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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)

Study Findings

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

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

The key role of the practitioner

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

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

> "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.well, I could anyway." Belton et al (2014) 28

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

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

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

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

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

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

The key role of parents/caregivers

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

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

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

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

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

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

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

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

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

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

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

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

Seeing the bigger picture

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

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

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

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

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

Communication and disclosure

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

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

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

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

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

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

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

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

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

Developing self and learning skills

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

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

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

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

Implications

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

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

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

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

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

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

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

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

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

Conclusion

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

Appendix A – Search terms from MEDLINE (Illustrative example)

Searches

Population Terms

1 (sex* adj2 (harm* or risk* or abus* or agress* or unacceptable or offen* or force* or impos* or overly or coer* or inappropriate* or manipulat* or stigma* or shame or victim* or danger* or threat* or assault* or pressure* or violent or violence)).ti,ab.
2 (problem* adj2 sex* adj2 (behavio?r* or conduct*)).ti,ab.
3 *Sex Offenses/
4 *Rape/
5 (rape or rapist).ti,ab.
6 *Unsafe Sex/
7 (unsafe adj2 sex).ti,ab.
8 or/1-7
9 (harm* or unacceptable or force* or impos* or coer* or inappropriate* or danger* or threat* or assault* or pressure* or violent or violence).ti,ab.
10 *Sexual Behavior/
11 (coitus or sexual intercourse).ti,ab.
12 (penetrat* adj2 sex).ti,ab.
13 *Coitus/
14 (masturbat* or self stimulat$).ti,ab.
15 *Masturbation/
16 (sexual interaction or sexual exploration).ti,ab.
17 or/10-16
18 9 and 17
19 inappropriate touching.ti,ab.
20 (harm* or unacceptable or innappropraite*).ti,ab.
21 ((sexual* adj3 (swear* or word* or phrase* or slang or jargon)) or sexual* explicit).ti,ab.
22 20 and 21
23 sexting.ti,ab.
24 ((sex* or nud*) adj2 (message* or image* or picture* or photo*)).ti,ab.
25 23 or 24
26 8 or 18 or 19 or 22 or 25
27 *Child/
28 (child* or girl* or boy*).ti,ab.
29 (young people or young person* or young wom?n or young m?n or young female* or young male* or young adult* or youth*).ti,ab.
30 *Young Adult/
31 *Adolescent/
32 (adolescen* or teenage*).ti,ab.
33 Juvenile Delinquency/
34 delinquen*.ti,ab.
35 *Minors/
36 (minor or minors).ti,ab.
37 *Schools/
38 school*.ti,ab.
39 *"Latency Period (Psychology)"/
40 *Child, Preschool/
41 (preschool* or pre-school*).ti,ab.
42 (infant* or toddler* or youngster* or early adult* or kid or kids or underage or under age or teen* or offspring* or juvenile* or student*).ti,ab.
43 or/27-42
44 26 and 43

Intervention Terms – Specific Search

Population Terms (1-44) above
AND
45 Cognitive Therapy/ or Behavior Therapy/
46 inter-agency.ti,ab.

47 lucy faithfull foundation.ti,ab.
48 ((sexual violence against children and vulnerable people national group) or SVACV).ti,ab.
49 typology of abused children.ti,ab.
50 referral route*.ti,ab.
51 youth justice system.ti,ab.
52 multisystemic therapy.ti,ab.
53 ((resilience or desistance) adj2 model*).ti,ab.
54 abuse specific approach*.ti,ab.
55 custodial setting*.ti,ab.
56 developmental approach*.ti,ab.
57 family support approach*.ti,ab.
58 goal orientated.ti,ab.
59 holistic approach*.ti,ab.
60 rehabilitative.ti,ab.
61 restorative approach*.ti,ab.
62 safe care.ti,ab.
63 (J-SOAP-II or juvenile sex offender assessment protocol).ti,ab.
64 "latency age sexual adjustment and assessment tool".ti,ab.
65 letting the future in.ti,ab.
66 (services for teens engaging in problem sexual behaviour or STEPS-B).ti,ab.
67 turn the page project.ti,ab.
68 strengths based approach*.ti,ab.
69 young people's project.ti,ab.
70 intervention*.ti.
71 or/45-70
72 44 and 71
73 limit 72 to (english language and humans and yr="1990 -Current")

Intervention Terms – Sensitive Search

Population Terms (1-44) above

AND

74 intervention*.ab.
75 *Health Promotion/
76 *Health Education/
77 *Primary Prevention/
78 *Secondary Prevention/
79 (promotion* or campaign* or program* or initiative* or information or prevent* or educt* or scheme*).ti,ab.
80 or/74-79
81 44 and 80
82 limit 81 to (english language and humans and yr="1990 -Current")
83 82 not 72

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