11: Assessment Of Females Who Engage In SABs

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

NOTE:
Read this guide in conjunction with the following guide:

- **13: Treatment considerations for females who engage in sexually abusive behaviours**

Other relevant guides are:

- **7: Assessment and treatment for SABs: A general overview**
- **8: Risk assessment of youth who engage in SABs: An overview**
- **9: Assessment: The ERASOR**
- **10: Assessment: The J-SOAP II**
- **12: Treatment: The *Four-Pillar* model**

Introduction

Before the mid-1980s, there was little in the sex-offender literature about sexually abusive youth. All the work with sexually abusive youth was derived from adult sex offender treatment.

From the late 1990s through the early 2000s, researchers/practitioners interested in youth exhibiting Sexually Abusive Behaviours (SABs), including, but not limited to Jim Worling, Tracy Curwen, Robert Prentky and Sue Righthand, began a process of looking at the literature, thinking about what they were seeing with their young clients and then 'translating' what they were seeing into a 'new' body of work. This dealt specifically with youth who sexually harmed, and no longer looked at this group as 'mini adults'.

As a diverse group, these researchers/practitioners developed remarkably similar assessment tools; Prentky & Righthand; the J-SOAP II and Worling & Curwen; the ERASOR. Both tools integrated input from adult sex offender research findings, wisdom from adolescent therapeutic practice, and issues arising in the – mainly – adult literature, which seemed to fit with adolescent practice. Via these processes, the J-SOAP II and the ERASOR were 'born'. Over time, they have become the most widely used adolescent assessment tools in the western world. (See guide **9: 'Assessment: The ERASOR'** and guide **10: 'Assessment: The J-SOAP II"**)

Over the past 15 years the strengths and weaknesses of both these tools have been well identified through research. They "…do the job they were intended for". As well, a large body of literature dedicated to the treatment of adolescent males who engage in SABs has been produced, and continues to mature. Literally hundreds of books, articles and manuals exist related to the treatment of adolescent males who engage in SABs.

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But what about assessment and treatment of females? What do we know about them, in terms of why they engage in these behaviours? How do we assess the behaviours, and how do we treat them? Are they the same as boys who sexually harm? Let's look at the issues related to treatment of females, especially in the context of Victoria's Therapeutic Treatment Order (TTO) system.

Assessment of adolescent females who engage in SABs

Robinson (2006) writes that;

"…the assessment process for a sexually abusive girl is guided by a thorough understanding of female development and the research conducted so far on sexually abusive girls" (p.291).

Robinson also notes that because less is known about sexually abusive girls than boys, clinicians have had to rely more on self-reporting by girls than they do with boys.

This may present us with a problem, as many young people who come to us, both female and male, do not know why they engaged in this behaviour. Robinson believes it is essential to assess the type, extent and severity of each girl's own victimisation.

Clinicians assessing girls should pay particular attention to:

a) Relational aggression, and to be aware that in girls this may be subtle and covert,
b) Relational development, in conjunction with evolving identity and attachment styles, given that assessment and treatment aims at assisting female clients to "…attain a normal adolescent track of female development" (p.293).
c) Assessing overall sexual functioning. Areas to focus on include degree of sexual desire, sexual experience (promiscuity or inexperience), trauma bonding of sexual victimisation and arousal, sexual ownership versus sexual passivity, placement in unsafe sexual situations, and sexual re-victimisation, an identity defined by sexuality and desirability, sexual shame and inadequacy, sexual knowledge, reproductive health and healthy body image (all Robinson, 2006).
d) The SAB itself. In particular victim selection, and relationship with the victim of the SAB.

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How useful are risk assessment and risk factors used with boys, when used with girls?

At the time of writing this guide, there are ***no*** broadly available risk assessment tools designed for use with sexually abusive young women. The ERASOR and J-SOAP II are derived from all-male studies and the literature about male sex offending. As a result, "…the application of these risk assessments to the juvenile female population can be problematic" (Robinson, 2006; p. 296).

James Worling, the main author of the ERASOR, has noted in trainings that the ERASOR can be applied to adolescent females. However this statement must be treated with caution as no basis for its accuracy exists in the literature.

Research by Funk (1999) found that female risk factors are different from those for males, and that carrying out a risk assessment specific to females' general delinquency is twice as successful in predicting female recidivism, as using a risk assessment designed for both sexes.

Bonta, Pang & Wallace-Capretta (1995) noted that there are distinct differences in risk factors between males and females, and that using assessment tools with females that were designed for males, resulted in poor predictability and little generalisability.

In formulating a set of risk predictors, Funk (1999) noted that for female youth, family related problems - including poor parent-child relations, running away from home issues, child abuse and neglect victimisation histories, and criminally-involved parents – were all related to risk of sexual recidivism. Person-related crimes, and a history of running away predicted delinquency recidivism in female but not male youth. Female abuse history also predicted recidivism for females more strongly than males.

When it came to predicting 'general' violence recidivism for incarcerated female offenders, a history of self-injury such as suicide attempts was the greatest predictor according to Cunningham (2002).

In general, risk factors described in the adolescent male assessment literature, do not appear to assist in assessing adolescent females, as for example, girls are far less likely to engage in overt behaviours or pornography use. Therefore, conduct disorder history, juvenile anti-social behaviour, sexual preoccupation and pervasive anger tell us little about the recidivism risk of adolescent females. They do not 'capture' female behavioural patterns or predispositions.

There are a small number of risk factors that do appear similar for both male and female youth. These are (in no particular order);

- Caregiver inconsistency,
- High-stress family environment,
- Lack of intimate peer relationships, and;
- Social isolation.

A proposed risk assessment tool

In her chapter in Longo & Prescott (2006), Robinson proposes a risk assessment model for adolescent females, based on her clinical practice. This model is now more than 10 years old and has never been empirically validated. It is included here for your consideration.

This assessment tool comprises 27 different items, divided into: *Historic/static factors* (8 items), *Stable and dynamic factors,* further subdivided into *sexual factors* (2 items), *Factors of relational functioning* (4 factors), *Factors related to personal functioning* (9 factors), *Factors related to treatment responsivity* (2 factors), and *Environmental Factors* (2 factors), as follows:

Historic/Static Factors

1	**Sexual trauma history**	
None		0
Single or few instances with 1 perpetrator		1
Multiple perpetrators and/or chronic abuse by one perpetrator		2

2	**Physical trauma and/or history of other maltreatment (neglect, emotional abuse)**
None	0
Some evidence	1
Chronic and/or severe	2

3	**History of witnessed family violence or criminal behaviour among family members**
None	0
Some evidence	1
Chronic and/or severe	2

4	**Early maturation**
Not applicable	0
Somewhat early	1
Very early	2

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5	History of person-related offences	
One offence		0
A few offences		1
Offences on multiple victims		2

6	History of running away	
No history		0
One or two instances		1
Several instances		2

7	History of self-harm (e.g. suicide attempts)	
No history		0
One or two instances		1
Several instances		2

8	History of inconsistent caregivers	
No history		0
One or two instances before age 10		1
Significant inconsistency/numerous foster care placements/or loss of parental rights		2

Sexual Factors

9	Evidence of sexual pre-occupation	
No evidence		0
Some evidence		1
Significant evidence		2

10	Evidence of sexual subjectivity	
Evidence of healthy sexual agency		0
Some evidence of compromised sexual agency		1
Significant evidence of poor sexual agency		2

Factors of relational functioning

11	Social isolation, rejection, and/or lack of social skills	
Not applicable		0
Some		1
High		2

12	Use of relational aggression	
No evidence		0
Some evidence		1
High levels		2

13	Relationship to female caregiver	
Healthy and strong/supportive		0
Some difficulties		1
High discord, absent, or unhealthy role modelling		2

14	Attachment style	
Primary secure		0
Some attachment deficits (i.e. avoidant/preoccupied)		1
Significant attachment disturbances (i.e. dismissive)		2

Factors related to personal functioning

15	Attitudes reflecting non-normative beliefs	
No evidence		0
Some evidence		1
Entrenched attitudes		2

16	Emotional expressivity	
High		0
Average		1
Low		2

17	Posttraumatic Stress Disorder	
No symptoms		0
Some symptoms and/or mild disorder		1
Chronic and severe		2

18	Depressive Disorder	
No symptoms		0
Some symptoms and/or mild disorder		1
Chronic and severe		2

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19	Conduct Disorder	
No symptoms		0
Some symptoms and/or mild disorder		1
Chronic and severe		2

20	Anxiety Disorder	
No symptoms		0
Some symptoms and/or mild disorder		1
Chronic and severe		2

21	Hyperactivity/impulsivity/inattention	
No symptoms		0
Some symptoms and/or mild disorder		1
Chronic and severe		2

22	Other diagnoses of concern:	
No symptoms		0
Some symptoms and/or mild disorder		1
Chronic and severe		2

23	Investment in school	
High, or risk factor not applicable		0
Average		1
Low and/or dropped out		2

Factors related to treatment responsivity

24	Empathy/ability to engage in perspective taking	
Strong ability		0
Some deficits apparent		1
Significant deficits		2

25	Internal motivation to change	
High internal motivation to change		0
Some internal motivation to change		1
Significantly lacks internal motivation		2

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Environmental Factors

26	Stress within the family environment
No or low stress	0
Moderate amounts of stress	1
High levels of stress	2

27	Involvement in extracurricular activities
At least one involvement in extracurricular activities, e.g. athletics, music	0
No extracurricular activities	1
No extracurricular activities and no desire to pursue any	2

Note:
High scores denote higher risk. No norms or standards have been derived, therefore the level of risk is determined by clinical judgement.

Please read this information in conjunction with guide **13: Treatment Considerations For Females Who Engage in SABs**

References

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