The
University
Of
Sheffield.

Understanding the Treatment and Effects of Harmful Sexual Behaviour in Boys.

By:

Tansy Warrilow

A thesis submitted in partial fulfilment of the requirements for the award of Doctor of Clinical Psychology at the University of Sheffield

The University of Sheffield Faculty of Science Clinical Psychology Unit, Department of Psychology

Submission Date: May 2019

This page is intentionally left blank

Declaration

This thesis has not been submitted to any other institution, or for the purpose of obtaining any other qualifications

This page is intentionally left blank

Structure and Word Count

Section One: Literature review

Excluding references and tables	7651
Including references and tables	11950

Section Two: Research report

Excluding references and tables	7851
Including references and tables	9745

Total Word Count

Excluding references and tables	15302
Including references and tables	21695

This page is intentionally left blank

Lay Summary

Around 30% of sex offences against children are convicted by other children, a finding which is replicated across countries. Harmful Sexual Behaviour (HSB) refers to problematic behaviours such as risky sexual behaviour and using sexually explicit language but also encompasses behaviours including sexual assault and rape. It is the responsibility of social services, the police and the Crown Prosecution Service to determine whether the matter should be pursued criminally. Given the relatively high rates of young people demonstrating HSB it is important that there is a clear understanding of effective interventions.

Unfortunately there is a lack of published research into HSB interventions and disagreement across services about which psychological model is the most effective.

A literature review was completed to compare the available evidence. This was completed systematically to ensure all papers were similar enough to compare. Thirteen papers were included and all were assessed for quality although most papers were considered fair or poor. Six studies used Cognitive Behavioural Therapy (CBT), three studies used Multi-Systemic Therapy (MST) and four studies used an eclectic approach. The CBT and MST studies concluded these models were effective however there were a number of flaws with all studies so these results should be viewed with caution. Many studies used re-offending as an outcome, problems with this were discussed in the review. Studies did not seem to be following recommended guidance for working with HSB. There is no agreement in the academic field about how to assess effectiveness of HSB interventions which makes it difficult to conclude which methods are most effective and more stringent research is needed.

A study was then completed to explore the experiences of mothers and fathers who have a son who has displayed HSB. The aim was to understand their experience and explore their journey through services. Seven mothers and one father were interviewed and a qualitative analysis called Interpretative Phenomenological Analysis (IPA) was used to analyse the results. IPA involves two layers of analysis, the initial stage requires the participant to make sense of their experience, providing the first level of interpretation, secondly, the researcher consciously and systematically applies meaning to their testimonies by drawing upon psychological theory. Themes shared across participants are then grouped together. There were six main themes; 'Lack of Formulation', 'Maternal Attachment', 'Affiliation', 'Escape', 'Emotional Toll' and 'Structural Issues'. Parents noted that HSB existed within a wider context of behaviour but services typically did not acknowledge or address the broader circumstances. Parental distress often related to being overlooked by services during decision-making and feeling blamed by others or blaming themselves for the HSB. There were significant consequences on the emotional well-being of parents and many experienced significant life changes after the HSB. Parents spoke about difficulties accessing services and the value of having someone on their side. Often parents seemed more affected than the young person who displayed HSB. Services are encouraged to develop collaborative ways of working with parents, focus more on parental-well being and consider how to increase fathers involvement.

Acknowledgements

I must start by thanking the eight parents who took part. Without your time and honesty, this study would not be possible. I was struck by the resilience in each and every one of you while you navigate this unchartered territory. I feel grateful and honoured for the openness in which you spoke in our interviews and your sharing of your experience, both the good and the difficult. I remain in awe of your strength and resilience, and feel humbled by the love you so clearly have for your sons.

Thank you to Professor Nigel Beail for agreeing to take on a project that allowed me to pursue an area that I am passionate about, thank you for guiding me through and keeping me laughing along the way. Thank you to Dr Berit Richie for always being on standby whether it was for clinical guidance or frustrated rants, I appreciate you always having time, even when there were some other major things going on! A big thanks to Charlotte Heathcote and Paul Harries for your hard work behind the scenes identifying and contacting potential participants, the project would not have been possible without your help. Thank you to Scott Roache for being a proof reading genius.

To my dearest family, thank you for your eternal support. Thank you for always encouraging me to 'go for it' and instilling in me that I can be 'whatever I want to be' (well I did it!!) Thank you for always believing in me, having unwavering faith that I could achieve this, and keeping me going even when I lost the will.

And finally, to the DClin16 dreamteam. I simply could not have done this without you. Not without late library sessions, limitless support and a constant team spirit. Now all of you go out there and 'you do you!'

This page is intentionally left blank

Table of Contents

Declaration iii

Structure and Word Count.. v

Lay Summary vii

Acknowledgements ix

Section One: A systematic literature review into the effectiveness of psychological interventions in treating harmful sexual behaviour in juveniles.... 1

Abstract.. 3

Introduction... 5

Method 11

Quality Assessment of studies.. 14

Narrative Synthesis of Findings 26

Discussion 38

References 42

Appendix A: Downs and Black Checklist 52

Appendix B: Template of all the checklist questions..................... 55

Appendix C: Summary of NICE guidelines.................................. 59

Section Two: Harmful sexual behaviour in boys. The lived experiences of parents. An Interpretative Phenomenological Analysis.............................. 61

Abstract... 63

Introduction.. 65

Method 69

Design... 69

Reflexivity 70

Recruitment 71

Data Collection 72

Analysis 77

Ethical Considerations 78

Public and Participant Involvement 80

Quality Control 82

Results 83
Discussion 96
Strengths, Limitations and Future Research 102
Clinical Implications 103
Conclusions 103
References 104
Appendix A: Reflexive Diary Example... 109
Appendix B: Reflexive Statement.. 110
Appendix C: Invitation Letter 111
Appendix D: Participant Information Sheet....................................... 113
Appendix E: Participant Consent Form 119
Appendix F: Demographic Information 120
Appendix G: Semi Structured Interview 122
Appendix H: Example Coded Transcript 125
Appendix I: Example List of all Themes 126
Appendix J: Example List of Grouped Themes 127
Appendix K: Example Themes Transferred to Coloured Paper 128
Appendix L: Themes Grouped. Colours Represent Participants............... 129
Appendix M: Table of All Themes.. 131
Appendix N: NHS Ethical Approval 133
Appendix O: HRA Approval 136
Appendix P: Scientific Approval 143
Appendix Q: Research and Innovation Approval.................................. 144
Appendix R: Debrief Form... 147
Appendix S: Audit Form 148

Section One.

A systematic literature review into the effectiveness of psychological interventions in treating harmful sexual behaviour in juveniles

This page is intentionally left blank

Abstract

Objectives: This systematic literature review had three aims. First, to systematically identify and review the quality of studies examining the effectiveness of psychological interventions in the treatment of Juvenile Harmful Sexual Behaviour (J-HSB); Second, to provide a synthesis of the effectiveness of psychological interventions of J-HSB; third, a meta-analysis on the effectiveness of J-HSB interventions.

Methods: The search strategy involved the search of four major electronic databases and an additional grey literature database. Thirteen papers met the inclusion criteria. The Downs and Black (1998) checklist was used to appraise the quality of included paper. Data from each paper was extracted and grouped by outcome variable for meta-analysis.

Results: Six studies used Cognitive Behavioural Therapy (CBT), three studies used Multi-Systemic Therapy (MST) and four studies used an eclectic approach. No study was rated excellent, others were rated good (n = 2), fair (n = 4) or poor (n = 7). Studies used a mix of psychometrics, arrest and recidivism data as outcome variables. All studies in the CBT and the MST groups concluded these models were effective; outcomes for the eclectic studies were mixed. Many studies do not appear to follow clinical guidelines or draw from an evidence base. Inconsistencies and missing raw data meant there was insufficient data for a meta-analysis.

Conclusions: It is not possible to determine the most effective intervention modality due to a lack of agreement between researchers about methodologies and outcome variables. Implications of using recidivism as an outcome variable are discussed.

Practitioner points:

- HSB in juveniles remains an under-researched area.

- Studies should use an RCT methodology to improve study quality.
- Consensus is required between researchers on outcome variables.
- Clinicians should treat J-HSB in line with published guidance.

Limitations:

- This review was likely to be influenced by publication bias
- The narrative synthesis may be subject to researcher bias

Key words: HSB, interventions, juvenile, sex offending, psychology

Introduction

Harmful Sexual Behaviour and Juvenile Sexual Offending

Of individuals convicted of a sexual offence, 20% are under 18 years old (Home Office, 2003). Whilst figures vary, studies have found that about a third of child sexual abuse was carried out by children and young people (Hackett, Phillips, Masson, & Balfe, 2013) and the same finding was observed in the USA (Puzzanchera, Smith, & Kang, 2017). Throughout this literature review, problematic sexual behaviour will be referred to as Harmful Sexual Behaviour (HSB) the word 'juvenile' will be used to refer to a young person under 18. Juvenile HSB will be termed J-HSB and juvenile sexual offending will be termed J-SO. There are a wide range of definitions for HSB. The National Society for the Prevention of Cruelty to Children (NSPCC, 2017) specifies that HSB can include using sexually explicit language, inappropriate touching of oneself or another person, the use or threat of sexual violence up to full penetrative sex. HSB therefore ranges from non-contact behaviour (including viewing images online, exposure, voyeurism) to contact behaviour (including sexual assault and rape) (Hackett, 2014). Finkelhor, Ormrod, and Chaffin (2009) found that males account for an estimated 93% of juveniles who commit sexual offences and are thought to have different treatment needs from female sexual offenders. It is worth noting that not all J-HSB results in a criminal offence. In the UK, it is the responsibility of social services, the police and the Crown Prosecution Service to determine whether it is in the child's, the victim's and the public interest for the matter to be pursued criminally. A distinction therefore can be made between sexual behaviour which may be considered harmful (e.g. excessive masturbation, risk taking behaviour and touching of another) and those that are more clearly defined by the law as illegal (e.g. penetration without consent).

Understanding Juvenile Sexual Offending

Historically, J-SO has not received much attention, financial investment or research. The National Task Force on Juvenile Sexual Offending (1988) noted that J-SO was often characterised as experimental or sexual curiosity which resulted in a lack of accountability and intervention. This 'boys will be boys' attitude contributed to an inconsistent policy towards J-HSB and targeted treatment interventions (Lab, Shields, & Schondel, 1993). More recently, there has been an increased emphasis placed on the prevention and management of J-HSB. For example, in the UK juveniles convicted of a sexual offence must now sign the Sex Offender Register. This was established by the Sex Offenders Act 1997 (amended by the Sexual Offences Act 2003), requiring all convicted sex offenders to register with police in person within three days of their convictions. There is also recognition that J- HSB requires different treatment needs from non-sexual offenders. Most research into sexual offending is concerned with the etiology of HSB. Common risk factors in J-HSB include an emotionally deprived upbringing, sexual, physical and emotional abuse within the home, family instability and dysfunction (Vizard, Hickey, French, & McCroy, 2007). A descriptive study of 280 juveniles referred to a national forensic Child and Adolescent Mental Health Service (CAMHS) for HSB found that 71% of this population had been sexually abused, 74% had suffered physical neglect, 66% had suffered physical abuse, 49% has been exposed to violence at home and 25% had suffered all five forms of abuse (Vizard, Hickey, French, & McCrory, 2007). Many other studies highlight the dysfunctional and troubled nature of the families to which juveniles displaying HSB belong (Hackett, 2014). Fanniff and Kimonis (2014) explored similarities and differences between J-SO and juveniles who had committed non-sexual offences. Whilst they found some similarities, for example antisocial thoughts and behaviour, J-SO's demonstrated increased social and emotional problems,

had increased levels of atypical sexual interests and had experienced a higher level of sexual abuse, physical abuse and neglect than those who committed non-sexual offences. Seto and Lalumiere (2010) hypothesised two models for understanding J-SO. The authors distinguished between generalist and specialist offenders. The generalist model posited that sexual offences were committed within a wider profile of delinquency. The specialist model suggests that these young people are distinct from other offenders and have their own treatment needs. A focus on identifying and intervening for victims of child sexual abuse has long been a priority. Child perpetrators, however, have been overlooked. In the UK this means that the needs of victims are far more understood than those who perpetrate HSB (Allnock et al., 2009).

Evidence Base

The National Institute for Health and Care Excellence (NICE, 2016) provide clear and detailed advice for working with J-SO and J-HSB. Guidelines highlight the importance of early intervention, multi-disciplinary working, involving family/caregivers and clear assessment. Regarding psychological intervention, NICE recommends cognitive behavioural therapy (CBT) multi-systemic therapy (MST) for problematic sexual behaviour, psychotherapeutic approaches, strengths-based approaches and systemic therapy (a type of family therapy). See Appendix C for a comprehensive list of pertinent NICE recommendations. NICE direct treatment services to the Assessment Intervention Moving on Project (AIM, under 12s) and AIM2 (12-18) (AIM, 2008) assessment and intervention programmes developed to treatment J-HSB. The National Society for the Prevention of Cruelty to Children (NSPCC, 2019) has also published a framework for working with J-HSB in boys.

Multi-Systemic Therapy

MST (Borduin & Henggeler, 1990; Henggeler & Borduin, 1990) targets specific identified risk factors associated with juvenile antisocial behaviour including peer relationships, family functioning and social issues. In a longitudinal study Wijk et al. (2005) found similar risk factors between violent juvenile sexual offenders and violent juvenile non-sexual offenders. MST is an intensive community intervention that involves regular contact with both the juvenile and his/her family. Studies of MST and J-SO are included in this review.

Cognitive Behaviour Therapy

CBT (Beck, 1967) is based on the theory that cognition (thought) is the driver of emotion, physiology and behaviour. Therefore, if cognition distorts perception and guides behaviour, altering cognition can alter behaviour. There is an abundance of evidence suggesting CBT is effective in reducing recidivism in juveniles (e.g. Jewell, Malone, Rose, Sturgeon, & Owens, 2015). Studies have also documented reduced sexual recidivism after a CBT intervention (e.g. Mcgrath, Cumming, Livingston, & Hoke, 2003).

Effectiveness of Treatment

The goal of sex offender treatment programmes is to reduce the risk of future HSB. Tracking recidivism (reoffending) rates can be difficult because of problems in the capturing and quantifying of this information. There are certain types of adult offenders with higher rates of re-offending over a 25 year period, for example rapists (re-offence rate 39%) and child molesters (re-offence rate 52%) (Prentky, Lee, Knight, & Cerce, 1997). Rates of juvenile sexual recidivism also vary depending on the study. A recent meta-analysis found an approximate rate of juvenile sexual recidivism of 5% (Caldwell, 2016). Generally, rates between 3-15% is considered average for juvenile sexual

recidivism (Caldwell & Dickinson, 2009). It should be noted, however, that it is difficult to identify a clear estimate of sexual recidivism, given that much sexual offending goes unreported and undocumented (Wittbrood, 2006). It is thought that the rates of sexual recidivism have declined significantly over the last 15 years which has been attributed to the improved quality of treatment (Caldwell, 2016). Research on J-SO treatment and sexual recidivism is, however, sparse. Existing literature varies in terms of study design, outcome variables, treatment models and participant characteristics (Dopp, Borduin, & Brown, 2015).

Greer (1991) observed that the majority of literature relating to sexual offending is focussed on programme development and description than the efficacy or effectiveness of the treatment to eliminate recidivism. Reitzel and Carbonell (2006) also highlight the need for further research in the area after noting the relative absence of randomised controlled trials (RCT). Recently, Kettrey, and Lipsey (2018) completed a systematic literature review and meta-analysis exploring the effect of specialist sex offending programmes for juveniles updating previous meta-analyses. The study concluded that specialist sex offender programmes did not confidently indicate a significant reduction in sexual recidivism compared to treatment as usual. The study pointed out that interventions should differentiate between generalist and specialist offenders, given that specialist offenders are a higher risk of sexual recidivism. The study also concluded that future research should include use RCT design. A recent meta-analysis exploring the effects of treatment on recidivism, found that treatment groups, compared to comparison groups, achieved a reduction in recidivism by as much as 20.5% with a moderate effect size (d = 0.37) (Beek et al., 2018). This paper reviewed 14 studies, four of which were unpublished. Whilst this could raise questions as to the legitimacy of the findings as these

research papers have not been through the rigorous process of peer review, this does not necessarily negate the findings, and helps to reduce publication bias.

Objectives:

This literature review has three objectives:

1) To review the quality of studies examining the effectiveness of psychological interventions in the treatment of J-HSB;
2) To provide a narrative synthesis on the available literature on the effectiveness of psychological interventions of J-HSB;
3) To complete a meta-analysis on available data to explore the effectiveness of interventions on J-HSB.

Method

Search Strategy

This review followed a structured approach to arrive at the final selection of included articles (see Figure 1 for PRISMA diagram). The search strategy involved the search of four major electronic databases (Medline, Psychinfo, Scopus, CINAHL). Due to the limited amount of research in this area, the search was not date limited. On 10th February 2019 the following search string was used: ("child" OR "young" OR "youth" OR "juvenile" OR "teen" OR "adolesce*2) AND ("harmful sex* beh" OR "sex* off*" OR "problem* sex*") AND ("intervention" OR "treatment" OR "therapy" OR "evaluation" OR "effectiveness"). The initial search resulted in 525 studies. Duplicates were removed leaving 302 studies. The titles of all studies were reviewed, removing unsuitable studies, leaving 68 studies. The abstracts of these 68 studies were screened according to the inclusion and exclusion criteria leaving 11 studies. The references of these 11 studies and similar meta-analyses and reviews were checked for eligible studies. In an attempt to compensate for publication bias (Song et al., 2010) an additional search of OpenGrey was completed though this did not reveal any suitable unpublished studies. In total, the search strategy yielded 13 relevant studies to be included in the review. Figure 1 depicts the retrieval process in the form of a PRISMA diagram (Moher, Liberati, Tetzlaff, Altman, & The PRISMA group, 2009).

Inclusion Criteria

To be included in this systematic literature review and meta-analysis, studies were required to include a psychological component to the treatment of J-HSB, whether convicted or not. Eligible studies could include community or residential treatment. RCTs are gold standard (Stolbeg, Norman, & Trop, 2004) but due to the limited literature

in the area, quasi-experimental studies were also included. Studies were required to be written in English or translated into English.

Exclusion Criteria

Studies in which psychology was not the core component were excluded. An initial exclusion criteria was to exclude ‘female only’ trials as boys and girls are considered to have different treatment needs (Wijkman, Bijleveld, & Hendriks, 2011). There were no female only studies, however, and due to the limited available literature, studies in which the sample included a few girls but were predominately boys were included. Case studies were excluded due to their small samples and lack of comparison data. Studies that did not contain original data were also excluded (for example systematic reviews).

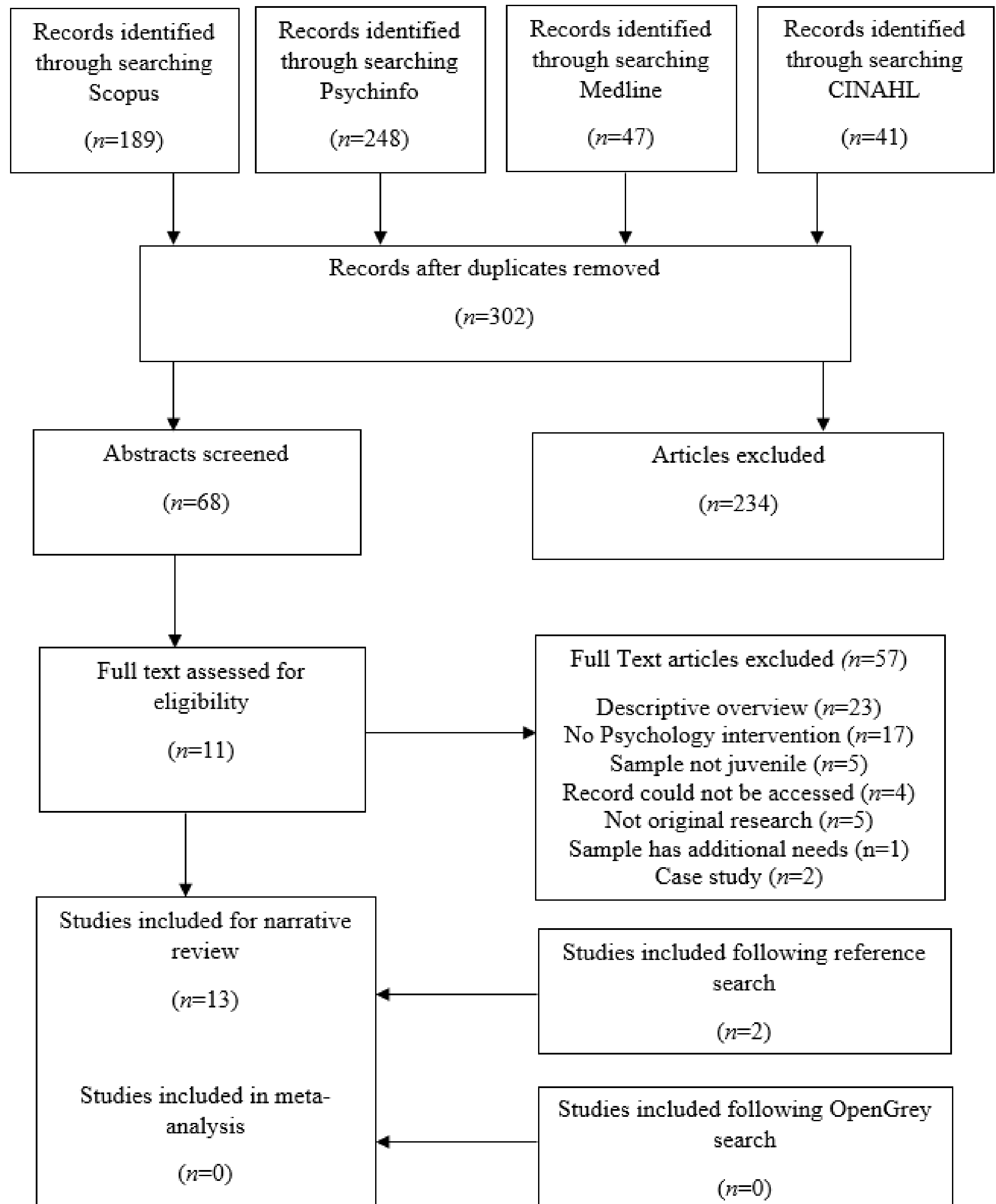


Figure 1. PRISMA diagram describing the search strategy

Quality Assessment of Studies

An adapted version of the Downs and Black checklist (1998) was used to appraise the quality of the studies (Appendix A). This checklist was selected because it was designed to appraise studies of health care interventions and can be used for both randomised and non-randomised studies. The checklist was modified to make it more applicable to practice-based research. As found elsewhere in the literature (e.g. Hooper, Jutai, Strong, & Russell-Minda, 2008) the final item on the checklist "*Did the study have sufficient power to detect a clinically important effect where the probability value for a difference being due to chance is less than 5%*" was given a score of either yes (1 point) or no (0 points). The total score achievable (28) could only be achieved by an RCT. For non-randomised studies the highest score was 25. The total score then corresponds to a category that represents the level of quality for each study. The categories are; Excellent (scores 26-28); Good (scores 20-25); Fair (scores 15-19) and Poor (scores <14) (Hooper, Jutai, Strong, & Russell-Minda, 2008).

The checklist provides quality assessment in two ways. Firstly it provides an overall score of quality, and secondly it provides subscale scores on four dimensions. The four categories are: Reporting, External Validity, Internal Reliability and Internal Reliability confounding (selection) bias.

All papers were appraised using a template of all the checklist questions (Appendix B). An independent Trainee Clinical Psychologist rated a random selection of just over half of the included articles (n = 7) and was blind to the author's ratings. An intra-class correlation coefficient (ICC) estimate between raters was 0.89, with 95% CI (0.829, 0.929) indicating good inter-rater reliability (Koo & Mae, 2016).

Meta-Analytic Strategy

To assess suitability for meta-analysis, all papers were grouped by outcome variable. Studies were grouped if they used the same or a similar outcome measure for a particular construct. The following outcome variables were grouped: self-esteem, behaviour problems, self-reported behaviour problems, attitudes, emotional distress and recidivism. Due to a lack of raw data and differences in reporting findings, there was insufficient data to complete a meta-analysis.

Study Characteristics

Ten out of 13 studies used a quasi-experimental design and three studies used an RCT design. Across the studies, a number of psychological treatment models were used. Six studies used a CBT informed approach, three studies used MST and four studies used an eclectic approach, that is, they drew from a range of psychological models. The majority of studies were conducted in the USA (n = 11), one study was conducted in Canada and one in the Netherlands. Interventions were implemented both in community settings (n = 8) and in residential settings e.g. prison or secure children's home (n = 4) and one study included both. The majority of studies had a predominantly male sample. Six studies had an entire sample of boys. One study did not report clearly the percentage of gender. One study had a much larger gender mix, but it should be noted that this study was focussed on sexualised behaviour problems in much younger children. These were behaviours that would not likely be considered as criminal offences (either because the child was below the age of criminal responsibility or because his/her behaviour was dealt with as a social issue) and therefore represented a slightly different sample. When aggregating all the available data on gender across the study samples, 95.05% were male. A range of outcome variables were used to measure the efficacy of the interventions, highlighting a problem regarding measuring efficacy. Seven studies used recidivism data,

two studies used a selection of psychometrics and four studies used both recidivism data and psychometric outcomes. A full summary of all included studies can be found below in Table 1.

Table 1

Study Characteristics

Study	Context and Country	Intervention details	Participant characteristics	Design	Relevant outcome measures	Findings	Quality /Appraisal
Borduin, Schaeffer & Heiblum (2009)	USA Community	MST v USC Family focussed intensive community therapy. Mean length MST treatment 30.8 weeks (*SD* = 12.3) USC mean 30.1 weeks (*SD* = 18)	Referrals via court following sexual offence. MST *n* = 24 USC *n* = 24 Mean age 14 (*SD* = 1.9) Gender = 95.8 % boys	RCT	**Psychometrics** GSI, FACES-II, MPRI, SRD **Recidivism** Follow up mean 9.9 years (*SD*=1.02). Arrests classified as sexual or nonsexual. **Incarceration** measured by days incarcerated	**Psychometrics** GSI: MST mother, father and youth = sig decrease in symptoms (increase in USC). FACES-II: MST = increased cohesion and adaptability (decreased in UCS). MPRI: MST = increased emotional bonding and social maturity (decreased in USC). SRD: MST decrease in person and property (increase in USC) **Recidivism** MST had 83% fewer arrests for sexual crimes and 70% fewer arrests for nonsexual crimes than comparison. **Incarceration** = MST spent 80% fewer days in detention facilities. Survival analysis showed two groups sig difference $p<.01$	18/28 Fair
Borduin, Henggeler, Blaske & Stein (1990)	USA Community	MST v IT Family focussed intensive community therapy. Mean length treatment 37 hours (no = *SD*) Individual therapy mean 45 hours (no = *SD*)	Recruited after arrested for sexual offence MST *n* = 8 IT *n* = 8 Mean age 14 (no = *SD*) Gender = 100% boys	QE	**Recidivism** Follow up mean 37 months (no *SD*). Arrests classified as sexual or nonsexual.	MST recidivism = 12.5% for sexual offences 25% nonsexual. IT recidivism = 75% for sexual offences, 50% nonsexual	14/28 Poor

Study	Context and Country	Intervention details	Participant characteristics	Design	Relevant outcome measures	Findings	Quality /Appraisal
Letourneau et al. (2009)	USA Community	MST v TAU-JSO Mean treatment MST 7.1 months (*SD* =2.8) TAU-JSO 14.6 months (*SD* = 11) for probation yp 8.2 months (*SD* = 5.5) for diverted yp	Recruited via court after charged sexual offence MST *n* = 67 TAU-JSO *n* = 60 Mean age 14.6 (*SD* = 1.7) Gender = 97.6% boys	RCT	**Psychometrics** ASBI, SRD, CBCL, YRS, PEI	**Psychometrics** ASBI: MST group sig greater reduction in sexual behaviour compared to TAU-JSO. SRD: MST sig reduced delinquent behaviour compared to TAU-JSO. CBCL and YRS: baseline scores were all in normal range. Externalising behaviours sig reduced in MST compared to TAU-JSO. PEI: MST group sig reduced reported substance use	23/28 Good
Lab, Shields, Schondel (1993)	USA Community	SOT v control Psychoeducation 20 peer group meetings, individual and family sessions	Recruited via court referrals *n* = 155 Mean age SOT = 14.2 Control = 14.6 Gender SOT 100% boys Control 99% boys	QE	**Recidivism** Categorised as a sexual offence after treatment or any deviant act (sexual or otherwise)	**Recidivism** Regarding sexual offending, SOT (2.2%) no better than Control (3.7%). Regarding any other offence, SOT (24%) was statistically not less than Control group (18%)	9/28 Poor
Worling & Curwen (2000)	Canada Community	SAFE-T v comparison CBT, family therapy and psychoeducation Mean treatment 24.43 months (*SD* = 10.72)	Recruited after conviction of sexual offence SAFE-T *n = 58* Comparison *n = 90* Mean age 15.5 (*SD* = 1.5) Gender = 94% boys	QE	**Recidivism** Follow up mean 6.23 years (*SD* = 2.02). Criminal charges categorised as sexual offences, violence non-sexual offences, non-violent offences.	**Recidivism** Sexual offending in the Treatment group (5%) was 72% lower than the Comparison group (18%). Nonviolent offending in the Treatment group (21%) was 59% lower than the Comparison group (50%). Survival analysis show significant difference between Treatment and Comparison groups across all categories of reoffending	18/28 Fair

Study	Context and Country	Intervention details	Participant characteristics	Design	Relevant outcome measures	Findings	Quality /Appraisal
Seabloom, Seabloom, Seabloom, Barron & Hendrickson (2003)	USA Community	P/SA Individual and group psychotherapy, family therapy, family retreats, psychoeducation	Recruited via attendance on P/SA programme developed in response to HSB 122 families, 491 individuals Gender = 57% male (inc yp, mothers, fathers)	QE	**Recidivism** Follow up mean 18.34 years (no SD). Arrests, charges, convictions. Categorised as sex-related, violent, drugs and other.	**Recidivism** No arrests or conviction for sex-related crimes in programme completers. Programme completers less likely to be arrested (p =0.14) or convicted (p=0.04). Dropouts highest sex-related conviction at 8%.	10/28 Poor
Silovsky, Hunter & Taylor (2019)	USA Community	PSB-CBT Group family CBT informed treatment plus individual sessions	Recruited via referrals from multi agencies e.g. child welfare n = 189 Mean age = 12.8 (SD = 1.6) Gender = 91% boys	QE	**Psychometrics** YSBPI, YSR, CBCL, UCLA, FSSS	**Psychometrics** YSBPI: significantly lower reported sexual behaviour problems post treatment with large effect size. UCLA: Statistically significant reduction in trauma symptoms CBCL and YSR: Statistically significant reduction in emotional and behavioural concerns FSSS: Statistically significant increase in parenting skills	14/28 Poor
Hendriks & Bijleveld (2008)	Netherlands Residential	Group therapy and relapse prevention delivered by psychologists. Psychotherapy also offered	Recruited via correctional sexual offending programme n = 114 Mean age = 16 Gender = 100% boys	QE	**Recidivism** Classified as reconviction, sexually, violent and all offending	**Recidivism** After treatment, 11% sexually reoffended and 27% committed a non-sexual violent offence. Of all young people 70% reoffended to any offence.	13/28 Poor

Study	Context and Country	Intervention details	Participant characteristics	Design	Relevant outcome measures	Findings	Quality /Appraisal
Keiley, Zaremba-Morgan, Datubo-Brown, Pyle, & Cox (2015)	USA Prison	MFGI Skills development, group therapy, 8 sessions across 4 months	Recruited a correctional facility, young people detained following a sexual offence *n* = 115 Mean Age = 15.7 (*SD* = 1.7) Gender = 100% boys	QE	**Psychometrics** YSR, CBCL, ERC **Recidivism** Any offence	**Psychometrics** CBCL and YSR: Statistically significant reduction in maladaptive emotion regulation and behavioural concerns in child and mother, no change in father reports of maladaptive emotion regulation. ERC: Statistically significant reduction in attachment dependence **Recidivism** Only 4% of young people discharged from facility commit sexual offence and 19% for any other offence	14/28 Poor
Viljoen et al. (2017)	USA Residential	CBT treatment programme	Recruited from: *n* = 163 Mean Age = 15.39 (*SD*= 1.50) Gender = 100% boys	QE	**Psychometrics** JSOAP-II SAVRY **Recidivism** Classified as sexual, violent nonsexual and all other offending Mean follow up = 8.07 (*SD*=3.50)	**Psychometrics** Significant decrease on JSOAP-II after treatment for dynamic subscales (p=<.001) Significant decrease on SAVRY after treatment for dynamics subscale (p=<.001) **Recidivism** Total recidivism was 46%, sexual recidivism 7.4% and violent nonsexual 12.9%	16/28 Fair
Underwood, Dailey, Merino, & Crump (2015)	USA Prison and community	Sex offender treatment programme CBT informed, Psychoeducation	Evaluation of all participants of State wide programme. *n* = 312 Aged between 12-21, median ages 14-15. Gender = 100% boys	QE	**Psychometrics** JSOAP-II **Recidivism** Sexual and nonsexual reoffending	**Psychometrics** Significant decrease on JSOAP-II after treatment for both the intervention subscale (p=.006) and the community stability subscale (p=.007) **Recidivism** Total recidivism was 4.1%, sexual recidivism 1.6%	12/28 Poor

Study	Context and Country	Intervention details	Participant characteristics	Design	Relevant outcome measures	Findings	Quality /Appraisal
Waite et al (2005)	USA Residential	Two CBT based programmes based on differing degrees of intensity (self-contained = more intense and prescriptive)	All participants at residential unit. *n* = 256 Mean age at incarceration Self-contained = 16.9 (*SD*=1.22) Prescriptive = 18.8 (*SD*=0.94) Gender 100% boys	QE	**Recidivism** Categorised by re-arrest, months in community before re-arrest, and type of offence; sexual, non-sexual against the person or property offences.	**Recidivism** Sexual offences: 4.9% self-contained, 4.5% for prescriptive. Nonsexual: 27.8% self-contained, 39.3% for prescriptive Property offences: 13.2% self-contained, 39.3% for prescriptive. All offences: 47.2% self-contained, 70.5% for prescriptive. Self-contained group has longer mean time before arrest.	19/28 Poor
Carpentier, Silvosky, Chaffin (2006)	USA Community	2 session CBT v group play compared to control	Recruited via referrals from a range of services *n* = 291 SPB-CBT Mean age at baseline = 8.8 (*SD*=2) Gender 63% boys SBP-PT Mean age at baseline = 8.1 (*SD*=1.6) Gender 60% boys Control Mean age at baseline = 8.8 (*SD*=2.0) Gender 78% boys	RCT	**Recidivism** Sexual and nonsexual reoffending	**Recidivism** Baseline age significant associated with sex offence survival $p < .01$ (time taken before sexual offence) CBT statistically significantly longer survival time than PT $p < .05$ Children with CBT indistinguishable to control group in term of later sexual offending	22/28 Good

Table 1. Includes mean and SD where reported.

Individual Therapy (IT); Multi-Family Group Intervention (MFGI); Multi-Systematic Therapy (MST); Problematic Sexual Behaviour - Cognitive Behaviour Therapy (PSB-CBT); Sex Offender Treatment (SOT); Sexual Abuse, Family Education and Treatment (SAFE-T); Sexualised Problem Behaviour Cognitive Behaviour Therapy (SPB-CBT); Sexualised Problem Behaviour Play Therapy (SPB-PT); The Personal/Social Awareness programme (P/SA); Treatment As Usual for Juvenile Sexual Offenders (TAU-JSO); Usual Community Services (USC).

Quasi-experimental (QE); Randomised Controlled Trial (RCT).

Adolescent Sexual Behaviour Inventory (ASBI); Child Behaviour Checklist (CBCL); Emotion Regulation Checklist (ERC); Family Adaptability & Cohesion Evaluation Scales II (FACES-II); Family, Skills, Supports, and Stressors Scale (FSSS); Global Severity Index (GSI); Interpersonal Reactivity Index (IRI); Juvenile Sex Offender Assessment Protocol – II (JSOAP-2); Missouri Peer Relations Inventory (MPRI); Personal Experiences Inventory (PEI); Self-Report of Delinquent Behaviour (SRD); Sexual Knowledge Questionnaire (SKQ); University of California-Los Angeles Posttraumatic Stress Disorder Index (UCLA); Youth with Sexual Behaviour Problems Inventory (YSBPI); Youth Self Report (YSR).

Assessment of Quality Results

The ICC estimate suggested that the inter-rater reliability was good (Koo & Mae, 2016). Following independent scoring, the author and the independent rater discussed any discrepancy in scores and agreed a final rating. The final quality assessment rating for each question are illustrated in Table 2.

None of the studies included was able to demonstrate that there was a comprehensive attempt to measure adverse events (Question 8; *Have all important adverse events that may be a consequence of the intervention been reported*?). Similarly, none of the studies completed a power analysis (Question 27; *Did the study have sufficient power to detect a clinically important effect where the probability value for a difference being due to chance is less than 5%?*). Power refers to the sensitivity or probability that the statistical analysis will correctly reject the null hypothesis and demonstrates that the study has the necessary requirements to detect an effect, if one exists (Hinklemam & Kempthorne, 2008).

None of the studies achieved a quality rating of excellent. Two studies (Letourneau et al., 2009; Carpentier, Silovsky, & Chaffin, 2006) achieved a quality rating of good. Both these studies used a RCT design. Four studies (Borduin, Schaeffer, & Heiblum, 2009; Worling & Curwen, 2000; Viljoen et al., 2017, Waite et al., 2005) achieved a quality rating of fair. The remaining seven studies (Borduin, Henggeler, Blaske & Stein, 1990, Lab, Shields, & Schondel, 1993, Seabloom, Seabloom, Seabloom, Barron & Hendrickson, 2003; Silovsky, Hunter, & Taylor, 2019; Hendriks & Bijleveld, 2008; Keiley, Zaremba-Morgan, Datubo-Brown, Pyle, & Cox, 2015; Underwood, Dailey, Merino, & Crump, 2015) achieved a quality rating of poor. A breakdown of each dimension of the Downs and Black (1998) checklist can be found in Table 3.

Table 2

Quality Assessment Scores per Question per Study

Question	Borduin, Schaeffer & Heiblum (2009)	Borduin, Henggeler, Blaske & Stein (1990)	Letourneau et al. (2009)	Lab, Shields, Schondel (1993)	Worling & Curwen (2000)	Seabloom, et al. (2003)	Silovsky, Hunter, & Taylor (2019)	Hendriks & Bijleveld (2008)	Keiley et al. (2015)	Viljoen et al. (2017)	Underwood, Dailey, Merino, & Crump (2015)	Waite et al. (2005)	Carpentier, Silovsky, & Chaffin (2006)
1	1	1	1	0	1	1	1	1	1	1	1	1	1
2	1	1	1	1	1	1	1	1	1	1	1	1	1
3	1	1	1	1	1	0	1	1	1	1	0	1	1
4	1	1	1	0	1	1	1	1	1	1	1	1	1
5	0	0	0	1	1	0	1	1	0	0	0	1	2
6	1	1	1	1	1	0	1	0	1	1	0	1	1
7	1	0	1	0	1	0	1	0	1	1	0	1	1
8	0	0	0	0	0	0	0	0	0	0	0	0	0
9	1	1	1	0	1	0	0	1	0	0	0	1	1
10	0	1	0	0	0	1	0	0	0	1	1	1	0
11	1	0	1	1	1	0	1	0	1	1	1	1	1
12	1	0	1	0	1	0	0	0	1	1	1	0	1
13	1	1	1	1	1	1	1	1	1	1	1	0	1
14	0	0	1	0	0	0	0	0	0	0	0	1	0
15	0	0	1	0	0	0	0	1	0	0	0	0	0
16	1	1	1	0	1	1	1	1	1	1	1	1	1
17	1	0	1	0	0	0	0	1	1	1	0	0	1
18	1	1	1	0	1	1	1	1	1	1	1	1	1
19	0	0	1	0	0	0	1	0	0	0	0	0	1
20	1	1	1	1	1	0	0	0	1	1	1	1	1
21	1	1	1	1	1	1	1	1	1	1	1	1	1
22	1	1	1	0	1	1	1	0	0	1	1	1	1
23	1	0	1	0	0	0	0	0	0	0	0	0	1
24	0	0	0	0	0	0	0	0	0	0	0	0	0
25	0	0	1	0	1	1	0	1	0	0	0	1	1
26	1	1	1	1	1	0	0	0	0	0	0	1	1
27	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	18	14	22	9	18	10	14	13	14	16	12	19	22

Table 3
Breakdown of Scores Across Dimensions

	Borduin, Schaeffer & Heiblum (2009)	Borduin, Henggeler, Blaske & Stein (1990)	Letourneau et al. (2009)	Lab, Shields, Schondel (1993)	Worling & Curwen (2000)	Seabloom et al. (2003)	Silovsky, Hunter & Taylor (2019)	Hendriks & Bijleveld (2008)	Keiley et al.(2015)	Viljoen et al. (2017)	Underwood Dailey,Merino& Crump (2015)	Waite et al. (2005)	Carpentier, Silovsky, & Chaffin 2006
Reporting total	7/11	7/11	7/11	4/11	8/11	4/11	7/11	6/11	6/11	7/11	4/11	9/11	9/11
Reporting %	63.64%	63.64%	63.64 %	36.36%	72.72%	36.36%	63.64%	54.55%	54.55%	63.64%	36.36%	81.82 %	81.82%
External Validity total	3/3	1/3	3/3	2/3	3/3	1/3	2/3	1/3	3/3	3/3	3/3	2/3	3/3
External Validity %	100%	33.33%	100%	66.67%	100%	33.33%	66.67%	33.33%	100%	100%	100%	66.67 %	100%
Internal validity total	4/7	3/7	7/7	1/7	3/7	2/7	3/7	4/7	4/7	4/7	3/7	4/7	5/7
Internal validity %	57.14%	42.86%	100%	14.29%	42.86%	28.57%	42.86%	57.14%	57.14%	57.14%	42.86%	57.14 %	71.43%
Internal validity confounding (selection bias) total	4/6	3/6	5/6	2/6	4/6	3/6	2/6	2/6	1/6	2/6	2/6	4/6	5/6
Internal validity confounding (selection bias)%	66.67%	50%	83.33 %	33.33%	66.67%	50%	33.33%	33.33%	16.67%	33.33%	33.33%	66.67 %	83.33%
Power	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
Total	18/28	14/28	22/28	9/28	18/28	10/28	14/28	13/28	14/28	16/28	12/28	19/28	22/28
Total %	64.29%	50%	78.57 %	32.14%	64.29%	35.71%	50%	46.43%	50%	57.14%	42.86%	67.86 %	78.57%
Rating	Fair	Poor	Good	Poor	Fair	Poor	Poor	Poor	Poor	Fair	Poor	Fair	Good

Narrative Synthesis of Findings

The following will refer only to data recorded relating to the treatment of J-HSB. The findings have been broken down into treatment type comprising of CBT, MST and ‘eclectic’.

CBT

Six studies used CBT as their intervention with quality ratings of ‘good’ (Carpentier, Silolvsky & Chaffin, 2006), ‘fair’ (Worling & Curwen, 2000; Viljoen et al., 2017; Waite et al., 2005) and ‘poor’ (Silovsky, Hunter, & Taylor, 2019; Underwood, Dailey, Merino & Crump, 2015).

Carperntier, Silolvsky, and Chaffin (2006) used an RCT design (all other studies were quasi-experimental). This paper was slightly different from other studies, whose main focus were J-SO, as it had a much younger sample. This paper focussed on sexual behaviour problems of 135 children aged 5-12 years old. The outcome variable measured future offending rates to establish effectiveness of the CBT intervention. The study used two comparison groups. Firstly it randomised children with sexual behaviour into two groups, a CBT group and a play therapy (PT) group. There was another comparison group of children with disruptive behaviour not receiving treatment. The intervention was a highly structured programme relying on behaviour modification and psychoeducational principles. The CBT group had significantly fewer sexual offences (2%) than the play therapy group (10%) and were indistinguishable from the comparison group (who did not display sexually problematic behaviour). A survival analysis found that the CBT group were significantly better at survival than the PT group, that is, they were significantly less likely to be arrested for a sexual offence. In addition, survival analyses showed that the CBT group were indistinguishable from the clinical comparison

group who did not display HSB at base line. Authors concluded this provided evidence for the efficacy of using structured CBT to target problematic sexual behaviour. Waite et al. (2005) also use offending data as an outcome measure. This paper outlines two programmes (a 'self-contained' programme and a less intensive 'prescriptive' programme) for sex offenders within a specialist residential unit. Both received CBT interventions. The findings indicated that the self-contained intensive group had a sexual reconviction rate of 4.9% (56 months follow up) and the prescriptive group had a reconviction rate of 4.5% (69 months follow up). For all offences the self-contained group had a lower rate (47.2%) compared to the prescriptive group (70.5%). Whilst these rates appear low for both groups, since there was no comparison or control group in this study these figures are best understood when compared to other studies of recidivism (see Recidivism section).

Viljoen et al. (2017) compared scores on two risk assessments and recidivism data to explore the treatment efficacy of CBT. The risk assessments used were the Juvenile Sex Offender Assessment Protocol-II (J-SOAP; Prentky & Righthand, 2003) and the Structured Assessment of Violence Risk in Youth (SAVRY; Borum, Bartel, & Forth, 2006). This study did not have a control group. The programme was a community based residential CBT intervention (so participants could leave). The analysis of the J-SOAP-II and SAVRY found a significant reduction in risk from pre to post intervention on all dynamic risk factors except one of the six scales on the SAVRY (Social/contextual). Protective factors on the SAVRY increased at discharge (post measures) although the magnitude of this effect was small. Additional findings indicated that juveniles who showed reliable decreases on the Intervention subscale of the J-SOAP-II were less likely to re-offend. The study did collect recidivism rates in order to try and develop a predictive model of recidivism based on risk assessment scores, but the model was not a good fit

and the raw data has not been clearly described and therefore cannot be reported. Blind scoring of the risk assessments would have improved reliability of this study. The J-SOAP-II is an assessment recommended by NICE (2016) it is therefore positive that this measure was selected.

Underwood, Dailey, Merino, and Crump (2015) completed an evaluation of a CBT based J-SO programme. This study also looked at the J-SOAP-II and recidivism rates. The programme's focus was on re-entering young people into the community and the challenging of cognitions, inner dialogue beliefs and behaviour. Like the Viljoen et al. (2017) study, this study also found a significant decrease in the J-SOAP-II on both dynamic scales (intervention and community) after treatment. Recidivism rates were recorded at 4.1% for total recidivism and 1.6% for sexual recidivism. Again, as with the Waite et al. (2005) study because there was no control group it is difficult to interpret in isolation (see Recidivism section).

Silovsky, Hunter, and Taylor (2019) focused on HSB rather than convicted offences. Like Carperntier, Silolvsky and Chaffin (2006) which also focussed on problematic sexual behaviour, the sample involved younger participants than other studies (ages 10-14). The rationale for this study was based on literature that suggests that early intervention and diversion programmes involving caregivers were the most successful. The study focussed on three community based programmes that used CBT for problematic sexual behaviour. It used a range of psychometric tools as outcome measures and did not follow up on future offence rates. The results showed a significant decrease of scores, with a large effect size, on the Youth with Sexual Behavior Problems Inventory (YSBPI; Silovsky, Chaffin, Swisher, & Pierce, 2011) indicating that the intervention had been successful. The follow up period, however, was only 4.2 months which is relatively short. As such, conclusions cannot be drawn about the long-term implications of this

intervention. It should also be noted that the YSBPI is an unpublished measure and therefore the utility of it has not been thoroughly explored or peer reviewed. The Child Behavior Checklist (CBCL; Achenbach, 1995) and the Youth Self Report (YSR; Achenbach, 2001) also indicated a statistically significant reduction in both youth report and care giver report of internalising behaviours (e.g. feeling fearful, inhibited and overcontrolled) and externalising behaviour (e.g. aggressive, anti-social or under controlled behaviour). Whilst these results seem promising for the use of CBT in treating problem sexual behaviour in juveniles, it is difficult to make conclusions given the lack of comparison group and follow up.

Worling and Curwen (2000) evaluated a community-based intervention for J-SOs. The programme used cognitive behavioural and relapse prevention strategies and involved family input as well as individual therapy. The study used a comparison group, which was a strength of the study, but some of the comparison group were receiving treatment elsewhere, meaning that this group was not homogenous. Additionally, there was a small proportion of girls in both the treatment and comparison group. The study collected psychometric data and recidivism information. It completed a survival analysis and found significant differences between the treatment and comparison group: sexual recidivism for the treatment group (5%) was 72% lower than for the comparison group (18%) and nonviolent offending in the treatment group (21%) was 59% lower than the Comparison group (50%). Whilst this study again found evidence to support the use of CBT, it did not report a power analysis or report the effect size.

In summary, the two studies that compared a CBT intervention with a comparison intervention group found that the CBT intervention was statistically more likely to reduce sexual re-offending compared with the control group (Carperntier, Silolvsky, & Chaffin,

2006; Worling & Curwen, 2000). The other four studies report statistically significant reductions in psychometric and risk assessment scores.

MST

The three studies that used MST as a psychological model of treatment had varying degrees of quality: one study was rated good (Letourneau et al., 2009), one has a rating of fair (Borduin, Schaeffer, & Heiblum, 2009) and one was rated poor (Borduin, Henggeler, Blaske & Stein, 1990). Two studies used an RCT design which is the gold standard (Stolbeg, Norman, & Trop, 2004) and it was a strength of these studies that they each used a comparison group. All three studies found that MST provided superior results in the treatment of J-HSB compared to the comparison group.

Letourneau et al. (2009) had the largest sample size (n = 127) and measured MST effectiveness using psychometric tools. Of all studies in this review, this was the only study to score 100% for internal validity, it was also one of the few that scored 100% for external validity, according to the Downs and Black checklist (1998). The study found that both youth report and care-giver report of problem sexual behaviour as measured by the Adolescent Sexual Behavior Inventory (ASBI; Friedrich, Lysne, Sim, & Shamos, 2004) were significantly lower after MST compared to the Treatment As Usual (TAU) group. The MST group displayed a considerable reduction on self-report delinquent behaviour as measured by the Self-Report Delinquency Scale (SRD, part of the National Youth Survey; Elliott, Huizinga, & Ageton, 1985). The MST group reported a decrease in scores from pre-treatment to 12 months post treatment of approximately 60% whereas the TAU group reported decreases of 18%. MST also demonstrated statistically significant decreases in self-report in externalising behaviour (e.g. aggressive, anti-social or under controlled behaviour) compared to the TAU group, as measured by the Youth

Self-Report (YSR; Achenbach, 2001). However, there was no difference between the MST and TAU groups in care-giver report of externalising behaviour, as measured by the CBCL (Achenbach, 1995) or self-report and caregiver report of internalising behaviour (e.g. feeling fearful, inhibited and overcontrolled). Whilst the authors concluded that MST was effective, and there were other findings not reported here, regarding measures of self-report and care-giver report of behaviour, MST was not dissimilar to TAU.

Borduin, Schaeffer, and Heiblum (2009) had a relatively small sample size (n = 48) and used both psychometric tools and recidivism as outcome variables. As with Letourneau et al. (2009) one of the psychometrics was the SDR. This study found that the MST scores were significantly lower for delinquent behaviour, but the scores for the comparison group had significantly increased. These scores, however, only relate to pre and post treatment, and unlike Letourneau et al. (2009) , there was no psychometric follow up, so it is unknown whether these treatment gains were maintained. This paper did record recidivism rates and found that the MST group had 83% fewer arrests for sexual crimes than the comparison group and 70% fewer arrests for other crimes. A survival analysis showed that at the end of collecting data (8.9 years later) MST participants were statistically at a lower risk of being re-arrested: 29.2% of MST participants had a further arrest compared to 75% in the control group. This study appears to provide overwhelming support for MST as an intervention for HSB, but it should be noted that a power analysis was not completed, so there is the risk that these findings represent a Type 1 error. Authors concluded that the efficacy of MST was in part due to the specific focus MST has on the key social-ecological risk factors related to HSB, for example promoting healthier pro-social relationships with family and peers and targeting unhelpful socialisation into contexts where HSB may occur. Authors commented that increased

family support, opportunity to experience success and improved peer relations may have contributed to the mechanism of change.

Borduin, Henggeler, Blaske, and Stein (1990) also explored the efficacy of using MST with J-HSB. This study had a small sample size (n = 16). It was one of the studies included in this review with the lowest score on external validity (see Table 3). The paper used a comparison group who received individual therapy, the outcome variable was recidivism. Follow-up recidivism data was collected between 21 - 49 months after treatment. The results found that the MST group had fewer arrests for sexual offences (12.5%) compared to the comparison group (75%). These results were also replicated for non-sexual offences whereby the MST group had significantly fewer arrests (25%) compared to the comparison group (50%). Differences in frequency of arrest for non-sexual offences were not significant. A power analysis was not calculated and nor was an effect size. In summary, percentages of arrests appear to show a large difference between groups, and support the hypothesis that MST is most efficient in treating J-HSBs. Yet, the sample was very small there is no evidence of a power calculation or an effect size it therefore again it is possible that this is a Type I error. This paper achieved a quality assessment rating of poor. If it were to be replicated, some methodological improvements and a larger sample size may produce reliable statistically significant results.

In summary, all MST studies used a comparison group. All studies concluded that compared to other interventions, MST participants were statistically significantly less likely to sexually re-offend (Borduin, Henggeler, Blaske, & Stein,1990; Borduin, Schaeffer, & Heiblum 2009) and show statistically significant reduced psychometric scores of problem sexual behaviour (Borduin, Schaeffer, & Heiblum, 2009; Letourneau

et al., 2009). Due to mixed quality of the MST papers, conclusions should be viewed with caution.

Eclectic

Despite not providing a rationale for using an eclectic model of intervention and seemingly without being driven by the evidence base, almost a third of papers used an eclectic model. Of the four studies that used an eclectic use of psychological models, none of them used an RCT design and all four studies received a quality rating of poor (Lab, Shields, & Schondel, 1993; Seabloom, Seabloom, Seabloom, Barron & Hendrickson, 2003; Hendriks & Bijleveld, 2008; Keiley, Zaremba-Morgan, Datubo-Brown, Pyle, & Cox, 2015).

Lab, Shields, and Schondel (1993) explored the utility of a court-based programme. The programme made use of psychological concepts to develop a psycho-social-educational intervention plan. It included family counselling, individual sessions and group meetings. The study compared a treatment group to a comparison group and used recidivism as the outcome measure. Follow up time was different across groups and survival analysis was not conducted. Despite this, the results indicated little differences in sexual re-offending between the treatment group (2.2%) and comparison group (3.7%). Similarly, with non-sexual offending, there was little difference between the treatment group (24%) and the comparison group (18%) with treatment participants displaying higher offending rates, although not statistically significant. In summary, this treatment programme did not have a coherent psychological model and was no better at reducing recidivism than the comparison group. It was helpful that this paper was published as often non-significant studies are not published (Song et al., 2010)

Seabloom, Seabloom, Seabloom, Barron, and Hendrickson (2003) conducted a follow up of a J-SO programme called the ‘Personal/Social Awareness Program’. This

programme involved weekly 3 hour psychotherapy groups, bi-weekly individual psychotherapy, family therapy, bi-monthly ’27 hour marathons’ which involved an extended group session in a retreat and twice a year a family awareness seminar. The paper used recidivism as a measure of effectiveness. The follow up mean was 18.34 years, and the paper reports that of programme completers (*n* = 50) there was not one single arrest or conviction for any further sexual offences. The analysis reports that programme completers were statistically less likely to be arrested or convicted for other offences than participants who refused or withdrew from the programme. The complete absence of sexual recidivism after such a long time appears suspect. Interventions were not driven by psychological literature (also reflected in the lowest rating for internal reliability) indicating that any successes may be due to confounding reasons and not the programme.

Hendriks and Bijleveld (2008) explored the effectiveness of a residential juvenile sex offender treatment programme. The programme was based on a relapse prevention model, social skills training and psychotherapy for those who needed it. The programme was delivered by psychologists. Recidivism rates were collected after a median time of 9 years and indicated that 11% of participants sexually re-offended, after three years 70% of those who went on to re-offend had done so. Twenty-seven per cent of participants went on to commit a non-sexual violent offence, again, after three years, 60% of those who went on to offend had done so. Without a comparison group, these figures are difficult to interpret and should be done so with caution (see Recidivism section for further discussion).

Keiley, Zaremba-Morgan, Datubo-Brown, Pyle, and Cox (2015) explored the effectiveness of a multi-family group intervention. The aim was to target maladaptive emotion regulation, and reduce problematic behaviours by altering habitual responses,

increasing attachments to caregivers, regaining access to cognitive functioning, and managing arousal. This was completed in individual therapy, group therapy and for some parents, couples counselling. The programme appears to use psychological concepts and tools from cognitive, systemic and family therapy, but did not follow a cohesive model. The study used psychometric tools as an outcome measure and reported decreases in mothers' report of maladaptive emotion regulation on the CBCL (Achenbach, 1991) and self-report on the YSR (Achenbach, 2001) but the fathers' scores indicated no change. Authors report a decrease in externalising behaviours reported by caregivers and self-report following the programme. Authors reported programme recidivism data at 4% for sexual re-offending and 19% for all offences (Burkhart, 2013) but did not collect this data themselves. This paper received the lowest score for internal validity (confounding) and a low rating for external validity therefore it is not possible to determine effectiveness of the programme.

In summary, of studies that adopted an eclectic model of psychology, two used a comparison group. One found no difference in recidivism between treatment group and comparison group (Lab, Shields, & Schondel, 1993). Conversely, and perhaps surprisingly, the other study reported that of the programme completers there were no further sexual offences at all (Seabloom, Seabloom, Seabloom, Barron, & Hendrickson, 2003). This is unusual given that approximate rates of juvenile sexual recidivism are thought to be 5% (Caldwell, 2016) or a less specific estimate of average sexual recidivism 3-15% (Caldwell & Dickinson, 2009). One study reported statistically significant reduction in psychometric scores before and after treatment, although also noted that fathers did not report a change in the young person's behaviour (Keiley, Zaremba-Morgan, Datubo-Brown, Pyle, & Cox 2015), and finally another study only reported recidivism without referring to a comparison group (Hendriks & Bijleveld, 2008) (see the

Recidivism section to explore this further). The lack of psychological rationale, neglect of clinical guidance and poor methodological quality of studies, raises questions as to the validity of these results.

Recidivism

Recidivism rates across studies vary. Caldwell (2002) completed a meta-analysis using data from 12 recidivism studies of juvenile sex offenders, using reconviction as the outcome variable. Follow up time varied between 24-120 months. Analysis revealed sexual recidivism ranged from 1.7% to 19.6% with an overall percentage of 11%. Caldwell (2016) later completed a meta-analysis and reported a weighted mean of 5% official recidivism by juveniles. Eleven of the 13 studies in this review report recidivism data but only five report comparison data, making interpretation difficult. It is difficult to synthesise and interpret these data due to different methodological designs and poor reporting. Some studies report arrests, others report convictions, and all use different follow up times, even within studies. Table 4 provides a breakdown of arrest/recidivism information reported in the studies. Visual inspection suggests that the studies that used CBT all report recidivism rates around or below 5% similar to that found by Caldwell (2016), whereas there is more variance in the MST and eclectic groups.

Table 4

Recidivism Data from All Studies

Paper	Intervention	Follow up	Sexual recidivism	Control group	Comments
Carperntier, Silolvsky & Chaffin (2006)	CBT	10 years (120 months)	2%	Play therapy 10% Clinical comparison 3%	CBT group significantly better at survival than play therapy group, and indistinguishable from the comparison group. CBT effective tool to treat harmful sexual behaviour. Did survival analysis.
Waite et al. (2005)	CBT	56 and 69 months	4.9% and 4.5%	-	Did survival analysis
Viljoen et al. (2017)	CBT	-	-	-	Raw data not clearly reported Unable to determine
Underwood, Dailey, Merino, & Crump (2015)	CBT	Not stated. Not possible to be over 51 months	1.6%	-	Data collected Dec 2012 – March 2013. This includes info on all participants from 2008-2012 so follow up minimal. No survival analysis.
Worling & Curwen, (2000)	CBT	2-10 years mean 6.23 years (78 months)	5.17%	17.8%	CBT statistically more efficient. Did survival analysis
Borduin, Schaeffer & Heiblum (2009)	MST	8.9 years (107 months)	8.3%	45.8%	MST statistically more efficient 83% fewer arrests for sexual crimes
Borduin, Henggeler, Blaske, & Stein, (1990)	MST	Approx. 36 months	12.5%	75%	Incorrect stats recorded regarding alpha levels set for two-tailed analysis. Statistically not significant. No survival analysis.
Lab, Shields, & Schondel (1993)	Eclectic	Not stated. Not possible to be over 60 months	2.2%	3.7%	Statistically not significant Study published Oct 1993. Follow up includes all participants from 1988-1991 so follow up minimal. No survival analysis.
Hendriks & Bijleveld (2008)	Eclectic	Median 9 years (108 months)	11%	-	70% of these offences happened within 3 years
Seabloom et al. (2003)	Eclectic	Mean 18.4 years (221 months)	0%	Not clear	
Keiley, et al. (2015)	Eclectic	Not stated	4%	-	Data quoted elsewhere (Burkhart, 2013)

Discussion

This systematic literature view had three objectives, each of which will be discussed.

Firstly, the review aimed to explore the quality of studies examining the effectiveness of psychological interventions in the treatment of J-HSB. Within the literature, there are surprisingly few studies that explicitly explore the effectiveness of psychological interventions with J-SO. After a systematic literature search, 13 studies were identified. The majority of these studies had flawed methodologies, with the majority of studies achieving a quality rating of fair (n = 4) or poor (n = 7) with problems frequently related to internal validity (see Table 3). Studies did not appear to have a clear rationale or be driven by an evidence base.

Looking at the existing studies it would seem that in terms of the translational science continuum (Thornicroft, Lempp., & Tansella, 2011) research in this area seems to have started without sufficient basic science work. The field would benefit from establishing a theoretical consensus as to what would work for J- HSB. In recent years clinical guidance in the UK has been published for working with J-HSB (e.g. NICE, 2016, NSPCC, 2014) which recommends MST, CBT family approaches ad strengths based approaches. Moving forward, research should be evidence based as per these frameworks.

A major methodical criticism of all studies was the lack of power analysis, which may contribute to a Type 1 error. However, calls for more RCT's need to consider power analyses as there is a significant difficulty evaluating interventions for sex offenders. One issue is that 'no treatment' control groups in sex offender studies would be unethical. It would be unethical to sanction sex offenders to be placed in a no treatment group where the outcome variable is recidivism. Thus, all RCTs would need to compare two treatment

conditions. This has the impact of significantly increasing the number of participants required, time to complete the study and cost.

It is likely that the literature is subject to publication bias. Hopewell, McDonald, Clarek, and Egger (2007) investigated health care intervention research studies and found that published trials show a greater treatment effect than unpublished material. Recommendations were for researchers to include grey literature to minimise this bias. Unfortunately, no grey literature met the inclusion criteria for this study.

The second objective was to provide a synthesis of the available literature. Given the range of methodological designs and outcomes variables this proved difficult and so studies were broken down into three psychological models used: CBT, MST and eclectic approaches. Bearing in mind the general fair to low quality of the studies, all the studies in both the CBT and the MST groups showed a positive effect of using these specific interventions. Outcomes for the eclectic studies were more varied. The rationale underlying these treatment approaches were unclear. The recidivism data is hard to interpret but by comparing recidivism figures across modalities, CBT studies had the consistently lowest rates of recidivism. However, the use of different designs, lengths of treatment, use of comparison groups, offence type (conviction vs problem sexual behaviour) outcome variables and different lengths of follow up, mean that it is difficult to compare these studies with each other, and any conclusion should be interpreted with caution.

The final objective was a meta-analysis on available data to explore the effectiveness of interventions on self-reported behavioural problems. After the data was grouped by outcome variable it became apparent that due to a lack of raw data and differences in reporting findings, there was insufficient data to complete a meta-analysis.

Recidivism is often used as an outcome variable to measure effectiveness of criminogenic interventions. Using recidivism as an outcome variable is problematic because it is impossible to know true figures of sexual recidivism. Wittebrood, (2006) argues that the rarity of documented sexual offending means the literature is likely to vastly under-represent the proportion of true recidivism. This is illustrated by a National Women's Study conducted in the USA. In this study 4,000 adult women were surveyed. Of these women, 341 (8.5%) reported being victims of rape before the age of 18. Of the 341 who had been raped before 18, only 11.9% reported the rape to authorities meaning that almost 90% of rapes had gone unreported (Hanson, Resnick, Saunders, Kilpatrick, & Best, 1990). Moreover, of these offences, only a small proportion is likely to have resulted in a conviction. Whilst this study is somewhat dated, it highlights the complexities of recording recidivism data. This illustrates how few offences were reported to the police, despite it being a penetrative offence. The survey study focussed on rape, sexual recidivism, however, could refer to a range of sexual offences, including sexual assault, attempted rape, exposure, and voyeurism, offences which may be even less likely to be reported to authorities. This therefore presents a problem in assessing the efficacy of an intervention based on recidivism because we know official statistics do not represent the extent of sexual offending. Conversely, it could be argued that those with an offence history may be under increased scrutiny. However, once a person has served a sentence, whilst he/she may be required to sign the sex offenders register and report his or her address, he or she is not subject to formal surveillance. With that in mind, the recidivism data captured within this review is also flawed for a number of additional reasons. Firstly, there is a disparity of specifically what is being recorded, some studies report arrests and others report convictions. Secondly, there is inconsistency in terms of

follow up time in the collection of recidivism data, both between and within studies, some studies do not even state the length of follow up time. Length of follow up time is extremely important given individuals who commit sexual offences may remain at risk of reoffending for many years post treatment (Hanson, Steffy, & Gauthier, 1993). Finally, whilst these studies aim to measure a psychological intervention, it is not possible to determine that it was the programme alone that contributed to outcome, particularly recidivism. For example individuals in residential settings may also be accessing other therapeutic interventions at the same time, before or after the programme that is not captured by study. Therefore, it is impossible to conclude that it is the treatment programme alone that is responsible for lowering recidivism rates.

Limitations and future research

There are a number of limitations with this review. It is possible that there is undiscovered literature in the public domain that has not been accessed. Given that there was no unpublished literature, it is likely that this review will have suffered the effects of publication bias. It was not possible to complete a meta-analysis, due to different methodological designs, outcomes measures and dependent variables across studies. As a result of this, it is possible that the narrative synthesis was also subject to researcher bias. Whilst efforts were taken to minimise this bias, for example the implementation of inter-rater reliability assessment, the conclusions may still be susceptible to subjectivity. Unfortunately most of the papers were of poor quality, consequently it is difficult to draw conclusions about the effectiveness of psychological treatments of J-HSB. Clinicians, academics and research would benefit from developing a theoretical consensus as to what would work for J-HSB and the measures to explore this. There is a lack of available psychometric data available to inform power analyses and as discussed relying on recidivism data is problematic. Future research should aim for the use of RCT designs

comparing two treatment groups. The review focussed only on studies that reported a psychological element to the intervention. It may be useful in future to widen this to include all treatment programmes and compare whether having a more explicit psychological component makes any difference.

Conclusions

This primary objective was to explore the effectiveness of psychological interventions with juveniles that display harmful sexual behaviour. However, it was not possible to draw conclusions effective interventions due to poor quality studies and disagreement between researchers about how this should be measured. In summary, researchers in this field needs to consider the current evidence base and develop a consensus on interventions and them measurement of them. This would help to improve the quality of future research in the area. Clinicians are encouraged to follow published guidelines for working with J-HSB.

References

Achenbach, T. M. (1995). *Youth self-report.* Burlington: University of Vermont, Research Center for Children, Youth and Families.

Achenbach, T. M. (2001). *Child behaviour checklist for ages 6 to 18*. Burlington: University of Vermont, Research Center for Children, Youth and Families.

AIM. (2008). *Assessment, intervention and moving o*n. Retrieved from http://aimproject.org.uk/

Allnock, D., Bunting, L., Price, A., Morgan-Klein, N., Ellis, J., Radford, L., & Staffrod, A. (2009). *Sexual abuse and therapeutic services for children and young people: The gap between provision and need*. London: NSPCC

Beck, A. T. (1967). *Depression: Causes and treatment*. Philadelphia: University of Pennsylvania Press.

Beek, E., Spruit, A., Kuiper, C., van der Rijken, R., Hendriks, J., & Stams, G. J. (2018). Treatment effect on recidivism for juveniles who have sexually offended: a multilevel meta-analysis. *Journal of Abnormal Child Psychology, 46,* 543-556. doi: 10.1007/s10802-0.7-0308-3

Borduin, C. M., & Henggeler, S. W. (1990). A multisystemic approach to the treatment of serious delinquent behaviour. In R. J. McMahon & R. Dev. Peters (Eds.), *Behavior disorders in adolescence: Research, intervention, and policy in clinical and school settings* (pp. 62-80). New York: Plenum.

**Borduin, C. M., Henggeler, S. W., Blaske, D. M., & Stein, R. J. (1990). Multisystemic treatment of adolescent sexual offenders. *International Journal of*

Offender Therapy and Comparative Criminology, 34, 105-113. https://doi.org/10.1177/0306624X9003400204

**Borduin, C. M., Schaeffer, C. M., & Heiblum, N. (2009). A randomized clinical trial of multisystemic therapy with juvenile sexual offenders: Effects on youth social ecology and criminal activity. *Journal of Consulting and Clinical Psychology, 77*, 26-37. doi: 10.1037/a0013035

Borum, R., Bartel, P., & Forth, A. (2006). *Manual for the structured assessment for violence risk in youth (SAVRY*). Odessa, FL: Psychological Assessment Resources.

Burkhart, R. B. (2013). *Accountability based sexual offender program.* Paper presented at Department of Youth Services: Juvenile Probation Officers Meeting, Montgomery, AL.

Caldwell, M. F. (2002). What we do know about juvenile sexual offence risk. *Child Maltreatment, 7*, 291-302. https://doi.org/10.1177/107755902237260

Caldwell, M. F. (2016). Quantifying the decline in juvenile sexual recidivism rates. *Psychology, Public Policy and Law, 22*, 414-426. doi: 10.1037/law0000094

Caldwell, M. F., & Dickinson, C. (2009). Sex offender registration and recidivism risk in juvenile sexual offenders. *Behavioral Sciences and the Law, 27,* 941-56. https://doi.org/10.1002/bsl.907

**Carpentier, M. Y., Silovsky, J. F., & Chaffin, M. (2006). Randomized trial of treatment for children with sexual behaviour problems: Ten-Year follow up. *Journal of Consulting and Clinical Psychology, 74,* 482-488. http://dx.doi.org/10.1037/0022-006X.74.3.482

Dopp, A. R., Borduin, C. M., & Brown, C. E. (2015). Evidence-based treatments for juvenile sexual offenders: review and recommendations. *Journal of Aggression, Conflict and Peace research, 7*, 223-236. https://doi.org/10.1108/JACPR-01-2015-0155

Downs, S. H., & Black, M. (1998). The feasibility of creating a checklist for the assessment of the methodological quality both of randomised and non-randomised studies of health care interventions. *Journal of Epidemiological Community Health, 53,* 377-384. doi: 10.1348/014466509X470789

Elliott, D. S., Huizinga, D., & Ageton, S. S. (1985). *Explaining delinquency and drug use.* Beverly Hills, CA: Sage.

Fanniff, A. M., & Kimonis, E. R. (2014). Juveniles who have committed sexual offenses: A special group? *Behavioural Sciences and the Law, 32*, 240-257. https://doi.org/10.1002/bsl.2111

Finkelhor, D., Ormrod, R., & Chaffin, M. (2009). Juveniles who commit sex offenses against minors. *Office of Juvenile Justice and Delinquency Prevention (OJJDP) – Juvenile Justice Bulletin*. Retrieved from https://www.ncjrs.gov/pdffiles1/ojjdp/227763.pdf

Friedrich, W. N., Lysne, M., Sim, L., & Shamos, S. (2004). Assessing sexual behaviour in high-risk adolescents with the Adolescent Clinical Sexual Behavior Inventory (ACSBI). *Child Maltreatment, 9* 239-250 https://doi.org/10.1177/1077559504266907

Greer, W. C. (1991). “Aftercare: Community Integration Following Institutional Treatment”. In G. D. Ryan and S. L. Lane (Eds.), *Juvenile Sexual Offending*, (pp. 377-390). Lexington MA: Lexington Books.

Hackett, S. (2014). *Children and young people with harmful sexual behaviours research in practice.* Totnes: Dartington Hall.

Hackett, S., Phillips, H., Masson, M. & Balfe. (2013). Individual, family and abuse characteristics of 700 British child and adolescent sexual abusers. *Child Abuse Review, 22*, 232-245. http://dx.doi.org/10.1002/car.2246

Hanson, R. F., Resnick, H. S., Saunders, B. E., Kilpatrick, D. G., & Best, C. (1990). Factors related to the reporting of childhood rape. *Child Abuse & Neglect, 23*, 559-569. https://doi.org/10.1016/S0145-2134(99)00028-9

Hanson, R. K., Steffy, R. & Gauthier, R. (1993). Long-term recidivism of child molesters. *Journal of Consulting and Clinical Psychology, 61*, 646-652. http://dx.doi.org/10.1037/0022-006X.61.4.646

**Hendriks, J., & Bijleveld, C. (2008). Recidivism among juvenile sex offenders after residential treatment. *Journal of Sexual Aggression, 14,* 19-32. https://doi.org/10.1080/13552600802133852

Henggeler, S. W., & Borduin, C. M. (1990). *Family therapy and beyond: A multisystemic approach to treating the behaviour problems of children and adolescents.* Pacific Grove, CA: Brooks/Cole.

Home Office. (2003). *Criminal statistics: England and Wales 2002. Statistics relating to criminal proceedings for the year 2002*. London: The Stationary Office.

Hooper, P., Jutai, J. W., Strong, G., & Russell-Minda, E. (2008). Age-related macular degeneration and low-vision rehabilitation: a systematic review. *Canadian Journal of Ophthalmology, 43,* 80-187. https://doi.org/10.3129/i08-001

Hopewell, S. McDonald, S. Clarek, M. J., Egger, M. (2007). Grey literature in meta-analyses of randomized trials of health care interventions. *Cochrane Database of Systematic Reviews 2007*. doi: 10.002/14651858.MR000010.pub3

Jewell, J. D., Malone, M. D., Rose, P., Sturgeon, D., & Owens, S. (2015). A multiyear follow-up study examining the effectiveness of a cognitive behavioural group therapy program on the recidivism of juveniles on probation. *International Journal of Offender Therapy and Comparative Criminology. 59*, 259-272. https://doi.org/10.1177/0306624X13509065

**Keiley, M. K., Zaremba-Morgan, A., Datubo-Brown, C., Pyle, R., & Cox, M. (2015). Multiple-family group intervention for incarcerated male adolescents who sexually offend and their families: change in maladaptive emotion regulation predicts adaptive change in adolescent behaviors. *Journal of Marital and Family Therapy, 41*, 324-339. https://doi.org/10.1111/jmft.12078

Kettrey, H. H., & Lipsey, M. W. (2018). The effects of specialized treatment on the recidivism, of juvenile sex offenders: a systematic review and meta-analysis. *Journal of Experimental Criminology, 14,* 361-387. doi: 10.1007/s11292-018-9329-3

Koo, T. M., & Mae, L. Y. (2016). A guideline of selecting and reporting intraclasss correlation coefficients for reliability research. *Journal of Chiropractic Medicine, 15,* 155-163. http://dx.doi.org/10.1016/j.jcm.2016.02.012

**Lab, S. P., Shields, G., & Schondel, C. (1993). Research note: An evaluation of juvenile sexual offender treatment. *Crime & Delinquency, 39*, 543-533. https://doi.org/10.1177/0011128793039004008

**Letourneau, E. J., Henggeler, S. W., Borduin, C. M., Schewe, P. A., McCart, M. R., Chapman, J. E., & Saldana. (2009). Multisystemic therapy for juvenile sexual offenders: 1-year results from a randomized effectiveness trial. *Journal of Family Psychology*, 23, 89-102. https://doi.org/10.1037/a0014352

McGrath, R. J., Cumming, G., Livingston, J. A., & Hoke, S. E. (2003). Outcome of a treatment program for adult sex offenders: From prison to community. *Journal of Interpersonal Violence, 18*, 3-17. https://doi.org/10.1177/0886260502238537

Moher, D., Liberati, A., Tetzlaff, J., Altman, D. G., & The PRISMA Group. (2009). Preferred reporting items for systematic reviews and meta-analyses: The PRISMA statement. *PLOS Medicine, 6*. https://doi.org/10.1371/journal.pmed.1000097

National Institute of Health and Clinical Excellence. (2016). *Harmful sexual behaviour among children and young people*. (NICE Guideline NG55). Retrieved from: https://www.nice.org.uk/guidance/ng55

National Task Force on Juvenile Sexual Offending (1988). Preliminary Report. *Juvenile and Family Court Journal, 39*, 5-52. https://doi.org/10.1111/j.1755-6988.1988.tb00614.x

National Society for the Prevention of Cruelty to Children. (2014). *Harmful Sexual Behaviour Framework*. Retrieved from: https://learning.nspcc.org.uk/research-resources/2019/harmful-sexual-behaviour-framework/

National Society for the Prevention of Cruelty to Children. (2017). *Harmful Sexual behaviour. What is harmful sexual behaviour.* Retrieved from: https://www.nspcc.org.uk/preventing-abuse/child-abuse-and-neglect/harmful-sexual-behaviour/

Prentky, R., Lee, A., Knight, R., & Cerce, D. (1997). Recidivsm rates among child molesters and rapists: A methodological analysis. *Law and Human Behavior, 21*, 635-660. doi: 10.1023/A:1024860714738

Prentky, R., & Righthand, S. (2003). *Juvenile sex offender assessment protocol II (J-SOAP-II) manual*. Washington, DC: Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention, U.S. Department of Justice.

Puzzanchera, C., Smith, J., & Kang, W. (2017). *Easy access to NIBRS victims, 2015: Victims of violence*. Retrieved from www.ojjdp.gov/ojstatbb/ezanibrsdv/

Reitzel, L. R., & Carbonell, J. L. (2006). The effectiveness of sexual offender treatment for juveniles as measured by recidivism: A meta-analysis. Sexual Abuse. *A Journal of Research and Treatment, 18,* 401-422 https://doi.org/10.1177/107906320601800407

**Seabloom, W., Seabloom, M. E., Seabloom, E., Barron, R., & Hendrickson, S. (2003). A 14- to 24- year longitudinal study of a comparative sexual health model treatment programme for adolescent sex offenders: Predictors of successful completion and subsequent criminal recidivism. *International Journal of Offender Therapy and Comparative Criminology, 47*, 468-481 https://doi.org/10.1177/0306624X03253849

Seto, M. C., & Lalumiere, M. L. (2010). What is so special about male adolescent sexual offending? A review and test of explanations through meta-analysis. *Psychological Bulletin, 136*, 523-575. https://doi.org/10.1037/a0019700

**Silovsky, J. F., Hunter, M. D., & Taylor, E. K. (2019). Impact of early intervention for youth with problematic sexual behaviors and their caregivers. *Journal of Sexual Aggression, 25,* 4-15. https://doi.org/10.1080/13552600.2018.1507487

Silovsky, J. F., Chaffin, M. C., Swisher, L. M., & Pierce, K. (2011). *Youth sexual behaviour problems inventory.* Unpublished measure.

Song, F., Parekh, S., Hooper, L., Loke, Y. K., Ryder, J., Sutton, A. J., … Harvey, I. (2010). Dissemination and publication of research findings: an updated review of related biases. *Health Technology Assessment*, *14*, 1-220 https://doi.org/10.3310/hta14080

Thornicroft, G., Lempp, H., & Tansella, M. (2011). The place of implementation science in the translational medicine continuum. *Psychological Medicine, 41*, 2015-2021. https://doi.org/10.1017/S0033291711000109

**Underwood, L. A., Dailey, F. L. L., Merino, C., & Crump, Y. (2015). Results from a multi-modal program evaluation of a four year statewide juvenile sex offender treatment and reenty program. *Journal of Prison Education and Reenty, 2,* 19-32. http://dx.doi.org/10.15845/jper.v2i2.861

**Viljoen, J. L., Gray, A. L., Shaffer, C., Latzman, N. E., Scalora, M. J., & Ullman, D. (2017). Changes in J-SOAP-II and SAVRY scores over the course of residential Cognitive-Behavioural treatment for adolescent sexual offending. *Sexual Abuse: A Journal of Research and Treatment, 29,* 324-374 https://doi.org/10.1177/1079063215595404

Vizard, E., Hickey, N., French, L., & McCrory, E. (2007). Children and adolescents who present with sexually abusive behaviour: A UK descriptive study. *The*

Journal of Forensic Psychiatry & Psychology, 18, 59-73 https://doi.org/10.1080/14789940601056745

**Waite, D., Keller, A., McGarvey, E. L., Wieckowski, E., Pinkerton, R., & Brown, G. L. (2005). Juvenile sex offender re-arrest rates for sexual, violent and property crimes: A 10-year follow up. *Sexual Abuse: A Journal of Research and Treatment, 17*, 313-331. https://doi.org/10.1177/107906320501700305

**Worling, J. R., & Curwen, T. (2000). Adolescent sexual offender recidivism: success of specilaised treatment and implications for risk prediction. *Child Abuse & Neglect, 24,* 965-982. https://doi.org/10.1016/S0145-2134(00)00147-2

Wijk, A., Loeber, R., Vermeiren, R., Pardini, D., Bullens, R., & Doreleijers, T. (2005). Violent juvenile sex offenders compared with violent juvenile nonsex offenders: Explorative findings from the Pittsburgh Youth Study. *Sexual Abuse: A Journal of Research and Treatment,* 17, 333–352. https://doi.org/10.1007/s11194-005-5062-3

Wijkman, M., Bijleveld, C., & Hendriks, J. (2011). Female sex offenders: Specialists, generalists and once-only offenders. *Journal of Sexual Aggression, 17,* 34-45. https://doi.org/10.1080/13552600.2010.540679

Wittebrood, K. (2006). *Slachtoffers van criminaliterit: Feiten en achtergronden. (Victims of crime: facts and backgrounds).* Den Haag: Sociaal Cultureel Planbureau.

Appendix A. Downs and Black Checklist (1998)

Appendix

Checklist for measuring study quality

Reporting

1. *Is the hypothesis/aim/objective of the study clearly described?*

yes	1
no	0

2. *Are the main outcomes to be measured clearly described in the Introduction or Methods section?*
   If the main outcomes are first mentioned in the Results section, the question should be answered no.

yes	1
no	0

3. *Are the characteristics of the patients included in the study clearly described ?*
   In cohort studies and trials, inclusion and/or exclusion criteria should be given. In case-control studies, a case-definition and the source for controls should be given.

yes	1
no	0

4. *Are the interventions of interest clearly described?*
   Treatments and placebo (where relevant) that are to be compared should be clearly described.

yes	1
no	0

5. *Are the distributions of principal confounders in each group of subjects to be compared clearly described?*
   A list of principal confounders is provided.

yes	2
partially	1
no	0

6. *Are the main findings of the study clearly described?*
   Simple outcome data (including denominators and numerators) should be reported for all major findings so that the reader can check the major analyses and conclusions. (This question does not cover statistical tests which are considered below).

yes	1
no	0

7. *Does the study provide estimates of the random variability in the data for the main outcomes?*
   In non normally distributed data the inter-quartile range of results should be reported. In normally distributed data the standard error, standard deviation or confidence intervals should be reported. If the distribution of the data is not described, it must be assumed that the estimates used were appropriate and the question should be answered yes.

yes	1
no	0

8. *Have all important adverse events that may be a consequence of the intervention been reported?*
   This should be answered yes if the study demonstrates that there was a comprehensive attempt to measure adverse events. (A list of possible adverse events is provided).

yes	1
no	0

9. *Have the characteristics of patients lost to follow-up been described?*
   This should be answered yes where there were no losses to follow-up or where losses to follow-up were so small that findings would be unaffected by their inclusion. This should be answered no where a study does not report the number of patients lost to follow-up.

yes	1
no	0

10. *Have actual probability values been reported(e.g. 0.035 rather than <0.05) for the main outcomes except where the probability value is less than 0.001?*

yes	1
no	0

External validity

All the following criteria attempt to address the representativeness of the findings of the study and whether they may be generalised to the population from which the study subjects were derived.

11. *Were the subjects asked to participate in the study representative of the entire population from which they were recruited?*
    The study must identify the source population for patients and describe how the patients were selected. Patients would be representative if they comprised the entire source population, an unselected sample of consecutive patients, or a random sample. Random sampling is only feasible where a list of all members of the relevant

population exists. Where a study does not report the proportion of the source population from which the patients are derived, the question should be answered as unable to determine.

yes	1
no	0
unable to determine	0

12. *Were those subjects who were prepared to participate representative of the entire population from which they were recruited?*
The proportion of those asked who agreed should be stated. Validation that the sample was representative would include demonstrating that the distribution of the main confounding factors was the same in the study sample and the source population.

yes	1
no	0
unable to determine	0

13. *Were the staff, places, and facilities where the patients were treated, representative of the treatment the majority of patients receive?*
For the question to be answered yes the study should demonstrate that the intervention was representative of that in use in the source population. The question should be answered no if, for example, the intervention was undertaken in a specialist centre unrepresentative of the hospitals most of the source population would attend.

yes	1
no	0
unable to determine	0

Internal validity – bias

14. *Was an attempt made to blind study subjects to the intervention they have received ?*
For studies where the patients would have no way of knowing which intervention they received, this should be answered yes.

yes	1
no	0
unable to determine	0

15. *Was an attempt made to blind those measuring the main outcomes of the intervention?*

yes	1
no	0
unable to determine	0

16. *If any of the results of the study were based on "data dredging", was this made clear?*
Any analyses that had not been planned at the outset of the study should be clearly indicated. If no retrospective unplanned subgroup analyses were reported, then answer yes.

yes	1
no	0
unable to determine	0

17. *In trials and cohort studies, do the analyses adjust for different lengths of follow-up of patients, or in case-control studies, is the time period between the intervention and outcome the same for cases and controls ?*
Where follow-up was the same for all study patients the answer should yes. If different lengths of follow-up were adjusted for by, for example, survival analysis the answer should be yes. Studies where differences in follow-up are ignored should be answered no.

yes	1
no	0
unable to determine	0

18. *Were the statistical tests used to assess the main outcomes appropriate?*
The statistical techniques used must be appropriate to the data. For example nonparametric methods should be used for small sample sizes. Where little statistical analysis has been undertaken but where there is no evidence of bias, the question should be answered yes. If the distribution of the data (normal or not) is not described it must be assumed that the estimates used were appropriate and the question should be answered yes.

yes	1
no	0
unable to determine	0

19. *Was compliance with the intervention/s reliable?*
Where there was non compliance with the allocated treatment or where there was contamination of one group, the question should be answered no. For studies where the effect of any misclassification was likely to bias any association to the null, the question should be answered yes.

yes	1
no	0
unable to determine	0

20. *Were the main outcome measures used accurate (valid and reliable)?*

For studies where the outcome measures are clearly described, the question should be answered yes. For studies which refer to other work or that demonstrates the outcome measures are accurate, the question should be answered as yes.

yes	1
no	0
unable to determine	0

Internal validity - confounding (selection bias)

21. ***Were the patients in different intervention groups (trials and cohort studies) or were the cases and controls (case-control studies) recruited from the same population?***
For example, patients for all comparison groups should be selected from the same hospital. The question should be answered unable to determine for cohort and case-control studies where there is no information concerning the source of patients included in the study.

yes	1
no	0
unable to determine	0

22. ***Were study subjects in different intervention groups (trials and cohort studies) or were the cases and controls (case-control studies) recruited over the same period of time?***
For a study which does not specify the time period over which patients were recruited, the question should be answered as unable to determine.

yes	1
no	0
unable to determine	0

23. ***Were study subjects randomised to intervention groups?***
Studies which state that subjects wererandomised should be answered yes except where method of randomisation would not ensure random allocation. For example alternate allocation would score no because it is predictable.

yes	1
no	0
unable to determine	0

24. ***Was the randomised intervention assignment concealed from both patients and health care staff until recruitment was complete and irrevocable?***
All non-randomised studies should be answered no. If assignment was concealed from patients but not from staff, it should be answered no.

yes	1
no	0
unable to determine	0

25. ***Was there adequate adjustment for confounding in the analyses from which the main findings were drawn?***
This question should be answered no for trials if: the main conclusions of the study were based on analyses of treatment rather than intention to treat; the distribution of known confounders in the different treatment groups was not described; or the distribution of known confounders differed between the treatment groups but was not taken into account in the analyses. In non-randomised studies if the effect of the main confounders was not investigated or confounding was demonstrated but no adjustment was made in the final analyses the question should be answered as no.

yes	1
no	0
unable to determine	0

26. ***Were losses of patients to follow-up taken into account?***
If the numbers of patients lost to follow-up are not reported, the question should be answered as unable to determine. If the proportion lost to follow-up was too small to affect the main findings, the question should be answered yes.

yes	1
no	0
unable to determine	0

Power

27. ***Did the study have sufficient power to detect a clinically important effect where the probability value for a difference being due to chance is less than 5%?***
Sample sizes have been calculated to detect a difference of x% and y%.

	Size of smallest intervention group	
A	$<n_1$	0
B	n_1–n_2	1
C	n_3–n_4	2
D	n_5–n_6	3
E	n_7–n_8	4
F	n_8+	5

Appendix B. Template of all the checklist questions

Author				**Notes**
Reporting	**0**	**1**	**2**	
1. Is the hypothesis/aim/objective of the study clearly described?				
2. *Are the main outcomes to be measured clearly described in the Introduction or Methods section?* If the main outcomes are first mentioned in the Results section, the question should be answered no				
3. *Are the characteristics of the patients included in the study clearly described*? In cohort studies and trials, inclusion and/or exclusion criteria should be given. In case-control studies, a case-definition and the source for controls should be given.				
4. *Are the interventions of interest clearly described?* Treatments and placebo (where relevant) that are to be compared should be clearly described.				
5. *Are the distributions of principal confounders in each group of subjects to be compared clearly described?* A list of principal confounders is provided.				
6. *Are the main findings of the study clearly described?* Simple outcome data (including denominators and numerators) should be reported for all major findings so that the reader can check the major analyses and conclusions. (This question does not cover statistical tests which are considered below)				
7. *Does the study provide estimates of the random variability in the data for the main outcomes?* In non-normally distributed data the inter-quartile range of results should be reported. In normally distributed data the standard error, standard deviation or confidence intervals should be reported. If the distribution of the data is not described, it must be assumed that the estimates used were appropriate and the question should be answered yes.				
8. *Have all important adverse events that may be a consequence of the intervention been reported?* This should be answered yes if the study demonstrates that there was a comprehensive attempt to measure adverse events. (A list of possible adverse events is provided).				
9. *Have the characteristics of patients lost to follow-up been described?* This should be answered yes where there were no losses to follow-up or where losses to follow up were so small that findings would be unaffected by their inclusion. This should be answered no where a study does not report the number of patients lost to follow-up.				
10. *Have actual probability values been reported (e.g. 0.035 rather than <0.05) for the main outcomes except where the probability value is less than 0.001?*				
External Validity				

All the following criteria attempt to address the representativeness of the findings of the study and whether they may be generalised to the population from which the study subjects were derived				
11. *Were the subjects asked to participate in the study representative of the entire population from which they were recruited?* The study must identify the source population for patients and describe how the patients were selected. Patients would be representative if they comprised the entire source population, an unselected sample ofconsecutive patients, or a random sample. Random sampling is only feasible where a list of all members of the relevant population exists. Where a study does not report the proportion of the source population from which the patients are derived, the question should be answered as unable to determine				
12. *Were those subjects who were prepared to participate representative of the entire population from which they were recruited?* The proportion of those asked who agreed should be stated. Validation that the sample was representative would include demonstrating that the distribution of the main confounding factors was the same in the study sample and the source population.				
13. *Were the staff, places, and facilities where the patients were treated, representative of the treatment the majority of patients receive?* For the question to be answered yes the study should demonstrate that the intervention was representative of that in use in the source population. The question should be answered no if, for example, the intervention was undertaken in a specialist centre unrepresentative of the hospitals most of the source population would attend.				
Internal validity – bias				
14. *Was an attempt made to blind study subjects to the intervention they have received?* For studies where the patients would have no way of knowing which intervention they received, this should be answered yes				
15*. Was an attempt made to blind those measuring the main outcomes of the intervention?*				
16. *If any of the results of the study were based on "data dredging", was this made clear?* Any analyses that had not been planned at the outset of the study should be clearly indicated. If no retrospective unplanned subgroup analyses were reported, then answer yes.				
17. *In trials and cohort studies, do the analyses adjust for different lengths of follow up of patients, or in case-control studies, is the time period between the intervention and outcome the same for cases and controls?* Where follow up was the same for all study patients the answer should yes. If different lengths of follow up were adjusted				

for by, for example, survival analysis the answer should be yes. Studies where differences in follow-up are ignored should be answered no.				
18. *Were the statistical tests used to assess the main outcomes appropriate?* The statistical techniques used must be appropriate to the data. For example nonparametric methods should be used for small sample sizes. Where little statistical analysis has been undertaken but where there is no evidence of bias, the question should be answered yes. If the distribution of the data (normal or not) is not described it must be assumed that the estimates used were appropriate and the question should be answered yes.				
19. *Was compliance with the intervention/s reliable*? Where there was non compliance with the allocated treatment or where there was contamination of one group, the question should be answered no. For studies where the effect of any misclassification was likely to bias any association to the null, the question should be answered yes.				
20. *Were the main outcome measures used accurate (valid and reliable*)? For studies where the outcome measures are clearly described, the question should be answered yes. For studies which refer to other work or that demonstrates the outcomes measures are accurate, the question should be answered as yes.				
Internal validity - confounding (selection bias)				
21. *Were the patients in different intervention groups (trials and cohort studies) or were the cases and controls (case control studies) recruited from the same population?* For example, patients for all comparison groups should be selected from the same hospital. The question should be answered unable to determine for cohort and case control studies where there is no information concerning the source of patients included in the study.				
22. *Were study subjects in different intervention groups (trials and cohort studies) or were the cases and controls (casecontrol studies) recruited over the same period of time?* For a study which does not specify the time period over which patients were recruited, the question should be answered as unable to determine.				
23. *Were study subjects randomised to intervention groups? Studies* which state that subjects were randomized should be answered yes except where method of randomisation would not ensure random allocation. For example, alternate allocation would score no because it is predictable.				
24. Was the randomised intervention assignment concealed from both patients and health care staff until recruitment was complete and irrevocable? All non randomised studies should be answered no. If assignment was concealed from patients but not				

from staff, it should be answered no				
25. *Was there adequate adjustment for confounding in the analyses from which the main findings were drawn?* This question should be answered no for trials if: the main conclusions of the study were based on analyses of treatment rather than intention to treat; the distribution of known confounders in the different treatment groups was not described; or the distribution of known confounders differed between the treatment groups but was not taken into account in the analyses. In non randomised studies if the effect of the main counfounders was not investigated or confounding was demonstrated but no adjustment was made in the final analyses the question should be answered as no.				
26*. Were losses of patients to follow-up taken into account?* If the numbers of patients lost to follow up are not reported, the question should be answered as unable to determine. If the proportion lost to followup was too small to affect the main findings, the question should be answered yes.				
Power				
27. Did the study have sufficient power to detect a clinically important effect where the probability value for a difference being due to chance is less than 5%? Sample sizes have been calculated to detect a difference of x% and y%				
Total score = /28 = %				

Appendix C. Summarised pertinent elements of guideline NG55

- Ensure multi-agency, multidisciplinary teams promote continuity of care and, wherever possible, ensure the child or young person has contact with the same staff over time, so they can develop trust in their care team.

- Consider a range of care pathways based on the 5 core domains identified in the NSPCC harmful sexual behaviour framework.

- Immediately inform your organisation's named safeguarding lead when a child or young person displays sexualised behaviour that is always inappropriate, regardless of age, such as public masturbation.

- Develop a care plan using an established risk assessment model, such as J-SOAP-II, ERASOR, AIM assessment for under-12s, or AIM2, and a recognised treatment model such as the Good Lives Model, AIM or AIM2.

- Use recognised treatment resources or guided interventions such as AIM, AIM2, Barnardo's Cymru Taith project for girls – assessment and treatment workbook. The California Evidence-Based Clearinghouse for Child Welfare Children with problematic sexual behaviour cognitive-behavioural treatment program: preschool program and school-age program. Good Lives Model, a strengths-based programme. NSPCC manualised treatment programme Change for good[5] aimed at boys aged 12 to 18 in residential care. NSPCC harmful sexual behaviour programme Turn the page, a guided intervention that follows certain key principles for boys and girls aged 5 to 18 and those with learning disabilities.

- Use therapeutic approaches such as: cognitive behavioural therapy, multisystemic therapy for problematic sexual behaviour, psychotherapeutic approaches, strengths-based approaches, systemic therapy (a type of family therapy).

- Consider 1 or more of the following modes of delivery: individual therapy, group therapy, family therapy.

This page is intentionally left blank

Section Two: Research report

Harmful sexual behaviour in boys. The lived experiences of parents: An Interpretative Phenomenological Analysis.

This page is intentionally left blank

Abstract

Objectives: The study had two aims. The primary aim was the exploration of the lived experience of mothers and fathers whose son displayed Harmful Sexual Behaviour (HSB). A secondary aim was to understand parents' journey through professional services.

Methods: Purposive sampling was used. Seven mothers and one father participated in semi-structured interviews. Interpretative Phenomenological Analysis was used. Research quality was ensured in several ways including public and participant involvement, audit, triangulation and supervision.

Results: Six superordinate themes emerged; 'Lack of Formulation', 'Maternal Attachment', 'Affiliation', 'Escape', 'Emotional Toll' and 'Structural Issues'. Four of the superordinate themes produced subordinate themes. Participants noted that HSB existed within a wider context of behaviour but services typically did not acknowledge or address the broader circumstances. Key sources of parental distress related to being overlooked during decision-making, self-directed and external blame, consequences on emotional well-being and significant life changes. Parents spoke about difficulties accessing services and the value of having an ally.

Conclusions: HSB appears to exist in the context of wider complex behavioural and systemic issues however the insular nature of services fail to recognise this. Parents of young people who display HSB are in many cases more effected than may initially be evident or expected. For reasons that are unclear, but likely due to a restriction of services, parents of children who display HSB do not feel able to access services and when they do, do not feel heard or supported.

Practitioner points:

- Psychological formulation with parents/caregivers may alleviate a number of pertinent negative experiences.
- A specific focus on parental well-being should be a vital aspect of HSB interventions.
- Psycho-education to professionals of trauma responses and containment may help to meet needs of parents.
- Further consideration on supporting fathers/step-fathers/partners to have a more active role in HSB intervention.

Limitations:

- Participants did not validate themes; respondent validation would increase quality reliability.
- The sample contained mainly mothers; therefore may not be reflective of other caregivers.
- This study did not consider or reflect upon cultural differences.

Key words: Parents, HSB, IPA, intervention, psychology

Introduction

The National Society for the Protection of Cruelty to Children (NSPCC, 2017) highlight that Harmful Sexual Behaviour (HSB) includes sexually explicit language, inappropriate touching of oneself or another person, the use or threat of sexual violence and full penetrative sex. Society traditionally believes that adults are the primary perpetrators of sexually harmful behaviour. However, whilst figures vary, studies have found that up to a third of child sexual abuse is carried out by children and young people (Hackett, Phillips, Masson, & Balfe, 2013).

Most research into sexual offending is concerned with the aetiology of HSB. Common risk factors of HSB in children include an emotionally deprived upbringing, sexual, physical and emotional abuse at home and family instability and dysfunction. It has been a long-standing priority to identify and intervene for child victims of sexual abuse; however, child perpetrators have been overlooked. In the UK, this means the needs of victims are far more understood than the needs of perpetrators (Allnock et al., 2009).

Evidence suggests that young offenders' outcomes are improved when treatment involves parents/caregivers. This is more prominent when the intervention targets communication within the family (Latimer, Dowden, Morton-Bourgon, Edgar, & Bania, 2003). Recent guidance from the National Institute for Health and Care Excellence (NICE, 2016) highlight the importance of involving families/carers in HSB interventions. These recommendations include (where appropriate) multi-systemic therapy (MST), family therapy, encouraging caring relationships between parent and child, helping parents to create a sense of belonging and trust, helping the parent come to terms with the behaviour and work with parent/carer denial. In an expert testimony, Hackett (2016) highlights the importance of maintaining a family focus and placement stability because

a stable living environment is known to positively affect outcomes. However, as of 2013, services continued to rely on one-to-one interventions, resulting in an absence of family work (Smith, Bradbury-Jones, Lazenbatt, & Taylor, 2013).

Whilst key recommendations for HSB interventions involve families, little is actually known about the experiences of the parents of children who engage in HSB. One study noted that child perpetrators of HSB and their parents can suffer hostility, stigma and rejection from their community (Zimring, 2009). Smith and Trepper (1992) conducted a qualitative study in the USA exploring the experiences of parents whose children had committed sexual offences. The study used a phenomenological approach that included several group interviews with participants. Several themes emerged including; *Preoccupation with the offence, Re-evaluation of the early parent-child relationship, Confronting thoughts on punishment and treatment, Difficulty communicating with their sons about the offence, Dealing with the effect on the family* and *Focussing on the future*. This paper is now over 25 years old and it is possible that the group design may have affected participant's willingness to answer openly. None-the-less, the paper provides some helpful insights into the experiences of parents. It would be useful to know whether similar themes are found in parents of children the UK today given changes in technology and social media and its use in these offences (McCartan & McAlister, 2012).

Jones (2015) presented two studies after interviewing parents, guardians and extended family about the experience of being a parent of a son engaging in HSB and coping. Participants were parents, guardians and family members of adolescent boys engaging in a sexual offending programme. Individual and group interviews took place. Content analysis was used to analyse the data. Findings highlighted the emotional toll that parents suffered. The overarching theme was *Prevent reoffending*, with three

subthemes; *Being there, Parental toll,* and *Parental aspirations for the child's future*. The second study identified a number of themes; *Coping with the initial response, Coping with feeling responsible, Coping with feeling alone and overwhelmed* and *The benefits of treatment*. Whilst these studies had relatively small sample sizes (*n* = 4) they provide helpful insights into the experience of having a family member who has sexually offended. It should be noted that the families in this study were actively involved in all aspects of treatment. This level of involvement may not be representative of other families with a child with HSB, some of whom may be more fragmented or chaotic and therefore less likely to engage with interventions (Vizard, Hickey, French, & McCrory, 2007).

Pierce (2011) used content analysis to summarise interviews with four caregivers (grandmother, aunt, biological mother and step-grandmother) of young people convicted of a sexual offence. Four conceptual themes emerged, the first *The initial reaction* had subthemes of *disbelief, making up excuses, alone, ashamed, judged, taking responsibility*; The second *The Relationship with their child*, had subthemes of *anger, questions, hopes*; The third *Dealing with it* had subthemes of *need information, telling, effects on family*, *overwhelmed* and the fourth theme was *I am a survivor*.

There seems to be an emerging theme across all of these studies relating to the overwhelming nature of the situation on the parents themselves. Hackett (1988) suggested that parents and caregivers often have difficulties in offering and providing support to a young person who has sexually offended because they too must process and cope with the experience. This experience was compared to feelings associated with grief following a death.

Whilst work has begun to understand the experiences of parents whose children display HSB it remains in its infancy. Most of the literature relies on case study data, small sample sizes, group designs and sexually offending (rather than HSB, which may not include criminal involvement). Given the protective nature of parents and families regarding the reduction of future risk, it is concerning that there is not a clear understanding of parents' experiences and an understanding of how to support parents. Clinical guidelines (e.g. NICE guideline NG55, 2016) repeatedly highlight the importance of involving families and caregivers with interventions and rehabilitation. Therefore, it is imperative to establish an understanding of the experiences of parents so that services are able to appropriately support parents to enable them to support their child to work towards the reduction of HSB.

Aims

The study aims to further develop the literature and build an understanding of the lived experience of parents with children displaying harmful sexual behaviour in the UK.

The primary aim is to explore the lived experience of parents whose son displays HSB and to understand their interpretations of this experience. A secondary aim is to understand parents' journey through professional services.

By conducting this research, it is hoped that new insights into this experience will emerge, which will contribute to an understanding of this under researched area. With the recommended focus on systemic practices, parents and caregivers have such a pivotal role in keeping young people who display HSB safe. It is therefore vital that there is a clear understanding of the needs of parents. This study could therefore also be used to consider current clinical practice within the context of effective service delivery specifically focusing on how services work in a systemic way with HSB in children.

Method

Design

Several qualitative methods were considered for the analysis of this study. Grounded Theory (Glaser & Strauss, 1967) uses theoretical sampling with the aim to develop theory. The aim of the current study is to identify convergence and divergence of experiences rather than to produce theory. Discourse Analysis explores the use of language to identify and investigate narratives of life experiences (Potter & Wetherell, 1995), whilst this could have been used, this study was less interested in *how* parents describe their experience, rather the experience itself. Interpretative Phenomenological Analysis (IPA; Smith, Flower, & Larkin, 2009) was selected as the most appropriate analysis. IPA is concerned with the *particular*. It is therefore an idiographic approach, contrasting with much of psychological research, which is largely nomothetic, aiming to understand phenomenon at a population level. Its purpose is to *give voice* to specific experiences and to make sense of them (Larkin, Watts, & Clifton, 2006). The objectives of this study were to explore the lived experience of parents in the UK whose son displays HSB and their journey through professional services. This specific experience has little representation in scientific literature. Clinicians in the HSB field also report there to be a lack of awareness of the experiences of parents. With this is mind IPA was selected to give voice and make sense of parents' experiences.

IPA is committed to examining how individuals make sense of life experiences. IPA has two theoretical foundations. Firstly, phenomenology which refers to the study of 'being' (existence and experience) (Larkin & Thompson, 2012). The second theoretical underpinning of IPA is its hermeneutic nature, hermeneutics refer to the theory of interpretation. IPA recognises the double hermeneutic process involved in this

interpretation because the initial stage requires the participants to attempt to make sense of their experience, providing the first level of interpretation. Next, the researcher consciously and systematically applies the same sense-making skills to the material that the participant brings (Smith, Flower, & Larkin, 2009). IPA is therefore concerned with examining an experience, which is interpreted by the participant and then re-interpreted by the researcher. Whilst researchers should attempt to approach research material from a neutral position, it should be accepted that one can never be truly neutral, because the researcher brings to the interview and analysis his/her own history, experience and expectations. This highlights the importance of reflexivity in qualitative research.

Reflexivity

As the researcher's role in IPA is to both collect and interpret the data, the researcher is viewed as a co-constructor of meaning (Smith, Flower, & Larkin, 2009). It is vital therefore, that there is a process to identify, acknowledge and explore the researcher's own perspectives, influences and biases. The implication of qualitative research lacking in a stringent and transparent approach could be the misinterpretation or misrepresentation of participants' lived experience.

Whilst conducting the interviews the researcher took field notes and completed a reflexive journal. Walsh (2003) describes 'personal reflexivity', that is, the ability to expose the author's judgments, reactions and reflections on the research. Walsh also recommends engaging with 'interpersonal reflexivity', that is, the observation and documentation of dynamics between the author and the participants. Excerpts of the author's reflexive journal are included in the report, highlighting the researcher's own interpretations and relationship with the data and participants in order to improve transparency. See Appendix A for further examples. Shaw (2010) recommends including

in a research paper a dedicated section for the researcher to detail his or her position in relation to the research. See Appendix B for a reflexive statement.

Recruitment

Studies using an IPA methodology are typically small in nature, aiming to establish a reasonably homogeneous sample to explore convergence and divergence in detail (Smith, Flower, & Larkin, 2009). Smith et al. recommend three to six participants for undergraduate and masters level IPA research, and four to ten for doctoral studies.

Purposive sampling was used to enable the exploration of this specific experience. An Assistant Psychologist and a Youth Offending Worker working within two local children's services in England identified potential participants according to the inclusion/exclusion criteria (see Table 1). These workers sent out invitation letters (See Appendix C) and contacted potential participants via telephone to give a brief overview of the study and requested consent for the researcher to call them. All potential participants who consented for the researcher to contact them via phone, were then contacted by the researcher and given further information about the study. Those that did not consent were not contacted again. For participants who consented to take part, interviews were arranged to suit the participant, either at the participant's home (n = 5), over the phone (n = 2) or at a CAMHS building (n = 1). All participants were informed that they had a right to withdraw without giving a reason at any point before, during or up to four weeks after the interview.

Table 1

Inclusion and Exclusion Criteria

Inclusion Criteria	Exclusion Criteria
Mothers and fathers (adoptive and biological) who have a son who displayed HSB when he was aged between 10-18 (sex and age specified to increase the homogeneity of the experience)	Extended family or foster parents (placements often temporary, experience likely to be different to adoptive/biological parents)
	Known perpetrators of abuse
Referred to the Forensic CAMHS team for this reason.	Parents of girls who displayed HSB (small number of female HSB incidents, focus on boys to capture homogeneity of experience)
Able to give capacity to consent	
Speak English as a first language	

Participants

The sample consisted of eight participants, seven mothers and one father. One parent reported becoming a step-parent when their son was a toddler, though considered their son to be their own; another parent adopted their son at a young age and considered their son their own. Table 2 outlines the demographic information for all participants.

Data Collection

Before each interview, the researcher explained the aims of the study and each participant was provided with an information sheet (Appendix D) and given space to ask any questions. Participants were asked to sign two informed consent forms (Appendix E). The researcher and participant kept copy each. Participants were also invited to complete a demographic information sheet (Appendix F). Once the researcher was

satisfied that the participant had no more questions and had consented to take part, the interview began. A semi-structured interview was used to guide the interview See Table 2 (and Appendix G). The semi-structured interview was developed by the researcher and the clinical supervisor, feedback was then sought from experts in the field (both people that have accessed services and professionals working in the area. See Participant and Public Involvement). The interview was broken down into five parts, these were: *The incident of HSB, life, parenting, relationships* and *professional and informal support.* Questions involved an initial question with follow up prompts dependant on the participant's answer. Interviews were audio-recorded using an encrypted digital recorder. Interviews lasted between 32 and 83 minutes, the mean length of interviews was 58 minutes. The researcher transcribed all interviews.

Table 2 *Interview Schedule*

1. **The incident of HSB**

- How many behaviours have there been? Agree on which ones to talk about [be mindful if any are currently undergoing police proceedings and discuss boundaries]
- How would you like to refer to what happened? (agree terms to use to talk about it e.g. *the incident, the offence*, '*it*')
- How old was he when HSB [insert term agreed] happened?
- What is it like when you first found out about the HSB?
    - *Prompt*: How did you find out? Your immediate reaction? Your partner's reaction (if appropriate), what did you do? Did you talk about it? What was that like?
- Have you had any thoughts about why it happened?
    - Prompt: For example, why do you think it happened? Were there any triggers you can identify?
- Have your thoughts and feelings changed since then or are they the same?
    - *Prompt:* What is different? Is there anything that helped or hindered that process?
- Was there any use of technology in the HSB?
    - *Prompt:* e.g. Mobile phones, internet, laptop and games consoles, e.g. PlayStation, X Box and Nintendo
- How comfortable do you feel using the internet? How comfortable are you knowing the young person has access to the internet?
- Does the young person have any additional needs?

2. **Life**

- Are you employed? What do you do? Has it affected work?
- Would you be able to tell me about the ways it affected your life?
    - *Prompt*: Did it change anything? Is anything different as a
    - *Prompt*: What was it like as a baby/child/teenager? Where there any changes at any point? Were you happy with how you got on?
- After the incident, what was your relationship like?
    - *Prompt:* Did you notice a change in how you got on? What happened after? What is it like now?
- Have you been able to talk about it together?
    - *Prompt*: If so what was that like? If not, why not? Do you feel that was for better or for worse?
- Did anything change in how your family got on with each other?
    - *Prompt*: What were things like at home? Were people any different?

4. **Relationships**

- You said that X was involved in X's life, what was their reaction?
    - *Prompt:* was it the same as yours? What was this like?
- What were other people's reactions?
    - Prompt: Family, friends, community? Did it affect any of X's relationships?
- (If yes) How have you coped with these changes? What did you do?
- Have your relationships with anyone changed?
    - *Prompt*: What happened? Was it led by you or them?

5. **Professional Support and informal Support**

- Before the incident happened, were any other agencies involved?
    - *Prompt:* mental health services, substance use support, physical health, social workers.
- What professional support have you received (if any) following the HSB?
    - *Prompt*: From the forensic CAMHS team? From outside

<table>
<tr>
<td>
result of the incident?
• Can you tell me about the impact it had on you?
  ○ Prompt: emotional, financial, friends, work, personal?
• How has it made you feel?
  ○ Prompt: has it affected your mental or physical health?
• What about X’s siblings, how did it affect them if at all?
• Did you move/stay in the same place?
• Is life the same now as it was before?
  ○ Prompt: What about leisure time? Work? Social life?
• Could you tell me how you feel about moving towards the future?
  ○ Prompt: IS this any different from how you saw the future before HSB?
3. Parenting
• Did you have any support with parenting? E.G. a partner or family support?
  ○ Prompt: Did that change?
  • Tell me about your relationship with him.
</td>
<td>
agencies? Did you seek support or was it offered?
• Can you tell me why he was referred to Forensic CAMHS?
• How long were you involved with the Forensic CAMHS service?
• Tell me about your experience of accessing services following HSB
  ○ Prompt: How involved were you? Did you feel heard/supported?
• Do you think your young person has received adequate support?
  ○ Prompt: What support do you feel the young person has benefitted from?
• Is there anything you would change about how services interacted with you or X?

• If you could give advice to professionals after your experience, what would it be?
• What kind of informal support have you received (if any) following the HSB?
  ○ Prompt: From friends? Family? Charities or organisations?
• When was that support most useful?
• What was the most useful aspect of that support?
• Did you seek any support for yourself? If so, did you get to see anyone? How long did you wait?
</td>
</tr>
</table>

Table 3

Demographic Information of Participants

Participant	Age	Relationship to child	Ethnicity	Age when son referred to F-CAMHS	How long did he access F-CAMHS	Was the HSB contact or non-contact?	Was your son charged with a criminal offence?
1	31-40	Mother	White British	13	9-12 months ongoing	Both	No
2	31-40	Father	White British	13	9-12 months ongoing	Both	No
3	41-50	Mother	British	10	6-9 months	Non-contact	No
4	41-50	Mother	White British	11	18-21 months	Not completed	Not completed
5	41-50	Mother	Pakistani	16	3-6 ongoing	Both	No
6	>50	Mother	White British	13	3-6 months	Contact	Yes
7	31-40	Mother	White British	12 and then 14	Waiting list	Contact	No
8	31-40	Mother	British, Mixed White Caribbean	12	Waiting list	Contact	No

Analysis

IPA does not have an exact prescribed method of analysis and is characterised by some degree of flexibility. The overall goal is to move from the particular to the shared and from the descriptive to the interpretative (Smith, Flower, & Larkin, 2009). The researcher followed guidance by Smith, Flower, and Larkin to analyse the transcripts.

Having transcribed each interview and then listened to it again, the researcher was familiar with the data. The first stage of analysis was line-by-line coding of each transcript. This was completed independent of the other transcripts to allow the researcher to become fully immersed in each participant's individual experience. Particular attention was given to the descriptive, linguistic and conceptual nature of the participant's reported experiences. Descriptive, linguistic and conceptual elements were coded using different colours. Down the right hand side of the transcript, exploratory and reflexive comments were noted. Down the left hand side of the transcript, possible emerging themes were noted down, grounded in both the participant's narrative and the researcher's interpretations. Throughout this process, the focus was brought back to the research question. See Appendix H for an example coded transcript.

Once all of the transcripts were coded, emerging themes from each transcript were listed chronologically, as they appeared in the interview (Appendix I). All emerging themes from this chronological list were then grouped together, resulting in each participant having a condensed list of themes relating to their interview (Appendix J).

Once each participant had an independent list of themes, these were transferred to a coloured sheet of paper (Appendix K), each participant was represented by a different colour paper. Themes were then all compared to identify convergent and divergent themes (See Appendix L). A list of all participant themes can be found in Appendix M.

The final level analysis involved interpreting the resulting themes through a psychological lens drawing upon psychological theory.

Ethical Considerations

Due to the potentially sensitive nature of the study, approval was required from a number of agencies. Ethical approval was obtained via the Integrated Research Application System (IRAS, 253220) following full Research Ethics Review (Appendix N) and Health Research Authority approval (Appendix O). Scientific approval from the University of Sheffield (Appendix P) was gained, as well as approval from the Research and Innovation department at the recruiting NHS Trust (See Appendix Q). A range of ethical issues were considered and addressed before and during the study, see Table 4.

Table 4

Ethical Considerations and Measures Taken

Ethical issue	Measures taken to address ethical issue	Was there a concern during the study?
Lone working	Prior to any home visit, risk to the researcher was assessed in accordance with the NHS Lone Working Policy (Sheffield Health and Social Care NHS Foundation Trust, 2014) and a 'buddy' system was in place to ensure the safety of the researcher.	No
Informed consent and right to withdraw	Clear written and verbal communication.	No
Confidentiality	Due to the sensitive nature of the interviews, participant's anonymity was of utmost importance. No identifiable information was transcribed or included in the research report. Under no circumstance was a participants' information revealed unless there was a risk issue (see below).	No
Disclosures	Participants were made aware from the start of the interview that should the participant disclose a new incident of HSB, an undocumented offence or a risk issue, the researcher may need to explore this in more detail and possibly pass it over to a safeguarding team or the police. This would be the only instance that confidentiality would be breached.	No
Emotional Distress	It was not anticipated that the interview would cause significant emotional distress but it was recognised that participants were likely to have experienced or be experiencing difficult life experiences. Previous literature found that individuals were willing to discuss painful experiences as long as they felt the information would remain confidential and the research was meaningful (Graham, Grewel, & Lewis, 2007). All participants were given space to talk to the researcher after the interview (and after the recorder was switched off) and were given a debrief sheet (Appendix R) listing contact numbers of external support agencies and the contact number of the researcher should they need additional support. The researcher had access to supervision to discuss and explore any emotional responses that she had in response to the interviews.	No

Public and Participant Involvement

Consultation with professionals working in the HSB field and three families with experience of HSB who are described as Experts by Experience (EbE) were organised. The purpose of this was to further develop and enhance the interview schedule and study materials to ensure that they were sensitive, appropriate and relevant to participants. The consultation did not include potential study participants and was not analysed.

Three families with personal experience of HSB were individually consulted with. This was on an individual basis to maintain confidentiality. The families included; two grandparents who were legal guardians of a young person with HSB, a foster carer who has looked after a young person with HSB for the past 2 years and one mother who sought private support for her son following an incident of HSB.

Given the researcher does not work in the HSB field, a focus group of professionals was also held to increase rigour and ensure relevance. Seven professionals attended, comprising of; four youth justice officers, one social worker employed by the sexual exploitation team, a speech and language therapist, and a trainee clinical psychologist who works with HSB and families. All study materials were reviewed with both EbE and professionals and amended accordingly. See Table 5for key changes made.

Table 5

Public and Participant Involvement feedback

Add in	Include a question asking if the young person has additional needs. Two of the EbEs noted that the young person in their care had a diagnosis of autism and/or learning disabilities. Professionals also noted this. Include a question about siblings (Professionals feedback). Include a more specific question around parent mental and physical health (EbE feedback).
Remove	Remove the term "sexual offending/offence" from material where possible and replace with HSB. This is because it can cause upset or defensiveness within some families (Professionals feedback).
Edit	On the demographic sheet, give examples of contact and non-contact behaviours so that it is clear (Professionals feedback).
General feedback	Be clear at the start of the interview which incident the interview refers to, and be clear about the boundaries of what can be discussed (e.g. not to discuss anything currently under investigation) (Professional feedback). Soften the questions. Rather than "tell me about…" add words like "could you tell me…". Suggestions to make the questions less 'wooden' (EbE feedback). Be aware of professional jargon. The main example of this involved one question that everyone involved commented on. The question "*How did you make sense of what happened?*" was not clear. All agreed that this was an important area to capture but required new wording. Following the feedback, this was reworded to: "*Have you had any thoughts about why it happened? Prompt: For example, why do you think it happened? Were there any triggers you can identify*?" (Professionals and EbE feedback). The debrief form is appropriately formal and provides closure to the interview. Positive to end with something that the participant can take away (Professional and EbE feedback) All EbE groups stated independently that they felt that it was valuable research because they had little chance to talk to professionals about their own experience and did not always feel heard.

Quality Control

Tracy (2010) presents an eight point criteria of achieving quality in qualitative research. Tracy argues that having a structure of quality control for qualitative methodologies encourages researchers to adhere to best practices and provide evidence for the efficacy and legitimacy of qualitative research. To ensure high quality of research, alongside an ongoing process of reflexivity, a 24 item audit checklist created by the researcher adapted from Tracy's eight point criterion. The eight point criteria that the study was rated against were; *worthy topic, rich rigor, sincerity, credibility, resonance, significant contribution, ethical,* and *meaningful coherence*. Two independent colleagues (one Trainee Clinical Psychologist and one Assistant Psychologist experienced in IPA research) rated each aspect of the study and approved each item (Appendix S). This process ensured that the data collection, coding and analysis were transparent and the research remained consistent and of a high standard. Triangulation is a process of using multiple sources to explore and confirm findings. Patton (1999) describes analyst triangulation, the process of using multiple analyst to review data to check for bias, identify 'blind spots' and identify multiple ways to view the data. The researcher checked selected themes with one independent colleague for further discussion and later checked all themes with another independent colleague. Randomly selected transcripts, codes and themes were reviewed with the researcher's academic supervisor.

Additionally, the researcher independently transcribed all of the transcripts providing an added richness to the data that reading written text transcribed by an external person does not provide. The researcher consulted with both the academic research supervisor and clinical research supervisor throughout to ensure a high level of consistency and rigour.

Results

Detailed analysis of participant transcripts revealed six superordinate themes. These were: *Lack of Formulation, Maternal Attachment, Affiliation, Escape, Emotional Toll* and *Structural Issues.* Four of the superordinate themes produced subordinate themes. Seven participants were mothers and one participant was a father. The researcher considered whether the father's transcript should be removed, but once it was analysed, whilst there were some differences in the content of the interview, the themes arising from the coded transcript mirrored the other transcripts and there did not appear to be any significant difference in themes. Participants' contributions to each theme are displayed in Table 6. Participants differed in the extent to which they had been involved with services. There was a variety of different services involved with each of the participants. Whilst not formally collated as a demographic, participants were asked which services they had been involved with (see Table 7 for services that participants noted to be working with historically or presently). There were also differences in the severity of the HSB, and the nature of it (e.g. ongoing or one off event), whilst there were some individual differences, many of the themes remained similar.

Table 6
Summary of Participant Contributions to Each Theme

	1	2	3	4	5	6	7	8
1. Lack of Formulation	**√**	**√**	**√**	**√**	**√**	**√**	**√**	**√**
1a. Not understood	√	√	√	√	√	√	√	√
1b. Told not involved	√	√	√	√	√		√	
1c. Different norms			√	√	√			
1d. Barriers to partnership			√	√	√			√
2. Maternal Attachment	**√**	**√**	**√**	**√**	**√**	**√**	**√**	**√**
2a. Unconditional positive regard	√		√	√		√		
2b. Father absent		√	√	√	√		√	√
2c. Dissonance					√		√	√
3. Affiliation	**√**	**√**	**√**	**√**	**√**	**√**	**√**	**√**
4. **Escape**		**√**	**√**	**√**	**√**	**√**		**√**
5. Emotional Toll	**√**	**√**	**√**		**√**	**√**	**√**	**√**
5a. Life changing consequences	√	√	√	√		√	√	√
5b. Intense emotions	√	√			√	√	√	√
5c. Blame (internal and external)	√	√	√		√	√	√	√
5d. Stuck	√	√	√		√	√	√	
6. Structural Issues	**√**	**√**	**√**	**√**	**√**	**√**	**√**	**√**
6a. Service power	√	√		√	√			
6b. Services not accessible	√		√		√	√	√	√

Table 7
Summary of Services Referred to During Interview

	1	2	3	4	5	6	7	8
Social Services	√	√	√	√	√	√	√	√
MAST	√	√	√	√				√
CAMHS	√	√	√		√	√	√	√
Additional School meetings	√		√	√			√	√
Forensic CAMHS	√	√	√	√	√	√		
Police	√	√	√		√	√		
Charity					√		√	√
Other				√	√	√	√	√

Themes

1. **Lack of formulation**

The Lack of Formulation theme describes an experience identified by all participants of not being involved in a collaborative sense making process of the child *and* the family's needs following HSB. Participants reported feeling ignored, dismissed and not involvedin decision-making.

1a. Not understood

All participants referenced not feeling understood. Often this was related to professionals and services failing to recognise that the needs of the family were often wider than the HSB. Participants documented other issues that were also pressing:

P5: "*He had attacked me, he basically tried to kill me, he strangled me and didn't let go, there have been violence incidents for the past three years and it has been really difficult …* [later on] *so battling with a lot of things at the moment so it's not just one thing.*"

Participants also reported HSB affecting other aspects of family life, which was not appreciated.

P1: "*I've said can we have a day where [sibling] is involved so she gets to understand, but she said no because obviously I am only here for [son.]"*

1b. Told not involved

Participants described a directive rather than collaborative approach that was often taken, which resulted in feelings of powerlessness.

P4: "*she handed over my case two days before I was due to go.. I didn't even know [son] was due to go on a protection list, they made it out to be something else in the*

meeting and I'm agreeing to it and it ended up being a child protection list but they worded it all different and used different…"

Examples of good practice involved specific examples of being involved in decision-making.

P2: "*The social service worker was very 'this is how it's going to be'. Whereas us [sic] forensic CAMHS worker yeah she's really easy to talk to she understands what's going off and if we say look I don't think we're ready for that she will be like 'okay we will try it next week' or 'we'll ask about it next week', she works with us really well."*

> Reflexive entry:
>
> "Had to bite my tongue. X was explaining the X meeting and I realised that the process didn't make any sense to her, I don't think it was explained, no wonder she didn't like it. Wanted to explain how it should be, then felt angry on behalf of the whole family".

1c. Different norms

Three participants felt their own boundaries, what they deemed 'normal' or acceptable was significantly different from that of services.

P7: "*And I spoke to school, and it was like it's just kids that, they're going through puberty, they learn about sex education at school so not to worry. And now here I am.*"

P5: *"…didn't really seem to care or think it was a problem."*

1d. Barriers to partnership

There were a number of examples where participants appeared to have a good understanding of his/her son and his needs, however felt this was overlooked. There was also a deep-rooted mistrust in professionals.

P3: "*No matter how many degrees and qualifications whatever the doctor has done there is nobody that knows the child more than probably mum but possibly dad as well.*"

P8: "*You kind of feel like you can't talk to the professionals because you don't know what you're going to say that might be used against you.*"

2. Maternal attachment

Throughout every interview (including the interview with the father) there was a reference to the bond that mothers and sons have. Whilst attachment was not directly assessed, mothers seemed to be the main attachment for the boys spoken about in this study.

2a. Unconditional positive regard

Participants spoke of a range of challenging experiences relating to the relationship with their son. Yet, despite what he may or may not have done, he was still their child.

P1: *"In my head, I've got to believe him, I'm his mum, no matter what, the person that has got to believe him is me and that's what I went with."*

P6: *"One social worker said, 'I am surprised you are standing by him', and I have never thought about disowning him or anything but I think people were surprised, but I think 'no he's my son and I love him'."*

Reflexive entry:

"I felt a bit overwhelmed again during the interview. So much has happened and I suspect more has happened that we didn't talk about and things still aren't okay, but mum holds an unwavering love for her son. It was really powerful"

2b. Father absent

Of the seven mothers, two were separated from the child's father and were responsible for childcare and four mothers had no contact with the biological father.

P1: *"That person* [biological father] *can't be in his life because he was a violent man and a drug dealer..."*

P3: *"See the other thing with [son] was that he never wanted his dad, even when his dad was there he would say 'oh mum can we go on holiday together mum, can we go on holiday just me and you'..."*

P6*: "They say that sons and mothers have a particular relationship."*

2c. Dissonance

There were some compelling accounts of a psychological conflict that some participants experienced where they were confronted with powerful, unexpected feelings for their son, whilst at the same time maintaining their love for him.

P7*: "I'm paranoid he is going to come in and rape one of the kids. Yet I have to love this boy. This is still my boy, this is someone I carried and parted with..*[later] *every single day I say to my kids I love you I will see you later… but I couldn't do that with him… I couldn't look at him and it was killing me inside."*

P5: *"…if thought about [family] he wouldn't be in our lives… he tried to kill me… he's touched me inappropriately…As a mother it is hard to reconcile those feelings…But I still love him, we love each other .. and I miss him terribly."*

P8: "…emotions that you really didn't expect to have towards your child."

3. Affiliation

Some participants spoke of ‘being in it alone’ and others spoke of seeking or having an ally. For many, when talking about sources of support or valued professional input, what was most gratefully appreciated was the sense of having an ally, someone alongside them to try to solve the problem together. Affiliation refers to the sharing of a problem with another and asking others for help to resolve emotional conflict.

P5: *I don’t have a problem with them [forensic CAMHS], I have found them really helpful and have felt like they are the only people on my side.”*

P6: *“He [Psychologist] made a point of phoning me, I think it was every week, for quite a while, he spoke to me as a mum, ‘how are you’? And he actually really I think cared about how I was as well.”*

P8: “*I spent quite a lot of time searching on Facebook, I found a few forums on Facebook which have been massively beneficial.. just judgement free areas.*”

Reflexive entry:

“I noticed that mum used my name quite a few times during the interview, I noticed it a number of times and wondered what it was about. People don’t usually use my name, do they? It seemed to draw us closer together, like we knew each other or made us more familiar somehow”.

“In the interview today mum seemed to be telling me stories, I didn’t get it at first and kept looking at my questions panicking we were going off track, but then I realised she may have just valued someone listening to what she had to say”

4. Escape

There were a few coping mechanisms noted, from drinking, withdrawing and talking to friends, yet commonly there was a shared sense of wanting to escape. In some cases this was temporary, sometimes a fantasy and others literally escaped.

P4: "*and I said if we move we're going to move once, and I said you know if I do move I'm moving to Skeggy, I've told everybody that.*"

P3: "*…I started taking anti-depressants and eventually things got so bad I moved out … Yeah it helped me personally yeah because I was at the point where I couldn't carry on then, I just had to do that and have a break.*"

P2: "*As soon as I get to work it's like, not forgotten about but it doesn't get mentioned, no one talks about it it's just..two different world's almost.* Interviewer: It's separate. *P2: It is an escape."*

P6: "*…I sorted all the finances out and I did all the moving and we did that without actually seeing a soul, we hid away and then we left.*"

5. Emotional toll

There was a significant toll on participants following the HSB. Most participants reported intense feelings such as feeling horrified, disgusted, embarrassed and ashamed. Many had to give up training/employment, and others felt they lost themselves or that life had irreversibly changed. Significantly, the toll seemed to be greater for the parents compared to the sons who had displayed the HSB.

5a. Life changing consequences

Many participants reported significant life changes following the HSB, this included not being able to meet their own basic needs or having to give up work.

P1: "*my life is completely.. I was training.. a year ago I was training as [X] …I've had to completely stop all my training. I just can't cope…"*

5b. Intense emotions

Regardless of whether the HSB had been a single incident or an ongoing pattern of behaviour, most participants reported a range of intense emotions in response to it.

P1: "*yeah it's just anxiety it's just very tiring and constantly like palpitations constantly, constantly got..my heart's just constantly.. sat here watching tv alright then I'll be like [partner] feel my heart beat.*"

P8: after finding out about HSB *"the world falls out underneath you ... and then kind of emotionally there's the loss and I suppose grief and then you've got the humiliation and embarrassment."*

P7: re daily feelings "*Panic, fear dread"* [later in interview] *"I was mortified..."*

5c. Blame (internal or external)

Almost all participants blamed themselves for his or her son's behaviour.

P1: "*But I blame myself you know..."*

P5: "*It makes me feel rubbish because I feel like I have failed him as a parent."*

P6: "*No matter what people say, I will always feel guilty..."*

Some also experienced blame and criticism from professionals, most commonly this was reported to be an issue with documentation, sometimes which contained inaccurate information.

P2: "*And that's all they were doing [CAMHS], like finger pointing which was very difficult for me and [partner] because parenting is obviously an important thing, we don't like people say you're not doing it properly."*

P3: "*.. then the social worker and MAST also then put forward that 'mum didn't complete the practical parenting course'. So that was mum's fault once again if mum*

had done that, everything would've been alright. But why does mum need to do a practical parenting course when there is no concern in the home with my other children?."

P5: Regarding a report "*I wrote to the social worker and I said 'where has this come from? Who has said this? I want to make a complaint because I am unhappy about it', and he just said it would have been the previous social worker….I was really upset and really angry to see that, even if it was true you wouldn't put that in a report, you wouldn't say that, you just wouldn't.*"

P6: "*One of the youth offending team whom I met later on she very much tried to blame me as a parent, as a mother, you know her report was quite negative of me."*

P8: *"You know parent shaming doesn't help anyone, shaming parents doesn't help anyone at all and if they want people to go on parenting courses than they need to rebrand them as parent support courses.."*

5d. Stuck

There was some divergence in participant experience relating to processing the HSB. For some participants, the HSB was in the past, for other participants they had not reached a stage of processing and felt paralysed in their current situation.

P7: *"I'm just sort of living in this moment, I don't know how to move forward to the future. I can't go mad but I don't know how to move on."*

P5: *"…if I dwell on it too much then I can't function.."*

P5: *"I don't know how it will be resolved…"*

Reflexive entry:

"I found it so hard during the interview not to go into therapist mode, I could see mum was so stuck, re-living what had happened, she didn't know what do next, she didn't know when she would be seen by [service] and I didn't know either. I wanted to call up [X] and ask what was happening but knew that would be inappropriate."

6. Structural Issues

Whilst there were positive and negative experiences of individual professionals or specific teams, there was a theme around structural and systemic issues. Many parents reported how they had been trying to access services prior to the HSB incident that triggered the referral into services.

6a. Service power

There was a theme around power. In some cases, certain professionals were seen to hold a lot of power, this was experienced in some cases as reassuring and in others as overwhelming. The way that some systemic processes operated made some participants feel even more powerless

P4: *"..I only got it* [report] *the day before, the CAMHS, no the social workers report I got on the day, on the morning that I got there so I had no time to read it, forensic CAMHS had already sent me theirs so that was okay ... school rang me and read off what they wrote but I'd not got a thing till that day ... I'm meant to get these three or four days before so I could sit down and highlight things, I had not time to do that ….*[in the meeting] *I was still reading through everything, trying to process all of that."*

6b. Services not accessible

There was a theme throughout of participants believing that their son needed specific support and due to service criteria requiring a certain level of behaviour, were not able to access support until a more serious incident had happened.

P5: "*…it seems like they would help ... but that seems really out of reach now and it feels like we were given a carrot and now that's gone.* [Later] *... so he would have to rape somebody in order to get [help] which I think is completely wrong."*

P7: "*I had shouted from the roof tops about it to everybody… everybody knew he'd been doing or displaying that behaviour around porn and stuff… and we got referred off to everybody and nobody was interested.*"

Discussion

This study aimed to explore the lived experience of parents whose son had displayed HSB and to explore parents' journey through professional services. There were parallels in findings from this study and that of Jones (2015). Whilst Jones only interviewed four primary caregivers in the USA, there seems to be some universal similarities. The theme *Parental toll*, was similar to the superordinate theme in this study labelled *Emotional toll*, the theme *Coping with feeling responsible* was similar to the subordinate theme *Blame* and the theme *Coping with feeling alone* was similar to the superordinate theme in this study *Affiliation*.

Lack of formulation

Smith, Bradbury-Jones, Lazenbatt and Taylor (2013) reported that whilst there are recommendations for systemic approaches to HSB interventions, services continued to rely on one-to-one interventions, resulting in an absence of family work. Since then, NICE (2016) guidelines recommend MST, family therapy, encouraging caring relationships between parent and child, helping parents to create a sense of belonging and trust, helping the parent come to terms with the behaviour and work with parent/carer. However, there was very little evidence of collaborative working noted within the testimonies of most participants. According to Johnstone (2018), "Formulation can be defined as the process of co-constructing a hypothesis or best guess about the origins of a person's difficulties in the context of their relationships, social circumstances, life events, and the sense that they have made of them" pp 32. A formulation approach to understanding HSB would allow for the contribution of wider contextual life experiences and influences to be considered, which may help to alleviate feelings captured in the *Not understood* subtheme. Formulations are usually co-constructed, which may alleviate

feelings captured within the *Told not involved* and *Barriers to partnership* subthemes. Participants described their extensive knowledge and understanding about their sons, in this way they are the experts of their child. Professionals also have a broad range of specialist knowledge. Formulation would bring together both of these forms of expertise and may be one way to meet the NICE (2016) guidance.

Maternal Attachment

Bowlby (1969) first described attachment, defining it as a deep and enduring emotional bond, that one person has with another person. Developed in early years, a child's attachment experience guides how that child relates to other people through life. Attachment in children can be observed in behaviour such as seeking proximity to the attachment figure, particularly when upset. Attachment was not directly assessed, however mothers seemed to be the main attachment for the boys spoken about in this study. This highlights the importance of looking after mother's well-being as part of the HSB intervention. Whilst the findings of this study highlighted the mother-son bond, this cannot be generalised for all families. Firstly, the inclusion criteria specified *only* mother and fathers (rather than other caregivers). Secondly, there are likely to be unidentified reasons for the absence of fathers in this study. Finally, there are a range of family structures, including; single parent families; nuclear families (two parents and children); extended families (where extended family live with or care for children); step or blended families and foster families. Therefore, there are likely to be other attachment relationships found outside of the dynamics highlighted in this study.

During the interviews, noticeably a number of participants described an unwavering affection towards his/her son. Unconditional positive regard (Rogers, 1951) is central to person-centered therapy and refers to the acceptance and support of another person

regardless of what they do. Even when describing violent behaviour or challenging life situations many participants held an unconditional positive regard for their son despite the focus of the interview (HSB). Other participants described unexpected negative feelings towards his/her son, which caused a disruption to unconditional positive regard. Some participants described trying to reconcile thoughts and feelings of disgust, hate and fear with love and respect for their son. Festinger (1957) developed a theory of cognitive dissonance, which describes psychological discomfort when a person holds contradictory beliefs, values or ideas. The theory proposed that humans strive for consistency in beliefs, values or ideas and it therefore becomes uncomfortable or even distressing when a person experiences an internal challenge to their own beliefs, values or ideas. Emotional ambivalence refers to the experience of strong conflicting emotions (rather than indifference) (Rees, Rothmam, Lehavy, & Sanchez-Burks, 2013). The experience described by participants appeared to include both conflicting cognitive experiences (e.g. belief of their son as innocent, good or respectful paralleled with his HSB) and conflicting emotional experiences (e.g. feelings of love and hate). This subordinate theme was therefore changed from 'Cognitive Dissonance' to 'Dissonance' to reflect the captured experience of both cognitive and emotional conflict.

Affiliation

Some participants reported that clear guidance and strategies were valuable, but what seemed more universally valued was a sense of having an ally. Whether this was a close friend or family member, an online acquaintance or a professional, it seemed most important not being alone. Participants appeared to value having someone 'on their team'. Freud (1937) built upon a list of subconscious strategies that people use to manage anxiety and distress, known as defence mechanisms. According to psychodynamic theorists, affiliation is a mature (or healthy) defence mechanism that individuals employ

to help them cope with emotional conflict. Affiliation refers to the sharing of a problem with another and asking others for help to resolve emotional conflict. Affiliation is an understanding response to this situation, particularly in light of the dissonance theme as described above. The affiliation theme was evidenced both in explicit statements from almost all participants but also the researcher's reflexive journal. There are references within the reflexive journal in which the researcher noted a sense of bonding. At times it seemed the participant was aligning with the researcher (e.g. asking her opinion or seeking reassurance) or the researcher felt a pull towards aligning with the participant (e.g. after a participant described harmful consequences of an inaccurate report). The emotional nature of most of the interviews required a certain level of mutual trust and respect between the researcher and the participant, which may have also increased a sense of affiliation. Finally, the experience of being able to share experiences and opinions without repercussion may have also increased a sense of affiliation.

Escape

There were varying degrees of escape described by participants. Some spoke of feeling trapped and unable to escape, in contrast, one participant described the role of employment as an escape from the pressures at home. One participant described ideas of moving away (fantasy escape), one participant moved out for a short time (temporary escape) and another participant described moving cities away from everyone who knew about the HSB (permanent escape). It is possible that escape is a form of avoidance from intolerable feelings, responses and experiences and in the context of the participants' experience, an understandable response.

Emotional Toll

Hackett (1988) suggested that parents and caregivers often have difficulties in offering and providing care to a young person who has sexually offended because they must cope themselves with the experience. This seemed to relate to some of the participants in this study who found it difficult to care for their child and return to normality following an incident of HSB because they were processing what had happened. It seemed for many participants that the HSB had affected the parents more than the young person displaying the HSB. Participants reported both self-blame and guilt and some felt blamed and criticised by professionals.

There were a multitude of services working with most participants (see Table 7), and often a number of professionals within each service. Some participants appeared indifferent to this and for others it was overwhelming and was very demanding of their time. One participant gave an analogy of feeling that she had two jobs, one as mother of her children and secondly as administrator, minuting meetings and relaying information from one professional to the next.

Some participants had made sense of the HSB and the wider context of the behaviour of the son and were able to reflect on it with a certain level of distance. For some it remained an ongoing behaviour that caused a constant state of unrest. For others the emotional and social consequences of a single HSB incident remained present. These participants reported feeling stuck or paralysed by the situation and felt unable to see how the future would be. In some ways this can be likened to a trauma response. Shapiro (2001) suggested that trauma can be defined by any event that triggered a prolonged detrimental effect to the self or to the psyche. Unprocessed traumas (large or small) can have long-lasting negative effects on a person, which can manifest in depression, anxiety

and a sense of feeling stuck or paralysed in the situation. This was an experience described by a number of participants. The concept of 'containment' was first coined by Bion (1962) and refers to a process in which a person receives and understands emotional communication from another (emotional) person but without sharing the overwhelming nature of the emotion. The receiving person 'absorbs' the emotion, temporarily holding it for the person and then reflects back an understanding of the emotion. This process of containment then restores the capacity in the emotional person to think (Douglas, 2007). Participants that described intolerable emotions, feeling stuck or wanting to escape did not appear to have access to emotional containment. It would be useful for services to consider how emotional containment for parents could be incorporated into HSB interventions.

Structural Issues

The NICE (2016) guidance explicitly encourages professionals to report to safeguarding leads when a young person displays sexualised behaviour not appropriate to development, e.g. viewing porn not appropriate to age and development. Historically many participants spoke of reporting problematic behaviour or HSB, but it was not considered 'serious enough' to gain access to services, consequently resulting in an escalation of behaviour. Additionally the guidelines highlight the importance of involving families/carers in HSB interventions. What emerged from the participants' accounts was a lack of use of these guidelines in services. These recommendations include (where appropriate) MST or family therapy. The parents of two young people reported being referred to family therapy. One had not yet attended, and the other found it unhelpful and chose not to attend again. There may be variety of reasons this guidance has not been followed, including; assessment deeming other interventions as more appropriate or a lack of resources to provide intensive treatments such as MST.

Strengths, limitations and future research

This study addressed a gap in the literature of understanding the experiences of parents who have a son who has displayed HSB. It highlighted parent's experiences and needs and provides examples and suggestions for helpful intervention. It has been useful to consider how to meet the needs of this group more effectively, which will in turn benefit the young people who have displayed HSB. Successful intervention would hopefully reduce future HSB.

A limitation of this study was the lack of validation of themes before the conclusion of the study. Respondent validation involves participants checking initial data (e.g. transcripts), drafts of reports, themes to ensure the interpretative analysis and conclusions are recognizable, fair and reasonable (Bloor, 1978). A further limitation was the sample. The study aimed to access the experiences of both mothers *and* fathers; unfortunately seven of the eight participants were mothers. This is likely to be somewhat reflective of the population overall, where mothers are the primary caregivers. Data of participants who declined to take part was not officially recorded, anecdotally it seems more fathers than mothers declined to take part. It would be useful for future research to consider the needs of fathers and help services identify how fathers could be supported to have a more active role in HSB intervention. The demographic information collected was minimal, this was designed with the intention of being the least intrusive, however it may have been useful to have included additional contextual information for example, siblings or marital status. Future research could also explore the sibling experience of HSB. This study did not consider or reflect upon cultural differences, the sample was predominantly white British, and all participants spoke English as a first language. It is likely that parents outside of this demographic have a different experience. Particularly given the Eurocentric nature of many UK health services (Patel & Keval, 2018).

Clinical Implications

The use of psychological formulation with parents or caregivers of young people who display HSB may alleviate a number of pertinent negative experiences that emerged as themes across the data. The 'co-constructing' nature of formulation may make parents feel more involved. It may allow room for parents to express their own needs and how this impacts the young person and would take into account family context, relationships, social circumstances and life events, all of which participants felt were overlooked. The process of making sense of the HSB by using formulation may help those parents who feel stuck and unable to process what has happened.

Given the striking effect juvenile HSB has had on parental well-being, a specific focus on parental well-being should be a vital aspect of future HSB intervention. Psycho-education to professionals of trauma responses and containment may be useful to meet the needs of parents.

It would be useful for more consideration and an active focus on how fathers, step-fathers and partners could be supported to have a more active role in HSB intervention.

Conclusions

HSB appears to exist in the context of wider complex behavioural and systemic issues and parents of young people who display HSB are in many cases more affected by the HSB than may initially be evident or expected. For reasons that are unclear, but likely to be due to a restriction of services, parents of children who display HSB are not able to access services and when they do, do not feel heard or supported.

References

Allnock, D., Bunting, L., Price, A., Morgan-Klein, N., Ellis, J., Radford, L., & Staffrod, A. (2009). *Sexual abuse and therapeutic services for children and young people: The gap between provision and need*. London: NSPCC.

Bloor, M. (1978). On the analysis of observational data: A discussion of the worth and uses of inductive techniques and respondent validation. *Sociology, 12,* 545-552. https://doi.org/10.1177/003803857801200307

Bion, W. (1962). *Learning from experience*. London: Karnac Books.

Bowlby, J. (1969). *Attachment. Attachment and loss: Vol. 1. Loss*. New York: Basic Books.

Douglas, H. (2007). *Containment and reciprocity: Integrating psychoanalytic theory and child development research for work with children.* Hove: Routledge.

Festinger, L. (1957). *A theory of cognitive dissonance*. California: Standford Univeristy Press.

Freud, A. (1937). *The ego and the mechanisms of defence*. London: Hogarth Press and Institute of Psycho-Analysis.

Glaser, B., & Strauss, A. (1967). *The discovery of grounded theory: Strategies for qualitative research.* Chicago: Aldine.

Graham, J., Grewel, I., & Lewis, J. (2007). *Ethics in social research: The views of research participants.* NatCen: London.

Hackett, S. (1988). Facing the future: *A guide for parents of young people who have sexually abused*. Lyme Regis, Dorset: Russell House Publishing Ltd.

Hackett, S., Phillips, H., Masson, M., & Balfe. (2013). Individual, family and abuse characteristics of 700 British child and adolescent sexual abusers. *Child Abuse Review, 22*, 232-245. http://dx.doi.org/10.1002/car.2246

Hackett, S. (2016). *Expert testimony to inform NICE guideline development*. NICE. Retrieved from: https://www.nice.org.uk/guidance/ng55/evidence/expert-paper-13-an-overview-of-policies-and-procedures-across-the-devolved-administrations-including-the-role-of-primary-prevention.-what-are-the-elements-of-a-good-service-response-to-the-issue-of-h-pdf-95786912919

Johnstone, L. (2018). Psychological formulation as an alternative to psychiatric diagnosis. *Journal of Humanistic Psychology, 58,* 30-46 https://doi.org/10.1177/0022167817722230

Jones, S. (2015). Parents of adolescents who have sexually offended: Providing support and coping with the experience. *Journal of Interpersonal violence, 30,* 1299-1321. http://dx.doi.org/10.1177/0886260514540325

Larkin, M., & Thompson, A. R. (2012). Interpretative phenomenological analysis in mental health and psychotherapy research. In D. Harper & A. R. Thompson (Eds.), *Qualitative research methods in mental health and psychotherapy: A guide for students and practitioners* (pp. 101-116). London UK: Wiley.

Larkin, M., Watts. S., & Clifton, E. (2006). Giving voice and making sense in interpretative phenomenological analysis. *Qualitative Research in Psychology, 3*, 102-120. https://doi.org/10.1191/1478088706qp062oa

Latimer, J., Dowden, J., Morton- Bourgon, K. E., Edgar, J., & Bania. (2003). *Treating youth in conflict with the law: A new meta-analysis*. Ottawa, Canada: Youth Justice Research, Department of Justice.

McCartan, K. F., & McAlister, R. (2012). Mobile phone technology and sexual abuse. *Information and Communications Technology Law, 21,* 257-268. http://dx.doi.org/10.1080/13600834.2012.744223

National Institute of Health and Clinical Excellence. (2016). *Harmful sexual behaviour among children and young people*. (NICE Guideline NG55). Retrieved from: https://www.nice.org.uk/guidance/ng55

NSPCC. (2017). *Harmful Sexual behavior. What is harmful sexual behavior.* Retrieved from: https://www.nspcc.org.uk/preventing-abuse/child-abuse-and-neglect/harmful-sexual-behaviour/

Patel, P. & Keval, H. (2018) Fifty ways to leave …… your racism. *Journal of Critical Psychology, Counselling and Psychotherapy, 18*, 61-79. Retrieved from https://www.researchgate.net/publication/328601850

Patton, M. (1999). Enhancing the quality and credibility of qualitative analysis. *Health Service Research, 34,* 1189-1208. Retrieved from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1089059/

Pierce, S. (2011). The lived experience of parents of adolescents who have sexually offended: I am a survivor. *Journal of Forensic Nursing, 7,* 173-181. https://doi.org/10.1111/j.1939-3938.2011.01116.x

Potter, J., & Wetherell, M. (1995). Discourse analysis. In J. Smith., R, Harre, & L. Van Langenhove (Eds.), *Rethinking methods in psychology* (pp. 27-49). London: Sage.

Rees, L., Rothman, N., Lehavy, R., & Sanchez-Banks, J. (2013). The ambivalent mind can be a wise mind: Emotional ambivalence increases judgment accuracy.

Journal of Experimental Social Psychology, 49, 360-367. https://doi.org/10.1016/j.jesp.2012.12.017

Rogers, C. R. (1951). *Client-centered therapy: Its current practice, implications and theory.* Boston: Houghton Mifflin.

Shaw, R. (2010) Embedding reflexivity within experiential qualitative psychology, *Qualitative Research in Psychology, 7*, 233-243. http://dx.doi.org/10.1080/14780880802699092

Sheffield Health and Social Care NHS Foundation Trust. (2014). *Policy: Lone Working.* Retrieved from: https://shsc.nhs.uk/wp-content/uploads/2017/11/Lone-Worker-Policy-v3-Final-June-2014-Revised-19-10-17.pdf

Shapiro, F. (2001). *Eye movement desensitization and reprocessing: Basic principles, protocols and procedures*. (2nd ed.). New York: Guilford.

Smith, B. J., & Trepper, T. S. (1992). Parents' experience when their sons sexually offend: A qualitative analysis. *Journal of Sex Education and Therapy, 18*, 93-103. https://doi.org/10.1080/01614576.1992.11074043

Smith, J. A., Flower, P., & Larkin, M. (2009). Interpretative phenomenological analysis: Theory, method and research. *Qualitative Research in Psychology,* 6, 346-347. http://dx.doi.org/10.1080/14780880903340091

Smith, C., Bradbury-Jones, C., Lazenbatt, A., & Taylor, J. (2013). *Provision for young people who have displayed harmful sexual behaviour.* London: NSPCC.

Tracy, S. J. (2010). Qualitative quality: Eight "Big-Tent" criteria for excellent qualitative research. *Qualitative Inquiry, 16*, 837-851. https://doi.org/10.1177/1077800410383121

Vizard, E., Hickey, N., French, L., & McCrory, E. (2007). Children and adolescents who present with sexually abusive behaviour: A UK descriptive study. *The Journal of Forensic Psychiatry & Psychology, 18*, 59-73 https://doi.org/10.1080/14789940601056745.

Walsh, R. (2003). The methods of reflexivity. *The Humanistic Psychologist*, *31*, 51–66. http://dx.doi.org/10.1080/08873267.2003.9986934

Zimring, F. E. (2009). *An American travesty: Legal responses to adolescent sexual offending*. Chicago: University of Chicago Press.

Appendix A. Reflexive Entry Examples

"First interview today. Mum seemed all consumed by the incident and the ongoing concerns with her son. It sounds so difficult. She seems to be carrying a lot of responsibility and feels burdened by her son but I noticed even when she seemed annoyed with him she wouldn't say anything "bad" about him unless it was a fact. When she was talking, she seems to cling on to the psychologist and her involvement seems very important to her. Is she a bit dependent on her maybe? Could it be related to hope? That she will change things maybe. I noticed I felt a pull to provide her with some reassurance and containment and validate her difficulties, which I think are very valid. Perhaps this is because it was the first interview and I was new to it? Keep an eye on it.

The house was smart and tidy in the lounge and dining room. There were lots of family, loving style photos on the wall and a big tv. It seemed like a nice home. It wasn't the typical kind of house or family that is described in the literature. Makes me think again about how questionable the literature is. Does it represent all people? Or maybe an example of people not being able to access services until things are really bad.. and it is those people that the literature represents.

There seemed to be a narrative around the son as "he is very complex", was it externalising? Or trying to understand? Or create some context for me that this wasn't just a straight forward child that she just couldn't manage?. She seemed to be doing her best. I could tell Mum doesn't feel her needs are being met (and perhaps this reflected the pull I had to meet her needs?) Also feels her children's needs aren't being met. Feels very 'stuck'. Really felt for her."

Appendix B. Reflexive Statement.

The researcher is a female clinical psychology trainee. She has a background working in forensic services with young people and adults who display offending behaviour. This may include sexually harmful behaviour, but her work has not specifically focused in this area. During her clinical psychology training, the researcher developed a reasonable understanding of some of the community services that the participants may have accessed although has never worked within these services.

The researcher aligns with the social constructionist epistemological stance. She holds a belief that there are few universal 'truths' and each individual's experience of the world is created from their own life experiences. The researcher was drawn to IPA as an approach due to its epistemological position and its requirements to approach participants with flexibility, empathy, open-mindedness and understand their experience the best they can (Smith, Flower & Larkin, 2009). The researcher draws upon a range of therapeutic approaches in her clinical work and has a collaborative approach with clients when choosing therapeutic modalities.

Appendix C. Invitation Letter

Dear

I am contacting you as you and your son have recently had engagement with the Forensic CAMHS/Youth Offending Team.

Please note, this letter is nothing to be alarmed about, it is about a research project.

We are looking into the experiences of parents. We are interested in asking you some questions such as what it is like as a parent to have a child that has been referred to specialist services, what your experiences have been like, hear about things that have been helpful and things that haven't been and how you were supported by friends, family and professionals.

Little is known about the experiences of families with children who are seen by forensic CAMHS or the Youth Offending Team. The results of the study will be used to understand parents' needs and hopefully contribute to a better delivery of services for young people.

The write up of the study will be completely anonymous and neither you, nor your son's details will be revealed. You don't have to take part; it is completely voluntary.

If you would like to or even if you don't want to take part in the study, please contact the researcher via any of the methods below. If we do not hear from you in two weeks, someone will give you a quick confidential call. If you opt in, the researcher will call you on the number you have

previously supplied. If you have a new number, or a number which you would prefer to be contacted on, please write this down below.

Email [redacted] Telephone [redacted]

Post: Use the stamp addressed envelope and include a completed copy of the form below.

I ………………………….. am a parent of a child who was referred to the CAMHS or Youth Offending Service. I WOULD / I WOULD NOT like further information about the research project exploring parent's experiences.

Date………………….. Signed…………………………………..

The number I would like to be contacted on is: ………………………………..

Appendix D. Participant Information Sheet

Information Sheet

Project Title: Exploring the lived experience of parents who has a son that has displayed harmful sexual behaviour.

You are invited to take part in a piece of research exploring what it is like for a parent when their child has displayed some form of Harmful Sexual Behaviour. Harmful Sexual Behaviour (HSB) includes non-contact behaviour (e.g. viewing images online, exposure, voyeurism) to contact behaviour (including sexual assault and rape). You have been identified as a possible suitable participant as your son was referred for support from the Forensic CAMHS or Youth Offending Team.

What is the purpose of the study?

Most research into HSB is concerned with the why harmful sexual behaviour occurs in the first place. Lots of research also focusses on how to support victims. Recommendations about working with people who have displayed HSB suggest that involving family members, where appropriate, is very helpful. However, little is known about what it is like to be a family member in this circumstance. This study would like to explore the experiences of parents so that there can be a better understanding about what it is like for them, how life changed, what helped them through this and what was difficult, what they need from other people, and how services can support them in the future.

What will happen if I choose to take part?

The study is looking for participants to take part in one confidential and anonymous interview. During the interview, you will be asked questions about your experience, how it made you feel and your opinions on the support you and your child received. This interview will be audio recorded. We will not record your name or any other private information about you. Your responses will then be anonymously compared (by the researcher) with interview with other parents who have also taken part to see whether there are any similarities or differences.

How and when would this happen?

The researcher will find a time to suit you. The interview itself will take approximately one hour, an additional half an hour will also be allotted to allow for any questions before or after the interview. The interview will take place in a private room at Star House (where the forensic CAMHS/Youth Offending Team is based). Under particular circumstances, the researcher may be able to visit you at home to complete the interview.

Please note: The interview is **NOT** a therapy session or a place to make a formal complaint. No payment will be made.

Do I have to take part?

No. The study is voluntary and you can withdraw at any time before the interview or during the interview. If afterwards you change your mind, you can contact the researcher up to four weeks later to withdraw your interview from the study. If you chose not to take part the researcher will be informed so that they do not contact you again.

Will I be recorded, and how will the recorded media be used?

The interview will be recorded, only audio recording will be used (e.g. only voices, no pictures or filming). The audio recording of the interview will be used only for analysis and for illustration in conference presentations and lectures (e.g. an anonymous quote may be taken to highlight a finding). Quotes may be used in the write up of the study, however these will only be included if the quotes are completely anonymous and unidentifiable. No other use will be made of them without your written permission, and no one outside the project will be allowed access to the original recordings.

What are the possible benefits?

We will be asking you to reflect upon your experiences of living in a family where a young person has displayed HSB. Whilst it may be difficult to talk about, our hope it that this feels meaningful for you, allowing you to offer your reflections on what life has been like for you. We hope that by completing this research project we gain a better understanding of how to support parents in the future.

What are the possible risks/disadvantages?

We do not anticipate any significant risks with taking part in this study. However, it might be upsetting to recall certain aspects of your experience. Whilst every effort has gone into ensuring the questions are not distressing (including consultation with other families with the same experience as well as professionals who work with families) some of the questions may feel intrusive. You do not have to answer anything you do not feel comfortable with and can stop the interview at any time. We also appreciate that it may be time consuming, therefore the researcher will make every effort to arrange the interview to suit you.

What happens after the interview?

The results of the study will form part of a Clinical Psychology Doctoral thesis. After the interview, the interview will be typed up by either the researcher or a transcriber. The interview is completely anonymous, the transcriber will not be aware of any identifiable information and will sign a confidentiality agreement. The researcher will then analyse the interviews by comparing all the interviews to explore whether there are any similarities and differences across different participant's experiences. Once the study has been written up and submitted to the University of Sheffield, it is also the researcher's aim to publish the results of this project in a relevant academic journal. Again, participants will not be identifiable in the publication as all data will be anonymous. If you would like a copy of the report once it is ready, please contact one of the lead researchers and ask to be added to our circulation list.

Confidentiality

The researchers in this project will not have access to any personal information about you other than the information you provide. The lead researcher will only have access to your name and number once you have agreed to take part. Your telephone number and address will be kept for up to four weeks (you can withdraw your information during this time period) after which it will be destroyed. Once the study has been completed, if you wish to receive a copy of the study, the researcher will discuss this with you and store an address or email address to send you a copy. Once this has been sent, your details will be destroyed. It is expected that the study will be completed by September 2019. A consent form with your name and signature will be kept and stored in a locked cabinet at the University of Sheffield for 5 years and then it will be destroyed. Some anonymous demographic information will be collected (for example which age bracket you are in) however you do not have to complete this. The interviews will be written up anonymously and will not include your name or anything that could identify you. If

a home visit is completed, another member of the research team will be made aware of your address, as per the University of Sheffield Lone Working Policy. Once the interview has finished, this will be deleted. None of your information will be shared with anyone outside of the study under the General Data Protection Regulation (GDPR, 2016. Implemented via Data Protection Act 2018).

The University of Sheffield is the sponsor for this study and will act as the data controller. This means that we are responsible for protecting your information and using it properly. The University of Sheffield will keep all saved information anonymous and saved on a password protected computer. Anonymous data will be stored as per university regulations (5 years) on an encrypted memory stick.

Your rights to access, change or move your information are limited, as we need to manage your information in a specific way in order for the research to be reliable and accurate. However you can withdraw all of your information up until four weeks after the interview. To safeguard your rights, we will use the minimum personally-identifiable information possible.

It is important that we ensure the safety of you and other people. There may be rare occasions when your confidentiality needs to be breached, for example if you were to disclose further un-reported incidents, or if there were concerns that you or someone else may not be safe. Depending on the nature of the disclosure, this will be reported as a safeguarding issue or if it is serious disclosure it will be reported to the police, we will make every effort to discuss with you any concerns we have.

The Forensic CAMHS or Youth Offending Team will collect information from your medical records for this research study in accordance with our instructions. The Forensic CAMHS or Youth Offending Team will use your name, and contact details to contact you about the research study, and make sure that relevant information about the study is recorded for your care, and to oversee the quality of the study. Individuals from University of Sheffield and regulatory organisations may look at your medical and research records to check the accuracy of the research study. The Forensic CAMHS or Youth Offending Team will pass these details to the University of Sheffield along with the information collected from you. The only people at the University of Sheffield who will have access to information that identifies you will be the researcher or the academic supervisors who will contact you to complete the interview or

audit the data collection process. The people who analyse the information will not be able to identify you and will not be able to find out your name, or contact details.

The University of Sheffield will keep all saved information anonymous and saved on a password protected computer. Anonymous data will be stored as per university regulations (5 years) on an encrypted memory stick. Records kept at the Forensic CAMHS/Youth Offending Team will be unaffected by your involvement in this study and no additional data about you will be stored as a result of your participation in the study.

You can find out more about how we use your information at https://www.hra.nhs.uk/planning-and-improving-research/policies-standards-legislation/data-protection-and-information-governance/gdpr-guidance/ or by contacting one of the lead researchers for this study.

Who has ethically reviewed the project?

This study has approved by Sheffield Research Ethics Committee. This means that it has been agreed that it is unlikely to pose risk to those that take part, and it has approval to be conducted in the NHS and in the community.

Who is organising and funding this research?

The project is being conducted by Tansy Warrilow (Clinical Psychologist in Training) as part of their training towards becoming a Doctor of Clinical Psychology at the University of Sheffield. Tansy is being supervised by Professor Nigel Beail who is based at the University of Sheffield and Dr Berit Richie who is based in Sheffield Forensic CAMHS.

How do I make a complaint?

If you would like to make a complaint about this project, in the first instance you should contact the lead researcher or their supervisor. If you do not feel satisfied that your complaint has been dealt with appropriately you can contact the University of Sheffield's Registrar and Secretary to take your complaint further. The University of Sheffield's Registrar and Secretary is Professor Pam Shaw, Vice President for Medicine, Dentistry and Health who can be contacted at the following address: Professor Pam Shaw, The Registrar and Secretary's Office, University of Sheffield, Firth Court, Western Bank, Sheffield S10 2TN, UK.

Thank you very much for taking the time to participate in this study, you time and input is much appreciated.

Further information and contact details

Lead researcher contact details:

Tansy Warrilow: twarrilow1@sheffield.ac.uk

Supervisor contact details:

Professor Nigel Beail: nigel.beail@swyt.nhs.uk
Dr Berit Richie: berit.richie@sch.nhs.uk

Appendix E. Participant Consent Form

<u>Consent form</u>

Exploring the lived experience of parents who has a son that has displayed harmful sexual behaviour.

If you are happy with the information you have received so far and have no further questions, please read the following statements and put a tick in the box if you agree and then sign your name at the bottom.

I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.	
If a disclosure of a new criminal offence is made, the researcher may have to pass this on as a safeguarding/police matter	
I agree to take part in the above study.	
I agree that an audio (sound) recording can be made of the interview.	
I agree for anonymous quotes to be used for publications, teaching and presentations.	
I would like to receive a copy of the study results, once available.	

____________________ ____________ __________________
Name of Participant Date Signature

____________________ ____________ __________________
Name of Person taking consent Date Signature

One copy to be kept by the researcher and one copy to be given to the participant.

Appendix F. Demographic Information

Demographic Information

For the purposes of the study it is helpful to know a little about you and the young person. This will remain completely confidential and anonymous. If you have questions or need any help, please contact the researcher who will help you with the form.

Please complete the following questions by selecting the option which best suits you:

1. How old are you?

□ < 20 □ 21 – 30 □ 31 – 40 □ 41 – 50 □ >50 □ Prefer not to say

2. Are you male or female?

□ Male □ Female □ Prefer not to say

3. What is your relationship to the young person? …………………………………….

4. Please state your ethnicity …………………………………………..

5. How old was he when he was referred to the Forensic CAMHS service? ………..

6. How long did he access Forensic CAMHS for?

□ 0-3 months □ 3-6 months □ 6-9 months □ 9-12 months □ 12-15 months

□ 15-18 months □ 18-21 months □ 21-24 months □ 2 years +

7. Was the nature of the behaviour; Contact (e.g. touching, penetration) or Non-Contact (e.g. it happened online, he used sexualised language or exposing)?

☐ Contact ☐ Non-contact ☐ Both ☐ Prefer not to say

8. Was the young person charged with a criminal offence?

☐ Yes ☐ No ☐ Prefer not to say

Appendix G. Semi Structured Interview

Semi- Structured interview guide

1. **The incident of HSB**

- How many behaviours have there been? Agree on which talk about [be mindful if any are currently undergoing police proceedings and discuss boundaries]
- How would you like to refer to what happened? (agree terms to use to talk about it e.g. *the incident, the offence*, '*it*')
- How old was he when HSB [insert term agreed] happened?
- What is it like when you first found out about the HSB?
    - *Prompt*: How did you find out? Your immediate reaction? Your partner's reaction (if appropriate), what did you do? Did you talk about it? What was that like?
- Have you had any thoughts about why it happened?
    - Prompt: For example, why do you think it happened? Were there any triggers you can identify?
- Have your thoughts and feelings changed since then or are they the same?
    - *Prompt:* What is different? Is there anything that helped or hindered that process?
- Was there any use of technology in the HSB?
    - *Prompt:* e.g. Mobile phones, internet, laptop and games consoles, e.g. Playstation, X Box and Nintendo
- How comfortable do you feel using the internet? How comfortable are you knowing the young person has access to the internet?
- Does the young person have any additional needs?

2. **Life**

- Are you employed? What do you do? Has it affected work?
- Would you be able to tell me about the ways it affected your life.
    - *Prompt*: Did it change anything? Is anything different as a result of the incident?
- Can you tell me about the impact it had on you?
    - *Prompt:* emotional, financial, friends, work, personal?

- How has it made you feel?
    - *Prompt:* has it affected your mental or physical health?

- What about X's siblings, how did it affect them if at all?

- Did you move/stay in the same place?

- Is life the same now as it was before?
    - *Prompt*: What about leisure time? Work? Social life?

- Could you tell me how you feel about moving towards the future?
    - *Prompt*: Is this any different from how you saw the future before HSB?

3. Parenting

- Did you have any support with parenting? E.G. a partner or family support?
    - *Prompt*: Did that change?

- Tell me about your relationship with him.
    - *Prompt*: What was it like as a baby/child/teenager? Where there any changes at any point? Were you happy with how you got on?

- After the incident, what was your relationship like?
    - *Prompt:* Did you notice a change in how you got on? What happened after? What is it like now?

- Have you been able to talk about it together?
    - *Prompt*: If so what was that like? If not, why not? Do you feel that was for better or for worse?

- Did anything change in with your family got on with each other?
    - *Prompt*: What were things like at home? Were people any different?

4. Relationships

- You said that X was involved in X's life, what was their reaction?
    - *Prompt:* was it the same as yours? What was this like?

- What were other people's reactions?
    - Prompt: Family, friends, community? Did it affect any of X's relationships?

- (If yes) How have you coped with these changes? What did you do?

- Have your relationships with anyone changed?
    - *Prompt*: What happened? Was it led by you or them?

5. Professional Support and informal Support

- Before the incident happened, were any other agencies involved?
    - *Prompt:* mental health services, substance use support, physical health, social workers.

- What professional support have you received (if any) following the HSB?
    - *Prompt*: From the forensic CAMHS team? From outside agencies? Did you seek support or was it offered?

- Can you tell me why he was referred to Forensic CAMHS?

- How long were you involved with the Forensic CAMHS service?

- Tell me about your experience of accessing services following HSB
    - *Prompt:* How involved were you? Did you feel heard/supported?

- Do you think your young person has received adequate support?
    - *Prompt:* What support do you feel the young person has benefitted from?

- Is there anything you would change about how services interacted with you or X?

- If you could give advice to professionals after your experience, what would it be?

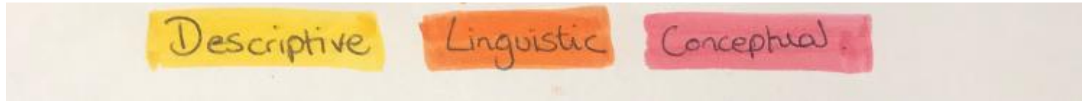
- What kind of informal support have you received (if any) following the HSB?
    - *Prompt*: From friends? Family? Charities or organisations?

- When was that support most useful?

- What was the most useful aspect of that support?

- Did you seek any support for yourself? If so, did you get to see anyone? How long did you wait?

Appendix H. Example Coded Transcript



Emerging themes. I am

Exploratory comments

Emerging themes		Transcript	Exploratory comments
different. Not usual self.	P1:	I can't be bothered. I just get up on a morning and go as school as I am, I just wash my face and that's it, I can't be bothered	Lost motivation. Implica… that things used to be different.
	Int:	Lost a bit of your… how you used to be	
Wanting change. Things are different. Mum as responsible. Dread.	P1:	Yeah and I need to get it back, I feel like, I mean, I've got a hen.. hen holiday coming up in May, we're going to Benidorm and I'm really not looking forward to it and normally I would, normally id be like yeah I can wait to go but I'm actually dreading it because of X is going to be at home with [husband] and I don't know how X is going to be. The other three children I've got no problem whatsoever but them two clash really bad so I'm dreading it (feeling stuck?)	Wanting things to be different. Can't enjoy life. Things aren't normal any more – feel… stuck where… Mum is responsible for childcare + the relationship between everyone.
	Int:	Mmm	
Sleep.	P1:	Yeah. Another thing it affects as well is sleep	Sleep – another exampl… of mum's needs not being met as a result of this.
	Int:	Okay	
Own needs aren't met.	P1:	I want to sleep a lot, I don't get enough sleep, then at night when I go to bed I can't sleep	
	Int:	What do you think is stopping you sleeping?	
Constant / Stuck.	P1:	Probably anxiety, yeah, yeah it's just anxiety it's just.. very tiring and constantly like palpitations constantly, constantly got, my heart's just constantly, sat here watching here TV being alright, normal and then I'll be like [husband] feel my heart beat	Anxiety and weight… Situation is all consu… for P1. Physically an… emotionally impact… Mum seems to be carrying the burden.

31

Appendix I. Example List of all Themes

P7

Escalated 1
Horrified 2
Lost innocence 2
Don't have the skills to manage 3
Can't protect son 3
Life changing - initial response 4
Normality ended 4
Desperate 5
Unprepared 5
Parental conflict (baby or baby) 5
Unprepared 5
Absent father 6
Family shock 6
Blame myself 6
Waiting to understand 7
Can't make sense of it 7
Dismissed 7
Desperately asking for help 7
Prev. ref didn't reach threshold 7
"good mum" so no input 8
Nobody listened 8
Avoidable 8
Failed 8
Still waiting 8
Effect on siblings 9
Balancing needs of all children 10
Lost innocence 10
Mum's lost innocence 10
Repulsed 11
Dismissed (by school) 11
Conflict love son but terrified of what he could do 12
Don't sleep 12
Convinced something will happen 12
Burden of trying to keep him + others safe 12
Panic, fear, dread 12
Received good social support 13
Hatred v love 13
Stuck in mind 14
Shocking for mum - out of normality Unexpected 14
Panic children be removed 14
Motherly conflict 15
Too much to handle 15
Didn't just listen, he motivated me 15
Unknown consequences 16
Childrens needs are mum's priority 16
Emotional impact on mum 17
Unexpected 18
Constantly on edge 18
Events are overshadowed 18
Living in the moment 19
Stuck 19
Changed how mum views the future 19
Unconditional love for son 20
Addiction to porn 20 constant
HSB violating 21
Don't want to be exposed to it 21
Protecting siblings 21
Strong negative feelings for son 21
Reconciling ben 22
Conflict - powerful emotions 22 (35)
Conflict love - hate 22
Mother - son bond restored 22
Couldn't accept what happened 23
Trying to understand 23
Open rel - talking about issue 23
Mum couldn't process 24
Family distance 26
Trying to find normality 26
Range of services 28
Children's needs come first 28
Mum open with services 28
Referred historically (not received) 29
Not communicated with 29
Reactive not proactive 29
Overwhelming amount of professionals 30
Unprepared expectations 30
All children have additional needs 31
Not informed 31
Anxious about what to expect from services 32
Concerns dismissed 33
How do I know what's normal? 33
Having an ally 34
Strong emotions - disgust, mortified 34
No resources 34
Hidden subject 34
No one else was listening 34
Practical help 35
Can't get answers to help self 35
Not on same page 36
Not able to access services 36
Not at risk enough 36
Can't understand why she didn't get help 36
Waiting 37
Stuck 37
Trying to find normality 38
Wants to understand 38
Was it me? 38
Listen to me. 38
Desensitised services 38
Begging for help 39
Anger at being let down 39
Not respected - concerns not valid 39
~~Being~~ Having someone in it with me 39
Non-judgemental 39
Listen 40
Hear my call for help 40.

Appendix J. Example List of Grouped Themes

(P7)

Desperate for help
Desperate 5
Desperately asking for help 7
Listen to me 38
Begging for help 39
Too much to handle 15

Loss of Innocence
Lost innocence 2, 10
Mum's lost innocence 11
Shocking for mum - out of normality / unexpected 14
Don't want to be exposed to it 21
HSB violating 21
? Changed views of future 19

Internal conflict
Parental conflict 5
baby - today
Conflict - love for son but terrified of what he could do 12
Hatred v. love 13
Motherly conflict 15
~~Reconciling ben 22~~
Conflict love - hate 22
Conflict - powerful emotions
Jimmy Savile 22

Fragility
Unknown consequences 16
Convinced something will happen 12
Constantly on edge 18
Living in the moment 19

Unprepared for this
Unprepared 5
Unexpected 18
Unprepared what to expect 30
Who do you ask? 35
How do I know what's normal? 33
Anxious - what to expect from services 32

Stuck
Stuck 19, 37
Couldn't accept what happened 23
Mum couldn't process
Can't make sense of it 7
Still waiting
Stuck in mind 14

Coming to terms
Reconciling ben 22
Trying to understand 23
Trying to find normality 26, 38
~~Wants to understand 38, 7~~

Not heard
Listen to me 38
No one was listening 34
Concerns dismissed 33
Concerns not valid 37
Hear my call for help 40
Nobody listened 8
Won't listen 40
Dismissed (school) 11
Dismissed 7
Can't understand why not helped 36
Dismissed

Help is out of reach
Waiting 32
Waiting to understand 7
Not risky enough 36
Can't access services 36
Can't get answers to help self 35
Referred historically (not accepted) 29
No resources 7
Previous ref didn't reach threshold
"good mum" so no input 8
Don't have skills to manage 3

Children come first
Children's needs come first 28
Children's needs are mum's priority 16
Balancing needs of all children 10

Life changing
Life changed - initial response 4
Normality ended 4
Life events over shadowed 18
Burden trying to keep everyone safe 12
Don't sleep 12
Can't protect son 3

~~Unmanageable~~
Reactions + emotions
Horrified 1
Panic, dread, fear 12
Strong emotions - disgust
mortified 34
Anger at let down 39
Emotional impact on mum 17

One-way communication
Mum open with services 28
Not communicated with 27
~~Reactive not~~ Not informed 31
Not on the same page 36
Densensitised services 38?

Finding an ally
An ally 34
Someone in it with me 37
Non judgemental 39
Practical help 15

Waiting to get answers 38
hidden 34

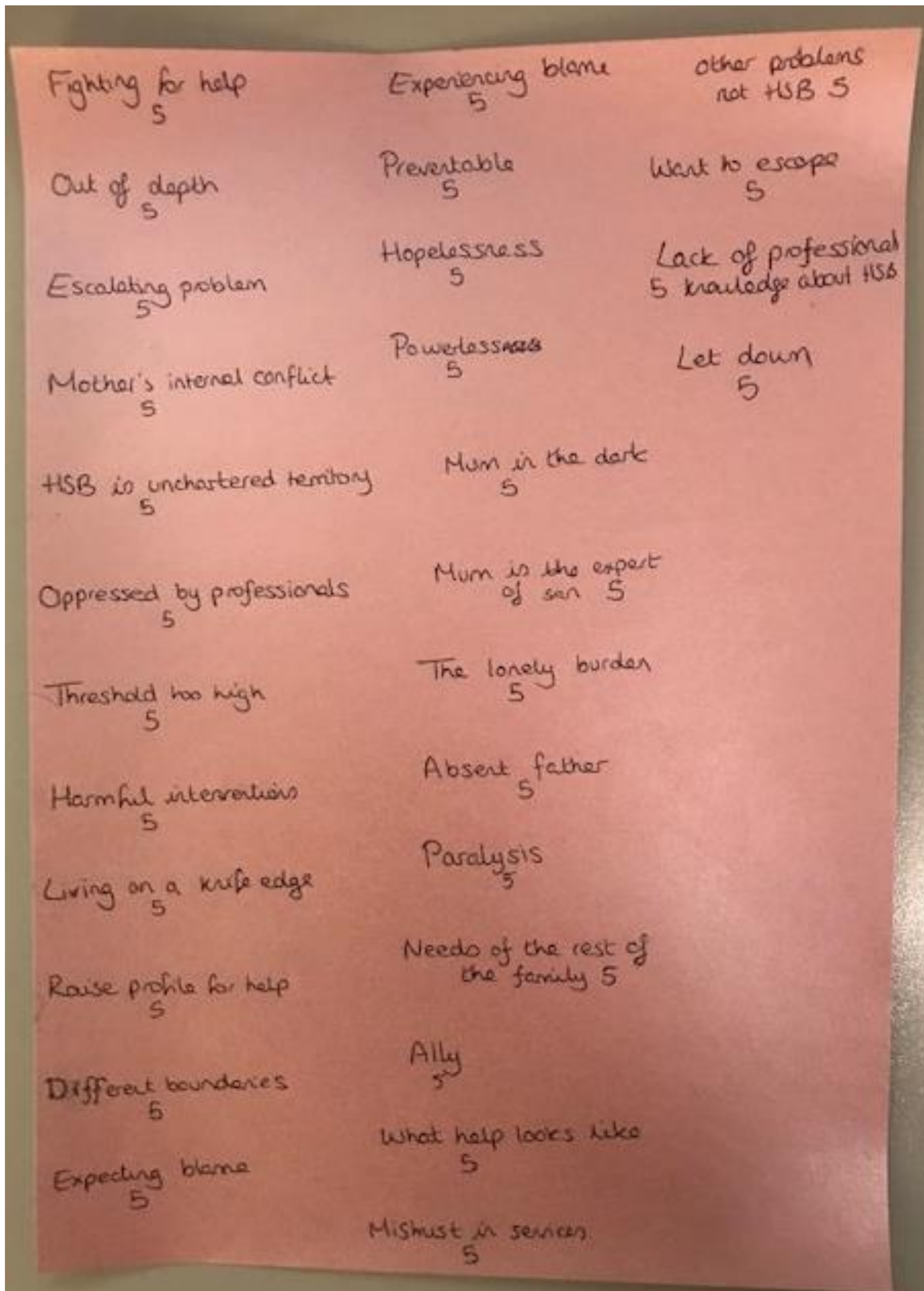
Distant family 26
Family shock 6
Good social support 13
Didn't just listen - motivated
Effect on siblings 15
Addiction to porn? —
Range of services 27
Overwhelming amount of professionals
All children add needs 31

Avoidable
Avoidable 8
Failed 8
Reactive not proactive 29

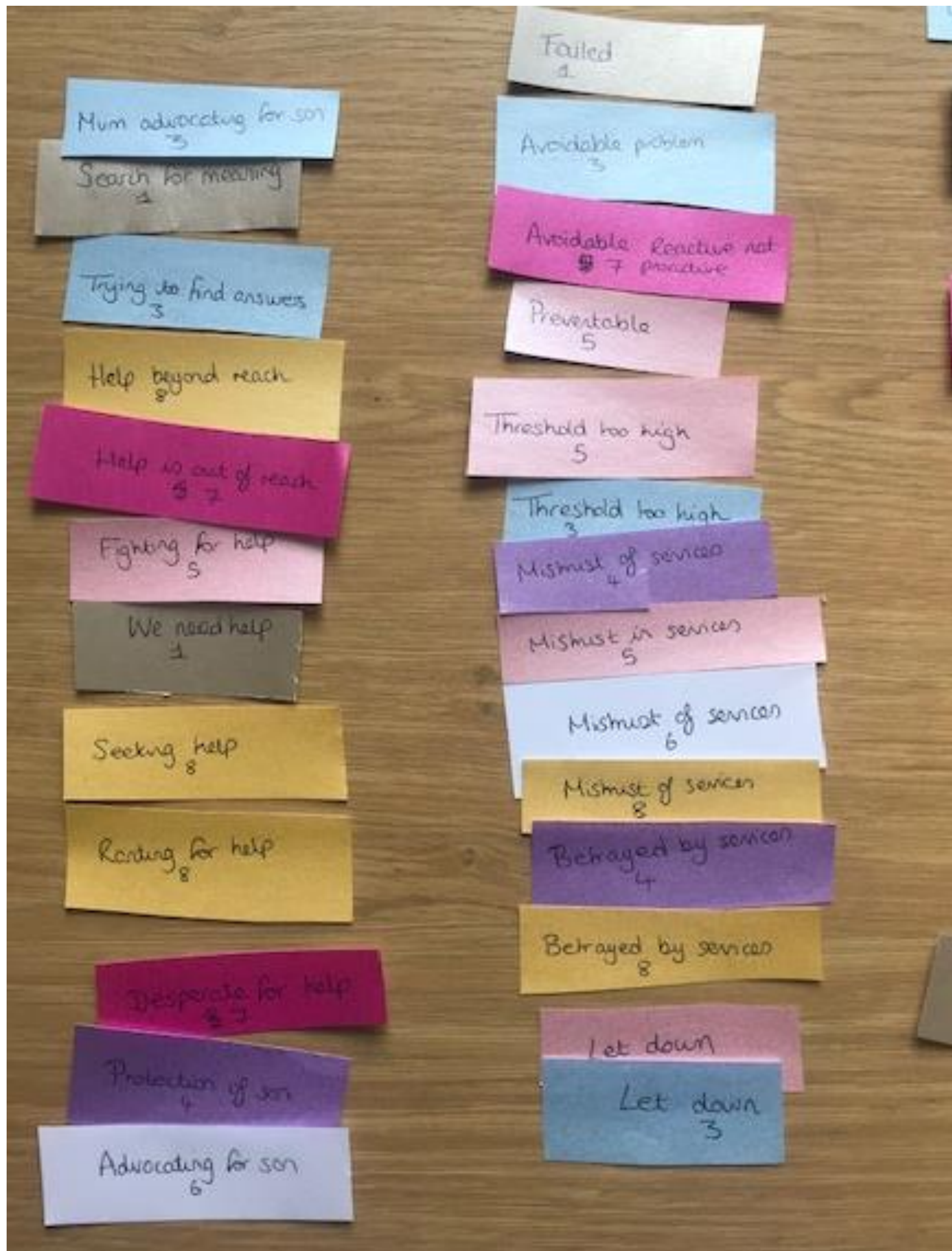
Blame
Blame myself 6
Was it me? 38

Absence of father 8

Appendix K. Example Themes Transferred to Coloured Paper



Appendix L. Themes Grouped. Colours Represent Participants.



Appendix M. Table of All Themes

Participant 1	**Participant 2**
Intense emotions Mother-son bond Consequences to mum All consuming Bigger picture than just HSB What about our needs? Power of Psychology Waiting Failed Help others Needs of children Search for meaning On edge No control No voice We need help Self-blame Fault Disregarded Overwhelming Life has changed Told not Involved Stuck Unquestioned loyalty to son Can't cope	Strong emotions Escape/no escape Parental toll Behaviour other than HSB Progress Helping others The unspeakable The needs of others Unacknowledged Mum's responsible Containment help Blame Family's needs dismissed Dad's role is different Power of CAMHS Stuck on my mind Good to be involved Structure helps
Participant 3	**Participant 4**
Not heard It is unrelenting Not just HSB Moving forward Services are punishing The unhelpful "expert" Blame No support Mum's unconditional positive regard for son Trying to find answers Different priorities mum and services The unsaid Threshold too high Avoidable problem Mum is the expert (should be) Consequences on mum Mum carries responsibility / burden Absent dad Not on same page as services Needed a break Mum advocating for son Let down	Protection of son Anxiety about what is to come Dismissed Mum inferior Fantasy Life Absent dad different norms / priorities Not a chance against the system Being told not involved Mistrust of services Alone Ally Not just HSB Mum educating son as an on-going process Mother and son bond Mum is the expert on her son Person-centred care works Life changed after HSB Betrayed by services
Participant 5	**Participant 6**
Fighting for help Out of depth Escalating problem Mother's internal conflict HSB is uncharted territory Oppressed by professionals Threshold too high	Shame Escape Guilt Judged Services are procedural Punitive Can't win

<table>
<tr>
<td>Harmful interventions
Living on a knife-edge
Raise profile for help
Different boundaries
Expecting blame
Experiencing blame
Preventable
Hopelessness
Powerlessness
Mum in the dark
Mum is the expert of son
The lonely burden
Absent father
Paralysis
Needs of the rest of the family
Ally
What help looks like
Mistrust in services
Other problems not HSB
Want to escape
Lack of professional knowledge about HSB
Let down</td>
<td>The secret
Needing validation
New burden
Surreal
Intense emotions
Out of depth
Alone
Life changed
Escaped old life
Unconditional love
Advocating for son
Mistrust of services
Paralysing emotion
Nor having knowledge to navigate system</td>
</tr>
<tr>
<td>Participant 7
Desperate for help
Fragility
coming to terms
Children come first
One-way communication
Avoidable reactive not proactive
loss of innocence
unprepared for this
Not heard
dismissed
life changing: normality ended
finding an ally
Self-blame
Internal conflict re son
Stuck
Help is out of reach
Reactions and emotions
Absence of father</td>
<td>Participant 8
Help beyond reach
Ranting for help
Firefighting
It's mother's responsibility
Dad withdrew
Mum is an expert of son
Seeking help
Learning and educating
Judgemental experts
Shared experiences
Betrayed by services
Mistrust of services
Self-blame
Navigating the system
Boiling point
Escape – wanted
Processing
Unexpected maternal emotions
consequences of HSB
Intense emotions</td>
</tr>
</table>

Appendix N. NHS Ethical Approval

Health Research Authority

Yorkshire & The Humber - Sheffield Research Ethics Committee

NHSBT Newcastle Blood Donor Centre
Holland Drive
Newcastle upon Tyne
NE2 4NQ

Tel: 0207 104 8082

Please note: This is an acknowledgement letter from the REC only and does not allow you to start your study at NHS sites in England until you receive HRA Approval

17 December 2018

Miss Tansy Warrilow
Clinical Psychology Unit
Cathedral Court, Vicar Lane
Sheffield
S1 2LT

Dear Miss Warrilow

Study title:	**Exploring the lived experience of parents who have a son that has displayed harmful sexual behaviour.**
REC reference:	**18/YH/0424**
Protocol number:	**158697**
IRAS project ID:	**253220**

Thank you for your letter of 12 December 2018. I can confirm the REC has received the documents listed below and that these comply with the approval conditions detailed in our letter dated 19 November 2018

Documents received

The documents received were as follows:

Document	*Version*	*Date*
Interview schedules or topic guides for participants [Appendix D - Interview Schedule]	4	12 December 2018
Other [Response to Conditions Letter]		12 December 2018
Participant information sheet (PIS) [Appendix A - PIS]	6	12 December 2018
Response to Additional Conditions Met		14 December 2018

Approved documents

The final list of approved documentation for the study is therefore as follows:

Document	*Version*	*Date*
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Insurance Certificate]	1	31 August 2018
Interview schedules or topic guides for participants [Appendix D - Interview Schedule]	4	12 December 2018
IRAS Application Form [IRAS_Form_18102018]		18 October 2018
Letter from sponsor [Scientific Approval Letter]		06 September 2018
Letters of invitation to participant [Appendix C. Invitation. V3]	3	01 October 2018
Non-validated questionnaire [Appendix E. Demographics. V3]	3	01 October 2018
Other [Dr Berit Richie CV]		
Other [Appendix H. Audit checklist. V1]	1	01 October 2018
Other [Appendix F. Debrief. V3]	3	01 October 2018
Other [REC invalid application]		11 September 2018
Other [Letter to REC - response to Invalid Letter]		01 October 2018
Other [Response to Conditions Letter]		12 December 2018
Participant consent form [Appendix B. Consent form. V3]	3	01 October 2018
Participant information sheet (PIS) [Appendix A - PIS]	6	12 December 2018
Research protocol or project proposal [Research Proposal]	3	01 October 2018
Response to Additional Conditions Met		14 December 2018
Summary CV for Chief Investigator (CI) [Tansy Warrilow CV]		
Summary CV for student [Student CV - TW]		
Summary CV for supervisor (student research) [Professor Nigel Beail CV]		

You should ensure that the sponsor has a copy of the final documentation for the study. It is the sponsor's responsibility to ensure that the documentation is made available to R&D offices at all participating sites.

18/YH/0424	Please quote this number on all correspondence

Yours sincerely

Kerry Dunbar
REC Manager

E-mail: nrescommittee.yorkandhumber-sheffield@nhs.net

Copy to: *Miss Tansy Warrilow*
Ms Michelle Horspool, Sheffield Health and Social Care NHS Foundation Trust

Appendix O. HRA Approval

Email: hra.approval@nhs.net
Research-permissions@wales.nhs.uk

Miss Tansy Warrilow
Clinical Psychology Unit
Cathedral Court, Vicar Lane
Sheffield
S1 2LT

29 January 2019

Dear Miss Warrilow

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**Exploring the lived experience of parents who have a son that has displayed harmful sexual behaviour.**
IRAS project ID:	**253220**
Protocol number:	**158697**
REC reference:	**18/YH/0424**
Sponsor	**The University of Sheffield**

I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

How should I continue to work with participating NHS organisations in England and Wales?
You should now provide a copy of this letter to all participating NHS organisations in England and Wales, as well as any documentation that has been updated as a result of the assessment.

Following the arranging of capacity and capability, participating NHS organisations should **formally confirm** their capacity and capability to undertake the study. How this will be confirmed is detailed in the "*summary of assessment*" section towards the end of this letter.

You should provide, if you have not already done so, detailed instructions to each organisation as to how you will notify them that research activities may commence at site following their confirmation of capacity and capability (e.g. provision by you of a 'green light' email, formal notification following a site initiation visit, activities may commence immediately following confirmation by participating organisation, etc.).

It is important that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details of the research management function for each organisation can be accessed here.

IRAS project ID	253220

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within the devolved administrations of Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) has been sent to the coordinating centre of each participating nation. You should work with the relevant national coordinating functions to ensure any nation specific checks are complete, and with each site so that they are able to give management permission for the study to begin.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?
HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?
The document "*After Ethical Review – guidance for sponsors and investigators*", issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

I am a participating NHS organisation in England or Wales. What should I do once I receive this letter?
You should work with the applicant and sponsor to complete any outstanding arrangements so you are able to confirm capacity and capability in line with the information provided in this letter.
The sponsor contact for this application is as follows:

Name: Mr Amrit Sinha
Tel: 01142226650
Email: a.sinha@sheffield.ac.uk

Who should I contact for further information?
Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **253220.** Please quote this on all correspondence.

IRAS project ID	253220

Yours sincerely

Maeve Ip Groot Bluemink
Assessor

Email: hra.approval@nhs.net

Copy to: *Mr Amrit Sinha, The University of Sheffield – Sponsor Contact*
Ms Michelle Horspool, Sheffield Health and Social Care NHS Foundation Trust – Lead R&D Contact

IRAS project ID	253220

List of Documents

The final document set assessed and approved by HRA and HCRW Approval is listed below.

Document	*Version*	*Date*
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Insurance Certificate]	1	31 August 2018
HRA Schedule of Events	1 (HRA final)	09 January 2019
HRA Statement of Activities	1 (HRA final)	09 January 2019
Interview schedules or topic guides for participants [Appendix D - Interview Schedule]	4	12 December 2018
IRAS Application Form [IRAS_Form_18102018]		18 October 2018
Letter from sponsor [Scientific Approval Letter]		06 September 2018
Letters of invitation to participant	4	24 October 2018
Non-validated questionnaire [Appendix E. Demographics. V3]	3	01 October 2018
Other [Dr Berit Richie CV]		
Other [Appendix H. Audit checklist. V1]	1	01 October 2018
Other [Appendix F. Debrief. V3]	3	01 October 2018
Other [Response to Conditions Letter]		12 December 2018
Participant consent form	4	24 October 2018
Participant information sheet (PIS)	8	15 January 2019
Research protocol or project proposal [Research Proposal]	3	01 October 2018
Summary CV for Chief Investigator (CI) [Tansy Warrilow CV]		
Summary CV for student [Student CV - TW]		
Summary CV for supervisor (student research) [Professor Nigel Beail CV]		

IRAS project ID	253220

Summary of assessment

The following information provides assurance to you, the sponsor and the NHS in England and Wales that the study, as assessed for HRA and HCRW Approval, is compliant with relevant standards. It also provides information and clarification, where appropriate, to participating NHS organisations in England and Wales to assist in assessing, arranging and confirming capacity and capability.

Assessment criteria

Section	Assessment Criteria	Compliant with Standards?	Comments
1.1	IRAS application completed correctly	Yes	IRAS Form [A78] corrected to 'No', it is not expected that the research will lead to new IP.
2.1	Participant information/consent documents and consent process	Yes	Changes have been made to the PIS and CF by non-substantial amendment after the REC opinion to align them with HRA & HCRW Approval standards.
3.1	Protocol assessment	Yes	No comments
4.1	Allocation of responsibilities and rights are agreed and documented	Yes	A statement of activities has been submitted and the sponsor is not requesting and does not expect any other site agreement to be used.
4.2	Insurance/indemnity arrangements assessed	Yes	Where applicable, independent contractors (e.g. General Practitioners) should ensure that the professional indemnity provided by their medical defence organisation covers the activities expected of them for this research study
4.3	Financial arrangements assessed	Yes	No application for external funding has been made. There will be no financial provisions to the sites.
5.1	Compliance with the Data Protection Act and data security issues assessed	Yes	No comments
5.2	CTIMPS – Arrangements for	Not Applicable	No comments

IRAS project ID	253220

Section	Assessment Criteria	Compliant with Standards?	Comments
	compliance with the Clinical Trials Regulations assessed		
5.3	Compliance with any applicable laws or regulations	Yes	No comments
6.1	NHS Research Ethics Committee favourable opinion received for applicable studies	Yes	REC Favourable Opinion was issued by the Yorkshire & The Humber - Sheffield REC.
6.2	CTIMPS – Clinical Trials Authorisation (CTA) letter received	Not Applicable	No comments
6.3	Devices – MHRA notice of no objection received	Not Applicable	No comments
6.4	Other regulatory approvals and authorisations received	Not Applicable	No comments

Participating NHS Organisations in England and Wales

This provides detail on the types of participating NHS organisations in the study and a statement as to whether the activities at all organisations are the same or different.

There is one type of participating NHS organisation; therefore, there is only one site type.

The Chief Investigator or sponsor should share relevant study documents with participating NHS organisations in England and Wales in order to put arrangements in place to deliver the study. The documents should be sent to both the local study team, where applicable, and the office providing the research management function at the participating organisation. Where applicable, the local LCRN contact should also be copied into this correspondence.

If chief investigators, sponsors or principal investigators are asked to complete site level forms for participating NHS organisations in England and Wales which are not provided in IRAS or on the HRA or HCRW websites, the chief investigator, sponsor or principal investigator should notify the HRA immediately at hra.approval@nhs.net, or HCRW at Research-permissions@wales.nhs.uk. We will work with these organisations to achieve a consistent approach to information provision.

Principal Investigator Suitability

This confirms whether the sponsor's position on whether a PI, LC or neither should be in place is correct for each type of participating NHS organisation in England and Wales, and the minimum expectations for education, training and experience that PIs should meet (where applicable).

IRAS project ID	253220

Local Collaborator (LCs) are expected for this type of study. The LC has been identified at the NHS sites and is listed in IRAS Form [Part C]. GCP training is not a generic training expectation, in line with the HRA/HCRW/MHRA statement on training expectations.

HR Good Practice Resource Pack Expectations

This confirms the HR Good Practice Resource Pack expectations for the study and the pre-engagement checks that should and should not be undertaken.
Use of identifiable patient records held by an NHS organisation to identify potential participants without their prior consent should be undertaken by a member of the direct care team for the patient, so it would not normally be acceptable for this to be done by staff not employed by that organisation. Where arrangements are not already in place, research staff not employed by the NHS host organisation undertaking any of the research activities listed in the research application would be expected to obtain a Letter of Access based on standard DBS checks and occupational health clearance.

Other Information to Aid Study Set-up

This details any other information that may be helpful to sponsors and participating NHS organisations in England and Wales in study set-up.
The applicant has indicated that they do not intend to apply for inclusion on the NIHR CRN Portfolio. Some participants may also be recruited outside the NHS and some activity may take place outside the NHS. HRA & HCRW Approval does not cover activity outside the NHS. Before recruiting or undertaking activity outside the NHS the research team must follow the procedures and governance arrangements of responsible organisations.

Appendix P. Scientific Approval

Department Of Psychology.
Clinical Psychology Unit.

Doctor of Clinical Psychology (DClin Psy) Programme
Clinical supervision training and NHS research training & consultancy.

Clinical Psychology Unit
Department of Psychology
University of Sheffield
Floor F, Cathedral Court
1 Vicar Lane
Sheffield
S1 2LT

Dr A R Thompson, Clinical Training Research Director
Please address any correspondence to Amrit Sinha
Research Support Officer
Telephone: 0114 2226650
Email: a.sinha@sheffield.ac.uk

6th September 2016

To: Research Governance Office

Dear Sir/Madam,

RE: Confirmation of Scientific Approval and Indemnity of enclosed Research Project

Project title: "Exploring the experiences of parents and families who have children who display sexually harmful behaviour"

Investigators: Tansy Warrilow (DClin Psy Trainee, University of Sheffield); Prof Nigel Beail (Main Academic Supervisor, University of Sheffield); Dr Shona Goodall (Shadow Academic Supervisor, University of Sheffield); Dr Berit Richie (SCH Supervisor)

I write to confirm that the enclosed proposal forms part of the educational requirements for the Doctoral Clinical Psychology Qualification (DClin Psy) run by the Clinical Psychology Unit, University of Sheffield.

Three independent scientific reviewers usually drawn from academic staff within the Psychology Department have reviewed the proposal. Review includes appraisal of the proposed statistical analysis conducted by a statistical expert based in the School of Health and Related Research (ScHARR). Where appropriate an expert in qualitative methods is also appointed to review proposals.

I can confirm that approval of a proposal is dependent upon all necessary amendments having been made to the satisfaction of the reviewers and I can confirm that in this case the reviewers are content that the above study is of sound scientific quality. Consequently, the University will if necessary indemnify the study and act as sponsor.

Given the above, I would remind you that the Department already has an agreement with your office to exempt this proposal from further scientific review. However, if you require any further information, please do not hesitate to contact me.

Yours sincerely

Appendix Q: Research and Innovation Approval

NHS Foundation Trust

D Floor Stephenson Wing
Sheffield Children's NHS Foundation Trust
Western Bank, Sheffield S10 2TH

Tel: 0114 226 7980 Fax: 0114 226 7844

Date 04/02/2019

Miss Tansy Warrilow
Clinical Psychology Unit
Cathedral Court
Vicar Lane
Sheffield
S1 2LT

Dear Tansy

SCH-2461 – Exploring the lived experience of parents who have a son that has displayed harmful sexual behaviour.

IRAS Ref: 253220

The Directorate of Research & Innovation at Sheffield Children's NHS Foundation Trust has completed a capacity and capability review for the above study and can confirm authorisation for the study to be undertaken within the Trust. The list of documents reviewed is given in appendix 1 of this letter.

The Trust authorisation for this research study is on the understanding and provision that you will adhere to the following conditions:-

That the research should:

Be conducted in accordance with, ICH Principles of Good Clinical Practice, The World Medical Association Declaration of Helsinki 1996 and the UK Policy Framework for Health and Social Care Research (Third Edition, 2017).

- Comply with regulatory requirements and legislation including subsequent amendments. This includes but not limited to: The Medicines for Human Use (Clinical Trials) Regulations 2004, Data Protection Act 2018, Human Tissue Act 2004, Health Service (Control of Patient Information) Regulations 2002, Ionising Radiation (Medical Exposure) Regulations 2000, Medical Devices Regulations 2002, Medicines (Administration of Radioactive Substances) Regulations 1978 and the Trust's Caldicott Guidelines.

You must also:

- Ensure you and your team are familiar with issues of informed consent within research having completed the Good Clinical Practice (GCP) training in accordance with the Sponsor's requirements.
- Request written approval for any change to the approved protocol/study documents that you or the Chief Investigator wishes to implement.

- Ensure that all study personnel, not employed by Sheffield Children's NHS Foundation Trust hold either an honorary contract with the Trust or a letter of access issued by the Trust, before they have access to any facilities, patients, staff, their data, tissue or organs/

- Ensure you and the relevant members of your research team are trained in the use of EDGE and are able to upload participant recruitment data in a timely manner.

- Complete and return progress report requests and notify the Directorate of Research & Innovation when your research is completed. At the point of completion, please submit your findings and any publication or presentations of your findings.

- Inform the Directorate of Research & Innovation If you decide to terminate this research prematurely, by sending a report and indicating the reason for the early termination.

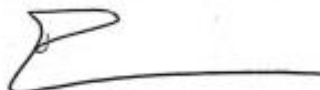
- Advise the Directorate of Research & Innovation of any unusual or unexpected results that raise questions about the safety of the research.

In line with our continued commitment to the above mentioned laws, guidance and statutes, it will be necessary for the Directorate of Research & Innovation to be involved in the conduct of your study as it progresses. Therefore, please ensure that your documentation, including this letter is maintained in the Investigator Site File the appropriate manner and up-to-date.

The target date for recruitment of the first participant is **06/03/2019**. If you are unlikely to meet this target date, please let us know as soon as possible.

I would like to take this opportunity to wish you every success with your project. If you have any questions or we can be of any further assistance to you, do not hesitate to contact the Directorate of Research & Innovation.

Yours sincerely



Professor Paul Dimitri
Director of Research & Innovation

Appendix 1
Documents reviewed:

These are the documents that have been approved for SCH-2461

Document	Version	Date
Evidence of sponsor insurance	1	31/08/18
HRA schedule of events	1	09/01/19
HRA statement of activities	1	09/01/19
IRAS application form		18/10/18
Letter from sponsor		06/09/18
Letters of invitation to participant	4	24/10/18
Non-validated questionnaire	3	01/10/18
Other (audit checklist V1)	1	01/10/18
Other (debrief V3)	3	01/10/18
Other (response to conditions letter)		12/12/18
Participant Consent Form	4	24/10/18
Participant Information Sheet	8	15/01/19
Research Protocol	3	01/10/18
Summary CV for Chief Investigator		

Appendix R. Debrief Form

Debrief form

Dear Sir/Madam

Thank you for taking part in the study.

Your participation is now complete and it is unlikely the researcher will need to contact you again.

Hopefully your participation in the study did not cause you distress, however if you do feel that you would like to talk to someone following your interview, please contact Tansy (the researcher) using the contact details below who will be able to identify someone for you to talk through how you feel. Also listed are some useful numbers that you can access.

As there is so little research into this area, it is hoped that by exploring the experiences of parents we can understand more about what this is like, what families go through and how services can support them in the future.

Once again, thank you for your time, we are very grateful for your participation and support of the study.

Tansy Warrilow

Samaritans: 116 123 (free to phone, 24 hours a day)

Mind: 0300 123 3393 (Mon-Fri, 9am-6pm)

Family Lives: 0808 800 2222 (mon-Fri 9am-9pm, Sat-Sun 10am-3pm, parenting support)

Appendix S. Audit Form

Audit Checklist

Worthy topic;

1. Is there evidence that the research has clinical significance?

Yes/Partially/No

2. Is there evidence that is it relevant to the current literature or clinical field?

Yes/Partially/No

Rich Rigor;

3. Is there evidence that raw data was collected and is appropriate for the research aims?

Yes/Partially/No

4. Does the study use a sufficient and appropriate use of theoretical constructs?

Yes/Partially/No

5. Is the sampling appropriate given the nature of the study?

Yes/Partially/No

6. Has the data been sufficiently coded? (e.g. is all the relevant data coded?)

Yes/Partially/No

7. Has the data been systematically coded?

Yes/Partially/No

8. Is it clear that the researcher has engaged in a process of refining and redefining the themes and subthemes and are these processes justified?

Yes/Partially/No

9. Are changes in themes justified?

Yes/Partially/No

Sincerity;

10. Has the researcher engaged appropriately in supervision as part of the research process?

Yes/Partially/No

11. Has there been a sufficient level of transparency about methods and challenges?

Yes/Partially/No

12. Is there a documented process of self-reflexivity of the researcher?

Yes/Partially/No

Credibility;

13. Does the research contain context and detail of the participants' own context?

Yes/Partially/No

14. Has the researcher shown evidence of triangulation of themes?

Yes/Partially/No

Resonance;

15. Are quotes sufficient to provide evidence of the themes and subthemes?

Yes/Partially/No

16. Does the write up allow for the reader to consider whether the themes generated may also be found in other areas of experience?

Yes/Partially/No

Significant Contribution:

17. Does the research add to the current literature?

Yes/Partially/No

18. Can the study lead to new insights that can be used to improve practice?

Yes/Partially/No

19. Could the study be used to generate ongoing research?

Yes/Partially/No

Ethical;

20. Has the research taken all reasonable steps to assume a 'do no harm' approach?

Yes/Partially/No

21. Are the participants identifiable?

Yes/Partially/No

22. Is the representation of the participants experience free from stigma or judgment?

Yes/Partially/No

Meaningful Coherence;

23. Does the results/write-up sufficiently address the aims of the study?

Yes/Partially/No

24. Has relevant demographic and background information been collected to contextualize the sample (e.g. gender, age, time in service)?

Yes/Partially/No

Signature of researcher [signature] TANSY WARRILOW

Signature of peer auditor: [signature] KIRSTEEN MEHERAN

22/5/19