**

Below is a written report following the style of assessment outlined in this chapter. The case example for Peter Hill is fictional but we hope realistic. Figure 6-1 provides a genogram for the Hill family while figure 6-2 provides a diagram summarising the case formulation. The approach to case formulation utilised emphasises predisposing, precipitating, maintaining, and protective factors and follows the model for formulating clinical problems developed by Carr (1999).
Name: Peter Hill.


Family Composition:

Karen McKenzie – mother, 37 years.
Tom McKenzie – step-father, 37 years.
Adam Hill – father, 48 years.
Emma Hill – sister, 18 years.
Peter Hill – referred client, 14 years.
Mark McKenzie, half-brother, 7 years.
Eleanor McKenzie, half-sister, 5 years.

The Nature of This Report.

This report outlines the findings from a comprehensive assessment with Peter Hill (14 years), his mother Karen McKenzie, and his step-father Tom McKenzie following confirmed allegations that he had sexually abused his half-sister Eleanor (5 years). The information in this report is drawn from the following sources. The letter of referral from Jim Burns (Social Worker), the CSA assessment reports from the Community Care Social Work Team, individual and joint assessment sessions with Peter, Karen and Tom, and psychological testing with Peter.

Reason for Referral:

Peter Hill was referred for assessment by Jim Burns, Community Care Social Worker. In his letter of referral Jim stated the reason for referral as follows:

'Peter Hill, 14 years, has admitted to sexually abusing his 5 year-old half-sister Eleanor on three separate occasions. His abusive behaviour came to light when Eleanor told her mum that that Peter had been “doing bold things” to her when babysitting. Karen took Eleanor to her local General Practitioner who made a referral to Community Care Social Services. At an assessment meeting with two social workers Eleanor repeated that Peter had been “doing bold things” to her while he was babysitting. She disclosed that this included touching her vagina with his hand and getting her to touch his penis. Eleanor reports that Peter behaved in this way “a few times” but was unable to specify how many. When confronted by his mum and step-father Peter initially denied Eleanor’s allegation. However, after the family went to their General Practitioner Peter admitted to his mum that ”something happened”. During an interview with the social work team Peter admitted that Eleanor’s allegations that he had sexually abused her were correct. According to Peter he touched Eleanor on the vagina on three separate occasions. These incidents occurred while he was baby-sitting Eleanor and their brother Mark while both parents were at work. Peter denies
getting Eleanor to touch him. He reports that he engaged in the abusive behaviour because he was curious to see what it would be like.

The family are willing to accept a referral for Peter for an assessment of his sexually abusive behaviour. However, they have decided against making a formal complaint to the police. Consequently although the police have been made aware of the incidents through community care notification no charges are pending at present. Peter is currently residing in a Health Service Residential Home on a voluntary care basis. I would be grateful if your team could see Peter and his family for assessment with a view to his participation in the adolescent intervention programme.'

Developmental History.

During the course of the assessment the following developmental information regarding Peter was reported.

Peter was born 5 weeks before full-term. He had a low-birth-weight of 3 lbs. Following delivery Peter was placed on an incubator for three weeks. On discharge from hospital Peter is reported to have been a healthy baby. He attained motor and speech and language milestones within normal limits. He is reported to have been a ‘hyper’ child who ‘was always on the go and into everything, and constantly demanded attention.’

Karen reports that Peter’s first two years of childhood were the final two years of her marriage to his father Adam. She reports that this time was marked by a significant amount of marital conflict. She indicated that Adam had alcohol abuse problems and that when he was drunk he would frequently become violent towards her and at times towards their two children. Karen explained that during her initial separation and subsequent divorce from Adam she became depressed and was prescribed anti-depressant medication by her General Practitioner for roughly one year. Since this time she has not had any recurrence of depressive symptoms. However, she acknowledges that this was a particularly difficult time for Peter and his older sister Emma and that both children spent long periods of time staying with Karen’s sister Frances.

Peter began to attend his local National School at four years of age. His teachers reported that he had significant behavioural problems through-out his time in primary school. In particular his behaviour is reported to have been characterised by poor concentration, over-activity, excessive talking, frequently leaving his seat during class, and significant levels of fighting with classmates. Peter reports that he did not like primary school and that he was bullied by other pupils. Academically his performance during this time is described as ‘low-average’. From second-class onwards he attended a remedial teacher three times per week for additional tuition for reading and mathematics. At eight years of age Peter was referred by his school to the local child guidance service where he was assessed and diagnosed with Attention Deficit Hyperactivity Disorder. Peter was prescribed Ritalin and consequently enjoyed significant improvements in his concentration and general behaviour in school.

Peter enrolled at his local secondary school at twelve years of age. Although he has not experienced the same behavioural problems that he encountered during primary school he continues to have difficulty in establishing and maintaining friendships with peers.
Psychosexual Development.
Peter reports that he had his ‘first crush’ when he was eleven years of age. He reports that this was on a girl in his class who was the same age. He indicated that he has had two girl-friends but was unable to recall their names. He reported that he went out with each of these girls for just a few days and his level of intimacy with them involved kissing. Peter reports that he is only sexually attracted to females and that there is usually no age difference between him and the girls he likes. Peter indicated that he has not had a sexual experience that made him feel uncomfortable or which he regards as abusive. He reports that he has never seen ‘adult’ films or magazines. His parents report that Peter did not engage in any sexualised behaviour as a child that was a source of concern to them.

Family History.
As noted previously Karen reported significant difficulties, including intra-familial violence, in her relationship with her first husband Adam. She also described her family of origin as follows. Her mother Laura died when Karen was four years of age. Karen left home at seventeen years of age when she met Adam. She reports that initially things went well in her relationship with Adam but their relationship deteriorated with his increasing alcohol abuse. Karen explained that it is her understanding that Adam’s father Steve also had an alcohol abuse problem and that Adam’s brother Ken has served a prison sentence for car theft.

Karen reports that when Peter was six years of age she met her current partner Tom. The couple have been married seven years and have two children, Mark (6 years) and Eleanor (5 years). Karen indicated that since she met Tom the couple have enjoyed a stable and satisfying relationship. Prior to Eleanor’s disclosure of Peter’s abusive behaviour they have not encountered any significant problems within their family.

Karen, Tom and Peter report the following features of relationships within the family. Karen and Tom report that their relationship is close, mutually supportive with little conflict. Eleanor enjoys a close relationship with both her parents. Karen describes herself as particularly close to her sister Frances who has been very supportive of her in the past. Karen indicated that she deliberately has no contact with her first husband Adam and that he has chosen not to have any contact with Peter or Emma. Peter is reported to have a close relationship with his older sister Emma. Prior to the disclosure of Peter’s sexually abusive behaviour he was seen as having a reasonable relationship with his step-father Tom and his two half-siblings. However, since then there has been a considerable amount of strain in the relationships between all family members.

Peter’s Account of His Sexually Abusive Behaviour.
During the course of this assessment Peter acknowledged that he sexually abused Eleanor on three separate occasions over a one-month period. He reports that the incidents took place while he was baby-sitting in the evening time while both Karen and Tom were at work. In describing the incidents Peter reported that they ‘just happened’ and was unable to acknowledge any thoughts, feelings or actions that were part of the build-up to his abusive behaviour. He acknowledges touching his sister but denies getting her to touch him. After the abusive incidents he felt guilty and was afraid of getting caught. He told Eleanor not to tell anyone what he had done or they would both get into trouble. Peter reported that at the time he knew his behaviour was wrong because it was ‘bad’ for his sister. However, he was unable to be specific about the way in which it is bad for her. With regard to his future risk Peter reported that he views
himself as low risk of reoffending because he has ‘learnt a lesson from what has happened’. However, he was unable to describe any changes he has made to his relationships or behaviour that reflect the lessons he feels he has learnt. Peter reports that he is unsure if he needs to attend an intervention programme but is prepared to do so if this is a recommendation from the assessment.

**Psychometric Assessment.**
As part of this assessment Peter completed the Adolescent Sexual Offender Assessment Pack (ASOAP). The ASOAP is a battery of psychological tests currently being developed for use with adolescents who have engaged in sexually abusive behaviour. It is designed to measure personality, offence specific, and socially desirable responding factors thought to be related to sexually abusive behaviour. In some instances a young person’s current level of functioning on the questionnaires is compared to a preliminary pool of normative data collected from non-offending adolescents. In most instances the current normative data is based on adult non-offenders. Consequently, considerable caution is required in interpreting the results. However, the findings reported below regarding Peter have been discussed with him and he indicates that he feels they are accurate. They are also consistent with our clinical opinion of Peter based on his assessment.

The results from Peter’s completion of the ASOAP questionnaires indicate the following.

- An average level of honesty in responding to general behaviour and personality questionnaires.
- An average level of honesty in responding to questionnaires relating to sexual behaviour and sexual behaviour problems.
- Low self-esteem.
- An external locus of control (i.e., tends to place responsibility for own behaviour externally).
- Difficulties in cognitively taking the perspectives of others.
- Impulse control problems.
- Anger management difficulties, particularly through high levels of verbal and physical expression of anger.
- Victim empathy distortions specific to his sister Eleanor.
- An absence of global cognitive distortions regarding children and sexuality.
- The acknowledgement of previously undisclosed sexual behaviour problems of peeping and masturbating while secretly watching somebody.

**Summary and Recommendations.**
In summary, Peter Hill is a 14 year old who has acknowledged sexually abusing his five year old half-sister Eleanor on three separate occasions over a one month period. He admits to touching her in an inappropriate manner but denies that his abusive behaviour included getting his sister to touch him despite the fact that this was clearly reported by his sister during her disclosure. During the course of this assessment Peter and his family have identified a number of important predisposing, precipitating, and maintaining factors that may have had a role in the development of his sexually abusive behaviour. These are outlined above and summarised in figure 1 which accompanies this report along with a number of strengths that the family hope will help Peter work towards developing an abuse-free lifestyle in the future. Peter has shown a moderate degree of motivation to change his abusive behaviour during this assessment and has agreed to participate in a group based intervention programme for young people who have engaged in sexually abusive behaviour.
We strongly recommend that during his participation in this programme that Peter’s work should have a particular emphasis on the following.

- Improving Peter’s moderate degree of motivation to acknowledge and change his abusive behaviour.
- An acknowledgement by Peter of the full extent of his sexually abusive behaviour.
- The development of an understanding and acknowledgement of the emotional, cognitive and behavioural build-up to his abusive behaviour.
- Appropriate psycho-education on the effects of sexually abusive behaviour on people.
- The development of an appropriate awareness of the damaging effects of his abusive behaviour on Eleanor and other members of the family.
- The development of clear relapse prevention plans and skills.
- Building self-esteem.
- Building appropriate social skills.
- Encouraging perspective taking skills.
- Developing impulse control skills.
- Life story awareness work.
- Anger awareness and the development of anger management skills.
- Healthy relationship and sexuality education.

Joseph Lane,  
Clinical Psychologist.

Mary Street,  
Social Worker.

**INSERT FIGURE 6-2 ABOUT HERE**

**Feedback and contracting for intervention**

The final stage in a formal assessment of sexually abusive behaviour problems is the provision of feedback on problem formulation to the young person and his care-givers. This should form the basis for the negotiation and agreement of a plan for the young person and his family that logically follows from the formulation. The formulation model outlined in figure 6-2 gives a structure around which feedback can be given. At the conclusion of this meeting all concerned should be clear on the formulation and where possible working toward the intervention goals outlined in the report should be agreed. These goals should be outlined in a contract for intervention signed by the young person, key family members, and the intervention team. An example of a contract, including...
some key rules of the intervention programme such as confidentiality, respectful behaviour, and no aggression, is given in figure 6-3.

INSERT FIGURE 6-3 ABOUT HERE

SUMMARY

In this chapter we have tried to outline an approach to the assessment of young people with sexually abusive behaviour problems which is informed by theory and research. We have also attempted to incorporate simple strategies to maximise the young person’s motivation to participate in the assessment process. Clear guidelines on content and structure for assessment interviews were outlined. A case example was provided to illustrate how information from the assessment can be formulated to integrate and summaries findings and set intervention goals.

References


Table 6-1 Therapist features identified by Marshall, Anderson and Fernandez (1999) as reliably linked to a positive intervention outcome.

<table>
<thead>
<tr>
<th>Therapist features</th>
<th>Encourages active participation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Empathic</td>
<td>Directive and reflective</td>
</tr>
<tr>
<td>Non-collusive</td>
<td>Encourages pro-social attitudes</td>
</tr>
<tr>
<td>Respectful</td>
<td>Confident</td>
</tr>
<tr>
<td>Appropriately self-disclosing</td>
<td>Asks open ended questions.</td>
</tr>
<tr>
<td>Warm and friendly</td>
<td>Interested.</td>
</tr>
<tr>
<td>Appropriate use of humour</td>
<td>Deals with frustration and difficulties.</td>
</tr>
<tr>
<td>Sincere and genuine</td>
<td>Non-confrontational challenging.</td>
</tr>
<tr>
<td>Communicates clearly</td>
<td>Spends appropriate time on issues.</td>
</tr>
<tr>
<td>Rewarding and encouraging</td>
<td></td>
</tr>
</tbody>
</table>

**Empathic**

**Non-collusive**

**Respectful**

**Appropriately self-disclosing**

**Warm and friendly**

**Appropriate use of humour**

**Sincere and genuine**

**Communicates clearly**

**Rewarding and encouraging**

**Encourages active participation**

**Directive and reflective**

**Encourages pro-social attitudes**

**Confident**

**Asks open ended questions.**

**Interested.**

**Deals with frustration and difficulties.**

**Non-confrontational challenging.**

**Spends appropriate time on issues.**
Table 6-2 Strategies to promote change at different points on the Prochaska and Di Clemente transtheoretical model of readiness for change.

<table>
<thead>
<tr>
<th>Stage of Readiness</th>
<th>Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pre-contemplation:</strong></td>
<td>A person whose pre-contemplation is based on reluctance may be more likely to consider change when provided with individual feedback on their problem behaviour presented in a sensitive and empathic manner. A person whose pre-contemplation is based on rebelliousness may be more likely to consider change when provided with choices that make sense to them regarding their problematic behaviour framed within a discussion on why change may be a good idea. A person whose pre-contemplation is based on resignation may be more likely to consider change when provided with hope for the future and a discussion that explores barriers that are perceived to prevent change. A person whose pre-contemplation is based on rationalisation may be more likely to consider change when their perspective is acknowledged and the limitations of their position are explored in a sensitive and non-confrontational style.</td>
</tr>
<tr>
<td><strong>Contemplation:</strong></td>
<td>A person in a contemplative stage of change may be more likely to become determined to change when provided with a ‘risk-reward analysis’ of the potential costs and benefits of change. This should be developed from the perspective of the client. It can also be used to clarify the clients goals for change and explore how the barriers to change can be removed. The contemplation stage also allows an opportunity for the discussion of client ambivalence, the exploration of successes and failures in past attempts to change, and the promotion of an individual’s sense of self-efficacy regarding his ability to cope with the challenges of change.</td>
</tr>
<tr>
<td><strong>Determination:</strong></td>
<td>A person in the determination stage of change may benefit from assistance that shapes interventions that (a) support and strengthens commitment to change, (b) promote a realistic understanding of what change will be like, and (c) promote problem solving skills that will assist change and help overcome barriers to change.</td>
</tr>
<tr>
<td><strong>Action:</strong></td>
<td>A person in an action stage of change may be more successful if they are provided with (a) a public forum where they can make a commitment to change, (b) objective feedback on their plans and efforts in implementing change, (c) support during change, (d) the promotion of internal attributions regarding self-efficacy and change, (e) the provision of information on successful and flexible models of change, (f) external monitoring of change, and (g) skills training.</td>
</tr>
<tr>
<td><strong>Maintenance:</strong></td>
<td>A person in a maintenance stage of change may be assisted by (a) clear relapse prevention plans and skills, (b) opportunities to reflect on changes made and unexpected barriers to change that have been encountered, (c) skills and opportunities to identify small slips that may lead to the re-emergence of problem behaviour, (d) emergency plans to deal with unexpected urges or opportunities to engage in problem behaviour, and (e) positive encouragement regarding constructive changes made to date.</td>
</tr>
</tbody>
</table>
Table 6-3 APA recommendations for the clinical assessment of a young person with sexually abusive behaviour.

<table>
<thead>
<tr>
<th>APA Task Force recommendations for the main factors that should be included in an assessment of a young person with sexually abusive behaviour.</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Victim statements to police, social services, mental health professionals, etc.</td>
</tr>
<tr>
<td>• Background information including family history, educational history, medical history, psychosocial history and developmental history.</td>
</tr>
<tr>
<td>• Interpersonal relationship history.</td>
</tr>
<tr>
<td>• Sexual history including deviant sexual interests and the emergence of sexually aggressive behaviour over time.</td>
</tr>
<tr>
<td>• Reported use of deviant sexual fantasies and interests.</td>
</tr>
<tr>
<td>• The intensity of sexual arousal during the time surrounding each offence.</td>
</tr>
<tr>
<td>• The dynamics and process of victim selection.</td>
</tr>
<tr>
<td>• Use of coercion, force, violence, and weapons.</td>
</tr>
<tr>
<td>• Behavioural warning signs.</td>
</tr>
<tr>
<td>• Identifiable triggers leading to inappropriate sexual behaviours.</td>
</tr>
<tr>
<td>• Thinking errors such as cognitive distortions or irrational beliefs.</td>
</tr>
<tr>
<td>• The spectrum of injury to the victim from the violation of trust, creation of fear to physical injury.</td>
</tr>
<tr>
<td>• Sadistic elements to the sexually abusive behaviour.</td>
</tr>
<tr>
<td>• Ritualistic and obsessive characteristics of the sexually abusive behaviour.</td>
</tr>
<tr>
<td>• Deviant non-sexual interests.</td>
</tr>
<tr>
<td>• History of assaultive behaviour.</td>
</tr>
<tr>
<td>• Issues related to separation and loss.</td>
</tr>
<tr>
<td>• Antisocial characteristics.</td>
</tr>
<tr>
<td>• Psychiatric diagnosis including disruptive behaviour disorders, affective disorders, developmental disorders, personality disorders, post-traumatic stress disorder, substance abuse disorder, and organic mental disorder.</td>
</tr>
<tr>
<td>• Ability to accept responsibility.</td>
</tr>
<tr>
<td>• Degree of denial or minimisation.</td>
</tr>
<tr>
<td>• Understanding wrongfulness.</td>
</tr>
<tr>
<td>• Concern for injury to victim.</td>
</tr>
<tr>
<td>• Quality of social, assertive, and empathic skills.</td>
</tr>
<tr>
<td>• Family’s response (from denial, minimisation, support, to ability to intervene appropriately).</td>
</tr>
<tr>
<td>• Exposure to pornography.</td>
</tr>
<tr>
<td>• History of sexual, physical and/or emotional victimisation.</td>
</tr>
<tr>
<td>• Ability to control deviant sexual interest.</td>
</tr>
<tr>
<td>• Knowledge and expression of appropriate sexual interests.</td>
</tr>
<tr>
<td>• School performance and educational level.</td>
</tr>
<tr>
<td>• Mental status examination.</td>
</tr>
</tbody>
</table>
### Table 6-4  Assessment Session One.

<table>
<thead>
<tr>
<th>Main areas covered in a developmental interview during assessment session one</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Development During Infancy and Early Childhood:</strong></td>
</tr>
<tr>
<td>• Mother and child’s health status during pregnancy.</td>
</tr>
<tr>
<td>• Any complications during delivery.</td>
</tr>
<tr>
<td>• Mother and child’s health after delivery.</td>
</tr>
<tr>
<td>• Any disruptions to parental bonding after delivery due to health difficulties or other factors.</td>
</tr>
<tr>
<td>• Child’s temperament as an infant.</td>
</tr>
<tr>
<td>• Child’s pattern of sleeping as an infant.</td>
</tr>
<tr>
<td>• Child’s pattern of feeding as an infant.</td>
</tr>
<tr>
<td>• Child’s accomplishment of main motor milestones including ages for sitting-up, crawling, standing, walking with assistance and walking independently.</td>
</tr>
<tr>
<td>• Any unusual features of motor development such as delay in motor development or not crawling, unusual gait or attendance with an occupational therapist for assessment and intervention.</td>
</tr>
<tr>
<td>• The child’s level of activity as reflected in their accomplishment of different stages of motor development - (inactive, normal, overactive).</td>
</tr>
<tr>
<td>• Child’s accomplishment of main speech and language milestones including ages for babbling, first words, two word combinations, and use of sentences.</td>
</tr>
<tr>
<td>• Any unusual features of speech and language such as delayed speech, articulation difficulties or attendance with a speech and language therapist for assessment and intervention.</td>
</tr>
<tr>
<td>• Accomplishment of toilet training and any difficulties with toileting such as encopresis or enuresis.</td>
</tr>
<tr>
<td>• Any significant separations from primary care-givers during infancy and early childhood.</td>
</tr>
<tr>
<td>• Opportunities for the development of social skills in early childhood through contact with siblings, members of the extended family, peers and family friends.</td>
</tr>
<tr>
<td>• Any unusual features of social skills development.</td>
</tr>
<tr>
<td>• Any general behaviour difficulties.</td>
</tr>
<tr>
<td>• Any sexualised behaviour difficulties.</td>
</tr>
<tr>
<td>• Any difficulties in learning rules of social behaviour.</td>
</tr>
<tr>
<td>• Any difficulties in the regulation of affect such as temper tantrums.</td>
</tr>
<tr>
<td>• Any significant emotional difficulties.</td>
</tr>
<tr>
<td>• Any significant family events or difficulties during early childhood.</td>
</tr>
<tr>
<td>• Attendance at pre-school including the child’s reaction to separation from primary care-givers, relationships formed with teachers, relationships formed with peers, and response to pre-school rules and tasks.</td>
</tr>
<tr>
<td>• Any additional strengths from infancy and early childhood not previously identified.</td>
</tr>
<tr>
<td>• Any other important information from infancy and early childhood.</td>
</tr>
<tr>
<td><strong>Development During Middle and Late Childhood:</strong></td>
</tr>
<tr>
<td>• Attendance at primary school including the child’s reaction to separation from primary care-givers, relationships formed with teachers, relationships formed with peers, and response to primary school rules and tasks.</td>
</tr>
<tr>
<td>• Any significant behavioural problems in primary school.</td>
</tr>
<tr>
<td>• General academic performance in comparison to peers in primary school.</td>
</tr>
<tr>
<td>• Any significant general or specific learning difficulties in primary school.</td>
</tr>
<tr>
<td>• Any additional educational resources made available during primary school.</td>
</tr>
<tr>
<td>• Any change in class or school.</td>
</tr>
<tr>
<td>• Relationships developed with peers outside of primary school.</td>
</tr>
<tr>
<td>• Relationships with siblings and adult family members.</td>
</tr>
<tr>
<td>• The general development and expression of social skills in middle and late childhood.</td>
</tr>
</tbody>
</table>
• Any significant family events or difficulties during middle or late childhood.
• Any significant life events influencing development during middle or late childhood.
• Any significant general behaviour problems.
• Any sexualised behaviour difficulties.
• Any significant emotional problems.
• Any additional strengths from middle and late childhood not previously identified.
• Any other important information from middle and late childhood.

**Development During Adolescence:**

• Attendance at secondary school including the child’s reaction to separation from primary care-givers, relationships formed with teachers, relationships formed with peers, and response to secondary school rules and tasks.
• Any significant behavioural problems in secondary school.
• General academic performance in comparison to peers in secondary school.
• Any significant general or specific learning difficulties in secondary school.
• Any additional educational resources made available during secondary school.
• Any change in class or school.
• Relationships developed with peers outside of secondary school.
• Relationships with siblings and adult family members.
• The general development and expression of social skills in adolescence.
• Development of interest in age appropriate relationships that have a sexual dimension.
• Any significant family events or difficulties during adolescence.
• Any significant life events influencing development during adolescence.
• Any significant general behaviour problems.
• Any sexualised behaviour problems.
• Any significant emotional problems.
• Use of alcohol or drugs.
• Use of pornography.
• Any additional strengths from adolescence not previously identified.
• Any other important information from adolescence.

**Medical History:**

• Any current medical conditions.
• Any current medication.
• Any significant past medical conditions.
• Any past hospitalisations.
• Any significant past head injuries.
• Any past genital injuries.
• Any allergies.
• Any significant family medical history.
Table 6-5 Assessment Session Two.

<table>
<thead>
<tr>
<th>Main Areas Covered in Assessment Session Two with the Young Person’s Primary Care-givers</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Obtaining a detailed genogram of members of the young person’s immediate and extended family and other important people who are not family members. A detailed guide for constructing genograms can be found in Carr (2000).</td>
</tr>
<tr>
<td>• Areas of strength and family coping skills.</td>
</tr>
<tr>
<td>• Personal strengths of the young person referred with sexually abusive behaviour problems.</td>
</tr>
<tr>
<td>• Difficult problems that have been faced by the family and effective and non-effective coping skills that have been utilised to manage these.</td>
</tr>
<tr>
<td>• Any additional current difficulties that are being faced by the family.</td>
</tr>
<tr>
<td>• Close, positive relationships within the family system.</td>
</tr>
<tr>
<td>• Negative and conflictual relationships within the family system.</td>
</tr>
<tr>
<td>• The care-giver’s understanding of the young person’s account of his sexually abusive behaviour.</td>
</tr>
<tr>
<td>• The level of acceptance by the primary care-givers of the young person’s responsibility for his sexually abusive behaviour.</td>
</tr>
<tr>
<td>• The care-giver’s availability and capacity for supervision of the young person.</td>
</tr>
<tr>
<td>• The care-giver’s attitude towards the provision of assessment and intervention for the young person.</td>
</tr>
<tr>
<td>• The care-giver’s opinion on the level of readiness of the young person for assessment and intervention.</td>
</tr>
<tr>
<td>• The level of awareness of the young person’s sexually abusive behaviour within the extended family system and within the broader community.</td>
</tr>
<tr>
<td>• The primary care-giver’s attitude towards participation in parents’ work as part of the young person’s intervention programme.</td>
</tr>
<tr>
<td>• Any immediate or extended family history of substance abuse, mental health difficulties, sexual victimisation, physical violence, sexually abusive behaviour difficulties, and criminality.</td>
</tr>
<tr>
<td>• Positive goals for the future.</td>
</tr>
</tbody>
</table>
Main Areas Covered in Assessment Session Three.

General Areas Covered in Interview 3:
- The young person’s interests, hobbies, likes, and dislikes.
- Important friendships in the young person’s life.
- Activities engaged in by the young person with friends and peers.
- Any socialisation difficulties reported by the young person.
- Any conduct disorder type behaviour engaged in by the young person individually or with peers.
- Any difficulties with low mood experienced by the young person and approaches used to manage them.
- Any difficulties with strong angry feelings experienced by the young person and approaches used to manage them.
- Any difficulties with conflict and aggression experienced by the young person and approaches used to manage them.
- Any difficulties with attention and concentration experienced by the young person and approaches used to manage them.
- Use of alcohol and drugs.
- Use of pornography.

Comprehensive Sexual History:
- What age was the young person the first time they had a ‘crush’ on someone. Who was that person and what were the circumstances.
- What age was the young person the first time they kissed someone. Who was that person and what were the circumstances.
- What age was the young person the first time they saw a male naked. Who was that person and what were the circumstances.
- What age was the young person the first time they saw a female naked. Who was that person and what were the circumstances.
- What age was the young person the first time they touched someone in a sexual way. Who was that person and what were the circumstances.
- What age was the young person the first time someone touched them in a sexual way. Who was that person and what were the circumstances.
- The young person is invited to provide information on each person with whom they have had any form of sexual contact. Information sought should clarify who each person was, what age they were, the level of activity engaged in and whether the activity was wanted or unwanted by either party. If it becomes apparent that the young person has been the victim of sexually abusive behaviour then the appropriate child protection guidelines should be fully followed in relation to this.
Table 6-7  *Assessment Session Four.*

<table>
<thead>
<tr>
<th>Main Areas Covered in Assessment Session Four.</th>
</tr>
</thead>
</table>

### Antecedents to the Sexually Abusive Behaviour:
- Where was the young person before the offence took place. Who else was around or nearby.
- What was the young person doing before the offence.
- What was the young person thinking before the offence.
- How was the young person feeling before the offence.
- When did the young person start to think about offending (including pre-offence fantasy).
- How did the young person set up the offence situation.
- How did the young person select the person who they assaulted.
- What steps did the young person take to avoid detection.

### Abusive Behaviour:
- Where did the offence take place. Who else was around or nearby.
- What behaviours did the young person engage in during the offence.
- How did the young person feel during the offence.
- What thoughts were going through the young person’s mind during the offence.
- What did the young person notice about the reaction of the person who was assaulted during the offence.
- What methods of coercion were used by the young person during the assault.

### Consequences:
- What did the young person do after the offence.
- How did the young person feel immediately after the offence.
- What thoughts were going through the young person’s mind immediately after the offence.
- What did the young person notice about the reaction of the person who was assaulted after the offence.
- What did the young person say or do to the person who was assaulted in an effort to prevent detection of their abusive behaviour.
- What other steps did the young person take to avoid detection.
- What thoughts went through the young person’s mind as he took steps to avoid detection or after a period of time had passed.
- How did the young person feel as he took steps to avoid detection or after a period of time had passed.
- How was the young person’s offence discovered.
- How did the young person feel about and respond to the discovery of his abusive behaviour.
- The young person’s understanding of the harmfulness and illegality of his abusive behaviour.
- How did others respond to the discovery of the young person’s abusive behaviour.
- How does the young person feel about his abusive behaviour now.
- What does the young person recognise as risky thoughts, feelings, behaviours and situations now. How does he manage these.
- What does the young person think and feel about his participation in assessment. Has there been any change in his attitude since his first attendance.
- What does the young person think and feel about participating in intervention.
- What does the young person think and feel about his care-givers participation in intervention in support of him.

### Concluding Questions:
- How does the young person feel about the future with and without intervention.
- What positive wishes does the young person have for his future.
Figure 6-1. Genogram for Peter Hill and family
Possible Predisposing Factors
- Premature delivery
- Low birth weight.
- History of criminality in father's family of origin.
- History of alcohol abuse in father's family of origin.
- Father's alcohol abuse.
- Relationship difficulties between parents during first two years of Peter's infancy.
- Witnessing marital violence.
- Victim of physical abuse as a child.
- Coercive relationship style in early family.
- Maternal history of depression.
- Separation from parents.
- ADHD.

Possible Precipitating Factors
- History of behavioural problems at school.
- Academic difficulties.
- Impulse control problems.
- Difficulties making and maintaining friendships with peers.
- Onset of puberty.
- Anger problems.
- Low self-esteem.
- External locus of control.
- External locus of control.

Possible Maintaining Factors
- Low self-esteem.
- External locus of control.
- Lack of good peer relationships.
- Impulse control problems.
- Poor perspective taking skills.
- Absence of relapse prevention skills.

Possible Protective Factors
- IQ in the average range of ability.
- Early detection of sexually abusive behaviour.
- Consequences to detection of abusive behaviour.
- Stable relationship between mother and step-father.
- Support of mother and step-father for intervention.
- Partial acknowledgement of sexually abusive behaviour.
- Moderate level of willingness to participate in intervention.
- Absence of global cognitive distortions regarding children and sexuality.

Figure 6-2 Formulation diagram for Peter Hill.
## Contract for Intervention for Peter Hill

I, Peter Hill, agree to take part fully in the weekly intervention programme.

I agree to work on the following as my main goals:

- Improving my motivation to acknowledge and change my abusive behaviour.
- Acknowledging the full extent of my sexually abusive behaviour.
- The development of an understanding and acknowledgement of the emotional, thinking and behavioural build-up to my abusive behaviour.
- Learning about the harmful effects of abusive behaviour on people.
- Learning about the harmful effects of my abusive behaviour on Eleanor and other members of my family.
- The development of clear relapse prevention plans and skills.
- Building self-esteem.
- Building social skills.
- Learning perspective taking skills.
- Learning impulse control skills.
- Life story awareness work.
- Anger awareness and the development of anger management skills.
- Learning about healthy relationship and sexuality.

I understand and agree to keep the all of the rules of the programme, including:

- Strict confidentiality
- No aggressive behaviour towards people or property
- No disrespectful behaviour towards staff or other people on the programme
- No meeting other people on the programme outside of group

Signed:

<table>
<thead>
<tr>
<th>Peter Hill</th>
<th>Date</th>
</tr>
</thead>
</table>

I, Karen McKenzie, mother of Peter Hill, agree to support Peter in his work on the intervention programme and will be attending the Parents Programme as part of my support. I fully agree with the goals he has indicated that he is going to work towards.

Signed:

<table>
<thead>
<tr>
<th>Karen McKenzie</th>
<th>Date</th>
</tr>
</thead>
</table>

On behalf of the intervention team we agree to fully help Peter achieve the goals he has outlined above.

Signed:

<table>
<thead>
<tr>
<th>Joseph Lane</th>
<th>Mary Street</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Psychologist</td>
<td>Social Worker</td>
</tr>
</tbody>
</table>

Date:

---

**Figure 6-3** Contract for intervention for Peter Hill.