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Article:

Campbell, F., Booth, A., Hackett, S. et al. (2020) Young people who display harmful sexual behaviors and their families. A qualitative systematic review of their experiences of professional interventions. *Trauma, Violence, & Abuse*, 21 (3). pp. 456-469. ISSN: 1524-8380

<https://doi.org/10.1177/1524838018770414>

Campbell F, Booth A, Hackett S, Sutton A. Young People Who Display Harmful Sexual Behaviors and Their Families: A Qualitative Systematic Review of Their Experiences of Professional Interventions. *Trauma, Violence, & Abuse*. 2020;21(3):456-469. Copyright © 2018 The Author(s). DOI: <https://doi.org/10.1177/1524838018770414>. Article available under the terms of the CC-BY-NC-ND licence (<https://creativecommons.org/licenses/by-nc-nd/4.0/>).

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Young people who display harmful sexual behaviors and their families. A qualitative systematic review of their experiences of professional interventions

Abstract

It is estimated that 30-50% of all childhood sexual abuse involves other young people as perpetrators. The treatment of harmful sexual behaviour (HSB) in young people has evolved from interventions developed for use with adult perpetrators of sexual offenses. Increasingly these approaches were not seen as appropriate for use with young people. The purpose of this qualitative systematic review was to establish what intervention components are viewed as acceptable or useful by young people and their families in order to inform the development of interventions for young people with HSB. We conducted searches across 14 electronic databases, as well as contacting experts to identify relevant studies. Thirteen qualitative studies were included in the analysis, reporting findings from intervention studies from the UK, USA, New Zealand, Australia and Ireland. Thematic analysis was used to combine findings from the studies of young people and parent/carers views. Five key themes were identified as critical components of successful interventions for young people with HSB. These included the key role of the relationship between the young person and practitioner, the significance of the role of parents and carers, the importance of considering the wider context in which the abuse has occurred, the role of disclosure in interventions and the need to equip young people with skills as well as knowledge. The evidence was limited by the small number of studies which were mainly from the perspectives of adolescent males.

Introduction

Since the early 1990s, there has been increasing recognition that children and youth may display sexual behaviors that lie outside normative developmental parameters and can be experienced as harmful or abusive by others (Hackett, 2014). Changing terminology to describe this group of children and their behaviors reflects a shift in understanding and approach away from viewing them simply as ‘mini’ adult sex offenders (Hackett et al 2005) to an approach which embodies a positive and child-centred philosophy (Myers, 2002). In this paper, we use ‘harmful sexual behavior’ as a descriptive term that avoids labelling children as sexual offenders, recognising the considerable variation among children and youth in terms of the nature and range of the harmful sexual behaviors expressed as well as their motivating factors.

Despite increasing interest in youth with harmful sexual behaviors, there is relatively little population-based epidemiological data about such youth or their offenses (Finkelhor, Ormrod and Chaffin, 2009). The largely hidden nature of child sexual abuse makes recognition difficult. The stigma and shame associated with victimisation may lead to under-reporting and the broader social context is one of hostility towards individuals responsible for acts of sexual abuse. All these factors make it difficult to measure accurately the true scale of the problem. Nonetheless, official statistics and existing research suggest that at least a quarter of all sex offenders in the USA are juveniles (Finkelhor, Ormrod and Chaffin, 2009) and that between a fifth and a third of all child sexual abuse in the UK involves other children and adolescents as perpetrators (Hackett, 2014).

An inspection of the effectiveness of multi-agency work with youth with harmful sexual behavior in the UK found that practice responses were generally poor: opportunities for early intervention at the onset of harmful sexual behaviors were often missed; there were few

examples where holistic, multi-agency assessments had been undertaken and shared or of subsequent multi-agency interventions; and case management was often compromised by poor communication and information sharing (Criminal Justice Joint Inspection, 2013).

Examples of good practice were identified, but the needs of youth were generally poorly met by the services working directly with them (Criminal Justice Joint Inspection, 2013).

In this review we consider the perspectives of children and youth, and their families, undergoing interventions for harmful sexual behavior. The work was undertaken as part of an evidence synthesis of quantitative and qualitative evidence to support the development of National Institute for Health and Care Excellence (NICE) guidance 'Harmful sexual behaviour among children and young people' (NICE, 2016). The results of the evidence synthesis of quantitative studies are the focus of a forthcoming article.

Methods

We used a qualitative evidence synthesis methodology for this study, drawing upon established principles of systematic review. Systematic reviews are undertaken using explicit and transparent methods to identify, appraise and synthesise research (Gough et al 2012).

Qualitative evidence synthesis is a process of combining evidence from individual qualitative studies which have undertaken an in-depth enquiry to understand meaning, not to simply gather a description of how people feel about an issue or a treatment but to reach an understanding of 'why' they feel and behave the way they do (Popay, 2005). Qualitative research is broadly characterised as studies that use qualitative methods both for data collection and data analysis (Noyes & Lewin, 2011).

Identification of evidence.

An initial scoping search was conducted across multi-disciplinary bibliographic databases to inform the strategy for the final search. Subsequently, a two-strand approach was applied to the final searches, whereby a search using terms for specific interventions was conducted, followed by a sensitive search using generic intervention terms. We developed the final search terms from the scoping search and in discussion with the NICE team. Thesaurus and free-text terms were utilised, relating to the population (children and youth who demonstrate harmful sexual behavior) and intervention terms. All searches were limited to English Language, Humans, and the publication time span of 1990-Current. All searches were conducted in March 2015 and updated in February 2017. See Appendix 1 for an illustrative strategy from the MEDLINE database. We also undertook citation searching for each identified study following inclusion.

We searched the following electronic databases: MEDLINE, MEDLINE In-Process & Other Non-Indexed Citations, Embase, Cochrane Database of Systematic Reviews, Database of Abstracts of Reviews of Effects, Health Technology Assessment Database, Science Citation Index and Social Sciences Citation Index , Social Care Online, PsycINFO , Social Policy and Practice, EPPICentre – Bibliomap , Dopher , TRoPHI, and The Campbell Library.

We screened all references from the specific search through review of titles and abstracts. We screened references from the sensitive search using the ‘progressive fractions’ technique (Booth et al 2015). This method, developed for undertaking systematic reviews within a time-constrained period, involves conducting a sensitive search strategy in order to populate a project reference management database. The resultant data set is progressively ‘mined’ for titles and abstracts which contain any markers of qualitative research (i.e. “qualitative”, “focus group(s)” or “interview(s)”) until reaching a point of diminished returns (when each progressively less relevant term yields very few, if any, additional studies for inclusion). In

this way the time taken in identifying relevant studies is managed so as to be proportionate to the total time available for the completed review.

Inclusion of Relevant Evidence

We included studies that examined experiences of children and youth (aged < 21 years) who had received interventions for harmful sexual behavior or that elicited the experiences of parents or carers. We included studies that used qualitative methods of data collection and analysis, or mixed methods studies where qualitative findings were reported. By including studies that elicit views of youth and/or their care givers we could examine their experiences to inform an understanding of service provision from the perspectives of those receiving them. Both published and unpublished studies were considered.

Methods of synthesis

For the purpose of the original NICE guidance, and given the practical time constraints, our preliminary synthesis involved coding of verbatim extracts and author observations against broad themes generated from the data. Subsequently, we identified the potential to revisit the data using a more formal and reflexive synthesis process conducted within a more considered timeframe. For this re-analysis we used thematic synthesis as a technique for identifying, analysing and reporting patterns or themes within the data (Braun & Clarke, 2006; Thomas & Harden, 2008). Thematic synthesis combines and adapts approaches from both meta-ethnography and grounded theory (Barnett-Page and Thomas (2009) and was developed out of a need to conduct reviews that addressed questions relating to intervention need, appropriateness and acceptability, to complement those relating to effectiveness. The first stage of our thematic synthesis involved identification of themes across the included studies. This activity is primarily concerned with translating the findings of studies into a common language so that it is possible to compare and contrast findings across studies. The aim at this

stage is to be descriptive, remaining close to the text contained in the primary studies. In this review, we included both the reported primary findings, i.e. what the participants have said or are reported to have said and the authors own interpretations as findings. Each entire paper was treated as 'data' and subject to line-by-line coding of text using NVivo (version 11) software. As a result of careful reading and coding, underpinning themes and concepts were identified. Once applied to the first study, the themes were then applied to the next study using a process of constant comparison. If the text revealed new concepts that did not fit with the existing themes then a new theme was created. In the second stage of the analysis, analytical themes were generated, taking the synthesis beyond the content of the primary studies, to provide new conceptualisations and explanations to address the review questions. Common and divergent concepts were explored. In order to further explore the interrelationships between themes and to develop higher-order analytical themes, in order to understand the elements of interventions that lead to positive behavior change.

Quality assessment

We assessed the quality of individual studies using the CASP checklist for qualitative research (Critical Appraisal Skills Programme (2017), which explores dimensions of study design reported in the paper. The CASP checklist is consistently the appraisal tool most commonly used within qualitative systematic reviews and allows assessment of the resulting transferability and trustworthiness of the study findings (Hannes et al 2012). In accordance with the NICE guidance for reviewing scientific evidence we rated each study as '++', '+' or '-' indicating high, medium or low quality evidence determined by the extent to which the checklist criteria had been fulfilled (NICE 2012). No studies were excluded on the basis of the quality appraisal but the process was used to aid exploration and interpretation of the study findings (Noyes et al 2017). Clearly, a distinction may be made between quality of studies and the quality of the underpinning interventions described in the studies. For

example, it is possible that a well-designed and credible qualitative study could explore an intervention that is not shown to be effective with empirical studies. However, as our focus in the paper is not on the validity of the various interventions themselves, but on the experiences of service users of a range of interventions, we believe that including a diversity of types of intervention strengthens, rather than weakens our approach.

Results

The search yielded 2405 citations. Of these, 2209 were ineligible after review of the title and abstract. Of the remaining 196 studies, 183 were excluded following application of the pre-specified criteria for inclusion. Excluded items comprised items that, on close inspection of the full text, were not eligible, abstracts that contained insufficient detail, or dissertations or other items that were unavailable within the constraints of the review. Thirteen studies were included in the review and are summarised in Table One. Included papers were published between 2002 and 2014 and were conducted in the United States, United Kingdom, Australia, New Zealand, Ireland and South Africa. All of the studies used interviews to gather data. Two studies used focus groups and one direct observation in addition to interviews.

The results of quality assessment are presented in Appendix B. Only three papers were rated as being high quality (++) (Draper et al., 2013; Geary et al., 2011; Halse et al., 2012) six medium (+) (Belton et al., 2014; Duane et al., 2002; Jones, 2015; Pierce, 2011; Somervell & Lambie, 2009; Miller, 2011;) and four low (-) (Lambie et al., 2000; Lawson, 2003; Martin, 1994; Slattery et al., 2012). Areas where papers received low ratings include: the unclear role of the researcher; the thin description of context; the uncertain reliability of analysis; and the lack of 'richness' of the data reported. As observed in previous qualitative systematic reviews, we found that these low quality studies contributed less to the findings. (Carroll et al 2012)

1

2 **Study Findings**

3 Seven studies reported the views and experiences of adolescents who were participating, or
4 had participated in a treatment programme specifically designed to treat harmful sexual
5 behavior (Belton et al., 2014; Geary et al., 2011; Halse et al., 2012; Lawson, 2003; Martin,
6 1994; Miller, 2011; Slattery et al., 2012). Three studies focused on the experiences of
7 adolescents undergoing sexual offender treatment which incorporated a physical activity
8 (Draper et al., 2013; Lambie et al., 2000; Somervell & Lambie, 2009). Three studies explored
9 the experiences of parents of adolescents who had sexually offended and were participating
10 in treatment programmes (Duane et al., 2002; Jones, 2015; Pierce, 2011).

11 Five major themes were identified from the perspectives of youths and their carers as being
12 central to successful interventions. These were: the key role of the practitioner/therapist; the
13 key role of parents/caregivers; seeing the bigger picture; communication and disclosure; and
14 developing self and learning skills. Table Two lists the studies that reported or discussed each
15 theme.

16 ***The key role of the practitioner***

17 The relationship that the youth develops with the practitioner was described in five studies as
18 critical to intervention engagement, the acquisition of skills, and to positive outcomes (Belton
19 et al., 2014; Draper et al., 2013; Geary et al., 2011; Halse et al., 2012; Lawson, 2003). In
20 these studies, the practitioner role most frequently mentioned by youth was that of a
21 confidante; someone with whom the young person felt able to be open and to talk. In such
22 circumstances, youths were able to share emotions with the practitioner that were otherwise
23 difficult to express. The practitioner also performed an important role as an advisor or

24 educator. Youths sought them out for information and help with acquiring the skills they
25 needed to address their harmful sexual behaviors.

26 “I got more than enough time, if I ever wanted to say anything. I mean I used to
27 always apologise to him for changing the subject but he said “it’s fine, it’s fine”. If I
28 just need a question answering or some advice on anything you can always ask.well, I
29 could anyway.” Belton et al (2014) 28
30

31 In one study, the practitioner also provided a quasi-paternal role model (Draper et al., 2013),
32 modelling appropriate and non-violent behavior to adolescent males who often did not have a
33 male parental figure.

34 Several practitioner attributes were described as enabling the development of an effective
35 therapeutic relationship between the youth and the practitioner. Most frequently cited was a
36 non-judgemental approach; creating an environment in which young people did not feel
37 labelled by their past behaviors (Draper et al 2013). Such an approach was critical to the
38 development of a relationship in which the youth felt safe and within which trust could
39 develop. Adolescents also valued practitioners who listened attentively, enabling openness.
40 The development of trust was helped when the youth had a sense of being understood by the
41 practitioner. Trust was facilitated by the practitioner sharing, or showing an interest, in the
42 interests of the youth (Belton et al., 2014; Geary et al., 2011). Knowledge of the adolescent’s
43 interests proved helpful when designing tailored and relevant strategies (Geary et al.,
44 2011).Other practitioner attributes that youth described as finding helpful included; being
45 understanding, caring, encouraging, challenging, supportive, respectful and maintaining a
46 sense of humour. Such positive behaviors also helped in setting boundaries for what was and
47 was not acceptable. Being able to relate to the therapist was facilitated in one study by the
48 therapist and young sharing a black and minority ethnic background (Geary et al., 2011).
49 Factors that were described by youths as hindering the development of the therapeutic
50 relationship occurred when the practitioner was also advising and supporting parents, proving

51 to have a detrimental effect on establishment of trust (Belton et al 2014). Youth also
52 considered it unhelpful when there was a lack of continuity between therapist and the
53 practitioner who had previously undertaken the assessment. The assessment process enabled
54 a relationship of trust to start to build and it was unhelpful for young people if this was then
55 disrupted (Belton et al 2014). Other practitioner behaviors which were unhelpful included
56 poor time management and lack of courtesy, failure to notify of changes to appointments, not
57 replying to messages and missing sessions. When practitioners expressed anger and used
58 difficult language, this was seen by youth as a barrier to the development of a positive and
59 trusting relationships (Geary et al 2011) .

60 Two studies (Lambie et al., 2000; Somervell & Lambie, 2009) evaluated interventions which
61 included outdoor activities as part of the therapeutic intervention (so-called ‘Wilderness
62 therapy’) and another including boxing in the ‘Fight with Insight’ programme (Draper et al.,
63 2013). The activities required the learning of specific skills together with values such as
64 respect and discipline that could be transferred to other areas of the young persons’ lives and
65 could help to build relationships and trust. Engaging in such activities could lead to greater
66 self-confidence and self-discipline.

67 In one study (Slattery et al., 2012), the role of the practitioner did not appear as important for
68 youth. This may reflect the nature of the intervention involved, which did not rely on one-to-
69 one work. This study evaluated a community-based treatment programme, and targeted
70 adolescent males serving sentences for sex offences. The intervention was psycho-
71 educational and covered target areas (anger management, drugs and alcohol, emotions and
72 coping, empathy, offence-specific, relationships and sex and sexuality) in 6 weekly group
73 sessions (Slattery et al 2012). This finding was reported in a study (Slattery et al 2012)
74 judged to be of poorer methodological quality. A lack of rigour in the methodology may
75 impede the richness of the findings and the rigour of these results. In studies using

76 qualitative data as part of the evaluation, and where key workers or practitioners worked on a
77 one-to-one basis, the practitioner role did appear to be a particularly valued element of the
78 overall intervention for youth, especially when the practitioner possessed the positive
79 attributes described above.

80 *The key role of parents/caregivers*

81 A strong theme in the included studies was the key role that parents or caregivers played in
82 successful interventions for youth with harmful sexual behaviors. Many youths valued the
83 involvement of parents and caregivers feeling that without such support they would not have
84 remained engaged with the work. Parental or caregiver involvement took diverse forms
85 including supporting youth to attend the programmes, reinforcing consistent messages about
86 the intervention and helping to reinforce the work after sessions (Belton et al., 2014, Draper
87 et al., 2013, Lawson, 2003). Additionally, parents and caregivers played an important role in
88 helping to keep youth safe by monitoring and setting up barriers to reduce the likelihood of
89 reoffending (Geary et al., 2014, Jones, 2015). Families also provided a source of clemency to
90 the adolescent who had violated social norms (Lawson, 2003). Parents' participation
91 demonstrated love, despite the offending, which encouraged engagement with the programme
92 (Geary et al., 2011). Parents were expected to reinforce strict behavioral guidelines to prevent
93 relapse, as well as recognising the need for open communication with their child (Jones,
94 2015).

95 However, the data also reveals challenges experienced by parents because of their child's
96 harmful sexual behavior that may hinder and limit their capacity to provide support. In one
97 study (Jones, 2014), the burden upon parents to undertake roles in the supervision and
98 support of their child who had committed a sexual offence meant that the parents felt that
99 they themselves were being punished. Parents often felt stigmatised and alone with

100 overwhelming feelings of grief, shame, loss and hatred. Parents sometimes also experienced
101 isolation and stigma, sometimes becoming victims of verbal abuse and threats within their
102 communities (Duane et al., 2002). They could feel deskilled as a parent and helpless
103 regarding their child's offence (Duane et al., 2002), feeling that the behavior represented a
104 failure on their part (Pierce, 2011):

105 *... it's always there in your mind that you did something wrong, that you must have failed*
106 *him somewhere, to make him go that direction, you know? ... there's a certain amount of*
107 *guilt for me, you know, cos I think ... em maybe if I had of spoken to him or ... you know he*
108 *wouldn't have done this.* (Duane et al., 2002: 55)

109 For some parents, their child's harmful sexual behavior was analogous to a trauma:

110 *You have to be brave and strong, kind of like if your kid had cancer. You'd have to put on the*
111 *brave face and you may fall apart in your private times, but you have to be strong and brave .*
112 *. . We were traumatized; I still don't know how I got out of bed every day and functioned.*
113 *When we first found out about this, he went to a counselor and he kind of described this as a*
114 *type of death, except without the sympathy. It is a death where you don't have any support.*
115 (Jones et al., 2015: 1312)

116 Not all parents or caregivers became actively involved in the intervention programme, in
117 some instances, the young person's offenses led to greater estrangement (Jones, 2015). In one
118 study parents described having lost hope for their child's future and they grieved for what
119 could have been (Pierce, 2011). Relationships became marred by distrust and hatred:

120 *One father whose son had committed an intra-familial offence struggled with divided*
121 *loyalties between his son and daughter, saying "But still it's like hatred for one, you know..."*
122 (Duane et al., 2002: 53)

123 For parents, accepting that their child had carried out a sexual offence required a process of
124 adjustment, and one which may not run smoothly, leaving parents in a vicious cycle of
125 confusion, searching for answers, disbelief, minimisation of the offense and a return once
126 again to confusion (Duane et al., 2002).

127 Some parents experienced denial, finding it difficult to believe that their child had committed
128 a sexual offence (Pierce, 2011) and they transferred blame to the victim of the offense (Jones,

129 2016). Such denial could undermine the work carried out on the programme. Sometimes it
130 was clear that the parent or carer did not feel able to fulfil their expected roles, for example in
131 supporting the young person with homework required between sessions (Belton et al., 2014).
132 Other parents were supportive of their child but were themselves struggling to make the
133 changes needed, for example being able to talk openly to their child about their sexual
134 behavior. Sometimes, parental health or personal problems limited their capacity to support
135 their child. The burden could be overwhelming and lead to feelings of helplessness,
136 frustration, anger and personal defeat (Jones, 2015). A sense of shame could also limit their
137 ability to engage in the treatment programme (Pierce, 2011).

138 Parental groupwork could help to reduce a sense of isolation and stigmatization and sharing
139 experiences with other parents in similar situations could ease their feelings of guilt (Geary et
140 al., 2011). Parents needed someone to talk to without them feeling that they were being
141 judged (Pierce, 2011). Parents' anxieties were greatly eased by friendly, approachable and
142 respectful behaviors of reception and therapeutic staff at the outset of treatment (Geary et al.,
143 2011). Hearing the stories of adolescents who had completed the programme also gave them
144 a sense of hope (Geary et al., 2011). Interventions that incorporated family therapy appear to
145 have positive benefits, aiding communication and helping to restore relationships (Geary et
146 al., 2011).

147 *Seeing the bigger picture*

148 Youths felt that interventions that tried to understand their harmful sexual behavior within
149 their wider life context were better able to identify their needs and to support them in
150 changing. Involving the young person's wider network, family, school and other social
151 groups and community activities contributed to successful programmes (Geary et al., 2011).

152 Wider involvement supported rehabilitation by enabling adolescents to practice what they
153 had learnt in a safe and contained environment.

154 External contextual factors in the lives of the youths affected their ability to implement
155 material learnt in the programme. Where there was instability, change or other entrenched
156 problems, the young person had limited capacity to apply what they had learnt through the
157 programme (Belton et al., 2014). Impaired learning abilities could also influence how an
158 adolescent engaged with the programme (Belton et al., 2014). To be used effectively, the
159 material needed to take into account both development and contextual issues (Geary et al.,
160 2011). Drug and alcohol misuse could also be factors contributing to a youth's difficulties
161 (Slattery et al., 2012). The youths' own experience of abuse and neglect needed to be taken
162 into account when tailoring the intervention to their needs (Belton et al., 2014). This was a
163 particularly striking explanatory narrative used by young women who were in a correctional
164 centre having committed a sexual offence. The young women were directed to see previous
165 sexual victimization as instrumental in the development of their harmful sexual behavior
166 (Miller, 2011).

167 Seeing the youth within the context of this 'bigger picture' not only related to identifying the
168 challenges and problems they were facing, but also enabled them to change their self-
169 perception away from identification as a sexual offender towards the picture of a young
170 person on a journey towards becoming a 'success story', and the behavior representing not
171 what they 'are' but what they 'did' (Lawson, 2003, Miller, 2011).

172 At first I was reluctant [to take responsibility] but then IU was open to it. My
173 favourite saying is – well one that I came up with is – 'What you done is just that:
174 What you've done, not who you are.' Miller et al 2011, 320

175
176

Communication and disclosure

177 An important element of successful interventions, not only as part of the intervention but also
178 as an outcome of the intervention, was the youth communicating effectively with the
179 therapist, family members and more widely. Learning to share information appropriately was
180 critical to achieving a positive outcome (Lawson, 2003). Openness in talking was considered
181 evidence of positive engagement in therapeutic work (Miller, 2011; Somervell & Lambie,
182 2009).

183 However, adolescents often found this very difficult. Describing and taking responsibility for
184 their offending via disclosure was frequently a difficult and embarrassing task (Somervell &
185 Lambie 2009). In most interventions, youth were expected, as a necessary element of the
186 treatment, to be able to discuss information about their harmful sexual behavior and its
187 impact on victims, themselves and their families. In one study with young women, the
188 intervention was described as socialization into a ‘talking orientation’ (Miller, 2011). Often
189 such conversations were so difficult that youth would avoid being honest with the practitioner
190 (Belton et al., 2014). However, disclosure was viewed as a marker of progress, indicating that
191 the young person was accepting full responsibility for what they had done. Parents regarded
192 disclosure as a very significant step in their child’s progress (Duane et al., 2002). Where this
193 worked well it appeared to offer considerable benefits as exemplified by one young man:

194 *“I’ve no thoughts now about anything, I’ve got it all out my head and it’s all cleared. That’s*
195 *got the pressure off me as I’ve been able to talk and explain things and tell them things. If I*
196 *keep it all bottled up it would explode.”* (Belton et al., 2014: 43)

197 Interventions that incorporated activities and groupwork appeared to help some youth to
198 share information (Draper et al., 2013). The opportunity for adolescents to challenge and
199 support each other was regarded as a key strength of an intervention programme, as indicated
200 by one young person:

201 *“I get feedback from the group. It’s read to me. It helps me get different views from different*
202 *sides of the square. Everybody sees different things*everybody’s challenging me*I get a*
203 *whole picture of myself.”* (Geary et al, 2011, pg 190)

204 The studies evaluating ‘wilderness therapy’ described how being ‘on camp’ helped
205 adolescents with disclosure. Being away from their normal environment, sharing the new
206 terrain and experiences with the group and having time facilitated disclosure (Somervell &
207 Lambie 2009). The experience of being on camp also contributed to the ability of youth to
208 engage in disclosure by enabling a more positive view of self and enhanced relationships with
209 peers.

210 However, group therapy could present difficulties for others because it required them to talk
211 openly about their sexual behaviors and other problems in front of others. While the accounts
212 within the studies suggested the importance of openness and sharing as an important
213 indication of progress, some of the potential dangers were highlighted in one study of young
214 women in a correctional centre (Miller, 2011). The expectations of disclosure could lead to
215 youth superficially adopting the narratives of others:

216 *“At times, a participant’s narrative sounded as if she was parroting something she had heard*
217 *from someone else. Other times, a participant directly referenced ways that correctional*
218 *facility treatment staff had interpreted the young woman’s past actions to her.* (Miller 2011:
219 317).

220 It may be that the expectation of disclosure, and its use as a marker of progress and as an
221 indicator of success, may not work for all children and youth. Expectations of disclosure may
222 lead to the development of ‘false narratives’, ones they feel others want to hear. Tailoring an
223 intervention needs careful work in understanding ways the child communicates, the best
224 means of supporting disclosure, and careful non-judgemental listening.

225 ***Developing self and learning skills***

226 Another theme in many of the interventions valued by youth and carers was that of building
227 skills in managing offending behavior by developing their social competency, self-esteem

228 and self-efficacy. These were considered critical to the long-term success of interventions,
229 essentially equipping the youth with attributes needed to prevent future reoffending. The
230 interventions included skills in identifying triggers to sexually abusive behavior and
231 strategies to deal with such triggers (Belton et al., 2014; Duane et al., 2002), skills in
232 handling high risk situations (Lawson, 2003) and skills in managing anger and impulsivity
233 (Belton et al., 2014; Draper et al., 2011; Geary et al., 2011). Improved skills in anger
234 management, self-esteem, personal responsibility and in communicating were felt by
235 participants to lead to improved relationships with family members, peers and in turn these
236 served to further improve self-esteem (Halse et al., 2012).

237 In particular, activity based interventions, which required intense involvement, physical
238 challenges, natural consequences, group work and away from familiar environments were
239 viewed positively by participants. Indeed it was the intensity of these experiences and the
240 rather than the practical skills themselves that the young people appeared to value and helped
241 them to engage with the process of therapy (Somervell & Lambie (2017). In other studies,
242 some skills were not always sufficiently well practiced. One example was the development of
243 empathic skills with few able to articulate how their behaviours may have impacted
244 negatively on their victims and caused them emotional pain (Halse et al., 2012). Empathy is a
245 feature that may be developmentally sensitive and empathic skills may not be fully formed
246 until into adulthood, therefore this element of skills development may need careful and
247 realistic planning. More broadly, it is clear that simply having knowledge (e.g. about the
248 harm created by sexually abusive behavior) does not guarantee being able to act appropriately
249 on that knowledge, hence the importance of skills development. Lawson (2003), for example,
250 found that:

251 *Knowing the right thing to do did not guarantee they could do the right thing without help.*
252 (Lawson, 2003: 265)

253 **Implications**

254 The studies included in this qualitative systematic review add to knowledge about successful
255 interventions for children and youth with harmful sexual behaviours and their families.

256 Importantly, this paper has outlined five themes of importance to youth and carers who have
257 received services because of their harmful sexual behavior. These include the critical role of
258 the relationship with the practitioner, the needs and important role of carers, the need to see
259 the youth's wider context in tailoring interventions, developing their skills as well as
260 knowledge, and the role of sharing and disclosure. These core findings resonate with the
261 philosophical approach described by leaders in the field of harmful sexual behavior in
262 childhood for over the last two decades which have emphasised the importance of
263 developmental, familial and contextual approaches (such as the work of Chaffin et al 2002;
264 Ryan, 2000; Hackett et al., 2006; Letourneau and Borduin, 2008; Creedon, 2013). Whilst
265 therefore, far from novel, the findings of the current review are however significant as
266 published user perspectives are rare in the field of sexual aggression, particularly given a
267 continued dominant emphasis on quantitative research methodologies. In one of the few
268 international studies addressing user perspectives relating to youth who had sexually abused
269 others, Hackett et al (2006) argue that the lack of research into user views and experiences
270 constitutes a glaring omission in the sexual aggression field, reflecting a traditional
271 standpoint of youth who have committed sexual offences as unreliable and an orientation of
272 control rather than empowerment. By contrast, they suggest that practitioners have much to
273 learn from users about their experiences of professionals. The qualitative studies analysed in
274 the current review, though not exclusively reporting user experiences, each contain the direct
275 testimony of users. Taken together they highlight a range of core factors of importance that
276 can inform the development of interventions that benefit from the lived experiences of those
277 at the receiving end of interventions.

278 Some messages for the development of practice responses to harmful sexual behaviour in
279 childhood and youth emerge strongly. First, whilst it is now widely accepted that
280 interventions should be supported by parents and carers (Letourneau and Borduin, 2008),
281 practitioners should be careful to address the needs of parents and caregivers before
282 expecting them to support their child in treatment. The evidence from these studies suggests
283 that parents may need particularly extensive support at the outset of the intervention process
284 in order to come to terms with what their child had done. The outset of treatment is a time
285 where denial and confusion is likely to be particularly challenging, but this challenge may not
286 in itself prove indicative of the capacity of parents, with support, to move from resistance to
287 acceptance of the abuse and of their role in challenging it. Parents therefore need support to
288 assist them in understanding what has happened, in achieving acceptance of the situation and
289 in supporting their child. Such interventions should be tailored to the needs of individual
290 situations, as parents' experiences of self-blame and the process and timescale required for
291 them to address these issues are likely to vary considerably. Interventions with parents and
292 carers should support them in their transition and focus on the strengths they have that can
293 contribute to supporting their child (Jones, 2015). Parents need to be encouraged to openly
294 communicate how they feel and they need help acknowledging and accepting that the offense
295 did occur (Pierce, 2011).

296 Second, the studies in this review support the move towards interventions that focus on the
297 whole person, rather than merely on offence-focused work targeting the harmful sexual
298 behavior. Practitioners need to be able to hear and respond to events in youth's broader lives
299 and in their wider social context so that they can tailor their interventions to support them in
300 developing an identity that is free from sexual deviance (Lawson, 2003). As such, the
301 findings of this review support the move towards models such as Multi Systemic Therapy

302 (Letourneau et al, 2013), The Good Lives Model (Wylie & Griffin, 2013) and resilience
303 based models (Hackett, 2006) which seek to address the broader social context.

304 Third, the findings of the review reinforce the move towards relational, or relationship based,
305 practice with children and youth who present with harmful sexual behavior. Young people
306 themselves are clear that they need practitioners with a particular skill-set and with a range of
307 personal attributes and abilities if they are to benefit from programmes of work undertaken
308 with them. It is critical that the practitioner is skilled, able to maintain consistent tailored
309 support from assessment throughout the process from assessment to completing therapeutic
310 work.

311 Finally, knowledge based programmes are limited without paying attention to the
312 concomitant skills development elements. Opportunities must be provided to reinforce
313 learning – such as activity based work. Activities may have a particularly valuable place in
314 helping youth who have sexually abused others to build relationships with therapists and
315 peers, affording a ‘safe’ place to develop skills and put into practice the skills being learnt.
316 Therapeutic services for children and youth with harmful sexual behaviors and their families
317 need to be nuanced and tailored. Building on the findings of this review, what would such a
318 ‘tailored’ service look like? It would address the sexual behaviors causing concern and harm
319 directly but sensitively, but it would also carefully explore the context in which the behaviors
320 developed. As such, it would address family relationships and attachments and it would
321 consider the role of earlier life experiences, such as of victimisation and trauma as underlying
322 developmental influences. It would, however, go beyond the family to consider school,
323 friendships and wider environmental factors that could act both as risk and protective factors.
324 Critically, it would carefully address the cultural implications of the approach being offered,
325 particularly the power of positive relationships, recognising too that groupwork and one-to-
326 one work may impact differently at different times in the life of a child.

327 This review was limited to the experiences of participants in the included primary studies
328 and, through the challenges of study recruitment, will have under-represented the
329 perspectives of those who withdrew from treatment, or who declined to participate in
330 treatment. It also did not capture the views of younger children (pre-adolescent) and their
331 parents, nor the views of young women, or youth with learning difficulties and their parents
332 and carers. The review was further limited in that the included studies mainly focused on
333 adolescent male sex offenders, and/or their parents. The range of interventions explored was
334 quite diverse, requiring a focus on shared mechanisms rather than individual intervention
335 components. Further research that includes the views of those youth who have not had
336 successful experiences is needed, as are the views of children and youth who are at present
337 poorly represented in this data, including those with learning difficulties and their families,
338 the views of parents of younger children and young women. There is also a need to hear the
339 experiences of siblings of youth who have sexually abused, so that their needs are understood
340 and to ensure that interventions protect and enhance their wellbeing.

341 This is a systematic review of qualitative studies, designed to elicit views and attitudes of the
342 respondents. A limitation when interviewing people is the strong tendency to give socially
343 desirable answers (Kelle 2006). Additionally, peoples' explanation of their own feelings,
344 judgements and behaviors are often incorrect and sometimes people have difficulty in
345 knowing the exact determinants of their attitudes and feelings (Wilson & Stone 1985, Wilson
346 (2013). Indeed, examples exist where positive attitudes of proponents of a programme for
347 young offenders, including the views of the young people themselves, do not result in
348 improved outcomes. The evaluation of 'scared straight' models of crime prevention
349 strategies whilst, viewed positively by the judicial service, the community, parents and young
350 people themselves, found that the programmes may actually increase the likelihood of
351 reoffending and of negative attitudes toward the criminal justice system, when compared with

352 those not receiving the intervention (Klenowski et al 2010, Homant et al 1982). It is
353 therefore important to review the qualitative evidence alongside studies designed to test
354 effectiveness empirically. For this our parallel publication seeks to examine the outcomes of
355 intervention for young people with HSB.

356 **Conclusion**

357 Our qualitative evidence synthesis of empirical research studies that have sought the views of
358 youth who have exhibited harmful sexual behaviors and their families has identified features
359 of interventions that appear critical to their success. While there remain gaps in knowledge,
360 this work nonetheless provides guidance for the development and implementation of services
361 that are appropriate for such children. In particular, this review has highlighted the context
362 dependent nature of harmful sexual behaviors and how important it is to understand the
363 mechanisms that lead to positive outcomes so that these can be used to inform intervention
364 design and delivery.

365

366 Appendix A – Search terms from MEDLINE (Illustrative example)

Searches

367 **Population Terms**

- 368 1 (sex* adj2 (harm* or risk* or abus* or agress* or unacceptable or offen* or force* or impos* or overly or
369 coer* or inappropriate* or manipul* or stigma* or shame or victim* or danger* or threat* or assault* or
370 pressure* or violent or violence)).ti,ab.
371 2 (problem* adj2 sex* adj2 (behavio?r* or conduct*)).ti,ab.
372 3 *Sex Offenses/
373 4 *Rape/
374 5 (rape or rapist).ti,ab.
375 6 *Unsafe Sex/
376 7 (unsafe adj2 sex).ti,ab.
377 8 or/1-7
378 9 (harm* or unacceptable or force* or impos* or coer* or inappropriate* or danger* or threat* or assault* or
379 pressure* or violent or violence).ti,ab.
380 10 *Sexual Behavior/
381 11 (coitus or sexual intercourse).ti,ab.
382 12 (penetrat* adj2 sex).ti,ab.
383 13 *Coitus/
384 14 (masturbat* or self stimulat\$).ti,ab.
385 15 *Masturbation/
386 16 (sexual interaction or sexual exploration).ti,ab.
387 17 or/10-16
388 18 9 and 17
389 19 inappropriate touching.ti,ab.
390 20 (harm* or unacceptable or innappropraite*).ti,ab.
391 21 ((sexual* adj3 (swear* or word* or phrase* or slang or jargon)) or sexual* explicit).ti,ab.
392 22 20 and 21
393 23 sexting.ti,ab.
394 24 ((sex* or nud*) adj2 (message* or image* or picture* or photo*)).ti,ab.
395 25 23 or 24
396 26 8 or 18 or 19 or 22 or 25
397 27 *Child/
398 28 (child* or girl* or boy*).ti,ab.
399 29 (young people or young person* or young wom?n or young m?n or young female* or young male* or
400 young adult* or youth*).ti,ab.
401 30 *Young Adult/
402 31 *Adolescent/
403 32 (adolescen* or teenage*).ti,ab.
404 33 Juvenile Delinquency/
405 34 delinquen*.ti,ab.
406 35 *Minors/
407 36 (minor or minors).ti,ab.
408 37 *Schools/
409 38 school*.ti,ab.
410 39 *"Latency Period (Psychology)"/
411 40 *Child, Preschool/
412 41 (preschool* or pre-school*).ti,ab.
413 42 (infant* or toddler* or youngster* or early adult* or kid or kids or underage or under age or teen* or
414 offspring* or juvenile* or student*).ti,ab.
415 43 or/27-42
416 44 26 and 43

417

418 **Intervention Terms – Specific Search**

419 *Population Terms (1-44) above*

420 **AND**

- 421 45 Cognitive Therapy/ or Behavior Therapy/
422 46 inter-agency.ti,ab.

423 47 lucy faithfull foundation.ti,ab.
424 48 ((sexual violence against children and vulnerable people national group) or SVACV).ti,ab.
425 49 typology of abused children.ti,ab.
426 50 referral route*.ti,ab.
427 51 youth justice system.ti,ab.
428 52 multisystemic therapy.ti,ab.
429 53 ((resilience or desistance) adj2 model*).ti,ab.
430 54 abuse specific approach*.ti,ab.
431 55 custodial setting*.ti,ab.
432 56 developmental approach*.ti,ab.
433 57 family support approach*.ti,ab.
434 58 goal orientated.ti,ab.
435 59 holistic approach*.ti,ab.
436 60 rehabilitative.ti,ab.
437 61 restorative approach*.ti,ab.
438 62 safe care.ti,ab.
439 63 (J-SOAP-II or juvenile sex offender assessment protocol).ti,ab.
440 64 "latency age sexual adjustment and assessment tool".ti,ab.
441 65 letting the future in.ti,ab.
442 66 (services for teens engaging in problem sexual behaviour or STEPS-B).ti,ab.
443 67 turn the page project.ti,ab.
444 68 strengths based approach*.ti,ab.
445 69 young people's project.ti,ab.
446 70 intervention*.ti.
447 71 or/45-70
448 72 44 and 71
449 73 limit 72 to (english language and humans and yr="1990 -Current")
450
451 Intervention Terms – Sensitive Search
452 *Population Terms (1-44) above*
453 *AND*
454 74 intervention*.ab.
455 75 *Health Promotion/
456 76 *Health Education/
457 77 *Primary Prevention/
458 78 *Secondary Prevention/
459 79 (promotion* or campaign* or program* or initiative* or information or prevent* or educt* or scheme*).ti,ab.
460 80 or/74-79
461 81 44 and 80
462 82 limit 81 to (english language and humans and yr="1990 -Current")
463 83 82 not 72

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