ADVERSE CHILDHOOD EXPERIENCES AMONG FEMALES WHO SEXUALLY ABUSE

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ABSTRACT

Female perpetrated sexual abuse has historically been a neglected area of research. Encouragement for more dedicated research has followed the recognition that females who display this behaviour have often experienced adversities in their early life. The aim of this thesis is to further professional understanding of the aetiology of sexual abuse among females. The first chapter provides an introduction to the topic, and the justification and aims of the thesis. The following chapter is a systematic review of the prevalence of adverse childhood experiences among children and adolescents who display harmful sexual behaviour. The third chapter explores the characteristics and motivations of females who sexually abuse employing a mixed methods research design, using data pertaining to female children and adolescents in the community and adults in prison. The fourth chapter is a case study of an adult female sex offender, providing an account, rich in detail, of the cycle of victim to offender. The following chapter is a critique of the adverse childhood experiences scale, with the benefits and limitations of this measure discussed. This research develops and extends professional knowledge of sexual aggression, assessment and treatment methods and seeks to improve policy and practice. Insecure attachments resulting from adverse childhood experiences is a theme which runs throughout all chapters, and the clinical utility of using attachment theory to understand the motivations for sexually abusive behaviour is highlighted.

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CHAPTER ONE

INTRODUCTION

"The mother symbol comprises an image that tends to have the universal understanding that a mother provides unconditional nurturing, caring, and love. Many societies prefer to keep the mother image untarnished and pure, and when called into question, the mother image falls into the category of a topic not to be discussed."

(Waholek, 2016: iv).

Interest in the needs and offending pathways of female offenders has grown in recent years, as has the discourse on the politics of gender and penal justice (Carlen & Worrall, 2013). Female sexual offending was a neglected area of research for a long time, but has gained momentum in recent years. Cortoni, Babchishin and Rat's (2016) meta-analysis found that female sex offending (internationally) is more prevalent than the existing body of literature suggests. Based on 17 samples from 12 countries, the authors found that while victimisation surveys showed approximately 12% of sexual offences were committed by females, only 2% of offences reported to police involved a female perpetrator. This finding highlights the underreporting of female perpetrated sexual abuse and suggests that its prevalence is likely higher than conviction rates suggest. The authors highlight the need to develop empirically based theoretical accounts of female sex offending.

Studies have also highlighted the specific treatment needs (Beech, Parrett, Ward & Fisher, 2009), mental health needs (Fazel, Sjostedt, Grann & Langstrom, 2008) and different offence styles (Gannon, Rose & Ward, 2010) of female sexual abusers. The need for more dedicated research on the characteristics and motivations of females with sexually abusive behaviour at different ages has been highlighted (inter alia Cortoni, Babchishin & Rat, 2016; Gannon, Rose & Ward, 2010). Gannon, Rose and Cortoni (2010) emphasise the need for research focused on understanding the relationship between early victimisation and later sexual offending among women.

Adverse childhood experiences and sexual offending

Research on sexual offending has long paid attention to the aetiological significance of poor attachments in childhood. Attachment theory provides a means of "conceptualising the propensity of human beings to make strong affectional bonds to particular others" (Bowlby, 1977: 201). Marshall's aetiological model (1989, 1993) stresses the importance of attachment in both the onset and maintenance of the perpetration of sexual abuse. Poor or failed attachments to caregivers are considered vulnerability factors which can inhibit an individual's healthy sexual development and lead them to find maladaptive ways to have their basic human needs and desires met (Marshall & Barbaree, 1990). Ward and Seigert's (2002) pathways model describes four interactive psychological mechanisms which may be present in sex offenders: intimacy and social skills deficits, distorted sexual scripts,

emotional dysregulation, and offence supporting beliefs. Ward and Beech (2006) have gone on to develop the integrated theory of sexual offending, which continues to highlight the long lasting effects of adverse experiences in early life.

Adverse childhood experiences (ACEs) are defined as stressful experiences that require significant psychological, social and neurodevelopmental adaptation by the developing child (Lacey & Minnis, 2019; McLaughlin, 2016). When early experiences incur serious physical and/or psychological harm and stress, an individual can develop into dysfunctional or problematic views including beliefs about themselves, others and the world around them (Streeck-Fischer & van der Kolk, 2000). As such, trauma effects may become the central core around which behaviours and even personality are organised. Ricci and Clayton (2016) consider developmental adversity and trauma as contributory and vulnerability factors which they label as offence drivers. These are defined as features and cognitions that, when exposed to situational or environmental cues, drive the individual to carry out sexually abusive behaviour. They propose that criminogenic factors - characteristics, traits, problems or issues of an individual that directly relate to the individual's likelihood to reoffend and commit a crime - are often symptoms which originate from ACEs.

Harmful sexual behaviour

Harmful sexual behaviour (HSB) refers to 'sexual behaviours expressed by children and young people under the age of eighteen years old that

are developmentally inappropriate, may be harmful towards self or others, or be abusive towards another child, young person or adult' (Hackett, 2014). This term is used when referring to children and adolescents due to the stigmatising and potentially harmful consequences the label of sex offender carries, and additionally recognises that the vast majority of young people who display HSB do not go on to sexually offend as adults (NSPCC, 2017). Although there has been a growth in research on HSB among young people, criminal justice statistics do not include those who are under 10 years old, the age of criminal responsibility. Additionally, statistics may not be an accurate representation due to a myriad of factors, including the growth of community treatment for young people with HSB, who may not come to the attention of the criminal justice system unless the severity and risk of their behaviour warrants it (Pratt, 2013). In their aforementioned meta-analysis, Cortoni, Babchishin and Rat (2016) highlighted that the perpetration of sexual abuse was more common among juveniles than adults. Indeed, existing research suggests that early adolescence is typically when sexually abusive behaviours start to emerge (Veneziano & Veneziano, 2002), due, in part, to the social and biological pushes of puberty (Hackett, 2014).

The existing evidence base suggests that young people (i.e. under the age of 18) with sexually abusive behaviour often come from backgrounds of family breakdown, insecure attachments, socioeconomic difficulties and have witnessed domestic violence (Vizard, Hickey,

French & McCrory, 2007). Experiences of physical abuse, sexual abuse, neglect, poor continuity in care and experiences of loss are also common findings (Hackett, 2014; Richardson et al., 1995). In addition to this, the existing literature indicates that female sexual abusers experienced more ACEs compared to their male counterparts (Kubik, Hecker & Righthand, 2003; Mathews, Hunter & Vuz, 1997; Oliver & Holmes, 2015). Prior sexual victimisation, physical abuse, family breakdown and witnessing domestic violence are frequent background characteristics of females who sexually abuse, where the cumulative stress of childhood adversity has caused social, emotional or cognitive impairment (Levenson, Willis & Prescott, 2016).

JUSTIFICATION OF THESIS

There is an increasing awareness that females sexually abuse, but there are many questions about what works in addressing this behaviour in females. There has been far less development in policy and practice regarding female perpetrated abuse then there has been with male. This thesis addresses this gap in knowledge by exploring ACEs among females who sexually abuse at different ages to further our understanding of this under-researched population. There is limited research in this area with small samples comprising mainly adult participants. Using the definition of sexual abuse (as opposed to sexual offending) allows the incorporation of behaviour which has not involved criminal justice proceedings, and behaviour that cannot be defined as

sexual offending due to the individual involved being under the age of criminal responsibility.

AIMS OF THE THESIS

The aim of this thesis is to further professional understanding of the cycle of victim to offender. The existing body of research suggests sex offenders have often been victims of abuse themselves - including emotional, physical and sexual abuse – which act as precipitating and perpetuating factors in their own offending (Strickland, 2008). However, there remains a paucity of information on how this manifests for females. Exploring the lived realities of women who have carried out sexual abuse will help us understand how trajectories of sexual offending can follow adverse experiences in childhood.

As Widom (1989) reminds us, the scientific issue is not just the extent of the association between victimisation and later criminal behaviour, but the processes involved. Findings will aid with the assessment and psychological intervention of females who commit sexual abuse by furthering our understanding of their needs at different stages in the life course and using this to inform treatment. To reduce victimisation, the focal point must be on treating the offenders and supporting their rehabilitation through the development of policy and practice with children and adults with HSB, ensuring that this applies to females as well as males. Exploring histories of women who have committed sexual abuse and examining their possible victimisation histories (which has

been a theme consistent in various existing studies), is necessary in order to develop the evidence base for initiatives. The present study will improve professional understanding of the precursors and antecedents, the processes involved, factors associated with an increase or decrease in risk, and the personal goals of females convicted of sexual abuse. In elucidating the association of ACEs with the perpetration of sexual harm, Chapter Two reviews studies of both males and females to provide a more robust understanding of the phenomena of HSB, before focussing on females in Chapters Three and Four.

CHAPTER TWO

THE PREVALENCE OF ADVERSE CHILDHOOD EXPERIENCES AMONG CHILDREN AND ADOLESCENTS WHO DISPLAY HARMFUL SEXUAL BEHAVIOUR: A SYSTEMATIC REVIEW OF THE EXISTING RESEARCH

ABSTRACT

Despite the existence of opinion papers and reviews, there is no existing published piece of work that has systematically reviewed the current body of research on the prevalence of ACEs among young people who display HSB. This study addresses the existing gap in research to further our understanding of the aetiology of HSB among children and adolescents. The full text of 87 articles was retrieved and assessed for eligibility, following which 9 articles were deemed relevant for inclusion in the review. These 9 studies were then subjected to quality assessment, data extraction and synthesis. The findings of the present review corroborate many of the hypotheses discussed in the introduction, emphasising that children and adolescents who display HSB are more likely to have come from backgrounds of trauma, signalling the importance of multi-agency responses, early intervention and the importance of protective factors. The present review included only studies that used data pertaining to both males and females, although some studies provided a comparison between males and

females. Studies described higher rates of sexual victimisation among females who display HSB. Additionally, findings suggested that child sexual abuse perpetrated by female caregivers is likely to be higher than the majority of the existing body of research suggests.

1. INTRODUCTION

1.1 BACKGROUND

Only relatively recently has research into the perpetration of sexual harm shifted from an adult focus to include adolescents and, more recently, children (Hawkes, 2011), with HSB employed as a term to refer to this behaviour among those aged under eighteen. This research has found that children and adolescents who display such behaviours are more likely to have experienced ACEs in some capacity, including experiencing physical abuse, emotional abuse, sexual abuse, neglect, family break-down/bereavement, witnessing and/or experiencing domestic violence, and parental substance abuse (Hackett, 2014; Hawkes, 2009; McCartan et, 2011). Although this emerging body of research has led to an improvement in the recognition of, and practice in response to, this group of children and adolescents, there is still much to be learnt about the aetiology and manifestation of HSB.

Systematic reviews collate empirical evidence that fits specified eligibility criteria, using an explicit and systematic procedure, to answer a particular research question. Following a clear and reproducible methodology, collated empirical evidence is assessed for its quality and risk of bias. The aim of systematic reviews is to provide more reliable findings over literature reviews (Higgins & Altman, 2008). For the present study, although literature reviews exist which speculate the

prevalence of adversity in childhood and harmful sexual behaviour, there is no systematic review in order for conclusions to be drawn. The present study aims to address this gap in the literature to further our understanding of the aetiology of HSB among children and adolescents.

1.2 SCOPING EXERCISE

In order to gauge the volume of existing primary research and locate any relevant systematic reviews, a scoping exercise was carried out between October and November 2018. ASSIA, Campbell Collaboration Cochrane Google Scholar PubMed Scopus, ScienceDirect, Social care online and Web of Science libraries were searched for 'adverse childhood experiences and harmful sexual behaviour' (exploded), 'adverse childhood experiences and sex offending' and associated search terms. No systematic reviews on the association between ACEs and HSB were located.

1.3 DEFINING ADVERSE CHILDHOOD EXPERIENCES

Felitti and colleagues' (1998) study, from which the ACE questionnaire was formed, proposed ten categories of childhood adverse experiences. They defined these as deeply distressing or disturbing experiences a young person was subject to or was exposed to before the age of eighteen. These ten categories are helpful in conceptualising the broad range of traumatic early experiences, and have been utilised in studies

seeking to explore possible consequences of adversity in childhood (inter alia Flaherty et al., 2013; Hillis et al., 2004; Levenson, Willis & Prescott, 2016). More recently there has been a focus on how to prevent adverse experiences in childhood as studies have evidenced how they can lead to long-term psychological and physical health impairments (Hughes et al., 2017), and have been associated with trajectories of offending (Fox et al., 2015).

1.4 CHARACTERISTICS OF YOUNG PEOPLE WITH HSB

As with adult perpetrators of sexual abuse, it is now widely accepted that the healthy sexual development of children and young people who display HSB has been compromised in some way (Salter et al., 2003). Almond, Canter and Salfati (2006) attempt to distinguish three categories of children and adolescents who sexually harm: 'abused', 'delinquent' or 'impaired'. The final category incorporates variables that (potentially) impair a young person's capability to develop a healthy sexual understanding, including educational difficulties, special education needs and social isolation. The category of delinquency involved variables associated with antisocial behaviour or criminality, such as property offences, bullying others and substance abuse. More recently, studies have focused largely on the vulnerability of most children and young people who display HSB, with a focus on prevention and education as opposed to stigmatisation and criminalising. Statistics

indicate that approximately 30–50% of HSB involves other young people as perpetrators (Campbell, Booth, Hackett & Sutton, 2018).

1.5 PURPOSE OF THE CURRENT SYSTEMATIC REVIEW

Preliminary literature searches revealed opinion papers, reviews as well as research studies that hypothesise the prevalence of ACEs among this population. The purpose of this study is to address the existing gap in research through systematically reviewing the research on the prevalence of ACEs among children and adolescents who display HSB, in order to make recommendations for future research and practice. Despite the existence of opinion papers and reviews, there is no existing published piece of work that has systematically reviewed the current body of research. The scoping exercise highlighted that while empirical research on ACEs and HSB among young people existed, samples usually comprised male only or male and female participants. Although studies on HSB among female young people exists, there were not enough in order to carry out a systematic review focusing only on this population. Thus, the present review includes studies where the sample includes both males and females, which allows differences between victimisation histories to be explored.

It provides a comprehensive, critical and objective analysis of the current knowledge on this topic using a narrative synthesis. Conducting a meta-analysis was not possible due to the heterogeneity of included studies which made them too dissimilar to combine.

2. METHOD

2.1 SEARCH STRATEGY

Scopus, ScienceDirect, Web of Science, PubMed, Social care online and ASSIA were systematically searched in December 2018. The following terms were used to search for relevant literature:
(harmful sexual* OR inappropriate sexual* OR abusive and sexual*) AND (behaviour* OR behavior*) AND (child OR infant OR adolescent) AND (life change events OR emotional abuse OR child abuse OR physical abuse OR sexual abuse OR psychosocial stress OR childhood adversity OR child maltreatment OR neglect OR parental substance misuse OR parental substance abuse OR family in prison* OR bereavement OR parental mental illness OR family breakdown).

The citation, author, title, year and abstract of each study was assessed to determine if the subject is relevant. If deemed relevant the full paper was obtained. The full papers were then read in line with the inclusion/exclusion criteria outlined in Table 1 to determine which papers should be included.

Table 1: Inclusion and exclusion criteria

	Inclusion	Exclusion
Population	Children and adolescents (<18 years) who have been exposed to any category of ACEs Studies focusing on males *and* females	Post-adolescent ACE exposure Adult men and women (=/> 18 years) Studies focusing solely on males *or* females
Exposure	Any exposure to ACE/s, based on the	No exposure to ACE/s

	categories of the Adverse Childhood Experiences Questionnaire, which are: 1). Emotional abuse 2). Physical abuse 3). Sexual abuse 4). Emotional neglect 5). Physical neglect 6). Family separation/breakdown/bereavement 7). Domestic violence 8). Substance misuse/abuse 9). Poor parental mental health 10). Family member in prison	No HSB
Comparator	No comparator or other types of adverse experience	N/A
Outcomes	Sufficient evidence of harmful sexual behaviour from self-disclosure, parents/guardians, police, health care professionals or other professionals involved in the young person's care	Post-adolescent HSB.
Context	Community, secure setting, residential, young offenders' institution, hospital wards English language articles	Non-English articles
Study design	Cohort, case control and cross sectional studies	Reviews, opinion papers

2.2 SEARCH RESULTS

The electronic searches yielded 3366 hits. Reference lists were also hand searched for relevant studies, which resulted in 8 further articles being identified. Two experts in the field were contacted but this did not result in any further studies being included. Overall, 3374 articles were deemed to be relevant. However, 725 of the articles were duplicates. The remaining 2649 articles were filtered using the inclusion/exclusion criteria outlined in Table 1, which resulted in 2532 being excluded. The full text of 87 were retrieved and assessed for eligibility, following which

9 articles were deemed relevant for inclusion in the review. The characteristics of the included publications are displayed in Table 2. These 9 studies were then subjected to quality assessment, data extraction and synthesis. The selection process is presented using the PRISMA flow template (Moher et al., 2009) in Appendix A.

2.3 QUALITY ASSESSMENT

The author and one additional reviewer assessed the methodological quality of the included studies using the Joanna Briggs Institute (JBI; 2014) critical appraisal tools and data extraction forms.

2.4 DATA EXTRACTION

With a pre-defined pro-forma, the following data were extracted by the author: objectives, sample size and demographics, sampling method, country of publication, category of ACE/s, incidence of sexualised behaviour and findings.

3. RESULTS

3.1 CHARACTERISTICS OF INCLUDED STUDIES

Table 2: Characteristics of included studies

Study reference, location of study and design	Setting/context	Sample size (*n*)	Gender	Age range	Objective	Findings
Bladon, Vizard, French & Tranah, 2005 England Cross-sectional	Community forensic treatment service	141	Male (*n* =130, 92.2%) Female (*n*=11, 8%)	5-21	To investigate the nature and prevalence of psychopathology in a cohort of children and adolescents displaying HSB	Significant psychosocial and psychiatric vulnerabilities including high prevalence of sexual and physical abuse and frequent diagnoses of posttraumatic stress disorder and conduct disorder.
Hackett, Masson, Balfe & Phillips, 2013 England Cross-sectional	Community treatment service	700	Male (*n* =676, 97%) Female (*n*=24, 3%)	5-28	To present the individual, family and abuse characteristics of a cohort of children and adolescents displaying HSB	High rates of sexual and non-sexual victimisation. The most common age at referral was 15, though a third of all referrals were for children aged 13 or under. Over a third of the sample were learning disabled. Victims were usually known to the perpetrator but in 75% of cases were not related. Just over half of the sample abused females only, but 49% had at least

						one male victim.
Hutton & Whyte, 2006 Scotland Cross-sectional	Community treatment services (national)	189	Male (*n* =178, 94%) Female (*n*=11, 6%)	5-20	To report characteristics pertaining to Scottish children and adolescents who display HSB	Disrupted childhoods of sample, including witnessing violence within the family and physical or sexual assault and disengaged from education. Indications that HSB manifests differently between males and females.
James & Neil, 1995 England Retrospective cohort	Community (postal survey)	34	Male (*n*=31, 91%) Females (*n*=3, 9%)	12-17	To estimate a 1 year prevalence of HSB among children and adolescents and present the sociodemographic and victimisation histories	Backgrounds of neglect, physical, and/or sexual abuse. Behavioural and psychological problems were common.
Manocha & Mezey, 1998 England Cross-sectional	Assessment and treatment centre	51	Male (*n*=49, 96.1%) Female (*n*=2, 3.9%)	13-17	To describe the characteristics of a cohort of sexually abusive youth	Prior histories of abuse and victimisation and lack of protective parenting among sample. Authors suggest young people with harmful sexual behaviour may have experienced environmental, familial, interpersonal and developmental difficulties.

McClellan, McCurry, Ronnei, Adams, Storck, Eisner & Smith, 1997 America Retrospective cohort	Tertiary psychiatric hospital	499	Males (*n*=314, 63%) Females (*n*=185, 37%)	5-18	To examine the differences in abuse histories and the development of HSB in a sample of children and adolescents with mental health difficulties	Females in sample were more likely to have been sexually abused, and their abuse histories were more severe. Males had a lower threshold of abuse exposure required to develop sexually inappropriate behaviours and were more likely to display victimising behaviours.
Montgomery-Devlin, 2004 Northern Ireland Cross-sectional	Community based treatment project	71	Male and female*	12-18	To examine the characteristics of children and adolescents referred to the project and behaviour that led to referral	Sample experienced considerable disruption in their lives, including domestic violence and physical or sexual abuse.
Ryan, et al, 1996 America Cross-sectional	The National Adolescent Perpetrator Network (NAPN)	1616	Males (*n*=1574, 97.4%) Females (*n*=42, 2.6%)	5-21	To describe the sociodemographic factors of young people with HSB	Physical and sexual abuse, neglect, and loss of a parental figure were common among the sample's histories. Approximately a quarter of the sample who had been victims of sexual abuse

						reported that the perpetrator was female, and the vast majority of offences perpetrated by the sample involved female victims.
Vizard, Hickey, French & McCrory, 2007 England Cross-sectional	Community NHS specialist service	280	Males (*n*=256, 91.5%) Females (*n*=24, 8.5%)	5-21	To describe the psychosocial and behavioural characteristics of young people with HSB	Prevalence of developmental risk factors among sample, including extremely emotionally neglectful and abusive backgrounds, family instability and dysfunction, neuropsychological deficits and mental health problems.

* The author does not specify the number of males and females in the sample, but states that the majority of were male.

3.2 RISK OF BIAS IN STUDIES REVIEWED

Studies were assessed using critical appraisal tools by the Joanna Briggs Institute (JBI; 2014), assessing their selection, exposure, outcome and reporting bias. Bias occurs if there are flaws or limitations in the design, conduct or analysis which misrepresent the results of a study. Table 3 summarises the risk of bias in each study included in the current review. The following forms of bias were assessed: sampling and selection bias, referring to the distortion of analysis resulting from the method of collecting samples; measurement bias, where the accuracy of information collected about or from participants is not equal between cases and controls; and reporting bias, which occurs when the dissemination of research findings is influenced by the direction of the results. The most common area of bias was the sampling and selection due to most studies only including a small proportion of females in comparison to males. Where there existed limitations and partial risk of bias in studies, these were acknowledged and discussed by the authors. There was no significant risk of bias in any of the included studies.

Table 3: Quality of included studies

Study	Sampling and selection bias	Measurement bias for exposure	Reporting bias
Bladon, Vizard, French & Tranah, 2005	○	Θ	○

Hackett, Masson, Balfe & Phillips, 2013	ϴ	ϴ	○
Hutton & Whyte, 2006	ϴ	ϴ	○
James & Neil, 1995	ϴ	ϴ	ϴ
Manocha & Mezey, 1998	ϴ	○	ϴ
McClellan, McCurry, Ronnei, Adams, Storck, Eisne & Smith, 1997	○	ϴ	ϴ
Montgomery-Devlin, 2004	ϴ	ϴ	ϴ
Ryan et al., 1996	ϴ	ɵ	ϴ
Vizard, Hickey, French & McCrory, 2007	○	ϴ	○

○ minimal risk of bias; ɵ partial risk of bias; ● significant risk of bias.

3.3 PREVALENCE OF ADVERSE CHILDHOOD EXPERIENCES

Each study reported a high prevalence of ACEs, however these were not always categorised in the same way. Most of the studies grouped separate ACEs and described their prevalence. Hackett et al. (2013) note that 66% (n=412) were known to have experienced at least one ACE, however they did not discuss the experiences separately apart from sexual abuse which is discussed below.

3.3.1 EMOTIONAL ABUSE

In Bladon et al.'s (2005) study, the majority (68.1%, n=96) had experienced emotional abuse. Similarly, in James and Neil's (1995) study, this was prevalent among 61.2% (*n*=19) of their sample. Hutton and Whyte (2006) found slightly less – 50% (*n*=95), although a further 29% (*n*=55) disclosed bullying within their family. The highest prevalence of emotional abuse was found in Vizard et al.'s (2007) study, with the authors reporting 74% (n=206) of their sample who presented with HSB having experienced what they described as emotional or psychological abuse.

Manocha and Mezey (1998) found that 13.7% (n=7) of their sample had been victims of emotional abuse, which was the lowest prevalence in the included studies. However, the authors note that almost a third (29.4%, n=15) described their caregivers as 'rejecting', 'uncaring', 'unloving' and 'disinterested'. It is ambiguous as to whether such perceptions are indicative of emotional abuse or neglect.

3.3.2 PHYSICAL ABUSE

The lowest prevalence of physical abuse was found in Montgomery-Devlin's (2004) study conducted in Northern Ireland, which found that 31% (*n*=16) of her sample in Belfast and 16% (*n*=3) in Derry were

subject to confirmed physical abuse. Bladon et al. (2005) found that just over half (51.8%, *n*=73) of their sample had been victims of physical abuse. Ryan et al. (1996) note that at the point of referral, and prior to potential further disclosures made by patients during the treatment process, it was known that 41.8% (*n*=675) had been victims of physical abuse. Hutton and Whyte's (2006) and James and Neil (1995) were shared similar findings, reporting the prevalence rates of 37% (*n*=69) and 41.9% (*n*=13) respectively. McClellan et al. (1997) found that 64% (*n*=80) of the males in their sample had been physically abused, compared with 67% (*n*=99) of females. The highest prevalence was found in Vizard et al.'s (2007) study, with two thirds (66%, n=186) of their sample known to have suffered physical abuse. Manocha and Mezey (1998) found regular parental violence towards the child or adolescent to have been present in 23.5% (n=12), but this is not termed as physical abuse per se by the authors. They also note that sibling violence was reported in 9.8% (n=5) of cases.

3.3.3 SEXUAL ABUSE

Bladon et al. (2005) found a high prevalence (71.6%, *n*=101) of the children and adolescents in their sample were recorded as being sexually abused in childhood. Vizard et al., (2007) report almost identical findings (71%, *n*=200). McClellan et al. (1997) found a similar prevalence (80%, *n*=148) among the females in their sample, but this was significantly less

(40%, *n*=126) among males. Additionally, the authors found that females had more severe sexual abuse histories than males, with higher rates of abuse by intercourse and multiple victimisers.

In Hackett et al.'s (2013) study, 50% (*n*=350) of their sample had been victims of sexual abuse. Ryan et al., 1996 note that at the point of referral, again, prior to potential further disclosures made by patients during the treatment process, it was known that 39.1% had been victims of sexual abuse. James and Neil (1995) and Manocha and Mezey (1998) report similar findings (35.4%, *n*=11 and 29.4%, *n*=15 respectively). Hutton & Whyte (2006) found the prevalence of known sexual abuse among their sample to be 19% (*n*=35), however they also measure suspected sexual abuse among a further 31% (*n*=59), which constitutes half of their sample being either known or suspected victims of sexual abuse.

As well as sexual abuse, Manocha and Mezey (1998) also describe a 'lack of sexual boundaries', with 15.7% (*n*=8) of children and adolescents in their study disclosing that they had frequently witnessed sexual acts between their parents of caregivers. A third (33.3%, *n*=17) of their sample had regular access to sexually explicit material within their family home, although the nature (i.e. legality) of this pornographic material is not recorded.

3.3.4 NEGLECT

The highest prevalence (61.2%, *n*=19) of neglect was found by James and Neil (1995), with Vizard et al., (2007) reporting similar findings (59%, *n*=166). Among the children and young people in Bladon et al.'s (2005) study, neglect was experienced by over half (58.9%, *n*=83). Similarly, Hutton & Whyte (2006) found the prevalence to be 45% (*n*=85) among their sample. They also measured parental rejection, which was found to have been experienced by 43% (*n*=81). McClellan et al. (1997) found the prevalence of neglect to be slightly higher among males than females (31%, *n*=39 and 26%, *n*=39 respectively). Ryan et al. (1996) reported similar findings. At the point of referral, just over a quarter of the sample, 25.9%, were subject to neglect. The lowest prevalence was found in Manocha and Mezey's (1998) study, where neglect was found to have been experienced by 11.8% (*n*=6) of their sample. However, as previously discussed, the authors also note that a third of the children and adolescents in their sample described their caregivers as 'rejecting', 'uncaring', 'unloving' and 'disinterested'.

3.3.5 FAMILY SEPARATION/BREAKDOWN/BEREAVEMENT

The breakdown of families and high levels of social care involvement were recurrent themes in the included studies. Bladon et al., (2005) found that 39% (*n*=55) of their sample were on full care orders (with the local

authority holding most of the responsibility over the child/adolescent). 34% (*n*=48) of the sample had experienced multiple (at least three) placements. Hackett et al. (2013) found that 14% (*n*=91) of their sample were on full care orders, with 6% (*n*=38) in secure accommodation as a result of their HSB. James and Neil (1995) found that 16.1% (*n*=5) of their sample were adopted, 3.2% (*n*=1) was fostered, 9.7% (*n*=3) were accommodated by social services and 12.9% (*n*=4) were in the care of social services. In total, 42% (*n*=13) were not in the care of their parents.

Hutton & Whyte (2006) found that just over half, 54% (*n*=102), of their samples' parents had separated. They also measured the experience of bereavement in childhood (although not necessarily of a parent). This was experienced by 15% (*n*=29) of their sample. Ryan et al. (1996) found that 13.6% (*n*=220) had suffered a bereavement of a significant person in their life. 57% (*n*=921) had experienced the loss of a parental figure, of which 12% (*n*=194) resulted from the death of one or both parents, and 34.2% (*n*=553) from the child or adolescent being removed from the care of their parents. Vizard et al., (2007) found that the majority (73%, *n*=204) of their sample had experienced loss of their parents, either through parental separation or bereavement.

Manocha and Mezey (1998) established that at the time of referral, 31.4% (*n*=16) of their sample lived at home with both biological parents, 21.6% (*n*=11) were living with one biological parent and one step-parent, 13.7%

(*n*=7) came from single-parent households, higher than the national average (Rabindrakumar, 2013). Out of the 23.6% (*n*=12) who were out of the care of their biological parents, 9.8% (*n*=5) lived with foster parents, 5.9% (*n*=3) with grandparents or other relatives, 5.9% (*n*=3) with multiple caregivers, and 2% (*n*=1) with no parental figure. 13.7% (*n*=7) had lost one or more biological parents through death. Montgomery-Devlin (2004) reports similar figures, with 33% (*n*=17) in Belfast and 16% (*n*=3) in Derry not living with their immediate family at the point of referral.

3.3.6 WITNESSING DOMESTIC VIOLENCE

Not all of the included studies included domestic violence as a variable, and it was overall discussed less than other adverse experiences (such as sexual abuse). Despite this, the studies that did include the variable of violence within the family home concluded that it was common among the samples. The highest prevalence was found in Ryan et al.'s (1996) study, where 63.4% (*n*=1025) of their sample had witnessed violence within their family home. Almost half of Vizard et al.'s (2007) and Hutton and Whyte's (2006) samples had witnessed domestic violence (49%, *n*=136 and 40%, *n*=75 respectively). To a lesser degree, Montgomery-Devlin (2004) found that 33% (*n*=17) of the sample in Belfast and 32% (*n*=6) in Derry had witnessed violence within their family. Manocha and Mezey (1998) record

marital (as opposed to domestic) violence. They report this was found in 37.3% (*n*=19) of cases.

3.3.7 PARENTAL SUBSTANCE MISUSE

Parental substance misuse was only measured in three of the included studies. There are two possible reasons for this: methodological, as it is a variable which is more difficult to assess, and theoretical, as it is often used as evidence of neglect rather than a separate variable in cases of child maltreatment. McClellan et al. (1997) found that 57% (*n*=71) of the males and 69% (*n*=102) of females in their sample came from families where there was a history of substance abuse among one or more family members in the household. Hutton and Whyte (2006) found this to be the case among one third, 33% (*n*=62), of their sample. Ryan et al. (1996) assessed that 27.9% (*n*=451) of their sample came from homes where there was some indication of parental substance misuse, but note that this could be higher.

3.3.8 POOR PARENTAL MENTAL HEALTH

The only study to include parental mental health as a variable was McClellan et al. (1997). They differentiate between 'mood disorders' and 'psychotic disorders'. Mood disorders were prevalent among 30% (*n*=37) of the males and 45% (*n*=66) of females in their sample. For psychotic

disorders, the prevalence was 12% (*n*=15) among males and 6% (*n*=9) among the females in their sample. This indicates that parental mood disorders were more common for females with HSB, and having parents who suffered from psychotic disorders were more common for males with HSB. The generalisability of this single study is unknown, but it does highlight the benefit in distinguishing between male and female adverse experiences to investigate any differences between genders.

3.3.9 FAMILY HISTORY OF OFFENDING

Three studies included information about their sample's family history of offending. Vizard et al., (2007) found that almost a third (28%, *n*=78) had a convicted 'Schedule One' offender (convicted of an offence against a child) within their family. McClellan et al. (1997) and Manocha and Mezey (1998) did not record such specificities. The former study uses the variable of 'antisocial histories', as opposed to family criminality. Thus, this does not necessarily mean the child or adolescent's caregiver was involved with the criminal justice system. They found antisocial histories prevalent in 46% (*n*=58) among the males and 51% (*n*=76) among the females in their sample. Manocha and Mezey (1998) found that parental criminality existed in 27.5% (*n*=14) of their cases, including three instances where the child or adolescent had a father or stepfather in prison at the time of data collection.

3.3.10 OTHER NEGATIVE CHILDHOOD EXPERIENCES

The included studies reference other potential traumas which are worth noting. Vizard et al., (2007) recorded that 44% (n=123) of the children and young people in their study experienced what they deemed to be 'inappropriate sexual boundaries' within their family home. However, as their study was based on case file reviews, such terminology is ambiguous and potentially subjective.

Other studies note complex histories of social care involvement. Montgomery-Devlin (2004) found that 38% (*n*=27) of her sample were subject to child protection planning at the time of referral to their project, however there is the possibility that the percentage of children and adolescents who had social care involvement but were not necessarily on the child protection register is higher. They noted that 39% of their sample from Belfast and 29% in Derry had a long history of social care involvement. Manocha and Mezey (1998) established that 27.5% (*n*=14) of their sample been placed on the child protection register at some point in their lives, including 7.8% (n=4) who were on the register at the point of referral. Over one fifth, 21.6% (*n*=11), of the sample had experienced numerous care placements. 64% (n=180) of children and adolescents in Vizard et al.'s (2007) study were subject to child protection planning.

In Manocha and Mezey's (1998) study, child protection investigations or criminal proceedings were occurring in 84.2% (*n*=16) of cases at the time of the study. Ryan et al. (1996) note that only a minority of the disclosures made by children and adolescents resulted in prosecutions (16.9% of physical abuse and 37% of sexual abuse disclosures). Being involved in criminal prosecutions is likely to be traumatic in itself for a child or adolescent, and thus the impact of this should also be considered.

4. DISCUSSION

4.1 IMPLICATIONS OF THE REVIEW

There are no existing published reviews where the existing research on the prevalence of ACEs among children and adolescents with HSB has been systematically searched and appraised, and the present study has addressed this gap. The current review provides evidence that children and adolescents who display HSB are more likely than not to have experienced adversity. In each included study, the majority of young people with HSB had come from backgrounds where their development had been compromised. Hutton and Whyte (2006) found that only 12% (*n*=23) of their sample had no recorded ACEs, and Bladon et al., (2005) found this to be the case among only 3.5% (*n*=5). Vizard et al., (2007) found that

almost all (92%) of the children and adolescents in their sample had experienced emotional abuse, physical abuse, sexual abuse, neglect or witnessed domestic violence.

There are other factors to consider which may contribute to the manifestation of HSB. For example, Bladon et al. (2005) found that almost half of their sample had some degree of learning disability. Indeed, children and adolescents with sexually inappropriate or abusive behaviours are more likely to have a neurodevelopmental disability than those who do not display such behaviours (Almond & Giles, 2008). Disabilities and ACEs should not be viewed in isolation, and children with disabilities are potentially at a higher risk of abuse and neglect than non-disabled children (Corr & Santos, 2017).

4.2 THEORETICAL AND METHODOLOGICAL ISSUES

There is a difficulty defining ACEs, as discussed earlier, which presents limitations. Studies were difficult to source due to no consistent definition. Many studies did not specifically define each risk factor they measured. Future research would benefit from an agreed set of definitions expanding on the current typology of ACEs, which has recently been highlighted by researchers in this field. Amongst them, Finkelhor (2018) postulates that the current ten item typology requires the inclusion of a more comprehensive range of adversities.

Not all studies covered all the ACEs delineated in the introduction. For example, James & Neil (1995) only focused on the experiences of emotional, physical and sexual abuse and neglect. McClellan et al. (1997) did not include social care (or the American equivalent), domestic violence or family breakdown or separation as variables. They included 'antisocial', though it is not clear if this necessarily means criminality as the authors do not expand on their definition of this term and how it is assessed.

Another problem relates to the challenge in this area of research of finding a global consensus for the terminology referring to sexual abuse carried out by children and adolescents. Preliminary searches of the 'grey literature' produced by the charity sector that work with child and adolescent perpetrators of sexual abuse and produce briefings and publications on this area (inter alia NSPCC, Barnados, Stop It Now) used the term 'harmful sexual behaviour', defined initially by Hackett (2014). However, it does not seem that this is the same phrase used in other countries, a difficulty also noted by Smith et al. (2014). Although the searches included syntax variations, there is the possibility that studies from other countries were not found as they used different terminology to refer to sexual abuse carried out by children and adolescents. Additionally, only English language studies were included in the review due to time and resource constraints. Including non-English studies would provide a much more robust picture of the global prevalence of ACEs among children and

adolescents who sexually abuse. Despite an exhaustive search, the majority of the included studies were from England (6 out of 9). This may be attributed to the defining terms of 'adverse childhood experiences' and 'harmful sexual behaviour', which may differ from the terms used in different countries. Thus, studies using different terminology may not have been located during the search process.

5. CONCLUSIONS AND RECOMMENDATIONS

The findings of the present review corroborate many of the hypotheses discussed in the introduction, emphasising that children and adolescents who display HSB are more likely to have come from backgrounds of trauma, though there is a distinction between correlation and causation. As Masson, Hackett, Phillips and Balfe (2015) note, it is more helpful and hopeful to consider ACEs as markers of vulnerability as opposed to risk factors. It is much more helpful and hopeful to understand this population as requiring protection, treatment and education rather than criminalisation.

Leach, Stewart & Smallbone (2016) prospective cohort study found that exposure to multiple types of maltreatment was significantly associated with all types of offending (including sexual), signalling the importance of multi-agency responses, early intervention and the importance of

protective factors. This echoes Falshaw, Browne & Hollin (1996), who emphasise that while a cycle of abuse, referring to the transmission of abuse through generations in a likewise manner, may exist, this chain of events is not an inevitable one. There are many psychological consequences of experiencing direct and indirect harm. Additional research on children who experience such adverse early experiences but do not go on to abuse others may be helpful in helping policy makers and practitioners improve outcomes for children and adolescents with these trauma histories.

Interventions for young people with HSB have largely evolved from those developed for use with adult perpetrators. In response to the limited evidence base for the appropriateness of this, Campbell et al.'s (2018) review found that promoting the role of parents or carers, considering the environmental context of the young person, and equipping young people with interpersonal skills as well as knowledge were critical components of successful interventions for young people with HSB. This must be underpinned by a relationship between the young person and practitioner built on trust, where a young person feels safe. Considering the prevalence of ACEs the present study revealed, ensuring feelings of safety for a young person during intervention is imperative.

An interesting area for future research is how specific adverse experiences are associated with different types of HSB. McClellan et al. (1997) found that a history of neglect was associated with what they term as sexually

reactive behaviours (responses which indicate maladaptive coping mechanisms or developmentally inappropriate behaviours) and victimising behaviours (which are more controlling, coercive and threatening). They also found that among the males in their study, HSB was associated with higher rates of sexual abuse perpetrated by mothers or stepmothers, which supports postulations that child sexual abuse perpetrated by female caregivers is likely to be higher than the majority of the existing body of research suggests (Gannon & Cortoni, 2010; Vandiver & Kercher, 2004).

Indeed, gender difference was a recurrent theme. The present review included studies that used data pertaining to both males and females combined, although some studies provided a comparison between them. For example, Hackett et al. (2013) found significantly higher rates of sexual victimisation among the females in their sample than the males, corroborating McClellan et al. (1997) who found that not only were females with HSB much more likely to have been sexually abused, but tended to have more severe sexual abuse histories than males, with higher rates of abuse by intercourse and multiple victimisers. Such findings indicate that it would be helpful for comparative studies in order to elucidate possible gender differences in both the prevalence of adverse experiences and sexual abuse patterns. The literature on female sexual abusers is sparse in comparison to the male counterparts (Saradjian, 1996), and in order for assessment and intervention to be effective, research is needed to elucidate the needs of this population.

Finally, the present review has discussed, in detail, the prevalence of different types of ACEs and considered the impact on the child or adolescent. As Taylor-Robinson, Straatmann and Whitehead (2018) point out, using one overarching term of ACEs to include such varied traumatic experiences may be 'conceptually muddled' and thus attention should be paid to the nuances. Qualitative research focussing on individual experiences will improve the understanding of how HSB manifests, and can be used to aid assessment and treatment in order to mitigate the cycle of victim to offender. Chapter Three addresses this gap in existing literature by exploring the lived realities of females convicted of sexual abuse, exploring how they internalised their early experiences, developed their schemas of self and others, and their pathways to offending.

CHAPTER THREE

THE CHARACTERISTICS AND MOTIVATIONS OF FEMALES WHO SEXUALLY ABUSE

ABSTRACT

This study was carried out in response to the limited qualitative research on females convicted of sexual abuse. Those convicted of sexual offences are often reported to have been victims of abuse themselves with this trauma linked to their own offending. However, there remains a paucity of information on how this manifests for females. Exploring the lived realities of women who have sexually harmed helps us understand why some people who have experienced adverse childhood experience may go on to abuse others. The study involved two methods of data collection: Phase 1 and Phase 2, focused on young people (children and adolescents) and adults respectively. For those aged under 18, anonymised data was used from a database of closed cases from a specialist child and adolescent HSB service in the south of England. For Phase 2, interviewees were recruited from two prisons. The use of this method provided the opportunity to gain a rich and deep understanding of lived experiences, identifying risk/vulnerability factors which are needed to inform and improve treatment strategies. Additionally, the study furthers professional understanding of the cycle of victim to offender and the heterogeneity of

offences. The similarity among all cases was how ACEs appeared to be inextricably linked with their perpetration of sexual abuse.

1. INTRODUCTION

Female perpetrated sexual abuse has historically been a neglected area of research. This has been attributed to small samples limiting justification of studies (Finkelhor, 1984) and broader assumptions that sexual offending is a male phenomenon and that 'women don't do such things' (Wijkman, Bijleveld & Hendriks, 2010). Saradjian (1996), one of the first researchers to publish on females who sexually abuse children, conjectured that female perpetrated sexual abuse violates the 'general schema of femaleness' as nurturing and caregiving. There is a societal reluctance to accept women as sexual offenders as it violates societal views of a woman's role as the recipient of sex rather than the initiator in behaviour controlled by men (Vandiver & Teske, 2006). The cultural construct of males is more accepting that they can be sexual offenders. Furthermore, Crake and Australia (1993) noted how our cultural lexicon adds to the idea that sexual abuse perpetrated by women is less harmful than that carried out by males, as women cannot be convicted of rape as this is defined as involving penetration with a penis (see Sexual Offences Act, 2003).

The 'culture of denial' (Denov, 2004) surrounding female perpetrated sexual abuse has serious implications, in terms of a paucity of information resulting in lacking treatment programmes for perpetrators when they come into contact with the criminal justice system, as well as public

protection and victim safety in considering women to be perpetrators in the first place (Tozdan, Briken & Dekker, 2019). Giguere and Bumby (2007) posit that sexual abuse perpetrated by females is less likely to be reported to the police and, when it is, female perpetrators are not as aggressively pursued as males accused of the same offences. Hetherton (1999) notes that victims (and potentially professionals) may reframe the behaviour as non-abusive, deterring them from reporting it. There are subsequent implications for how professionals assess risk in boys and girls, and men and women.

The number of women in prison in England and Wales has more than doubled since 1993, with prisons currently holding 3,774 women (Prison Reform Trust, 2019). Although they still make up a small percentage compared to the general female prison population, the number of adult females in prison for a sexual offence has grown in recent years. As of 2019, sex offences account for 2-3% of offences among convicted women and those held on remand (Ministry of Justice, 2019), increasing 18% from 109 in 2015 to 129 in 2019 (Sturge, 2019). This growth may be because there is an increase in the number of girls and young women displaying this behaviour, or it may be attributed to the growing recognition that females can cause sexual harm. It is important to consider that the rise in sex offenders in prison is seen across both the male and female prison estate: the number of prisoners serving custodial sentences

for sexual offences is at its highest level since 2002 (Ministry of Justice, 2019). There has been an increase in the reporting of sexual offences (Crown Prosecution Service, 2016), which may be associated with the high-profile inquiries and media coverage of convictions of historical sexual offences increasing public confidence in the police to take disclosures seriously (McCartan, Hoggett & O'Sullivan, 2018).

As will be discussed in the literature review, there is no sex offender treatment programme for females in prison. The majority of women are imprisoned for crimes acquisitive in nature (Ministry of Justice, 2018a). The offence of theft accounts for approximately 37% of convictions among women (Prison Reform Trust, 2019). Offending behaviour programmes in prison have focussed attention on interventions for these types of offending behaviours. Despite the relatively small numbers of female sex offenders compared to males, there remain women who are being held in prison and may not be receiving the offence-focused work needed in order to assess and address their crimonogenic needs and reduce their risk. This questions the very purpose of prison and goes against the rehabilitation culture policy-makers promote.

2. LITERATURE REVIEW

2.1 TYPOLOGIES OF FEMALES WHO SEXUALLY ABUSE

For a long time, the lack of research on female perpetrated sexual abuse was attributed to the small number of females who displayed such behaviour and the concept that those that did were considered unlikely to do so of their own accord (Wakefield & Underwager, 1991). There emerged a narrative that most women were coerced into offending by males, which feeds into the notion that sexual offending is a male phenomenon. Grayston and De Luca (1999) found that female sex offenders are likely to co-offend, a finding contradicted by Johansson-Love and Fremouw (2006) who found that less than a third of their sample (n=13) had a co-defendant. Nathan and Ward (2002) found that while most of the female sex offenders in their sample were convicted with a co-defendant, only a minority reported being coerced to offend, highlighting the importance of gathering the characteristics and motives of the offenders and offences in order to understand nuances.

Typologies group individuals based on common motivations, demographics, or personality traits in order to condense and generalise research findings. The development of typologies of females' sexual offending have emerged since the 1980s and have been useful in elucidating offence patterns and pathways to offending. Matthews,

Mathews, and Speltz (1991) were the first known research team to develop a specific typology of female sexual offending, and introduced three categories of offender: the teacher/lover, the predisposed and the male-coerced. Their sample consisted of 16 adult females who had been referred to a specialist service for perpetrators of sexual abuse in Minnesota, USA. Matthews et al's (1991) study provided the basis for further research building on this typological explanation.

One of the most robust typologies has been introduced by Vandiver and Kercher (2004), whose categories were based on a large sample (471 female sex offenders registered in Texas, USA), analysed using cluster analysis. They introduced six offender types: heterosexual nurturers (similar to Matthew's et al's (1991) teacher/lover category) in that these women victimised underage males who viewed the abuse as a relationship; noncriminal homosexuals, who offended against post-pubescent females; sexual predators, who offended mainly against young males and appeared to hold more antisocial beliefs and who engaged in more criminality generally; young adult child exploiters, who offended against prepubescent females and males; homosexual criminal subtypes, who often offended against females, typically as a form of exchange to obtain financial or material gains; and aggressive homosexual offenders, who sexually abused female adults, typically within intimate relationships. A prominent limitation of Vandiver and Kercher's research, however, is that they were unable to obtain information with regard to whether the

females in their sample were acting alone or in the company of others. This shortcoming highlights the usefulness of qualitative research on this area first to clarify such details but also to obtain the individuals' reflections on their offending.

More recently, Wijkman, Bijleveld, and Hendricks (2010) distinguished four offender types based on their sample of 111 female contact sexual offenders registered with the Netherlands central prosecution service between 1994 and 2005. The first type, the young assaulters, was young (18-24 years old) who acted alone. The abuse typically took place where they were in a position of care (such as babysitting), involved physical violence, and the victim was generally male and a relative of the perpetrator. Wijkman, Bijleveld and Hendricks (2014) draw similarities between this type of abuser and the young adult child exploiter from Vandiver and Kercher (2004)'s research. The second group, the rapists, use sexual intercourse and penetration, usually on older male or female victims. The perpetrators typically had been victims of sexual abuse in their childhood by someone from outside their family. This type partly resembles the Vandiver and Kercher's (2004) female sexual predator, and also the predisposed molester from Matthews et al.'s (1991) typological description. The third group, the psychologically disturbed co-offender, were aged between 30 and 35 years on average, and committed their offence together with one or more other individuals. The relationships to their victims varied; they often abused their own children but the victims

were also in their extended family or living in close proximity. The women in the fourth and final group, the passive mothers, were generally the oldest (on average over the age of 41). These women were either involved in watching the abuse of a child or facilitated the abuse, but viewed their role as an inactive observer. The abuse involved the woman's own children or stepchildren. This group shares similarities with the male-coerced type proposed Matthews et al. (1991).

Darling (2018) developed five categories of female perpetrators who sexually abuse children in organisational contexts, developed from a sample of 136 cases arising in the UK and North America between 2000 and 2016. The female perpetrators ranged from 21-56 years old (mean=31.2 years). Most abused male adolescents with typically one victim (86%). The most common category, immature regressed (41.9%) comprised women who tended to be younger (in their twenties) and often fairly new to their profession. They demonstrated problems with professional boundaries and developed overfriendly relationships with young people. The second category, sexual and risky (34.6%) were generally in their 30s, in long-term adult relationships and some abused more than one victim. Their victims tended to be male, younger adolescents. The third category, saviour syndrome (7.4%) were generally in their mid-40s to mid-forties and experiencing personal stress and/or problems in their own long-term adult relationships. Fourth, the unrequited infatuated (2.2%) category comprised women in their thirties

and forties and infatuated with male victims in their mid-teens. They may be experiencing mental health difficulties and idolise their victims as potential romantic partners. Finally, the psychologically troubled category made up only 1.5% of the sample and consisted of women with long-standing diagnosed mental health issues and displayed extreme immaturity in their thinking and behaviour.

As much as typological descriptions are useful in grouping offence types and characteristics among this heterogeneous group of offenders, even the most robust typological explanations may oversimplify complex cases and not acknowledge idiosyncrasies. Qualitative research is needed in order to unpick and describe individual differences in more detail, to illuminate these idiosyncrasies.

2.2 CHILD AND ADOLESCENT FEMALE SEXUAL ABUSERS

As discussed, the last twenty years has seen the emergence of typological explanations for adult female sexual offending, however there is much less research specifically focussed on female children and adolescents (under the age of 18) who sexually offend. Historically, researchers relied largely on attachment theory (Marshall, Hudson, & Hodkinson, 1993) and learning theory (McGuire, Carlisle, & Young, 1965) in understanding the aetiology of sexually abusive behaviour among juveniles. Whilst research into the perpetration of sexual harm has begun to include adolescents and, more

recently, children (Hawkes, 2011), the majority focus on males or group males and females together.

Vandiver and Teske (2006) note there is no empirical evidence to corroborate that both male and female abusers share the same characteristics and offending patterns. In their study seeking to address this gap, Vandiver and Teske compared file information pertaining to male and females who had been arrested for crimes of a sexual nature. They found multiple differences between male and female offenders in their sample of juvenile (aged 17 years old and under) male and female sexual offenders in Texas, USA. Females were on average younger than the males in their sample (suggesting that the average age for the onset of HSB is younger for females than males) and that whereas the males in their sample offending mainly against females, the females in their sample offended against both males and females equally.

In seeking to elucidate offending patterns, offender and offence characteristics and the motives of female juvenile sexual offenders, Wijkman, Bijleveld, and Hendriks (2014) studied a sample (n=66) of female juveniles convicted for sexual offences in the Netherlands between 1993– 2008. They derived five distinct themes/subtypes from the data through grounded theory. The largest of these (n = 23) was the group (peer) pressure subtype, which consisted of females who felt coerced into abusing others; the second largest subtype (n = 16) consisted of females who sexually abused others as means to regulate their own emotions; the

third subtype (*n* = 9) consisted of females who abused others as a result of a lack of knowledge and understanding of sexual consent and boundaries; the fourth subtype (*n* = 4) consisted of females who abused others because of their own needs, and who profited from their offences (sexually or financially); and finally, a small proportion (*n*=5) of the females in their sample committed their offence induced by a psychiatric disorder such as psychosis and dissociation. It should be noted that such experiences can be a result of trauma, and the authors highlight that their sample experienced high levels of trauma with only a minority (27%) reporting no ACEs.

Kubik, Hecker and Righthand (2003) compared an age-matched sample of 11 adolescent females with sexual and non-sexual offence histories. The sexually offending group presented with fewer antisocial behaviours, such as alcohol or drug use, aggression and violence but began their offence behaviours at younger ages than the non-sex offending group. The authors also found that when compared to males, the female sample appeared to have experienced more substantial abuse and over a longer period of time.

In summary, the existing literature indicates that juvenile female sexual abusers experienced more severe and pervasive abuse compared to their male counterparts (Kubik, Hecker & Righthand, 2003; Mathews, Hunter & Vuz, 1997; Oliver & Holmes, 2015). As with adults, prior sexual victimisation, child maltreatment, dysfunctional families, inadequate social

skills and psychopathology are frequent background characteristics of female children and adolescents who sexually abuse.

2.3 OFFENCE PROCESSES OF FEMALE SEXUAL OFFENDERS

Gannon, Rose and Ward (2008) sought to build on the descriptive accounts and provide a better understanding of the cognitive, behavioural, contextual and emotional factors associated with female sexual offending and have produced the only known model of the offence process for female sexual offenders. The authors used grounded theory to analyse interviews carried out with 20 convicted female sexual offenders and two women who were not registered sex offenders but whose offence involved a sexual element. All were British. Their model is divided into three parts: background factors (which comprise five categories: early family environment, abusive experiences, lifestyle outcomes, vulnerability factors and major life stressors), the pre-offence period (event up to one year prior to the sexual offending) and the offence and post-offence period. Gannon et al, (2008) found four main approaches of offending: maternal, maternal avoidant, aggressive and operationalised, all of which were affected by substance use, sexual arousal, cognition and emotions.

The maternal approach referred to women who typically offended alone and against teenage boys. Their approach was not aggressive but coercive, and who put themselves either in obviously risky situations or

directly made contact with their victim. Maternal avoidant offenders also take a nonaggressive but coercive approach; they wish to avoid offending and only do so as a result of violent and abusive partners who coerce them into sexual offending. The women who fall into this category experience cognitive dissonance in their reasoning, and sexually offend not for their own sexual gratification but for their partner's. Aggressive offenders carried out their abuse not because of their own sexual arousal, but as a way to exert power and humiliate their victim. Finally, the operationalised process revolves around exchange; the women who fall into this category view the sexual element of their offence as necessary in order to obtain certain goods (e.g, trafficking).

Gannon et al. (2008) highlight how women demonstrate approach and avoidant goal behaviours, akin to the existing body of research on male sex offenders (Ward & Hudson, 1998), but their goals and motivations differ from males. It is important to understand the underlying needs females are seeking to meet through their sexual offending in order for treatment to be effective.

2.4 ASSESSMENT AND TREATMENT NEEDS OF FEMALES

There is no validated risk assessment tool for female sex offenders. Sandler and Freeman (2009) found that measures designed to assess the risk of sexual recidivism for male sex offenders are not appropriate for

female sex offenders. For example, the STATIC-99 (Harris et al., 2003) is the most widely used measure for assessing risk of sexual recidivism for male sex offenders (Jackson & Hess, 2007), however this includes variables that conceptually may not translate to female sex offenders (Sandler & Freeman, 2009). Similarly, in their meta-analysis Cortoni, Hanson and Coache (2010) examined the recidivism rates of female sexual offenders (2,490 offenders; average follow-up 6.5 years). They found lower recidivism rates for female sexual offenders than male, highlighting the need for distinct policies and procedures for assessing and managing the risk. There is potential danger in using risk assessment measures which have not been developed for women, as they may overestimate or underestimate risk, resulting in individuals receiving either harsher consequences (e.g. a longer sentence and difficulties at parole hearings) or their risk not being recognised, which is a serious public protection concern.

Nathan and Ward (2002) emphasise that the assessment and treatment of female sex offenders should take into account the motivational and offence-specific differences described in empirical studies and address their underlying psychological needs (such as post-traumatic stress disorder and emotion regulation difficulties). Additionally, treatment of sexually abusive women should be tailored to their distinct needs and characteristics rather than assume that all individuals should receive the same interventions. Unlike for male sex offenders in prison, there is

currently no specific sex offender treatment programme delivered in women's prisons in England and Wales. Initiatives for female adolescents are largely based on the same treatment as their male counterparts, but there is a paucity of information regarding how their offending needs differ. The Lucy Faithful Foundation carries out work with adult females who have sexually abused children, covering conditions or schemas, arousal, relationships and self-regulation (see Gannon, Rose & Cortoni, 2010). Even so, this intervention has been adapted from work with males rather than developed specially for females. This is because the existing research on the characteristics, motivations and treatment needs of this population needed to develop interventions is so limited. Furthermore, this work is only carried out with adults who have abused children and is not designed for the women who have offended against any other group, yet a significant proportion of female sexual abusers commit their offences against adolescents and adults. Within the Prison Service, a female sex offender framework was introduced (Women Sexual Offenders; WSO), however it was not accredited and women's prisons have now stopped using it entirely. One of the reasons for the lack of sex-specific assessment and intervention is the limited professional understanding of the precursors and antecedents, the processes involved, risk factors and the personal goals of females who have carried out sexual abuse.

2.5 RATIONALE FOR THE CURRENT STUDY

The present study addresses this gap in knowledge by exploring the characteristics and motivations of females at different ages, in order to further our understanding of female perpetrated sexual abuse. There is limited research in this area with small samples comprising mainly adult participants. The present study's sample consists of children (aged under 12) and young people (aged between 12 and 18) as well as adults (aged over 18). Using the definition of sexual abuse (as opposed to sexual offending) allows the incorporation of behaviour which has not involved criminal justice proceedings, and behaviour that cannot be defined as sexual offending due to the individual involved being under the age of criminal responsibility.

A further aim of this research is to further professional understanding of the cycle of victim to offender. The existing body of research suggests sex offenders have often been victims of abuse themselves - including emotional, physical and sexual abuse - and it is this trauma which is linked to their own offending (e.g. Strickland, 2008). However, there remains a paucity of information on how this manifests for females. Exploring the lived realities of women who have carried out sexual abuse will help elucidate the association between prior victimisation and the perpetration of sexual harm. Findings will aid with the assessment and psychological intervention of females who commit sexual abuse by furthering our understanding of their needs at different stages in the life course and

using this to inform treatment. To reduce the number of victims, the focal point must be on treating the offenders and supporting their rehabilitation. The present study will aid assessment and treatment by exploring the lived realities of this group, and potentially inform preventative strategies.

3 METHOD

3.3 RESEARCH DESIGN

The study comprised two methods of data collection, Phase 1 and Phase 2 focusing on young people (child and adolescent) and adults respectively. For those aged under 18, anonymised data was used from a database of closed cases from a specialist child and adolescent HSB service in the south of England. Information was gathered about the service-user's history and background, age, living and education circumstances and social care status. For Phase 2, interviewees were recruited from two prisons in different parts of the country. The use of this method provided the opportunity to gain a rich and deep understanding of lived experiences.

Ethical approval was granted by the Faculty of Medicine and Health Sciences Ethics Committee at the University of Nottingham and the National Research Council of HMPPS and was conducted in line with the British Psychological Society (BPS) Code of Ethics and Conduct.

3.2 PHASE 1

Phase 1 was carried out in advance of devising the interview schedule for Phase 2, with the aim of identifying themes and areas which would be helpful to explore in detail during the qualitative element of the study. The data pertained to child and adolescents based in the Thames Valley region who had been referred to a specialist HSB service between 2012 and 2018. Although only one region within the country, it covers a large area and two counties in the South East of England. Information was gathered from approximately 163 cases, with participants aged between 4 and 18. The number of referrals, the referring agency, the home environment, education and social care status were included. The analysis involved classifying the data using Excel 2010 to calculate descriptive statistics. Unfortunately, the nature of the HSB was categorised and recorded in different ways between 2012 and 2018 and thus it was not possible to include in the analysis. Chi-square tests were carried out to test for the strength of association between variables to explore correlation. These tests revealed no correlation between variables; however, themes did emerge. These are discussed and descriptive statistics presented in Table 4.

Table 4: Characteristics of females referred to a HSB service

		2012	2013	2014	2015	2016	2017	2018	Total
	Number of referrals	9	26	29	26	26	21	26	**163**
	Average age at referral	10	11	10	9	10	10	10	**10**
Referring agency % (*n*)	Social Care	77.8 (7)	65.4 (17)	48.3 (14)	50 (13)	61.5 (16)	28.6 (6)	46.2 (12)	**52.1 (85)**
	School	0 (0)	7.7 (2)	34.5 (10)	27 (7)	27 (7)	38.1 (8)	26.9 (7)	**25.2 (41)**
	CAMHS	22.2 (2)	26.9 (7)	6.9 (2)	15.4 (4)	3.8 (1)	14.3 (3)	23.1 (6)	**15.3 (25)**
	GP/Other health	0 (0)	0 (0)	10.3 (3)	3.8 (1)	3.8 (1)	9.5 (2)	3.8 (1)	**4.9 (8)**
	Criminal justice	0 (0)	0 (0)	0 (0)	3.8 (1)	3.8 (1)	4.8 (1)	0 (0)	**1.8 (3)**
	Not recorded	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	4.8 (1)	0 (0)	**0.6 (1)**
Home environment % (*n*)	Birth family	66.7 (6)	53.8 (14)	82.8 (24)	73.1 (19)	73.1 (19)	57.1 (12)	73.1 (19)	**69.3 (113)**
	Foster care	22.2 (2)	27 (7)	10.3 (3)	15.4 (4)	19.2 (5)	9.5 (2)	11.5 (3)	**16.0 (26)**
	Other family	0 (0)	0 (0)	0 (0)	7.6 (2)	7.7 (2)	19.0 (4)	3.8 (1)	**5.5 (9)**
	Adoptive family	0 (0)	15.4 (4)	3.4 (1)	0 (0)	0 (0)	0 (0)	11.5 (3)	**4.9 (8)**
	Residential care	11.1 (1)	3.8 (1)	3.4 (1)	0 (0)	0 (0)	4.8 (1)	0 (0)	**2.5 (4)**
	Not recorded	0 (0)	0 (0)	0 (0)	3.8 (1)	0 (0)	9.6 (2)	0 (0)	**1.8 (3)**
Education status % (*n*)	Mainstream	77.8 (7)	80.8 (21)	69 (20)	53.8 (14)	69.2 (18)	62.0 (13)	80.8 (21)	**70.0 (114)**
	Special education	11.1 (1)	11.5 (3)	27.6 (8)	15.4 (4)	15.4 (4)	19.0 (4)	11.5 (3)	**16.6 (27)**
	Not recorded	0 (0)	0 (0)	0 (0)	23.1 (6)	11.5 (3)	19.0 (4)	3.8 (1)	**8.6 (14)**
	Out of school	11.1 (1)	3.8 (1)	3.4 (1)	7.7 (2)	3.8 (1)	0 (0)	3.8 (1)	**4.3 (7)**
	Pupil referral unit	0 (0)	3.8 (1)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	**0.6 (1)**
Social care status % (*n*)	Not recorded	0 (0)	0 (0)	27.6 (8)	77.0 (20)	46.2 (12)	57.1 (12)	26.9 (7)	**36.2 (59)**
	Child in Need (S. 17)	44.4 (4)	34.6 (9)	17.2 (5)	19.2 (5)	30.8 (8)	14.3 (3)	26.9 (7)	**25.2 (41)**
	None	11.1 (1)	26.9 (7)	44.8 (13)	0 (0)	0 (0)	0 (0)	34.6 (9)	**18.4 (30)**
	Look after (S. 31)	33.3 (3)	30.8 (8)	3.4 (1)	3.8 (1)	11.5 (3)	4.8 (1)	0 (0)	**10.4 (17)**
	Child Protection (S. 47)	11.1 (1)	7.7 (2)	3.4 (1)	0 (0)	7.7 (2)	14.3 (3)	11.5 (3)	**7.4 (12)**
	Look after (S. 20)	0 (0)	0 (0)	3.4 (1)	0 (0)	3.8 (1)	9.5 (2)	0 (0)	**2.5 (4)**

Most young people lived with their birth family and were in mainstream education. In many cases, the social care status was not recorded. A quarter of cases were recorded as a Child In Need, which is an expected finding as in cases where HSB is reported it would be expected for the family to be receiving a level of support from social care. Just over an eighth (12.9%) of cases were Looked After Children, with 10.4% cared under Section 31 (full care order). These orders are sought when there is sufficient evidence to indicate a child is suffering or are likely to suffer significant harm, and the harm is attributable to the care being provided by their current caregivers and environment. 5% were cared for under Section 20, where a child can be accommodated with formal Local Authority foster carers or, alternatively, with a family member who has been approved by the Local Authority.

Every year, apart from 2017, the majority of referrals came from social care. In 2017 a small majority of referrals came from education. One possible reason for this spike was the publishing of the guidance by the Department for Education (2017) on responding to sexual violence between children in schools, promoting knowledge about responding to HSB. Research briefings were also circulated by the NSPCC (2017), emphasising the importance of school response. On average, the young people referred were ten years old. Sex and relationship education (SRE) is compulsory from age eleven onwards in schools in England, and it is

likely that the majority of cases included in the present study had not received education on sex and relationships within school.

3.3 PHASE 2

Phase 2 consisted of semi-structured interviews with women in prison, where interviewees also completed the ACE Questionnaire.

3.3.1 PARTICIPANTS

For Phase 2, the eligibility criteria for interviews were individuals who identified as women at the time of their offence and who were serving a sentence for a sexual offence. They needed to be aged over 18 and have the capability to give informed consent (one potential participant could not participate because of this). The sample was selected using a convenience sampling procedure: women who fitted the eligibility criteria were identified by a member of the Offender Management Unit (OMU) and were provided with the participant information sheet (Appendix D), which included information about the ACE questionnaire. Those who agreed to be interviewed were provided with further verbal information about the ACE questionnaire. Participants were informed that it was not being used because of expectations that they had experienced adverse childhoods, but because most of the existing research suggested that females who

have sexually abused often have, so the present study is exploring whether this is the case. A copy of the questionnaire can be found in Appendix G.

They had ample time to review this before agreeing (or declining) to meet with the principal investigator for an introductory meeting. The interviews took place in a private, calm area within the Offender Management Unit. All interviewees signed a consent form (Appendix E) before the interview commenced. The Principal Investigator spent 6 full days (not consecutively) in each establishment over the course of 2 months, conducting between 1 and 2 interviews per day. Out of fifteen women approached by their Offending Supervisor within the prison, twelve agreed to meet for an introductory interview. Following this, eleven agreed to take part in the study; however two women withdrew their participation at a later stage. This resulted in nine participants, seven of whom agreed for their interview to be audio recorded and two requesting to not be recorded but consented to notes being taken. Participants were aged between 27 and 62, with varied offending behaviours and sentence lengths. Table 5 provides details of how old they were at the time of their interview, their offence, victim and sentence length. All women were convicted as adults, however some described displaying sexually inappropriate or harmful behaviour earlier on in their lives, but this had not come to the attention of the criminal justice system. As will be discussed in Chapter Four, one

participant, Alesha, was arrested as an adult, however the crimes she was convicted for were alleged to have begun when she was 16 years old.

Table 5: Interviewee characteristics

Participant	Age at interview	Offence type		Victim/s	Sole or co-offender	Sentence (years)
		Contact	Distribution of images or videos			
Alesha	27	■		Female - multiple	Co-offender	17
Janet	47	■		Female – daughter	Co-offender	8
Juliet	62	■		Male	Co-offender	5
Angela	40	■	■	Female – daughter	Sole	12
Melanie	31		■	Female – daughter	Co-offender	15
Sonia	43		■	Female – daughter	Co-offender	6
Monica	45	■	■	Male	Sole	3
Regina	29	■		Male	Sole	3 (IPP)[1]
Melissa	34		■	Female – daughter	Sole	6

[1] Indeterminate Sentences for Public Protection (IPP)

3.3.2 SEMI-STRUCTURED LIFE STORY INTERVIEWS

The interviews covered the life story of individuals. Broadly, the interviews covered the background/context, crime and arrest, experience of imprisonment and future goals and hopes for release. The life story interview provided a structured way of reflection on the person's entire life and allowed the individual to speak about what they perceive to be the precipitating and perpetuating factors associated with their offending. This provided them with the opportunity to reflect on their early life experiences and possible disruptions (e.g. experiences of neglect or abuse). The interview was semi-structured, using open questions, with emphasis placed on subjective experience: 'how did you feel?'. The interview schedule can be found in Appendix F.

Cognitive interviewing techniques were used whilst going through the ACE questionnaire, in order to collect additional verbal information about the responses (as opposed to just yes or no answers) and explore responses. Participants were asked about their thoughts and feelings, encouraging them to reestablish the environmental and personal context and report details related to the question put to them, even if they thought that detail was trivial. This helped in provided a clearer description about specific experiences as well as the general environments the women had grown up in and how these had affected them. Verbal probing techniques were used, as described by Willis (2004), in order to gather more specific perceptions and opinions from participants. This was also helpful in checking whether

the participant understood the questions, both consistently across participants and in the way intended by the researcher.

Time was spent with the participants following their interview, providing them space to reflect on how they had experienced the interview and how they were feeling. They were encouraged to think about their repertoire of coping strategies and those that they would use following the interview if they needed to, recognising that the interview may have evoked difficult memories and associated emotions. This allocated time aimed to help the interviewee feel present and safe. On their debrief letter (Appendix H) they were provided information about support services (e.g. Samaritans). If they showed signs of distress, staff within the prison were informed and an appropriate person within the establishment was asked to follow up with the participant. The debrief letter provided contact details if they had any questions at a later date.

The research was conducted in line with the General Data Protection Regulations (GDPR). A voice recorder with password protection was used to record interviews with participants who consented to their interviews being audio recorded. Interview data was transferred to an encrypted laptop. Audio recordings were transcribed verbatim (or written up where notes had been taken) by the Principal Investigator and saved on a secure

database. Abiding by the Data Protection Act, no names were kept in proximity to transcripts - pseudonyms were assigned beforehand[2].

3.3.3 DATA ANALYSIS

The interview data were analysed using thematic analysis (Braun & Clarke, 2006), with a process adapted from Smith, Flowers and Larkin (2009). This process of analysis involved associating themes, finding patterns and developing new clusters; examining transcripts for oppositional relationships; recording how often a theme was supported and mapping where an emergent theme became a superordinate theme. Each life story was analysed to this level and coded thematically in NVivo12.

The findings are based on the accounts of the participants concerned, which have been represented accurately and honestly. Taking reflective notes and revisiting the data numerous times yielded different insights and mitigated the risk of biased reporting. Despite being familiar with the existing research on this topic and the existing typologies, the results did not fit pre-established expectations; the themes emerged purely from the data collected.

[2] Pseudonym assigned by *Random Name Generator*
Available at: http://random-name-generator.info (Accessed: 1st October 2018)

4 RESULTS

The analysis revealed five superordinate themes and nineteen constituent themes which emerged from the data using inductive coding. The themes followed the chronology of the life stories from their childhood and development, the process of their offending, their arrest and imprisonment, experiences of imprisonment and plans for release.

4.1 NEGLECT AND FAMILY BREAKDOWN

4.1.1 Negative Parenting

Can't say I had a brilliant childhood. My dad was quite violent towards my mum. He used to hit her.

- Sonia

'Negative parenting' refers to parenting behaviours that are inconsistent, controlling and harsh (Taraban & Shaw, 2018), lacking 'positive parenting' components: emotional warmth, responsivity, boundary setting and appropriate scaffolding (Waller et al., 2015). Participants described their earliest memories tainted by a poor relationship with one or both of their parents. A consistent theme – whether it came to the attention of social care or not – was a 'dysfunctional' home, a finding paralleling previous

studies (*inter alia* Eldridge, Elliott & Ashfield, 2009; Matthew et al., 1997; Tardif et al., 2005). Dysfunction includes parental substance misuse, neglect and witnessing domestic violence.

Every participant spent at least the first few years of their life with their biological parents, although some of them went into care later because of the extent of their neglect. For the purpose of definition, neglect is as a broad term to refer to caregivers' persistent failure to meet the physical and psychological needs of a child (Horwath, 2013). Indeed, every interviewee shared reflections of how their physical and emotional needs were not met. This involved feeling that they had nobody at home to keep them safe and cared for, witnessing domestic violence and parental substance misuse.

They lived in the pub… we were pub reared as they say.

- Janet

The impact of disrupted attachments in childhood is key in the aetiology of maladaptive behaviors including violence (Ryder, 2007). Adshead (2002), in summarising the overrepresentation of insecure attachment styles among forensic populations, notes the commonality of these individuals to have been conditioned to accept and ignore distress, and navigate alternative methods of managing their vulnerabilities as they learn that others won't keep them safe from harm.

4.1.2 Experiences Of Loss

All of a sudden my dad's got this new life and he's dropped us, dropped me and my sister.

- Melanie

When I was eight, my father – I was a bit of a daddy's girl – my father left home. So there was a bit of sort of thinking perhaps it was my fault […] I missed the love, I was very, very close to my father. And I missed that love. My mum was lovely, very loving, but I missed my father. It had a big impact on me.

- Juliet

The loss of a significant person in their childhood was shared as a traumatic event for most interviewees, both through bereavement and parental separation. This included families moving due to parents' new relationships, which was experienced as a disruption. The lack of consistency impeded their experience of a safe and secure base.

For Regina, following the death of her biological father, her family uprooted from Wales to the east coast of England to live with her mother's new partner, which Regina begrudged both because of the move and because of her dislike for her stepfather. She described learning to "self-soothe" through obsessive behaviours and, later, through self-harm.

Similarly, Juliet, who was now in her sixties, recalled her father leaving the home when she was seven as a poignant moment in her life from which she developed a fear of men leaving her. She related this to her offending, because she developed a strategy to do anything to "please men" in order for them to stay.

4.1.3 Perceived Rejection

I always felt rejected from my mum. She never showed affection […] I'd always felt like I was always… rejected.

- Janet

She weren't like a mum to me. Like she was to everyone else.

- Alesha

Almost all spoke about how they did not feel loved in their family home, that they were not wanted. This usually came from parents, overwhelmingly the mothers. But also to a lesser extent, fathers and siblings. The recurrent theme was the feeling of not belonging within the family home, and how this shaped their sense of self.

My sisters gave me the impression that they didn't like me. I never knew why […] I grew up… believing them, that I was a spoilt brat. And then as I

got older, the other insults started, like 'you're disgusting, you're dirty, you're spotty, you're fat'. And then as I grew up even further, more insults come, 'no one's ever gonna want you, you're fat'.

- Monica

For Melanie, following the death of her paternal grandfather, who she described as her "role model", she started to find her comfort in food. However, she felt ridiculed by her father for her consequential weight gain. This mirrored her school experiences where she felt criticised by her peers. She described feeling judged both at school and at home, and found no place for her to feel safe and secure.

I started getting really badly bullied at school because of the weight I was putting on… and was getting that at home from my dad as well, who would make comments about my weight and call me fat and things like that.

- Melanie

The perception of a lack of emotional warmth was prevalent, mirroring Sigre-Leirós, Carvalho and Nobre's (2016) study, which found that sex offending groups perceived their parents to have shown less emotional warmth compared to non-sex offenders. As well as interviewees' early years being characterised by their emotional and physical needs not met, for the majority they also experienced harm within their family home.

4.2 PHYSICAL AND SEXUAL TRAUMA

4.2.1 Violence From Caregivers

Growing up as kids we used to have the leather belt off of dad. And mum used to have, she called it her whippet stick, she used to have a little cane stick. So if we played up she'd sort of smack us with her stick.

- Sonia

Interviewees were recipients of violence from caregivers, typically guised as physical chastisement. Janet disclosed how her dad "took her tooth out" when he beat her when she was a child, and others spoke of the feeling of an omnipresent threat of violence. Almost all had witnessed or experienced physical abuse within their family home in some capacity.

4.2.2 Sexual Abuse

The cycle of abuse – the concept that abuse is transferred through generations - is well known among those who study sexual abuse (Adshead et al, 1994; Saradjian, 1996; Tardif, Auclair, Jacob & Carptentier, 2005). Indeed, sexual victimisation in childhood/adolescence was a frequent theme in the present study, with all but two participants disclosing some form of sexual trauma. Most participants (*n*= 6)

experienced this within their family, perpetrated by a brother (Regina), father (Sonia), sister (Melissa) stepfather (Melissa and Angela), stepbrother (Juliet) or cousin (Janet).

[My sister] was made by my mother to sexually abuse me. She did all kinds of things to me. It only stopped when I was 12, because the sexual abuse from my step-father started. He used to pick me up from school and take me to a lane off the M25 and rape me. This happened frequently.

- Melissa

This relationship with my stepbrother, feeling that I had to give sexual favours to him, to make him like me, and to not say no.

- Juliet

Fonagy (1998) describes the cognitive dissonance experienced by children abused by their attachment figures, where an inability to comprehend the situation and acknowledge the harmful intent of their caregiver compromises their ability to process their feelings. Juliet described how she felt her stepbrother was showing her that he was fond of her. Janet used the word "practice" when describing what her older male cousin used to do to her, as she seemed to struggle to comprehend it as rape.

Alesha disclosed being raped on three separate occasions by different men when she was between the ages of twelve and fourteen, and believed that she had earlier episodes of sexual abuse when she was an infant. She was

unable to recall the details, which she attributed to her young age at the time of the alleged abuse, but believed her mother was complicit:

I was having flashbacks of being in my bedroom as a child, and a bloke coming in. I couldn't see his face. But a bloke would walk into my room. Undo his trousers, and the next minute my bed had blood on it and my mum was changing my bed.

- Alesha

As well as within their family, Juliet and Janet had also experienced sexual abuse outside at the hands of strangers when they were eight and sixteen respectively. Both recalled feeling ashamed of themselves and the physical and psychological violation of these events tarnishing them as 'dirty', with Janet stating "I never told a soul because I was ashamed". Juliet reflected on how she had experienced her father leaving the family home *as a result* of her abuse, which happened shortly after he found out she had been victimised:

I remember, at the time, when I had been abused and I came home and my mum discovered… you know, the marks, and my father went absolutely ape, as a father would. And he was angry. And I just have this picture of me, sitting on the stairs, listening to my dad being angry. And I remember… I know it sounds, not silly, but in a child's mind, really

important. The ice cream man turned up as he would every weekend. And I asked for an ice cream and he said no. And I felt I was being punished.

- Juliet

4.2.3 Feeling Blamed Or Not Believed

The majority of participants who had been sexually abused stated that they had not disclosed at the time. Janet, whose mother walked in on her older male cousin abusing her, "got the blame", which deterred her from disclosing when she was sexually abused several years later.

S*he called me a dirty little bitch. I didn't understand what was going on, I was 12 years old.*

-Janet

The very act of recalling abuse was re-traumatising and served as a barrier to disclosing. A tenet such as this is important to consider when thinking about the skill and specialism treatment requires, yet much of the support provided to the women was offered by non-psychology staff, such as prison or probation officers. Alesha was particularly reticent, despite being open about various other aspects of her life and history. She found speaking about her experiences of abuse as re-violating every time she

revisited the memories, and coped by avoidance, rather than processing that people in positions of care and authority could cause her such harm.

They ask you details. What did the person look like? What did the person smell like? Did they have scars? It's disgusting. To speak in that detail about things. It's degrading.

- Alesha

Participants reflected on feeling that there was nothing that could stop the abuse and no one that could help them. They were made to feel that their abuse was in some way their fault and responsibility to cope with. The feeling of being blamed and even shamed left the long-lasting impact of feeling alone and helpless.

That's how they did it in those days. They didn't take you seriously. And I thought, then, who's gonna take me seriously?

- Juliet

For some interviewees, it was their experiences of sexual abuse, part of a web of other ACEs, that served as the catalyst for them feeling they needed to escape from their family home. Melissa tried to run away to her father's house, who returned her to her mother and step-father's home

where she continued to be abused. For Alesha, being sexually assaulted by her neighbour and not being believed by her parents led her to leaving her family home when she was fourteen and becoming a Looked After Child.

My dad didn't get it, he said I was being a stupid teenager. I didn't tell him about the abuse because I was too scared. My step-father said that no one would believe me.

- Melissa

The impact of the aforementioned disclosures was profound and multiple interviewees reflected on how their negative experiences paved the way for an adulthood of feeling that their wellbeing was not important. The disbelief and victim blaming increased feelings of fear, guilt and shame which not only prevented further disclosures of abuse but also had long-lasting negative effects on how the women saw themselves and the treatment they believed they deserved. Based on their early experiences, participants developed a view that the world around them was dangerous. This in line to the 'dangerous world' implicit theory (Ward & Keenan, 1999), which the authors describe as a schema one uses to make sense of the world. Those that develop an implicit theory of the world as dangerous see it, and the people around them, as unsafe, and feel that harm is inevitable.

4.2.4 Maladaptive Coping

Janoff-Bulman (1979) hypothesised that survivors use denial, minimisation, and behavioural self-blame in their attempts to cope, assimilating the trauma into their personal schema of their world. Abuse, neglect and family dysfunction often lead to mistrust and hostility, which then contributes to negative peer associations, and delinquent behaviour (Hanson & Morton-Bourgon, 2005). By the time interviewees reached their teenage years, most were living semi-independently, with Alesha and Regina both moving between children's homes and hostels. The average age participants disengaged from school was fourteen.

I just didn't care about anything. I didn't want to go to school, I didn't have respect. I used to get into trouble […] I used to take anything. If I wanted it, I'd take it. I didn't give a shit. I didn't care about anyone but myself.

- Alesha

Previous research has highlighted the importance of interpersonal difficulties and emotion-regulation difficulties for females (Gannon et al., 2008; Grayston & De Luca, 1999), and these difficulties appeared prevalent for interviewees. Regina, Melanie and Alesha engaged in self-harm in the form of cutting. They spoke about it as a release of emotions

which they struggled to regulate, but also reflected on it as a form of communication and a maladaptive problem-solving strategy. For example, Alesha cut her arms when she feared she might be returned to live with her parents, and reflected on how she saw it as the only way her distress would be 'heard', as her words were ignored.

Regina spoke about the limited ways she had to cope with her experiences of sexual trauma and depression, and had starting cutting her arms when she was thirteen. She was referred and seen by CAMHS who identified "emotional instability" but this was in the context of her family home breaking down. She felt disenfranchised, following her mother's departure from the family home when she was fifteen, and she described how she and her brothers had to "fend" for themselves. She attributed this desperation to her involvement in criminal activity, following meeting another female with whom she felt an immediate bond because of their circumstances:

We had to fend for ourselves, 'cause she's had a shit upbringing as well […] We used to just have to con men with money. Just… just used to con them for money.

- Regina

Alesha reflected on the constant moving of placements as worsening her substance misuse, alluding to her taking more to cope with feelings of

rejection she experienced when placements broke down. She also got moved between different cities, where she did not know anyone. She reflected on using substances as a way to connect with others (for example, "*sharing* a line of coke" and "*sharing* a joint").

And I never said anything about it and I just hit the bottle, just to hide what had happened. But, from there I got very promiscuous.

-Janet

Following feeling blamed for her sexual abuse, Janet reflected on coping through alcohol. She referred to herself as "promiscuous" when she was fifteen, spending time with older men who would supply her with substances. Interestingly, Janet did not refer to herself as a victim in these circumstances, despite the scenario indicating she was being sexually exploited. The way she described her actions indicated that she saw herself as a participant rather than a victim. This may have been a result of her earlier experiences of feeling blamed for being abused, which skewed her understanding of her right to deny sexual activity and her locus of control, increasing her feelings of shame and blame.

4.3 ABUSIVE ADULT RELATIONSHIPS

4.3.1 Low Self-Esteem

Participants appeared to internalise their experiences of abuse and the shame that was felt alongside it. This is in line with Spencer's (1999) suggestion that whilst males are more likely to externalise ('acting out' behaviours such as anger and aggression towards others) following abuse, females internalise the impact of their abuse (such as experiencing psychosomaticism, social withdrawal and engaging in self-harming behaviours). Their early experiences shaped how they saw themselves, and how they believed other people saw them.

I was thinking that no one would ever want me, no one would ever love me, I was too fat, I was too ugly and stupid and worthless.

- Monica

I'd grew up feeling dirty […] I always thought I was never good enough.

- Sonia

Based on their early experiences with others close to them growing up, they made judgements about their competence and likelihood of success in relationships with others. All participants described low self-esteem and

feeling that they were unlovable, but, further to that, struggled to articulate what a healthy and loving relationship looked like. Most had only been exposed to those that were unhealthy, even abusive, and this shaped what they expected in their own relationships. As Levenson et al. (2016) point out, those who have grown up in what they perceive to be a dangerous world, where those in positions of care have been unable to protect them, have a hindered ability to trust others and they approach others with wariness. However, as the authors note, self-doubt and a lack of faith in their own instincts cause them to put these feelings aside as they have grown up believing that their needs and safety are not important.

4.3.2 Perceptions of intimacy

I suppose, because I didn't get the attention from my mum, I sought it in men. Perhaps in later life, and then… I don't know. As a teenager I saw sex as love. I didn't know what love was. I didn't know what it was […] And I felt like after I'd been raped, all the relationships, that to me was all I knew. That was love to me.

- Janet

Intimacy is understood as a positive emotional bond that includes understanding and support yielding feelings of warmth and connectedness

(Reis & Patrick, 1996). Interviewees described how they had (in the past) considered sexual activity as synonymous with love; it was how they had experienced closeness with another person. It appeared that the apparent lack of emotional warmth in their early years led them to only experience intimacy in the form of physical intimacy (as opposed to emotional). Similarly, Vandiver and Teske (2006) described the desire for intimacy experienced by female sex offenders, and how their offending is associated with displaced emotions stemming from early trauma. Indeed, skewed perceptions of intimacy were prevalent during interviews, with sex being described as "a comfort blanket" (Alesha) even when it occurred within physically violent relationships. Additionally, Melanie and Juliet reflected on how they never enjoyed sexual activity (with Melanie referring to it as a "chore" a woman *had* to do in a relationship), but they sought to please men. It was viewed as a form of exchange; they needed to be sexual in order to obtain a man's attention, because it was the only thing they could offer that was worth anything.

It all started, I think, from when I was abused first of all, and my father left, and feeling unworthy because I was trying to please other people. When my step-brother abused me, I wanted him to like me. I wanted him to… you know… I suppose you could say, he was my first love. I was very close to him and I wanted to please him […] And I hated it, but I went along with it because I didn't want him to not like me. So, in my head,

even at an early stage, I felt that I had to please men, or they don't like you.

- Juliet

4.3.3 Harm Within Relationships

He used to rape me, basically. He'd force me into sex […] There was a lot of mental torture. He did things like holding me down and holding acid over my face and saying "I'm going to stop people looking at you".

- Juliet

Interviewees experienced relationships which repeated histories of neglect, physical and sexual abuse, which appeared based on their implicit theories of relationships. This refers to their assumptions or beliefs about the nature of relationships, which in turn influenced how relationship events are perceived and interpreted (Knee, 1998). The content of such assumptions or beliefs is dependent on the social interactions that a person navigates early in life (Rudolph, 2010). The idea of men being driven by sex and using violence to get what they want was widely accepted by interviewees, all of whom experienced domestic abuse within their adult relationships. A consistent theme was the omnipresent threat of harm, with physical and sexual abuse used as control. Melissa spoke about

being strangled and hit (resulting in her miscarrying their child), and her view of how a common male trait was possessiveness and jealousy. She reflected on this as him "caring" about her, rather than viewing this as abusive behaviour.

The need to remain in these relationships mirrored the concept of trauma bonding, which refers to situations where victims feel attached to those and the situation where they are being harmed. Studies have found that women who remain in abusive relationships report high rates of trauma symptoms and low self-esteem (Dutton & Painter, 1993). Graham and Rawlings (1991) conceptualised the bond a victim can feel with an abuser as a survival strategy, and leaving the relationship is difficult because it means losing the only relationship now available and the sense of identity formed in the relationship. Trauma survivors may become physiologically addicted to the hyperarousal state (van der Kolk et al., 1985), and this physiological addiction may help us understand why victims remain in traumatic situations with abusers (van der Kolk, 1994). Alesha attempted to make sense of why she stayed in contact with the multiple men who harmed her sexually and physically. She felt that the only thing she could control, in a world which she felt was dangerous and threatening, was her use of substances to detach her from her feelings and reality.

They make you believe that no one out there will ever want you. That you're not worth anything. They'll do anything for you. And sex is just sex,

it doesn't mean anything […] I used to go running back to him. I still went back to him. It's hard.

- Alesha

4.3.4 Understanding Of Consent

I understand that people think it's wrong, but I consented. He was my partner. Like, I don't understand what the problem is. I'm old enough to know what I'm doing.

- Alesha

Ford (2010) notes how the acceptance of harmful behaviour may be because an individual has only have experienced physical closeness where there were abusive power inequalities. Indeed, participants' expectancies were modelled on their early experiences, shaping how they viewed others relating to them, and how they related to others. Melissa and Alesha, whose first sexual encounters were being raped as children, were in relationships with men who (in the eyes of the law) were committing statutory rape. Both spoke about how they "consented", despite there being clear power imbalances and differences in circumstances and lifestyles. They did not view their sexual activities with older men as abusive, as their only experiences of sex *had been* abusive and therefore

normalised. Bearing in mind that most had disengaged from school around the age of fourteen, interviewees reflected on having little, if any, education on sex and relationships, resulting in a seemingly poor understanding of the importance of capacity as fundamental to consent.

4.4 ISOLATION AND LONELINESS

4.4.1 Emotional Loneliness

I just didn't want to be on my own.

- Sonia

Akin to DeCou et al.'s (2015) study, loneliness and perceived lack of support was prevalent. The loneliness alluded to by interviewees was influenced by social factors such as poor social and familial support, lone parenting, difficult financial circumstances, and interrelated psychological factors such as low self-esteem, internalised guilt, shame and confusion about their early experiences of abuse. Bound Alberti (2018) argues that loneliness needs to be understood firstly as an "emotion cluster" composed of a variety of affective states. She defines loneliness as a "conscious, cognitive feeling of estrangement or social separation" (2018: 243). Blake and Gannon (2011) describe emotional loneliness as a subjective experience of lacking closeness with others and social loneliness arising

from an absence of a network of social relationships, often experienced by sex offenders (Levenson, 2014). For interviewees, they were physically and emotionally distant from others; they not only lacked support networks often a result of being estranged from their families due to their ACEs, they lacked the feeling of connectedness with others and typically felt they had no confidante to whom they could turn to for support.

I had nowhere to go. I had nowhere. He had isolated me from everyone. All my family were against me. I had nowhere to go.

Janet

Marshall (1989) observed that sex offenders suffered from a lack of intimate relationships and poor interpersonal skills to develop such relationships, emanating from poor attachments developed with caregivers during infancy. Interestingly, interviewees that alluded to failing to develop secure attachment bonds with their caregivers appeared to struggle to develop healthy attachments with their own children. Furthermore, Angela, Janet, Melanie, Melissa and Sonia all described emotional detachment, rejection, or sexual and/or sexual abuse from one or more caregivers during their infancy, and in each case the victim of their later offending was their own daughter.

4.4.2 Virtual Companionship

At first it was very normal messages, after a few days the messages were becoming sexual. And a lot more flirtatious. Because at first it was lovely just to have a chat. I knew it, half an hour had gone of the day. And I'm like, oh my god, I've lost time because I've been talking to somebody. I can't remember the last time that had happened.

- Monica

Sonia, Melanie, Monica and Melissa used internet chat rooms or dating websites and, in most cases, it was on these platforms that they met their co-offender (Sonia and Melanie) or their victim (Monica). Melanie identified how easy it was for her to use the online platform from her phone. She was experiencing what she now considered to be post-natal depression, and became, in her words, "a robot", whose only purpose was to care for her newborn daughter. She rarely left the house but could be in contact with an array of people via social networking from her mobile phone. This mitigated the isolation and loneliness and allowed her to present a different version of herself. Monica literally made a fake account, using photos of a teenage girl she had retrieved off the Internet. She highlighted how easy it was for her to add 'friends' and create the illusion of having a support network around her.

I turned to the Internet and chat rooms as some company, 'cause I lost a lot of trust in people from the bullying. And I found that I constantly walked around with a barrier up, like, you will only get as close to me as I'll let you get […] I just thought that on there they didn't need to know… all they'll see picture wise is my head. They don't need to see my body; they don't need to know what I've been through.

- Melanie

The stupid thing is…. My profile picture is a picture of me and my daughters. And this bloke just messaged one night and said 'what a beautiful little family you've got'. And we started talking […] I was just love struck, that this really good-looking guy could be interested in me.

- Sonia

For a long time, Sonia had believed that she was un-lovable. As with other interviewees, she turned to online platforms to receive validation she felt she could not receive in real life. As with all interviewees who met their co-defendant via online platforms, her profile picture was of her and her children. The reason for this was because she did not have any photographs just of herself because she didn't like the way she looked.

4.4.3 Fear Of Loss Or Rejection

He did it in a way that made you feel special. That you were important. That you were valuable. And at the time my husband didn't, because he was always cheating on me and things like that. I was in a bad place when I left him. And I think it was just that attention… that, 'oh my god my life is actually worth something'.

\- Janet

In these cases where interviewees who had met their co-defendant online, participants described a sense of dependency on the validation they received. How the man had said "all the right things" (Sonia) was echoed in these interviews, and a process of grooming was alluded to, where the men enticed the women with virtual affection. The offences involved a variety of behaviours and processes, differing in each case, but what was similar was the fear of loss. This was used to manipulate the women, once dependency had been achieved. This mirrors Matthews (1993), who described women coerced by men to sexually offend as experiencing low self-worth and fearing rejection.

My thoughts, my doubt thoughts, were coming into my head: 'you're gonna have no one to talk to'. You know when you've got two sides of your brain battling, it was very much like that. It was like, I don't want to be talking like that, it's wrong. And the other side was like, but if you don't,

you're gonna go back to having no one to talk to. This person's willing to talk to you. This person doesn't know you. This person doesn't think you're stupid and ugly and fat. So I kept talking to him.

- Monica

I was like, right ok, so I sent her a picture, just of her, she was in her normal clothes, and he was like 'she's so pretty, she's so pretty', stuff like that. And he was like, 'will you send me a picture of her naked?'. And… I don't even know why I did it. I think it was because if I don't do it, I'm gonna lose him. 'Cause he'd tried to pull away before when I didn't go to see him. And I just thought, what harm is me sending a picture of her naked gonna do? So I did. And he was like, 'yeah I like that, I want more'.

- Melanie

Similar to DeCou's (2015) findings, Melanie was desperate to maintain the emotional connection with the man encouraging her to produce explicit material of her daughter. Despite articulating how she would never have produced this material had she not been asked by her co-defendant; this did not amount to coercion. Rather, she felt in need of the validation she received from him. In contrast, Sonia had disclosed that she had been abused by her father and the immense amount of shame she carried, and her coercer used this to his advantage. He threatened to use this

information unless she shared explicit material of her daughter. Whilst Melanie maintained some control, Sonia felt she had none.

The fear of loss appeared to mirror their childhood experiences, where they felt psychological pain caused by the loss of an important figure in their lives. A desire for emotional intimacy with either the accomplice to the offending or the victim was notable, similar to Gannon et al's (2008) findings. Those who offended against their daughters appeared far from narcissists proposed by Mayer (1992), but rather women who were desperate to hold on to the attention and feigned affection that they felt their codefendants either provided or promised to provide.

4.4 DENIAL, SHAME AND PERCEPTIONS OF JUSTICE

4.4.1 Rationalisation And Minimization

Then he told me to Google him. And then I found out he was a convicted paedophile […] I'm a non-judgmental person, I don't judge anybody. And at the time, I just thought everybody deserves a second chance.

- Sonia

Unlike other participants, Sonia shared that she was aware that the man she had embarked on a relationship with had been in prison for sexual offences against children. He disclosed this to her after meeting her in

person and being introduced to her children. She reasoned that she felt he had served the punishment for his crimes, but implied that she would rather be ignorant of his past and current paraphilia because she was so desperate to make the relationship work. She sent him pictures of her pre-pubescent daughters after he disclosed his offences but reasoned that they were not *that* different from what people post on their social media (such as photos of her children in the bath and in their underwear).

He was like, 'just remember you said you accept this as my fantasy, it's just a fantasy'. So in my head, I'd kind of thought to myself, it's just words on a screen. That's all it is. Just words on a screen.

- Melanie

Melanie described how her co-defendant began to test the boundaries of what she would accept as a trajectory. It began through him describing "fantasies" where he wrote about him perpetrating child abuse, which Melanie attempted to minimalise, akin to how the 'online' version of herself was far removed from her persona in reality. However, descriptions of child sexual abuse escalated to requests for explicit images, which in turn moved to requests for images of Melanie perpetrating sexual abuse. Because she had engaged in the earlier stages, she struggled to withdraw her participation because of fear of the consequences. This was her

overcoming the internal inhibitors of offending as postulated by Finkelhor (1984), providing rationalisation and justification to the abusive behaviour. Similarly, Sonia experienced threats of what would happen if she did not continue to share images of her children:

He said, 'if you don't send me pictures of [your daughter], I'm gonna go and meet this woman'. […] I sent him a couple of pictures just to keep him quiet. Because, my way of thinking was, I can protect my daughter because she's not in [with him]. So I thought I'll send him what he wants.

- Sonia

Strickland (2008) elucidates the cycle of victim to offender. Her account suggests the sexual abuse often experienced by female sex offenders shapes cognitive distortions about how a person is perceived to be sexually interested. For many interviewees, their first sexual encounter was rape. Regina, who was raped by her brother as a child, reflected on herself as an "immature" teenager. Social care provided her with her own flat to live independently, yet she lacked the basic life skills to do so. She felt there were no developmental differences between her and the victim of her offence during what she considered to be their consensual relationship, when she was eighteen and he was thirteen. Because of the traumatic experiences in her early teenage years, she felt her healthy development had been compromised.

4.4.2 Justice

The feelings of un-just treatment echoed during interviews. This included a lack of distributive justice, which is based on the exchange principle and that people judge the fairness of the outcome based on what they have done to receive it (Lambert & Hogan, 2013). Participants generally saw their sentences as illegitimate, especially Regina who was serving an indeterminate sentence, which meant that she would only be released from prison when she was able to evidence to the parole board that she no longer posed a risk to the public. Due to the lack of risk reduction courses suitable for her due to the nature of her offence, she felt hopeless. There were feelings of an erosion of procedural justice, which refers to the processes behind outcomes (Greenberg, 1990). Procedural justice is achieved by consistent decisions based on accurate information, free from personal bias (Leventhal, 1980). Participants overwhelmingly described how they felt the legal process was against them.

My barrister, she didn't fight my case at all. Literally, didn't even read my case notes. Then the judge we thought we were having, we didn't have. We had this male judge […] He hadn't read the case notes. He read them through lunch time. He said to my solicitor before he went off to read them, 'why should Sonia be treated different to anybody else?', and all she

said was, 'well she's female' […] And his face. He went red. He literally… he glared over the top of his glasses.

- Sonia

The judge swayed [the jury] because, you know when they do the summing up, he spent about nearly an hour summing them up and spent about twenty minutes summing us up. So that, basically, it was kind of 'she's done this, she's done that, this is the kind of person she is, blah, blah.'

- Juliet

Juliet described the impact of the media coverage had on her family, and described how she felt this stole her the opportunity of a fair trial. She also spoke of how this meant her wider family, including her elderly mother, were punished. During her trial, she described how the judge "painted a picture":

That picture was a predator. A predator. A woman that goes out to seek young boys to have sex with. Nothing could be further from the truth.

- Juliet

In line with existing literature (e.g. Crewe, Hulley & Wright (2017), findings from the present study highlight the gendered pains of

imprisonment. Termed by Sykes (1958), this refers to the intrinsic and potentially damaging consequences of incarceration which include the deprivation of liberty, goods and services, heterosexual relationships, autonomy and security. For example, most of the women in this study were the primary caregivers and their imprisonment resulted in their children being placed in care with contact prohibited, with significant psychological impact for all involved.

4.4.3 Adapting

It went round like wildfire. And then the bullying started. The pushing. The legging over. The punching. You know, vile, the name calling […] Nonce, is the word isn't it. Nonce. That's what they call paedophiles, isn't it. So hurtful.

- Juliet

A common theme was the desire for anonymity but how difficult this was due to the wide media coverage each of their cases received. Almost every participant made the point of saying that they had been advised at court to not disclose their offence to other prisoners, and to say they were convicted of drug offences.

Despite agreeing to participate in the study, Angela, who was convicted of sexually abusing her daughters, maintained her innocence. Janet had

denied her offence against her daughter throughout the court proceedings and during her time in prison, and had only admitted it a matter of months before her interview:

For the whole time I felt, because I'd seen the abuse that the other girls had had, that had sexual offences, I just kept quiet. 'cause the bullying in prison for girls with those kinds of offences is awful. It's awful. I didn't know who to talk to. I didn't know who I could trust. Because I've got no trust.

- Janet

She noted how her lack of trust in people and 'the system' made her less inclined to embark on therapeutic work. However, almost all of the participants were engaged in education or employment, with some having also completing therapeutic groups relating to domestic violence. However, no interviewee appeared to have engaged in intervention that would point towards risk reduction.

4.4.4 Identity As A 'Sex Offender'

There is nothing in prison for people like me.

-Angela

Most participants had experienced some fallout from their community and/or family network as a result of their offences. They were thus cut off

from the major form of social support, and were more in need of support and services from the prison (which was limited).

I found very little support, even like when I started to open up. Like, who can I open up to, who can I trust? I just don't know what's there, who can you go to? Who can help you with these situations?

- Janet

There was a lack of hope expressed about the future, owing to an absence of ontological security, which Giddens (1991) refers to as a sense of order and continuity with regard to an individual's experiences. This can foster anxiety when it is eroded because one can feel out of control. Indeed, the words "terrified", "scared" and "anxious" were used by interviews when they spoke about their release. Participants described *being* different people, with this being positive in most cases, but in others women felt they were defined by their offence. The very fact that not all approved premises accepted sex offenders meant that some participants were preparing to live in areas they were unfamiliar with, far away from their sources of support.

Getting out of jail with a crime like mine… it's gonna be hard to say the least. I'm gonna be on a register. It's gonna be hard for me to find a job. The lot. But I wanna get out. I wanna be happy.

- Alesha

Participants described a process of 'mortification of the self'; a term used by Goffman (1961) to refer to the process where individuals' self-concepts are challenged and reformed; 'a recoding of existence' (Foucault, 1979: 236). A process of deconstruction and reconstruction of the self was described, with an acceptance of an 'old me' and new me, with the future post-prison very different to the life they led before. Their imprisonment led them to question the values they hold and even reconstruct their identity.

I actually feel sorry for the woman I was. Because I'm a very different person now. It's changed me. I look back and I think to myself, if only I'd had the strength to say no. If only I'd had the strength to say, what are you doing? But at that time I was a very different person.

- Juliet

5 DISCUSSION

5.1 GENERAL DISCUSSION

Findings highlight the multiple ACEs among all interviewees, with lack of protective factors identified. Although it is only possible to speculate from the quantitative data, there was social care involvement in each case in some capacity. The number of children living away from their parents also suggests disruption. Such findings corroborate Rich (2011) and Hackett's (2014) assertion that HSB should not be considered in isolation as a distinct phenomenon, but as a developmental experience that sits alongside – and may be a symptom of – other developmental challenges.

The results from the present study, where results from Phase 1 showed that the average age of children referred for HSB was ten years old, highlighting the importance of educating children about sex and healthy relationships, and to include the more abstract tenets such as boundaries. This is important considering the technological age where explicit material can easily be obtained on mobile devices which many primary school aged children have. Recent changes have made relationships education compulsory for all pupils receiving primary education, and relationships and sex education compulsory for all pupils receiving secondary education (Department for Education, 2019). However, schools are free to determine

how to deliver the content, and it has been suggested the focus lies more on education on reproduction, sexuality and sexual health, and less so on consent (Long, 2018). Learning how to distinguish between healthy and unhealthy sexual practices is important for maintaining healthy relationships, and fundamental to this are key foundations such as trust, respect and equality. Because the average age interviewees left school was fourteen, and for most their formal education had been sporadic at best, meant that most had undertaken no formal sex education and did not receive this from their caregivers. Unhealthy sexual practices were normalized to them, and they also lacked information about support services (such as the NSPCC), which is now recommended to be incorporated into sex and relationship education in schools (Department for Education, 2019).

Evidence suggests that early trauma disrupts brain development and chemistry, which can affect one's ability to regulate emotions (Stien & Kendall, 2004). Multiple interviewees reflected on feeling overwhelmed with emotions that they struggled to regulate (and thus engaged in maladaptive strategies to manage them such as substance misuse and self-harm). Associations with poor emotion regulation and sexual abuse have been noted (Eldridge & Saradjian, 2000; Nathan and Ward, 2002; Saradjian, 1996). Interpersonal difficulties were also prevalent, and appeared to be motivational factors for sexual offending. Interviewees had developed a view of themselves as subordinate, and struggled to make

and maintain healthy relationships as a result. They were susceptible to grooming as a result of their low self-esteem and desire for intimacy and emotional loneliness. These findings echo Williams et al. (2019), who found that the female solo offenders experienced lower levels of self-esteem and assertiveness, and greater emotional loneliness than male sole offenders and female co offenders. However, findings from the present study suggest low self-esteem and high levels of emotional loneliness among all interviewees, regardless of whether they were a sole or joint offender.

Most interviewees did not fit easily into the typologies described in the literature review. The typology proposed by Wijkman, Bijleveld, and Hendricks (2010) of passive mothers, who were either involved in watching the abuse or facilitating the abuse of their own children or stepchildren, was similar to Janet's, Melanie and Sonia's case, particularly as they viewed their role as an inactive observer. This typology shares similarities with the male-coerced type proposed by Matthews et al. (1991). However, it is important to consider the difference between coercion and encouragement; despite the women in the present study feeling manipulated into distributing explicit material and perpetrating sexual abuse, they still maintained control and choice. Using Finkelhor's (1984) model, their external barrier was overcome as they had access to the victims (their children, in each case) and their rationalisation and justification helped them overcome their internal inhibitors. Monica's case

shared similarities with Vandiver and Kercher (2004) category of heterosexual nurturers and Matthew's et al's (1989) teacher/lover category, in that she posed as a teenage girl on social media, and engaged in sexual activity with a teenage boy she had met using her fake profile. Unlike the aforementioned typologies, where the women viewed the abuse as a relationship, Monica reflected on knowing the behaviour was wrong, but experienced her isolation and emotional loneliness as so overwhelming that she used what she believed to be the only asset she had, her sexuality, to communicate with him.

The findings of poor emotion regulation, low self-esteem, emotional loneliness and interpersonal difficulties, mirror prior studies and highlight the importance of them as treatment needs. Many interviewees were engaged in some form of intervention (such as the Freedom Programme, aimed at women who have experienced abuse within relationships). Such courses may be helpful but cannot be argued as risk reduction programmes. Many described feeling there was "nothing" available for them, and they noted that the stigma surrounding their offences made them reluctant to seek support or request psychological intervention. Feeling ill equipped for life post-prison emerged from interviews, interviewees describing themselves as "terrified", "anxious", "don't know where I'll be", "with a sex offence hanging over me". Thought must be paid to mitigate this, but ensuring safeguarding is held in mind. The

repercussions interviewees felt they would experience if their offences were known evoked fear in them, and with this reasoning all said they would not engage with group work (the format typically offered for sex offence treatment) but would consider offence focussed intervention delivered on an individual basis.

5.2 LIMITATIONS

The main limitation imposed on the present was the time scale. The principal investigator allocated one day per week over the course of three months for data collection within prison establishments, and there were restrictions imposed by the prison regime. The prison day is short, with a large part of the day over lunch being protected time for prisoners. This meant that on occasion only one interview was carried out per day, owing to the life story interviews which elicit considerable information and thus take longer to carry out.

A limitation which is inherent in this study is subjectivity; both in terms of the data and the data analysis. Regarding the former, the information collected is essentially what participants were willing to share, which may deviate from actual events. As this study is primarily concerned with sense-making (how the women have internalised and made sense of their experiences and behaviour) this is unavoidable. Participants may not all have been telling the truth, both to help them navigate prison life and

cope, and none of their accounts are verified. However, part of the analysis included exploring the function denial, rationalisation or minimisation may serve, and considering the exploratory nature of the study it is not necessary to ensure that all information relayed by interviewees is factually correct. Finally, as is the case with qualitative research methods, even with the same data, different analysts may produce different results (Brocki & Wearden, 2006). Although the reliability and validity of the data is difficult to measure, assuring it has been collected correctly and ethically ensures the clearest and most "true" accounts.

For the quantitative data, brief descriptions were provided for some cases outlining the nature of the behaviour that warranted the referral, but it was not possible to categorise behaviour only based on this. Results were limited by the quality of data recording from the service, with different categorisations and terminology used in each year. Because of this, it was difficult to carry out statistical tests and findings are deduced rather than based on evidence. In order to ensure that we have an accurate representation of the extent of female perpetrated sexual abuse it is imperative to ensure that data is recorded correctly and consistently. As well as ensuring characteristics, such as age, social care and education status and family/living environment, using a framework to categorise behaviour, such as the continuum presented by Hackett (2014) could be helpful in identifying and correlations between individual characteristics

and the nature of the HSB displayed. Recording data accurately and consistently would allow us to examine potential relationships between adversities and types of HSB displayed.

5.3 CONCLUSION

The findings from this study can be used to improve policy and practice with children and adults with sexually abusive behaviour, ensuring that this applies to children and adults of all genders. There has been far less development of policy and practice regarding female perpetrated abuse compared with male, due to a lack of understanding about their criminogenic and psychological needs. The needs of released women are often overlooked because they comprise such a small proportion of the incarcerated population across the world (Stanton, Kako, & Sawin, 2016), and this is of a much greater extent for females convicted of sexual offences. There are likely to have been missed opportunities for women to have received alternative sanctions or treatment. Improving assessment and treatment at earlier stages in the life course could result in fewer women ending up in prison. Imprisonment is costly, in economic terms as well as to families.

The impact of ACEs appeared contributory factors in interviewees' offending trajectories. Many interviewees had experienced sexual abuse, both within and outside of their family. Rather than them later playing out

what they have experienced and observed (e.g. social learning theory), it appeared that the trauma shaped how they saw themselves, how they believed others saw them, and their expectations from the world around them. Andersen and Cyranowski (1994) use the term 'sexual self-schema' to refer to the cognitive generalisations about sexual aspects of oneself derived from past experience, influencing the processing of social cues from others and guiding sexual behavior. Interviewees generally had negative self-schemata, based on their overwhelmingly negative experiences. For many, the only time they had experienced closeness with another was in a sexually abusive situation, and it was difficult for them to disentangle this from intimacy. They described their early years of life as characterised by attachment insecurities, with an absence of feelings of closeness, connectedness, validation and safety. The present study highlights how sexually abusive behaviour can be understood as associated with unmet needs emanating from adverse childhoods, with a lack of protective factors in adulthood. The following chapter will focus on one participant's account in detail, providing a comprehensive history and formulation of her offending behaviour.

CHAPTER FOUR

ALESHA: A CASE STUDY OF A FEMALE SEX OFFENDER

ABSTRACT

Most existing literature on sexual offending pertains to contact offending and, more recently, online offending. There is little existing research on non-contact sexual offending which involves causing or inciting child prostitution. Furthermore, there are few case studies of females who perpetrate sexual harm in detail. This study describes the case of Alesha, a 27 year old who was serving a 17 year sentence for sex offences. It describes her early experiences and the circumstances of her offending and examines her reflections to provide an insight into how she has internalised her traumatic life experiences. Her early years were characterised by disruption, unsettlement and uncertainty both emotionally, in terms of her relationship with her biological parents and subsequent foster carers, and logistically, as she was placed in a number of different regions throughout her adolescence. Understanding her victimisation and trauma is key to understanding her perpetration of sexual harm. A formulation, both written and diagrammatic, is presented, followed by the clinical implications and recommendations for research and practice.

1. INTRODUCTION

This study aims to provide a deeper exploration of ACEs and sexual offending. Case studies provide an in-depth view of a specific experience and value the idiographic perspective and personal meaning to improve our understanding of a phenomenon (Mills, Durepos, Wiebe, 2009; Larkin, Shaw & Flowers, 2019). Using a descriptive case study, this chapter seeks to reveal patterns and connections, in relation to theoretical constructs, to improve our understanding of ACEs and female sexual offending. A case study design is especially appropriate when relatively little is known about a phenomenon, in this case, female sexual offending. Case studies are also useful in research contexts because they generate new ideas, which may result in the discovery of unique characteristics.

The life story is described with use of formulation, constructing hypotheses about the possible drivers behind the participant's offences. Johnstone (2018) describes formulation as the process of constructing a hypothesis about the causes of a person's difficulties in the context of their life events, social circumstances, relationships and how (and if) they have made sense of them. The formulation included in this chapter combines knowledge derived from theory and research with the participant's expertise about her own life and the meaning of her experiences.

The following describes Alesha[3], who was a participant in the study in Chapter Three. Her story is presented as a case study due to the complexity of her background and experiences of ACEs and the nature of her offences differing from offence types described in the literature on female sexual offenders. Her case differs from any published case descriptions, as there is virtually no existing research on non-contact sexual offending among females that involves causing or inciting child prostitution.

2. BACKGROUND TO CASE

At the time of her interview, Alesha was 27 years old and a resident at a women's closed prison in England. Despite numerous arrests in her adolescence, she had never been in prison before. She had a long forensic history, however the crimes she had been arrested for, prior to her index offence, were acquisitive in nature.

The sexual offences for which Alesha was convicted were alleged to have spanned 2007 to 2011, starting when she was 16 years old. Alesha was found guilty of twelve counts of arranging or facilitating child prostitution and two counts of causing or inciting child prostitution. She was also tried but cleared on seven other charges, including one count of trafficking

[3] Pseudonym assigned by *Random Name Generator*
Available at: http://random-name-generator.info (Accessed: 1st May 2019)

within the UK for sexual exploitation. She had been on trial with four men who were also accused of similar offences involving young girls. Three were acquitted but one, a seventy-year-old male, who received a fourteen-year sentence. She maintained during her trial and since that she had brought girls, some of whom she knew were under the age of sixteen, to parties, but denied involvement in their prostitution. Despite this, she had never appealed her sentence. Alesha was 23 years old when she was convicted and received a 17-year sentence, which is considered a long sentence when compared to other female prisoners who, on average, receive sentences of less than six months (Ministry of Justice, 2018b; Prison Reform Trust, 2019).

3. METHOD

Alesha agreed to be interviewed as a participant in the study in Chapter Three. She was met on two occasions, one month apart. The first occasion was an introductory meeting, where Alesha spoke about the circumstances of her imprisonment and her depiction in the media. During the second meeting, a life story interview was carried out where Alesha reflected on her early life experiences and possible disruptions. The interview was semi-structured, using open questions, with emphasis placed on her subjective experience. This allowed Alesha to construct a chronological narrative of her life. In total, Alesha's interview was approximately three hours long, and followed her earliest memories up to her present life.

Alesha was provided with full information of how the information she provided would be used. Full informed consent was obtained and can be found in Appendix I. Her interview was audio recorded and transcribed verbatim. Fidelity to the original source was paramount; Alesha's audio recording and transcript were revisited numerous times to ensure that the case study was an accurate account. Additionally, owing to the qualitative nature of this research, the author kept notes pre, during and post interviews to ensure that nonverbal, environmental and ethical aspects were recorded. It is helpful for the qualitative researcher to be aware of their own thoughts and feelings, and this can in fact be important data (Howitt, 2012). The present study is concerned with Alesha's subjective account, and, although it has been written truthfully according to her life story, it is still based on the information she is willing to share. It may not be the *true* factual account, but it is *her* account. The primary interest of this study is how she internalised her experience, developed her core beliefs and her pathway to sexually offending, and this is presented through her lens. Discussion of alternative perspectives and perceptions are presented in the proceeding sections.

Alesha completed the ACE Questionnaire, with the items read out to her during her interview. Briefly, the ACE Questionnaire is a 10-item scale where participants endorse whether they have experienced different types of adversity prior to the age of eighteen. The ten items are categorised as

abuse (emotional, physical and sexual), neglect (emotional and physical) and household dysfunction (witnessing domestic violence, parental separation, family substance misuse, mental illness within the family home, incarcerated family member). Higher scores on the ACE Questionnaire reflect more ACEs. An in-depth description of the utility of this measure and its limitations are presented in Chapter Five. Alesha endorsed eight out of the ten items: psychological abuse, physical abuse, sexual abuse, emotional neglect, physical neglect, witnessing domestic violence, substance misuse within the family home, familial mental illness and having an incarcerated family member. Whilst completing the ACE Questionnaire, Alesha spoke in detail about each of these experiences and how they affected her, and this is referred to throughout this chapter. The following presents the life story of Alesha, followed by a written formulation which is presented diagrammatically in Appendix J.

4. PERSONAL HISTORY AS REPORTED BY ALESHA

Early years

"You know, when you just feel like you don't belong somewhere? That was me at home."

Alesha was born in the north of England. She has four older brothers, one older sister and one younger brother. Her father had been in prison prior to Alesha and her siblings' birth, though Alesha stated she was unaware of

why. Alesha's memories of her early years were fragmented and she struggled to form a coherent narrative of her childhood. She only discovered during her trial for her index offence that she was known to social services when she was very young because she attended nursery with bite marks and bruising on her inner thighs. She believed she experienced sexual abuse when she was very young, but her memories were too vague for her to remember. She also alluded to her lack of memories being a survival strategy, stating: "my head's fucked up enough".

Her relationship with her parents was frayed; although she recounted a positive relationship with her father, she spoke about the relationship with her mother as being plagued with arguments and physical fights. She spoke about her childhood as being void of emotional support where she was made to feel neither loved nor cared for.

"People talk about their upbringing; I feel alienated because I didn't have that. I get jealous, a lot, a lot. Because I haven't had the lifestyle people have had."

Violence was accepted within her family. Her parents used physical chastisement towards Alesha and her siblings, most of hers coming from her mother. Whereas she described how she was her *"Dad's girl"*, she reflected on how her father would work long hours and her mother was

primarily responsible for caring for Alesha and her siblings, during which *"we've all had beats"*. She described her brother getting *"battered"* by her parents when they found out he was homosexual, which was not accepted within their family. As well as being homophobic, she also noted how her parents and extended family were racist. She described the view they held as *"if they're not white, they're not right".* She recalled how her grandfather would *"go out Pakki bashing"* (instigating unprovoked attacks on Asian men).

Adolescence

When she was twelve years old, Alesha was raped by three Pakistani men who worked at a local shop. Alesha described feeling lured in with the promise of gifts. As she approached her teenage years, and the biological and social push of puberty, she found the attention she lacked at home in men. Likely owing to her lack of a safe and secure base, Alesha found ways to meet her needs (e.g. attention, feeling wanted) but this often found her placed in un-safe situations. She stated that she did not disclose what happened to her at the time. Shortly after, when she was thirteen years old, the family moved to a different region of the country because of the people Alesha and her siblings were becoming involved with (older peers who were using drugs). Alesha recalled feeling displaced by this move and how *"things just got worse".* Alesha experienced a violent sexual assault perpetrated by her male neighbour who was in his early twenties.

She disclosed this assault to her parents, who did not believe her. She stated this was the precipitant for her running away when she was fourteen years old.

For a short period, Alesha stayed with her sister who is approximately ten years her senior. This move was short-lived due to her sister's concern that Alesha was continuing to associate with older men, drinking and taking drugs (namely cocaine).

"It was just fun. I loved drugs, loved the drink, and they didn't treat me like a kid. I understand I was a kid… but… it's boring… they used to look after me."

When Alesha feared that she might be returned to live with her parents she self-harmed in the form of cutting her arms. She reflected on this not as a suicide attempt but because she was unable to regulate her emotions and also wanted to show others how much she feared living with her biological family. As a result, she moved to another city to stay with her friend whom she knew from school and her mother. She reflected on this period as happy and a point where she could have been offered a sense of normality.

"I tried to get back into school but the school said they couldn't take me back because my mum and dad weren't involved. So they wouldn't take me. So then I got a job in a Pakistani shop. A clothes shop."

It was at this point that Alesha began socialising with older Pakistani men, including the manager of the shop with whom she began a sexual relationship despite her being aged fourteen and him being twenty-eight years old. As discussed in the previous chapter regarding the understanding of sexual consent, Alesha dismissed the idea that she was a victim of statutory rape in the eyes of the law, instead framing her sexual encounters with him as consensual.

"I understand that people think it's wrong, but I consented. He was my partner. Like, I don't understand what the problem is. I'm old enough to know what I'm doing."

Their relationship was punctuated with violence where Alesha describes herself as getting *"battered"*. For several months, during the time Alesha was staying with her friend and her friend's mother, she worked in the shop full time and spent time with her boyfriend and his friends. Their relationship came to an end when social services, who had been involved in Alesha's care ever since she first ran away from home, discovered that she was not in an organised and formal placement.

"[He] bust my nose. He weren't happy. 'Cause social services found out where I were, they threatened to take me away, so I ran away again and went to his. And I told him, and he was just going mad. And he was like 'they can't find out about us'. And it got me mad and upset. Like, why are you denying the relationship? You're meant to love me. I didn't get it. But he didn't care, and then he just lost his temper with me again. Battered me, told me he never wants to see me again."

Social care involvement

Following this, when Alesha was fourteen, she was moved by social services again to another city (closer to her parents). She was moved to multiple emergency foster care placements during which her use of substances worsened.

"It weren't my home. You're forcing me to live somewhere I don't wanna live. They're not my family. What's the point? I hated it […] I kept running away, so they got rid of me."

She was then moved to a children's' home which she described as *"disgusting"* where *"the staff were perverts".* Sexualised language and terms were ingrained in her vernacular, and she appeared hyper vigilant about older men who she expected to try to take advantage of her. This consolidated her view of others as not to be trusted. Around this time she

became known to the police for stealing, notably from older men who she would pretend to seduce and then rob.

"Men are easy. If they think that they're gonna get into your knickers, they'll do anything."

Her first appearance in youth court followed her assaulting a male care worker in the children's home who she accused of walking into her room without permission whilst she was getting dressed.

"I just got a tag, 'cause they read out all of my record, and my social worker had to come in because of my behaviour, and because of my drugs and drink and that they put me on a tag for six months. But then they moved me as well, because no one wanted me… they don't give you anything bad, 'cause you're a kid and they're like, 'oh she'll grow out of it'. So it's a slap on the wrist, like community orders and that… especially when you're in care. 'Cause you just pull out the care card. And they're like, 'oh, poor kid'."

This move was a time Alesha pinpointed as the turning point where her engagement in serious criminal activity began and she became detached from her life before. She described how she was a *"a complete and utter bitch… I used to take anything. If I wanted it, I'd take it. I didn't give shit. I didn't care about anyone but myself."*

She was placed with a foster carer, with whom she argued frequently and once assaulted. She reflected on how her foster carer *"let it slide"* because Alesha received a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) which she felt people involved in her care attributed her behaviour to. She was prescribed medication to treat ADHD, however Alesha refused to take it, preferring only illicit substances (stating *"if it's not gonna give me a buzz, I'm not gonna pop a pill"*).

Criminality and involvement with gangs

Because of her electronic tag, Alesha was required to attend her local probation office, which is where she met older men, who would later be her co-defendants. From this point, she started associating with different gangs of males, who she separated according to their race: *"the Asians… the white lads, the black lads".* With these men, primarily Asians, Alesha's life revolved around events she described as 'parties', which were events where the adult men of various ages would pay to have sex with underage girls. She described how she became indoctrinated into this lifestyle, beginning first with her being raped by six older men. She reflected on how her being raped by them was them showing her she had no choice and that they had control over her.

"The first party I went to with them, I think I only had two drinks, and I started to feel lightheaded and dizzy. I knew it weren't right, 'cause I can drink a lot. And, next thing I know, I'm in bed, naked, with a bunch of lads... [they're] not very nice people. But you can't really say no to going to parties with them."

Immediately after this, Alesha disclosed to the police, for the first time in her life. She detailed how they took her clothes, took photographs of her naked body and the bruising, took invasive swabs, took samples from underneath her fingernails, as well as being interviewed for hours. However, for reasons she was only able to attribute to the police not caring, no further action was taken against the men who Alesha identified to the police.

"They did nothing. Nothing. Nothing at all… they're just useless, selfish police… and you start to believe things. For me, until I started counselling, I used to think it was normal, going to parties and having sex and that, it was normal. It was just my life. That was the way I lived it. Sex was… a bit like a comfort blanket for me. It was normal."

Child sexual exploitation

Having lost faith that the police would help her, Alesha became fully indoctrinated into what she saw as their world. She described how she

would have been unable to escape if she had tried because she needed the professionals involved in her care to help but she viewed them as powerless.

"The police didn't help me. Social services didn't help me. There's records of me being abused, me being dragged into places. Police never helped me. Neither did my workers. It's their fault. No one really cares. They don't wanna get their hands dirty."

The language she used appeared to be her seeking to attribute the blame and move the responsibility away from her, at least in part, to others. Rather than this being the actual perpetrators, she blames the agencies – the police and social care. She described feeling they neglected her, mirroring her experiences of her parents and subsequent foster carers. She used this to justify her having to navigate her own ways to survive. This could possibly have been her defence strategy to justify her actions or cope with her involvement.

She considered how she was involved in the exchange of services for goods; her requirement was to have sex with the males and introduce them to her 'friends' (who were underage girls she would meet in the local area). She spoke about how her role with them made her feel special.

"They used to give me a roof over my head… and they'd feed me, and used to always buy me clothes, and presents, and I used to get a new phone every couple of months. They was always buying me a new phone, always putting credit on. I never went without anything, if I needed anything they'd get it for me."

Despite describing sex as a comfort blanket, Alesha was adamant that she never enjoyed the actual sexual activities she felt required to carry out. She describes being in almost constant pain, with bruises all over her body as a result of the force the older men used against her. She was able to mask the physical (and psychological) pain with the alcohol and drugs that men would supply to her. She recalled this situation lasting around nine months, before social services agreed to pay for her accommodation in hostels. However, this introduced her to *"down and out druggies".*

Shortly after her sixteenth birthday, Alesha disclosed the details of one of the most traumatic events of her life. She was coerced to attend a house under false pretences, following which she was locked in and kept as a slave for sex for four months. She disclosed how she found out a number of years later that it had been set up by the man she considered to be her boyfriend. During the four months she was raped every night, along with other girls who were around the ages of thirteen years old.

"My abuse makes me sick. It does. I have times where I'll be in the shower with those green scourers and scrub myself 'cause I feel disgusting."

When she was allowed to leave the house, she spoke about how her body was covered in cuts and bruises, including a knife wound where one of the men stabbed her and she was not able to get medical assistance. Her reasoning for being kidnapped and used for sex was *"because I'm a sixteen-year-old girl that looks like I'm twelve. I make [them] good money".* She alluded to how although her facial features made her look prepubescent; her body was sexually developed, which was preferred. She made the decision to not inform the police about what had happened, despite wanting to save the other girls that were still being held there, because she feared reprisals from the men who were orchestrating the brothel.

"You can't put charges on [them]. 'Cause you're dead. Fuck that! They're ruthless. They're not very nice people. I've been around them all my life. I know what they're like. Never."

Early adulthood

From the age of sixteen to eighteen, Alesha described her life as moving between hostels and continuing to attend 'parties'. This continued to be

her life until the birth of her child, when she was nineteen. Social care were involved when Alesha gave birth and her son remains in the care of her parents. She believed her pregnancy was the result of her being raped at a party, but she did not recall who by and never reported the incident to the police. In her eyes sexual abuse and exploitation was normal and expected. Additionally, she felt that she had no other worth apart from what she was able to offer men sexually. She experienced cognitive dissonance making sense of the events; denying involvement in what she viewed as law-breaking, but simultaneously expressing guilt:

"I feel disgusted in myself, because I've put people in bad situations… I've never forced my friends to do it, but… by not stopping them coming to parties… as far as I'm aware, nothing happened to them girls. But when I'm upstairs with a client, I don't know what's going on downstairs."

Alesha described her immersion as extreme to the point where she felt there were no alternative options to her, and no escape from the life she led. She felt caught in a web of organised crime where masking what was going on using alcohol and drugs was the only option she felt she had.

"I'm one of the lucky ones. I just got abused in this country. There's girls out there that get abused over here and then they're gone out this country 'cause it's easier for the men to deal with. They're not stupid. These men are not stupid."

4. FORMULATION

Formulation is the process of constructing hypotheses about the causes of a person's difficulties in the context of their life events, using knowledge derived from theory and research. This formulation is aimed at providing an understanding of Alesha's offending trajectory, behavioural history, beliefs and emotions.

Alesha's childhood was characterised by attachment insecurities, with an absence of feelings of closeness, validation, safety and support. She experienced her parents as unavailable and unable to meet her needs, which shaped her expectancies of future relationships – her internal working model (Bowlby, 1980; Sroufe, 1988). She experienced her mother as rejecting and unable to provide consistent care. She described herself as always more comfortable with males, from whom she sought approval and validation. Because her sense of self was fragmented, she sought a sense of belonging and found an identity with the groups with which she associated. This is key when considering her involvement with the child sexual exploitation ring. Being part of an organised crime group provided her a role and sense of belonging.

The period where Alesha was transitioning from childhood and adolescence, entering puberty and developing into a woman, was beset with sexual harm. Her first sexual contact was when she was raped, aged twelve, which left physical and psychological scarring. The trauma of this

event initiated a downward spiral in Alesha's behaviour, exacerbated by the use of alcohol and drugs to cope. She did not inform the police when she was first raped because of the fear of being accused of lying, having been warned not to by the perpetrators, and because of the fear of being shamed and blamed for provoking the sexual assault on herself. Her parents did not believe her when she disclosed sexual abuse perpetrated by her neighbour, which corroborated her core belief that no one will protect her and keep her safe. Her views and expectations were that the world was a dangerous and unsafe place where people were not to be trusted.

Because of her experiences where she felt not only let down by the police, but ridiculed by them in a way that made her feel ashamed and blamed, Alesha held a belief that the police were not to be trusted and would not be able to help or protect her. This is a narrative likely to have been used by her associates and the organised crime groups, which served as a form of control. It influenced her to join them because she had no alternatives. She spoke about foster carers who "got rid" of her, suggesting she viewed herself as an object to be discarded. She disclosed the various fights she had with those responsible for caring for her, as she expected placement breakdowns because she saw herself as un-loveable and unwanted. As such, these experiences with foster carers served as a self-fulfilling prophecy whereby those who were responsible for her were unable to provide care.

The attachment insecurities present for Alesha have been highlighted as leading to low self-worth, poor compassion for others and difficulties with interpersonal relationships (Marshall, 2010). For Alesha, these were key factors that caused her emotional loneliness and skewed perceptions of intimacy. She referred to those who abused her as "boyfriends" who provided care in the form of material goods rather than emotional comfort. She craved love and affection and described sex as a "comfort blanket" because she was able to obtain physical and emotional closeness with the other person in that moment. Her concept of love and affection was synonymous with sex because this was the only way people had shown her attention throughout her life.

She was open about her difficulties with interpersonal relationships, particularly with females who she struggled to trust. She had considered the victims of child sexual abuse who disclosed to the police that Alesha had been facilitating child prostitution as friends who normalised what was going on as she had. In order to make sense of why some of the victims had disclosed to the police, Alesha was of the view that there was financial incentive for them (for compensation). Although she stated that victims were lying for financial gain, she simultaneously accepted that she was immersed in a world of sexual violence and cruelty. She tried to manage these feelings by feigning obliviousness, that she "didn't see it" although she was quite aware that it may have been going on.

Alesha described feeling "ashamed" of herself when speaking about the events (the 'parties') during which her offences occurred, yet simultaneously denied that sexual abuse had taken place and she was adamant that she had not taken the role of facilitating it. Alesha oscillated between corroborating abuse had taken place but minimising it to absolute denial, but maintained that she had not committed sexual offences. Her denial (assuming that she is not innocent) potentially helps her cope; by minimising her role in causing physical, sexual and psychological harm to vulnerable females she is able to differentiate herself from a perpetrator and see herself only as a victim – the *abused* not the *abuser.* Further, the impact of shame among sex offenders can be profound and cause much internal conflict for a person (Blagden et al., 2011). This points towards her denial being a psychologically adaptive function. Additionally, there is much research about the hierarchy of offences where sexual offences fall to the bottom, and the perpetrators of such offences are vulnerable to bullying and violence from fellow prisoners in mainstream prisons (Levins & Crewe, 2015). Alesha's denial may be her way to manage life in prison among her peers and staff, considering her experiences of shame and belief that people could and would easily abandon her. Denial, rationalisation and minimisation may also be a psychological coping strategy.

During the years where she was immersed with child sexual exploitation, Alesha used maladaptive coping strategies to live through the distress she

was experiencing in her present as well as her past. Whilst in prison she has continued to use her main coping mechanism of substances, detailing her use of Subutex, alongside prescribed medication, which she was not prescribed but obtained from trading with other prisoners. This not only indicated that she was struggling psychologically and was without healthier ways of coping, but also that she was continuing to engage in the illicit economy within prison through trading goods and possibly services, perhaps in order to obtain a sense of control or to maintain what she considered to be her identity.

Alesha has undertaken some counselling during her time in prison, but has not engaged in psychological intervention nor any offending behaviour programmes. In this sense, Alesha's needs have continued to be neglected in prison, but she coped largely through use of substances, which provided her a sense of detachment from her emotions. She did, however, express that she had developed trusting relationships with prison staff, which was a protective factor. The prison environment appeared to provide her a sense of safety and predictability that helped her feel secure, but she feared release and felt unprepared for living in the outside world.

6. CLINICAL IMPLICATIONS

Alesha's case does not appear to fit neatly with the typologies and pathways to offending defined by existing studies (Gannon et al., 2014;

Gannon, Rose & Ward, 2010; Matthews et al, 1991; Vandiver & Kercher, 2004). In some ways, her behaviour fits the homosexual criminal subtype articulated by Vandiver and Kercher (2004), in how she used sexual abuse as a form of exchange to obtain financial or material gains. Although males were very much involved in her offending, she would not say that she was coerced; rather, she insisted "they looked after me". Differing from the Vandiver and Kercher's (2004) subtype, Alesha's offending behaviour served the psychological function for her. Whereas she saw herself as a victim in her experiences of rape, she viewed the 'parties' in which the sexual offences against children took place as environments in which she was very much in control and a powerful figure. The world in which she was immersed normalised sexually abusive behaviour to the extent that the absence of sexual consent was not something she viewed as important.

It is useful to consider the diathesis-stressor paradigm (Davidson & Neale, 1990) in that Alesha's abusive behaviour is the outcome of the interaction between her vulnerability factors and external stressors. Burk and Burkhart (2003) propose that individuals with disorganized attachment experiences do not adequately develop and internalise self-regulatory skills and rely on externally based means of self-regulation. She sought attachment figures but her perception of safety, care, compassion and affection was distorted by her experiences of multiple ACEs. Sexual abuse appears to have been her strategy for intra and interpersonal control,

emerging primarily in adolescence in response to several pressures: a frightening experience of the self, poor interpersonal relationships, childhood experience with adult sexuality, and the biological changes during puberty.

With regard to her initiation into child sexual exploitation, Alesha shares some of the known vulnerability factors for child sexual exploitation including homelessness, misuse of substances, being in care, running away/going missing and gang-association (Beckett et al. 2013; Coy, 2009; Jago et al. 2011; Klatt, Cavner & Egan, 2014; Smeaton, 2013). Her case highlights the importance of multi-agency working and early intervention. Multi-agency working which enable different organisations to carry out their specific role whilst developing shared perspective through sharing information is key in supporting victims of child sexual exploitation. In Alesha's case, understanding her victimisation and trauma is key in understanding her perpetration of sexual harm. Beech and Mitchell (2005) report that attachment styles resulting from ACEs make it likely that an individual will confuse sex with intimacy or may seek out intimate attachments through inappropriate means. As was the case with Alesha, those who experience changes in caregivers and placements may be more vulnerable to intimacy deficits because they have been deprived of the love, affection and warmth needed in their early years.

Alesha developed implicit theories to make sense of these experiences. Her descriptions fit into Ward and Keenan's (1999) 'dangerous world'

theorem; she saw the world as unsafe and threatening where people were out to exploit one another, which she felt was consolidated by her experiences of the police. She viewed them as the only people that could have saved her from the situation she was becoming involved in, and when they were unable, Alesha attributed this to the fact that they did not care about her. Additionally, she described them as "useless" in comparison to the organised crime group who she saw as powerful. She felt she had no choice but to join them, as they made it clear they would continue to use violence against her if she didn't. Her desensitisation – through exposure and by masking her reality through the use of illicit substances - disguised sexual abuse as acceptable, as described by Young (1997). From a young age Alesha had been exposed to grooming and an economy where sexual services were the acceptable form of payment for goods by girls with little money. Her social milieu shared her skewed perception of intimacy, care and love and poor understanding of sexual consent.

It is important to consider her seemingly poor understanding of the legislation regarding sexual consent; she described how she "consented" to sexual activity when she was fourteen years old with adult men who had plied her with alcohol and drugs. She received no formal sex and relationship education, even since being in prison. Her sexual education was largely gained by exposure to sexual violence, which has skewed her understanding of what healthy sexual relations and sexual consent look

like. She believed that a child can consent to sexual activity based on her own experiences; she struggled to understand how and why the underage females were not able to consent by virtue of their age. This highlights the importance of education on consent as well as sex and relationships. For young people like Alesha, who disengaged from school around the age of twelve and dropped out by the age of fourteen, careful consideration needs to be paid to how best to provide them with this education.

Despite speaking of her traumatic experiences and recognising how they affected her, it appeared Alesha coped by bottling up rather than processing what happened, compartmentalising traumatic experiences. She developed expectations that those around her will hurt her, cause her pain or abandon her, but at the same time she has a very strong need to feel secure, loved and valued. Alesha felt that as well as carers neglecting her needs and welfare, professionals had as well. For example, she stated that people were aware of her history of physical and sexual harm however, at the time, she felt that little was done to protect her. She developed a safety strategy to reject through displays of indifference, refusing to engage with services she believes let her down in the past (e.g. the police). In light of this, it is important that she saw the various professionals involved in her care as a team working together to support her who are consistent in their approach.

7. RECOMMENDATIONS

Because of a lack of offending behaviour programmes deemed suitable for sex offences, Alesha was not undertaking any psychological work. There was group work for victims of domestic violence which Alesha would have been eligible for, however she did not identify herself as a victim and was reluctant to engage in such work. Individual therapy based on case formulation had not been carried out due to limited resources, and it appeared that her needs continued not to be met, which mirrored the neglect she had experienced throughout her life.

As her behaviour also involved prior antisocial behaviour, comprehensive psychosocial assessment would be needed, to explore her offending attitudes. Time and sequencing of interventions is important, and, in order for treatment to be successful, it is crucial that Alesha feels she is involved in the discussions about her treatment and feels she has choice (Spencer, 1999). Alesha refers to her experiences of sexual harm as "traumatic" which tells us that she considers them to be stressful and abnormal events. Further, she referred to her ongoing adverse experiences which she associates with these experiences, such as flashbacks. Therapeutic work could provide Alesha the space, physically and emotionally, to process her traumatic experiences and help her make sense of them. Trauma therapy may help address the contributing and vulnerability

factors and offence drivers. The trauma effects became the central core around which Alesha's behaviour and even personality was organised.

A growing body of research yields positive results for eye movement desensitisation and reprocessing (EMDR) with sex offenders who have experienced trauma (Clark et al., 2014; Ricci & Clayton, 2016; ten Hoor, 2013). EMDR is a treatment modality designed to help people end the effects of their previous traumatic experiences and the resulting distorted thinking processes (Shapiro, 2001). For example, Ten Hoor (2013) found that EMDR used with an adult convicted of a sexual offence was effective in restructuring cognitive distortions and enhanced his engagement in offence-focussed intervention. In considering recidivism among sex offenders, Ricci and Clayton (2016) note that one's own history of childhood adversity may interfere with positive treatment outcomes. Offence focussed intervention is unlikely to be effective unless the underlying offence drivers are addressed through a therapeutic component. As Clark and colleagues (2014) note, in order to avoid retraumatisation and exacerbation of symptomatology, offenders presenting with unresolved trauma relating to their offences should not undertake offence-related interventions until they are psychologically prepared to do so.

Sex offender treatment informed by the Good Lives Model (Ward & Stewart, 2003) would focus on the management and reduction of Alesha's risk by helping develop the capabilities to meet her needs in socially

acceptable and personally meaningful way. It is advisable for this strengths-based and skills focussed work to be carried out towards the latter stage of her sentence, to mitigate her learning being eroded whilst she remains in prison. Clinicians may find it helpful to use the Finkelhor (1984) precondition model to unpick Alesha's motivations, the external factors and her cognitive processes involved in overcoming internal and external barriers to perpetrating sexual abuse. This model has been found to be helpful to inform intervention and risk management of females (Collins & Duff, 2016).

Of most importance and key to Alesha's progress with psychological work is the therapeutic rapport. Developing trust is a key issue, and Alesha has had great difficulty in maintaining relationships with others and has therefore been reticent to share her internal world. The key to psychological work is cultivating a therapeutic relationship over a period of time in which she would have the opportunity to explore her maladaptive schemas and modes. The existing literature highlights the importance of working with deniers sensitively, non-judgmentally and free from confrontation (Marshall et al., 2001). Despite her avoidance of the psychology service within the prison, she engaged well with the present project during which she described her thoughts, feelings and behaviours in depth and opened up about her past and on-going difficulties. This suggests that she is able to engage in therapy if she feels the environment and therapeutic relationship is safe and secure.

8. CONCLUSION

The present study elucidates victim to offender mechanisms, and the importance of viewing her case history holistically, understanding vulnerability factors and offence drivers. The offence drivers of implicitly held beliefs, vulnerability factors and maladaptive coping strategies propelled Alesha's sexual offences. Her early years were characterised by disruption, unsettlement and uncertainty both emotionally, in terms of her relationship with her biological parents and subsequent foster carers, and logistically, as she was placed in number of different regions throughout her adolescence. Her offending trajectory appears to have developed from her seeking attachment figures and a desire for the feeling of belonging and closeness. Her abusive behaviour appears to be the outcome of the interaction between her vulnerability factors and external stressors. She described sexual activity as her way of achieving emotional closeness with another person, her "comfort blanket" to cope with feeling emotionally isolated, unloved or rejected. However, her ACEs in early years and disrupted patterns of attached skewed her understanding of what healthy relationships were. This led her to seek intimate attachments through inappropriate means. The following chapter describes the benefits of assessing ACEs, and how this can elucidate the development of an individual's attachment style in adulthood.

CHAPTER FIVE: A CRITIQUE OF THE ADVERSE CHILDHOOD EXPERIENCES SCALE

ABSTRACT

ACEs can affect us psychologically, physically and socioeconomically, and the research base on their long-lasting effects has broadened in recent years. Use of the ACE Questionnaire has become a common approach for considering childhood adversities but their use is also controversial. The ACE Questionnaire is easy to obtain, use and interpret, but it has limitations. This study reviews the conceptualisation and measurement of ACEs in research, clinical practice and public health. The use of the ACE Questionnaire and its benefits are reviewed, before a detailed summary of its limitations is presented. Suggestions are made for future research, including developing our conceptualisation of ACEs and broadening the existing categories based on current research, how individual ACEs should be weighted and clustered, and the implications of these findings for clinical work and policy. Maintaining the accessibility and simplicity of the ACE questionnaire, but revising with suggestions described in the present critique, could be helpful in research and practice.

1. INTRODUCTION

It is widely recognised that childhood experiences have long lasting consequences that pervade adult life (Sweeney et al., 2018). In recent years, across research, policy and practice, there has been more focussed attention on the potential consequences when childhood experiences are negative. Stress and trauma affect healthy child development, and this recognition has led to an interest in adversity experienced in childhood. ACEs are considered to be occurrences that cause significant biological and psychological stress to a developing child (Lacey & Minnis, 2019). ACEs are understood to be physical or emotional harm, and direct (e.g. experiencing physical or sexual violence) and indirect (e.g. witnessing domestic violence or parental substance abuse). There exists a body of literature on how exposure can affect biology, in terms of brain structure (Kaufman et al., 2000), neurotransmitters and reward pathways (Somaini et al., 2011), and mental illness (Benedetti et al., 2014; Danese et al., 2009).

ACEs have garnered attention in the last twenty years, alongside the growing body of evidence of the effects of trauma and neglect on the developing brain and the neurobiology of attachment (Perry et al., 1995; Perry & Pollard, 1998; Fonagy, Luyten & Strathearn, 2011). These authors propose that early maltreatment causes changes in neurobiology that have the potential to cause enduring changes in brain development and impact

on children's abilities to regulate their emotions. Gunnar et al (2001) found evidence that early life stress can disrupt the hypothalamic–pituitary–adrenal (HPA) axis, our central stress response system. These disruptions are associated with mental health difficulties such as depression and posttraumatic stress disorder (Thorn et al. 2011). The major structural consequences of early stress include attenuated development of the hippocampus and amygdala – areas of the brain implicated in threat response (Danese & McEwen, 2012; Teicher et al., 2013). Despite the caution in making longitudinal claims from cross-sectional studies, this growing body of research has expanded our understanding of how ACEs may play a significant role in the development of psychiatric disorders.

2. DEVELOPMENT AND THEORETICAL UNDERPINNINGS

Over the course of the last century the cultural concept of childhood has changed, as have ideas about what is deemed to be inadequate treatment towards them. In England and Wales, the Children's Act 1989 reformed the existing legislation and promoted the welfare and safeguarding of children as paramount, giving every child the right to protection from abuse. Since then, research began to develop demonstrating the correlation between abuse and neglect, and the onset of emotional and behavioural problems in children (Dore, 1999). There was a paradigm shift where the negative impact of a child's maltreatment

began to be recognised, whereas before the impact of harm on a child was minimised (see, for example, Yorukoglu, & Kemph's (1966) article on how children were not 'damaged' by incest with a parent). Language moved away from referring to children as 'damaged' and 'disordered' to understanding trauma (Eth & Pynoos, 1985). The recognition that bad things that happen to a child can be harmful is relatively new. Prior to the conceptualisation of ACEs, trauma was used to describe deeply distressing experiences in childhood, although there were disagreements about how it was defined and observed (Finkelhor, 2010). In the last 30 years research on the longlasting effects of trauma in childhood and its effects on behaviour has expanded (Basson et al., 1991; Lanyado, 1985; Monahon, 1993). However, there lacked a consistent language and way of recording what people had experienced in their childhood to cause them to feel traumatised.

The original ACE Study, from which the ACE questionnaire was produced, was conducted by the Centres for Disease Control (CDC) and the health care company Kaiser Permanente. Between 1995 and 1997, over 17,000 (54% female and 46% male) members of a health insurance program in the United States (54% female) completed surveys asking questions about abuse, neglect or other family dysfunction they experienced as children and their health status and other behaviour in adulthood. The study highlighted that childhood trauma and stress early in life potentially impaired social, emotional and cognitive

development, and caused people to be at a higher risk of developing health problems in adulthood. The authors of the study identified ten traumatic emotional experiences that positively correlated with chronic disease in adulthood, forming the basis for the ACE questionnaire. The ACEs included were abuse (psychological, physical and sexual) and household dysfunction (living with a household member with substance abuse problems, mental illness or who had ever been to prison, and mother was treated violently). These categories were developed by adapting items from instruments that demonstrated validity and reliability in earlier studies: the Conflict Tactics Scale (Straus, Gelles, & Smith, 1990), the Childhood Trauma Questionnaire (Bernstein et al., 1994), and questions from a survey about sexual abuse (Wyatt, 1985). The ACEs included were expanded by Anda et al. (1999) to add parental separation/divorce, and emotional and physical neglect were later included by Dong and colleagues (2004). The test–retest reliability of the ACE Questionnaire was assessed by administering the survey twice to more than 600 participants and Kappa coefficients were found to range from good to excellent (Dube et al., 2004).

The categories and associated questions can be found in Table 6. Each affirmative answer to the ten questions is assigned one point totalling a score out of ten, which is known as the cumulative ACE score. The questionnaire is accompanied by administration guidelines, an interviewer's guide and scoring instructions.

Table 6: ACE Questionnaire categories

Category of ACE		Question
Abuse	Psychological abuse	1. Did a parent or other adult in the household often… - Swear at you, put you down, or humiliate you? - Act in a way that made you afraid that you might be physically hurt?
	Physical abuse	2. Did a parent or other adult in the household often… - Push, grab, slap or throw something at you? - Ever hit you so hard that you had marks or were injured?
	Sexual abuse	3. Did an adult or person at least 5 years older than you ever… - Touch or fondle you or have you touch their body in a sexual way? - Try to or actually have oral, anal or vaginal sex with you?
Neglect	Emotional neglect	4. Did you often feel that… - No one in your family loved you or thought you were important or special? - Your family didn't look out for each

		other, feel close to each other, or support each other?
	Physical neglect	5. Did you often feel that… - You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? - Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
Household dysfunction	Parental separation	6. Were your parents ever separated or divorced?
	Witnessing domestic violence	7. Was your mother or stepmother: - Often pushed, grabbed, slapped, or had something thrown at her? - Sometimes or often kicked, bitten, hit with a fist, or hit with something hard? - Ever repeatedly hit over at least a few minutes or threatened with a gun or a knife?
	Substance misuse within the family home	8. Did you live with anyone who was a problem drinker or alcoholic or used street drugs?
	Familial mental illness	9. Was a household member depressed or mentally ill or

		did a household member attempt suicide?
	Incarcerated family member	10. Did a household member go to prison?

Fellitti et al.'s (1998) study demonstrated the significant relationship between certain risk factors in childhood and medical problems in later life. The study also demonstrated the synergistic effect of these risk factors. In addition, risk factors often cluster in individuals: if a person had exposure to one experience, there is an 80% chance of exposure to another risk factor (Felitti et al., 1998). Since its creation, the ACE questionnaire has had widespread use in both research and practice. Internal consistency of the 10-item measure and construct validity has been found to be good, showing high correlations with mental and physical health measures and childhood trauma inventories (Ford et al., 2014; Murphy et al., 2014; Wingenfeld et al., 2011).

The authors of the ACE study also created the ACE Pyramid (Figure 1) to provide a framework for how ACEs ultimately affect a child's life from conception until death, demonstrating how ACEs occur at the beginning of a child's life and set the groundwork for life-long risks and poor decisions and behaviours. As well as suggesting that an individual exposed to multiple ACEs may be at a heightened risk of experiencing health issues later in life, the study drew attention to how childhood trauma can affect

mortality. One study has since found that the life expectancy of an individual with an ACE score of six or more may be reduced by up to 20 years (Brown et al., 2009). The ACE pyramid is helpful in providing a visual representation of factors pre and post ACE exposure; however, there is a lack of justification for the organisation of the pyramid template, and a lack of inclusion of factors we know can mitigate the impact of negative experiences, such as engagement with education and having a positive relationship with at least one person involved in their care (Bethell et al., 2014; Middlebrooks, 2007).

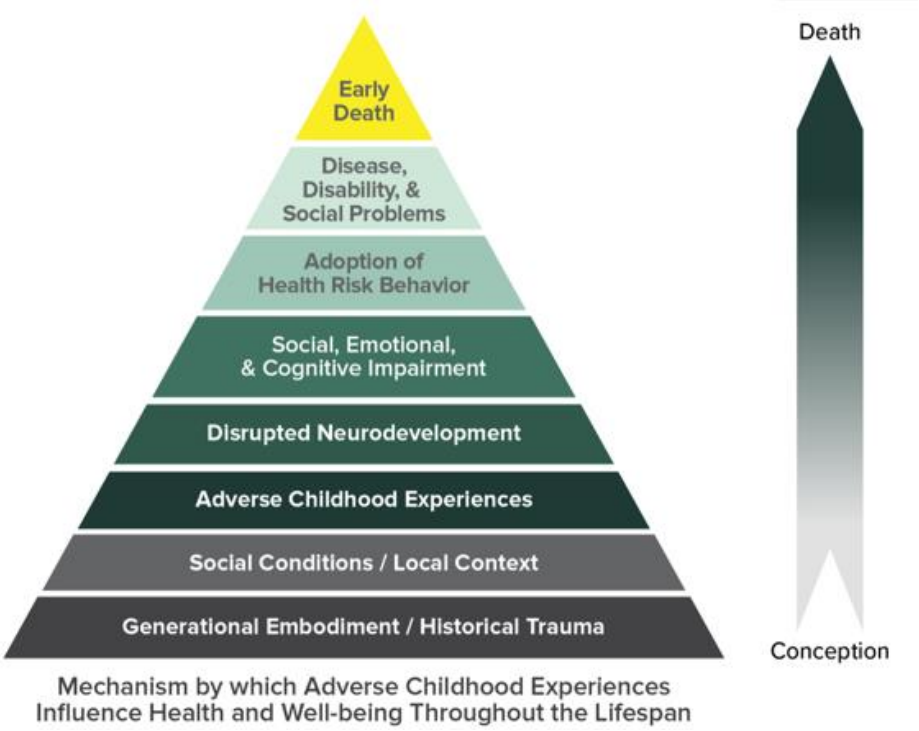

Figure 1: ACE pyramid

Content source: National Centre for Injury Prevention and Control, Division of Violence Prevention

However, the ACE questionnaire has limitations. Data used in the original study being limited to a sample of insured, primarily white, educated participants. The majority of studies about ACEs since have been carried out in high-income countries. It has been adapted by the World Health Organisation (WHO) and the United States Centers for Disease Control and Prevention to form the International Questionnaire (ACE-IQ), which uses the same framework from the original study claiming to be valid for use around the world, including low and middle income countries (WHO, 2009). Although the ACE-IQ has been used in several countries, e.g. Brazil (Soares et al., 2016), Saudi Arabia (Almuneef, Qayad, Aleissa, & Albuhairan, 2014), Iraq (Al-Shawi & Lafta, 2015) and Vietnam (Tran et al., 2015), data on its psychometric properties are limited. The occurrence of some ACEs also differs substantially according to gender, and usually females are more likely to have a higher number of childhood adversities than males (Soares et al., 2016).

3. USE IN EXISTING RESEARCH

The original ACE study by Fellitti and colleagues (1998) was a crucial body of work which has improved our understanding of how experiences in childhood affect trajectories of antisocial behaviour. Prior to this, the research base exploring antisocial behaviour among young people had predominantly focussed on social learning theory

(Bandura, 1977), which postulates that the use of violent conduct would provide a model of behaviour from which a child would learn. The child would believe that this was an acceptable and legitimate way to interact with others and have needs met. Findings also added to the Farrington study (1995) of how antisocial behaviour can follow generations; we can understand how a child who experiences ACEs are more likely to experience difficulties in later life which could thus lead their own children to experience ACEs, and so on. One of the earliest studies exploring ACEs among young people in youth custody (Browne & Falshaw, 1997) found that the majority of their sample (72%) came from abusive and neglectful family environments. Often, they not only have been the victim of maltreatment at the hands of parents or siblings, but they also witnessed violence within the home between other family members, and this highlighted the impact of both direct and indirect harm. This work has furthered the professional understanding of the interplay of nature and nurture.

ACEs have since been associated with neurodevelopment (Anda et al., 2010; Cicchetti, 2013; Danese & McEwen, 2012), 'sexually risky behaviours' (Hillis et al., 2001) and sexually violent behaviour in adulthood (Grady, Levenson & Bolder, 2017). Studies utilising the ACE questionnaire have found that higher cumulative ACE scores are associated with imprisonment, poor educational and employment outcomes and violence (Bellis et al., 2013). Those who have experienced

four or more ACEs have been reported to be twelve times more likely to experience these outcomes in adulthood (Felitti et al., 1998). Other studies have found that higher ACE scores are present among adults suffering from mental health difficulties, including depression, anxiety, panic, hallucinations, psychosis and suicide attempts, along with overall psychopathology, psychotropic medication use (Anda et al., 2006; Bellis et al., 2014; Bielas et al., 2016; Clark et al., 2010; Koskenvuo & Koskenvuo , 2015; Pirkola et al., 2005; Varese et al., 2012), all of which are prevalent among forensic populations.

More recently, studies on ACEs among sexual offenders suggest that their trauma histories may be more complex than non-sexual offenders (Levenson, Willis & Prescott, 2016; Levenson, Willis & Prescott, 2015). In their study exploring influence of ACE on arrest patterns, Levenson and Socia (2016) found that ACE scores were correlated with the number of sex offences among their sample of convicted sex offenders. In particular, they found that sexual abuse, emotional neglect and witnessing domestic violence in childhood were significant predictors of a higher number of arrests. It is important to note that Levenson and Socia's (2016) sample of 740 was only 6.5% (*n*=48) female, compared to 93.5% (*n*=692) male (93.5%) and female (6.5%), and all information pertaining to them was provided by offender self-report rather than official documentation to confirm the truth in responses.

4. STRENGHTS OF THE ACE QUESTIONNAIRE

The ACE Questionnaire is widely used in practice as a screening tool to help understand a person's early experiences and identifying what someone was exposed to in their developmental years. The focus on events rather than experience can be helpful to mitigate subjectivity. As Clark et al. (2014) note, although trauma symptomatology is typically assessed as part of mental health screenings, the nature of the trauma is rarely identified.

There are alternate tools to assess childhood trauma, however these typically measure specific forms of harm. For example, The Child Abuse and Trauma Scale (CATS; Sanders & Becker-Lausen, 1995), a 38-item scale designed to measure sexual abuse, negative home environment/neglect and punishment; The Conflict Tactics Scale (CTS; Strauss, 1999), which contains a five-item psychological aggression subscale; and The Family Environment Questionnaire (FEQ, Briere & Runtz, 1988), which is focused on psychological abuse. The main limitation for using these measures to assess for ACEs is their focus on only certain types of adversity, thus multiple tools would be required to provide a robust picture of an individual's childhood.

The Childhood Trauma Questionnaire (CTQ; Bernstein & Fink, 1998) is one of the most widely used tools and shows good validity (Church et al.,

2017). The 28-item measure has five subscales pertaining to physical abuse, sexual abuse, neglect, emotional abuse, and emotional neglect (Bernstein et al., 2003). However, unlike the CTQ, the ACE Questionnaire is free to download and use and requires no prior knowledge or training. It is brief and easy to score by summing up the number of questions endorsed. Shapiro (2017) promotes it due to its brevity and simplicity to use as part of an assessment process, for its ability to identify vulnerabilities of an individual and potential treatment targets through identifying what the individual has, or believes they have, experienced. Even studies that utilise an alternate tool to measure ACEs rely on 10 categories prescribed by Felitti et al. (1998). For example Bielas and colleagues (2016) used the Multidimensional Clinical Screening Inventory (Bauer et al., 2011) in order to deduce the number of ACEs their sample of imprisoned young men had experienced.

4. LIMITATIONS AND SUGGESTIONS FOR IMPROVEMENT

4.1 Content of the ACE Questionnaire

One of the most helpful aspects of the ACE questionnaire is its categorisation of different types of harm. However, some inherent limitations should be held in mind when using this tool and interpreting the scores. Under the domain of sexual abuse, the question posed to the participant insinuates that behaviour only qualifies as sexual abuse if it was

carried out by an adult or person at least five years older. This fails to take into consideration HSB among same age children, ignoring the fact that most sexual abuse experienced by young people is carried out by peers of a similar age (Hackett, 2010; Hackett et al., 2016). The potential negative effect of the question being posed in this way could lead participants to reframe behaviour they had experienced as abusive (because, for example, lack of consent or power differentials) as non-abusive. Rather than the question of sexual abuse focusing solely on age, it should include other tenets which would limit someone's ability to consent to sexual activity (e.g. because of limited freedom, choice or capacity).

The questionnaire omits other experiences which we know cause psychological harm. For example, as highlighted by Finkelhor et al. (2013), the current ACE questionnaire does not include rejection under emotional neglect, despite the evidence base highlighting this as an experience for childhood which can have a multitude of adverse outcomes (Danense et al., 2009). Finkelhor et al. (2013) also note how the questionnaire focuses on domestic violence, yet there is no exploration for exposure to violence outside of the family home. No questions relate to the wider environment of a child, such as their schooling and community, despite the exposure and experience in these settings playing a large part in their life. For example, bullying in school can have a long lasting negative psychological impact (Ortega et al., 2012).

As well as missing some important predictors in the questionnaire, there are assumptions made which could potentially miss out important information. Under the domain of witnessing domestic violence, the questionnaire assumes the violence was experienced by a mother or stepmother. This assumes that the victim of domestic violence is female. Further, the choice of words means that it ignores witnessing violence against anyone but a mother or stepmother (such as a foster parent). There is no exploration of whether domestic violence was witnessed but involving someone other than one's mother or stepmother. In Chapter four, Alesha shared that she had never witnessed violence directed towards her mother by her father, but had seen significant violence *from* her mother. This important detail could have potentially been missed had she not been provided the opportunity to provide qualitative detail, which deviated from the expectations of the questionnaire (i.e. that domestic violence was perpetrated by males).

The questionnaire asks the completer if they experienced physical abuse at the hands of adult, which discounts abuse from siblings. The evidence base indicates that physical abuse carried out by a sibling can cause significant stress and emotional and psychological damage (Hardy, 2001). Additionally, sibling sexual abuse is not considered, despite the evidence base, corroborated by the findings in Chapter Two, rates of this are likely to be higher than we currently believe (Yates, 2017), and the misconception that it is less traumatic than parental sexual abuse (Veigh, 2003). Finally, the question posed to the reader asks if an adult *tried* to or *actually* sexually

abused them, which refers to two distinct experiences but combines it to only one question. Due to the questionnaire only providing an opportunity for a completer to answer yes or no, important nuances can potentially be missed.

4.2 Practical use of the ACE Questionnaire

It is important to consider the ethical aspects when administering the ACE questionnaire. The questionnaire asks questions which have the potential to cause completers to re-visit painful experiences and memories. Using it with vulnerable populations requires consideration of how to mitigate these risks, considering they are more likely to have experienced trauma than the general population (Baranyi et al., 2018; Wolff & Shi, 2012). This is particularly the case for women in prison (Bartlett & Hollins, 2018; Moloney et al., 2009). Administering it as part of a structured interview would mean that a person is not left alone to complete it and is provided with the support of another person, and using this method also provides the opportunity for a person to add what they consider to be an ACE but may be missed through the questions posed to them. This proved to be crucial when using the ACE questionnaire in Chapter Three, where a number of participants shared that they witnessed violence within their family home but it was their mother carrying out violence towards their father. Using

open questions rather than those that required a 'yes'/'no' answer elicited informative answers and also served to check for participants' understanding of the question put to them.

Scoring reveals a total score calculated by the number of questions endorsed, which assumes that each adversity experienced is equally important. There is no rationale for summing up the scores, as it is not known whether the ACE categories are all of equal importance. This does not account for the interrelation between these ACEs, for example, someone who has a parent with mental health difficulties, suffers from substance misuse and has been imprisoned will score higher than someone who was sexually abused by multiple people throughout their childhood. Some experiences may have had a lesser or greater effect, and may be more implicated on an individual's outcomes than other ACEs. Furthermore, we know that ACEs tend to happen in multiples as factors are often interlinked (for example, a parent with mental health difficulties is more likely to suffer from substance misuse). Providing a cumulative score and arbitrarily categorising people is problematic; there is a lack of consistency in studies about the number of ACEs which qualify as 'high' or 'low' (Lacey & Minnis, 2019).

There are research studies that explore ACEs that examine one single adversity, whilst others disaggregate the ACE score and examine the effect of each adversity independently. For example, Merrick et al. (2017)

compared the strength of associations between individual ACEs and specific outcomes. Data were drawn from the original CDC-Kaiser Permanente ACE Study, and comprised 7465 adults in southern California, over 80% of whom reported exposure to at least one ACE. The authors found that sexual abuse, physical abuse, household mental illness and parental substance abuse remained significant predictors of lifetime drug use and moderate to heavy drinking. Sexual abuse, emotional abuse, physical abuse, household mental illness, parental incarceration and emotional neglect were significant predictors of reported depressed affect and suicide attempts in adulthood. Sexual abuse remained a significant predictor for all poor health outcomes in adulthood, highlighting the severity of child sexual abuse on adult outcomes. Unlike cumulative ACE scores, single adversity approaches allow the examination of potential mechanisms linking a specific adversity to a specific outcome, however this remains an under-researched area (McLaughlin, 2016; Lacey and Minnis, 2019).

The simplicity of scoring means that the effect of the ACE on that individual is not considered and this potentially misses contextual issues which could be pertinent to an individual's later outcomes. Providing the completer an opportunity to 'rate' the harm they feel that a particular ACE caused them could help mitigate this, and provide us with a better understanding of the mechanisms at play. This method would help elucidate possible positive and negative correlations between ACEs. Additionally, the questionnaire uses a broad definition of childhood; it may be that adverse experiences before the

age of six years, for example, have different effects from those experienced in later childhood (Reavis et al., 2013).

4 DISCUSSION

There are many reasons why a tool to screen for ACEs is helpful in research and practice. There is a significant link between what happens in a person's early years of life and their future, physically, psychologically and socioeconomically. The questionnaire reminds us that children can experience both direct and indirect violence which can reverberate into adult life, and can be used to help understand a person's vulnerabilities and make sense of their behaviour later on in life (e.g. formulation). The questionnaire may be able to help those who have a high ACE score to better understand their presenting problems and encourage them seek treatment.

In order to understand the longitudinal effects of ACEs it is necessary to use a revised questionnaire, or the existing ACE questionnaire should be used in conjunction with other measures, including a strengths focussed/protective questionnaire such as the Structured Assessment of Protective Factors (SAPROF; Vogel et al., 2009) with consideration of the ethical risk previously discussed. This would help us understand how

experiences may have had a lesser or greater effect, and may be more implicated on an individual's outcomes than other ACEs.

As the ACEs concept becomes popular in the context of policy interventions, concerns have been raised by (Kelly-Irving & Delpierre, 2019) who highlight that using the ACE Questionnaire as a probabilistic tool could ultimately exacerbate inequalities. Fellitti reminds us that these results show correlation, not causation (Fellitti et al., 1998). There are many intervening events and variables that mediate childhood exposure and later problems in adulthood, and the ACE study showed correlation, not causation. Not all children who experience ACEs will go on to suffer from poor mental health or embark on an offending trajectory, but the evidence base demonstrates that those who experience adversity in early life are more vulnerable to experience such difficulties. It appears that some children are provided with the support or are equipped with the resilience which serve to mitigate the harm caused by ACEs, and research should focus on this area. Understanding more about the intervening variables is an important goal of continued research. This could be helpful in identifying how some people might be exposed to the same ACE/s but demonstrate different outcomes.

Future work should continue to explore which additional adverse experiences are pertinent. Prospective studies using more nuanced measures of adversity would be particularly helpful to capture the complex

interplay among individual, household, and community factors shaping outcomes. As has been discussed, the data used in the original study was limited to a sample of primarily white, educated participants with health insurance. Though more diverse, the sample used in Finkelhor and colleagues study (2013), which identified additional predictors needed to expand the ACE questionnaire, was still predominantly small with a limited response rate (43%). In order to ensure its validity and generalisability, it is imperative that the ACE questionnaire is tested with diverse populations. As Cronholm and colleagues (2015) note, higher levels of adversity exist in minority and lower-income populations. Every person, regardless of their backgrounds, is unlikely affected by ACEs in the same way. There may also be differences relating to sex and whether a child has been removed from the care of their parents which affect their resilience. These are variances which require further exploration through longitudinal studies.

In conclusion, the findings of the ACE study yield important confirmation of the prevalence of childhood exposure to harm and the association of this exposure with poor health, mental health and lifestyle outcomes for adults. The challenge is to renew our efforts to understand the differences of how people cope and manage the impact of their childhood experiences. As has been discussed, the evidence base continues to highlight the prevalence of ACEs among those who commit harm to others. Understanding why some people who experience ACEs develop into antisocial adults, whilst others are prosocial is key to intervention if we are to effectively mitigate

offending trajectories. In line with the 'trauma informed' initiatives aiming to increasing empathy and compassion, those who work with forensic populations, who are more likely to have experienced ACEs (Miller & Najavits, 2012), are encouraged to move away from asking 'what is wrong with you?' to considering 'what happened to you?' (Sweeney et al., 2018). Even though this approach is understood as far more helpful, adult mental health services are still lacking in their identification of trauma in childhood (Read et al., 2018). The use of a brief and easy to comprehend questionnaire is of great use in this sense, in order to identify a history of ACEs. Individuals may not disclose trauma unless it is explored with them, as they may not recognise events as traumatic or realise the lasting effects they have had on them, especially if there has been a normalisation of ACEs within families and communities.

As this paper and the preceding chapters have argued, exposure to ACEs may hinder both the quality of attachment bonds with caregivers and the consistency of care and stability of the home environment. The effects can be profound and long lasting, and can shape one's sense of self, others, and the world around them.

CHAPTER SIX

GENERAL DISCUSSION

DISCUSSION

"Childhood attachments and the adult capacity for intimacy are essential links in the chain of development underlying the emergence of an inappropriate sexual disposition."

(Marshall, 1993:109).

The aim of this thesis is to further professional understanding of the cycle of victim to offender, exploring the lived realities of women who have carried out sexual abuse with the objective of furthering our understanding of how trajectories of sexual offending can follow ACEs. Females who display sexually abusive behaviour are a wholly under-researched population, and this thesis provides a much needed response to the paucity of information about their needs. Studying females of all ages allows for the detailed exploration of how ACEs may be associated with the perpetration of sexual abuse by females as a strategy for them to meet psychological, social or material unmet needs. In line with previous studies, this thesis suggests the aetiological significance of poor

attachments in childhood with sexual offending, which may be associated with vulnerabilities including intimacy deficits, cognitive distortions of self and emotional dysregulation (Burk & Burkhart, 2003; Craissati, McClurg & Browne, 2002; Hudson & Ward, 1997; Marshall, 1989, 1993). Having the perspective of different ages allows us to consider the factors which may potentially help to mitigate the trajectory of sexually abusive behavior, and these potential protective factors will be discussed.

Chapter Two highlights that many children and adolescents who display HSB come from backgrounds of trauma, with family breakdown, insecure attachments, socioeconomic difficulties and domestic violence frequent findings (Vizard, 2007). Experiences of physical abuse, sexual abuse, neglect, poor continuity in care and experiences of loss were also common findings (Hackett, 2014; Richardson et al., 1995). The review found significantly higher rates of victimisation among the females than males, in both the prevalence of adverse experiences and sexual abuse patterns. This pointed towards the need for qualitative research, rich in depth and breadth, to improve the understanding of how HSB manifests.

Chapter Three was carried out in response to this. Descriptive statistics pertaining to young people referred to a HSB service found high levels of social care involvement with families. The qualitative element of the study recruited participants from two prison establishments in England to provide robust findings across different age groups. The impact of ACEs

appeared instrumental in in interviewees' offending trajectories. Most interviewees had experienced sexual abuse, both within and outside of their family. Rather than them later playing out what they have experienced and observed (e.g. social learning theory), it appeared that the trauma shaped how they saw themselves, how they believed others saw them, and their expectations from the world around them. Interviewees generally had negative self-schemata, derived from their overwhelmingly negative past experiences. For many, the only time they had experienced closeness with another was in a sexually abusive situation, and it was difficult for them to disentangle this from intimacy. They described childhoods characterised by attachment insecurities, with an absence of feelings of closeness, connectedness, validation, and safety. Most were unable to recall being soothed or shown compassion from their parents, with *all* describing a feeling of rejection from their parents or caregiver. The combination of the legitimisation of violence (physical and sexual), low self-esteem, emotional loneliness, skewed perceptions of intimacy and the desire for validation were prominent factors. Sexually abusive behaviour and the difficulty in understanding and forming healthy relationships appeared a result of these factors. Thus, intervention should focus on these aspects. A strength of this study was its focus on experience and sense-making of an under researched group, however this may limit the validity of the findings as it uses only their perspective and testimony.

A key finding of Chapter Three was the harmful effects of labelling, and how this hindered experiences of organisational and procedural justice, as well as being psychologically harmful. Practitioners and researchers alike should be mindful of language; there are terms, such as sex offender, which are so embedded in our lexicon that we have detached ourselves from how stigmatising the label is. Working in forensic settings, there is a tendency to categorise people based on their diagnosis or type of offending. As tempting as this may be, it is important to be mindful of the impact of receiving a label on an individual, who may well feel they are being told that this is their new identity and how others will view them for the rest of their life. Using neutral language, seeing a person first and not defining them by their offence, is found to improve a person's willingness to engage and reduce their likeliness to label others (Lowe & Willis, 2019). As punitive approaches move towards more strengths based frameworks, we should hold in mind how an individual's treatment comprises not just of an intervention but their very environment. Thus, a systemic approach, multi-disciplinary approach with a shared language, is needed.

Chapter Four provides a deeper exploration through a case study using a hermeneutic methodology. This method elicited an in-depth exploration of the motivations and meaning behind the participant's offending behaviour. The study emphasises the importance of understanding the needs of vulnerable people embroiled in the complex and sophisticated web of child

sexual exploitation. The cycle of victim to offender is described and analysed. This study is unique in its offering of not just the details of the victimisation and subsequent offending, but the capturing of Alesha's thought processes and reflections. Her case highlights the importance of multi-agency working and early intervention. If not addressed and support put in place, HSB is likely to continue (Campbell et al., 2018). Multi-agency working which enables different organisations to carry out their specific role whilst developing shared perspective through sharing information is key in supporting victims of child sexual exploitation. As well as aiding our understanding of the mechanisms at play and Alesha's offending trajectory - which is useful from a policing perspective - the case study identifies the needs she was seeking to meet through her perpetration of sexual harm.

As Chapters One to Four have proposed, there is a significant link between what happens in a person's early years of life and their future, physically, psychologically and socioeconomically. Chapter Five reminds us that children can experience both direct and indirect violence which can reverberate into adult life, and can be used to help understand a person's vulnerabilities and make sense of their behaviour later on in life (e.g. using formulation). Measuring ACEs is helpful in both research and practice, but the existing questionnaire has limitations. Use of a revised questionnaire incorporating the additional ACEs discussed could be of great

value in advocating for increased investments to reduce childhood adversities and put in place support for families.

IMPLICATIONS FOR RESEARCH AND PRACTICE

This thesis examines the prevalence and features of ACEs among females who sexually abuse, and there are implications for the findings. First, in order to ensure that we have an accurate representation of the extent of female perpetrated sexual abuse it is imperative to make efforts to record data correctly and consistently. The results from Phase One of the primary study in Chapter Four was limited by the quality of data recording from the service. As well as ensuring characteristics, such as age, social care and education status and family/living environment, using a framework to categorise behaviour, such as the continuum proposed by Hackett (2014) could be helpful in identifying and correlations between individual characteristics and the nature of the HSB displayed. Recording data accurately and consistently would allow us to examine potential relationships between adversities and types of HSB displayed.

Second, the necessity of early intervention is a theme which run throughout the chapters of this thesis, with a particular focus on recognising the impact of trauma. Furthermore, despite the sexually abusive behaviour described in this thesis overlapping with general poor

mental health, there is a need for specialised treatment. Those that are responding to HSB need to feel well equipped and prepared to work with those who display this type of behaviour. Training on working with HSB is necessary for professionals such as social workers and youth offending workers, and this education should include information on how ACEs are prevalent characteristics among those who perpetrate sexual harm. Female perpetrated sexual abuse is a manifestation of maladaptive ways of meeting needs, but Chapter 4 described a lack of perceived procedural justice whereby participants felt their treatment was degrading during the judicial process and following their imprisonment. Interviewees described newspaper journalists, lawyers and judges viewing and describing them as inhuman because of how their offences violated what a woman should want and be. Hence, personal biases could impede the fairness of the judicial process, and these biases emanate from a lack of understanding.

One interviewee who participated in the study in Chapter Four spoke of what she described as the 'stigma' that those who are sexually abused go on to abuse others. What emerged in the study was that although sexual abuse in childhood had been experienced by most of the participants, it had not been experienced by all. Thus, it is potentially dangerous to assume sexually abusive behaviour has been learnt or observed in order for it to be perpetrated. Rather, it appears that HSB results from a sexual development disrupted by ACEs, and the task of the professional is to support the individual develop healthy ways to meet their needs (e.g.

using a strengths based approach such as the Good Lives Model, Ward & Stewart, 2003). This is not to say other psychological therapy, such as a trauma focussed modality, could not be beneficial in helping an individual understand their experiences and how they have shaped how they see themselves, others and the world around them.

Third, sex and relationship education should not only include consent and healthy relationships, but also the potential dangers of social media, dating apps and online forums. Those with difficulties in interpersonal relationships and social communication, and who are experiencing loneliness and isolation, may be particularly vulnerable to grooming online. As described in Chapter Three, women who shared explicit material online reflected on how there were people they encountered online who were skilled at manipulation and achieving trust and dependency. These women largely claimed naivety about the nature of their offending. They described a feeling that the risk of losing the person with whom they achieved a sense of connectedness and intimacy outweighed the risks they perceived to be associated with sexual abuse. Most of those who described this had also previously been in abusive relationships, and experienced what Van Der Kolk (1989) terms as the 'compulsion to repeat the trauma'. The case study of Alesha in Chapter Five describes this phenomenon in detail, and illustrates how people can take advantage of these vulnerabilities.

Fourth, the prevalence of emotional loneliness among interviewees in Chapter Two is an interesting finding which adds to the body of literature on loneliness among sex offenders (Blake & Gannon, 2011; Marshall, 1989; Marshall, 2010). How this emotional loneliness is related to the disruption of forming healthy attachment bonds in infancy is an area deserving of further research. Chapter Two identified a myriad of ACEs among participants, and the experience of feeling disconnected from their families as a child was a prominent finding. When working with females who sexually abuse, a holistic approach using case formulation is needed to explore the role of attachment, intimacy and loneliness. Additionally, taking into consideration the levels of blame experienced by the females who took part in this research and the subsequent shame they experienced, it is imperative that researchers and clinicians alike move away from focusing only on the 'problem' behaviour but to ask the important question - 'what happened to you?' - and take the time to explore this.

As our female sex offending population continues to expand, there is a need for robust research on female sex abusers. An interesting area for future research is how specific adverse experiences are associated with different types of sexual abuse. As discussed, the recording of data accurately and consistently would allow us to examine potential relationships between adversities and types of HSB displayed. Doing so

with a large data set would yield more valid results. Alongside this, further qualitative research on a larger scale, continuing to explore the lived realities of females who have sexually abused would further our understanding of individual differences and resilience to ACEs. This thesis included participants from two prison establishments in different areas of England; using multiple establishments as research sites would ensure different geographical regions are represented which would improve the generalisability of findings.

CONCLUSION

This thesis develops and extends the professional knowledge of sexual abuse among females across different ages, elucidating their treatment needs. Revealing the prevalence of ACEs among women who come into contact with the criminal justice system is not a new finding (see Carlen, & Worrall, 2013; Sharp, 2014). Despite this, penal policy appears to still have a long way to go to recognise that offenders are more often than not victims first, and, although this may not be a popular approach in terms of political discourse, criminogenic needs emanate from this earlier victimisation. If findings of the present study can be utilised to improve practice, this may mean that fewer women end up in prison as their behaviour has been identified earlier and intervention has been more effective in addressing their needs, mitigating their offending trajectory. Attachment theory provides a conceptual framework that can help us

understand how an individual can develop maladaptive ways of meeting their needs. Having an understanding of this is needed to develop and implement effective support, treatment and care.

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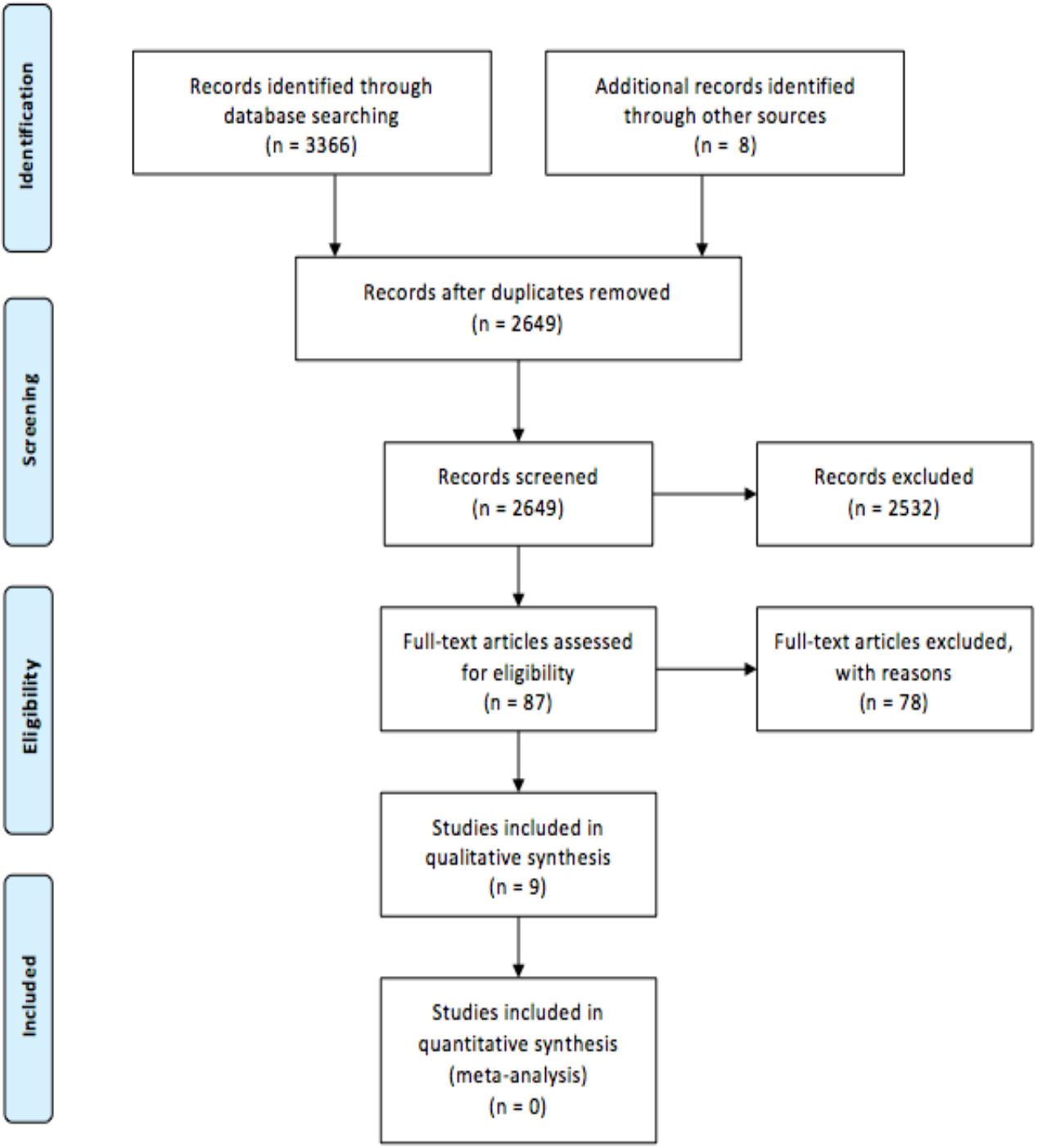
APPENDIX A: SYSTEMATIC REVIEW SELECTION PROCESS



APPENDIX B: UNIVERSITY RESEARCH ETHICAL APPROVAL

University of Nottingham
UK | CHINA | MALAYSIA

Email: FMHS-ResearchEthics@nottingham.ac.uk

Faculty of Medicine & Health Sciences
Research Ethics Committee
c/o Faculty PVC Office
School of Medicine Education Centre
B Floor, Medical School
Queen's Medical Centre Campus
Nottingham University Hospitals
Nottingham, NG7 2UH

22 February 2018

Dulcie Faure Walker
DForenPsy Trainee
c/o Dr Nigel Hunt
Associate Professor
Division of Psychiatry and Applied Psychology
Room B19, Yang Fujia Building
Jubilee Campus
University of Nottingham
Wollaton Road
Nottingham
NG8 1BB

Dear Ms Faure Walker

Ethics Reference No: 234-1802– **please always quote** **IRAS Project ID:** 238605	
Study Title: The characteristics and motivations of females who sexually abuse	
Short Title: Females who sexually abuse.	
Chief Investigator/Supervisor: Dr Nigel Hunt, Associate Professor, Division of Psychiatry and Applied Psychology, School of Medicine.	
Lead Investigators/student: Dulcie Faure Walker, Doctorate in Forensic Psychology Trainee	
Type of Study: Prison, Semi-structured interviews questionnaire, quantitative/qualitative	
Proposed Start Date: 01/05/2018	**Proposed End Date:** 31/08/2019 16 mths
No of Subjects: 20-30	**Age:** 18+years

The Committee considered this application at its meeting on 16 February 2018 and the following documents were received:

Females who sexually abuse:
- IRAS Full Set of Project Data dated 26.01.2018
- Protocol final version 1.0 dated 26.01.2018
- Participant Information Sheet Final version 1.0 25.02.2018
- Consent Form final version 1.0 25.02.2018
- Interview Schedule version 1.0 25.02.2018
- ACE Questionnaire ra hbr 10 24 06.
- E-mail confirmation that evidence of Sponsor not required 07.02.2018

These have been reviewed and are satisfactory and the study has been given a favourable opinion.

A favourable opinion has been given on the understanding that:

1. Permissions from the organisations/institutions involved are in place.

2. Please submit copies of these letters/e-mails for our records.

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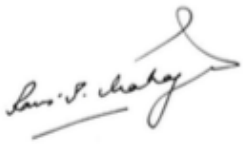
3. The protocol agreed is followed and the Committee is informed of any changes using a notice of amendment form (please request a form).

4. The Chair is informed of any serious or unexpected event.

5. An End of Project Progress Report is completed and returned when the study has finished (Please request a form).

Yours sincerely



Professor Ravi Mahajan
Chair, Faculty of Medicine & Health Sciences Research Ethics Committee

APPENDIX C: HMPPS ETHICAL APPROVAL

FINAL APPROVAL FOLLOWING ACCEPTANCE OF MODIFICATIONS – HMPPS RESEARCH

HM Prison and Probation Service
National Research Committee
Email:
National.Research@NOMS.gsi.gov.uk

HM Prison & Probation Service

Dulcie Faure Walker
Room B19 Yang Fujia Building
Jubilee Campus
University of Nottingham
NG8 1BB
04 July 2018

Ref: 2018-069
Title: The characteristics and motivations of females who sexually abuse

Dear Dulcie,

Further to you providing the additional information requested in our previous letter dated 14 March 2018 and email dated 13 June 2018, the National Research Committee (NRC) is pleased to provide final approval for your research project. The terms and conditions below will continue to apply to your research project.

Please note that unless the project is commissioned by MoJ/HMPPS and signed off by Ministers, the decision to grant access to prison establishments, National Probation Service (NPS) divisions or Community Rehabilitation Company (CRC) areas (and the offenders and practitioners within these establishments/divisions/areas) ultimately lies with the Governing Governor/Director of the establishment or the Deputy Director/Chief Executive of the NPS division/CRC area concerned. If establishments/NPS divisions/CRC areas are to be approached as part of the research, a copy of this letter must be attached to the request to prove that the NRC has approved the study in principle. The decision to grant access to existing data lies with the Information Asset Owners (IAOs) for each data source and the researchers should abide by the data sharing conditions stipulated by each IAO.

Please note that a HMPPS/MoJ policy lead may wish to contact you to discuss the findings of your research. If requested, your contact details will be passed on and the policy lead will contact you directly.

Please quote your NRC reference number in all future correspondence.

Yours sincerely,
National Research Committee

APPENDIX D: PARTICIPANT INFORMATION SHEET

Faculty of Medicine & Health Sciences

University of Nottingham
UK | CHINA | MALAYSIA

School of Medicine

Ethics Reference No: 234-1802
IRAS Project ID: 238605
Lead investigator: Dulcie Faure Walker
Supervisor: Dr Nigel Hunt

We would like to invite you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you. One of our team will go through the information sheet with you and answer any questions you have. Ask us if there is anything that is not clear.

What is the purpose of the study?
The aim of the study is to explore the characteristics and motivations of females at different ages to further our understanding of sexual abuse. This study will be submitted as part of a research portfolio for the qualification of Doctorate in Forensic Psychology.

Why have I been invited?
You are being invited to take part because you identify as a woman and are in prison for a sexual offence. We are inviting approximately 20 people to be interviewed.

Do I have to take part?
It is up to you to decide whether or not to take part. If you do decide to take part you will be asked to sign a consent form. Even when you have signed this you are still free to withdraw at any time and without giving a reason.

What will happen to me if I take part?
If you decide to take part you will be interviewed about your life, which will include questions about your childhood, adolescence and details about your crime. With your permission, interviews will be recorded. If you are not happy for your interview to be recorded I will need to take some notes to ensure that the interview is remembered accurately.
A questionnaire will be used called the Adverse Childhood Experiences (ACE) Questionnaire, which will ask questions about your childhood experiences. The survey consists of ten questions. At the end of the questionnaire, the points are totaled for a score out of ten, which is known as the ACE score. A higher score indicates that you might have experienced more difficulties when you were growing up.

Your interview will last between one and two hours in total. I will be carrying out research in the establishment you are currently based for around two weeks. You will only need to attend one interview, however, if we are not able to complete the interview (because we run out of time, for example), I can return another day to complete it. You do not have to answer any questions that you do not want to.

What are the possible disadvantages and risks of taking part?
As we may be discussing some sensitive information, there is a possibility you may experience adverse effects as a consequence of the interview (such as feeling distressed). If this happens, please contact a member of prison staff. You can speak to the Samaritans at any time by phoning 116 123. Your welfare is our main consideration, and if you are feeling distressed we will stop the interview.

What are the possible benefits of taking part?

This study will provide the opportunity for you to discuss your feelings and thoughts about your crime and imprisonment, but I cannot offer any other benefits to you.

Will my taking part in the study be kept confidential?
Your personal details and any identifying references will be removed when the recordings are transcribed to ensure anonymity. You will be given a code to protect your identity. The recordings will be transcribed accurately by the researcher and uploaded into a password protected database. We would like to be able to quote what you say in our report or a publication, but will make sure that your anonymity is protected.
Please note, your interview data will be kept confidential but there are some limits:

- If you disclose anything which involves causing serious harm to yourself or others, or causing a serious risk to the security of the prison, I have an obligation to inform prison staff.
- You should not discuss any current or ongoing criminal activity that you are involved in.
- I also have an obligation to inform prison staff if you disclose any offences that you have not yet been convicted for.

What will happen if I don't want to carry on with the study?
Your participation is voluntary and you are free to withdraw at any time, without giving any reason. If you wish to do so, we recommend doing this within 7 days of completing the interview. After that point, it may not be possible to remove your data from the study, meaning that it may still be used in our analysis. However, if you have any questions please do not hesitate to contact us. If you choose to withdraw from the study, this will not affect your sentence or the support you receive in any way.

What will happen to the results of the research study?
This data is for an academic thesis to be submitted by the end of 2019, and may later be considered for publication. Your identity will remain anonymous, and your pseudonym will be used if any of your quotes are used.

Who has reviewed the study?
All research in the University of Nottingham is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by the Faculty of Medicine & Health Sciences (FMHS) Research Ethics Committee.

What if there is a problem?
If you have a concern about any aspect of this study, you should contact the Chief investigator by post using the contact details given at the end of this information sheet. If you remain unhappy and wish to complain formally, you should then contact the FMHS Research Ethics Committee Administrator, c/o The University of Nottingham, Faculty PVC Office, B Floor, Medical School, Queen's Medical Centre Campus,

Nottingham University Hospitals, Nottingham, NG7 2UH. Please quote ref no: FMHS 234-1802

Further information and contact details:
Dulcie Faure Walker
Office of Nigel Hunt, Room B19
Faculty of Medicine & Health Sciences
Yang Fujia Building, Jubilee Campus
Wollaton Road
Nottingham, NG8 1BB

Thank you

APPENDIX E: PARTICIPANT CONSENT FORM

University of Nottingham
UK | CHINA | MALAYSIA

Faculty of Medicine & Health Sciences

School of Medicine

Ethics Reference No: 234-1802
IRAS Project ID: 238605

Lead investigator: Dulcie Faure Walker, Doctorate in Forensic Psychology Trainee
Supervisor: Dr Nigel Hunt, Associate Professor, Division of Psychiatry and Applied Psychology

1. I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions.

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. ☐

3. I understand that should I withdraw, more than 7 days after the interview has taken place then the information collected so far cannot be erased and that this information may still be used in the study analysis. ☐

4. I understand that relevant sections of my data collected in the study may be looked at by the research group and by other responsible individuals for monitoring and audit purposes. I understand that the data will be anonymised and my personal details and identity will be kept confidential. ☐

5. I confirm that I have agreed for notes to be taken and/or (delete as appropriate) for the lead investigator to write notes. ☐

6. I understand that what I say during the interview will be kept confidential unless I reveal something of concern that may put myself or someone else at any risk. It will then be necessary for the lead investigator to report this to the appropriate persons. ☐

7. I understand that anonymous direct quotes from the interview may be used in the study reports. ☐

8. I understand that information recorded during the study will be made anonymous before it is stored. It will be uploaded into a secure database on a computer kept in a secure place. Data will be kept for 7 years after the study has ended and then destroyed. ☐

9. I agree to take part in the above study. ☐

Name of Participant	Date	Signature
Name of Researcher	Date	Signature

APPENDIX F: INTERVIEW SCHEDULE

Interview Schedule

Introduction:

- Introduce interviewer
- Explain the aims and purpose of the study and give a brief description of the interview structure.
- Ensure Participants have read the information sheet
- Discuss digital recording of the interview and confidentiality
- Remind that they can stop the interview and recording at any time without giving a reason. The recording can be deleted straightaway if they decide to withdraw.
- Opportunity for participant to ask any questions.
- Complete the consent form and give a copy to participant.
- Ask participant to complete the ACE Questionnaire.

Questions and Topics:

1. **Background/context**
   - Where were you born? Please tell me about your early years, including details of who you were living with and schooling.
   - Can you tell me a bit more about your family/caregivers?
   - Details about adolescence and development?
   - Details about educational and employment experience?

2. Crime and arrest

- Could you tell me about the lead up to the crime you were imprisoned for?
- Tell me about the events that day, and how you felt.
- Explore precipitating and perpetuating factors.
- Could you tell me about your trial?
- How did you feel when you were sentenced?

3. Experience of imprisonment

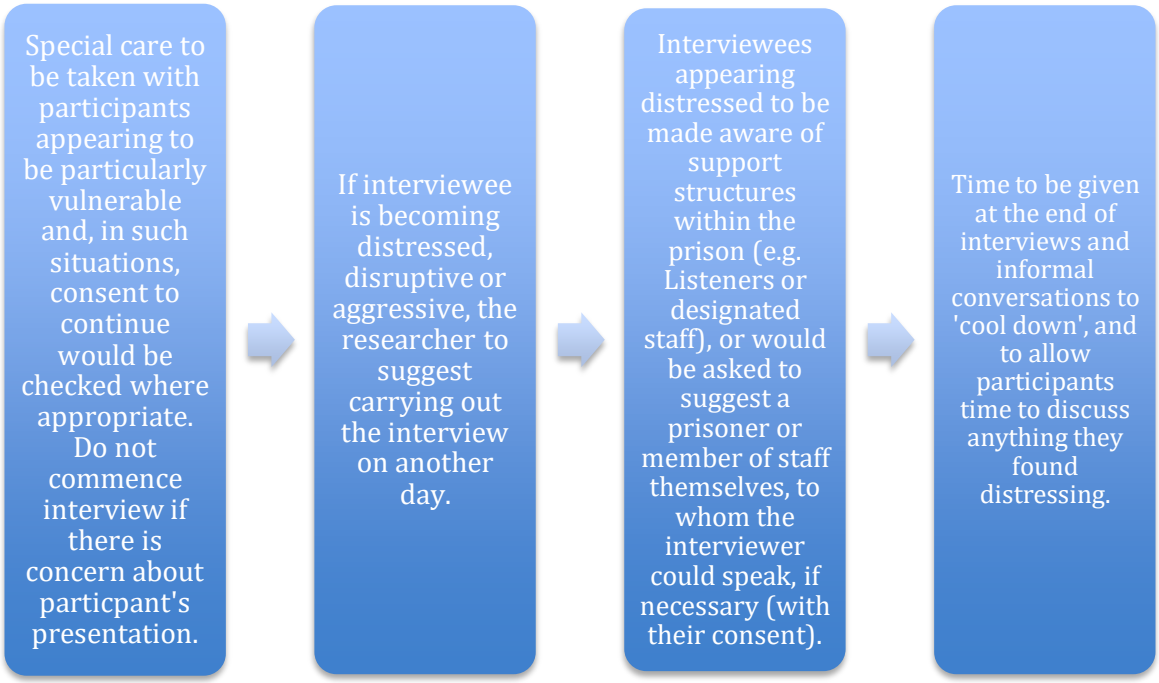
- Could you tell me about the prison/s you were held in?
- Were you supported (financially, emotionally, psychologically)?
- Are you able to maintain contact with family and friends?

4. Future goals and hopes for release

- How do you envision your future?

- What are your goals?

In the event of someone becoming very distressed, disruptive or aggressive during the interview:



If something of concern that needs reporting is revealed:
Inform a member of prison staff immediately.

Short Debrief:
The interviewer will now explain the interview is now officially over and there are no more questions. They will state when the project will be ending and that if after this date, it gets published that we will let them know. The volunteers will be thanked for their participation, and asked if they would like to have a more in depth debrief, for example if what has been discussed has made them feel particularly emotional. Even if they decline the debrief at the time, it will be reinforced that we can arrange for one if on reflection they feel they would like to talk to someone. The interviewer will ensure that participants are not left distressed, and we can signpost them to individuals with expertise in this topic area if they require extra support.

APPENDIX G: ACE QUESTIONNAIRE

Adverse Childhood Experience (ACE) Questionnaire

Finding your ACE Score ra hbr 10 24 06

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often** …
   Swear at you, insult you, put you down, or humiliate you?
   or
   Act in a way that made you afraid that you might be physically hurt?
   Yes No If yes enter 1 _____

2. Did a parent or other adult in the household **often** …
   Push, grab, slap, or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured?
   Yes No If yes enter 1 _____

3. Did an adult or person at least 5 years older than you **ever**…
   Touch or fondle you or have you touch their body in a sexual way?
   or
   Try to or actually have oral, anal, or vaginal sex with you?
   Yes No If yes enter 1 _____

4. Did you **often** feel that …
   No one in your family loved you or thought you were important or special?
   or
   Your family didn't look out for each other, feel close to each other, or support each other?
   Yes No If yes enter 1 _____

5. Did you **often** feel that …
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes No If yes enter 1 _____

6. Were your parents **ever** separated or divorced?
   Yes No If yes enter 1 _____

7. Was your mother or stepmother:
   Often pushed, grabbed, slapped, or had something thrown at her?
   or
   Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
   or
   Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
   Yes No If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes No If yes enter 1 _____

9. Was a household member depressed or mentally ill or did a household member attempt suicide?
   Yes No If yes enter 1 _____

10. Did a household member go to prison?
    Yes No If yes enter 1 _____

Now add up your "Yes" answers: _____ This is your ACE Score

APPENDIX H: DEBRIEF LETTER

Division of Psychiatry and Applied Psychology
School of Medicine
Jubilee Campus
Wollaton Road
Nottingham
NG8 1BB

Dear……..,

Thank you very much for participating in this research project. I appreciate you giving up your time and am grateful for your cooperation. The aim of the study is to explore the characteristics and motivations of females at different ages to further our understanding of female perpetrated sexual abuse. All the information you provided during your interview will be kept confidential, and the transcript of your interview will be labelled using an alias.

I am sorry if you experience any adverse effects as a consequence of the interview. If this happens, please contact a member of prison staff. You can speak to the Samaritans at any time by phoning 116 123.

If you have any queries, please feel free to contact me by post: Dulcie Faure Walker, Supervised by Nigel Hunt, Room B19, Yang Fujia Building, Jubilee Campus, Division of Psychiatry and Applied Psychology, University of Nottingham.

Thank you again for your participation.

Dulcie Faure Walker
DForenPsy Student, Division of Psychiatry and Applied Psychology

Dr Nigel Hunt
Associate Professor, Division of Psychiatry and Applied Psychology

Please note, if you have any complaints about this research project or your interview, you can contact: Faculty of Medicine and Health Sciences Ethics Committee, University of Nottingham, Medical School, Queen's Medical Centre, Nottingham, NG7 2UH

APPENDIX I: CASE STUDY CONSENT

THE UNIVERSITY OF NOTTINGHAM

DOCTORATE IN FORENSIC PSYCHOLOGY (D.FOREN.PSYCH)

CLIENT CONSENT TO COURSE WORK ASSIGNMENTS

I understand that Dulcie Faure Walker, hereafter referred to as 'the trainee' would like my permission to use information about me to complete a course work assignment (oral case presentation and/or written case report).

I understand that the work will not contain any information that would reveal my personal identity i.e. my name or address; rather I will be referred to via a pseudonym or case number.

The work may be discussed in the trainee's supervision and personal development group or looked at by other trainees to help their learning.

I understand that the work will be checked by the trainee's supervisor and The University of Nottingham to see that my anonymity and confidentiality have been safeguarded.

I understand that course work assignments (and material relating to these) are kept in securely locked premises and are not available for public access.

I understand that I do not have to allow information about me to be used in this way. I can change my mind and refuse my consent at any stage and this will have no effect on the treatment offered to me.

Name of Client:

Client's signature: 

Date: 19/12/18

APPENDIX J: CASE STUDY DIAGRAMMATIC FOMULATION