Young people, parent/carer, and professional experiences of harmful sexual behaviour assessment, intervention, and support: a qualitative evidence synthesis

Sophie Tulley

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The candidate confirms that the work submitted is his/her own and that appropriate credit has been given where reference has been made to the work of others.

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Abstract

Introduction: This qualitative evidence synthesis (QES) was guided by three research aims: (1) What do young people, parents/carers and professionals say about their experiences of harmful sexual behaviour (HSB) assessment, intervention, and support? (2) What aspects of HSB assessment, intervention and support could be considered as distressing from the perspective of young people, parents/carers, and professionals? (3) What aspects of HSB assessment, intervention and support could be considered trauma-informed from the perspective of young people, parents/carers, and professionals? Experiences of adversity are common amongst young people with HSB and their parents/carers. These experiences should be accounted for in HSB provision to support the experience and impact of services to prevent further victimisation. This research is a novel contribution to the evidence base; a trauma-informed conceptualisation of HSB provision has yet to be formulated.

Method: A systematic search was conducted; thirty-seven studies met the criteria for inclusion. Thematic synthesis was used to synthesise the content of the 'Results/Findings' sections of the included studies. A quality appraisal of the studies was undertaken and an assessment to determine the confidence in the analytical themes was completed.

Results: Five descriptive findings were identified in response to research aim one. The overarching theme 'Shame and Disempowerment' captured the nine analytical themes identified in response to research aim two. The overarching theme 'Relationships' was identified to capture the five analytical themes in response to research aim three.

Discussion: The findings revealed the aspects of HSB provision that could be considered potentially distressing, or trauma-informed, based on the voices and lived experiences of the three groups. Data synthesis highlighted commonality in experiences of HSB provision, particularly amongst young people and parents/carers. Clinical implications for the development of trauma-informed HSB services are provided.

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Introduction

Harmful sexual behaviour (HSB) assessment, intervention, and support (hereafter referred to as HSB provision) for young people with HSB and their parents/carers is delivered by a broad range of professionals in varying service contexts. This study aims to explore young people, parent/carer, and professional experiences of HSB provision through synthesising the voices and lived experiences of the three groups captured within existing qualitative studies. Research has demonstrated a relationship between experiences of trauma and adversity, and young people with HSB (Balfe et al., 2019; Hackett et al., 2013; Levenson et al., 2017). Whilst there is a growing evidence base on trauma-informed care across a variety of health, social care and justice services, there has yet to be a substantial consideration of how trauma-informed practice can be understood, developed, and operationalised within HSB provision. This study will draw upon the voices and lived experiences of the three groups to inform an understanding of how trauma-informed practice can be understood and conceptualised within HSB provision.

This chapter will firstly establish the meaning and parameters of the term HSB, and present available data on the scale of HSB. The prevalence of childhood trauma in young people with HSB and evidence on the neurobiological impact of trauma will then be discussed. Current theories on HSB within the literature will be presented, followed by an overview of the current forms of HSB assessment and treatment offered within UK services. Literature related to the parents/carers of young people with HSB and professionals who work in HSB services will then be discussed. Finally, a critical review of the concept of trauma-informed care (TIC) will be presented and followed by the three study aims.

What is HSB?

The term HSB is used within UK health and social care services to refer to "sexual behaviours expressed by children and young people under the age of 18 years old that are developmentally inappropriate, may be harmful towards self or others, or be abusive towards another child, young person or adult" (Hackett, 2014; Hackett et al., 2019, p. 13). The term 'HSB' is used to describe a diversity of behaviours that have been categorised through a continuum model (Hackett, 2014). The continuum model provides a resource for professionals to help conceptualise the sexualised behaviour displayed by young people as either 'normal' (e.g. consensual, mutual, reciprocal), 'inappropriate' (e.g. single instances of inappropriate behaviour), 'problematic' (e.g. may lack reciprocity or equal power, may include levels of compulsivity, developmentally unusual and socially unexpected), 'abusive' (e.g. intrusive, coercion and force to ensure victim compliance, lack of informed consent, may include elements of expressive violence) and 'violent' (e.g. physically violent sexual abuse, highly intrusive, instrumental violence which is psychologically and/or sexually arousing to the perpetrator, sadism) (Hackett et al., 2019, p. 15). In accordance with current practice, the term 'HSB' will be used throughout this project to refer to the sexualised behaviour displayed by young people in the included studies that is captured across the 'problematic to 'violent' pillars of the continuum model.

Scale of HSB

There are currently no official agreed figures on the scale of HSB perpetrated by young people (NSPCC, 2021). Internationally, it is estimated that around one third of childhood sexual abuse cases involve a perpetrator under the age of 18 (NSPCC, 2021). This estimate is based on multiple separate reviews of available statistics and research on HSB perpetrated by young people (Gewirtz-Meydan & Finkelhor, 2020; Hackett, 2014; NSPCC, 2021). The Office for National Statistics (ONS) reports that from the years ending March 2017 and March 2020,

18.8% of the reported incidences of rape or assault by penetration (including attempts) towards adults aged 16-59 years were perpetrated by young people aged 16-19, and victims aged between 16-19 reported that 41.3% of offence perpetrators were also aged between 16-19 (ONS, 2021). Despite the lack of consistent, reliable research on HSB perpetrated by young people, the impact on victims, perpetrators and their families can be significant. Therefore, continued research is key to ensuring that the needs of young people with HSB and their families are effectively met to limit the risk of continued HSB, advance the public protection agenda and prevent further victimisation.

Young People with HSB

Childhood Trauma

Research has demonstrated a link between Adverse Childhood Experiences (ACEs) and young people with HSB. The concept of ACEs is understood as the "breadth of exposure to abuse or household dysfunction during childhood", such as physical abuse, sexual abuse and domestic violence, and the impact that such exposure can have on the development of physical and mental health difficulties, such as alcoholism and suicide (Felitti et al., 1998, p. 245). A seminal, large-scale study analysed the individual characteristics within 700 case files of young people with HSB referred to nine UK services between 1992-2000 (Hackett et al., 2013). The study found that 66% of cases recorded individual exposure to at least one form of abuse or trauma, such as emotional abuse, physical abuse, sexual abuse and/or severe neglect (Hackett et al., 2013, p. 237). The authors hypothesised that childhood trauma and/or abuse could be aetiologically influential in the incidence of HSB in young people (Hackett et al., 2013).

This research was further supported by a large-scale quantitative study into the prevalence of ACE exposure in young people arrested on sexual offence charges (n = 6549) in Florida (Levenson et al., 2017). Results revealed that young people arrested on a sexual offence charge

had greater levels of exposure than comparison groups across multiple ACEs, including, physical abuse, neglect, sexual abuse, separation/divorce, and household mental illness (Levenson et al., 2017). Studies show that ACEs are generally over-represented in adolescent offender groups, however, this evidence adds additional support to the existence of a correlational relationship between ACEs in young people and adolescent sexual offence arrests (Baglivo et al., 2021).

There have also been qualitative attempts to further elucidate the link between childhood trauma and HSB in young people. A thematic analysis of 117 case files of young people referred across nine UK HSB community services provides a nuanced insight into the nature of the lived experiences of young people with HSB (Balfe et al., 2019). Within the case files, professionals commonly described the young people's home environments and family contexts as "chaotic" (Balfe et al., 2019, p. 181). The study also provided insight into the "turbulent" life experiences of the parents/carers of young people with HSB (Balfe et al., 2019, p. 183). Analysis highlighted that 22% of case files documented parents as having serious substance misuse problems (Balfe et al., 2019, p. 184). Qualitative case file information also detailed the impact of parental difficulties on family functioning, "he [young person] often left the home for extended periods of time when his parents were drinking" (Balfe et al., 2019, p. 184).

Of the reviewed case files, 17% recorded parents' own experience of being sexually abused, "His grandfather forced his mother to have sex with him in front of her siblings" (Balfe et al., 2019, p. 184). Findings on the prevalence of familial and household difficulties in the lives of young people with HSB are further supported by a recent quantitative study of youth who sexually harm (n=573) (Brown & Gardner, 2022). Latent class analysis revealed that family problem indicators such as family member exposure to violence, frequent moves and/or homelessness, and low attachment to mothers had the strongest effects in a logistic regression

model testing the differences between three identified risk factors associated with HSB (mental health, concurrent delinquency, and family contexts) (Brown & Gardner, 2022). Evidence suggests that the experiences of adversity amongst young people with HSB can often be relationally oriented, and therefore the trauma experienced by the young people could be considered interpersonal in nature. The limitations of the largely cross-sectional evidence base that informs the current assessment of childhood trauma are acknowledged later in this chapter.

One of the most prevalent problems identified in 60% of case files across nine UK community HSB services was young people's experiences of "social isolation" and "loneliness" (Balfe et al., 2019, p. 187). This further indicates the possible impact of interpersonal difficulties that may not be traditionally conceived as 'traumatic,' but may be present in the aetiology of HSB (Miner et al., 2016). Reliance on professional interpretations of young people's lived experiences can risk obscuring the nuances of experiences of interpersonal difficulties that cannot be readily identified or categorised through traditional ACE descriptors (Felitti et al., 1998). The study authors acknowledged that some of the case files reviewed described healthy family relationships and home environments, although detail regarding the experiences of these young people and families were not explicitly provided in the study (Balfe et al., 2019). Despite this, the study offered novel insight into the interpersonal and familial experiences of young people with HSB and their parents/carers.

Interestingly, research exploring the associations between male adolescents who have engaged in Technology-Assisted HSB (TA-HSB), offline HSB and dual HSB, highlighted that those with TA-HSB (n = 21) have experienced less childhood trauma and reported greater stability throughout childhood than those in comparison groups (Hollis & Belton, 2017). However, those in the TA-HSB group reported exposure to greater levels of online grooming and online sexual abuse than comparison groups (Hollis & Belton, 2017). The increasing exposure of

young people to online abuse and exploitation, particularly amongst young people with TA-HSB, requires a broader consideration by professionals and researchers of what may be considered as non-traditional exposure to childhood trauma (Hollis & Belton, 2017).

It is important to note that not all young people who experience ACEs go onto engage in HSB. The protective factors of young people (also known as strengths or resiliencies) such as the presence of a social support network, secure emotional relationships, hope, motivation, work, and leisure activities, can promote desistance and have the potential to moderate the relationship between ACEs and HSB (De Vries Robbé et al., 2015). Strengths-based HSB interventions such as the Good Lives Model are informed by protective, desistance factors (Fortune, 2018). Further research into protective and desistance factors in young people with HSB is required to inform the evidence base on the relationship between ACEs and HSB (De Vries Robbé et al., 2015).

Overall, experiences of ACEs appear to be a common feature in the developmental histories of some young people who display HSB; neglect, sexual abuse and/or physical abuse are identified as the most prevalent forms of ACEs experienced by these young people (Alexander et al., 2021; Levenson et al., 2016; Seto & Lalumiere, 2010). For young people with HSB, experiences of ACEs can also be cumulative (Alexander et al., 2021). One study found higher rates of poly-victimisation was associated with greater reported trauma symptomatology amongst young people adjudicated for illegal sexual behaviour (Alexander et al., 2021). Latent class analysis identified the high poly-victimisation subtype amongst young people adjudicated for illegal sexual behaviour (n=76) as 15.86 victimisations accompanied by scores within the clinical range on the Trauma Symptom Checklist for Children (TSCC) (Alexander et al., 2021).

The victimisation figure amongst the high poly-victimisation subtype of young people with HSB was contrasted to the high poly-victimisation subtype in a non-clinical sample of young people, which was categorised as at least 7 victimisation experiences (Alexander et al., 2021; Finkelhor et al., 2007). Experiences of poly-victimisation in childhood has been demonstrated to have a potential impact on neuropsychological development and may influence cognitive, interpersonal, behavioural, and emotional experiences throughout the lifespan (Alexander et al., 2021; Musicaro et al., 2019). The high prevalence of ACEs and poly-victimisation amongst young people with HSB, alongside the developmental risk posed to neurobiological and psychological functioning, demonstrates the importance of advancing an evidence base to support the development of trauma-informed HSB provision.

The Neuropsychological Impact of Trauma on Young People

A large body of evidence indicates a link between developmental trauma (early exposure to trauma and victimisation that is often repeated and chronic) and disrupted neurobiological development (Felitti et al., 1998; Hakamata et al., 2022; Schneiderman et al., 2005; Siegal, 2001). Over time, developmental trauma and exposure to chronic stress can impact brain development and lead to structural and functional alterations in "stress-sensitive areas" such as the prefrontal cortex, amygdala, and hippocampus (Cross et al., 2017; Tarullo & Gunnar, 2006). Such changes can lead to impairments in neurobiological development and functioning, and contribute to deficits in emotional regulation and executive functioning (including inhibitory control, cognitive flexibility, attention, and working memory), and detrimentally impact interpersonal relationships, physical health, and mental health (Aupperle et al., 2012; Cowell et al., 2015; Cross et al., 2017).

The adolescent brain is vulnerable and highly sensitive to the neurobiological impact of trauma as the brain and body are in a constant state of maturational development throughout

adolescence (Sharma et al., 2013). Evidence indicates that the process of adolescent brain maturation can occur up until the age of 25 (Sylwester, 2007). However, as this body of research is largely informed by cross-sectional and/or prospective longitudinal studies that have measured highly complex constructs, such as cognition, at one point in time, more nuanced research is required to further substantiate this evidence base (Danese, 2020; Widom, 2020). Despite this, given the prevalence of reported exposure to trauma, adversity, and victimisation amongst young people with HSB, researchers have started to integrate the substantial body of research on the neurobiological impact of trauma into the HSB evidence base (Creeden, 2009, 2013).

Limitations of the Research

Research is suggestive of an association between ACEs and HSB. However, there are known methodological limitations in studies which suggest a causal relationship between childhood trauma and subsequent pathology (Danese, 2020; Widom, 2020). There is little consideration within the research of the role of individual differences, severity, and duration of exposure to ACEs, which may have implications for why some young people go onto engage in offending behaviour, such as HSB, whilst others do not (Danese, 2020; Widom, 2020). Likewise, although difficult to measure, the nature of the distress experienced by young people in response to incidence(s) of adversity at the time is rarely understood. Furthermore, the role of contextual factors such as age, social class, sex, ethnicity, and race are rarely factored into studies as potential moderating factors in the relationship between ACEs and HSB (Widom, 2020). More nuanced research on the myriad of variables related to experiences of childhood trauma and pathology (e.g. HSB) is necessary to inform the provision of services that are equipped to sensitively meet the needs of service users (Widom, 2020).

Theories of Harmful Sexual Behaviour

An acceptable comprehensive theory on HSB in young people has yet to be established within the literature (Lateef & Jenney, 2020). However, as young people with HSB are not a homogenous group, there is value in having a comprehensive range of theories to support professional understanding and provision design. In response to existing research, emerging theories on young people with HSB have sought to link ACEs with the incidence of HSB, however, it is noted that not all young people who experience ACEs engage in HSB (Grady et al., 2017; Hackett, 2013). The victim to victimiser theory remains one of the leading aetiological theories of HSB and wider youth offending and is informed by multiple descriptive quantitative studies that have identified a relationship between prior victimisation through various forms of childhood abuse, such as sexual and physical abuse, and the subsequent incidence of HSB (Lateef & Jenney, 2020; Veneziano et al., 2000). The victim to victimiser theory is influenced by research on maladaptive learning social learning theory, which suggests that displays of HSB are influenced by young people enacting their own victimisation experiences (Daversa & Knight, 2007; Lateef & Jenny, 2020; Knight & Sims-Knight, 2003; Veneziano et al., 2000).

In an extension of the victim-victimiser theory, insecure attachment relationships that may emerge as a result of ACE exposure have also been implicated in the development of criminogenic needs in young people with HSB, such as emotional dysregulation, deficits in arousal/inhibition control, and relational difficulties (Grady et al., 2017; Lateef & Jenney, 2020). The theory of attachment was first understood as the process by which infants seek proximity to an adult caregiver in stressful situations (Bowlby, 1969). Children develop secure attachment relationships with adult caregivers who are attuned to their needs for physical care, safety, and security (Kaiser et al., 2018; Rees, 2005). A child who repeatedly experiences an adult caregiver as a safe base from which they can explore their environment and return to an

attuned parent may subsequently develop a secure internal working model of relationships based on the consistent and predictable responses of their caregiver (Atkinson et al., 2000; Kaiser et al., 2018).

Attachment theory suggests the internal working models of relationships that are developed as children serve as a template for future adult relationships (Hopkins & Phillips, 2009; Kaiser et al., 2018). Individuals who have an insecure attachment style may have experienced their adult caregiver as unresponsive and/or unpredictable in their ability to meet their needs, which can contribute to a sense of unsafety (Kaiser et al., 2018). Experiences of a caregiver as neglectful, abusive, or controlling, may lead individuals to approach relationships with threat and uncertainty; some individuals may develop maladaptive ways of coping to avoid feeling vulnerable and keep themselves safe (Grady et al., 2017).

The theoretical model driving an advancement of the victim-victimiser theory proposes that insecure attachment relationships may serve as an explanatory factor in a linear relationship between ACEs, the development of criminogenic needs and the incidence of HSB (Bowlby, 1969; Grady et al., 2017). Over the last two decades, HSB in young people has been linked to early experiences of adversity and trauma, wherein the young people develop maladaptive ways of communicating and relating to others as a form of “interpersonal survival” (Creeden, 2009; 2013; Levenson, 2014, p. 9). The prevalence of ACEs and disrupted attachment experiences in the lives of young people with HSB is suggestive of the need for relationally oriented, trauma-sensitive HSB provision (Levenson, 2014).

As demonstrated, there is a developing understanding that the neurobiological impact of trauma and adversity in adolescents may result in cognitive, emotional, and interpersonal functioning deficits, which may factor into the incidence of HSB. This suggests that some young people and their parents/carers are likely to have specific needs stemming from adverse life

experiences that require a trauma sensitive service response. However, there is currently no coherent approach to trauma-informed care in HSB provision that accounts for this emerging research. This study attends to this evidence gap and seeks to synthesise the voices and lived experiences of individuals engaging in HSB services. This study aims to understand their needs and experiences in services to develop trauma-informed practice implications for HSB provision.

Research has explored the relevance of trauma-informed care (TIC) to working with adults with a sex offence history in response to the high prevalence of early trauma amongst this population (Levenson et al., 2016). However, further research is required to demonstrate how the concept of TIC can be operationalised through practice implications for HSB provision that transcends specialist and individual assessment and intervention programmes. The aim of this study is to synthesise the voices and lived experiences of young people with HSB, their parents/carers, and professionals, and consider what aspects of HSB provision could be considered as trauma-informed, or potentially distressing. The goal is to understand how TIC can be conceptualised in the context of HSB provision based on the voices and experiences of stakeholders. Further detail and research on the concept of TIC will be presented later in this chapter following an overview of current UK HSB provision.

Current Assessment, Intervention and Support Offered by UK Services

HSB Assessments

Key aetiological theories have informed the development of HSB risk assessment tools and intervention approaches for young people. HSB assessments are designed to assess the presenting risks and needs of young people with HSB to inform safety and treatment planning (National Institute of Clinical Excellence [NICE], 2016). NICE recommends the use of selected risk assessment tools that are suitably matched to a young person's developmental age and

gender (NICE, 2016). For boys over the age of 12 years, risk assessment tools such as Juvenile-Sex Offender Assessment Protocol-II (J-SOAP-11) (Prentky & Righthand, 2003), and the Estimate of Risk of Adolescent Sex Offender Recidivism (ERASOR) (Worling & Curwen, 2001) are recommended for use in conjunction with clinical judgement (NICE, 2016). Whilst the effectiveness of HSB risk assessment tools does not form the focus of this study, existing research on the predictive validity of risk assessment tools for future sexual violence such as J-SOAP-II and ERASOR is limited and variable due to the small-scale nature of validation studies (NICE, 2016).

As yet there is no published data in relation on the reliability and validity of the most recently developed HSB structured professional judgement assessment tool, the AIM3 Assessment. However, the authors have sought to integrate a trauma-informed lens into the professional judgement tool to support the assessment of HSB (Leonard & Hackett, 2019). Whilst studies have been undertaken to investigate the predictive validity and reliability of assessment tools, there is notably limited research on how young people and parent/carers qualitatively experience such assessments. This limits the insight on what assessment approaches are experienced as helpful for young people and their parents/carers. Such information may be helpful to inform both a trauma-sensitive understanding of the HSB assessment process and understand how assessment experiences may impact future intervention engagement.

HSB Interventions

NICE recommends a variety of interventions that can be used with young people with HSB which take the form of both specialist treatment resources, guided interventions, and traditional therapeutic approaches (NICE, 2016). HSB interventions are intended to address the vulnerabilities and difficulties underlying a young person's HSB (as identified through the risk assessment) and reduce the risk of recidivism (NICE, 2016). NICE recommends therapeutic

approaches for young people with HSB such as systemic therapy (family therapy), cognitive behavioural therapy (CBT), multisystemic therapy for problematic sexual behaviours, psychotherapeutic approaches and strengths-based approaches which may be delivered in an individual, group, or family format (NICE, 2016). Specialist treatment resources and guided interventions for adolescent males over the age of 12 include the AIM Intervention model (now updated to the AIM Intervention Guidance 2nd Edition), the Good Lives Model and Change for Good (referred to as the NSPCC Turn the Page service) (McCrory, 2011; Fortune et al., 2012; NICE, 2016, p. 15; Guilhermino & McCarlie, 2019).

Again, whilst the effectiveness of HSB interventions does not form the focus of this study, evidence pertaining to intervention effectiveness is noted to be generally inconclusive and often limited to young people convicted of a sexual offence receiving treatment in residential and custodial settings in North America (NICE, 2016). There is currently limited evidence that is transferable to young people with HSB residing in the community, and young people who have displayed HSB but have not received a criminal conviction (NICE, 2016). Along with the methodological limitations the research, there are also few studies investigating the young person's subjective perspective on the intervention and why it may have been unsuccessful.

Support Services

As will be discussed later, this study has considered 'support services' to take the form of frontline statutory services that have direct input young people with HSB, such as social care, the police and youth justice services. These services are likely to work with most young people prior to referring some young people to specialist services for further HSB assessment and intervention depending on the young person's age and level of behavioural concern. There has been very limited research undertaken on the experiences of HSB support services.

Parents/Carers

Parent/carer involvement in HSB provision is identified by NICE as a key factor for professionals to consider in the delivery of assessments and interventions (NICE, 2016). From a clinical perspective, HSB assessments such as AIM3 and J-SOAP-II contain domains that require the assessment of the young person's developmental experiences, family context, and lived environment (Leonard & Hackett, 2019; Prentky & Righthand, 2003). In turn, difficulties highlighted within these areas necessitate the use of broad interventions that directly involve parents/carers and attend to relevant systemic factors to reduce recidivism risk. Interventions that focus solely on the young person as an individual risk having a limited impact on recidivism and recovery as the opportunity for parents/carers to support the young person in their intervention progress is restricted.

An existing qualitative synthesis of the barriers and facilitators of HSB interventions from the perspective of young people with HSB and their parents/carers highlighted the "critical" role that families play in the delivery of HSB interventions in relation to improving the young person's engagement and strengthening the family system to support the longer-term impact of intervention effects (Campbell et al., 2015, p. 5). However, it is important that such findings are considered in the context of research that has found that some parents/carers of young people with HSB have experienced their own difficulties and distress. Data collated from the review of 700 UK case files of young people with HSB found that 66% (n=412) of the young people had experienced at least one type of adversity specifically linked to a familial context, such as severe neglect, parental rejection, family breakdown and conflict, parental drug and alcohol misuse, domestic violence, severe neglect, emotional abuse and sexual abuse (Hackett et al., 2013, p. 237).

This data has been further corroborated in more recent, albeit smaller scale studies. A study of the assessment experiences of young people (n=18) who attended a specialist residential treatment service found that whilst 78% of young people had experienced early childhood trauma, 33% of the young people in the study specifically reported issues related to parental difficulties (such as parental mental health and/or learning difficulties) (Pitcher, 2020, p. 89). Such experiences may impact the ability of parents/carers to both engage in HSB provision and offer support to their young person throughout their engagement in services.

This evidence presents a pressing need for further research on parent/carer experiences of HSB provision based on the two key findings. Firstly, that parent/carers can play a "critical" role in HSB interventions, and secondly that the parents/carers of young people with HSB may have their own experiences of adversity, trauma, and distress (Campbell et al., 2015, p. 5; Hackett et al., 2013; Pitcher, 2020). These findings present a dilemma which suggest that whilst the inclusion of parents/carers in HSB provision is desired, the difficulties experienced by some parents/carers (both individually and in relation to their child), may impact both their ability to engage in provision and their general ability to support and care for their young person. On balance, there is a pressing need to elicit the voices of parents/carers to understand their experiences of HSB provision. This evidence can be subsequently used to inform practice implications that are sensitive to the lived experiences and specific needs of the parents/carers of young people with HSB.

Professionals

There is a small but growing evidence base that explores the experiences of professionals working with young people with HSB (Pelech et al., 2021). Young people with HSB are likely to encounter a diverse range of professionals from an array of services such as social care, CAMHS, education, youth justice services, and residential services (Pelech et al., 2021). Some

young people with HSB can have a dual profile as both perpetrators and victims of abuse, and therefore can have a complex psychological presentation that requires a multi-faceted and multidisciplinary treatment response (Pelech et al., 2021). A recent meta-ethnographic synthesis of ten studies explored professionals' experiences of working with children and young people with HSB (Pelech et al., 2021). The synthesis found that the work evoked "powerful emotions" in professionals in response to hearing young people's experiences of trauma and abuse, alongside witnessing young people exhibiting sexualised behaviour and enacting abuse (Pelech et al., 2021, pp. 274-275). Organisational challenges such as workload pressures and target-oriented services were also identified as factors that influenced the psychological and emotional impact of the work (Pelech et al., 2021). Professionals discussed the importance of managing their emotional reactions to the work through a variety of personal coping strategies, personal support avenues and professional supervision, although they found that the psychological impact of the work had affected their experiences of personal relationships and view of the world (Pelech et al., 2021). The trauma history of some professionals can also interact in a complex way with experiences of working in HSB services (Chassman et al., 2010).

Overall, the review concluded that working with young people with HSB had a disproportionately "negative impact" on professionals, although this was not exclusively the result of directly working with young people who have experienced trauma and abuse, and was partly influenced by the challenging organisational contexts in which the work was undertaken (Pelech et al., 2021). Although the synthesis explored the psychological and emotional impact of the work, there was limited consideration of how the professionals made sense of their experiences (Pelech et al., 2021). This study aims to advance the findings of the meta-ethnographic review and consider what aspects of the work could be considered trauma-informed or potentially distressing for professionals.

The trauma-informed and/or distressing nature of professional experiences is important to consider in the context of the complex nature of HSB work, which involves supporting young people with both high levels of risk and vulnerability. This dyad can enhance the potentially distressing impact of the work for professionals. This study aims to advance the review findings and uncover the potentially interactive nature between the responses and experiences of professionals in sessions and services, with the responses and experiences of young people and parents/carers in these contexts. The nature of the work demands a highly skilled workforce and a robust organisational infrastructure for professionals to work safely and effectively with high levels of risk, trauma, and emotional distress. Based on the voices and lived experiences of the three groups, this study aims to conceptualise how trauma-informed working can be understood in the context of HSB provision, and integrate these findings into trauma-informed practice implications.

Existing Qualitative Reviews on Harmful Sexual Behaviour: A Critical Appraisal

There is a small yet growing field of qualitative research on experiences of HSB provision from the perspective of young people, families/carers, and professionals. This research serves as a rich companion to the quantitative research that has pioneered the evidence base. Researchers have previously argued that the slower trajectory of qualitative research into the lived experiences of individuals is reflective of the dominant societal perspective that young people presenting with HSB, and their parents/carers are “unreliable” respondents (Campbell et al., 2020, p. 465). The limited qualitative research is also understood to be reflective of the societal marginalisation and disempowerment that young people and their families may have experienced because of the HSB (Balfe et al., 2019). The research gap in the HSB evidence has been considered as a potential “orientation of control” in the silencing of the voices of young people with HSB and their families (Campbell et al., 2020, p. 465; Hackett et al., 2006).

However, this does not discount the substantial knowledge generated from the quantitative studies on associations that have advanced HSB assessment and intervention approaches.

A recent qualitative systematic review undertaken on thirteen papers explored the components of HSB interventions that young people with HSB and their families view as "acceptable or useful" (Campbell et al., 2020, p. 456). Thematic analysis identified five themes capturing the key elements of "successful" HSB interventions: (1) the relationship between the young person and the professional; (2) the importance of parent/carer involvement (3) consideration of wider contextual factors of the HSB; (4) the presence of disclosure in HSB interventions; (5) the importance of supporting young people to develop knowledge and skills through interventions (Campbell et al., 2020, p. 456). The authors reported that review findings were aligned with the developing evidence base in relation to the focus on the developmental, systemic, and wider life contextual experiences of young people and their families in both the incidence and treatment of youths presenting with HSB (Campbell et al., 2020). The systematic review was initially developed in 2015 as part of the NICE Evidence Review to inform the 2016 NICE Guidelines (Campbell et al., 2015; NICE, 2016). The 2015 review was subsequently updated to incorporate relevant studies published between 2015-2017; the study was then published in 2020, hence the included studies date up to 2017 only (Campbell et al., 2020).

The 2015 NICE Evidence Review examined 26 published and unpublished qualitative studies and used a 'best fit' framework synthesis approach to explore the views of young people, parents/carers, and health/social care professionals on the "barriers and facilitators" to engagement in HSB interventions (Campbell et al., 2015, p. 83). The a priori 'best-fit' framework was derived from a meta-synthesis undertaken on adults' experiences of interventions for sex offending behaviour (Campbell et al., 2015; Walji et al., 2014). The authors justified this decision based on the "share(d) similarities across populations;" data that

did not fit the a priori framework was analysed through a "separate inductive phase process" (Campbell et al., 2015, p. 100).

The review identified two factors that were distinct from the comparative adult framework: the pivotal role of family support in successful interventions, and the value of a physical "safe place" amongst young people, rather than the "metaphorical" safe place identified by the adults (Campbell et al., 2015, p. 100). The 2015 review represents the first evidence synthesis of qualitative research on experiences of HSB interventions (Campbell et al., 2015). However, the 'best fit' framework synthesis method has been criticised due to the risk of inappropriately "forcing data into a framework for expedience" (Noyes et al., 2020, #section-21-10). Therefore, there is tension between use of the 'best fit' framework and the emerging "philosophical approach" of the current evidence base, which conceptualises young people with HSB through a developmentally sensitive lens and acknowledges their treatment needs and experiences as distinct from the needs of adults with sexual offending behaviour (Campbell et al., 2020).

Based on a critical appraisal of existing reviews, this study offers a unique contribution through exploring the voices and lived experiences of HSB provision from the perspective of young people, parents/carers and professionals. The constellation of experiences across the three groups will offer nuanced insight into the dynamic and reciprocal experience of provision. This research also attends to a recommendation from an existing synthesis for further research on young people who have not had successful experiences of HSB interventions (Campbell et al., 2020). When considered alongside research which demonstrates an association between HSB and ACEs, there is a clear need to understand the aspects of HSB provision that could be considered potentially distressing, or trauma-informed, to generate a trauma-sensitive

conceptualisation of HSB provision. This presents a clear departure from existing reviews (Campbell et al., 2020; Campbell et al., 2016; Campbell et al., 2015; Pelech et al., 2021).

Trauma-Informed Care Literature Review

Defining Trauma

The complexities of defining trauma have contributed to challenges in constructing a coherent definition of trauma in both clinical and academic contexts (Isobel, 2021). A clear definition of the concept of psychological trauma is required to consider the construct of TIC (Isobel, 2021). A comprehensive definition of trauma was developed by an expert panel following a review of the existing definitions of trauma within the literature:

"Individual trauma results from an event, series of events or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has long lasting adverse effects on the individual's functioning and mental, social, emotional or spiritual wellbeing" (Substance Abuse and Mental Health Services Administration [SAMHSA], 2013, p. 7).

This comprehensive definition of trauma comprises three core components: the event, the experience, and the effect (SAMHSA, 2013). The heterogeneity and diversity of the individual experience and effect following exposure to a traumatic event is acknowledged in the literature (SAMHSA, 2013). It is understood that exposure to a traumatic event that occurs in isolation or involves repeated exposure to traumatic experiences over time may be experienced by one individual as traumatic, and non-traumatic by another (SAMHSA, 2013). The breadth of events that could be considered traumatic to an individual has necessitated greater clarity and specificity in the definitions of psychological trauma, although the complexities of this definition has yet to be meaningfully incorporated into the evidence base on ACEs (Isobel et al., 2019).

Trauma that occurs within relationships is understood to have a clinically distinct impact on individuals when compared to trauma that is experienced in response to an environmental and/or single incident event (Herman, 1992; Van der Kolk, 2014; Siegal, 2001). A concept analysis review of the literature pertaining to constructs of psychological trauma was undertaken to meet the clinical need for a more nuanced understanding of the discrete and divergent forms of psychological trauma experienced by individuals within interpersonal relationships (Isobel et al., 2019). A review of sixty-two articles informed eight definitions of different forms of interpersonal trauma: attachment trauma; betrayal trauma; relational trauma; cumulative trauma; developmental trauma; complex trauma; intergenerational trauma (Isobel et al., 2019, p. 552). Whilst the review offers more distinct, evidence-based constructs of varying forms of interpersonal trauma, it is of note that some individuals, such as those with HSB, may experience several forms of interpersonal trauma, which may be cumulative in nature (Brown & Gardner, 2022). It is therefore challenging to conceive the psychological needs of individuals who may have experienced various forms of interpersonal trauma based upon the definitional distinctions offered by the review (Isobel et al., 2019).

The complexities embedded within the both the concepts and heterogenous lived experiences of individuals who have experienced interpersonal trauma demonstrates the challenge encountered by services who seek to respond to differing individual and group needs. Hence, whilst it is arguably inconceivable to develop a service that can attend to the heterogenous needs of individuals with complex lived experiences, there is a clear need for services to develop a shared and flexible approach to meeting the needs of such populations. Existing iterations of broad TIC principles and service models have attempted to operationalise and attend to such dilemmas (Harris & Fallot, 2001; SAMHSA, 2013).

Deconstructing TIC

TIC has been developed as a service-level approach to limiting the risk of iatrogenic trauma caused by inadvertently retraumatising individuals through insensitive and potentially harmful service provision (Harris & Fallot, 2001; Isobel, 2021). The concept of TIC recognises that past events may have a lasting traumatic impact on individuals (such as ACEs), and understands the impact that such trauma can continue to have in the lives of individuals who use mental health and/or justice services (Harris & Fallot, 2001). TIC service design and delivery aims to support and facilitate an individuals' participation in treatment through accounting for the potentially ongoing traumatic impact in some individuals' lives (Harris & Fallot, 2001). The frameworks embedded within TIC service delivery are designed to "transcend" specific methods of assessment, intervention or support offered within services and account for an understanding of problematic behaviours in the context of an individual's potential trauma experiences (Grady et al., 2021). The model is designed to meet the needs of both service users and staff through embedding the components of a TIC framework into the clinical output of services and wider organisational structures (American Association of Children's Residential Centers, 2014; Branson et al., 2017; Kusmaul et al., 2015).

Components of TIC

Two key models of TIC characterise the evidence base (Harris & Fallot, 2001; SAMHSA, 2013). Trauma-informed service delivery for service users and staff has been conceptualised through five key domains:

1. Safety (Ensuring Physical and Emotional Safety);

2. Trustworthiness (Maximising Trustworthiness through Task Clarity, Consistency, and Interpersonal Boundaries);

3. Choice (Maximising Consumer Choice and Control);

4. Collaboration (Maximising Collaboration and Sharing Power);

5. Empowerment (Prioritising Empowerment and Skill-Building) (Fallot & Harris, 2009).

These principles were advanced in 2013 by SAMHSA as part of the development of a TIC approach that is adapted for organisational implementation (SAMHSA, 2013). SAMHSA presented six key principles of TIC: 1. Safety; 2. Trustworthiness and Transparency; 3. Peer Support; 4. Collaboration and Mutuality; 5. Empowerment, Voice and Choice; 6. Cultural, Historical and Gender Issues (SAMHSA, 2013). The principles are intended to be both generalisable across diverse services and flexible to adaptation within service specific contexts (SAMHSA, 2013). A critique of the TIC model will be provided later in this chapter.

TIC in the Context of Youth Justice and Sexual Offending

As a generalisable and flexible concept, both the construct and the application of TIC within the context of youth justice and HSB/sexual offending services requires further exploration. A systematic review of 10 studies identified the most featured elements, interventions and/or policies across each of the definitions of a trauma-informed youth justice systems (non-HSB specific provision) within each study (Branson et al., 2017). The review revealed "relative consensus" between studies on the core principles of TIC within youth justice settings (Branson et al., 2017, p. 635). Ten shared domains of TIC were identified in the review and categorised across three levels: clinical services; agency context; system level (Branson et al., 2017, p. 639). Examples of the TIC domains identified include screening/assessment; services and interventions; cultural competence; workforce development and support; promoting a safe agency environment (Branson et al., 2017, pp. 640-641). However, less agreement was noted amongst the included studies on the specificities of the policy and practice that underpin the ten identified shared TIC domains (Branson et al., 2017). This suggests a need for further research and evidence on how the shared domains of TIC have been operationalised and can

be understood in the specific policy and frameworks of youth justice services, such as HSB service provision. There is also a need to elicit a service user perspective on the aspects of provision that could be considered trauma-informed, or potentially distressing; as this study aims to uncover.

Whilst there are gaps in the evidence base on TIC in youth justice services, a trauma-informed model for youth justice secure settings in England has been formulated through the new Framework for Integrated Care project (SECURE STAIRS) and is currently in the process of implementation and longitudinal evaluation (D'Souza et al., 2021). SECURE STAIRS aims to support organisational and cultural change through embedding trauma-informed and "formulation-driven" practice within youth custody establishments (D'Souza et al., 2021, p. 2). The project is designed to meet the needs of all young people (with a range of offences) across the UK youth justice secure estate, and is not designed to meet the specific needs of young people with HSB.

SECURE STAIRS consistents of components such as: staff are skilled, emotionally resilient and child-centred in their delivery of interventions and are supported by clear organisational structures; key theories on attachment, trauma and child development inform work in secure settings; every interaction in the system is of importance; young people's support is goal-centred and formulation driven; outcomes are monitored; and transition planning is undertaken from the outset (D'Souza et al., 2021, p. 2). SECURE STAIRS is intended to support the wellbeing and service experience of staff and young people through developing "trauma-informed therapeutic environments" (D'Souza et al., 2021, p. 3). A realist process evaluation of the SECURE STAIRS initiative will explore implementation experiences from the perspective of young people and staff (D'Souza et al., 2021). This will add to the evidence base

on the application of a TIC model to English youth justice secure settings. However, there is no explicit consideration of the role of parents/carers in the twelve components of the model.

In England, approximately one in seven young people with a conviction of HSB are sentenced to custody (Eastman et al., 2019). These young people are likely to experience the implementation of SECURE STAIRS if sentenced to a UK youth custody establishment. However, some young people with HSB will either be required to serve a sentence under community supervision or will not receive a custodial sentence. Hence, the SECURE STAIRS initiative will not be widely experienced by young people with HSB, their parents/carers or professionals. At present, existing and developing research on TIC in youth justice service does not specifically account for HSB provision (Branson et al., 2017; D'Souza et al., 2021). The lived experiences and complex needs of this population group justifies the need for focused research on how the principles of TIC could be conceptualised within HSB provision.

TIC in HSB

The delivery of adult sex offender treatment has been considered from the perspective of trauma-informed care in the literature, although substantial research has yet to emerge on the application of the principles of TIC to HSB provision (Grady et al., 2021; Levenson, 2014; Levenson et al., 2016). The conceptualisation of TIC within adult sex offending treatment has been considered from a relational and strengths-based perspective (Levenson, 2014). This was conceived to involve understanding an individual's developmental experiences, interpersonal relationships and exposure to potentially traumatic events as contributing to maladaptive interpersonal functioning that has been expressed through offending behaviour (Levenson, 2014).

The primary focus of a strength-based approach to TIC in adult sex offender treatment was considered to be professionals developing a relationship of empowerment, collaboration and

choice with individuals to ensure that the prior dynamics of unhealthy and/or abusive interpersonal relationships are not inadvertently replicated within the helping relationship (Harris & Fallot, 2001; Levenson, 2014). The ability for practitioners to empathically and therapeutically respond to an individual's potential expressed hostility and resistance within sessions in a manner that acknowledges the influence of the potential experiences of interpersonal trauma is considered key to maintaining intervention engagement (Levenson, 2014).

Calls for the integration of trauma-informed HSB input have been growing over recent years in response to the recognition of the adversity in the lives of some young people with HSB and their parents/carers (Rasmussen, 2013; Reed, 2020). It is also important that this evidence is integrated with the growing awareness of the vicarious trauma encountered by professionals working in HSB provision (Pelech et al., 2021). One study identified that professionals who provide treatment to young people with a sex offence recognised the importance of trauma-informed treatment and had the highest level of professional consensus in the rating of interventions on a survey (Reed, 2020).

TIC has a dual purpose to meet the needs of individuals both accessing services and staff who work in organisations (Harris & Fallot, 2001). TIC recognises the potential for staff to be exposed to trauma through directly working with individuals or through organisational practices that can have a negative psychological impact (SAMHSA, 2013). The importance of a trauma-informed approach to meet the needs of staff working with young people who offend or display problematic behaviour has received scant attention in the literature. A systematic review of TIC within youth justice services reported that only 50% of studies reviewed (k = 5) recommended an organisational level preventative approach to staff experiences of vicarious trauma and "work-related traumatic stress" (Branson et al., 2017, p. 642). This sits in contrast

to research undertaken around TIC in alternative services (such as homelessness services), which highlights staff support as a key component of TIC (Hopper at al., 2010; Branson et al., 2017). There is a need for further research on how TIC can be applied to professionals working within both youth justice settings and HSB services. The need for this research is particularly pertinent considering the hypothesised relationship between reduced occupational effectiveness and experiences of secondary trauma amongst staff working within youth justice services (Denhof & Spinaris, 2013; Branson et al., 2017; Severson & Pettus-Davis, 2013).

Critique of TIC

A critical appraisal of the concept of TIC targets the failure of the concept to offer a coherent service model that can be informed by measures of fidelity (Isobel, 2021). The limitations of TIC as a concept are also compounded by inconsistencies in the definition and conceptualisation of 'trauma' in clinical contexts and within the wider literature (Isobel, 2021). TIC has been overtly criticised by clinicians for perpetuating a diluted and all-encompassing definition of trauma that is used by individuals to describe an array of troubling experiences as traumatic (Isobel, 2021; Isobel et al., 2021). The use of trauma as a broadly inclusive, and thereby diluted label, can become problematic for individuals who wish to use the label to describe the significant psychological impact of exposure to highly distressing, threatening, and abusive events (Isobel, 2021; Isobel et al., 2021). Despite these tensions, an individual's subjective perception and interpretation of an experience as traumatic can be extrinsic to the conceptual conflicts and warrants acknowledgement accordingly.

Separately, individuals who have been exposed to highly distressing, threatening and harmful events or circumstances may choose not to ascribe the label of 'trauma' to their experience of events (Isobel, 2021). Services who adopt a TIC service delivery may potentially restrict the autonomy of individuals to ascribe meaning to their own experiences, and instead impose

meaning and the label of trauma on an individual's experiences against their will. Hence, there is a risk that the concept of TIC may inadvertently perpetuate iatrogenic trauma in paradox to the principles of choice, collaboration and empowerment that underpin the concept of TIC (Harris & Fallot, 2001; SAMHSA, 2013). However, a more nuanced approach to TIC acknowledges that whilst individuals may choose to either use or not use the label of 'trauma' to describe their experiences; TIC aims to reduce the risk that the delivery of care within health and justice services replicates "dynamics of power, coercion and control" that may have been present within relational experiences that were experienced as distressing or traumatic (Harris & Fallot, 2001; Isobel, 2021, p. 605). The fundamental aim of TIC is for organisations to deliver a service that does not replicate prior experiences of events and/or relationships that could be considered traumatic and does not exacerbate the personal impact of such events, which some individuals may describe as trauma (Harris & Fallot, 2001).

Project Rationale

There is a gap in the current evidence base regarding the conceptualisation of TIC in HSB provision. This evidence gap is misaligned with the broader evidence base which has demonstrated an association between experiences of ACEs and HSB (Balfe et al., 2019; Hackett et al., 2013; Levenson et al., 2017). Such experiences of adversity and trauma, which may be interpersonal in nature, may subsequently impact young people and parent/carer experiences of HSB provision as a service that is characterised by interpersonal dynamics. The interaction of such dynamics within HSB provision may inform experiences that could be considered potentially distressing, or trauma-informed. This requires further attention to inform the development of responsive HSB provision.

The conceptualisation of TIC within youth justice services also requires a more nuanced consideration that integrates service user perspectives. Review authors recommended that future developments in the concept of TIC within youth justice services should be directly informed by stakeholders (young people, families/carers, and professionals), and be driven by research that explores the impact or experience of youth justice practice, policy, and/or interventions (Branson et al., 2017). This study will attend to these evidence gaps through a synthesis of the experiences of HSB provision based on the voices of young people, their parents/carers, and professionals. This study will consider what aspects of these experiences could be considered as trauma-informed, or potentially distressing, in order to conceptualise trauma-informed practice implications that attend to the current evidence gap.

This study also presents a unique departure from previous qualitative syntheses that have discretely explored HSB assessments and interventions (Campbell et al., 2020; Campbell et al., 2016; Campbell et al., 2015). To date, published reviews have focused on the benefits of interventions from the perspective of young people and their parents/carers (Campbell et al., 2020). This study intends to bridge the gap between the absence of service user perspectives on what aspects of provision could be considered trauma-informed, along with the need for further research that uncovers the voice of young people who have not had successful experiences of HSB interventions (Campbell et al., 2020).

Furthermore, a review of the experiences of HSB provision from all three groups (young people, parents/carers and professionals) has yet to be undertaken. The constellation of these experiences may reveal similarities and/or differences in the aspects of provision that could be considered as trauma-informed or potentially distressing. The opportunity to collectively synthesise these experiences and highlight themes of commonality will advance existing reviews that have explored the experiences of young people and parents/carers separately from

the experiences of professionals (Campbell et al., 2020; Campbell et al., 2016; Campbell et al., 2015; Pelech et al., 2021). A common factors approach to exploring experiences of HSB provision from the perspective of the three groups is essential to inform a holistic conceptualisation of TIC within HSB provision. It is hoped that this development will enhance the experience and impact of HSB provision to meet the ultimate aim of reducing the risk of harm, improve wellbeing, and prevent further victimisation. To meet these objectives, this study will be guided by the following three research aims:

Research Aim 1: What do young people, parents/carers and professionals say about their experiences of HSB assessment, intervention, and support?

Research Aim 2: What aspects of HSB assessment, intervention and support could be considered distressing from the perspective of young people, parents/carers, and professionals?

Research Aim 3: What aspects of HSB assessment, intervention and support could be considered trauma-informed from the perspective of young people, parents/carers, and professionals?

Method

This chapter introduces qualitative evidence synthesis (QES) and thematic synthesis as the methods of systematic review that were used to attend to the three research aims of this study. A rationale and overview of the methods will be provided. The stages of the QES will be presented and a reflexive account will conclude the chapter.

What is a QES?

QES is a method of systematic review that collates and synthesises findings contained in primary qualitative research studies (Flemming & Noyes, 2021). A QES aims to develop rich interpretations and new insights into nuanced issues explored within qualitative studies, such as individuals' experiences of healthcare provision (Flemming et al., 2019). In primary qualitative studies, this insight is generally contained within the textual data generated through qualitative data collection methods such as focus groups and interviews (Flemming et al., 2019). QES methods were developed with the aim of going beyond primary qualitative research to identify theoretical and practice implications for healthcare professionals, policy makers and stakeholders based on knowledge generated from a cumulative evidence base (Flemming & Noyes, 2021).

The method has developed in response to demands from policy makers for evidence that "goes beyond what works," which is typically generated through quantitative systematic reviews (Flemming et al., 2019, p. 1). Instead, nuanced evidence is sought on why and how an assessment and/or intervention works from the perspectives of the recipients and/or providers to identify the components that either support or hinder the delivery of services (Flemming et al., 2019).

Method Rationale

There is growing, albeit still limited, research exploring the experiences of young people, parents/carers and professionals of the input offered by HSB services. A QES of the experiences of the three groups offers an opportunity to capture and synthesise a broad range of complex and dynamic experiences of assessment, intervention, and support to develop trauma-informed practice implications. The distinguishing feature of this QES is the opportunity to capture the complex interplay between each group's experience of HSB provision.

Two QES best practice guidance tools have informed this chapter. Firstly, the ENTREQ tool ('Enhancing transparency in reporting the synthesis of qualitative research') has informed the reporting of the method procedure (Tong et al., 2012). The 'RETREAT framework': (Review question; Epistemology; Time/Timescale; Resources; Expertise; Audience and purpose; Type of Data), is a seven-domain criterion-based approach to developing a robust methodological rationale to inform the choice of QES method (Booth, 2018; Flemming & Noyes, 2021). The RETREAT framework aims to address one of the prevailing methodological deficits within the evidence base related to the incongruence between the aims of a QES and the choice of synthesis method (Booth, 2018). The RETREAT framework has been used to inform the selection of thematic synthesis as the analytic method.

A brief overview of the consideration of the RETREAT framework components in this project is presented. Firstly, the critical realist epistemological position of the author and supervisory team aligns with the tentative epistemological underpinning of the thematic synthesis method (Barnett-Page & Thomas, 2009). Thematic synthesis has been tentatively classified within the literature as being informed by a critical realist approach as the output of thematic syntheses are generally considered to be "reproducible and correspond to a shared reality" (Barnett-Page

& Thomas, 2009, p. 6). Critical realism takes the philosophical position that an individual's knowledge and perception of reality is mediated by personal beliefs, values and perspectives (Flemming & Noyes, 2021; Tong et al., 2012). From an epistemological perspective, thematic synthesis allows researchers to undertake a synthesis that "stays close" to the original analysis contained within primary studies, whilst transparently synthesising data from multiple primary studies and generating new knowledge and understanding (Thomas & Harden, 2008, p. 1).

Thematic synthesis was also deemed to be an accessible method to use within the timescale of the study that can appropriately attend to the variability in the 'thickness' of data identified through the initial scoping process of relevant studies (Booth, 2018; Flemming & Noyes, 2021). The use of specialist resources such as screening and coding software that are used to support a thematic synthesis were also accessible as part of the DClinPsy thesis research budget (Booth, 2018). The clinical and academic expertise of the supervisory team in the field was deemed suitable to support the project. In line with the RETREAT framework, the audience and purpose of the project have been considered as part of the methodological rationale. Thematic synthesis is a method well-suited to producing findings that are accessible to the diverse range of professionals, policymakers, assessment and intervention authors involved in designing and delivering HSB provision (Booth, 2018; Thomas & Harden, 2008).

Finally, the conceptual richness and contextual thickness of the qualitative data contained within included studies, alongside the quantity of eligible studies, influenced the choice of the thematic synthesis method. The 'thickness' of data within a qualitative study is defined as "the extent to which included studies allow identification of the situational context" (Booth, 2018, p. 48). 'Thin' data, such as that which may be derived "from brief case reports or textual responses to surveys" is unlikely to "sustain contextual interpretation" due to the limited depth of detail within the data (Booth, 2018, p. 48). These factors were considered during the initial

scoping review which revealed variation in the quality and thickness of data contained within the studies. The studies were also varied in the 'richness' of data, which is understood as the extent to which individual studies contain "conceptual detail" that is based on primary data that has sustained "theoretical development and explanation" (Booth, 2018, p. 47). The methodology of thematic synthesis accounts for the variation in the thickness and richness of data in included studies (Thomas & Harden, 2008).

Procedure

Approach to Searching

A systematic approach to literature searching was undertaken which was both pre-planned and comprehensive (Harris et al., 2018; Tong et al., 2012). A pre-planned, and comprehensive systematic search was deemed necessary to support the identification of the relatively small number of qualitative studies within the evidence base (Booth, 2016; Shaw et al., 2004). Grey literature, such as PhD theses or third sector/governmental publications were also eligible for inclusion which further enhanced the comprehensive search.

Study Selection Criteria

The systematic screening of literature was informed by clear inclusion and exclusion criteria, as outlined in Table 1.

Table 1

Study Selection Criteria

Inclusion Criteria	Exclusion Criteria
Participant criteria: Young people with HSB (males aged 12-21) Parents/carers of young people with HSB Professionals working with young people with HSB	Victim-related literature
Qualitative studies that explore experiences of HSB assessment, intervention, and support (must have a qualitative method of data collection and/or qualitative analytic method, includes qualitative data contained within a mixed methods design)	Quantitative research
Papers that contain original research data (including grey literature)	Editorials, book reviews and systematic reviews
Studies published in any year and language	

Participant Inclusion Criterion

The participant inclusion criterion for this study spans the three groups who have either received or delivered HSB assessment, intervention, and support: young people with HSB (males aged 12-21 years); parents/carers of young people with HSB; professionals who work with young people with HSB.

Young People Inclusion Criterion

The 12-21 age range inclusion criterion was informed by the initial scoping review, which found that studies have generally recruited young people for participation in studies across a broad period of adolescence. The upper age limit of the young person inclusion criterion is reflective of the upper age limit of the 'young offender' status in the UK, which is currently set at age 21. Participants over the age of 21 years who discussed their experience of receiving HSB provision as adolescents between the ages of 12-21 years were not excluded from the study. This approach was deemed appropriate based on the retrospective nature of accounts within the studies. Female adolescents with HSB are understood to have distinct treatment and support needs which require separate research and synthesis, therefore the study inclusion criterion was to identify male adolescents only (Warrilow, 2019; Wijkman et al., 2011).

Parent/Carer Inclusion Criterion

The inclusion criterion for the parent/carer population group consists of parents/carers of young people with HSB who describe their own and their child's experiences of HSB provision. Initially, the aim was to synthesise the experiences of parent/carers that care for young people aged 12-21 years. However, inconsistencies were identified in the reporting of participant characteristics in the returned studies. Consequently, terms such as 'teenagers', 'adolescents', and 'young people' used to describe the children of parents/carers were accepted for inclusion in the absence of a specified age criterion. It is accepted that despite nuanced cross-cultural differences in terminology surrounding young people, these terms are likely to be used in studies to describe young people within the 12-21 age range.

Professionals Inclusion Criterion

The professional inclusion criterion captures a broad range of practitioners who are involved in delivering HSB provision. For the purposes of this study, the term 'professionals' may take

the form of psychologists, social workers, therapists, youth justice professionals, nurses, other mental health professionals and/or residential workers, and is reflected in the terminology used in the electronic database search strategy (Appendix A). The broad definition of 'professionals' is intended to capture the diverse experiences of a range of professionals to inform broad practice implications.

Research Phenomena Inclusion Criterion

The studies eligible for inclusion were required to contain qualitative data that focused on the experiences of young people with HSB aged 12-21 years, and/or their parents/carers, and/or professionals delivering HSB provision. The specific provision context and/or service did not serve as a factor in the study eligibility criteria as the study aims to consider experiences across multiple contexts such as community services, residential services, and custodial settings (Harris et al., 2018). Details on the service provision context of studies is documented in the 'Table of Included Studies' (Appendix B).

Study Method Inclusion Criteria

Studies eligible for inclusion were required to have used qualitative methods for data collection (e.g., semi-structured interviews and focus groups), and/or qualitative methods for data analysis (e.g., Interpretive Phenomenological Analysis and thematic analysis) (Glenton et al., 2013). This criterion allowed for the inclusion of research designs such as process evaluations, case studies, ethnographic research, and mixed methods studies with a clear qualitative data collection method (Glenton et al., 2013).

Studies that used qualitative data collection methods but presented the findings using quantitative analytic methods were excluded on the basis that the quantitative data in the study did not provide text for the researcher to code and analyse inform the qualitative synthesis of

findings (Glenton et al., 2013). Case studies and narrative accounts were identified in the search that met both the participant inclusion criteria and phenomena of interest inclusion criteria. However, the studies identified did not contain raw qualitative data that had been obtained through qualitative data collection methods. There was limited insight into the lived experiences of the individuals in these case studies and the author typically discussed the experiences of young people from the second-hand perspective of the author without providing raw participant data to support the perspectives (Gerber, 1994; Hodges et al., 1994; Kozlowska, 2010; McNevin, 2010; Venable & Guada, 2014; Wylie & Griffin, 2013). These studies were therefore excluded.

Time Period and Language of Publication Inclusion Criterion

As this project privileges the voice and experiences of the three population groups, it was not deemed justifiable to incorporate a time-period or English language inclusion criterion into the study eligibility criteria. This QES seeks to capture the perspectives of individuals who have experienced HSB provision both cross-culturally and temporally to inform integrative trauma-informed practice implications. As the initial scoping review revealed only a limited number of qualitative studies that would meet the criteria for inclusion, it was deemed unjustifiably restrictive and a potential risk to the breadth of the review to impose a time-period and English language inclusion criterion in this project. Two foreign language studies were deemed to meet the criteria for inclusion in the project. However, the quoted cost for the professional translation of the studies was in excess of the thesis research budget. These studies were therefore excluded from the QES.

Electronic Search Strategy

The electronic search strategy was originally developed to inform the initial scoping review undertaken on the OVID PsycInfo database with the support of Judy Wright (Senior

Information Specialist, University of Leeds Library). The terms contained within the search strategy were formulated and appraised during monthly supervision meetings. Four strings were developed to structure the electronic search strategy and satisfy the research aims. Brief examples of the content of each string of the electronic search are provided. The first string (population construct comprising three categories: young person, parents/carers, and professionals) contained terms such as “you* offen*", “adolescen* adj3 "sex* offen*", parent*, “Caregivers/ or carer”, professional*, Nurses/Clinicians/practitioner*, or Social Workers. The second string (HSB construct) contained terms such as harmful sex* behavio*, problem* sex* behavio*, and inappropriate sex* behav*. The third string (experiences construct) contained terms such as account, experience*, feelings, and narrative. The fourth string (intervention construct) contained terms such as intervention*, assessment*, therap*, and treatment*.

The search strategy contained a combination of free-text terms and exploded Subject Heading searches to maximise search results. A draft version of the search strategy was shared with Judy Wright and discussed with the project supervisors in December 2020. The author made the recommended amendments to the search strategy and submitted the draft strategy to Judy Wright for review in January 2021. The finalised Ovid PsycInfo search strategy designed for the initial scoping review is displayed in Appendix A.

Data Sources

Following the initial scoping review undertaken in January 2021, the author sought further input from Judy Wright between May and June 2021. Support was received to adapt the original search strategy developed on Ovid PsycInfo to meet the requirements of six further electronic databases (MEDLINE, Scopus, CINAHL, EMBASE, Web of Science, and ProQuest). Seven electronic databases were searched by the reviewer on 25.07.21 (Tong et al., 2012). The electronic database search was repeated on 18.03.22 across six databases to identify

any additional studies published since the original search. The search could not be repeated on ProQuest as the database license held by University of Leeds lapsed between July 2021 and March 2022.

The databases used to undertake the search contain a breadth of research undertaken by diverse disciplines such as nursing, medicine, and social sciences (Lachal et al., 2017). This was deemed necessary to capture the multidisciplinary nature of HSB provision, which can span diverse professional remits and contexts. Database searches that returned more than five studies published in the same journal prompted journal handsearching to identify further appropriate studies. Handsearching was undertaken of the following electronic journals: Journal of Sexual Aggression, Journal of Child Sexual Abuse, Child & Adolescent Social Work Journal, and Journal of Interpersonal Violence. The bibliographies of relevant studies and existing systematic reviews were also consulted to identify additional studies not returned through the electronic database search (Campbell et al., 2020; Pelech et al., 2021). An additional six studies were identified for full text review through handsearching journals and relevant bibliographies. It was anticipated that authors would be contacted via email if the database search returned five or more eligible studies published by the same author, although this step was ultimately not required based on the output of the electronic searches.

Grey Literature Search

Grey literature studies have been included to support the depth of the project and to enhance the opportunity to hear the voices of individuals who have experienced HSB provision (Harris et al., 2018). The identification of relevant grey literature sources for the project was supported by Judy Wright. Eight online grey literature sources were searched between 03.12.21 and 06.12.21. Examples of the search terms used in the grey literature search included: ‘young people/person’, ‘adolescent’, ‘juvenile’, ‘parent/carer/guardian’, ‘professional’, ‘practitioner’,

‘worker’, ‘harmful sexual behaviour’, ‘inappropriate sexual behaviour’, ‘atypical sexual behaviour’, ‘problematic sexual behaviour’, ‘assessment’, ‘intervention’, ‘support’, ‘experiences’ ‘views’, and 'narratives’. The search returned an additional twenty studies eligible for full text review. The grey literature search was undertaken on the following databases:

- British Library EThOS
- Children and Young People’s Centre for Justice (CYCJ)
- Google Scholar (first 110 results reviewed)
- National Society for the Prevention of Cruelty to Children (NSPCC)
- Open Access Theses and Dissertations (OATD)
- Social Care Institute for Excellence (SCIE) Online
- UK College of Policing
- Youth Justice Resource Hub

Study Screening Process

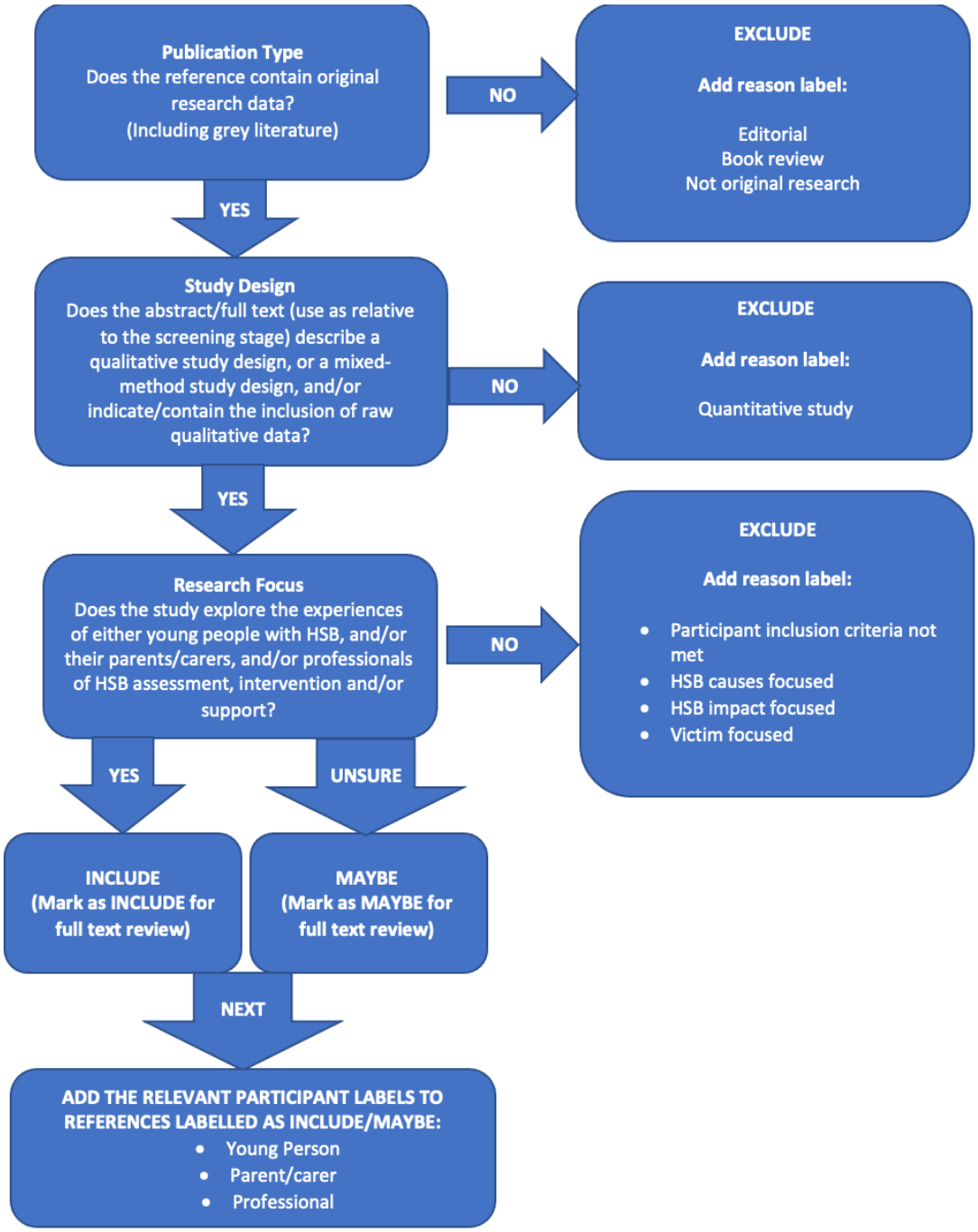
Cochrane values transparency as the “guiding principle” on the reporting of decision-making around QES study inclusion (Noyes et al., 2020, #section-21-9). The electronic database results were firstly deduplicated in the Endnote X9 reference management software using both the platform deduplication function and manual deduplication. The deduplicated results were then transferred to Rayyan, a free, online systematic review tool that supports citation sharing with project colleagues and allows for a comparison of independent decisions on study eligibility (Kellermeyer et al., 2018).

Title and Abstract Screening

The title and abstracts of 1769 studies were screened to rule out references that did not satisfy the study selection criteria. A 'Screening Protocol' (Figure 1) was developed to support the title and abstract screening process and was followed by both the author and two peer researchers (also Psychologists in Clinical Training undertaking systematic reviews). Approximately 15% of the title and abstracts of studies were independently screened by the two peer researchers. A total of 1529 references were excluded following title and abstract screening. A pre-set list of 'labels and 'reasons' for study exclusion were also used by reviewers in Rayyan to support the transparent recording and reporting of the process.

Figure 1

Screening Protocol



Full Text Review

Following title and abstract screening, 230 studies were included in the full text review stage. The author completed the full text screening of 230 studies on Endnote. A total of 15% of the studies were allocated to the same peer reviewers to undertake the full text review against the 'Screening Protocol' (Figure 1). A discussion was held with the peer reviewers regarding conflicts identified during the full text screening stage and a consensus was reached on final study eligibility. The supervisory team also completed a full text screen of 10 studies that required additional discussion to assess eligibility for inclusion. The decision-making on study eligibility was discussed by the supervisory team during meetings and via email until a consensus was reached.

The full text versions of 62 studies that originally satisfied the eligibility criteria based on title and abstract screening could not be located during the full text review process. Due to the high number of studies that could not be located, an additional title and abstract review was undertaken on the studies to inform a ranking process of the studies from most likely to least likely to meet the study eligibility criteria. This ranking process was used to identify the references that necessitated further efforts to locate the full text, such as requesting the text through the University of Leeds Library 'Document Supply' service.

The additional review and ranking process required the author to review the title and abstracts to identify the following factors: clear indication of a qualitative method and a clear indication of young people (males aged 12-21), and/or carers/parents, and/or professionals' experiences of HSB assessment, intervention and/or support. Abstracts that did not explicitly reference the eligibility criteria were given a lower rank in the table as the additional effort required to locate the papers was deemed not justifiable. A total of twenty-one references were deemed to require further efforts to locate the study based on the additional title and abstract review undertaken

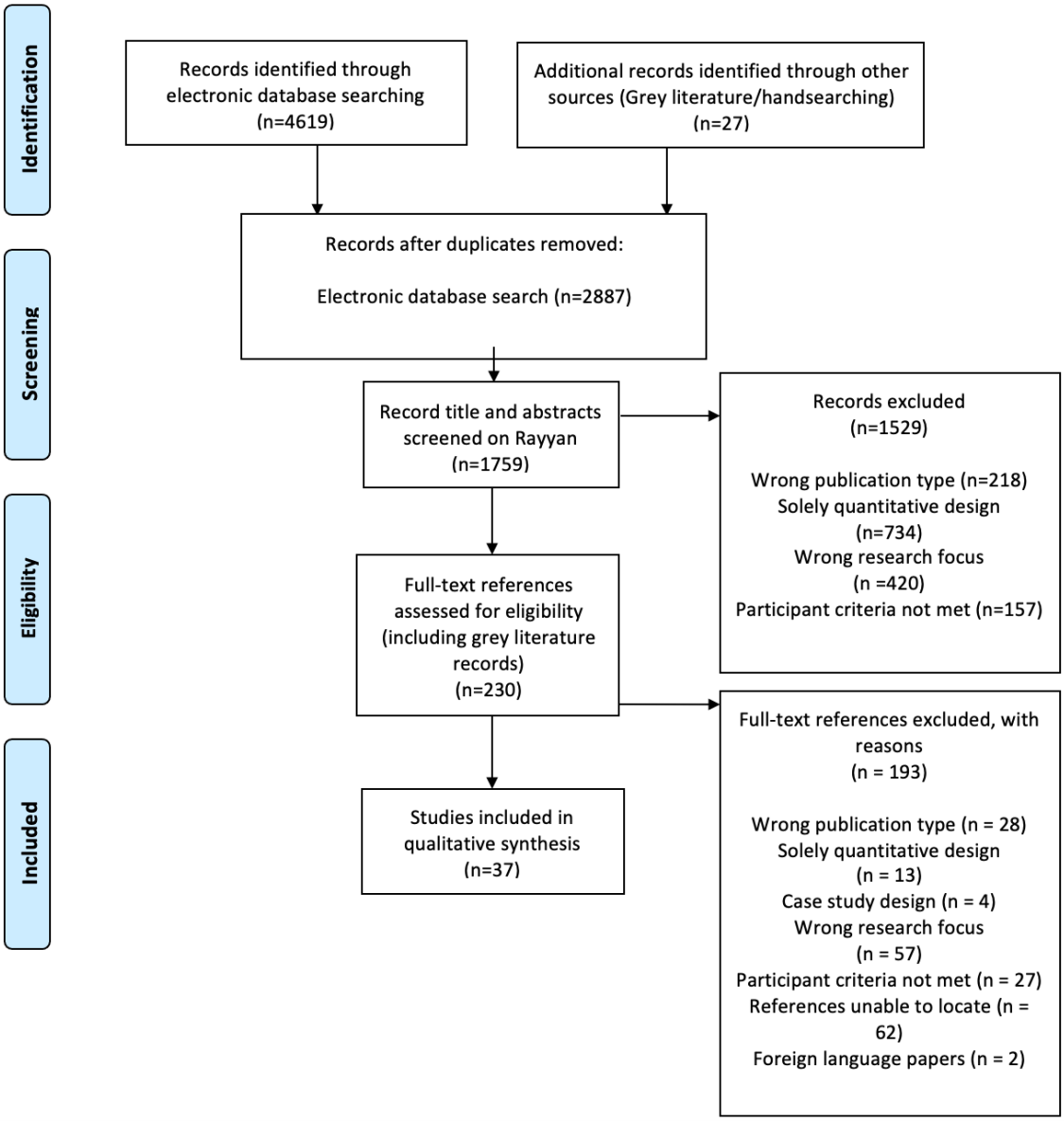
by the author. These studies were subsequently requested through the University of Leeds Library 'Document Supply' process.

Study Selection Results

A total of 37 studies met the criteria for inclusion in the QES following full text review. In accordance with best practice, the Preferred Reporting Items for Systematic Reviews (PRISMA) Statement Diagram has been used to record the details of the comprehensive approach to literature searching and screening and is displayed in Figure 2 on the following page (Finfgeld-Connett & Johnson, 2013; Moher et al., 2009).

Figure 2

PRISMA Statement Diagram (Moher et al., 2009)



Data Extraction Process

The extraction of data from the 37 studies was undertaken in two stages in line with the thematic synthesis method (Noyes et al., 2019; Thomas & Harden, 2008). A bespoke data extraction sheet (DES) was developed and used alongside the full text screening process. The DES was used to extract the relevant contextual, method and methodological characteristics

from studies which met the criteria for inclusion following full text review (Noyes et al., 2018). In line with Cochrane guidance, the extracted information was transferred from the DES and displayed in the 'Table of Included Studies' in Appendix B (Noyes et al., 2020, #section-21-10; Flemming & Noyes, 2021; Tong et al., 2012).

The second stage of data extraction involved extracting the 'findings' from studies in preparation for data coding, analysis, and synthesis (Flemming & Noyes, 2021). The identification of 'findings' in qualitative studies can be a complex task due to reporting inconsistencies between studies (Thomas & Harden, 2008). The 'findings' within individual studies consisted of direct participant quotes, analytic themes, subthemes, author interpretations, and "new theory or observational excerpts" (Flemming & Noyes, 2021, p. 4; Noyes et al., 2018). In this QES, the data contained within the labelled 'Results' and/or 'Findings' sections in the studies was coded, analysed, and synthesised; this included data in the form of both raw participant quotes and/or author interpretations.

EPPI-Reviewer software, a Cochrane recommended specialist online reviewing software, was used to support the extraction and inductive coding of data contained within the included studies (Noyes et al., 2018). Use of the EPPI-Reviewer platform was informed by the number of studies that satisfied the inclusion criteria and the time demands of the project. Optional EPPI-Reviewer software functionalities such as text mining and the creation of conceptual relationship diagrams were not used in this study. The analysis and synthesis of data was undertaken manually by the author to support the internal validity of the synthesis output.

Thematic Synthesis: Line-by-line Coding

There are three stages involved in undertaking a thematic synthesis: the line-by-line coding of textual data from included studies; the organisation of coded text into descriptive themes; and

the production of analytical themes that arise from an interpretation of the descriptive themes (Thomas & Harden, 2008, p. 1). Line-by-line coding of study findings was undertaken by the author to inductively identify meaning units within the data (Booth, 2018; Thomas & Harden, 2008, p. 5). The aim of this stage is to remain as close to the data as possible and produce at least one code for every sentence in the 'findings' sections (Thomas & Harden, 2008). Multiple codes were sometimes applied to each sentence and/or meaning unit in the data to support the breadth of the coding framework (Thomas & Harden, 2008). Codes were created and named by the author on EPPI-Reviewer and took the form of both 'free' codes and codes organised into a hierarchical tree structure (Thomas & Harden, 2008). A brief description of each code was created to support the internal consistency of the subsequent codes allocated to the data. The line-by-line coding of textual data within qualitative studies is reflective of the key task of a QES in the form of translating concepts identified in one study across to other studies where applicable (Thomas & Harden, 2008).

The 'free' and hierarchical tree structure codes formed the inductive coding framework. The data contained within each code was reviewed prior to finalising the coding framework to support the interpretive consistency of the codes and identify whether any additional codes were required to capture deviating data (Thomas & Harden, 2008). Three separate coding frameworks were developed that contained the data related to the three groups. The 'young person' coding framework/hierarchical tree structure contained a total of 57 themes and 430 codes grouped under 10 categories. The 'parent/carer coding framework contained a total of 31 themes and 196 codes grouped under 8 categories. The 'professional' coding framework contained a total of 23 themes and 165 codes grouped under 5 categories. The coding frameworks were shared with the project supervisors for feedback.

Thematic Synthesis: Developing Descriptive Themes

The finalised coding frameworks were reviewed to identify themes of similarity and difference across the original codes as part of the second stage of the method (Thomas & Harden, 2008). At this stage, the synthesis continues to remain close to the original study findings as the coded qualitative data is aggregated into a whole through a descriptive record of the themes (Thomas & Harden, 2008). This stage involved rereading the original extracted data and reviewing the accompanying themes and codes. The reviewed data, themes and codes were then compared, contrasted, and regrouped based on themes of similarity within the data. For example, during the initial coding stage, the codes 'feeling blamed', 'feeling shamed', and 'being perceived as poor mothers', were initially grouped under the theme 'Negative Support Experiences'. Through descriptive coding, these codes were regrouped together under the heading 'Parents feel criticised'. Overall, the regrouping of the coded data led to the formation of new descriptive themes which were accompanied by a brief theme definition to encompass the meaning of the original codes (Thomas & Harden, 2008). This resulted in the creation of 24 descriptive themes.

Thematic Synthesis: Developing Analytic Themes

The key characteristic of a QES is the process of researchers "going beyond" the descriptive findings of original studies to generate new knowledge (Lachal et al., 2017; Thomas & Harden, 2008, p. 7). This interpretative analytical stage required the author to connect, analyse and synthesise the data captured within the descriptive themes in response to the research aims. In this study, the analytic stage supported the author to answer study research aims two and three as the included qualitative studies did not directly address the content of the two review questions (Thomas & Harden, 2008). Research aim one, which is focused on the three groups' general experiences of HSB provision, was addressed directly by the included studies. The

coded data was relatively thin and often lacked richness. The findings identified to address research aim one are therefore descriptive in nature.

To meet research aims two and three, the analytic stage required the author to consider the specific terms and phrases contained within the coded data and descriptive themes that related to experiences of HSB provision that could be considered potentially distressing or trauma-informed. An a priori framework of the principles and components of practice that could be considered as trauma-informed and/or potentially distressing was not imposed on this analytical stage (Thomas & Harden, 2008). This decision was made for two primary reasons. Firstly, research on the application of TIC and/or understanding of distressing practice in HSB provision has received little attention in the evidence base. Secondly, as TIC is an evolving concept that informs practice frameworks that can be adapted to specific service contexts, this project sought to iteratively develop a conceptualisation of trauma-informed practice in HSB provision through the data synthesis (Johnson, 2018).

Therefore, to support the data analysis and synthesis to meet research aims two and three, specific terms and phrases were identified from the data to assist with the consideration of whether participant experiences of HSB provision could be considered potentially distressing, or trauma-informed. The following terms and phrases were identified in the data as suggestive of experiences that could be considered trauma-informed: feeling listened to, openness, comfortable, trust, non-judgemental, caring, validating, safe, and destigmatising. The following terms and phrases were identified in the data as suggestive of experiences that could be considered potentially distressing: intrusive, confronted, resistance, confusion, being attacked, fear, rejected, exposing, powerless, no sense of agency, distressing, scary, intimidating, blamed and helpless. Note these terms are not exhaustive.

The final stage of analysis is dependent upon the author's subjective interpretation of the data in response to the research aims (Thomas & Harden, 2008). The identification of coded data to inform the analytical findings that capture experiences that could be considered trauma-informed or potentially distressing was informed from three perspectives: (1) Participants' explicit reports using the terms that are suggestive of experiences that could be considered trauma-informed or potentially distressing; (2) original study author inferences on participant experiences based on raw data; (3) inferences made by the project author on experiences that could be considered trauma-informed or potentially distressing, based on raw data.

There was therefore no explicit requirement that the data that informed the analytical themes had to contain the previously listed terms. An example is provided to illustrate this process. The below participant data was initially coded 'fear of professional perception,' and then grouped under the theme 'parents feel criticised' at the descriptive coding stage. At the analytical stage, this code was captured by the theme 'Parent/carer powerlessness, sensitivity to blame and feeling neglected impacts engagement':

'"I kept saying the wrong things, and they're thinking, 'oh, she's just still not getting this situation, how serious it is, how severe it is, what's happened, she's in denial'. I was worried that that's how they were perceiving me, it was really hard" (Boyers, 2020, p. 215).

This quote did not contain any of the previously referenced terms. Hence, inferences were made on the participant's experience based on the content of their language. In line with critical realism, it was deemed important to be guided, where possible, by the language contained within the data when considering what aspects of HSB provision could be considered trauma-informed, or potentially distressing. The critical realist stance of this study is further evident through the researcher's tentative critical analysis of the data contained within the analytical themes presented in the 'Results' chapter. During the re-examination of the descriptive themes,

amendments were made until the newly emergent themes were “sufficiently abstract” to capture the relevant descriptive themes and make inferences on what aspects of HSB provision could be considered as trauma-informed or potentially distressing (Thomas & Harden, 2008, p. 7). To illustrate each stage of the thematic synthesis process, a sample of the data that was formed into descriptive themes and used to inform three analytical themes is provided in Appendix C.

Credibility

Following the generation of analytical themes and subthemes, a peer researcher who is also completing a QES thematic synthesis undertook a review of the themes and supporting data to support the credibility of the synthesis output (Lincoln & Guba, 1985; Nowell et al., 2017). The peer researcher reviewed a sample of three analytical themes and deemed the interpretation and abstraction of the themes as viable and coherent. Based on a review of the sample of data and themes, the peer researcher suggested a renaming of two themes to more coherently capture the conceptual underpinning. As a result, the original theme ‘Experiences of professional relationships’ was renamed to ‘Feeling valued by professionals supports engagement’. Similarly, the original theme ‘Early interactions with HSB support services’ was renamed ‘HSB support services: a powerful presence’. The author and the peer researcher agreed that the renaming of the themes more coherently captured the nuances and connections within the data set.

Study Quality Appraisal

The quality appraisal of included studies is an essential stage of a QES and is informed by three key QES quality considerations: the conduct of a study; the transparency in study reporting; the utility and content of findings (Tong et al., 2012; Noyes et al., 2020, #section-21-18). Cochrane recommend that review authors adopt an appraisal of the “methodological strengths

and limitations" of qualitative studies, although there is currently no quality assessment tool that is specifically designed for use in a QES (Noyes et al., 2020, #section-21-8; Noyes et al., 2019). Instead, Cochrane recommends the use of "validated" quality assessment tools, such as the Cochrane Appraisal Skills Programme (CASP) Qualitative Studies Checklist, to appraise the methodological strengths and limitations of studies (Noyes et al., 2020, #section-21-8; CASP, 2013). In line with Cochrane recommendations, the CASP tool was applied to all included studies (Noyes et al., 2018). The outcome of the quality assessment of each study against the CASP Qualitative Studies Checklist is summarised in Table 2 in the 'Results' chapter (CASP 2013, Rozbroj et al., 2020).

Two peer reviewers co-assessed the quality of 15% of the 37 included studies. There was considerable consistency between ratings; minor aspects of difference were discussed and co-rater agreement was ultimately reached. There is an ongoing lack of consensus regarding how quality appraisal criterion should be implemented in a QES, particularly in relation to whether quality appraisal should lead to study exclusion (Carroll et al., 2012; Lachal et al., 2015). Due to the limited number of studies within the evidence base and the privilege placed on participant voices in this QES, studies were not excluded based upon a pre-synthesis quality criterion (Lachal et al., 2017). A summary of the CASP assessment is provided in the 'Results' chapter and an analysis of the outcome is provided in the 'Discussion' chapter.

The GRADE-CERQual approach

Finally, the GRADE-CERQual approach ('Confidence in the Evidence from Reviews of Qualitative research') is a framework that supports the post-hoc assessment of how much confidence should be placed in QES findings (Lewin et al., 2018). The developers of CERQual have defined 'confidence' in this context as "an assessment of the extent to which a review finding is a reasonable representation of the phenomenon of interest" (Lewin et al., 2018, p.

11). The CERQual framework is comprised of four key components which are used to inform an overall assessment of confidence in a review finding (Lewin et al., 2018):

1. Methodological limitations (e.g. CASP quality appraisal) – An assessment of the design and conduct of the primary studies that inform a finding (analytical themes).

2. Coherence – The extent to which the review finding is well supported by the data from primary studies.

3 Adequacy – The extent to which the review finding is supported by data richness and a quantity of data.

4. Relevance – An assessment of whether the primary data that supports a review finding is applicable to the context of the review questions (e.g., to what extent do the details provided within studies satisfy the setting, population, perspective, and phenomenon of interest aspects of the research question/inclusion criteria).

A CERQual 'Summary of Qualitative Findings' table (SoQF) is used to support this process, The table contains each review finding (theme), along with an accompanying CERQual assessment of confidence in each theme (based on the above four components) (Lewin et al., 2018). An overall rating of confidence is provided for each review finding along the following spectrum (Lewin et al., 2018, p. 6):

- High confidence – The review finding is highly likely to be a reasonable representation of the phenomenon of interest.
- Moderate confidence – The review finding is likely to be a reasonable representation of the phenomenon of interest.

- Low confidence – It is possible that the review finding is a reasonable representation of the phenomenon of interest.
- Very low confidence – The extent to which the review finding is a reasonable representation of the phenomenon of interest is unclear.

CERQual uses the above confidence ratings to demonstrate that confidence in review findings exists across a spectrum (Lewin et al., 2018). However, CERQual has been criticised due to the arguably arbitrary nature of categorising confidence in findings (Lewin et al., 2018). Whilst QES methods remain in development, CERQual is an approach that is intended to support readers, practitioners, and policy makers to assess the extent to which they can place confidence in individual QES findings to support the translation of research findings into practice (Lewin et al., 2018). The completed SoQF table for this study can be found in Appendix D. The author's interpretation of the outcome of the CERQual assessment will be discussed in the 'Discussion' chapter.

Reflexivity

Finally, researcher reflexivity is essential to consider when undertaking qualitative research (Berger, 2015). Although there is continued debate around the meaning of reflexivity, the term has generally been understood as the process through which a researcher maintains an active consideration and critical self-reflection on their position as a researcher, and the extent to which this may affect the development and outcomes of a study (Berger, 2015). Reflexivity supports the credibility and trustworthiness of qualitative research through transparently documenting the researcher's personal beliefs, values, and knowledge (Berger, 2015; Cutcliffe, 2003).

Reflexivity is a layered construct that has been conceptualised has having multiple components (Berger, 2015). I have approached this study from the 'shared experience' position of reflexivity, which is described as the process by which researchers have a familiarity and connection to a research topic by nature of sharing lived experience (professional or personal) with the population group (Berger, 2015). I have previous clinical experience of working in a HSB service over a period of thirteen months as both an Assistant Psychologist and Trainee Clinical Psychologist. I have undertaken HSB assessments and interventions with young people living in the community and with young people sentenced to youth custody. I have some insight into the nature of the challenges and support available to professionals, and a tentative, clinical understanding of how individuals may experience HSB services. Through use of a reflective journal, I have maintained a reflexive stance on how my professional experiences and theoretical positionings have influenced the project (Noyes et al., 2018). This effort has supported me to maintain an awareness of my biases whilst undertaking a critical realist analysis of the data (Fletcher, 2017). Discussions held with my supervisors during monthly meetings also helped to maintain a reflexive stance, particularly during the analysis of coded data.

Every line of data within the 'Results' sections of studies was coded to minimise the risk that personal bias would lead me to privilege specific data extracts over others, which may be influenced by my own views on what aspects of HSB provision are of most importance. During coding, I encountered some discomfort when coding data that was not explicitly described as distressing by either the study participants or study author, but that appeared to hold the potential to be experienced as distressing. This response has been accounted for through a critical realist lens as I sought to consider the potential influence of broader contexts on participant experiences. During the coding, analysis and synthesis of professional data, there were also instances where I recognised myself identifying with their experiences of delivering

HSB work. In these instances, I made a reflective journal entry to capture my responses to consider during my analysis.

Finally, supervisory team reflections on positions and/or beliefs held in relation to the review question and/or phenomenon of interest are important to acknowledge in a QES (Flemming & Noyes, 2021, p. 9). As the project Academic Supervisor, Professor Mitch Waterman is an experienced researcher and academic who has supervised a variety of systematic reviews and primary research projects. Professor Waterman approaches research from a critical realist position. Relevant clinical experience is also identified as a factor of expertise that can strengthen a QES focused on intervention implementation (Booth, 2018). Jennifer Allotey (Social Worker and Psychologist in Forensic Training) has been involved in the project from inception due to her experience of HSB assessment and intervention as a clinician, author, and trainer. Jennifer's input has constituted a valuable clinical stakeholder perspective in the development and execution of this project.

Results

This chapter will begin with a presentation of the outcome the CASP quality assessment. The descriptive themes identified from the data to address the first research aim will then be summarised. Research aims two and three will also be addressed sequentially. A thematic map of the analytical themes identified in relation to research aims two and three will be presented to demonstrate how the aims have been met. The analytical themes pertaining to each research aim will be explored in further depth. Data will be presented to illustrate the themes and highlight the experiences of the three groups.

Table 2

Summary of Quality Appraisal Table

Author (Year)	Was there a clear statement of research aims?	Is qualitative methodology appropriate?	Was the research design appropriate to the aims of the research?	Was the recruitment strategy appropriate to the aims of the research?	Was the data collected in a way that addressed the research issue?	Has the relationship between researcher and participants been adequately considered?	Have ethical issues been taken into consideration?	Was the data analysis sufficiently rigorous?	Is there a clear statement of findings?	How valuable is the research?
Almond (2014)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes
Ape-Esera (2016)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Archer (2017)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Barnardo's (2017)	Can't tell	Can't tell	Can't tell	Can't tell	Can't tell	Can't tell	Can't tell	Can't tell	Can't tell	Yes (note these interviews were obtained through 'oral

										evidence sessions' to inform a parliamentary inquiry. The contextual details of the interviews are not provided in the published inquiry. The 'Can't tell' response was used to account for the absence of information).
Belton (2017)	Yes	Yes	Yes	Can't tell	Can't tell	No	Yes	Can't tell	Yes	Yes
Belton et al., (2014)	Yes	Yes	Yes	Yes	Yes	No	Can't tell	Can't tell	Yes	Yes
Boyers (2021)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Chassman (2010)	Yes	Yes	Yes	Yes	Yes	No	Can't tell	Yes	Yes	Yes
Crump (2018)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Derezotes (2000)	Can't tell	Can't tell	Can't tell	Yes	Can't tell	Can't tell	Can't tell	No	No	Can't tell
Duane et al., (2002)	Yes	Yes	Yes	Can't tell	Yes	No	Can't tell	Yes	Yes	Yes
Franey et al., (2004)	Yes	Yes	Yes	Yes	Yes	No	Yes	Can't tell	Yes	Yes
Fuller (2021)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Geary et al., (2011)	Yes	Yes	Yes	Yes	Can't tell	No	Can't tell	Can't tell	Yes	Yes
Glenny (2019)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Gorden et al., (2020)	Yes	Yes	Yes	Yes	Yes	No	Yes	Can't tell	Yes	Yes
Grady et al., (2018)	Yes	Yes	Yes	Yes	Yes	No	Can't tell	Yes	Yes	Yes
Griffin & Beech (2004)	Yes	Yes	Yes	Can't tell	Can't tell	No	Can't tell	Can't tell	No	Yes
Gxubane (2019)	Yes	Yes	Yes	Yes	Yes	No	Can't tell	No	Yes	Yes
Hackett (2006)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Can't tell	Yes	Yes
Jones (2015)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
Kjellgren (2019)	Yes	Yes	Yes	Yes	Yes	No	Can't tell	Yes	Yes	Yes
Kraus (2014)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Lambie & Price (2015)	Yes	Yes	Yes	Yes	Yes	No	Can't tell	Yes	Yes	Yes
Lawson (2003)	Yes	Yes	Yes	Yes	Yes	No	Yes	Can't tell	Yes	Yes
Marsay et al., (2018)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
Martin (2004)	Can't tell	Can't tell	Yes	Can't tell	Can't tell	No	Can't tell	No	Yes	Yes
Myles-Wright & Nee (2020)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
Northey (1995)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes
Northey (1999)	Yes	Yes	Yes	Yes	Yes	No	Can't tell	Can't tell	No	Yes
Pierce (2011)	Yes	Yes	Yes	Yes	Can't tell	No	Yes	Yes	Yes	Yes
Romano & Gervais (2018)	Yes	Yes	Yes	Yes	Yes	No	Yes	Can't tell	Yes	Yes
Russell & Harvey (2016)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
Shevade et al., (2011)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes

Somervell & Lambie (2009)	Yes	Yes	Yes	Yes	Yes	No	Can't tell	No	Yes	Yes
Thurston (2006)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Warrilow (2019)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Note. Use of the 'Can't tell' response was used when the information could not be obtained in the study and/or was not consistently supported by data in the study. Consideration of the outcome of the quality appraisal assessment outcome is addressed under the 'Limitations' heading of the Discussion chapter.

Synthesis Context

Analysis revealed the complex nature of the multiple layers of distress that primarily young people with HSB, but also their parents/carers report experiencing. The nature of the distress identified within studies appeared to be related to a range of lived experiences such as experiences of adversity prior to the incidence of HSB, distress related to the identification of HSB and the initial response of statutory services (e.g. police arrest, social care response, court response), distress related to the offence (e.g. the young person recognises the impact of the HSB on the victim and/or recognises the impact on their own future), distress related to the societal response (e.g. the local community is aware of the offence), and distress related to the experience of HSB provision (the primary focus of this study).

The ability of the researcher to accurately separate the complex nature of participant distress in this study was dependent upon factors such as the research aims and data collection methods in the original studies, the depth of contextual data provided by the original study authors, and the original study author's selection, presentation, and interpretation of data. The complexity of this issue was identified during the initial coding stage and remained at the forefront of the descriptive coding and analytical theme development stages. Some studies have been undertaken with participants who describe their experiences with a diverse range of services, such as statutory, non-specialist services (e.g., social care) and/or specialist HSB services (Boyers, 2020; Hackett & Masson, 2006; Warrilow, 2019). Hence, it was not always possible to clearly distinguish the data that was connected to a specific service. The broad nature of these findings is exemplified in themes such as Theme 10: 'Feeling valued by

professionals supports engagement' and Theme 5: 'Parent/carer powerlessness, sensitivity to blame and feeling neglected impacts engagement'. Consequently, data contained within some themes may be taken from a range of service experiences. This will be highlighted in the synthesis account where necessary.

Shared themes also emerged across the three groups in relation to the aspects of HSB provision that could be considered trauma-informed and/or distressing. These findings have been collectively synthesised, where justified by the data, to attend to the project rationale of producing a constellation of experiences across the three groups to inform a common factors conceptualisation of trauma-informed practice in HSB provision.

Research Aim 1: Findings

To meet the first research aim of understanding what young people, parents/carers and professionals say about their experiences of HSB provision, all data contained within the 'Results/Findings' section was coded and formed into descriptive themes. Data that described general experiences of HSB provision was deemed to meet this theme. This data was often limited in thickness and richness and therefore could not be translated into analytical codes to address research aims two and three, which ask about what aspects of provision could be considered potentially distressing, or trauma-informed. To ensure that the voices and lived experiences of all groups are privileged in this project, the descriptive themes that capture participant experiences of HSB provision and were not translated into analytical themes are summarised below.

Factors that Encourage Engagement

Young people described having a focus on the future as a factor that motivates intervention engagement, for example the desire to change, the desire to move on

with life, family reunification and gaining public acceptance (Belton et al., 2014; Grady, et al., 2018; Martin, 2004). Young people also cited recognising that they have a 'problem' and realising their personal responsibility for change as motivating engagement (Belton, 2017; Belton et al., 2014; Martin 2004). This was described in one study:

"One of the intrinsic motivating factors for young people was the recognition that their behaviour had been problematic and they genuinely wanted help in changing and stopping any further problems" (Belton et al., 2014, p. 9)

Relational factors such as remorse felt by the young person towards the victim and their own family, along with not wanting to let their family down and seeing other young people progress in treatment motivated some to engage (Belton, 2014; Martin 2004). Finally, young people described their general views on interventions as recognising that they had a second chance, understanding the need to work hard in interventions and the importance of taking interventions day by day (Barnardo's, 2017, Gxubane, 2019, Martin 2004, Northey, 1999)

The Content of Interventions

Young people described the content of interventions and identified what contributes to a positive intervention experience. Young people described the benefit of HSB psycho-education as understanding the reasons for their HSB, identifying triggers related to the HSB, learning strategies to manage triggers, feeling more in control of their behaviour and learning from their mistakes (Barnardo's, 2017; Belton et al, 2014; Franey, 2004; Geary 2011; Gorden et al., 2020; Grady et al., 2018; Kjellgren,

2019; Kraus, 2013; Lawson, 2003; Martin, 2004). One young person described this benefit:

"...at post-treatment it emerged as something the adolescents had gained. As one boy reflected, "it has given me great insight into how my offence came around and why" (Ppt 1 G1 T2, aged 16) (Grady et al., 2018, p. 84).

General educative components such as developing victim empathy, gaining an awareness of healthy living, skills for daily living, sex education, understanding of substances and improved manners featured in the reports of young people in the included studies (Geary, 2011; Grady et al., 2018; Martin, 2004). Factors that contributed to a positive intervention experience included having ex-offenders facilitate interventions, having a chaplain on call and having exercises that are fun (Ape-Esera, 2016; Belton et al., 2014, Franey, 2004; Gorden et al., 2020; Gxubane, 2019).

Benefits of Interventions

Young people and parents/carers described the personal impact of intervention engagement as improving perspective taking, consequential thinking, confidence, hope, resilience, motivation, insight, self-belief, decision-making, respect, spirituality, accountability, and honesty (Barnardo's, 2017; Belton, 2017, Belton et al., 2014; Franey, 2004; Grady et al., 2018; Kraus, 2014; Marsay et al., 2018). This is illustrated by one participant:

"I feel more stronger to handle it myself, which I know I am, and I think that's what Woodlands helped with the most, boosting my confidence, my inner strength and now I believe that I am a good person" (Gorden et al., 2020, p. 7)

Young people also described feeling less stress and worry, developing coping skills, and setting goals and future planning as the benefits of intervention engagement (Barnardo's, Belton, 2014; Kraus, 2014; Lawson, 2003; Martin 2004; Marsay et al., 2018). Changes in the young person's ability to relate to others were also reported, which included improvements in their ability to listen to others, trust, care for others, think about others' perspective, make better choices in friends and a greater ability to share their feelings (Belton et al, 2014; Derezotes, 2004; Gorden et al., 2020; Grady et al., 2018; Kraus, 2014; Lawson, 2003; Marsay et al., 2018; Martin, 2004).

Parents/carers also described their view on how intervention engagement led to change in the young person, and recognised that young people developed increased resilience, confidence, and hope through intervention engagement (Archer, 2017; Boyers, 2021; Duane et al., 2002; Kraus, 2014). Parents/carers also described the impact of interventions on them personally, which involved improved wellbeing, reduction in anger, improved parenting and recognising the young person's responsibility (Duane et al., 2002; Kraus, 2014; Geary et al., 2011; Pierce, 2011). For some, intervention engagement led to improvements in family communication and positive changes in household rules, roles, and boundaries (Archer, 2017; Ape-Esera, 2016; Duane et al. 2002; Kraus, 2014)

Experiences Following Intervention Discharge

Young people discussed varying experiences following intervention discharge. Some used the skills gained in treatment to manage difficult thoughts and feelings following discharge, whereas others struggled to apply the treatment to real life situations (Belton, 2017; Derezotes, 2000). Some believed that they were no longer a re-offending risk and wanted to move on with their lives, whereas others worried about the impact of HSB on their future job prospects and relationships (Barnardo's, 2017; Franey, 2004; Martin, 2004). These experiences are summarised in the following extract:

"These goals focused on the desire to better themselves and to never stop evolving. They made statements such as, "for me to be someone," "to walk the talk," "to always change, always work on myself, being aware of who I am, where I'm going and just never stop changing" and "to focus, practice, and just go for it." (Franey, 2004, p. 311).

Following discharge, some young people struggled with knowing how to communicate with family members and friends about the incidence(s) of HSB and their intervention experience (Gorden, 2020; Franey, 2004; Kjellgren, 2019; Martin, 2004).

Professional Experiences of HSB Provision

Finally, professionals described the working relationships developed with colleagues as important to managing the impact of the work, and valued the support offered by

colleagues to talk through aspects of the work that were experienced as challenging (Almond, 2014; Chassman et al, 2010; Crump, 2018; Russell & Harvey). Self-awareness with regards to their own mental health, sexuality, choice of clothing and behaviour in sessions was also discussed by professionals (Chassman et al., 2010; Crump, 2018; Myles-Wright & Nee, 2020; Shevade, 2011). Some professionals described the work as rewarding, both personally and professionally, due to the benefits of the work for young people (Almond, 2014; Crump, 2018; Russell & Harvey, 2016; Shevade, 2011). One professional described this experience:

"I get phone calls from kids who graduated from the program, and they want to come and talk to the current kids in the program how they can change and do good. When the client begins to take responsibility for their actions this is a positive experience" (Crump, 2018, p. 62).

Some professionals developed personal coping strategies to help manage the impact of the work such as faith, self-care, relaxation techniques, work-life boundaries, humour, personal therapy, hobbies, interests and relationships with partners, family, and friends (Almond, 2014; Chassman, 2010; Crump, 2018; Myles-Wright & Nee, 2020; Shevade, 2011).

Addressing Research Aims 2 and 3

In line with the thematic synthesis method, analytical themes have been developed through the ability to draw connections and inferences between related phenomena within the data (Thomas & Harden, 2008. All participant reports have been treated as equal and are not privileged based on the quality of studies or an aggregate of the data.

For the purposes of the second and third research aims, which sought to identify what experiences or aspects of interventions could be considered as potentially distressing or trauma-informed, specific language within the coded data was identified to inform the coding and analysis process to meet the aims (as discussed in the previous chapter). The coded data that informed the analytical themes therefore took the form of either the participant or study author stating that the experience was distressing or akin to trauma-informed working, or the thesis author made inferences based on the use of related language.

The analytical themes developed to address research aims two and three are captured in the two thematic maps presented in this chapter. A guide to the colour coding of the themes within the maps is provided at the bottom of the figures. As previously stated, the synthesis revealed some shared experiences of HSB provision amongst the three groups. The synthesis of the experiences of all three groups have been presented collectively in the thematic maps to demonstrate the dynamic and holistic nature of HSB provision and inform trauma-sensitive practice implications. To separate the experiences of the three groups across the forms of HSB provision would be antithetical to the objective of the study and the broader concept of a TIC as a holistic, service-wide approach.

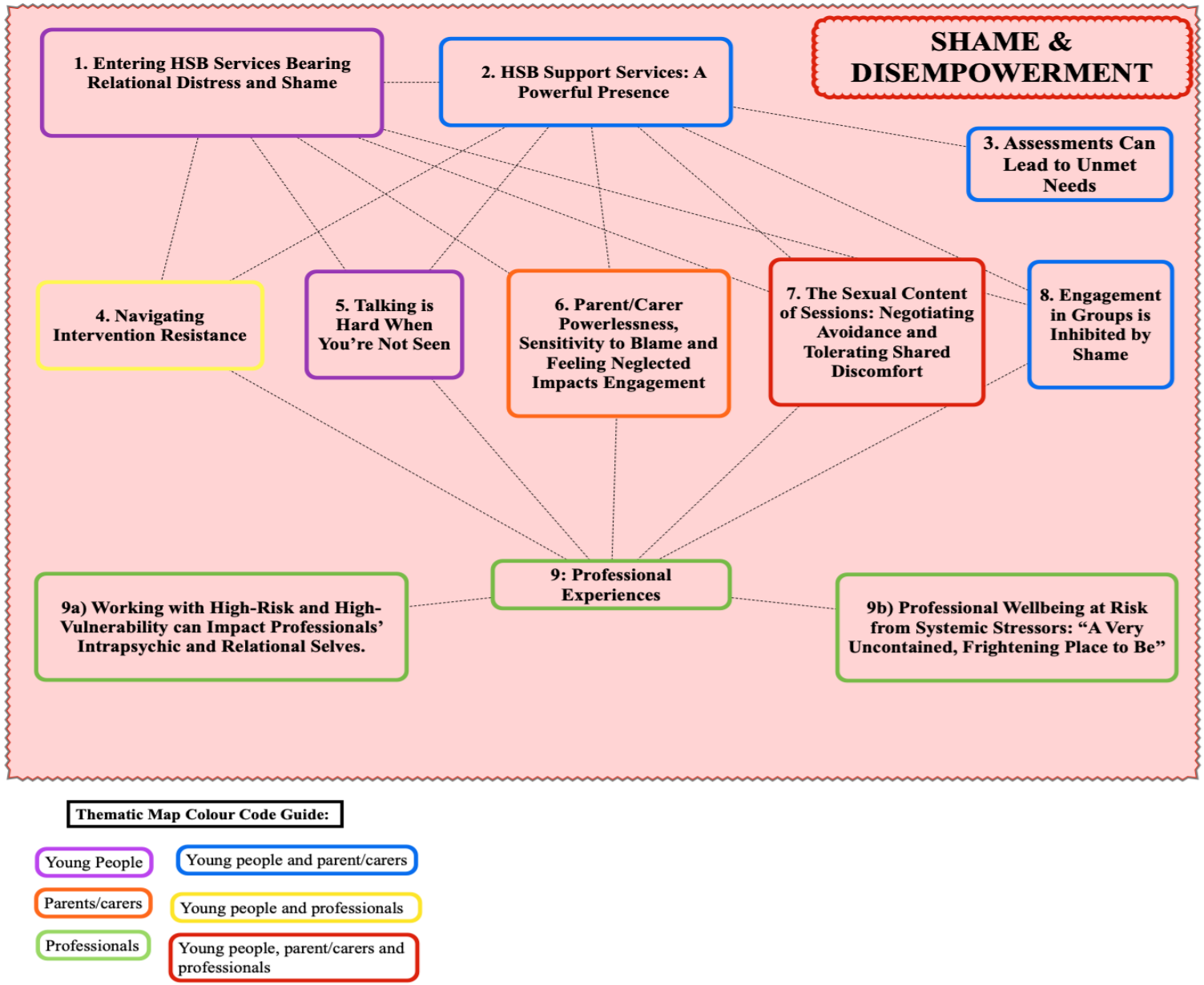
Research Aim 2: Findings

Firstly, a thematic map capturing the analytical themes developed to address research aim two is presented on the following page. The connecting lines between the themes on the map have been used to illustrate the relationships between the aspects of HSB provision that could be considered distressing. ‘Shame and disempowerment’ was

identified as an overarching theme that captured the shared experiences within the analytical themes identified to meet research aim two. This overarching theme will be addressed in further detail in the ‘Discussion section’. Each analytical theme is identified numerically on the map and will therefore be addressed sequentially in this chapter. Supporting data will be provided to illustrate the experiential aspects of the themes.

Figure 3

Research Aim 2: Thematic Map



Theme 1: Entering HSB Services Bearing Relational Distress and Shame

Whilst the psychosocial impact of HSB on young people and their parents/carers does not form the primary focus of this QES, due to the complexities in distinguishing the multiple layers of distress evident in the studies, data pertaining to the impact of HSB from the perspective of young people and their parents/carers was coded, analysed, and synthesised. It was deemed important to understand participants' sense-making of the impact of the HSB on both themselves and their familial relationships as the psychosocial impact could be considered to frame young people's experiences of HSB provision.

Due to the retrospective nature of the included studies, it cannot be definitively stated that some young people's reports of bearing relational distress as a result of the incidence(s) of HSB were not also framed by the awareness and insight potentially gained from engagement in HSB services. Furthermore, whilst young people in the studies have described the psychosocial impact of HSB on both themselves and their families, the potentially significant and wide-ranging impact of HSB on the victim and their family is fully recognised by the researcher. Fractured family relationships, a fragmented self-concept and experiences of isolation were identified as aspects of relational distress that were experienced by young people and parents/carers as they entered HSB services.

Young people described the fracturing impact of the HSB on their own familial relationships and the relationships between family members, which some described

as severed and irreparable (Barnardo's, 2017; Grady et al., 2018; Kraus, 2014; Martin, 2004; Northey, 1995). The impact of HSB on family members was described by one young person as being the most painful part of their experience, one young person believed that their foster parent had "a depression breakdown because of what I had done" (Barnardo's, 2017, p. 53; Grady et al., 2018; Northey, 1995). Attempts within the family to place blame on individuals for the HSB resulted in the disintegration of some family systems and some were isolated from their communities (Barnardo's, 2017; Northey, 1995). Young people described losing their parents'/carers' "trust" and believed that their parents now struggled with liking them due to their disappointment, which for some, led them to fear parental abandonment (Grady et al., 2018; Kraus, 2014).

The emotional impact of the HSB on the young person took the form of shame, guilt, sadness, anger, confusion, and fear (Barnardo's, 2017; Franey et al., 2004). These emotions appeared to be internalised by some young people and integrated into their sense of self (Barnardo's, 2017; Belton et al., 2014; Franey et al., 2004). Some young people questioned their character, "Am I a horrible person?" and believed that they were "bad" because of the HSB (Belton et al., 2014, p. 39; Franey et al., 2004, p. 309). Some experienced thoughts that their "life was over" and feared for their future, "Where am I going to go in life with all of these labels that are in my records?" (Barnardo's, 2017, p. 50; Franey et al., 2004, p. 309).

Some young people described experiencing shame which may have been further compounded by the secrecy required and isolation felt in response to the HSB being uncovered (Grady et al., 2018, p. 91). This may have may inhibited their ability to

build relationships and connect with others. Prior to engaging in a HSB intervention, young people described finding it difficult to think about the HSB due to "realising what a horrible thing it was" (Grady et al., 2018, p. 88). The shame of recognising the abhorrent nature of their HSB also impacted some young people's fear of societal judgement and some chose to "stay inside" as they "worried about being hurt" (Grady et al., 2018, p. 91). Overall, whilst the impact of the HSB on the victim is fully recognised by the researcher, there is evidence to suggest that some young people that have displayed HSB experience offence related distress, which may frame subsequent experiences of HSB provision. This distress may be related to the shame connected to the incidence(s) of HSB itself, and/or the psychosocial impact of the HSB through being identified, labelled, and fearing the myriad of statutory responses and consequences that can entail.

Theme 2: HSB Support Services: A Powerful Presence

The nature of HSB support services studied in the research comprises of young people and parent/carer experiences of the police, social care, and youth justice services prior to engaging with specialist HSB provision. Some young people and parents/carers described their experience of HSB support services as authoritative and powerful, which left some feeling devalued, unimportant, and disempowered (Archer, 2017; Barnardo's, 2017; Hackett & Masson, 2006). Young people and parent/carer interactions with the police and social care immediately following the identification of the HSB were described as "particularly distressing" and "demeaning", which instilled a sense of badness in one young person (Archer, 2017, p. 57; Barnardo's, 2017, p. 33). Practices experienced as distressing included experiences of the police making false promises, professionals threatening potential statutory punishment, and

disregarding a young person's intervention needs due to the high cost of specialist services (Barnardo's, 2017; Hackett & Masson, 2006).

The need for appropriate legal sanctions is not mitigated by a young person's experience of distress in response to statutory services. However, this evidence does indicate the complexity of the distress experienced by some young people upon engaging with statutory services. This distress may be related to the identification of HSB and fear of the potential consequences, and some may understandably engage with statutory services with a heightened vulnerability towards authority and potential sanction. This does not discount the role that statutory services can have in limiting the potential to cause further distress through their interactions. Experiences of professionals who do not actively inform, pursue, or promote appropriate HSB interventions could have a distressing impact for some in the context of the relational difficulties young people and parents/carers bring into services.

Theme 3: Assessments Can Lead to Unmet Needs

Two included studies explored young people and parent/carer experiences of HSB assessments (Griffin & Beech, 2004; Kjellgren, 2019). Some young people described their experience of assessments as limiting, noting that they were not afforded the opportunity to talk about their experiences, despite completing the assessment process (Kjellgren, 2019). This left one individual with unmet needs as an adult:

"Needed to talk with someone [...] it never happened, not that I remember anyway [...] I also think it sounds strange but that's the way it is [...] yes I still think so today. I would have liked to talk to someone about my problems" (Kjellgren, 2019, p. 125).

The above excerpt was offered retrospectively by a young person who engaged with a HSB assessment at 15 years old (average) but completed the research interview between 4-8 years after their service engagement (Kjellgren, 2019). Such experiences could be considered distressing, particularly in the context of data on experiences of HSB support services, which has indicated that young people perceived their own parents/carers as not understanding legal processes and parents/carers being uninformed about support options following the identification of HSB (Barnardo's, 2017; Hackett & Masson, 2006).

One study explored two parent/carer perspectives of HSB assessment. From a narrative perspective, one parent/carer shared their view that "there was not enough support for the professional to enable the worker [professional] to support me," which was believed to limit the ability of the professional to consider the family's wider support needs (Griffin & Beech, 2004). The data suggests that some services were cognizant of staff pressures and deficits within services. The young person building "a relationship and trust" with the assessing professional was also emphasised as important; the parent/carer inferred that this process had been impacted by the change in allocated professional following attendance at court (Griffin & Beech, 2004). Whilst from an organisational perspective, the continuity of professional relationships may not be feasible, the loss of such relationships may create a potential barrier for the young person and parent/carer's subsequent intervention engagement.

One parent/carer also described requiring greater gaps between planned sessions to support thinking and reflection on the previous session content (Griffin & Beech, 2004). Flexibility in the frequency and/or intensity of assessment sessions could be considered important for some to support safe and meaningful parent/carer engagement, particularly when challenging and sensitive content is discussed, such as experiences of adversity. This suggests that parent/carers of young people with HSB have a broad range of needs that may extend beyond the boundaries of the HSB assessment undertaken with their young person. This is further evidenced in parent/carer reports of HSB interventions.

Theme 4: Navigating Intervention Resistance

Seven studies revealed that some young people resisted intervention engagement, which appeared to be experienced as distressing for some young people and professionals (Crump, 2018; Glenny, 2019; Gorden et al., 2020; Martin, 2004; Myles-Wright & Nee, 2020b; Northey, 1995; Shevade et al., 2011). Some young people initially questioned their need to engage in interventions which led some to resist engagement, this appeared to be linked to feeling alone, fearful, confused and attacked during the early stages of an intervention (Martin, 2004; Northey, 1995). In describing their experience of the early stages of a custodial-based intervention, one young person shared:

"...that's when I didn't like to talk about nothing and I hated everything and I didn't care. So then I was like, I don't care, you all can send me wherever you want" (Northey, 1995, p. 250).

Some young people may have resisted engagement as they were psychologically unprepared to share their feelings and instead chose to "put on a front" to others to defend against vulnerability (Martin, 2004, n.p.). This behaviour could be understood as functioning as self-protective against the risk of rejection, which may be linked to prior adverse experiences of trauma and adversity (Martin, 2004; Northey, 1995). In specific contexts, such as residential and/custodial treatment, the early stages of an intervention appeared to be a time in which young people were particularly vulnerable to experiencing, enacting, and defending against distress. This could be understood in the context of young people feeling isolated from their family in an unfamiliar place, which may have been an attachment disruptor and stressor for some young people (Gorden et al., 2020).

Whilst such experiences can be conceived to be an understandable response to being placed in a residential or custodial setting, challenges adjusting to intervention engagement can also be understood in the context of young people's potential experiences of trauma and adversity both prior to and/or stemming from the incidence(s) of HSB. Feeling fearful, confused and under threat may impact some young people's ability to initially engage with interventions and lead to defensiveness or avoidance as part a threat response. Such responses are suggestive of a lack of safety experienced by young people when placed in an unfamiliar and restrictive

setting, this potentially indicates an intervention need for professionals to mitigate the impact of these responses.

Working with young people who resist intervention engagement was experienced as challenging and distressing for some professionals (Crump, 2018; Glenny, 2019; Myles-Wright & Nee, 2020b; Shevade et al., 2011). Some professionals experienced strong emotional reactions such as frustration and anger in response to young people who actively resisted intervention engagement through refusal and displays of negative behaviour (Crump, 2018; Glenny, 2019). One professional described the challenge of working with young people who may struggle to engage with an intervention:

"I think it's like a cycle that when we work with our clients you're supposed to meet the client where they're at, but that doesn't always work out and you see the kid move backwards and not forward, and this makes me angry" (Crump, 2018, p. 54).

Some professionals appeared to practice in a child-centred and trauma-informed manner, but still recognised the challenges of this when supporting a young person who may have experienced interpersonal distress (Shevade et al., 2011). Issues of power and control were described by professionals as particularly prevalent in the early stages of HSB interventions and had been understood to be linked to young people's previous experiences of interpersonal trauma (Shevade et al., 2011). Professionals recognised that young people may resist intervention engagement to defend against their own feelings of powerlessness within sessions:

"...their intention is to control you so that they are safe…Making me feel physically watched…I sometimes felt powerless and used" (Shevade et al., 2011, p. 59).

One young person also described their intervention within a custodial environment as a "power and control issue" (Martin, 2004, n.p.). Professionals described their understanding of this relational quagmire, whilst also recognising the notable impact that this had on them as individuals:

"*…he made me feel rubbish week in and week out for the first, I suppose, six months…I was still treated like an object 'till quite recently as I have said, but he very much pushed into me his feelings of powerlessness…"* (Shevade et al., 2011, p. 59).

This dynamic could be considered a potentially distressing aspect of interventions for both professionals, and potentially young people, who may be at risk of experiencing directed negative emotion from professionals as a defence against their own feelings of powerlessness if the professional is not supported to process such responses in supervision. As will be discussed later in the chapter, some professionals have expressed a marked dissatisfaction with the provision of supervision in some services (Almond, 2014; Ape-Esera, 2016; Myles-Wright & Nee, 2020b).

Theme 5: Talking is Hard When You're Not Seen

To further understand intervention resistance and engagement difficulties, some young people described the psychological challenge of talking about their HSB during

assessment and intervention sessions (Kraus, 2014; Martin, 2004; Northey, 1995). This can often be a lengthy process that requires sensitive therapeutic scaffolding and support, as one young person shared:

"At first just talking about sexual abuse…didn't make me feel good. When I first came to [program] I had to really get used it…It took like almost half a year to really adjust and to tell what you [youth] did…Like a lot of assignments…I would talk about how did I feel when I really actually [was] sexually abusing…it was tough. It was tough" (Kraus, 2014, p. 156).

The process of a young person feeling psychologically prepared to talk about their HSB indicates the potential role that shame can play an inhibitor to discussing and disclosing details related to HSB. This data excerpt indicates the importance of time as a factor that supports engagement. Young people who are not adequately supported to process the impact of shame may perpetuate denial as a self-protective defence, particularly during components of interventions that require a young person to admit to their HSB and discuss the details of the harmful behaviour:

"I had to deny it because it's hard to sit there and talk about your offense. I mean, you know, you just, you just want to go in a hole. Crawl in a hole and stay there - put a lid on yourself because it's hard to talk about something you did like that, especially if you love the person you did it [to] anyway. That's really hard to do" (Northey, 1995, p. 235).

The presence of shame within some young people's accounts presents a challenge for professionals who require a young person to engage in a highly sensitive psychological intervention. Denial can be used by young people as a defence against shame. Some young people describe coming to view themselves as a "bad person" as a result of the HSB, and therefore came to manage feelings of shame by defending against processing their experiences (Northey, 1995, p. 243). The environmental context, intervention delivery style and psychological process of the young person can all frame young people's intervention experiences and may lead some to resist engagement to increase their sense of control, agency, and safety (Martin, 2004; Northey, 1995). Although such experiences do not preclude the need for appropriate sanction and consequences of HSB, the potential for contexts such as residential and custodial settings to create additional distress for young people requires consideration for professionals who are planning and delivering HSB interventions.

Some young people's experiences of HSB interventions as distressing appeared to be compounded by experiences of the professionals who did not work in a child-centred way (Ape-Esera, 2016; Barnardo's, 2017; Kjellgren, 2019). Some young people described feeling unseen by staff and believed that staff had made assumptions about them based on professional documentation, without directly asking young people about their lived experiences (Barnardo's, 2017). One young person believed that a professional had assumed that they were able to manage difficult feelings, which led to them not receiving the support that was needed:

"For me what was not helpful was the recognition in general. I felt at times people didn't notice me and felt that because of my personality I was seen as someone who

could manage difficult feelings. That's the only thing I found unhelpful" (Barnardo's, 2017, p. 52).

Some young people experienced professionals as delivering interventions in a manner that was not attuned to their needs, which led them to disengage (Ape-Esera, 2016; Kjellgren, 2019). One young person described this experience:

"I started getting mixed up with their words cause I couldn't understand them properly. I just got angry and then just shut myself down. It was just sometimes too many words and too fast and I just get frustrated and I just think they're intimidating me" (Ape-Esera, 2016, p. 143).

These findings are problematic in the context of broader findings which suggest that some young people struggle to get their voice heard and needs met during service engagement, particularly in the context of experiencing services as powerful and hard to challenge (Barnardo's, 2017; Kjellgren, 2019; Martin, 2004; Northey, 1995). Working at the young person's pace and using child-centred language may be important to mitigate this impact. Feeling unheard and unimportant risks the perpetuation of shame and distress, particularly for young people that may have experienced prior adversity and/or trauma. This demonstrates the importance of professionals actively eliciting the voice of young people in identifying their intervention needs and seeking to integrate this into a collaborative intervention plan wherever possible. Professional adaptivity and responsivity to young people's needs is essential to developing trauma-informed practice.

Theme 6: Parent/Carer Powerlessness, Feeling Blamed, and Neglected Impacts Engagement

Four studies revealed that some parents/carers believed that they were blamed by professionals, which for some, led them to want to disengage from interventions (Boyers, 2020; Geary et al., 2011; Kraus, 2014; Warrilow, 2019). For some parents/carers, the sensitivity to feeling blamed was compounded by parents/carers experiencing anger directed towards them from professionals (Geary et al., 2011). Parents/carers also described feeling discouraged when professionals shared negative perceptions about them and their young person, which impacted their intervention engagement (Kraus, 2014, p. 119). Parents described being preoccupied with how professionals viewed them:

"I kept saying the wrong things, and they're thinking, 'oh, she's just still not getting this situation, how serious it is, how severe it is, what's happened, she's in denial'. I was worried that that's how they were perceiving me, it was really hard" (Boyers, 2020, p. 215).

For some parents/carers, sensitivity to feeling blamed by professionals was based on previous hostile interactions with services (Boyers, 2021). However other parents/carers felt shame about their young person's HSB, and spoke about needing support:

"As a parent you feel very ashamed and I would like to see some support given to parents" (Hackett & Masson, 2006, p. 191).

One parent/carer described how the use of language within HSB provision compounded feelings of shame:

"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" (Warrilow, 2019, p. 93).

Parent/carer sensitivity to shame or actual experiences of being blamed by professionals may contribute to heightened sensitivity to blame during interventions, particularly for those who have their own history of relational difficulties and/or adverse life experiences. Some parents/carers described feeling blameworthy and questioning themselves when engaged in the therapeutic process of interventions, such as family therapy (Kraus, 2014, p. 115). Whilst experiences of emotion and distress can be therapeutically beneficial to attend to and explore, such distress could risk the integrity of the intervention without appropriate therapeutic management.

Some parents/carers described feeling powerless in their ability to independently parent their child in the context of the perceived power held within statutory services (Archer, 2017; Boyers, 2020; Jones, 2015; Warrilow, 2019). Some experienced services as "overwhelming", which led some parents/carers to actively challenge the professional discourse that they believed framed them as failing to protect their child

without considering their parental strengths (Boyers, 2020; Warrilow, 2019, p. 94). However, others described instances where their voice was unheard, overlooked and dismissed during interventions, which led some to feel silenced by the system (Archer, 2017; Boyers, 2020; Jones, 2015; Warrilow, 2019).

These experiences interacted with some parent/carer feelings of mistrust towards professionals (Archer, 2017; Boyers, 2020; Warrilow, 2019). Some described being suspicious of professionals' intentions in the context of their ability to remove children from their care and felt uncomfortable when leaving their young person alone with professionals (Archer, 2017; Boyers, 2020; Warrilow, 2019). Parents/carers were cautious of the information that they chose to share with professionals as they worried about fair documentation, this led some to feel unsafe, unable and/or unwilling to share the content of their thoughts, feelings, and experiences with professionals (Archer, 2017; Boyers, 2020; Warrilow, 2019). Parent/carer mistrust and hypervigilance to professional threat can typify experiences of HSB provision as distressing if such concerns cannot be expressed and/or responded to by professionals in a reassuring and sensitive way.

In the context of this synthesis, it is challenging to discern the extent to which such parent/carer responses occur are as a result of intervention delivery, the impact of the incidence(s) of HSB or are driven by their own psychological needs related to past adversity. There is scope for experiences of potential parent/carer distress to be linked to one or many of the aforementioned factors. It is also of note that some HSB assessments and formulation may identify that the nature of the parent-child relationship has contributed to the incidence(s) of the young person's HSB, which

may therefore necessitate professional concern and monitoring of parents/carers. Hence, whilst professionals sharing sensitive and potentially emotive information with parents/carers may be unavoidable in the course of HSB provision, the development of a therapeutic relationship with the parent/carer may help manage the risk of triggering feelings of shame and blame that can compound professional mistrust (Geary et al., 2011; Kraus, 2014). The data is also suggestive of the need for attuned parental support as part of HSB interventions that is beyond the confines of individual sessions with the young person.

Alongside navigating feelings of powerlessness, blame and mistrust, some parents/carers felt pressured by HSB services to adhere to the significant demands placed on them, which was overwhelming and exhausting for some (Archer, 2017; Boyers, 2020; Jones, 2015). One parent stated:

“We're spinning so many plates at the moment, if you come in with your service and you want meetings um, he said actually it's gonna blow. You can't actually keep spinning that many plates. So we're now finding ourselves refusing services" (Archer, 2017, p. 58).

Some parents/carers described feeling uncared for as individuals whose also require space, time, and support to manage their own wellbeing needs (Archer, 2017). The requirement for parents/carers to manage supervision arrangements and potential safeguarding risks was described as placing a significant strain on parental wellbeing (Archer, 2017; Boyers, 2020; Jones, 2015). One parent described this experience:

"Totally consuming…at times you feel really helpless, you don't know what to do…It is extremely stressful on a family and our relationship. My husband and I haven't had any time alone in a year and a half ...but our lives are completely changed forever and they will never be the same" (Jones, 2015, p. 1312).

Parents/carers described services as failing to coordinate their input in a sensible and considered way, which compounded feelings of overwhelm and powerlessness; services were described as "rigid and inflexible" by one parent/carer (Archer, 2017, p. 236; Boyers, 2020; Jones, 2015). One parent/carer experienced services as failing to recognise their need for individualised support:

"Multiple times where no one actually sat up and went, 'wow, this family needs way more than what's happening" (Boyers, 2020, p. 196).

Some explicitly expressed a need for individualised support as part of service provision to support them to navigate the demands of multiple services, which was experienced as distressing for some (Archer, 2017; Boyers, 2020; Jones, 2015).

Alongside parents/carers mistrusting professionals, some described being uninformed and excluded from HSB provision (Ape-Esera, 2016; Belton, 2017; Belton et al., 2014; Derezotes, 2000; Hackett & Masson, 2006; Warrilow, 2019). This was distressing for some who described feeling worry, uncertainty, and frustration about not being fully informed of the young person's service involvement (Ape-Esera, 2016;

Belton, 2017; Belton et al., 2014; Derezotes, 2000; Warrilow, 2019). One parent/carer described their experience of professionals failing to consider their needs in the process of delivering a HSB service:

"...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" (Warrilow, 2019, p. 94).

Experiences of being uninformed left some parents/carers feeling "helpless" in their ability to support their young person as they were unaware of the nature of service involvement (Belton, 2017, p. 42; Belton et al., 2014, p. 34). Whilst it is the prerogative of young people to keep session content confidential, some parent/carer feelings of helplessness and uncertainty were further compounded by their child not sharing aspects of HSB intervention session with them (Ape-Esera, 2016; Belton, 2017; Belton et al., 2014; Derezotes, 2000). One parent/carer suggested the need for separate sessions with the parent/carer to support their understanding of the content (Hackett & Masson, 2006).

Parents/carers who were involved in HSB provision also provided examples of professionals demonstrating unprofessional behaviour during intervention sessions, such as frequently cancelling or failing to attend sessions without notifying

parents/carers, which impacted the intervention process (Ape-Esera, 2016; Geary et al., 2011; Kraus, 2014). The optics of such behaviour suggests professional insensitivity to the needs of parents who are attempting to engage in work that is emotionally challenging. Whilst this may be experienced by some parents/carers as merely inappropriate or frustrating, for others, such disruptions may directly impact on their ability to form a therapeutic relationship with a professional (Ape-Esera, 2016; Geary et al., 2011; Kraus, 2014). This may be a particular risk for parents/carers who have experienced interpersonal difficulties and/or had their own adverse life experiences.

These findings are problematic in the context of data which suggests that some young people value the engagement of their parents/carers in interventions. One young person described the impact of a parent/carer who chose not to engage in HSB interventions as maintaining a negative perspective on their character, "…[my] family still thinks of me like an unstable person…" (Franey et al., 2004, p. 303). For young people whose parents/carers did not take part in their intervention, they believed that the HSB had an enduring detrimental impact on their parents/carers, which limited their willingness to engage in the intervention and support them:

"him [father] coming to anything was practically a miracle… they were very numb" (Franey et al., 2004, p. 303).

Whilst the parent/carer of this young person may have made an independent choice to not actively engage in their treatment, the risk of professionals not actively

encouraging parent/carer involvement or offering joint sessions could further entrench the impact of the HSB for both the young person and their parent/carer.

Importantly, the analysis of secondary data limits the opportunity to form insights into the nature of parent-child relationships involved in the research, which may offer context to understanding why some young people choose not to discuss session content with their parents/carers. It is also acknowledged that parent/carer involvement in interventions may not be suitable for all young people due to difficulties within the parent/carer-child relationship, which could be experienced as unsafe. However, from a broader perspective, services can reduce parent/carer feelings of uncertainty and helplessness by encouraging and engaging parents/carers in the service management of the young person where appropriate.

Theme 7: The Sexual Content of Sessions: Negotiating Avoidance and Tolerating Shared Discomfort

Data from six studies suggested a shared discomfort with the discussion of sexual content within HSB sessions amongst young people, parents/carers, and professionals (Almond, 2014; Archer, 2017; Chassman et al., 2010; Jones, 2015; Shevade et al., 2011). Some parents/carers described discussing the content of their child's HSB as distressing and they described leaving sessions feeling "heavy (…) Cos' it's all based around sexual abuse you know" (Archer, 2017, p. 59; Jones, 2015). Parent/carers described the conflict of wanting to be involved in their child's intervention despite this requiring them to talk about sex with their child when they do not want to, particularly in their homes (Archer, 2017; Jones, 2015). Some described a process

akin to forcing themselves to look over their child's intervention homework:

"I hate to have to look over his homework. I just don't want to look at it, but I will make myself because it's what you have to do" (Jones, 2015, p. 1310).

These findings suggest the importance of professionals acknowledging and responding to the potential for parents/carer to experience discomfort when engaging in the sexual aspects of intervention work. The potential impact of parent/carer experiences of their own adverse life experiences on responses to the intervention work must also be acknowledged. These findings suggest the need for further professional scaffolding and support for parents.

One young person also indicated that they were "relieved" that they did not have to discuss details of the HSB in intervention sessions (Kjellgren, 2019, p. 123). However, the individual retrospectively viewed this omission from the intervention with scepticism as an adult:

"She [the therapist] didn't help me with the sexual things; she just helped me with the physical assault. We didn't even bring it up. Really weird, right? [...] In fact, I was kind of relieved [laughing] [...] but now as an adult [...] I have my own thoughts" (Kjellgren, 2019, p. 123).

Whilst the young person may have struggled to discuss HSB in the intervention at the time, interventions that fail to meet the long-term needs of young people through not

directly addressing the HSB may retrospectively be experienced as distressing, as the thoughts, feelings and circumstances associated with the HSB risk remaining unexplored and unprocessed. Another young person echoed this sentiment:

"actually [...] I would have liked to talk to someone about my problems" (Kjellgren, 2019, p. 123).

Whilst the potential shame experienced by the young person may have inhibited a willingness to discuss the HSB, young people may have also felt disempowered and unable to express their needs and direct the content of intervention sessions, which may have left them feeling silenced and unsupported. These findings are problematic in the context of data which suggests that young people experience a cathartic impact from therapeutically talking about their HSB, which encourages positive personal development and growth (Grady et al., 2018; Kjellgren, 2019; Lawson, 2003).

Whilst a direct connection cannot be drawn between the above young people's experiences in intervention sessions, and the experiences of the professionals within intervention sessions, three studies revealed that some professionals also experienced discomfort related to the sexual content of HSB sessions (Almond, 2014; Chassman et al., 2010; Shevade et al., 2011). Professionals described having a range of responses to experiencing sexual feelings and thoughts in response to the sexual content of sessions such as discomfort, confusion, guilt, and disgust (Almond, 2014; Chassman et al., 2010; Shevade et al., 2011). Some believed that these feelings were normative responses to the sexual content discussed in sessions, however, others pathologised colleagues who had a sexual response to the work (Chassman et al., 2010; Shevade et

al., 2011). Professionals who had been victims of abuse experienced diverse responses to discussing HSB in sessions, some experienced a visceral impact both during and outside of sessions, whilst others found it beneficial to support their own recovery (Chassman et al., 2010; Shevade et al., 2011). As noted, whilst a direct connection cannot be drawn to the young person's experience of a HSB session, professional responses to discussing sexual content in sessions, alongside the use of strategies such as avoidance and denial, may detrimentally impact the young person's experience of an intervention.

Theme 8: Engagement in Groups is Inhibited by Shame

Seven studies revealed that group programmes were experienced as distressing by some young people and parent/carers (Ape-Esera, 2016; Derezotes, 2000; Geary et al., 2011; Gxubane, 2019; Martin, 2004; Northey, 1995; Pierce, 2011). Some young people found it difficult to talk about their experiences in front of others in groups due to discomfort, shame, fear, and anxiety (Ape-Esera, 2016; Derezotes, 2000; Geary et al., 2011; Gxubane, 2019; Northey, 1995). The expectation to discuss the details of the HSB in front of group members contributed to one young person fearing that they would be laughed at:

"Some other issues are too sensitive to be spoken in groups. Kind of embarrassing to disclose the details about your rape … because others will laugh at you" (Gxubane, 2019, p. 9).

Some did not like sharing personal information with peers in groups without having the time to build relationships and feel safe with others; the negative behaviour of some members also impacted young people's engagement, which was a concern echoed by parents/carers (Ape-Esera, 2016; Geary et al., 2011; Northey, 1995). The requirement for young people to listen to the difficult life experiences and offence details of other group members was also challenging for some, and was similarly a concern felt by parents/carers (Geary et al., 2011; Northey, 1995). These findings are important to consider in the context of some young people's reports of being "confronted" by professionals and told "you need to talk about your problem" in a group setting, which led one young person to "act-out" and leave the group (Martin, 2004, n.p.). Such experiences could be experienced as particularly distressing for young people whom have experienced adversity, trauma, and interpersonal difficulties either prior to or as a result of the HSB. The expectation placed on young people to process their HSB and difficult life events in a context that could be experienced as threatening may not offer the containment and safety that could be conducive to therapeutic intervention work.

Similarly, some parents/carers also found it challenging to both discuss their young person's HSB in front of other group members and listen to the stories of other parents/carers (Duane et al., 2002; Geary et al., 2011; Pierce, 2011). Some described group programmes as "intrusive" and "stressful" due to the perceived expectation to share information with others (Duane et al., 2002, p. 51). As also experienced by some young people, the group engagement of some parents/carers was inhibited by feelings of shame and the belief that they would be judged by others:

"I would sit in parents' group and not say a word. Not a word…It's still something you just don't want to talk about because you're faced with it so much. I think the shamefulness kicks in. Mine did" (Pierce, 2011, p. 178)

The impact of shame on both parents/carers and young people in group interventions suggests that groups have the potential to have a distressing impact when delivered as an isolated intervention strategy. Some young people contrasted their negative experiences of groups with the more positive experiences of individual interventions, in which they felt more able to therapeutically discuss their personal histories and HSB (Ape-Esera, 2016; Gxubane, 2019). In the context of groups, the shame felt by young people and parents/carers may have functioned as a protective strategy against the feared judgement of others. Hence, groups could exacerbate the potential distress associated with the psychosocial impact of the HSB and/or adverse life experiences on young people and parents/carers. This indicates the potential need to provide individual interventions alongside a group intervention (Ape-Esera, 2016; Gxubane, 2019).

Theme 9: Professional Experiences

Theme 9a: Working with High-Risk and High-Vulnerability Young People Can Impact Professionals' Intrapsychic and Relational Selves

Eight studies revealed that some professionals experienced strong emotional responses to the work, which led to feelings of powerlessness, self-doubt, and perceptions of failure (Almond, 2014; Ape-Esera, 2016; Chassman et al., 2010; Crump, 2018; Fuller, 2021; Myles-Wright & Nee, 2020b; Shevade et al., 2011). Two studies found that some professionals experienced the delivery of interventions as

distressing due to feeling and/or perceiving threat from young people in sessions (Glenny, 2019; Shevade et al., 2011). One professional described the fear experienced during sessions in response to the risk of sustaining harm:

"Young people that have come in and been really aggressive or really sexualised, that's worrying. You don't want to put yourself in a scenario where you're open to being assaulted...so I'm gonna keep them a little bit over there [signals arms reach away]" (Glenny, 2019, p. 220).

One professional also experienced physical responses during sessions which can be likened to a visceral response to a traumatic event:

"(sighs) it was hard being able to continue to think…So actually just managing to contain him in the room and think about what was going on and just manage, just being with him was, was really – that was the challenge…it was a challenge to keep thinking" (Shevade et al., 2011, p. 59).

The data excerpt above epitomises the challenge for professionals to manage their visceral responses during sessions to support safe intervention delivery and limit the risk of the young person becoming aware of professional distress. This dynamic has the potential to become problematic to the integrity of the intervention if professionals are not equipped to manage such strong responses. Visceral responses were also accompanied for some by thoughts of failure, self-doubt, and frustration, particularly when young people continued to display HSB during the course of an intervention

(Crump, 2018; Fuller, 2021; Glenny, 2019; Myles-Wright & Nee, 2020b; Shevade et al., 2011). In these instances, professionals felt shocked, self-critical, and cast doubt on whether their expertise was sufficient to work with young people due to the ongoing HSB (Crump, 2018; Fuller, 2021; Myles-Wright & Nee, 2020b, p. 2064; Shevade et al., 2011).

Professional self-doubt was a common theme across the data and appeared to be compounded by some professionals' perception of societal responsibility to manage young people's risk (Crump, 2018; Fuller, 2021; Myles-Wright & Nee, 2020b). For some, professional self-doubt was further experienced in response to the extent of the young person's adverse life experiences and their ongoing exposure to traumatic situations (Russell & Harvey, 2016; Shevade et al., 2011). Data in three studies suggested that professional inexperience was linked to feeling unequipped to undertake the role, and it was noted that professionals who were less experienced encountered greater challenges in the work (Almond, 2014; Glenny, 2019; Myles-Wright & Nee, 2020a).

The impact of these emotional and cognitive responses led some to feel emotionally overwhelmed and struggle to "switch off" (Chassman et al., 2010; Russell & Harvey, 2016; Shevade et al., 2011, p. 8). Some professionals experienced changes in their personal relationships as they expressed their feelings of sadness, anger, and frustration towards family members, although this was not a consistently shared experience across the data (Almond, 2014; Chassman et al., 2010; Crump, 2018). Some professionals also became more suspicious, "paranoid" and hypervigilant of others' intentions and worried that family members may become victims of HSB

(Crump, 2018, p. 54; Shevade et al., 2011). However, some professionals also pathologised colleagues for whom the work had an emotional impact:

"You know, I would definitely think that, again, my [pause], my personal opinion would be that maybe that's not the work you need to be in if that continued" (Chassman et al., 2010, p. 272).

Such positioning may have led some professionals to feel isolated in managing the emotional and relational impact of the work. An awareness of societal judgement towards individuals who engage in HSB also led some to avoid sharing their challenging experiences of the work with others (Almond, 2014; Shevade et al., 2011). Experiences suggestive of isolation and an awareness of societal judgement could be considered distressing in the context of some professionals' experiences of feeling out in their "depth" when in the role due to the complexity of working with high-risk and high-vulnerability young people (Crump, 2018; Fuller, 2021; Myles-Wright & Nee, 2020b, pp. 2063-2064).

Some professionals described the discomfort of being placed in an expert position to manage young people's risk whilst simultaneously feeling deskilled as practitioners, which for one professional established "really difficult dynamics" in interventions; professionals engaged in hypervigilance and self-monitored the quality of the interventions delivered to manage their own fear, anxiety, and self-doubt (Crump, 2018; Myles-Wright & Nee, 2020b; Shevade et al., 2011, p. 61). This led some to absolve the responsibility of the young person to self-manage their own risk as they disproportionately absorbed this responsibility themselves (Myles-Wright & Nee,

2020b). This absorption of responsibility appeared to be driven by the responsibility felt towards the young person and the wider public to prevent further victimisation, where the risk of not doing so was internalised as a reflection on their own competence (Crump, 2018; Fuller, 2021; Myles-Wright & Nee, 2020b).

Professional supervision was deemed essential for some to be able to process the emotional responses and challenges involved in the work (Almond, 2014; Chassman et al., 2010). Whilst some professionals may have been consciously able to recognise, share and process the potentially distressing nature of the work, others may turn to denying the impact as a self-protective strategy to resist feelings of shame associated with personal responses. In the absence of supervision and opportunities for reflective discussions, the potentially distressing impact of the work may remain unprocessed and/or denied by some professionals, this may risk perpetuating the potentially distressing experiences of the work for both professionals, young people, and parents/carers.

Theme 9b: Systemic Stressors: Professional Wellbeing at Risk from Organisational Pressures: "A Very Uncontained, Frightening Place to Be''

This synthesis highlighted the considerable impact of organisational factors on professional experience of work (Almond, 2014; Ape-Esera, 2016; Myles-Wright & Nee, 2020b, p. 2062). For some professionals, organisational cultures and workload pressures were experienced as more emotionally challenging than the direct work undertaken with young people (Almond, 2014). Some professionals described the

personal impact of feeling overworked in the context of target-focused cultures and understaffed services (Almond, 2014; Ape-Esera, 2016). This led some to experience "guilt" in relation to organisational issues that directly impacted their ability to work in a child-centred way (Almond, 2014, p. 340). For some, such "unease" was further compounded by being excluded from decision-making processes, which led some to feel powerless within complex organisational systems (Almond, 2014; Ape-Esera, 2016; Myles-Wright & Nee, 2020b, p. 2062). Exclusionary decision-making process, understaffing and target-focused cultures appeared to be challenging and potentially distressing aspects of the work for professionals who were committed to child-centred practice. Professionals described the personal and professional impact of such organisational issues and inferred assuming responsibility for the individuals that they worked with due to the perceived organisational failings (Almond, 2014). The impact of carrying responsibility for organisational problems whilst also managing high levels of risk alongside experiencing an emotional impact from the work appeared to be distressing for some professionals (Almond, 2014; Ape-Esera, 2016; Myles-Wright & Nee, 2020b).

These findings are problematic in the context of data that revealed a general dissatisfaction amongst professionals towards organisational support and supervision arrangements (Almond, 2014; Ape-Esera, 2016; Myles-Wright & Nee, 2020b). Some professionals discussed concerns regarding confidentiality and safety in discussing their emotional wellbeing during line management supervision; some feared that they would be perceived as not managing their work, and therefore worried about the potential negative impact on their salary and progression (Almond, 2014). For some, supervision was dictated by the managerial monitoring of targets, which led some

professionals to feel unsafe and be unwilling to share strong emotions during supervision (Almond, 2014; Myles-Wright & Nee, 2020b). One professional described this experience:

"...the organisation is becoming more target this, target that; supervision is 'have you done this, have you done that in these timescales'...I don't think I would feel confident to sit down with my manager...and just cry...if you don't feel supported and contained that's what makes it so incredibly scary..." (Almond, 2014, p. 344).

The absence of clear supervision structures within services could potentially compound the distress associated with the strong emotional responses that some professionals may experience in response to both young people and organisational stressors. Due to this, some professionals described feeling isolated at work, which was described as "a very uncontained, frightening place to be'' (Almond, 2014, p. 343). Professionals perceived the recruitment of line managers who were inexperienced in HSB work as being indicative of organisations that devalue and underappreciate the importance of HSB provision:

"I don't feel that they (senior management) ...respect or really care about me...I'm just... a little cog in a wheel (and) if I disappeared tomorrow they wouldn't be that interested" (Almond, 2014, p. 342).

Feeling devalued was cited by some as one of the most prominent stressors of the work (Almond, 2014; Ape-Esera, 2016). Māori professionals undertaking a specialist

culturally-informed intervention described feeling particularly undervalued in relation to the uniqueness of their cultural knowledge and skill (Ape-Esera, 2016). Linked to feeling devalued, some professionals felt mistrust towards managers who they believed did not understand their needs and made assumptions that staff would respond to challenging nature of HSB work in the same way within the organisation (Almond, 2014; Myles-Wright & Nee, 2020b). Such experiences could be considered distressing as professionals described feeling unimportant, unsupported, and uncared for in relation to the impact of the HSB on their personal and professional selves (Almond, 2014; Ape-Esera, 2016; Myles-Wright & Nee, 2020b). When these findings are considered alongside findings on the emotional responses to the work, it can be suggested that professionals working within HSB services have broad relational support needs.

Research Aim 3: Findings

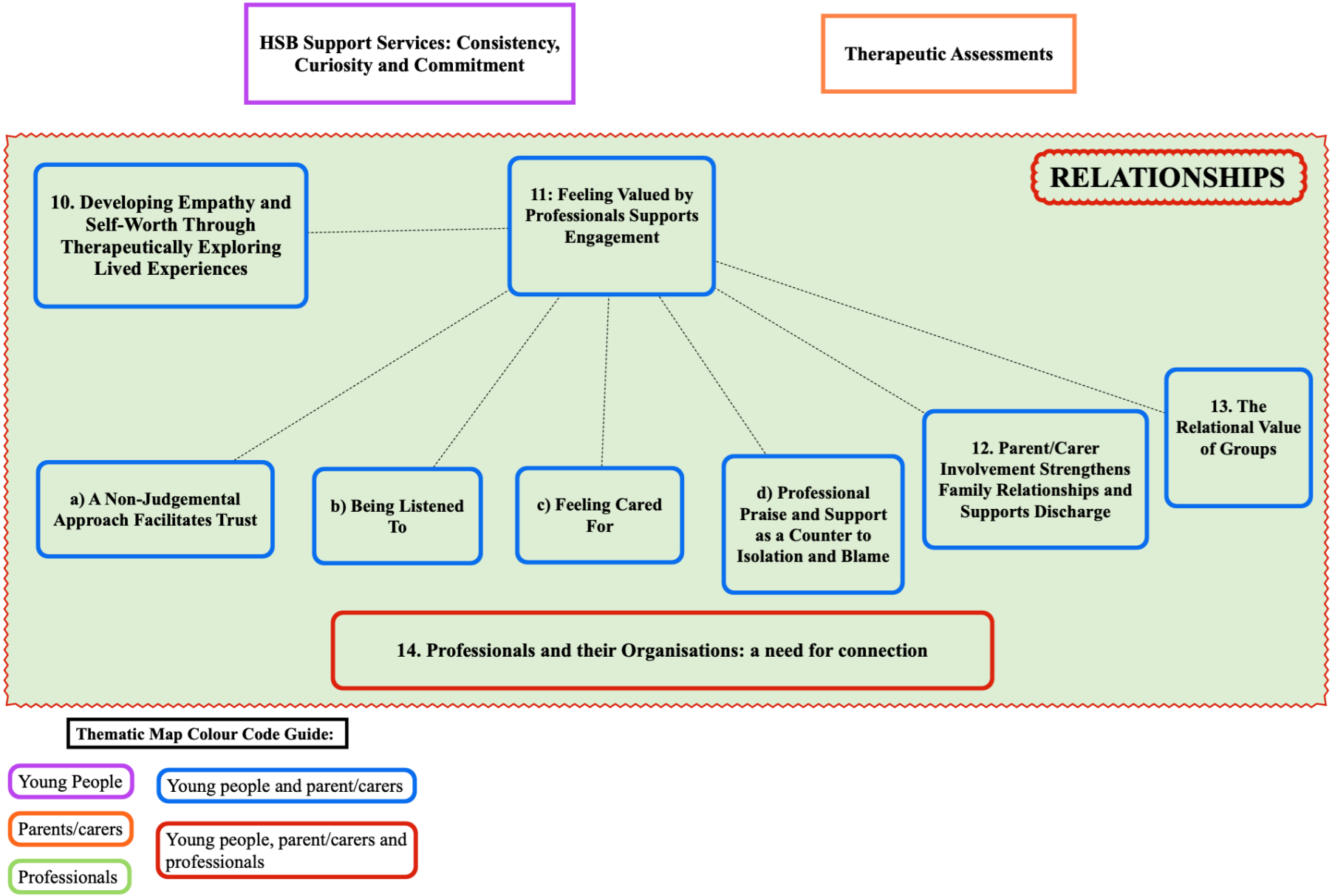
The analytical themes identified from the included studies to address research aim three are visually presented in the below thematic map. Participant data will be provided in the account of findings to illustrate participant experiences.

Research Aim 3: Thematic Map

The thematic map that captures the analytical themes developed to address research aim three is presented below. The connecting lines between the themes on the map are used to illustrate the interrelated aspects of HSB provision that could be considered trauma-informed. The overarching theme 'Relationships' was identified as a shared experience across the analytical themes identified to meet research aim three. This overarching theme will be addressed in further detail in the 'Discussion' chapter. Two findings presented in this section titled 'Relationships with Professionals in HSB Support Services' and 'Therapeutic Assessments' do not form analytical themes as data from only one study was identified to contribute to each finding, hence a synthesis of data was not possible. Instead, a narrative summary has been provided of the relevant data in each study. These findings are placed on the thematic map to support the reader's sense-making of participant experiences but sit external to the overarching 'Relationships' theme that captures the analytical themes. Again, each analytical theme is identified numerically on the map and will be addressed sequentially in this section.

Figure 4

Research Aim 3: Thematic Map



HSB Support Services: Consistency, Curiosity and Commitment

As stated, only one study in this synthesis contained data that related to young people's experiences of HSB support services and could be considered trauma-informed; a synthesis of data was therefore not possible (Barnardo's, 2017). From a narrative perspective, the relationship developed with professionals in support services appeared to be a key aspect of the young person's input. Specifically, social workers and youth justice workers who maintained contact with young people throughout their treatment and discharge, displayed curiosity through asking about their life experiences, and elicited their views on how to manage the impact and consequences of their offence/HSB, appeared indicative of trauma-informed working (Barnardo's, 2017). Young people described these professionals as straightforward, upfront, and non-judgemental (Barnardo's, 2017). Relationships developed with professionals in statutory services that are consistent and person-centred could be considered influential in framing some young people's early experiences of HSB provision.

Therapeutic Assessments

A data synthesis of experiences of HSB assessments was also not possible as only one paper explicitly discussed HSB assessment from a perspective that could be considered trauma-informed. In this study, the relationships developed between parents/carers and professionals during the assessment process appeared to be reassuring for some, and was described by one parent as making "all the difference…" (Griffin & Beech, 2004, p. 65). Some parents/carers described feeling "less isolated" during the assessment process and valued professional support, which was described

as crucial to them managing the emotional impact of the HSB:

"At first I was a wreck, if it wasn't for the worker I think I would have had a breakdown" (Griffin & Beech, 2004, p. 64).

The relational value of assessments also supported some young people to express their thoughts and feelings during sessions:

"...because I can get it [thoughts and feelings] off my chest and don't have to bottle it all up" (Griffin & Beech, 2004, p. 64).

The connection made by young people between emotional expression and being able to tolerate thinking about their own behaviour indicates a trauma-informed approach to assessment wherein young people felt supported to think, reflect and express challenging thoughts and feelings. This evidence is suggestive of the opportunity presented through HSB assessments for parents/carers and young people to develop a therapeutic relationship with the professional undertaking the assessment. This can support the young person to feel supported and listened to, which could be understood as sensitive to the potential interpersonal adversities experienced by young people and parents/carers. This may have a positive impact on subsequent intervention engagement.

Theme 10: Developing Empathy and Self-worth Through Therapeutically Exploring Lived Experiences

Some young people engaged in an exploration of their past experiences during interventions in ways that could be considered indicative of trauma-sensitive and informed practice (Barnardo's, 2017; Belton et al., 2014; Franey et al., 2005). Through feeling supported by professionals, some young people described making links between past life events, relationships and their HSB:

"I have been able to come to terms with it all, but that was only due to having an environment that was open and supportive enough to deal with it" (Barnardo's, 2017, p. 58).

Young people described how gaining an understanding of their family history supported their own socio-emotional development:

"I learnt quite a lot about my family history and stuff that had happened to us that I just couldn't remember and all that, which was actually very helpful but also, I…just learnt a bit of self-worth… and control and stuff" (Belton et al., 2014, p. 40).

Young people also developed empathy for their own experiences through connecting past experiences of abuse with their subsequent engagement in HSB:

"Somebody was hurting you, and you didn't know what to do with all that anger and hurt ...I had to get out somehow, but I hurt someone else" (Franey et al., 2004, p. 304).

One young person valued interventions in which they were supported to process the breadth of their lived experiences from both early childhood and more recent experiences:

"My therapist and keyworker have been fantastic with me and supported me a lot throughout my placement – with self- harm, my mum, and other struggles that have come up like nightmares about my dad and my sexual abuse, and the day I got stabbed in a prison kitchen during work-experience" (Barnardo's, 2017, p. 31).

The opportunity for this young person to explore a range of life experiences that could be considered distressing demonstrates the value of conceptualising the intervention needs of young people from a holistic perspective, which is sensitive to the potentially cumulative nature of trauma and adversity for young people. Young people described the benefit of professionals "speaking clearly and explaining things" during interventions, whilst another professional used a young person's interest in cars as an analogy to illustrate feelings and behaviours associated with anger (Barnardo's, 2017, p. 51; Geary et al., 2011). Experiences of strong emotion and distress can be an important component of therapeutic work. However, young people also placed importance on a flexible, child-friendly, person-centred, and empathic approach to holistically exploring difficult past experiences.

Some young people and parents/carers described the importance of professionals being attuned to their emotional experiences, holding hope, and recognising change

as valued aspects of their intervention experience (Barnardo's, 2017; Kraus, 2014). This was identified by one young person as supporting them to feel able to show their feelings:

"For me showing my feelings was difficult, my therapist says that I can mask my feelings really well when it comes to difficult situations. But for me when someone who knows you well it's good that they can recognise when you move to that position and that recognition is massive" (Barnardo's, 2017, p. 52).

Parents/carers also identified professional attunement as supporting them to express the shame they felt about their young person's HSB and share emotions such as anger, sadness, and disappointment during family therapy sessions (Kraus, 2014). Professional displays of hope for the family's future were identified as important to embed into session endings, which supported the family to leave sessions with a greater sense of clarity and reassurance (Kraus, 2014). This appeared to function as an emotional container for some at the end of intervention sessions. These findings can be considered indicative of trauma-informed and sensitive practice as families were supported to process strong emotions within the boundaried therapeutic frame of sessions. This appeared to limit the risk of pervasive distress between sessions for some.

Theme 11: Feeling Valued by Professionals Supports Engagement

Young people and parents/carers valued professionals who were patient, respectful, humble, honest, and direct in their approach (Ape-Esera, 2016; Barnardo's, 2017;

Geary et al., 2011; Gxubane, 2019). Some young people specifically cited these characteristics as supporting them to tolerate the challenging questions asked by some professionals (Barnardo's, 2017; Geary et al., 2011). Staff that were "friendly" and used appropriate humour during interventions were also identified as characteristics that put young people and parents/carer at ease and supported their engagement (Ape-Esera, 2016; Geary et al., 2011; Grady et al., 2018; Gxubane, 2019, p. 11; Hackett & Masson, 2006). Three professional characteristics were identified by some young people and parents/carers as particularly important to support safe engagement with HSB provision: a non-judgemental approach, being listened to, feeling cared for, and professional praise and support as a counter to isolation and blame. These four characteristics are discussed in further detail below.

11a) A Non-judgemental Approach Facilitates Trust

Six studies revealed that some parents/carers and young people valued professionals that were non-judgemental, some described this characteristic as the most significant aspect of their intervention experience (Ape-Esera, 2016; Barnardo's, 2017; Geary et al., 2011; Grady et al., 2018; Kraus, 2014; Romano & Gervais, 2018). Experiences of a non-judgemental approach had three key effects: feeling able to trust professionals, feeling protected against the risk of rejection, countering experiences of blame and supporting emotional processing.

A non-judgemental approach led some young people to feel less "fear" and uncertainty about potential professional responses to their behaviour and experiences, which increased their ability to trust professionals (Ape-Esera, 2016; Barnardo's, 2017; Franey et al., 2004; Geary et al., 2011; Grady et al., 2018, p. 90; Kraus, 2014).

This encouraged some young people to be more honest with professionals who they experienced as being consistent and tolerating all aspects of their behaviour without the risk of rejection (Franey et al., 2004; Grady et al., 2018; Kraus, 2014). One young person described this experience:

"Even if I do wrong and then I tell them about it. Instead of you're getting a consequence right now by being out of this program in two days. It's more of thank you [youth] for at least letting us [therapists] know…And it's usually no consequence…I won't be judged as long as I come out and be honest…he [therapist] told me that no matter what I won't be judged" (Kraus, 2014, p. 133).

The reduced risk of judgement appeared to foster relational security for some young people as the safe predictability of relationships with professionals encouraged them to fully express themselves during sessions. Some young people experienced this as leading them to feel supported by professionals (Gorden et al., 2020; Kraus, 2014; Lambie & Price, 2015). One young person described such an experience:

"Out of all the incidents that I've had they don't hold a grudge. I could have an incident one day and then we would be fine the next day…there was no grudge matches and I think that for that it also taught the kids like these people do care and it sort of showed us that we don't really want to be rebelling" (Gorden et al., 2020, p. 157).

Whilst these findings do not preclude the importance of boundaries and accountability within professional relationships in HSB services, a non-judgemental approach and feeling cared for by professionals supported some young people to recognise the reciprocal nature of the relationships as safe and dependable (Gorden et al., 2020). For some, this inhibited the pull to resist engaging in interventions and may have contributed towards the formation of a new relational template (Gorden et al., 2020, p. 157) The experience of unconditional and consistent support from professionals supported some young people being able to trust professionals during HSB interventions, which was identified as a key concern amongst a range of young people in the studies (Barnardo's, 2017; Belton, 2017; Belton et al., 2014; Geary et al., 2011; Gorden et al., 2020; Grady et al., 2018; Gxubane, 2019; Martin, 2004; Somervell & Lambie, 2009). The experience of trust within the professional-young person relationship was also acknowledged as important by professionals, particularly for young people who may have experienced adverse life events and interpersonal trauma, and therefore may be sensitive to feelings of "powerlessness" and being unsafe in relationships with others (Shevade et al., 2011, p. 59).

Parents also felt more able to trust professionals because of not feeling judged, which encouraged intervention engagement (Ape-Esera, 2016; Kraus, 2014). This was particularly important for one Māori whānau (parent/carer) who experienced a professional as non-judgemental due to having a shared cultural identity:

"It's the way they spoke to me and the way they greeted us. They are not judgemental, we opened up to them and they made us trust them, they blend in with us" (Ape-Esera, 2016, p. 140).

Countering anticipatory fear of rejection through a non-judgemental approach could be considered indicative of trauma-informed practice as the approach may potentially have mitigate some previous parents/carers experiences of statutory services where some felt judged and disregarded. Professionals who adopted a non-judgemental approach to HSB intervention was also supported some parents/carers to recognise that the HSB displayed by their young person was not their "fault" which reduced the distressing impact that feeling blameworthy had for some (Kraus, 2014, p. 115). Parents/carers also identified a non-judgemental approach from professionals as a key factor that supported them to feel able to express the grief and anger associated with their young person's HSB:

"[Therapist] would ask these real deep questions, and he never put me down. He wasn't judgmental. … There were places where I don't feel like I was allowed to really grieve and be angry and be sad and on the level that he knew I was on. And so, he would ask me these questions and it opened up the door for me to be free" (Kraus, 2014, p. 134).

Being able to express strong emotions without the fear or actual experience of professional judgement can be considered indicative of trauma-informed practice as parental sensitivity to feeling blamed and experiencing shame in relation to their young person's HSB is sensitively navigated by professionals. For some parents/carers, this allowed the distress related to the young person's HSB, to be processed safely and empathically. This may increase the capacity of some parent/carers to support their young person throughout their intervention.

11b) Being Listened To

The therapeutic value of being listened to by professionals during HSB interventions was identified by young people and parents/carers in seven studies as a key professional characteristic which led them to feel valued, respected, and accepted by professionals (Archer, 2017; Belton, 2017; Belton et al., 2014; Boyers, 2020; Gxubane, 2019; Martin, 2004; Northey, 1995). Young people described the importance of professionals listening to their stories and basing their professional opinions on what they had shared, rather than making assumptions based on professional documentation (Northey, 1995). One young person described this experience:

"…but the CSPs really did listen. They actually just said, 'well why do you think this? how did this make you feel?' and actually got you to think how you feel a lot more" (Belton, 2017, p. 40; Belton et al., 2014, p. 41).

Experiences of being listened to by professionals positively contributed towards some young people's willingness to listen to professionals in turn (Gxubane, 2019). Some young people recognised the mutuality of the relationships held with professionals and identified being listened to as essential to forming respectful, reciprocal intervention relationships (Gxubane, 2019). This could be considered as a counter to feelings of being unequal and powerless that were experienced by some young people during interventions.

Professionals reassuring young people that they still have agency and control whilst engaging in intervention sessions was also identified as an important intervention component for some (Belton et al., 2014; Martin, 2004). One young person described being reassured by a professional that they had a voice in their intervention:

"I got more than enough time, if I ever wanted to say anything. I mean I used to always apologise to him for changing the subject but he said, "it's fine, it's fine". If I just need a question answering or some advice on anything you can always ask [CSP]. Well, I could anyway." (Belton et al., 2014, p. 28)

As demonstrated, young people may experience disempowerment during interventions due to difficult lived experiences, interactions with empowered services and professionals, and the societal response to the HSB. Professionals who listen to young people and redistribute power within the intervention relationship could be considered indicative of trauma-informed practice as young people feel supported to meaningfully engage in interventions and take responsibility for their risk management upon completion of the intervention (Belton et al., 2014; Martin, 2004).

Parent/carer experiences of being listened to by professionals who were interested and open to understanding their experiences led some to feel accepted by services (Archer, 2017; Boyers, 2020). This can be contrasted against the previous experiences of some parents/carers who had a "constant feeling of fighting" with professionals (Boyers, 2020, p. 237). Parents/carers described feeling more able to fully engage in provision when they felt accepted by professionals as they were able to "talk to them [professionals] about everything without drama" (Boyers, 2020, p. 171). Data

synthesis suggested that some parents/carers may have previously experienced of professionals as blaming and reactionary and/or had their own interpersonal difficulties, therefore, experiences of being listened to by professionals could be considered an aspect of HSB provision that facilitates engagement (Archer, 2017; Boyers, 2020).

11c) Feeling Cared For

Some parents/carers described feeling cared for by professionals who encouraged contact between sessions to 'check in' and offer support (Archer, 2017; Kraus, 2014; Warrilow, 2019). This was valued by parents/carers as it led some to feel supported during times when they were they were personally struggling and needed someone to talk to, and increased hope in the intervention for some (Archer, 2017; Belton et al., 2014; Kraus, 2014). The accessibility of professionals was described by one parent/carer as "like a lifeline to me sometimes" (Belton, 2017, p. 41).

Some parent/carers also valued professionals incorporating the information that had been shared in contacts outside of sessions into young people's intervention sessions to support family involvement (Belton, 2017). The value placed on the accessibility of professional support outside of sessions demonstrates that the support needs of some parent/carers extend beyond the confines of individual sessions. It is acknowledged that wraparound support may not be wanted nor meet the needs of all parents/carers, for some, such support may be experienced as overbearing. Likewise, the ability of services to consistently provide wraparound support is dependent upon funding and resourcing. However, this finding does highlight the holistic person-centred needs of parents/carers.

11d) Professional Praise and Support as a Counter to Isolation and Blame

Finally, parent/carers described the importance of receiving professional praise and support during their engagement with HSB provision (Archer, 2017; Boyers, 2020; Kraus, 2014; Warrilow, 2019). One parent/carer described this experience:

"They're always telling me how great it is that I'm there for him. It feels really good…It made me feel really proud. And you know, it's not often a person gets to feel proud of themselves and knowing somebody says stuff like that, it helps. It makes you feel a lot better, especially in the midst of all this happening" (Kraus, 2014, p. 116).

Parent/carer experiences of receiving professional praise appeared to serve as a counter to the feelings of blame and shame experienced by some. Parents/carers found it particularly useful when professionals highlighted their strengths prior to providing constructive feedback on areas that parents were struggling with (Kraus, 2014).

Theme 12: Parent/Carer Involvement in Interventions Strengthens Family Relationships and Supports Discharge

The involvement of parents/carers in interventions was facilitative for some young people's intervention engagement:

"If it wasn't for my parents I wouldn't be doing it" (Geary et al., 2011, p. 187).

The involvement of parents/carers in interventions provided some young people with the experience of receiving praise and pride from their parents/carers, which increased the young person's hope and motivation to engage in the intervention (Geary et al., 2011; Kraus, 2014; Martin, 2004). Some came to recognise parental commitment through professionals facilitating young person-parent/carer connection during sessions:

"They [parents] were like, if we would've left you, then we would've done it a long time ago, but we're still here and we're not going to give up on you." Like I said, I think they really dug in on that one, and I think [therapist] kind of started that. He initiated that feeling of care and support, and just kind of initiated that so my parents could grab onto it and finish it up" (Kraus, 2014, p. 145).

The synthesis identified a relational benefit for some young people as a result of parent/carer involvement in the intervention, as they became aware of the unconditional support of their parents/carers despite the HSB (Kraus, 2014; Martin, 2004). Some parents/carers further described how their involvement in the intervention led them to realise that the process was a "shared journey":

"…I know deep inside this is helping my son, not only helping him and helping me. It's a journey for both of us. Both for me and him, not just for my son. My son had to make a journey but I'm still there beside him. The staff made me realise that" (Ape-Esera, 2016, p. 133)

Intervention engagement supported some parents/carers to recognise their unconditional support for their child and their own responsibility to learn and grow to support the intervention process (Ape-Esera, 2016; Kraus, 2014). Interventions provided some young people and parents/carers with the opportunity to collaboratively test out and practice intervention strategies with the scaffolding and support of a professional, which was believed to support service discharge and transition to the community (Kraus, 2014; Martin, 2004). Parent/carer awareness of the young person's "abuse cycle," was deemed helpful by some young people to help them "keep on track" following discharge (Martin, 2004, n.p.). The dyadic nature of parents/carers and young people engaging in interventions is indicative of trauma-informed and sensitive practice as both parties are provided with the opportunity for professional-assisted relational repair, which may strengthen their relational security (Kraus, 2014). This may be significant for young people and parent/carers who have experienced interpersonal trauma either by nature of the HSB and/or adverse life experiences.

Theme 13: The Relational Value of Groups

Group interventions have been described by some young people as both the most helpful and the most difficult aspect of interventions (Geary et al., 2011). The data synthesis revealed diverse experiences of group interventions amongst both young people and parent/carers. The experience of feeling less isolated and alone through attending group interventions was one of the most prominent themes of the synthesis (Ape-Esera, 2016; Archer, 2017; Geary et al., 2011; Gxubane, 2019; Jones, 2015; Lawson, 2003). For some young people, attending group interventions led them to realise that they were not the only ones who had engaged in HSB and had experienced

adverse childhood events (Ape-Esera, 2016; Geary et al., 2011; Gxubane, 2019; Lawson, 2003). The opportunity to relate to others in groups was described as destigmatising, which in turn encouraged some young people to contribute to the group as they felt supported and understood by other members (Ape-Esera, 2016; Geary et al., 2011; Gxubane, 2019; Lawson, 2003). Parents/carers also described their experience of groups as contributing to them feeling less isolated, which may have functioned as an "antidote" to shame; some stated that peer support should form a key part of service provision (Archer, 2017, p. 81; Geary et al., 2011; Hackett & Masson, 2006). The relational nature of groups was also beneficial for some young people as they witnessed others progress through the group intervention and received staff support to develop relationships with others (Ape-Esera, 2016; Franey et al., 2005; Gorden et al., 2020; Martin, 2004; Somervell & Lambie, 2009). Young people described the beneficial experience of building trust with others over time and having the opportunity to safely resolve interpersonal conflict within the confines of scaffolded group settings (Martin, 2004; Northey, 1995).

Importantly, time was identified as an important factor in parents/carers feeling able to share and explore their experiences in groups (Duane et al., 2002; Jones, 2015). Parents/carers described being more sensitive to feelings of shame, embarrassment, and judgement from group members during the early stages of group programmes (Duane et al., 2002; Jones, 2015). Relating to the experiences of other parents/carers in groups and feeling less isolated was described as a phenomenon that developed as a group progressed over a series of sessions (Archer, 2017; Duane et al., 2002; Geary et al., 2011; Jones, 2015).

Group interventions and/or support programmes could be experienced as trauma-sensitive and informed as they served an opportunity to connect and build relationships with others through shared experiences, which reduced feelings of isolation and shame for some. Such experiences may be particularly beneficial for young people and/or parent/carers who have experienced interpersonal difficulties either in relation to the incidence(s) of HSB and adverse childhood experiences. Hence, whilst 'Theme 8' suggests that some struggled to engage in interventions due to feeling shame around others, the time required for individuals to share experiences is identified as a crucial factor in the current finding. It is acknowledged that the group context, facilitators, and members may also impact findings on the diverse experiences of groups. However, the data highlights the importance of facilitators respecting the time needed to develop trust and safety within groups to support meaningful engagement as part of trauma-sensitive and informed practice.

Theme 14: Professionals and their Organisations: A Need for Connection

The findings in 'Theme 9 revealed that both systemic factors and the direct work with young people was experienced by some professionals as distressing. The current theme captures the aspects of HSB provision that help professionals manage potential distress. Some professionals described upholding clear therapeutic boundaries to manage the personal impact of the work whilst also attending to the importance of the developing relationship with the young person (Chassman et al., 2010; Myles-Wright & Nee, 2020b). The protective function of upholding appropriately boundaried working relationships for both professionals and young people was illustrated by one professional:

"…doesn't have to be a detached, staid, dry relationship. It can be a very loving, laughing, enjoyable relationship… But from my perspective, our relationship is not one of family. It's one of client and counsellor" (Chassman et al., 2010, p. 273).

Professionals who maintained compassion and empathy towards young people in the context of developing a safe and boundaried working relationship experienced the work as enjoyable and developed positive feelings towards young people (Almond, 2014; Russell & Harvey, 2016; Shevade et al., 2011). However, some professionals described the use of boundaries as a way to maintain distance from the young person due to the "unease" experienced by some (Myles-Wright & Nee, 2020b, p. 2063; Russell & Harvey, 2016).

Findings suggest that there is skill involved in being able to hold compassion and empathy for a young person who may be experienced as emotionally "draining" to the professional and/or be perceived as a risk to the safety of the professional (Chassman et al., 2010; Shevade et al., 2011). The importance of managing safe and boundaried relationships with young people during interventions is important to reducing the risk of the work being experienced as distressing for both the young person and professional. There appeared to be a connection across the data between the ability of the professional to uphold safe working relationships, which limited the experience of distress for some professionals (and by association, potentially young people, and parents/carers), and the professionals' relationship with their employing organisation. Some professionals described the importance of the alliance between professionals and their managers, and described managers who were "person-centred", "approachable" and "accessible" as protective, which in turn, positively impacted on

their confidence, motivation, and sense of feeling valued (Almond, 2014; Myles-Wright & Nee, 2020b).

Similarly, the provision of supervision can be considered an aspect of service delivery that is trauma-sensitive and informed as professionals described feeling increased worth, wellbeing, and clarity in their work through supervision (Almond, 2014; Ape-Esera, 2016; Chassman et al., 2010; Myles-Wright & Nee, 2020b; Shevade et al., 2011). Supervision was described by professionals as a "critical avenue of support" that enabled them to manage the sometimes distressing aspects of the work (Chassman et al., 2010, p. 273). Professionals delivering a Māori HSB intervention also emphasised the importance of receiving culturally-informed supervision to facilitate the safe and effective delivery of the cultural intervention components to young people and colleagues (Ape-Esera, 2016).

In the context of the organisational pressures explored in 'Theme 9', some professionals stated that the separation of HSB-specific supervision from line management supervision was essential for professionals to feel "held and safe" due to the discomfort that some experienced in talking about their emotional responses with management (Almond, 2014, p. 344; Ape-Esera, 2016; Myles-Wright & Nee, 2020b). However, the provision of supervision as external to the employing organisation presents a potential conflict in the context of 'Theme 9,' which revealed that some professionals felt devalued within their organisation. Therefore, supervision that is delivered entirely external to the professionals' organisation may further limit the ability of the organisation to respond and attend to the systemic challenges that impact the wellbeing of some professionals. Importantly, there appeared to be a relational

aspect to the provision of supervision for some professionals who clearly stated that the facilitation of effective supervision and reflective spaces was the responsibility of their organisation:

"...that we have a space where we can really go and sit in that we don't do that for ourselves but that we have somebody who facilitates that for us" (Myles-Wright & Nee, 2020b, p. 2066).

Feeling cared for by an organisation through the provision of appropriate staff support could be considered an essential component of trauma-informed HSB provision. The findings indicate that professionals have a need for connection with their organisation to support them to feel safely connected to the young people and parent/carers that they work with.

Grade CERQual Table

The outcome of the GRADE-CERQual confidence in the assessment of review findings is provided in the SoQF table in Appendix D. The confidence ratings of all but one finding (analytical themes) was moderate to high. Theme 3: 'Assessments Can Lead to Unmet Needs' was given a low confidence rating due to the limited number of studies and participants informing the theme, along with concerns around the methodological limitations of studies. The implications of this finding and others will be discussed in the next chapter.

Discussion

This chapter will revisit the study aims and demonstrate how the research fulfilled the aims. The analytical findings identified in response to the three research aims will be considered in the context of the wider literature in order to deconstruct the contrasting experiences of HSB provision. The strengths and limitations of the study will then be presented, followed by practice implications and future research recommendations.

Research Summary

A systematic search identified thirty-seven articles that met the inclusion criteria. A thematic synthesis of the study findings was undertaken. The initial codes identified through the thematic synthesis identified descriptive findings to fulfil research aim one. Fourteen analytical themes were identified to fulfil research aims two and three. This section will begin by addressing the first research aim that focused on what young people, parents/carers and professionals say about their experiences of HSB provision. The findings related to the second and third research aim will then be addressed, which focused on the aspects of HSB provision that could be considered as potentially distressing, or trauma-informed. Whilst these findings were presented separately in response to the three research aims in the previous chapter, for the purposes of this chapter, the findings from each research aim that are thematically linked (for example, experiences of group interventions that could be considered as either trauma-informed, or potentially distressing) will be considered together to demonstrate the shared contribution of the findings to the evidence base.

Summary of Key Findings

The data synthesis revealed aspects of shared experiences of HSB provision amongst the three groups. The descriptive findings identified in response to research aim one clearly identified the benefit of HSB provision for some young people and parents/carers. The findings identified the valued aspects of intervention content and uncovered what personal and relational factors were believed to motivate intervention engagement. Experiences following intervention discharge revealed the varied longer-term impact of HSB provision. Professional data revealed the emphasis on personal coping strategies to manage the impact of the work, and the importance of their working relationships.

The findings identified to address research aim two revealed that some young people described entering HSB services bearing relational distress and shame that may be related to the incidence of HSB and/or previous adverse life experiences. Some young people and parents/carers experienced HSB statutory support services as powerful and at times disregarding of their needs. This potentially distressing impact was mitigated by professionals who were consistent in their support and demonstrated curiosity and containment. The early stages of an intervention were characterised by fear, threat, and anxiety for some young people, who managed these feelings through resisting intervention engagement. Some professionals also reported parallel feelings of fear, anger, and powerlessness in response to young people's resistance and challenging behaviour during interventions.

For some young people, interventions were typified by a tussle for power and control with professionals, who were experienced as making assumptions about their lives

and behaviour. This was experienced as disempowering for some and was further compounded by some parents/carers not being involved in interventions, which risked perpetuating relational difficulties and shame. Experiences of interventions that could be considered trauma-informed involved professionals therapeutically exploring the lived experiences of both young people and parents/carers; professional characteristics such as being non-judgemental, listening, caring, and praising were identified as central to this process. For some, such professional characteristics supported the development of trust and mitigated feelings of shame, blame and powerlessness.

Parent/carer involvement in interventions was described as strengthening some young person-parent/carer relationships and supporting engagement. However, some parent/carers experienced powerlessness when engaging with services and felt blamed, which bred feelings of mistrust towards professionals. A shared discomfort with the sexual context of sessions was also reported by all three groups: some young people were not psychologically prepared to discuss sexual experiences in sessions, this was similarly reported by parents/carers, who shared that they struggled to manage the impact of such discussions outside of the confines of the sessions. Some professionals also experienced discomfort with the personal impact of the sexual content discussed in sessions. For both young people and parents/carers, there was a shared feeling of shame within group interventions, which inhibited their engagement. However, the opportunity to identify with other groups members was experienced as destigmatising for some, which could lead to relational strengthening over time. The potentially distressing experiences of interventions had a less pervasive impact for

those who experienced professionals as sensitive and responsive to the potential impact of adversity on young people and parents/carers.

Finally, for some professionals, working with young people who are high-risk and high-vulnerability impacted their intrapsychic and relational selves. Some professionals experienced anxiety, hypervigilance, thoughts of failure and self-doubt due to some young people's behaviour both within and external to sessions; this was compounded for some by an absorption of responsibility. Healthy therapeutic boundaries were identified as protective against such responses, however, this was undermined for some by systemic factors. Organisational pressures, such as target-focused cultures, posed a risk to professional wellbeing. Some absorbed responsibility and guilt for organisations that failed to meet the needs of young people. These experiences were further impacted by a lack of effective supervision, management support and/or reflective spaces for some professionals; supervision was identified as a critical provision from organisations. For some, the absence of support structures and positive managerial relationships bred mistrust towards the organisation and fuelled the belief that their work was not valued.

Results in the Context of the Wider Literature

Data synthesis suggests that young people and parents/carers experience a level of distress prior to engaging in HSB provision. As stated previously, this distress could be attributable to a variety of factors, such as prior adversity or harm, the incidence(s) of HSB, the identification and reporting of the HSB to statutory services, and the realisation of the potential consequences of the HSB once it is identified, such as Sex

Offender registration, community ostracisation, and potential imprisonment. All these factors can inform and frame experiences of HSB input for young people and parents/carers and potentially contribute towards feelings of shame, sensitivity to blame and experiences of disempowerment, which may impact service engagement and be further compounded by unhelpful professional responses. These experiences could be considered distressing. Findings revealed that relationships across the system underpin the aspects of HSB provision that are sensitive to these potential experiences and responses.

Two overarching themes were identified in the synthesis that capture the experiences of HSB provision that can be considered either potentially distressing, or trauma-informed. Firstly, whilst some experienced HSB provision through the lens of shame and disempowerment, the relationships developed between young people, parents/carers, professionals, and the wider organisational system mitigated these experiences for some. The overarching influence of these two themes is illustrated in the thematic maps presented in Figures 3 and 4. These overarching themes, stemming from the voices and lived experiences of all three groups, have implications for the understanding and development of trauma-informed practice in HSB provision.

Shame and Disempowerment

'Shame and disempowerment' was identified as the primary overarching theme that captured the findings suggestive of experiences of HSB provision that could be considered distressing. Shame is a complex concept that continues to be deconstructed within the literature (Gilbert, 2007; Leeming & Boyle, 2004; Lewis,1971). Broadly, shame is defined as a "master emotion" that arises through perceived or actual

experiences of the self being exposed and disapproved by an “observing other”, which can lead to social withdrawal to protect oneself from judgement (Scheff, 1995, p. 1055; Tangney et al., 1996, p. 1257). In the context of synthesis findings, experiences of shame appears to fit the “dual-dimensional” construct of being both an interpersonal and intra-personal phenomenon (Jo, 2013, p. 526). The “dual-dimensional” nature of shame appears to both frame engagement with HSB provision and is connected to experiences of adversity, trauma and the incidence(s) of the HSB, but can also be perpetuated through service provision (Jo, 2013, p. 526). Shame appeared as a theme throughout the experiences all three groups in relation to: navigating intervention resistance; the challenge of talking and not being seen; parent/carer experiences of powerlessness, professional neglect, blame and mistrust; shared discomfort with the sexual content of sessions; shame as an inhibitors of group engagement; changes to professionals’ intrapsychic and relational selves, alongside systemic stressors which risked professional wellbeing.

The implication of shame in the findings is reflected within the wider literature on the relationship between shame, trauma, and offending behaviour (Kerig, 2012; Walton, 2019; Taylor, 2021). Shame is a common emotion felt by individuals who have experienced trauma and adversity and is reflected in the recent addition of shame to the diagnosis of post-traumatic stress disorder (Diagnostic Services Manual, Hoekstra, 2021, Taylor 2015). For individuals who have experienced interpersonal or developmental trauma, shame may have developed through unsafe experiences of caregivers and/or close relationships (Hoekstra, 2021). Over time, this may lead the individual to evaluate their global self as unworthy, unlovable, and incapable of forming secure and safe relationships (Hoekstra, 2021; Loader, 1998, Taylor, 2015).

Power is implicated in the lived experience of shame, which has been understood as an inferior positioning in response to a "critical, powerful other," which can exist both external and internal to the individual (Gilbert et al., 1994; Leeming & Boyle, 2013; Lewis, 1971). Shame can instigate feelings of disempowerment. The emotional pain associated with shame can motivate individuals to use self-directed aggression, other-directed aggression, hiding from oneself or hiding from others as shame coping strategies and responses to disempowerment (Nathanson, 1997; Hoekstra, 2021). These behaviours are evident in some experiences of HSB provision across the three groups that could be considered distressing. The experiences identified through the findings are underpinned by the complex, reciprocal interplay between shame and power.

For both young people and parents/carers, shame can function as a barrier to treatment as it can fuel the denial of the incidence(s) of HSB, avoidance of distress associated with the HSB and/or potential adverse life experiences (Kerig, 2012; Walton, 2019; Taylor, 2021). Considering shame and disempowerment in the context of offending is pertinent as young people and their parents/carers are additionally vulnerable to experiencing 'disintegrative shaming', which is understood to occur as a result of the labelling of the individual as an offender, which can lead to societal ostracisation and erode an individuals' remaining bonds to dominant societal norms, which may in turn risk the perpetuation of harmful behaviour (Mullins & Kirkwood, 2019, p. 370). The inherent power embedded into statutory services and professionals may inadvertently add to the process of disintegrative shaming. Hence, for HSB provision to be trauma-informed, it is imperative that the design and delivery of services accounts for and

addresses the impact of shame and disempowerment that can arise from earlier adversity, HSB related distress, or through distressing service experiences.

Relationships

'Relationships' were identified as the second overarching theme in the data that characterises the aspects of HSB provision that were experienced as trauma-informed. This finding is reinforced in the literature. Experiences of relationships are important in the context of shame, adversity, and trauma. For individuals who have experienced adversity and trauma, relationships may have served as a source of threat through repeated instances of needs being unmet and disregarded (Hoekstra, 2021). Individuals may subsequently develop a relational template that others cannot be relied upon to meet their needs, which is physiologically reinforced through emotional and physical impulses associated with shame, such as the flight, fight, and freeze reaction (Hoekstra, 2021; Rothschild, 2017; van der Kolk, 2015). In the context of HSB provision, professional relationships may present an opportunity for individuals to experience a safe, consistent, and caring relationship in which the young person's individual needs are sensitively considered through the delivery of interventions.

The role of relationships within HSB service experiences that can be considered trauma-informed is congruent with the wider evidence base, which suggests that the ability for an individual to achieve repair (e.g., for inflicted harm) is intimately linked to the extent to which individuals believe that personal change is possible (Leach & Cidam, 2015; Walton, 2019). Experiences of relational security with professionals and potentially repaired or strengthened relationships with family members through HSB input can demonstrate to the individual that whilst their behaviour is harmful

and requires corrective intervention, they are not globally unworthy humans who are incapable of change (Cibich et al., 2016; Tangney & Dearing, 2002; Walton, 2019). Exposure to positive relational experiences, such as relationships developed with professionals during interventions, have been hypothesised to regulate the brain's stress response system, and support normative development when such interactions are consistently experienced (Cox et al., 2021; Ludy-Dobson & Perry, 2010). This concept is epitomised in the developmental trauma field through the assertion that 'relational trauma requires relational repair' (Treisman, 2016). Findings suggest that the relational aspects of HSB provision are a common factor throughout the experiences of all three groups and can be considered a core aspect of trauma-informed HSB provision.

Understanding Experiences of Support Services

As stated, the HSB support services that featured in the included studies consisted of statutory services such as the police, Social Care, and youth justice services. Data that was not explicitly linked to HSB assessment and intervention but was related to professional input and support for young people with HSB and/or their parents/carers was considered to constitute HSB support. Data from three studies suggested that the interactions between some young people, their parent/carers, and HSB support services were typified by power and threat, which left some participants feeling disregarded and devalued (Archer, 2017; Barnardo's, 2017; Hackett & Masson, 2006). However, data pertaining to young people and parent/carer experiences of HSB support services was scant within the consulted literature. This is reflective of a wider evidence gap on the experiences of statutory services from the perspective of adults with a sex offending history (Brown et al., 2018).

The minimal research into individuals' experiences of the police and courts is problematic in the context of evidence from adult research which suggests that adults who believe that they have been inappropriately and unfairly treated by legal authorities are more likely to continue to engage in criminal behaviour (Brown et al., 2018; Petersilia & Deschenes, 1994; Sherman, 1993; Sherman & Berk, 1984). Adults who believe that they have been treated fairly, respectfully, and with care are more likely to comply with authority decision making (Brown et al., 2018; Paternoster et al., 1997; Williams & Hawkins, 1992). It is important that such research priorities are replicated in studies of young people with HSB, particularly as research on adults with a sex offending history demonstrates that those with a sex offending history have more negative experiences of police interactions (involving directed anger and disgust from police officers) when compared with adults without a sex offending history (Holmberg & Christianson, 2002; Brown et al., 2018).

Experiences of shame and fear related to the incidence and potential consequences of HSB amongst adult participants in the research, and young people with HSB in the current study, may lead to more negative perceptions of professionals within statutory services. Whilst there is value in capturing the voices of individuals with lived experience, the impact of such complexities on the nature of individual and/or synthesised reports of service experiences cannot be discounted. Due to the limitations within included studies, it is not possible to elucidate connections from the data between potentially distressing experiences of the police and courts, and subsequent intervention engagement and recidivism. However, future research on the role that

statutory services may have in framing intervention engagement and recidivism risk, whilst complex, would be highly beneficial to inform a more robust evidence base.

One study indicated that young people and parents/carers valued developing relationships with professionals in HSB support services that were consistent and marked by professional curiosity and commitment to the young person and their parents/carers (Barnardo's, 2017). This demonstrates that whilst support service input may be restricted and time-limited, for some, there is a relational benefit in having a positive experience of HSB support services (Barnardo's, 2017). As demonstrated earlier, the value of relationships for young people and parent/carers within HSB provision is echoed throughout the findings and appears to be linked to the realisation that they are capable of change, based on the experience of developing secure and respectful relationships with professionals (Leach & Cidham, 2015). Whilst the ability to make definitive conclusions from the findings on HSB support services may be limited, a trauma-informed approach to HSB provision requires consideration of the potential role that the experiences of statutory services and staff relationships may have on subsequent service engagement.

Understanding Experiences of Assessments

Only two studies explicitly explored young people and parent/carer experiences of HSB assessments, and only one of these studies contained findings that could be considered trauma-informed (Griffin & Beech, 2004; Kjellgren, 2019). The ability to make inferences on the experiences of assessments is limited as a collective synthesis of data from multiple sources was not possible. Following the CERQual assessment, a low confidence rating was given to Theme 3: 'Assessments can Lead to Unmet

Needs' due to the limited contribution of participants, studies, and methodological concerns to the finding. Hence caution is advised on the contribution of this finding.

The findings suggested that organisational limitations such as a lack of support provided to parents/carers, severed professional relationships, and young people not being given the opportunity to talk about their experiences led to unmet needs (Griffin & Beech, 2004; Kjellgren, 2019). Tentatively, the findings suggested that the aspects of the assessment process that could be considered potentially trauma-informed include the relational connection that professionals established with parents/carers and the therapeutic and educational delivery of assessments (Griffin & Beech, 2004).

These findings are corroborated by the results of a recent doctoral thesis (which could not be included due to not meeting the age range inclusion criterion) that explored young people and professional experiences of HSB assessments (Pitcher, 2020). Young people in the study also valued the emotional support that had been offered by professionals during the assessment process (Pitcher, 2020). The study also found that most young people wanted to understand the assessments that were undertaken, be actively involved in the assessment process, and valued having their voice heard throughout the assessment to ensure accuracy in risk-related decision making (Pitcher, 2020). When considered collectively, data from the two studies suggests that young people value the relational and therapeutic aspects of the assessment process (Griffin & Beech, 2004; Pitcher, 2020). Further research elucidating young people's experience of ACE-related or HSB-related distress, and their subsequent experience of HSB assessment would illuminate the extent to which the characteristics of young people impact on experiences of HSB assessments.

Although there has been limited research undertaken on qualitative experiences of HSB assessments, the existing findings are supported in the wider psychology evidence base that demonstrates the relational benefit of 'Therapeutic Assessments' (TA) for individuals accessing psychology and therapy services (Finn, 2009; Fischer, 1994; Smith & Egan, 2017). The model of TA delivery is underpinned by six core therapeutic aims: humility, respect, compassion, collaboration, openness, and curiosity (Finn, 2017; Smith & Egan, 2017). The aims of the TA model broadly align with the core components of trauma-informed practice (Harris & Fallot, 2001; SAMHSA, 2013). Like some of the more recent HSB assessment tools, such as the AIM3 Assessment, the TA model values the holistic assessment of an individuals' presenting difficulties in the context of their lived experiences (AIM3; Leonard & Hackett, 2019; Smith & Egan, 2017).

Empirical studies have demonstrated that clients value the TA model and results suggest that the delivery of TA supports the development of a positive therapeutic relationship during the assessment process, which is linked to the theory of therapeutic change in the model (De Saeger et al., 2014; Hilsenroth et al., 2004; Smith & Egan, 2017). Whilst none of these studies have explored the use of TA with young people with HSB and their parents/carers, many of the participants in the TA studies were assessed to meet the DSM-IV criteria for the diagnosis of 'personality disorder,' which has been aetiologically linked to experiences of childhood adversity and trauma (De Saeger et al., 2014; Hilsenroth et al., 2004). Thus, this research may hold some value for considering its applicability to the current population group, many of whom may have also experienced adversity and trauma (Balfe et al., 2019; Hackett et al.,

2013; Levenson, 2016). Based on the limited, albeit valuable qualitative data from the HSB field and the broader research on therapy assessments, a TA approach to HSB assessment delivery may hold value in a trauma-informed HSB provision to frame the future intervention engagement of young people and their parents/carers.

Understanding Intervention Engagement

Eleven studies revealed that some young people and parent/carers struggled to engage with HSB interventions delivered across various settings (Ape-Esera, 2016; Archer, 2017; Franey et al., 2004; Geary et al., 2011; Gorden et al., 2020; Jones, 2015; Kraus, 2014; Martin, 2004; Northey, 1995; Pierce, 2011; Somervell & Lambie, 2009). Two studies suggested that the early stages of HSB interventions were marked by fear and threat for young people, which led some to resist engaging in interventions as a form of avoidance and rejection of professional intervention (Martin, 2004; Northey, 1995). Both studies were undertaken with young people placed in custodial and/or residential treatment setting. Hence, the contextual setting of HSB intervention delivery may bear some influence on how the intervention is experienced. It is of note that approximately one in seven young people with a conviction of HSB are sentenced to custody (Eastman et al., 2019).

As previously acknowledged, difficulties experienced during the early stages of HSB interventions are likely to also be framed by young people's prior experiences of the incidence and identification of the HSB, and their experiences of either the potential, or actual, consequences of the HSB. However, this finding provides some insight into the potential complexities of delivering mandated HSB interventions to young people in restricted environments. These findings, albeit limited, are consistent with the

literature on adults with a sex offending history, which also highlights the challenges faced by adults who are required to engage in court ordered treatment (Levenson, 2014). Studies suggest that some adults with a sex offending history also resist engaging in mandated interventions due to denial, feelings of shame, and anger (Jenkins-Hall, 1994; Jennings & Sawyer, 2003; Levenson, 2014; Marshall et al., 2001; Serran et al., 2003; Winn, 1996). However, the data in these studies do not explicitly explore the contribution of prior trauma, shame, anger, or denial as potential explanatory factors for why the early stages of interventions may be marked by fear, threat, and resistance. There is a lack of recent research into the process-oriented experiences of young people who engage in HSB interventions.

In the context of broader research on young people's experiences of psychological therapy, a narrative synthesis exploring therapeutic alliance and outcomes within children's mental health services found that professionals who work with young people who do not self-refer or independently choose to attend therapy struggle to collaboratively establish therapeutic goals, which are positively related to therapy outcomes (Green, 2006; Ryan et al., 2021; Wampold, 2015). When coupled together, both the synthesised data and evidence from the wider literature suggests the need for professionals to sensitively consider how treatment that is delivered in restricted environments to young people with limited agency may impact their experience and engagement of interventions. When such responses are not attended to or considered by professionals in the context of the young person's prior lived experiences and the loss of agency within the treatment context, there is a risk that the HSB intervention and professional relationship may be experienced as overtly threatening and distressing by the young person.

More broadly, both young people and parents/carers described feeling pressured to share their experiences during interventions when they did not feel psychologically prepared to do so, this was experienced as distressing and disempowering for some (Kraus, 2014; Martin, 2004; Northey, 1995) (Ape-Esera, 2016; Archer, 2017; Franey et al., 2004; Geary et al., 2011; Gorden et al., 2020; Jones, 2015; Kraus, 2014; Martin, 2004; Northey, 1995; Pierce, 2011; Somervell & Lambie, 2009). The experience of feeling pressured to share one's thoughts and feelings whilst not having the psychological readiness to do so may result in either intervention resistance or submissive intervention compliance from young people.

Evidence suggests that young people have the highest treatment attrition rates across the greater offender population, and treatment attrition rates amongst adults with a sex offending history/violent offence are greater than the general offending population (Carl et al., 2020; Olver et al., 2011). Both the QES data and existing evidence suggests that it is imperative that professionals delivering HSB interventions appropriately assess and attend to processes such as psychological readiness for therapy to ensure ethical and effective practice. The concept of treatment suitability has yet to be agreed upon as a comprehensive theoretical construct in the wider therapy literature (Nakajima, 2022; Valbak, 2004). However, from a trauma-informed perspective, treatment readiness is important to consider throughout the assessment and collaborative formulation process to support the delivery of person-centred interventions. Critically, young people and parent/carer experiences within the data that could be considered distressing may potentially stem from a lack of treatment readiness, rather than the behaviour of the professional or content of the intervention

itself. However, such nuances cannot be identified due to the limitations of the included studies.

The aspects of interventions that could be considered trauma-informed involved professionals who communicated in a young-person centred manner, which involved merging session content with young people's personal interests, and explaining things clearly (Barnardo's, 2017; Geary et al., 2011). This supported young people to tolerate the difficult subject matter in sessions (Barnardo's, 2017; Geary et al., 2011). In the context of developmental theory, adolescence has been theoretically conceptualised as being marked by identity vs. role confusion and thereby preoccupied by increasing autonomy and identity development (Erikson, 1980). It can be theorised that young people who engage in HSB experience a pronounced disruption to their identity development, which may be underpinned or exacerbated by adversity and trauma experienced either prior to, because of, or during the aftermath of the HSB (Creeden, 2013). Findings indicate that the idiosyncratic value of adapted interventions for young people can be important to support adolescent identity development and should be considered as part of the delivery of trauma-informed HSB provision.

The therapeutic benefit of interventions that are adapted to meet the communication and developmental needs of young people is supported within the broader literature. A narrative synthesis found that therapists in children's mental health services who adapted session content in line with the young person's needs and interests resulted in a stronger therapy alliance and greater intervention outcomes (Ryan et al., 2021). The current findings suggest that adapting to the developmental, psychological and communication needs of young people during interventions and enquiring about their

broader personal interests was experienced as an active redistribution of power within the intervention relationship, which supported engagement (Belton et al., 2014; Martin, 2004; Northey, 1995). This may function as a relationally reparative experience and mitigate the disempowerment that some young people may have experienced throughout their lives. Such professional approaches are consistent with the principles underpinning trauma-informed practice, such as collaboration, mutuality, and empowerment (Harris & Fallot, 2001; SAMHSA, 2013). These findings offer an important contribution to the evidence base. Whilst HSB interventions will involve some level of discomfort and potential distress by nature of the focus of interventions, professionals can play a role in mitigating this impact to ensure that the young person is supported to process the distress which may be elicited in a therapeutically beneficial manner, rather than it being experienced as damaging or harmful.

The Importance of the Service User and Professional Relationship

Five studies found that young people and parents/carers valued the exploration of lived experiences within sessions when they were facilitated by professionals in a manner that was experienced as therapeutic; this consisted of professional attunement, holding hope, and recognising change during the intervention (Barnardo's, 2017; Belton et al., 2014; Franey et al., 2004; Kraus, 2014; Martin, 2004). Young people and parents/carers described developing empathy and self-worth through exploring their lived experiences in the context of therapeutically facilitated interventions. The relationships established between young people, parent/carers and professionals were central to experiences of interventions that could be considered trauma-sensitive and informed. Seventeen papers revealed the most prominent valued professional

characteristics as displaying a non-judgemental approach, listening to the lived experiences of service users, and demonstrating care through being accessible and available for support when needed (Ape-Esera, 2016; Archer, 2017; Barnardo's, 2017; Belton, 2017; Belton et al., 2014; Boyers, 2020; Franey et al., 2004; Geary et al., 2011; Gorden et al., 2020; Grady et al., 2018; Gxubane, 2019; Jones, 2015; Kraus, 2014; Lambie & Price, 2015; Martin, 2004; Romano & Gervais, 2018; Somervell & Lambie, 2009; Warrilow, 2019). Through the lens of trauma-informed practice, a non-judgemental, listening, and caring approach to facilitating HSB interventions may potentially moderate experiences for young people and parents/carers who can feel shame, mistrust, and sensitivity to blame as a result of possible experiences of adversity and trauma, and/or the incidence(s) and impact of the HSB. Whilst findings on the valued characteristics of professionals do not present a novel contribution to the HSB evidence base, the synthesis of this data alongside parent/carer perspectives, professional experiences, and in the context of trauma-informed working does offer a unique contribution to the literature (Campbell et al., 2020).

The valued professional characteristics identified through the synthesis can be understood within the context of wider research on 'therapist effects' and the therapeutic alliance (Wampold, 2015). Therapist effects are understood as the process through which "some therapists consistently achieve better outcomes with their patients than other therapists, regardless of the nature of the patients or the treatment delivered" (Wampold, 2015, p. 274). Meta-analytic studies consistently show that specific treatment components account for minimal differences in therapeutic outcome (d=0.20), when compared with contextual model factors such as empathy, therapeutic alliance, goal consensus/collaboration and positive regard/affirmation

(Wampold, 2015, pp. 273-274). From a common therapy factors perspective, the approach of the professional holds greater value for therapeutic change than the specific intervention modality. Whilst HSB interventions delivered via traditional psychotherapeutic approaches are by nature considered therapeutic interventions, the delivery of specialist HSB treatment resources and guided interventions, despite being largely informed by cognitive behavioural therapy, have sometimes not been delivered with the same psychotherapeutic value (Rasmussen, 2013). The diversity in participant experiences of interventions is likely reflective of the nature of the intervention, the professional delivery of the intervention and the young person's own emotional responses; all of which cannot be accurately accounted for through a synthesis of primary studies.

It is noted that interventions such as Change for Good and the AIM Intervention Model emphasise the development of the professional-young person relationship within guidance manuals (Guilhermino & McCarlie, 2019; McCrory, 2011). However, the ability of the professional to enact the characteristics needed to develop and sustain a therapeutic relationship with individuals who have experienced interpersonal trauma is highly dependent upon professional characteristics, skill, and the young person's presentation. The professional voices captured in this synthesis described the importance of receiving specialist training to support the development of empathy towards the young people and gain an insight into their behaviour, which was believed to positively impact their working relationships (Glenny, 2019). Some felt "uneasy" in certain circumstances where they did not believe they had the specialist skills required to work with young people with HSB (Fuller, 2021 p. 78, Glenny, 2019, Myles-Wright & Nee, 2020).

The importance of specialist professional training is supported in the literature (Gannon et al., 2019). A meta-analysis revealed that adult clients with a history of poor attachment and relational difficulties can form a working alliance with therapists who are skilled in working with clients with interpersonal difficulties (Del Re et al., 2012; Wampold, 2015). The study found that therapy outcome and prognosis was not linked to a clients' relational style and interpersonal ability to form the therapeutic alliance (Del Re et al., 2012; Wampold, 2015). Whilst not specific to the current population, this evidence highlights that therapist skill in being able to form a working alliance with clients, such as young people with HSB, who may have a history of relational difficulties, is of high importance (Del Re et al., 2012; Wampold, 2015).

These findings are also important in the context of evidence which has found that for young people who have experienced trauma and adversity, their current functioning was more strongly predicted by their relational health than their developmental risk (Cox et al., 2021; Ludy-Dobson & Perry, 2010). Theoretical models such as the 'Trauma Recovery Model' further encapsulate the importance of establishing secure professional relationships to support the integrity of interventions undertaken with young people who have experienced trauma and adversity (Skuse & Matthew, 2015). When the synthesis findings are considered in the context of the wider literature, the training and skill of the professional delivering interventions is important to both the experience of interventions as being trauma-informed, and the efficacy of the intervention as a vehicle for change that may reduce recidivism risk.

Parent/Carer Involvement in HSB Provision

Experiences of parent/carer engagement in HSB interventions are varied in the data. Some parents/carers engaged in interventions from a disempowered position as a result of feelings of powerlessness, sensitivity to blame, and feeling neglected by professionals (Ape-Esera, 2016; Archer, 2017; Barnardo's, 2017; Belton, 2017; Belton et al., 2014; Boyers, 2020; Derezotes, 2000; Geary et al., 2011; Jones, 2015; Kraus, 2014; Warrilow, 2019). These findings are problematic in the context of data which revealed that parent/carer involvement in provision was experienced by both groups as key for relational strengthening and supporting the recognition of the intervention as a shared process, which supported hopes for discharge (Ape-Esera, 2016; Geary et al., 2011; Kraus, 2014; Martin, 2004).

Findings that suggest that some parents/carers had a distressing experience of HSB provision can be understood in the context of a conceptual model developed to account for parent/carer responses to the identification of their child's HSB (Duane et al, 2002). The model proposes that following the identification of HSB, parents/carers experience a range of strong emotions such as shock, confusion, acceptance, shame, anger, and sadness, which can lead to disbelief, minimisation, searching/questioning, guilt, and self-blame (Duane et al., 2002). Developed from the findings of a qualitative study exploring the psychological adjustment of parents/carers over the course of a psycho-educational programme, the conceptual model can be used to contextualise parent/carer reports of distress in relation to HSB provision (Duane et al., 2002). Responses such as shame, disbelief, minimisation, confusion, and questioning can be understood as defensive mechanisms that function to protect the parent/carer from the emotional impact of the HSB (Duane et al., 2002). These responses are likely to

influence the interactions with and experiences of HSB provision. For parents/carers who have experienced their own adversity, such emotions and responses may be even more heightened.

Parent/carer experiences of HSB provision that could be considered distressing cannot be conceived as wholly disconnected from their own responses to the HSB, and potential prior experiences of adversity. Whilst this does not discount the reality of insensitive service provision for some, generally, some study authors have failed to critically account for the potentially complex and layered responses of parents/carers to HSB provision. The tendency for study authors to accept parent/carer reports of poor HSB provision at face value is problematic as the multi-layered emotional distress experienced by some parents/carers may continue to go unrecognised.

This knowledge gap limits the understanding and ability to appropriately respond to potentially complex parent/carer support needs. However, consideration of the responses of parents/carers to HSB provision helps contextualise findings which suggests that parental sensitivity to blame and shame can be mitigated through professional praise, validation, and support (Archer, 2017, Boyers, 2021; Kraus, 2013, Warrilow, 2019). This review critically extends the findings of previous reviews that identified the importance of parent/carer involvement in HSB provision (Campbell, 2015; Campbell, 2020). Whilst the reviewers acknowledged that parent/carer responses to the HSB may impact their capacity to engage in interventions, this synthesis demonstrates that parent/carer experiences of provision (potentially predicated on personal defensive responses and/or experiences of poor professional

practice), can further undermine the ability of services to involve parent/carers in provision.

Practically, these findings demonstrate that parents/carers have distinct needs that should be attended to when necessary to support meaningful engagement in HSB provision. Models such as the Trauma Outcomes Process Model (TOP) provide a helpful conceptualisation of complex parent/carer needs that can be consulted by HSB services (Rasmussen, 2000). TOP is underpinned by the premise that responses to distress and trauma (either related to the incidence(s) of HSB or general lived experiences) can result in internalising and externalising emotions, which necessitate individual sessions with parents/carers to support emotional exploration (Pierce, 2011; Rasmussen; 2000). Parent/carer awareness of responses can then be drawn upon to support the young person-parent/carer relationships; the importance of dynamic interventions to sustain change is acknowledged (Pierce, 2011; Rasmussen; 2000). Whilst value is placed on the dynamic process of HSB interventions, parent/carer support may necessitate more specialist and wider ranging support such as the recruitment of systemically trained professionals in specialist services and advocating for a multiagency approach to support the complex needs of the family system.

The Use of Groups in HSB Provision

Contrasting data emerged on young people and parent/carer experiences of group-based intervention and support. Seven studies revealed that feelings of shame, fear and the presence of other young people inhibited both young people and parents/carer engagement in groups (Ape-Esera, 2016; Derezotes, 2000; Duane et al., 2002; Geary et al., 2011; Gxubane, 2019; Northey, 1995; Pierce, 2011). However, data from twelve

studies found that some valued the relational benefits of groups such as the potential for the group to have a destigmatising impact through identifying and connecting with others, which contributed to a strengthening of relationships for some (Ape-Esera, 2016; Archer, 2017; Duane et al., 2002; Franey et al., 2004; Geary et al., 2011; Gorden et al., 2020; Gxubane, 2019; Jones, 2015; Lawson, 2003; Martin, 2004; Northey, 1995; Somervell & Lambie, 2009). These contrasting findings align with the findings of previous reviews and highlight the subjective and variable experience of group HSB programmes (Campbell et al., 2015; Campbell et al., 2020).

More broadly, these findings are supported in both the general and HSB/offender specific literature (Yalom, 1995; Reimer & Mathieu, 2006; Sribney & Reddon, 2008). Twelve therapeutic factors which correspond to mechanisms of change in group therapy have been established in the wider literature: universality, altruism, catharsis, identification, the input and output of interpersonal learning, group cohesiveness, guidance, family re-enactment, instillation of hope, existential factors, and self-understanding (Yalom, 1995; Reimer & Mathieu, 2006). These interdependent factors are common across group settings and modalities, although the importance placed on the individual factors has been found to vary relative to the group context (Sribney & Reddon, 2008). The synthesis findings indicate that group factors such as universality and group cohesiveness were experienced as mechanisms of change for young people and parents/carers who experienced isolation and shame, potentially because of the incidence(s) of HSB and/or adverse life experiences (Pierce, 2011; Yalom, 1995).

There is limited research on the use of groups in adolescent HSB interventions. However, the synthesis findings can be considered alongside the findings from one

study of groups in a voluntary treatment facility for adolescents with a sex offence, which found that catharsis and group cohesiveness were ranked the most important group therapeutic factors by the adolescents (Sribney & Reddon, 2008). In line with the current findings, a significant correlational relationship was identified between treatment length and experience of group cohesiveness (Sribney & Reddon, 2008). Taken together, these findings indicate the importance of careful facilitation and time in a group to support stability and security in group member relationships. Furthermore, from a trauma-informed perspective, the process of establishing trust, collaboration and safety within groups can vary relative to the individual needs of group members (Grady et al., 2017). This is evident in the diversity of findings on experiences of groups.

Both the current findings and wider literature highlight concern over the potential for negative dynamics to emerge when young people with relational and behavioural difficulties gather for the purposes of an intervention. The ability to manage such challenging dynamics within groups may be further impacted by the tendency for HSB group provision to be delivered in a one size fits all format, which risks obscuring the individual treatment and support needs of both parents/carers and young people. From a critical perspective, the delivery of HSB interventions in a group setting offers a cost-effective way for some services to deliver HSB provision. Whilst it is noted that there are some benefits to group participation, such as relational strengthening and destigmatisation, from a trauma-informed perspective, the complex and multifarious needs of young people with HSB are complex to attend to within a group setting (Center for Sex Offender Management, 2006; Gxubane, 2019).

Understanding the Experiences of Professionals

Eight studies revealed that some professionals experienced strong emotional responses to the work, such as fear, anxiety, and frustration, which for some, led to a sense of powerlessness, self-doubt, and perceptions of professional failure (Almond, 2014; Ape-Esera, 2016; Chassman et al., 2010; Crump, 2018; Fuller, 2021; Myles-Wright & Nee, 2020b; Shevade et al., 2011). Although the experience of such emotions can be a normal response to challenging work, some professionals experienced distress that led to a shift in psychological functioning. These findings evidence the reciprocal dynamic experienced between young people, their parents/carers. and professionals through HSB provision. Professionals' ability to therapeutically attend to dynamic processes and recognise, accept, and manage such emotional responses is necessary to upholding trauma-informed practice by reducing the risk of reinforcing experiences of damaging relationships (Levenson, 2014).

Six studies identified therapeutic boundaries and the provision of reflective, and culturally informed supervision as aspects of the work that were protective against the pervasive impact of potential distress (Almond, 2014; Ape-Esera, 2016; Chassman et al., 2010; Myles-Wright & Nee, 2020b; Russell & Harvey, 2016; Shevade et al., 2011). Professionals discussed supervision as a "critical avenue of support" which led some to feel valued and cared for by their organisations, and hence can be considered an aspect of the work that is trauma-informed and sensitive to experiences of distress (Almond, 2014; Ape-Esera, 2016; Chassman et al., 2010, p. 273; Myles-Wright & Nee, 2020b; Russell & Harvey, 2016; Shevade et al., 2011). However, four studies revealed that organisational pressures, such as target-driven practice had impeded the quality of supervision for some, and influenced an insensitive management style,

which had a negative impact on professional wellbeing (Almond, 2014; Ape-Esera, 2016; Chassman et al., 2010; Myles-Wright & Nee, 2020b). This led some to feel mistrustful and devalued by the wider organisation, and some believed that the organisation had neglected to understand the challenging nature of HSB work (Almond, 2014; Ape-Esera, 2016; Myles-Wright & Nee, 2020b). Similarly, some young people and parents/carers also felt neglected, mistrustful, devalued, and powerless through their interactions with professionals in HSB provision.

Collectively, these findings can be understood through the concept of a parallel process, which has been defined as a phenomenon that occurs when two or more systems (individuals, groups, or teams) operate closely in relation to one another and come to develop similar behaviours, affects, and cognitions (Smith et al., 1989, p. 13). This phenomenon can be common within organisations that support individuals who have experienced trauma and adversity as the work is often occupied by powerful emotional responses and highly complex interpersonal interactions (Bloom, 2010). Such dynamics can have a powerful psychological impact on the wider professional systems and particularly on professionals who may have their own history of trauma and adversity (Bloom, 2010). A parallel process can emerge when organisations are ill-equipped to recognise, manage and sensitively respond to experiences of collective distress (Bloom, 2010). Such distress may instead be defended against or relieved through authoritarian, reactive or neglectful care, which can further reinforce service user experiences of interpersonal trauma (Bloom, 2010). The findings of the current study are suggestive of some of these processes at play.

Further, the erosion of reflective supervisory structures and the predominance of top-down interactions is identified as a key feature of trauma-organised systems as the ability to reflect, weigh-up and clearly communicate information is inhibited due to organisational stress and reactivity (Bloom, 2001, Kanter and Stein, 1992). Study findings revealed professional dissatisfaction with the reflective and supervisory structures within some organisations, which may have been functioning as trauma-organised systems. These processes can pose a risk to the delivery of safe, relationally based, and empathic care, and potentially perpetuate young people and parent/carer distress through iatrogenic trauma.

Organisational change is a necessary systemic process, although the demands of this on professional support structures, working cultures, and service users cannot be underestimated, particularly within organisations supporting high-risk and high-vulnerability individuals (Bloom, 2010; Pascale et al, 2000). Further investment in the development of trauma-informed and sensitive HSB provision from both a systemic and individual perspective has the potential to improve the experience and engagement of young people, parents/carers and professionals to uphold the ultimate aim of reducing recidivism risk and preventing further victimisation.

Limitations

Only the data contained within the results/findings sections of included studies was coded for the purposes of this synthesis. However, relevant data held elsewhere within studies may have been missed. The decision to analyse only the results/findings sections of studies was informed by the time limitations of the project.

Methods of qualitative syntheses have been criticised due to the risk of dismissing nuance through decontextualising the sources of qualitative data, which may obscure the complexities of the individual needs/and experiences of study participants, although the quality of such information is also dependent on the reporting of individual authors (Finfgeld-Connett, 2010; Lachal et al., 2017). This may be a particular limitation of the current study as the components of the specific assessment and intervention approaches have not been accounted for in detail, partly due to the limited information provided in included studies. The setting/context and nature of HSB provision that has formed the focus of included studies have been captured in the 'Table of Included Studies' for the purposes of supporting the reader to discern the study context of the included studies (Appendix B). It is acknowledged that the nature of assessment and intervention tools will frame young people and parent/carers' experiences of HSB provision. However, the value of this synthesis is in identifying the commonality within experiences that could be considered potentially distressing, or indicative of trauma-informed practice in order to consider how trauma-informed practice can be understood in the context of HSB provision.

Quality Assessment and Confidence in Review Findings

There are ongoing ethical concerns regarding the recruitment of young people with HSB into qualitative research studies due to the potential risk of revictimising or causing distress to those who are asked to recall the incidence(s) of HSB and/or explore their own experiences trauma or abuse for the purposes of the research. The impact of research participation on young people with HSB was documented within one study, which stated that, "participants were visibly uncomfortable during their

interviews…Many described how difficult it was for them to return to the treatment office, and the memories this brought up for them…asking participants to revisit their past was more distressing than was assumed" (Franey et al., 2004, p. 313). Few studies documented how young people and/or parents/carers experienced their participation in the research. Furthermore, the quality appraisal of included studies in this synthesis found that few authors referenced measures that had been implemented to support the potential impact of the research on participants. As such, whilst it was documented that ethical approval had been obtained in most (but not all) studies, it is not possible to assess whether support was made available for young people and/or parents/carers both during and after their participation in the studies. This problem featured as a key methodological limitation that contributed to a reduced confidence in some findings during the CERQual assessment. These issues are particularly problematic in the context of trauma-informed practice. It is integral that future research ensures that support is made available for participants and that this is clearly documented within studies to ensure that trauma-informed practice extends to the research undertaken with the three groups.

More so, quality appraisal highlighted limited information on why individuals either chose to take part in the studies, dropped out, or declined to take part. Whilst such detail can be difficult to obtain by nature of individuals often disengaging from contact with researchers, the absence of this information limits the potential for both review authors, researchers, and clinicians to understand why individuals chose not to engage in the research. Where possible and ethically appropriate, attempts to understand the reasons for drop out should be made. It can be reasonably hypothesised that most of the young people and parents/carers who chose to take part in the research felt able to

tell their stories. As such, the service experiences of young people and parents/carers who continue to have significant difficulties in their own lives are less likely to be captured in this QES.

It is also possible that there has been a degree of impression management displayed by participants when engaging in data collection. The potential for both impression management and social desirability bias to impact the nature of participant accounts has received little attention within the included studies. This is problematic when considered in the context of the prevalence of shame and experiences of disempowerment within the data. Social desirability bias is often more prevalent during studies that explore more sensitive subject matter, as is the case in all included studies (Bergen & Labonte, 2020; Grimm, 2010). Impression management and social desirability bias may be prevalent throughout participant accounts pertaining to experiences that could be considered either distressing or trauma-informed. The general absence of researcher reflexivity in most included studies further limits the ability to assess the extent to which researcher characteristics and the research agenda of studies may have impacted participant responses. This limitation has also impacted the CERQual assessment of confidence in some findings.

A proportion of the included studies also did not detail the specific ages of young people when they were either primary research participants, or whose parents/carers and/or allocated professionals were the primary research participants. The specific reporting of participant ages is often avoided to preserve participant anonymity. However, reporting of the participant age range is an approach that can be taken to preserve anonymity whilst also providing sufficient detail for the reader to assess the

relevance of the study to specific client groups, or for the purposes of evidence syntheses. This is reflected on the assessment of confidence in the 'relevance' component of CERQual for some findings. In line with the findings of a recent meta-ethnographic synthesis, caution is recommended in the interpretation of findings due to the possibility that potential nuances in the experiences of professionals working with young people across the broader child and adolescent age range could be missed (Pelech et al., 2021).

Project Limitations

Studies exploring parent/carer and/or professional experiences have not been excluded from the synthesis based on failing to meet the young people's 12-21 years participant age criterion. As the evidence base is still relatively small, the inclusion of parent/carer and/or professional data based on the young person's age criterion would have been limiting. However, included studies were required to use accepted terminology to describe young people with HSB, such as "teenager", "adolescent" and "juvenile," in the absence of providing an age-range. Within the evidence base, such terminology is typically used to describe young people who broadly fit the 12-21 years inclusion criterion. However, it is not possible to guarantee that all data from the included studies is made in reference to young people within the 12-21 years age criterion. This is an accepted limitation of the QES due to deficits within included studies. However, it is unlikely that participants in the studies are pre-pubescent children and/or adults as these groups have distinct treatment needs which are likely to be explicitly documented within published research.

A similar, albeit arguably unavoidable, limitation is that the accounts of participants in the included studies are to varying degrees, retrospective in nature. The retrospective nature of most of the research undertaken on experiences of HSB provision brought carried the dilemma of how to assess the extent to which participant accounts are deemed 'too' retrospective. Some participant accounts within the included studies were from individuals across a broad age range, for example, participants were aged 15-33 years old in one study, although the participants were aged between 12-18 years when they originally engaged in the intervention (Gorden et al., 2020, p. 3). As such, it was agreed that whilst it is methodologically challenging to implement a time-period in which participant accounts are deemed 'too' retrospective, included studies must have documented the age at which young people engaged in the intervention, and this must have been within the 12-21 age range criterion.

Some studies included the reports of participants who have an intellectual disability, although this did not form a specific inclusion criterion for included studies. The data offered by individuals with an intellectual disability has not been excluded from the synthesis as the voices of all young people who met the eligibility criterion have been privileged for inclusion. However, it is acknowledged that young people with intellectual disabilities have distinct needs that have not been accounted for in this project due to the limitations in the project scope (Malovic et al., 2018).

The parent/carers featured in the studies synthesised in this QES mostly identified as female. Whilst generalisability and representation are not principles that underpin the QES method, it is important to acknowledge that the parent/carer voices in the

synthesis are mostly derived from experiences of mothers of young people with HSB. Further research on male parent/carer experiences would diversify the evidence base. Furthermore, several studies do not document the ethnicity of young people with HSB, parents/carers and professionals, and there was scant consideration of how factors such as systemic racism and oppression may impact the both the lived experiences of individuals and the provision of care delivered by services. This may be reflective of a broader evidence gap on the statistics of HSB perpetration in relation to ethnicity. One HSB service case file review found that in 93% of reviewed case files that documented ethnicity, the young person was identified as white and only a small proportion of the work was undertaken with young people from minoritised groups; ethnicity was also not documented in 34.3% of the case files (Hackett et al., 2013). Whilst this data was collected from the 1990s and is potentially reflective of historical oversight, consideration of experiences that may be associated with the ethnicity of individuals is aligned with the principles of TIC and should be appropriately attended to both practically and academically (Hackett et al., 2013).

Strengths

This QES provides a novel contribution to the evidence base as it captures and synthesises the voices of some young people and parents/carers who have had experiences of HSB provision that could be considered distressing. The consideration of such evidence in the context of experiences that could be considered trauma-informed is a unique contribution to the evidence base.

This study attends to a recommendation arising from a previous synthesis of young people and families' experiences of HSB interventions, which advised that future research should explore the voices of young people who have not had successful experiences of interventions (Campbell et al., 2020). Such voices may be integral to supporting the modification and development of future HSB provision that is directly informed by, and flexibly responsive to, the complex needs of all three groups. Due to the often emotive and high-risk nature of HSB provision, it is arguably unrealistic that the risk of services being experienced as distressing will be completely eradicated. More so, there is therapeutic benefit in recognising one's own distress, and the distress of others, as part of the processing of difficult lived experiences and the incidence(s) of HSB. However, this project highlights areas of practice where there is an opportunity for the risk of iatrogenic trauma and distress to be mitigated based on the lived experiences of all three groups. These findings demonstrate how the concept of trauma-informed practice can be conceptualised in HSB provision.

Another key strength of this study rests in the synthesis of the experiences of HSB provision across three groups: young people with HSB, parents/carers and professionals. Whilst separate evidence syntheses have been undertaken on young people and parent/carer experiences of HSB interventions, and professional experiences of delivering interventions, the current study is the first synthesis of the personal experiences of HSB provision from the perspective of all three groups in the context of trauma-informed practice (Campbell et al., 2020; Pelech et al., 2021). The value in the constellation of the voices of all three groups resides in the opportunity to tease out nuances in the dynamic nature of HSB provision and consider how the experiences of the three groups can be interactive, reciprocal, and paralleled.

Crucially, this synthesis also highlights that some parents/carers and young people may experience distress prior to engaging with HSB services. Some experiences of HSB provision that could be considered distressing can be understood as a potential function of the interaction between professional delivery and the personal needs and lived experiences of the client group.

The broader function of this project has been to consider how experiences of HSB provision can inform an understanding of trauma-informed practice in this context. This project is the first study to explicitly integrate the experiences of HSB provision across the three groups with the concept of trauma-informed practice. The findings of this project have revealed how trauma-informed practice in HSB provision can be understood and applied through eliciting the voices and understanding of the lived experiences of the three groups. A data synthesis of the potentially distressing, and trauma-informed experiences of HSB provision provides insight into how services can be sensitive to both the pre-existing experiences of trauma and adversity, and/or the potential distress related to the incidence(s) of HSB. The practice implications that arise from the synthesised voices and lived experiences of individuals presents an opportunity to mitigate the risk of iatrogenic distress. Evidence is indicative of the benefit of trauma-informed approaches to HSB provision as facilitating service engagement, which is integral to supporting change and reducing recidivism risk.

Practice Implications

There are two distinct forms of HSB service provision in the UK, although it is noted that such structures may vary internationally. In the UK, both non-HSB specialist

statutory services (such as the police, social care, and youth justice), and specialist HSB services (which generally require a referral from a professional in statutory services) offer shared and distinct forms of direct input to young people with HSB and their parent/carers, such as assessment, intervention, and support. However, not every young person will have access to specialist HSB provision due to factors such as local availability and level of behavioural concern. Notwithstanding, most young people will have contact with at least one of the statutory services such as the police, social care and/or youth justice services following the identification of HSB. The practice implications stemming from this study will account for the distinct remits of both specialist and non-HSB specialist services.

Firstly, it is recommended that a specialist HSB professional is identified within non-specialist HSB statutory services to support the provision of trauma-informed HSB support. In most statutory services, young people with HSB do not form the primary focus of professional caseloads; it is therefore unrealistic to expect that every professional in these services will receive specialist HSB training. However, the identification of a specialist HSB professional is important to help mitigate the risk of the young person and/or parent/carer having early interactions with statutory services that could be considered distressing, which may potentially impact subsequent engagement in specialist or non-specialist provision.

Training in a HSB assessment and intervention model, alongside more general training on working therapeutically with individuals who have experienced trauma and adversity, would enhance the knowledge and skill set of the specialist professional. The specialist professional could be involved in working directly with

both young people and their parents/carers, whilst also providing specialist consultation and supervision to colleagues who may be less experienced in the area. The development of a regional and/or national network of specialist HSB professionals working in statutory services should be developed to offer reflective supervision and opportunities for peer connection to support professionals to process and manage the emotional impact of the work.

This project has further uncovered how trauma-informed care can be understood and applied in the context of specialist HSB provisions. Firstly, in the context of siloed organisations, professional engagement with young people and their parents/carers should commence at the point of referral from statutory to specialist services. This engagement can occur both directly with the young person and their parent/carer, and indirectly through liaison with the referring professional. Whilst there should be a professional handover of information pertaining to the young person and their family at the point of referral, engagement should also account for any difficulties experienced with service involvement up to the point of referral.

Assessment Recommendations

- Assessments should be conceived as a core element of the intervention process and therefore should be undertaken therapeutically to support the establishment of a working relationship between the young person, parent/carer and professional. The ‘Therapeutic Assessment’ Model can be consulted to support this process.

- Where appropriate, a developmentally sensitive HSB assessment tool should be used to structure professional judgement and assist in providing a holistic understanding of the young person's risk and vulnerability in the context of their lived experiences.
- Where possible, HSB assessments and interventions should be delivered by the same professional to support relational consistency for the young person and parent/carers, which may support subsequent intervention engagement.
- If the young person is reallocated to another professional to commence an intervention, a clear handover of care (including information sharing on the young persons' intervention engagement style and preferences) should be undertaken to support young person-centred service delivery.

Formulation Recommendations

- Each young person should have a bespoke formulation that is informed by a 'Therapeutic Assessment' that identifies how the young person's emotional state and vulnerabilities (e.g., lived experiences of trauma, adversity, and developmental challenges) are linked to the incidence(s) of harm.
- Formulations should be undertaken collaboratively with young people and parents/carers (where appropriate) to support the transition between assessment and intervention and capture the client's voice to support them to feel empowered in intervention engagement.
- Formulations should be seen as a pivotal process that connects the assessment process with risk safety planning and the identification of HSB intervention needs.

- Bespoke formulations should drive person-centred intervention planning to ensure that the young person and parent/carer's intervention needs are appropriately attended to through both the content and delivery of interventions (psychological and therapeutic readiness to engage should be considered as part of the formulation process).

Intervention Recommendations

- The concept of 'intervention' should be seen as more than just individual sessions with the young person and/or family. The opportunity for relational learning is exemplified by the study data and the principle "Every moment and interaction can be an intervention", which should be upheld and enacted by professionals in HSB services (Treisman, 2017).
- Based on a holistic assessment and formulation, interventions should not be solely narrowed to individual work with young people. Collaboration and carefully sequenced coordination with broader service input for the young person and wider family system should be considered wherever indicated.
- A systemically trained professional should sit within specialist services to support individual professionals to consider the intervention and support needs of parents/carers and the wider family system.
- A person-centred approach to the delivery of intervention and assessments that considers session frequency, session length, and assessment/intervention duration is indicated.

Professional Training Recommendations

The below recommendations are applicable to professionals in specialist services and the specialist HSB professional in non-specialist services. These recommendations are provided in addition to professional training in HSB assessment and intervention models.

- Short-course training in basic counselling skills, such as person-centred humanistic counselling, will support professional skill and confidence to establish secure therapeutic relationships with young people and parents/carers
- Bespoke training on the formulation process and the writing of HSB assessment and intervention reports should be delivered to support the sharing of sensitive information that could be potentially interpreted as blaming of the parent/carer and/or distressing to the young person.
- Bespoke training should be delivered that captures the experiences of trauma and adversity reported by some young people and parents/carers either prior to and/or as a result of the incidence(s) of HSB, which should be considered in the context of the potential impact on service engagement.
- Bespoke training should be delivered on non-specific therapeutic approaches to working with young people and parents/carers who have experienced trauma to support professionals to feel confident in adapting the delivery of structured intervention programmes to meet the complex needs of some of the client group.
- The suitability of group work should be individually assessed and provided alongside an individual intervention component.

Staff Support Recommendations:

- Supervision should be provided using an appropriate reflective supervision model to support the development of safety in the supervisory relationship, which may encourage exploration of the emotional impact of the work.
- Supervision should also be attentive to the cultural needs and experiences of the young person and/or parent/carer to ensure that provision delivery is sensitive and responsive to cultural differences, which may help support intervention delivery and engagement.
- The managers of HSB services should be experienced and trained in the delivery of HSB assessments and interventions to provide support to professionals to both develop their practice and explore practice challenges.
- Reflective practice groups and peer supervision should be facilitated for staff teams to support the recognition and processing of the emotional impact of the work and develop working relationships.

Research Recommendations

This study intended to synthesise young people, parent/carer, and professional experiences of HSB assessments. However, only two included studies explicitly explored experiences of HSB assessments. Likewise, there was also limited evidence on the experiences of HSB statutory support services such as social care, the police and youth justice services. Further research on experiences of HSB statutory services and assessments would generate knowledge on how interactions during the initial

stages of the identification of HSB are experienced by young people may impact subsequent service engagement.

Furthermore, whilst potentially challenging to undertake due to the often-siloed nature of HSB provision, case study research on a young person's experience from their initial interaction with services through to the months after service discharge would uncover how young people and parents/carers navigate services and experience the input received. More generally, although the synthesis of the three groups provides some insight into experiences of the therapeutic dyad, process-oriented studies into young people and professional experiences of interventions should be developed to elicit insight into the dyadic nature of interventions which can be used to inform intervention development and staff training.

Future research should document the specific occupational roles of professionals, the age-range and gender of participants, and the service context linked to participant experiences (e.g., statutory service or specialist service). Further research on strengths-based interventions, which have been considered to align with the general principles of trauma-informed care, should be undertaken to identify the specific components of interventions that fit with the emerging understanding of trauma-informed practice in HSB provision (Levenson, 2014).

Conclusion

Based on the voices and lived experiences of young people with HSB, their parents/carers and professionals, there is a clinical need for HSB provision to develop trauma-sensitive and trauma-informed practice. Experiences of HSB provision amongst the three groups were at times shared, and the impact of experiences that could be considered distressing were revealed. These experiences should be considered in the context of the potential interaction between service provision experiences and the distress stemming from adverse life experiences and/or the incidence(s) of HSB. The diverse nature of HSB services presents a challenge for implementing trauma-informed practice. However, the study justifies the development of trauma-informed HSB provision that is both sensitive and attentive to service user needs. Such advancements may improve the engagement, experience, and impact of HSB provision to achieve the aim of reducing young people's risk of harm and preventing further victimisation.

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Appendix A
Ovid PsycInfo Electronic Search Strategy

Date of search	Search Strategy Details	Total number of results found
25 July 2021		
	Population Construct	
	a) Young person	**25,159**
	1. "you* offen*".tw. - 1446	
	2. (adolescen* adj3 "sex* offen*").ti,ab. - 652	
	3. (juvenile* adj3 "sex* offen*").ti,ab. - 759	
	4. (you* adj3 "sex* offen*").ti,ab. - 217	
	5. 1 or 2 or 3 or 4 - 2798	
	49. (juvenile* adj3 "sex* behavio*").ti,ab. - 53	
	50. (adolescen* adj3 "sex* behavio*").ti,ab. - 1304	
	51. exp Juvenile Delinquency/ or exp Juvenile Justice/ or "juvenile delinquen*".tw. - 22933	
	56. 5 or 49 or 50 or 51 - 25159	
	b) Parents/carers	**585,807**

6. parent*.tw. - 284800

7. exp Caregivers/ or carer*.tw. - 36939

8. guardian.tw. - 1555

9. (family*or families).tw. – 391,098

10. 6 or 7 or 8 or 9 – 585,807

c) Professionals **502,259**

11. professional*.tw. – 252,331

12. exp Nurses/ or exp Clinicians/ or practitioner*.tw. or exp Social Workers/

13. exp Psychologists/ or psychologist.tw. – 49238

14. therapist*.tw. or exp Therapists/ - 105,119

15. youth justice practitioner*.tw. - 7

16. youth justice worker*.tw. - 8

17. youth offending team*.tw. - 74

18. youth offending service*.tw. - 24

19. custod*.tw. - 8626

20. you* offen* instit*.tw. - 123

21. mental health profession*.tw. – 17925

22. mental health work*.tw. - 2555

23. 11 or 12 or 13 or 14 or 15 or 16 or 17 or 18 or 19 or 20 or 21 or 22 – 490,409

53. facilitator*.tw. - 15802

61. 23 or 53 – 502,259

2. HSB Construct **39,345**

24. harmful sex* behavio*.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh] - 83

25. problem* sex* behavio*.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh] - 251

26. inappropriate sex* behav*.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh] - 264

27. atypical sex* behav*.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh] - 31

28. IIOC.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh]

29. "image-based sexual abuse".mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh] - 17

30. CSEM.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh] - 32

31. exp Sex Offenses/ or "sex* offen*".tw. - 38925

32. 24 or 25 or 26 or 27 or 28 or 29 or 30 or 31 - 39335

62. CSAM.mp. [mp=title, abstract, heading word, table of contents, key

concepts, original title, tests & measures, mesh] - 12 63. 32 or 62 - 39345	
3. Experiences Construct	**1,962,108**
38. focus group*.tw. - 37284 39. interview*.tw. – 339,682 40. exp Qualitative Methods/ or qualitative.tw. – 180,640 41. account*.tw. – 251,295 42. experience*.tw. – 661,611 43. views.tw. - 71696 44. narrative*.tw. or exp Narratives/ - 71526 45. perspective*.tw. - 292,555 46. phenomenolog*.tw. or exp Phenomenology/ - 46377 47. mixed method*.tw. - 26325 48. questionnaire.tw. or exp Questionnaires/ - 222,312 52. feelings.tw. or exp Emotions/ - 418,910 58. 38 or 39 or 40 or 41 or 42 or 43 or 44 or 45 or 46 or 47 or 48 or 52 – 1,787,605 59. impact.tw. – 343,957 60. 58 or 59 – 1,962,108	
4. Intervention Construct	**2,107,042**

33. intervention*.tw. or exp Intervention/ - 417,959

34. assessment*.tw. - 369,908

35. (therapy or therapies).tw. or exp Treatment/ - 1,137,393

36. follow-up.tw. – 122,710

37. 33 or 34 or 35 or 36 – 1,581,553

54. program*.tw. – 415,726

55. group.tw. – 611,879

57. 37 or 54 or 55 – 2,107,042

Search 1: Young Person search

656

64. 56 and 57 and 60 and 63

Search 2: Parent/carer search

225

66. 10 and 64

Search 3: Professionals search

162

65. 61 and 64

Appendix B
Table of Included Studies

Author(s) (Year)	Location	Aims	Participant Group and Sample Size	Nature of Provision (e.g. Assessment, Intervention, Support)	Details of Provision	Service Context	Data Collection Method	Analytic Method
Almond (2014)	UK	To explore practitioner stories of the impact of working with young people with HSB on professionals, and identify support components	Professionals (n=16)	N/P	N/P	N/P	SSI	Qualitative analysis (specific method not provided)

Ape-Esera (2016)	New Zealand	To explore young people's experience and understanding of the programme; identify the programme's strengths and weaknesses; understand if the programme met young people's individual and cultural needs; provide recommendations for future improvements. Explore professionals and parent care experiences of the programme goals and treatment approach.	YP (n=7) P/C (n=9) Professionals (n=33) Stakeholders (n=4)	Intervention	SAFE Programme	Community programme	SSI and direct programme observations	TA

Author(s) (Year)	Location	Aims	Participant Group and Sample Size	Nature of Provision (e.g. Assessment, Intervention, Support)	Details of Provision	Service Context	Data Collection Method	Analytic Method
Archer (2017)	UK	To explore the experiences of the parents/carers of young people who have engaged in HSB.	P/C (n=6)	Assessment, intervention, support	Specialist assessment and intervention service (multi-agency partnership provision)	Community	SSI	IPA
Barnardo's (2017)	UK	Data used to support parliamentary and governmental understanding of the support and sanctions for young people with HSB.	YP (n=3)	Intervention	Residential treatment (Glebe House)	Residential treatment	Individual interviews	N/P

Author(s) (Year)	Location	Aims	Participant Group and Sample Size	Nature of Provision (e.g. Assessment, Intervention, Support)	Details of Provision	Service Context	Data Collection Method	Analytic Method
Belton (2017)	UK	To understand how the Turn the Page Manual is experienced in a social care context and identify the barriers and facilitators to young people's engagement and programme progress.	YP (n=13) P/C (n=8)	Intervention	Change for Good (known as Turn the Page NSPCC Manualised Treatment Programme)	NSPCC	In-depth interviews and feedback questionnaires	TA
Belton et al., (2014)	United Kingdom	To understand how the Turn the Page Manual is experienced in a social care context.	YP (n=13) P/C (n=9)	Intervention	Change for Good (known as Turn the Page NSPCC Manualised Treatment Programme)	NSPCC	In-depth interviews	Framework approach – Case study with interviews (TA undertaken)

Author(s) (Year)	Location	Aims	Participant Group and Sample Size	Nature of Provision (e.g. Assessment, Intervention, Support)	Details of Provision	Service Context	Data Collection Method	Analytic Method
Boyers (2021)	Australia	To understand how mothers of young people who have used HSB against a sibling construct their experiences.	P/C (n=6)	Not specified.	Participants engaged with public service professionals, private practitioners, and juvenile justice.	Not specified.	SSI (telephone-based)	Feminist narrative thematic methodolog-y
Chassman et al., (2010)	USA and Australia	To explore how experienced counsellors understand, treat and experience young people with HSB.	Professionals (n=18)	Intervention	Counselling	Practice in various settings (private practice outpatient and drop-in mental health clinics, community clinics and residential treatment programmes)	SSI	GT

Author(s) (Year)	Location	Aims	Participant Group and Sample Size	Nature of Provision (e.g. Assessment, Intervention, Support)	Details of Provision	Service Context	Data Collection Method	Analytic Method
Crump (2018)	USA	To understand the lived experiences of counsellors who work with young people with HSB.	Professionals (n=8)	Intervention	Counselling	Mental health agency	SSI	Horizontali-sation, clusters of meaning and coding
Derezotes (2000)	USA	To evaluate the experience of a yoga and meditation experiences for young people with HSB.	YP (n=14) P/C (n=8)	Intervention	Yoga, breathing and meditation programme	Community	Face to face interviews	Not specified
Duane et al., (2002)	Republic of Ireland	To explore the changes in the psychosocial adjustment of parents/carers of young people with HSB taking part in a parent support group programme.	P/C (n=5)	Intervention/Support	Psycho-educational parent support programme	Community	SSI and standardised inventory outcome measures	Thematic content analysis

Author(s) (Year)	Location	Aims	Participant Group and Sample Size	Nature of Provision (e.g. Assessment, Intervention, Support)	Details of Provision	Service Context	Data Collection Method	Analytic Method
Franey et al., (2004)	USA	To explore how participation in a treatment programme has impacted the lives of young people with HSB who have not reoffended.	YP (n=7)	Intervention (mandated)	Day treatment programme	Community	Mixed approach: 1. Record review; 2. Questionnaire; 3. SSI	Emergent design analysis (Maykut & Morehouse, 1994)
Fuller (2021)	USA	To understand how licenced clinicians evaluate successful treatment for young people with HSB in residential treatment facilities.	Professionals (n=11)	Residential therapy	Intervention	Residential treatment	Semi-structured, open-ended interviews	TA with constant comparison method

Author(s) (Year)	Location	Aims	Participant Group and Sample Size	Nature of Provision (e.g. Assessment, Intervention, Support)	Details of Provision	Service Context	Data Collection Method	Analytic Method
Geary et al., (2011)	New Zealand	To identify service user perspectives of the strengths and weakness of a programme delivery undertaken at three New Zealand community treatment programmes for young people with HSB.	YP (n=24) P/C (n= 23)	Intervention	Integrative intervention (involved group, family, and individual intervention). Included therapy-based outdoor activities, CBT, relapse prevention, family therapy, motivational interviewing, Good Way model, Māori health models, experiential, and expressive activities	Community	SSI	TA

Author(s) (Year)	Location	Aims	Participant Group and Sample Size	Nature of Provision (e.g. Assessment, Intervention, Support)	Details of Provision	Service Context	Data Collection Method	Analytic Method
Glenny (2019)	England	To explore what factors Residential Care Workers perceive as impacting their relationship with young people who have engaged in HSB.	Professionals (n=9)	Intervention	Residential treatment (programme not specified)	Residential treatment	SSI	TA
Gorden et al., (2020)	Wales	To explore the experiences of young people with HSB who have completed residential treatment in North Wales.	YP (n=25)	Intervention	Holistic therapeutic treatment approach (four interwoven strands: Care, Education, Therapy and Engagement of Support System around the young person)	Residential treatment	SSI	TA

Author(s) (Year)	Location	Aims	Participant Group and Sample Size	Nature of Provision (e.g. Assessment, Intervention, Support)	Details of Provision	Service Context	Data Collection Method	Analytic Method
Grady et al., (2018)	Ireland	To describe the intervention expectations and experiences of young people with HSB both prior to and following intervention completion.	YP (n=35)	Intervention	Group, individual and family intervention based on CBT and incorporate strengths-based holistic approaches such as the Good Lives Model. Parent/carers attend a fortnightly support group.	Community	Pre and post treatment questionnaires	TA
Griffin & Beech (2004)	England	To explore the appropriateness, usefulness and accuracy of the AIM2 assessment tool.	YP (n=5) P/C (n=2)	Assessment	AIM-2 Assessment	YOT, Social Care, CAMHS, Police, Education	SSI	N/P

Author(s) (Year)	Location	Aims	Participant Group and Sample Size	Nature of Provision (e.g. Assessment, Intervention, Support)	Details of Provision	Service Context	Data Collection Method	Analytic Method
Gxubane (2019)	South Africa	To explore what aspects of the facilitation of an intervention programme (approach, modality, skills and facilitator characteristics) could promote behavioural change for young people with HSB enrolled on the programme.	YP (n=13)	Intervention	Therapeutic and educational individual and group programme guided by cognitive behaviour theories, circle of courage and restorative justice theories.	Residential diversion programme	SSI	Content and TA

Author(s) (Year)	Location	Aims	Participant Group and Sample Size	Nature of Provision (e.g. Assessment, Intervention, Support)	Details of Provision	Service Context	Data Collection Method	Analytic Method
Hackett & Masson (2006)	UK and Republic of Ireland	To understand young people with HSB and parents/carers experiences and views of professional systems and services.	YP (n=14); Parents (n=10)	Intervention	All participants were involved with specialist workers, however, involvement with other workers were variable (e.g. social care, police, and youth justice).	Specialist services working with young people with HSB	Questionnaires	Qualitative analysis (specific method not specified).

Author(s) (Year)	Location	Aims	Participant Group and Sample Size	Nature of Provision (e.g. Assessment, Intervention, Support)	Details of Provision	Service Context	Data Collection Method	Analytic Method
Jones (2015)	USA	To explore how parents/carers have experienced providing support to young people with HSB and explore the lived experience of parents/carers to understand how they have coped with the emotional impact.	P/C (n=8)	Intervention	Family Treatment Program	Community	SSI	Content analysis and constant comparison

Author(s) (Year)	Location	Aims	Participant Group and Sample Size	Nature of Provision (e.g. Assessment, Intervention, Support)	Details of Provision	Service Context	Data Collection Method	Analytic Method
Kjellgren (2019)	Sweden	To explore how young people with HSB remember the incidence(s) and disclosure of HSB, understand how they experienced interventions and examine whether the HSB had impacted on their lives as adults.	YP (n=22)	Assessment (n=3) and intervention (n=19)	Specialist residential or outpatient treatment focused on HSB (individual and group treatment) and residential or outpatient treatment	Social welfare services	SSI	Qualitative content analysis

Author(s) (Year)	Location	Aims	Participant Group and Sample Size	Nature of Provision (e.g. Assessment, Intervention, Support)	Details of Provision	Service Context	Data Collection Method	Analytic Method
Kraus (2014)	USA	To explore young people with HSB and their parents/carers experience of family therapy completed as part of treatment requirements and to understand how participation in family therapy impacts young people's participation in individual interventions.	YP (n=10) P/C (n=15)	Intervention	Family Therapy	Outpatient and residential treatment programmes	Mixed method: Individual and joint interviews; Focus Groups; demographic questionnaires	Constructivi-st GT

Author(s) (Year)	Location	Aims	Participant Group and Sample Size	Nature of Provision (e.g. Assessment, Intervention, Support)	Details of Provision	Service Context	Data Collection Method	Analytic Method
Lambie & Price (2015)	New Zealand	To examine the transition experiences of young people with HSB following treatment completion and explore whether additional services were required to support successful transition to the community.	YP (n=12) P/C (n=16)	Intervention	SAFE Programme	Community	SSI	TA
Lawson (2003)	USA	To understand how young people with HSB have experiences HSB interventions.	YP (n=7)	Intervention	Multiple systems models delivered over 18 months of outpatient treatment (Chaffin & Worley, 1995).	Community	Mixed methods: 1. Questionnaire; 2. Follow-up face-to-face interview	GT

Author(s) (Year)	Location	Aims	Participant Group and Sample Size	Nature of Provision (e.g. Assessment, Intervention, Support)	Details of Provision	Service Context	Data Collection Method	Analytic Method
Marsay et al., (2018)	South Africa	To investigate the effectiveness of a strengths-based intervention developed in South Africa that aims to cultivate a sense of hope for the future for young people with HSB.	YP (n=9)	Intervention	Hope-Infused Future orientation Intervention	Community	Questionnaires and SSI	Deductive thematic content analysis
Martin (2004)	N/P	To explore young people's experiences of a HSB treatment programme.	YP (n=7)	Intervention	N/P	Residential treatment programme	N/P	N/P
Myles-Wright & Nee (2020)	UK	To explore youth justice practitioners lived experiences of working with young people with HSB.	Professionals (n=5)	Support	Youth Offending Service Support	Community	SSI	TA

Author(s) (Year)	Location	Aims	Participant Group and Sample Size	Nature of Provision (e.g. Assessment, Intervention, Support)	Details of Provision	Service Context	Data Collection Method	Analytic Method
Northey (1995)	USA	To explore the mechanisms and processes involved in young people with HSB's experience of therapeutic change.	YP (n=40)	Intervention	Presumptive realities based treatment	Custodial (youth centres)	Individual interviews	GT
Northey (1999)	USA	To explore the therapeutic and practical consequences of requiring young people with HSB to admit to their offence during the treatment process.	YP (n=40)	Intervention	Sexual offender treatment programme (involved coercive elements: 1. Early release if disclosed offence; 2. Isolation/solitary confinement)	Custodial (youth centres)	Unstructured and open-ended interviews	GT

Author(s) (Year)	Location	Aims	Participant Group and Sample Size	Nature of Provision (e.g. Assessment, Intervention, Support)	Details of Provision	Service Context	Data Collection Method	Analytic Method
Pierce (2011)	USA	To describe the lived experiences of the parents/carers of young people with HSB to support the development of an individualised intervention to meet parent/carer needs.	P/C (n=4)	Intervention	Family Treatment Programme (weekly parent support group)	Community	Focus group and three individual interviews	Content analysis and constant comparison method
Romano & Gervais (2018)	Canada	To explore a range of collateral consequences experienced by the parents/carers of young people with HSB.	P/C (n=16)	Not specified	Hospital-based social worker and psychiatry support	Community	SSI and standardised measures	Qualitative analysis (specific method not provided)

Author(s) (Year)	Location	Aims	Participant Group and Sample Size	Nature of Provision (e.g. Assessment, Intervention, Support)	Details of Provision	Service Context	Data Collection Method	Analytic Method
Russell & Harvey (2016)	UK	To explore the psychosocial experiences of practitioners who work with young people with HSB.	Professionals (n=8)	Support	Youth Offending Service Support	Youth Offending Service Support	SSI	IPA
Shevade et al., (2011)	England	To explore the reactions of therapists working with young people with HSB and understand how these reactions can be managed	Professionals (n=9)	Intervention	Therapy (not specified)	Specialist services, private practice and CAMHS	Open-ended interview	TA

Author(s) (Year)	Location	Aims	Participant Group and Sample Size	Nature of Provision (e.g. Assessment, Intervention, Support)	Details of Provision	Service Context	Data Collection Method	Analytic Method
Somervell & Lambie (2009)	New Zealand	To explore the function of wilderness therapy camps and to theorise about the processes underlying the identified function.	YP (n=7)	Intervention (mandated)	SAFE Programme (wilderness therapy and group therapy)	Community	Three sources: Observation and SSI with young people and therapists.	TA

Author(s) (Year)	Location	Aims	Participant Group and Sample Size	Nature of Provision (e.g. Assessment, Intervention, Support)	Details of Provision	Service Context	Data Collection Method	Analytic Method
Thurston (2006)	USA	To understand how young people with HSB experience family interactions; to understand the emotional needs of young people regarding their family experience; to understand how sexuality is experienced in family interactions; to identify themes regarding young people's experiences of family interactions.	YP (n=20)	Intervention	18-22 month long 'sex offender treatment programme'. Weekly individual and/or group therapy.	Community	SSI	TA

Author(s) (Year)	Location	Aims	Participant Group and Sample Size	Nature of Provision (e.g. Assessment, Intervention, Support)	Details of Provision	Service Context	Data Collection Method	Analytic Method
Warrilow (2019)	UK	To explore the lived experiences of parents/carers of young people with HSB and understand how parents/carers experience professional services.	P/C (n=8)	Multi-agency input (assessment, intervention and support)	N/P	Community	SSI	IPA

Note. This table contains is a summary of the characteristics of included studies obtained during the data extraction process. Abbreviations used for parents/carers (P/C), not provided (N/P), SSI (semi-structured interview), TA (thematic analysis), IPA (interpretive phenomenological analysis) and GT (grounded theory).

Appendix C
Sample Coding Process

Analytical Theme: Theme 6. Parent/carer powerlessness, sensitivity to blame and feeling neglected impacts engagement	
Descriptive Theme: Parents feel disempowered	
Coded Data	**Initial Codes**
“Parents felt ruled by the mandates of the court: I almost feel like a probation officer. We don’t have much say-so, the courts tell us exactly what to do, what plans to follow, and depending on what judge you have, you really can’t interject into it, you can’t do this, you can’t do that" (Jones, 2015, p. 12).	Services hold the power
“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” (Warrilow, 2019, p. 107).	Unheard
“Anna, James and Laura spoke of not feeling that their own needs were held in mind by services when planning their provision. As such, there was an underlying narrative of not being cared for and thought of as a person whose wellbeing holds value" (Archer, 2019, p. 59).	Uncared for
“"I couldn’t make them understand, and that’s where it was really hard… they couldn’t see that I was genuinely trying to do the right thing by everyone… I really, honestly felt like they thought I was playing a game of just trying to get him home, not really caring about the situation and that’s where they were so very wrong. But I couldn’t make them see that” (Boyers, 2021, p. 224).	Parent perspective overlooked

“There is no coping to deal with that. There was no outlet. There was no support. Nothing. I asked through the courts, I asked through here, I asked through other therapists that he was going to what kind of support was out there, and there’s just none ...” (Pierce, 2011, p. 6).	Unsupported

Analytical Theme: Theme 9a. Working with high-risk and high-vulnerability young people can impact professionals' intrapsychic and relational selves	
Descriptive Theme: Impact of the work	
Coded Data	**Initial Codes**
"I didn't feel safe, he made my skin crawl" " (Glenny, 2015, p. 89).	Professionals can feel unsafe
"[…] you just feel that they tug on your heart strings a little bit, and you just think if only their situation had been different, or their history had been different, then their prospects would probably be very different" (Russell & Harvey, 2016, p. 198).	The work has an emotional impact
"I go home and take it out on my partner. I mean I went home feeling sad, frustrated and a little angry and I took these feelings home with me and was not pleasant to be around." (Crump, 2018, p. 59).	Taking the impact out on others
"That has to come on my own time. That has to come in my own therapy sessions or my own ride on the way home in the car. That is overwhelming, which is probably why I don't touch it. 'Cause it's so sad. So sad. You know. What a mess."" (Chassman et al., 2010, p. 273).	Processing the emotional impact of the work is overwhelming
"I have two nephews and I'm always asking them did anyone hurt you today. There's no reason it's just you now look at the world differently knowing that stuff.""(Crump, 2018, p. 54).	Being more suspicious of others

Analytical Theme: Theme 11. Feeling valued by professionals supports engagement	
Descriptive Theme: Positive professional characteristics	
Coded Data	**Initial Codes**
"…having someone to talk to without fear of judgement is probably the main reason it helped" (Grady et al, 2018, p. 90).	Staff are non-judgemental
"The staff are caring and supportive who are always there for you- which feels sometimes surreal." (Barnardo's, 2017, p. 50).	Feeling cared for by staff
"When asked what had helped him most throughout treatment, one reflected: "the kindness of the co-workers, it got me though the last two years with flying colours" (Grady et al., 2018, p. 90).	Kindness of staff is key
"They always listened, whereas you get some people at school and some people at home, they're just there, they pretend to listen, but the CSPs really did listen." (Belton, 2014, p. 41)	Staff listen
"One youth shared how good he felt when the therapist told him he was doing well in front of his family:" "It was like the best family counseling I could ever have … I saw the look on my mom and grandma's face. It made me feel nice and welcome … By [therapist] saying, "… we've got our [higher level] guy now. He's passed through the hardest [treatment] level they can ever pass." He just kept cheering me on and everything. It was really nice. (Kraus, 2014, p. 119)	Praising

Appendix D
GRADE CERQual Summary of Assessment of Qualitative Findings (SoQF) Table

Review Finding	Example Quote	Studies Contributing to the Review Finding	CERQual Assessment of Confidence in the Evidence	Explanation of CERQual Assessment
1. Entering HSB Services Bearing Relational Distress and Shame	*"At pre-treatment, one boy reflected how disclosure had separated him from his family. He described his biggest struggle to be "the relationship with my older brother which has stopped completely"* (Grady et al., 2018, p. 91).	Barnardo's, 2017; Grady et al., 2018; Kraus, 2014; Martin, 2004; Northey, 1995; Belton et al., 2014; Franey et al., 2004.	**Moderate confidence**	**Adequacy** Minor concerns – acceptable range of studies with data richness informed finding. **Relevance** Minor concerns - unclear participant age reporting in two studies (Barnardo's, 2017; Franey et al., 2004). **Cohesion** Moderate concerns. **Methodological limitations**

				Moderate concern– Lack of reflexivity across several studies. Lack of detail provided regarding study procedures and analytic approach. Some studies failed to sufficiently document considerations (Barnardo's 2017; Martin, 2004).
2. HSB Support Services: A Powerful Presence	"*The treatment that I got from [The Police] was completely different from the treatment I got from the youth worker, the social worker or from Glebe. It was very much a case of 'you know you've done bad. You're a nasty person. You're horrible.' It was very demeaning. I'm sat in a room with a solicitor I don't know at 15 with two police officers across the desk and the last thing I wanted to hear at that stage is 'you're a terrible person'"* (Barnardo's, 2017, p. 33).	Archer, 2017; Barnardo's, 2017; Kjellgren, (2019); Hackett & Masson, (2006).	**Moderate confidence**	**Adequacy** Moderate concerns – limited number of studies informed finding. **Relevance** High concern - unclear participant age reporting in all studies (e.g., three young people under the age of 11 in Archer, 2017, however, research focus in the study is on the experiences of parents/carers). **Cohesion** Moderate concern. **Methodological limitations**

				Moderate concern – Two studies did not clearly document the ethics process and provided in sufficient information regarding the study recruitment process, data collection and analytic (Barnardo's 2017; Kjellgren, 2019).
3. Assessments Can Lead to Unmet Needs	*"Needed to talk with someone [...] it never happened, not that I remember anyway [...] I also think it sounds strange but that's the way it is [...] yes I still think so today. I would have liked to talk to someone about my problems*" (Kjellgren, 2019, p. 125).	Griffin & Beech (2004); Kjellgren (2019).	**Low confidence**	**Adequacy** Moderate concerns – low number of studies and participants, and relatively thin data. **Relevance** Minor concerns. **Cohesion** Minor concerns. **Methodological limitations** High concern – method of data collection unclear in Griffin & Beech (2004). Absence of reflexivity and detailed ethics processes across both studies.

				Adequacy Minor concerns – relatively large number of studies informed finding and good data richness. **Relevance** Minor concerns - unclear participant age reporting in two studies (Barnardo's, 2017; Franey et al., 2004). **Cohesion** Minor concern (contradictory data accounted for in theme 7). **Methodological limitations** Moderate concern – Absence of researcher reflexivity across most studies. Some studies fail to sufficiently document ethical considerations.
4. Navigating Intervention Resistance	*"As illustrated by one of the participants when describing the early stages of his treatment, "...that's when I didn't like to talk about nothing and I hated everything and I didn't care. So then I was like, I don't care, you all can send me wherever you want" This type of challenge also speaks to the heterogeneity of JASOs, the need to individualize their treatment, and the important of context"* (Northey, 1995, p. 251)	Kraus, 2014; Martin, 2004; Northey, 1995; Ape-Esera, 2016; Gorden et al., 2020; Crump, 2018; Glenny, 2019; Gorden et al., 2020; Martin, 2004; Myles-Wright & Nee, 2020b; Northey, 1995; Shevade et al., 2011; Almond, 2014.	**High confidence**	
5. Talking is Hard When You're Not Seen	*"I hate to have to look over his homework. I just don't want to look at it, but I will make myself because it's what you have to do"* (Jones, 2015, p. 1310).	Kraus, 2014; Martin, 2004; Northey, 1995; Ape-Esera, 2016,	**Moderate confidence**	**Adequacy** Minor concerns – acceptable number of studies informed finding with good data richness.

		Barnardo's. 2017; Kjellgren, 2019.		**Relevance** Moderate concerns - unclear participant age reporting in two studies (Archer, 2017; Barnardo's, 2017). The ages and genders of young people that professionals worked with were not directly reported in one study (Shevade, 2011). **Cohesion** Minor concerns **Methodological limitations** High concern - Absence of researcher reflexivity across most studies. Some studies do not sufficiently document ethical considerations.
6. Parent/carer Powerlessness, Sensitivity to Blame, and Feeling Neglected	*"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"* (Warrilow, 2019, p. 93).	Archer, 2017; Boyers, 2021; Geary et al., 2011; Kraus, 2014; Warrilow, 2019;	**High confidence**	**Adequacy** Minor concerns - good number of studies informed finding with good data richness. **Relevance**

Impacts Engagement		Hackett & Masson, 2006; Jones, 2015; Ape-Esera, 2016; Belton, 2017; Derezotes; 2000; Belton, 2015; Franey at al., 2004.		No or very minor concerns. **Cohesion** Minor concern (contradictory data captured in theme 11). **Methodological limitations** Moderate concern – Absence of researcher reflexivity across some studies. Some studies fail to sufficiently document ethical considerations.
7. The Sexual Content of Sessions: Negotiating Avoidance and Tolerating Shared Discomfort	*"I hate to have to look over his homework. I just don't want to look at it, but I will make myself because it's what you have to do"* (Jones, 2015, p. 1310).	Almond, 2014; Archer, 2017; Chassman et al., 2010; Jones, 2015; Shevade et al., 2011; Kjellgren, 2019.	**Moderate confidence**	**Adequacy** Moderate concerns – only reported by a few participants in study, however relevant data was rich. **Relevance** Moderate concerns - unclear participant age reporting in two studies (Archer, 2017; Barnardo's, 2017). The ages and genders of young people that professionals worked with were not directly reported in one study (Shevade, 2011),

				Cohesion Minor concerns. **Methodological limitations** Moderate concerns – Lack of reflexivity across most studies. One study did not adequately document the ethics process (Kjellgren, 2019).
8. Engagement in Groups is Inhibited by Shame	*"I would sit in parents' group and not say a word. Not a word…It's still something you just don't want to talk about because you're faced with it so much. I think the shamefulness kicks in. Mine did"* (Pierce, 2011, p. 178)	Ape-Esera, 2016; Derezotes, 2000; Geary et al., 2011; Gxubane, 2019; Martin, 2004; Northey, 1995; Pierce, 2011; Duane et al., 2002.	**High confidence**	**Adequacy** Minor concerns - good number of studies informed finding with good data richness. **Relevance** No or very minor concerns. **Cohesion** Minor concern (contradictory data captured in theme 13). **Methodological limitations**

				Moderate concern – Absence of researcher reflexivity across most studies. Some studies fail to sufficiently document ethical considerations.
9. Professional Experiences	*"I don't feel that they (senior management) .respect or really care about me...I'm just... a little cog in a wheel (and) if I disappeared tomorrow they wouldn't be that interested"* (Almond, 2014, p. 342).	Glenny, 2019; Shevade et al., 2011; Almond, 2014; Chassman et al., 2010; Shevade et al., 2011; Crump, 2018; Glenny, 2019; Myles-Wright & Nee, 2020b; Shevade et al., 2011; Fuller, 2021; Russell & Harvey, 2016l Ape-Esera, 2016.	**High confidence**	**Adequacy** Minor concerns - good number of studies informed finding with good data richness. **Relevance** Moderate concerns – the ages and genders of young people that professionals worked with were not directly specified in some studies. **Cohesion** Minor concern (contradictory data accounted for in theme 14) **Methodological limitations** Moderate concerns – Consideration of researcher reflexivity is not consistently evident across studies. Several studies also lack consideration of credibility measures.

				Adequacy Minor concerns - good number of studies informed finding with good data richness. **Relevance** Moderate concerns – the ages and genders of young people that professionals worked with were not directly specified in some studies. **Cohesion** Minor concern (contradictory data accounted for in theme 14) **Methodological limitations** Moderate concerns – Consideration of researcher reflexivity is not consistently evident across studies. Several studies also lack consideration of credibility measures.
9a) Working with High-Risk and High-Vulnerability can Impact Professionals' Intrapsychic and Relational Selves	*"(sighs) it was hard being able to continue to think…So actually just managing to contain him in the room and think about what was going on and just manage, just being with him was, was really – that was the challenge…it was a challenge to keep thinking"* (Shevade et al., 2011, p. 59).	Glenny, 2019; Shevade et al., 2011; Almond, 2014; Chassman et al., 2010; Shevade et al., 2011; Crump, 2018; Glenny, 2019; Myles-Wright & Nee, 2020b; Shevade et al., 2011; Fuller, 2021; Russell & Harvey, 2016.	**High confidence**	
9b) Professional Wellbeing at Risk	*"…the organisation is becoming more target this, target that; supervision is 'have you done this,*	Almond, 2014; Ape-Esera, 2016;	**Moderate confidence**	**Adequacy** Moderate concerns - low number of studies informed

from Systemic Stressors: "A Very Uncontained, Frightening Place to Be"	*have you done that in these timescales'...I don't think I would feel confident to sit down with my manager...and just cry...if you don't feel supported and contained that's what makes it so incredibly scary..."* (Almond, 2014, p. 344).	Myles-Wright & Nee, 2020.		finding, although data richness was acceptable. **Relevance** Moderate concern – the ages and genders of young people that professionals worked in two studies (Almond, 2014; Myles-Wright & Nee, 2020. **Cohesion** Minor concerns (contradictory data accounted for in theme 14). **Methodological limitations** Moderate concerns – Consideration of researcher reflexivity is not consistently evident across studies. Several studies also lack consideration of credibility measures.
10. Developing Empathy and Self-Worth Through	*"I learnt quite a lot about my family history and stuff that had happened to us that I just couldn't remember and all that, which was actually very helpful but also, I...just learnt a bit of self-*	Barnardo's, 2017; Belton et al., 2014; Martin, 2004).	**High confidence**	**Adequacy** Minor concerns – acceptable number of studies and data richness.

Therapeutically Exploring Lived experiences	*worth… and control and stuff"* (Belton et al., 2014, p. 40).	Franey et al., 2004; Kraus, 2014; Geary et al., 2011.		**Relevance** Minor concerns - unclear participant age reporting in two studies (Barnardo's, 2017; Franey et al., 2004). **Cohesion** Minor concerns (contradictory data accounted for in themes 5, 6 and 7). **Methodological limitations** Moderate concerns – Lack of reflexivity across several studies. Lack of detail provided regarding study procedures and ethical consideration in some studies.
11. Feeling Valued by Professionals Supports Engagement	*"[Therapist] would ask these real deep questions, and he never put me down. He wasn't judgmental. … There were places where I don't feel like I was allowed to really grieve and be angry and be sad and on the level that he knew I was on. And so, he would ask me these questions and it opened up the door for me to be free"* (Kraus, 2014, p. 134).	Ape-Esera, 2016; Grady et al., 2018; Kraus, 2014; Romano & Gervais, 2018; Archer, 2017; Belton, 2017; Belton et al., 2014;	**High confidence**	**Adequacy** No or very minor concerns – High number of included studies and good data richness across studies. **Relevance** Minor concerns - unclear participant age reporting in three studies (Archer, 2017; Barnardo's, 2017; Franey et al., 2004).

		Boyers, 2020; Gxubane, 2019; Martin, 2004; Northey, 1995; Barnardo's, 2017; Warrilow, 2019; Hackett & Masson. 2006; Gorden et al., 2020; Lambie & Price, 2015; Shevade et al., 2011; Franey et al., 2004.		**Cohesion** Minor concerns (contradictory data accounted for in themes 5 and 6). **Methodological limitations** Moderate concerns – Lack of reflexivity and consideration of credibility across some studies. Lack of detail provided regarding study procedures, analytic method used and ethical consideration in some studies.
11a) A Non-Judgemental Approach Facilitates Trust	*"Even if I do wrong and then I tell them about it. Instead of you're getting a consequence right now by being out of this program in two days. It's more of thank you [youth] for at least letting us [therapists] know...And it's usually no*	Ape-Esera, 2016; Barnardo's, 2017; Geary et al., 2011; Grady et al., 2018; Kraus, 2014;	**High confidence**	**Adequacy** No or very minor concerns – High number of included studies and good data richness across studies.

	consequence...I won't be judged as long as I come out and be honest...he [therapist] told me that no matter what I won't be judged" (Kraus, 2014, p. 133).	Romano & Gervais, 2018.		**Relevance** Very minor concern - unclear participant age reporting in one study (Barnardo's, 2017). **Cohesion** Minor concerns (contradictory data accounted for in theme 6). **Methodological limitations** Moderate concerns – Lack of reflexivity and consideration of credibility across some studies. Lack of detail provided regarding study procedures, analytic method used and ethical consideration in some studies.
11b) Being Listened To	*"...but the CSPs really did listen. They actually just said, 'well why do you think this? how did this make you feel?' and actually got you to think how you feel a lot more"* (Belton, 2017, p. 40; Belton et al., 2014, p. 41).	Archer, 2017; Belton, 2017; Belton et al., 2014; Boyers, 2020; Gxubane, 2019; Martin, 2004; Northey, 1995.	**High confidence**	**Adequacy** Very minor concerns – Good number of included studies and good data richness across studies. **Relevance** Minor concern - unclear participant age reporting in two studies (Archer, 2017; Barnardo's, 2017).

				Cohesion Minor concerns (contradictory data accounted for in theme 5) **Methodological limitations** Moderate concerns – Lack of reflexivity and consideration of credibility across some studies. Lack of detail provided regarding study procedures, analytic method used and ethical consideration in some studies.
11c) Feeling Cared For	*"The staff are caring and supportive who are always there for you- which feels sometimes surreal"* (Barnardo's, 2017, p. 50).	Archer, 2017; Belton, 2014; Barnardo's, 2017; Kraus, 2014; Warrilow, 2019.	**High confidence**	**Adequacy** Moderate concerns – Acceptable number of included studies, although data thickness is limited in studies. **Relevance** Minor concern - unclear participant age reporting in two studies (Archer, 2017; Barnardo's, 2017). **Cohesion** Minor concerns (contradictory data accounted for in theme 5) **Methodological limitations**

				Moderate concerns – Lack of reflexivity and consideration of credibility across two studies (Belton, 2014; Barnardo's. 2017). Lack of detail provided regarding study procedures, analytic method used and ethical consideration in two studies (Belton, 2014; Barnardo's. 2017).
11d) Professional Praise and Support as a Counter to Isolation and Blame	*"They're always telling me how great it is that I'm there for him. It feels really good...It made me feel really proud. And you know, it's not often a person gets to feel proud of themselves and knowing somebody says stuff like that, it helps. It makes you feel a lot better, especially in the midst of all this happening"* (Kraus, 2014, p. 116).	Archer, 2017; Boyers, 2020; Kraus, 2014; Warrilow, 2019.	**High confidence**	**Adequacy** Moderate concerns – Small number of included studies, although good data richness noted within the studies. **Relevance** Very minor concern - unclear participant age reporting in one study (Archer, 2017). **Cohesion** Minor concerns (contradictory data accounted for in theme 6) **Methodological limitations** No concerns – Good reflexivity, consideration of credibility and detail provided regarding study procedures, analytic method used and ethical consideration across all studies.

				Adequacy Minor concerns – Acceptable number of studies and data richness across studies.
12. Parent/Carer Involvement Strengthens Family Relationships and Supports Discharge	*"They [parents] were like, If we would've left you, then we would've done it a long time ago, but we're still here and we're not going to give up on you." Like I said, I think they really dug in on that one, and I think [therapist] kind of started that. He initiated that feeling of care and support, and just kind of initiated that so my parents could grab onto it and finish it up"* (Kraus, 2014, p. 145)	Geary et al., 2011, Kraus, 2014. Martin, 2004; Ape-Esera, 2016.	**Moderate confidence**	**Relevance** No or very minor concerns. **Cohesion** Minor concerns. **Methodological limitations** Moderate concern – lack of detail provided regarding ethical considerations in two studies (Geary et al., 2011; Martin, 2004).
13. The Relational Value of Groups	*"Some other issues are too sensitive to be spoken in groups. Kind of embarrassing to disclose the details about your rape … because others will laugh at you. (YR 1)"* (Geary et al., 2018, p. 10)	Ape-Esera, 2016; Archer, 2017; Geary et al., 2011; Gxubane, 2019; Jones, 2015; Lawson, 2003 Duane et al., 2002;	**High confidence**	**Adequacy** Minor concerns - Minor concerns - high number of studies informed finding with good data richness. **Relevance** Minor concerns - unclear participant age reporting in two

		Ape-Esera, 2016; Franey et al., 2005; Gorden et al., 2020; Martin, 2004; Somervell & Lambie, 2009; Northey et al., 2015; Hackett & Masson, 2006.		studies (Archer, 2017; Franey et al., 2004). **Cohesion** Minor concern (contradictory data to theme captured in theme 8). **Methodological limitations** Moderate concerns - Lack of researcher reflexivity/credibility measures across most studies. Some studies do not sufficiently document ethical considerations.
14. Professionals and Their Organisations: a need for connection	*"...proper clinical supervision with somebody who is completely at ease with, yeah, talking about stuff that, that can feel quite uncomfortable and, and yeah, that we have that completely separate from line management quality assurance performance indicator type supervision, that we have a space where we can really go and sit in that we don't do that for ourselves but that we have somebody who facilitates that for us"* (Myles-Wright & Nee, 2020, p. 2066).	Chassman et al., 2010; Myles-Wright & Nee, 2020; Almond, 2014; Russell & Harvey, 2016; Shevade et al., 2011; Ape-Esera, 2016.	**Moderate confidence**	**Adequacy** Moderate concerns – acceptable number of studies and data richness, although these experiences were not discussed frequently and/or in depth across the studies. **Relevance** Moderate concerns – the ages and genders of young people professionals worked with were not directly specified (Almond, 2014; Myles-Wright & Nee, 2020; Shevade et al., 2011).

	Cohesion Minor concerns (contradictory data noted in theme 9a and 9b).
	Methodological limitations Moderate concerns - Lack of researcher reflexivity/credibility measures across most studies. Some studies do not sufficiently document ethical considerations.