‘It’s my normal’: An Exploration of Adversity, Attachment, Trauma, and Adolescent Harmful Sexual Behaviour

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Adversity, Trauma and Adolescent Harmful Sexual Behaviour

Abstract

This thesis investigates associations between adolescent harmful sexual behaviour (HSB) and experiences of adversity, trauma, and attachment disruption. After completing a qualitative systematic review of seven studies that met the inclusion criteria of exploring the attachment experiences of adolescents who have displayed HSB, the thesis presents two studies. The first study is quantitative, and data driven and the second is a qualitative study using Interpretive Phenomenological Analysis (IPA) to explore the narratives of six young people. In the first study, the life experiences and offence detail of a sample (N=43) of UK adolescents in custody for a sexual offence were investigated. The findings revealed developmental histories characterised by adversity, trauma, and attachment disruption, with rates of ACEs far exceeding those within the general population. Associations were identified between specific ACEs and offence detail, and a key finding was that the ACE score (indicating poly-victimisation) predicted the early onset of harmful sexual behaviours.

The aim of the second study was to explore narratives of adolescents with a sexual offence. Semi-structured interviews were undertaken with six adolescents and analysed through IPA. Four superordinate themes were identified in the data; '*No Safe Base'*; '*Angry Child'*; '*Learning to Cope'* and '*My Normal'*. Participants also completed self-report measures which offered further insight into trauma symptoms and experiences of warmth and safety in relationships. Results highlighted that the participants had experienced harm and disrupted attachments including family and school rejection, with wide ranging impact from an early onset of emotional dysregulation and aggression to dissociation, normalisation, and acceptance of adversity and trauma. It is hoped that the voices of these young people will aid clinical practice and intervention strategies through adding depth to research in this area.

Following the primary research studies a psychometric critique of the Trauma Symptom Checklist for Children (TSCC – Briere, 1996) is presented. This is a well-established and evaluated measure of trauma symptoms in children, with generally good results in relation to the reliability and validity of the tool. The evidence supports the conclusion that despite some limitations with 'total score' and the sexual concerns scale, the TSCC offers a relatively brief, but holistic, and standardised measure of trauma symptoms in children which can support in clinical decision making. However, there is limited validation of the use of trauma measures, including the TSCC, with young people in custody.

The thesis provides evidence to move away from a purely 'PTSD' model of trauma, taking into account increased knowledge of complex developmental trauma, with the potential

for this to present differently to more traditional conceptualisations of post-traumatic stress in young people in conflict with the law and involved with the criminal justice system.

The research evidence presented in the thesis improves our understanding of the 'harmed to harming' trajectory of youths that present with high rates of both vulnerability and risk. Implications of the findings for prevention and intervention are discussed.

1. CHAPTER ONE: INTRODUCTION

1.1 Adolescence

There is recognition of adolescence as a distinct developmental stage, occurring between childhood and adulthood (Ogilvie, 2022; Sawyer et al., 2018). Within the literature pertaining to adolescent harmful sexual behaviour, terms such as 'youth', 'juvenile', 'young person' and 'adolescent' are typically used, often interchangeably. Within this thesis 'adolescent' and 'young person' is used to cover the age range of 10-17 years. The lower age limit reflects the age of criminal responsibility in the England and Wales and the upper age limit takes into account the legal status in the UK in which an individual, on reaching the age of 18 years, would be considered an adult. It is however acknowledged that the developmental stage of adolescence is now recognised to span into the 20s (Sawyer et al., 2018), with some studies defining 'emerging adults' aged 18 to 25 years. It is also recognised that whilst 'child' is often used to refer to pre-adolescent children (typically pre-12), all those under the age of 18 are in fact a child as highlighted within the Children Act (1989, 2004) for England and Wales, which follows the UN Convention on the rights of the child (UNCRC, 1989). As literature tends to differentiate the stage of adolescence from childhood, the decision was made to use the terms 'adolescent' and 'young person' within this thesis.

1.2 Harmful Sexual Behaviour

Definitions & Terminology

There are complexities in defining the concept of harmful sexual behaviour as several definitions and conceptualisations exist in the literature. It is recognised from the outset of this thesis that language matters and the aim throughout is have a 'child first' perspective in line with the United Nations Convention for the Rights of the Child (1989). The significant impact of sexual harm is however also recognised from the outset. The aim of this thesis is to support efforts in the prevention of child sexual abuse, through increasing understanding of children and young people who have caused sexual harm.

The term harmful sexual behaviour (HSB) is used throughout this thesis to reflect the common use of this term in research and practice, marking a move away from more stigmatising language such as 'sex offenders' and 'perpetrators of abuse'. The change in terminology reflects the importance of viewing HSB as something (however harmful) that the child has done, rather than applying a label which defines the young person (Campbell

et al., 2020; Hackett, 2005; McCuish & Lussier, 2017; McPherson, 2023). The definition of harmful sexual behaviour (HSB) used within this study is: "*Sexual behaviours expressed by children and young people under the age of 18 years old that are developmentally inappropriate, may be harmful towards self or others, or be abusive towards another child, young person or adult."* (Hackett et al., 2019, p. 13).

It is important to recognise that just as adult sexual behaviour exists on a continuum, as does that of children and adolescents. Hackett (2014) developed a continuum of adolescent sexual behaviour in which behaviour can be considered within the domains of *normal, inappropriate, problematic, abusive or violent.* The primary research studies within this thesis focus on adolescents convicted of sexual offences resulting in a custodial sentence being imposed, and as such the behaviour would be within the '*abusive*' or '*violent*' domains of Hackett's continuum.

Within the primary research studies in chapters three and four of this thesis, all participants were convicted of sexual offences. To balance the avoidance of language that stigmatises, with the need to reflect the serious nature of the harmful sexual behaviour (within the *abusive* and *violent* domains of Hackett's continuum) displayed by these young people, the term 'adolescents with a sexual offence' (ASOs for brevity) is used within the primary research studies. This was deemed appropriate, as it is a factual description (all had been convicted of an offence), whilst using person-first language not intended to label or stigmatise. However, within the majority of this thesis the term harmful sexual behaviour (HSB) is used as this is the language most frequently used in current literature and practice, and this also reflects that many of the young people within studies will not have been convicted of an offence and so could not be referred to as ASOs.

There has also been a welcome move away from stigmatising language relating to more general offending by children and adolescents, and this thesis will avoid the use of terms such as 'young offenders' and 'juvenile delinquents', instead using the term justice-involved youth.

Prevalence

It is difficult to estimate the scale of HSB as it is well recognised that incidents of sexual harm can go unreported or be impacted by delayed disclosure for a variety of reasons (Campbell et al., 2020). As such, there are currently no agreed official figures for the prevalence of adolescent HSB, although a widely accepted estimate is that around 30-50% of childhood sexual abuse relates to HSB by a young person under the age of 18 (Campbell et al., 2020; NSPCC, 2021).

Whilst it is acknowledged that females display harmful sexual behaviours, research estimates that between 90% and 97% of young people who display HSB are male, with the onset of the behaviour most likely to be during early adolescence (Finklehor et al., 2009;

Hackett et al., 2016). Young people who have displayed harmful sexual behaviours are recognised as a heterogenous group (McCuish & Lussier, 2017) with research ongoing to advance understanding of these young people. Research and clinical practice continue to consider how to prevent harmful sexual behaviour and how to respond after occurrence, in the hope of providing these young people with the necessary support and prevent further victims.

1.3 Adverse Childhood Experiences

Felliti et al.'s (1998) Adverse Childhood Experiences (ACEs) framework provides a well-recognised conceptualisation for understanding the detrimental outcomes of early adversity. Within the framework ACEs are defined as, "*stressful or traumatic events, including abuse and neglect, that negatively impact a child's emotional, mental, and physical well-being*" (Felitti et al., 1998; p. 445). Felliti et al.'s ACEs framework is a 10 item scale with the identified ACEs reliably linked to negative outcomes in terms of physical and mental health, with additional detrimental outcomes such as financial stability and general life opportunities (Boullier & Blair, 2018). It is important to highlight that the ACEs framework was originally developed to explore health outcomes in adults as opposed to focussing on impact during adolescence (whilst still effectively in 'childhood').

There is compelling evidence which demonstrates that children experiencing early adversity have increased vulnerability to polyvictimisation (Alexander et al., 2021; Grady, Levenson & Bolder, 2017; Finklehor et al., 2005; 2011). Polyvictimisation is defined as "*the experience of multiple types of victimisation*" (Harrelson et al., 2017, p. 626). Polyvictimisation has been reported to be associated with increased impact on psychological adjustment following the adverse/harmful experiences (Finklehor et al., 2007, 2009).

As the understanding of early adversity has increased, there has begun to be consideration of additional experiences which could constitute adversity, such as poverty, racism and bullying (Firmin, 2015; 2017; Thomsen et al., 2023). Additionally, with the impact of ACEs now well established, research has begun to explore factors which may be associated with differences in the effects of adversity (Ohashi et al., 2019).

Links between ACEs and offending behaviour have long been established within research, and there is evidence that the association between early adversity and offending is more evident for young people who have displayed harmful sexual behaviour (DeLisi et al., 2017; Levenson et al., 2017; Ogilvie et al., 2022; Thomsen et al., 2023). Further, young people who have displayed harmful sexual behaviour have been found to have increased rates of polyvictimisation when compared to other justice-involved youth (DeLisi et al., 2017; Harrelson et al., 2017).

Whilst the association between ACEs and offending behaviour is well established, it is important to highlight that the majority of young people who experience adversity do not go on to be involved in offending behaviour (Hurren et al.,2017; Malvaso et al., 2017). It is therefore essential that research and clinical practice continues to explore the factors that increase risk of offending behaviour in young people with ACEs, but also to consider protective factors that may buffer the impact for those whose trajectory does not involve criminal behaviours or behaviours that harm others (Baglivio et al., 2014; De Vries Robbé et al., 2015; Hackett et al., 2022; Malvaso, 2021).

1.4 Trauma

As there is growing understanding and increased interest in trauma and the impact of trauma, defining the terms becomes more complex (Isobel, 2021). A holistic and well used definition was provided by Substance Abuse and Mental Health Services Administration (SAMHSA), *"Individual trauma results from an event, series of events or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has long lasting adverse effects on the individual's functioning and mental, social, emotional or spiritual wellbeing".* (SAMHSA], 2013, p. 7).

Difficulties in conceptualising trauma include the varied events and experiences which could be traumatic and the potential differing individual responses to these events and experiences. There has been increased interest in interpersonal or relational trauma which it appears can be distinguished clinically from other forms of trauma, such as single event trauma (Herman, 1992; Siegal, 2001; Van der Kolk, 2014).

To distinguish early developmental and cumulative trauma, the term 'complex trauma' is typically used (Herman, 1997). Complex trauma refers to multiple traumas, usually beginning in early childhood, but potentially continuing across the lifespan, and includes experiences such as neglect, domestic violence, physical, emotional, or sexual abuse (Herman, 1992;1997; Kisiel et al., 2013; Lawson & Quinn, 2013). Studies have identified that young people exposed to complex trauma are at risk of developing mental health problems, including symptoms of Post-Traumatic Stress Disorder (Briere, 1996; Dierkhising et al., 2013; Liddel et al., 2016). There is evidence that justice-involved individuals are more likely to have experienced complex trauma than the general population (Giarranto et al., 2020).

There has been significant discussion in the literature relating to the impact of trauma on neurodevelopmental, social, and emotional functioning, with complex trauma being reported as a transdiagnostic risk factor associated with impairment in a range of areas of functioning (McLaughlin et al., 2020; Perry, 2001). Furthermore, the adolescent brain has been found to be particularly sensitive to the neurobiological impact of trauma due to the critical stage of brain and body development (Creedon, 2009; Sharma et al., 2013).

Whilst research has demonstrated that trauma appears to be a key factor linking ACEs to heightened risk of offending behaviour (Abram et al., 2004, Grady et al., 2017, Malvaso & Day, 2016) it is important to also highlight that the link appears correlational as opposed to causal, and all individuals with high ACEs cannot be assumed to be traumatised, highlighting that it is crucial to distinguish between ACEs and trauma. Moreover, all individuals that are traumatised do not go on to be involved in offending behaviour (Finklehor, 2018; Malvaso, 2021).

1.5 Attachment

Attachment theory posits that early relational experiences have a significant influence on a child's development, with the potential to impact across the life course (Bowlby, 1969;1982; Benoit, 2004). Bowlby (1988) asserted, "*The propensity to make strong emotional bonds to particular individuals is a basic component of human nature*" (p.3). According to attachment theory, if children do not experience consistent, predictable, and nurturing care they will develop an insecure attachment style (Bowlby 1977; 1988, Shilkret & Shilkret, 2011). Furthermore, there is overwhelming evidence that those with insecure attachments have a range of psycho-social deficits, many of which are associated with offending behaviour (Felizzi, 2015; Irons et al., 2006; Savage, 2014).

Relational trauma including abuse and neglect from caregivers can leave children with feelings of betrayal, rejection, and of not being protected, all of which has clear potential to disrupt attachment formation (Bowlby, 1973; Burk & Burkhart, 2003; Harrelson, et al., 2017). As such, a failure of the caregiver to meet the child's needs for safety and protection can be viewed as causing disrupted attachments, resulting in children who struggle to trust and regulate their emotions (Main, 2000). Polyvictimisation has been found to be associated with attachment disruption (Cohen at al., 2021; Harrelson, 2017) as the child repeatedly experiences unmet needs, harm, and a lack of protection from caregivers which illustrates the benefit of viewing adversity and complex trauma through an attachment lens.

Decades of research has identified links between insecure or disrupted attachments and offending behaviour in children and young people. Bowlby's early work, '44 Thieves' highlights the impact of what he referred to as 'maternal deprivation', which he linked to the criminal behaviour of the children. Winnicott (1973) posited that the 'delinquent child' was seeking a sense of secure holding which was lacking in their family and/or from society. For Winnicott the criminal behaviour was viewed as a sign of the child's distress, fuelled by a sense of loss of self in the context of unmet care needs and ruptured family relationships.

More recent research had identified a correlation between insecure attachment and sexual offending in both adolescent and adulthood (Beech & Mitchell, 2005; Grady, Levenson & Bolder, 2017; Mitchell & Beech, 2011). Grady, Levenson & Bolder (2017) proposed an integrated model of sexual offending which links childhood adversity to insecure

attachments, which the authors suggest increase vulnerability to developing the criminological needs which underpin sexual offending behaviour.

1.6 Sexual Harm Prevention

In the context of the well documented evidence of the psychological, social, and even financial implications of sexual harm, there is growing interest in a shift from a purely criminal justice response to a public health approach to sexual abuse prevention (McCartan, Kemshall, & Tabachnick, 2015; McCarten et al., 2018; WHO, 2022).

A public health approach to sexual harm prevention, incorporating a multidisciplinary response has been proposed, aimed to prevent offending and re-offending and mitigate the impact where harm has occurred (McCarten, 2021). A public health approach is often based on a three-stage response of *primary, secondary, and tertiary* prevention (Laws, 2000; Smallbone et al., 2008), however McCarten (2021) suggested a fourth level of *quaternary* prevention as outlined below:

- Primary prevention - a more general and typically educative approach to prevent sexual harm taking place, with no specific individual or group targeted.
- Secondary prevention – an approach aimed to target those considered to have increased vulnerability sexual harm, or 'at risk' of displaying harmful sexual behaviour.
- Tertiary prevention – an approach targeted to those that have caused sexual harm such as support and interventions, aimed to reduce the likelihood of further sexual harm.
- Quaternary prevention – an approach targeted to those that have caused sexual harm with a focus on desistence and community (re)-integration.

1.7 Overview of Thesis

The aim of this thesis is to advance the evidence base relating to associations between experiences of adversity, trauma, and attachment disruption, and adolescent harmful sexual behaviour. It is hoped that each chapter, will enhance understanding of this group of young people, to support the development of trauma informed responses, with the overall aim of preventing sexual (re) offending.

Following this introduction chapter, chapter two contains a qualitative systematic review, undertaken as a qualitative evidence synthesis (QES) using thematic analysis methodology. The QES explores the attachment experiences of adolescents who have displayed harmful sexual behaviours, with a focus on the voices and lived experiences of the young people.

The aim of chapter two is to add depth of understating through synthesising qualitative research in this area.

The empirical research study in chapter three involves statistical analysis of a dataset with information pertaining to the life experiences and offence detail of a sample (N=43) of acescents serving a custodial sentence for a sexual offence. The study investigates the prevalence and type of adversity within the sample, with analysis of associations with offence detail.

Chapter four outlines a qualitative research study which explores the narratives of a sample (N=6) of adolescents serving a custodial sentence for a sexual offence. The study involved analysis of interviews using Interpretive Phenomenological Analysis (IPA), in addition to interpretation of psychometric assessment completed by participants. Four super-ordinate themes are outlined, providing rich, idiographic data with the perspectives of the young people central to this study.

A psychometric critique follows in chapter five, providing an overview and critique of the Trauma Symptom Checklist for Children (TSCC; Briere, 1996). This includes a summary of the psychometric properties and clinical utility of the TSCC, with specific reference to the use of the tool within a youth custody environment.

The thesis concludes with chapter six, within which a summary of each chapter is presented, drawing together the findings, in the context of the wider research base. This chapter consider implications for future research and clinical practice, with reference to a public health approach to sexual abuse prevention.

2. CHAPTER TWO: SYSTEMATIC REVIEW

Attachment Experiences of Adolescents who have Displayed Harmful Sexual Behaviours: A Qualitative Evidence Synthesis of the Narratives of the Young People

2.1 Abstract

This qualitative evidence synthesis (QES) explored the narratives of attachment experiences from adolescents who have displayed harmful sexual behaviour (HSB). This QES aims to add depth to the existing research base pertaining to adversity and attachment disruption in the developmental histories of justice-involved youth, and specifically young people who have displayed HSB. A systematic review was conducted of seven qualitative studies that met the criteria for inclusion, from 603 screened citations. Thematic synthesis was used to synthesise the results of the qualitative studies to explore the narratives of the young people within these studies. Four key themes were elicited, *Paternal Relationships; Maternal Relationships; Broken Attachments; Links to Harmful Sexual Behaviour*. The findings of the QES overwhelmingly revealed a range of detrimental experiences which had disrupted the attachment formation of these young people, with depth and richness in the data from the voices and lived experiences of the adolescents. Implications for clinical practice are considered.

2.2 Introduction

A relationship between attachment difficulties and criminal behaviour is well documented within research, including in the early work of John Bowlby in his study of '44 juvenile thieves' (Bowlby, 1944). Attachment theory has since been used to provide a number of ways in which sexual offending can be understood (Beech & Mitchell, 2005; Rich, 2006; Grady et al., 2017; Grady & Shields, 2018). Bowlby (1973) postulated that the development of relationships is heavily influenced by early attachment experiences which create an internal working model, shaping the way in which an individual views themselves, others, and the world, thus creating expectations of interactions and relationships with others (Bowlby 1969;1982; Bretherton, 2013).

In the context of the longstanding interest in associations between attachment experiences and sexual offending, there is now a compelling research base linking attachment disruption, and insecure attachment with adolescent sexual offending (Grady et al., 2018; Yoder et al., 2020). With evidence to support this association between attachment styles, attachment disruption and harmful sexual behaviour (Burk & Burkhart, 2003; Grady et al., 2018), there has been a shift to explore the reasons for an association. For example, Marshall & Marshall (2010) postulated, "*Unsatisfactory attachments between parent and child poorly equip the child to develop the skills, self-confidence and*

confidence in others necessary for them to develop effective relationships" (p.78), with these deficits being hypothesised as being related to harmful sexual behaviours.

Other factors which have been suggested to assist in understanding an association between attachment and sexual offending are reductions in empathic capacity because of insecure attachment, heightened emotional dysregulation, and increased risk of developing a coercive interpersonal style (Baker, Beech & Tyson, 2006; Shilkret & Shilkret, 2011; Smallbone, 2006).

Grady et al. (2017) have developed an integrated theory which proposes that adverse childhood experiences (ACEs) have the potential to impair the development of secure attachments, which in turn can create vulnerability to criminogenic needs that are related to sexual offending behaviours. The development of this model and the ongoing research relating to associations between attachment disruption and harmful sexual behaviour evidences the extent of interest from both a research and clinical perspective.

There is increasing recognition of the contribution of qualitative research in the field of health and social care (Booth, 2016; Thomas & Harden, 2008), with acknowledgement of the need to explore the lived experience of adolescents and those that have displayed harmful sexual behaviours (Garret, 2010; Somerville & Lambie, 2009). The relative increase in qualitative research relating to adolescent harmful sexual behaviour (HSB) is in the context of the previously recognised dearth of qualitative research methods in this area (Hackett et al., 2006). Hackett et al. (2006) suggested that qualitative research may have been lacking due to an outdated assumption that young people who have displayed HSB may be unreliable and therefore would not contribute honestly and openly to the research base. As the value of involvement of children and their families is now increasingly recognised, and young people taking part in research is viewed as essential within a children's rights framework, the importance of qualitative research in this area cannot be overstated. Indeed, it could be argued that advancements in this field of research and clinical practice cannot take place without the voices of those involved in, and impacted by, this behaviour.

Aims of this Qualitative Synthesis

In the context of the growing but still limited qualitative research base in the field of adolescent harmful sexual behaviour (Campbell et al., 2020; Hackett et al., 2022) this synthesis aims to add to the developing qualitative research base. Previous research has evidenced that attachment disruption is prevalent in the developmental histories of justice-involved youth, and specifically in the life experiences of adolescents who have displayed harmful sexual behaviour (Burk & Burkhart, 2003; Harrelson et al, 2017; Levenson et al., 2017;). As such, it is hoped that this review of qualitative literature can

provide insight into this issue from the perspective of the young people, moving beyond 'what' is relevant to consider for these young people, into 'why'.

Research Questions

What are the perspectives of adolescents who have displayed harmful sexual behaviour in relation to their attachment experiences?

How can these attachment experiences assist in understanding the harmful sexual behaviour displayed by the young people?

2.3 Method

This study used qualitative evidence synthesis (QES) methodology, following recognised principles of systematic reviews in which data is sourced and synthesised through transparent explicit methods (Fleming & Noyes, 2021; Gough, Thomas & Oliver, 2012). A QES was adopted as the chosen methodology as this study "*aims to make a conceptual and interpretive contribution*" (Booth 2016, p.6) to the research base pertaining to attachment experiences in adolescent that have displayed harmful sexual behaviour.

QES is also an appropriate methodology due to the limited qualitative research base in this area of interest. Booth (2016) argues that it is not the intention of a QES to identify all literature on a specific subject, rather the aim is the "*identification of papers with relevant characteristics relevant to the phenomenon being studied not statistical representativeness*" (p.6). There is debate in the literature in terms of how many studies to include in a QES. Booth (2016) recommends a "*preferred number of between six and 14 studies*" for a QES (p.7)

Data synthesis was undertaken using thematic synthesis, a method established to analyse qualitative data (Braun & Clarke, 2006; Thomas and Harden, 2008). This method of analysis was chosen in part due to the epistemological stance of critical realism which is tentatively associated with this method (Barnett-Page & Thomas, 2009). This allows a synthesis that "*stays close*" to the original researcher's analysis (Thomas & Harden, 2008, p.1) whilst the review also synthesises the multiple analyses of the included studies to increase the depth of understanding in the phenomena of interest. Additionally, it was intended that this QES would have clinical relevance and thematic synthesis is a method which allows findings to be produced which are accessible to a range of professionals in clinical practice, and those concerned with policy development (Booth, 2018).

Critical realism was identified as the appropriate epistemological perspective as the aim of the review is to elicit the perspectives of the young people within the studies, with the understanding that their values, beliefs, and experiences shape their perception, and therefore shape their 'reality' in terms of their attachment experiences.

Search Strategy

This review was deemed to require a comprehensive approach to searching due to the small number of qualitative studies anticipated following an initial scoping review (Booth, 2016). Search terms were refined during the scoping review.

To identify relevant papers for the QES, a search of the following electronic databases was conducted in September 2023: PsychInfo, Embase, Medline, Web of Science, Scopus, and CINAHL.

The initial search strategy had three strands. The first was to capture data relating to adolescents, the second to capture data relating to harmful sexual behaviour, and the third to capture data pertaining to attachment. An example search conducted on PsychInfo is provided as Appendix 1.

Due to the small research base and the intention to capture the voice of the young people within this review, a range of qualitative data was eligible for inclusion, including interviews, focus groups, and case studies with qualitative analysis. Studies were screened for study type at title and abstract screening stage, and further at full text review for those where methodology was not clear in the previous stage. No limitations were applied during database searches to ensure that all relevant literature was included.

Booth (2016) postulated that publication bias is a lesser issue within qualitative research, however inclusion of grey literature including dissertations and thesis is recommended in qualitative synthesis. Theses and dissertations accessed via Web of Science were included in the review, and an additional grey literature search was undertaken using Google Scholar and websites for the National Society for the Prevention of Cruelty to Children (NSPCC) and Children and Young People's Centre for Justice (CYCJ).

Following electronic database searching, handsearching of bibliographies of relevant studies was undertaken and the author of two studies included in the final review (Dr Bartosz Zaniewski) was contacted via email to enquire as to whether he was aware of any additional research not included in his publication. Further studies were identified following hand-searching, but none were identified through contact with Dr Zaniewski.

Table 2.1.
Study Inclusion and Exclusion Criteria

Inclusion	Exclusion
Young people who have displayed HSB	Adults with sexual offences
	Literature relating to victims of sexual abuse
Studies that include qualitative method of data collection and/or data analysis, including mixed methods	Quantitative research
Studies that include original research data	Systematic reviews, editorials and book reviews

Study Screening

The results from the electronic databases searches were imported to Endnote X9 reference management software which allowed all references to be amalgamated and de-duplicated. All references were then imported to Rayyan, for screening, and to allow results to be shared with co-reviewers.

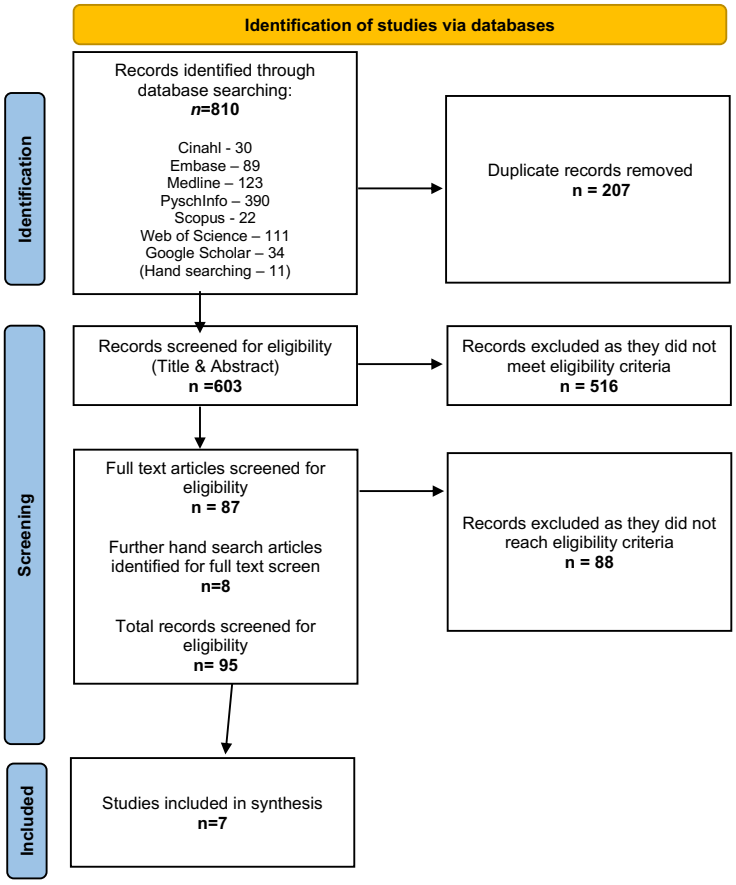
Study screening began with screening of titles and abstracts to exclude studies that did not meet the inclusion criteria. Two peer reviewers (an assistant psychologist and a clinical psychologist in training) independently screened approximately 20% of the titles and abstracts. Where there was disagreement in terms of study inclusion, discussion took place and consensus was reached in terms of which studies were included in the next stage of screening.

Full text screening then took place to identify studies that would be included in the review. At this stage, approximately 20% of references were allocated to the same independent peer reviewers with discussion relating to any conflict in decisions, and consensus reached about final study inclusion.

As outlined as best practice within systematic reviews, the Preferred Reporting Items for Systematic Reviews (PRISMA) flow diagram was completed to record the study screening process (Moher et al., 2008; Page at al., 2020). The PRISMA flow diagram is provided below as Figure 2.1.

Figure 2.1

PRISMA Diagram



Data Extraction

There was a two-stage approach to data extraction as identified within the method of thematic synthesis (Thomas & Harden, 2008). A data extraction sheet (DES) was developed and used to systematically extract relevant data from the studies included in the QES following full-test review (Noyes et al, 2018). In accordance with Cochrane guidance the information from the DES is outlined in Table 2.2. (Table of Included Studies).

The second stage of data extraction was to extract the results of included studies to allow the data to be coded, analysed, and synthesised (Fleming & Noyes, 2021). This QES included data contained within the 'results' or 'findings' sections of the papers. This included raw data from study participants and also included author analysis if this was contained in the 'results or findings' sections. Data from the 'discussion' section was not utilised within this QES. Data was coded using EPPI-Reviewer software, followed by manual analysis and synthesis.

Line-by-line coding of the data was undertaken using EPPI-Reviewer to create descriptive themes (Thomas and Harden, 2008). Following the creation of 29 descriptive themes,

analytic themes were then developed to take the review beyond simply describing the study results and moving into analysis of the rich qualitative data to answer the review questions. This is in line with a fundamental principle of a QES which is the researcher "*going beyond"* descriptive study findings to develop novel analytic findings (Thomas & Harden, 2008, p.7).

Quality Assessment

The Critical Appraisal Skills Programme (CASP, 2017) tool was used for quality appraisal of the seven studies included in the review. CASP is reported to be the quality assessment tool most frequently used within qualitative systematic reviews (Hannes & Macatitis, 2012). Critical appraisal was applied post hoc and considered study design, ethical considerations and rigour in data collection and analysis (see Table 2.3). No papers were excluded based on quality assessment due to the limited data available for this QES, however the assessed methodological quality contributed to the confidence in the data used to develop themes (Noyes & Lewin, 2011).

Reflexivity

It is important to explore researcher reflexivity in qualitative research~~,~~ to include consideration of critical self-reflection throughout the process (Berger 2015). The use of a reflective journal and discussion within clinical and research supervision supported in maintaining a reflexive stance in data collection and analysis.

2.4 Results

Following de-duplication of initial results, the search generated 603 citations of which 87 were eligible for inclusion following title and abstract screening. A further 8 studies were identified through hand-searching of bibliographies, which meant 95 studies progressed to full text review. A further 88 studies were excluded through full text review on the basis of the pre-defined inclusion criteria. The QES included seven papers, the characteristics of which are outlined in Table 2.2 followed by critical appraisal of methodological quality in Table 2.3.

The included studies were published between 2005 and 2023, with the research taking place in the UK, USA, and Sweden. All studies used interviews to gather qualitative data, with four also administering psychometric measures within the study. Although the psychometric data is likely to have influenced researcher analysis, this data was not directly used within this QES.

Although three studies (Vincent, 2010; Zaniewski et al., 2020; Zaniewski et al., 2023) included accounts of mothers, as the narratives of parents was not a focus of this review data from parents was excluded from the analysis. However, as practitioner perceptions and analysis were included, this would undoubtedly have been influenced by the

information from the young people's mothers and so to some extent this is likely to have been captured within the synthesised data.

Two papers (Zaniewski et al., 2020; Zaniewski et al. 2023) were based on the same study sample, however they have been included as two studies as there was different data contained within each paper.

One study (Reis, 2015) contributed less to the findings. This was due in part to being a mixed methods study and so there was focus on quantitative findings in addition to the qualitative element. Additionally, this study, undertaken with young people in residential care, explored participants perceptions of a VCO ('very close other') which was identified as a member of care staff for the majority of participants (n=11), with a parent chosen by only three of the 12 participants (alongside a staff member) As such, the narratives of the participants did not necessarily relate to early attachment experiences, but rather their current relationship with people identified as a VCO.

Table 2.2

Included Studies

Author (year)	Title	Geographical location	Study setting	Sample size	Sample age range	Sample ethnicity	Data collection method	Analytic method
Gerhard-Burnham, Underwood, Speck, Merino & Crump (2016)	The Lived experience of the adolescent sex offender: A phenomenological case study	USA	Secure treatment programme	4	14-15	Hispanic (1) Caucasian (2) African-American/Hispanic (1)	Semi-structured interviews	Phenomenological case study
Reis (2015)	Exploring the attachment style of sex offenders	UK	Community	12	12-19	White British (91%) Black (3%) Asian (3%) Mixed race (3%)	Semi-structured interviews Psychometric measures	Framework approach
Thurston (2005)	An exploration of family interactions and male juvenile sexual offending: A qualitative study	USA	Outpatient therapy clinic	20	13-17	Caucasian (14) African-American (2) Hispanic (2) Caucasian/African-American (1) Caucasian/Hispanic (1)	Semi-structured interviews	Thematic analysis
Tidefors & Skillback (2014)	The picture of me: Narratives about childhood and early adolescence	Sweden	Institutional care	13	14-19	Not clear (refence to whether parent was born in	Semi-structured interviews	Thematic Analysis

	by boys who have sexually abused peers					Sweden rather than ethnicity of participant)		
Vincent (2010)	Case studies on the attachment origins of adolescent sexual offending	USA	Community	4	12-18	Not reported	Semi-structured interviews Psychometric measures	Pragmatic Case Study (PCS)
Zaniewski, Dallos, Stedman & Welbourne (2020)	An exploration of attachment and trauma in young men who have engaged in harmful sexual behaviour	UK	Community	8	14-17	White British	Semi-structed interviews Psychometric measures	Critical Discourse Analysis (CDA)
Zaniewski, Dallos, Stedman & Welbourne (2023)	Boys don't cry: Trauma, trauma masculine practice among young males who engaged in harmful sexual behaviour narrative and	UK	Community	8	14-17	White British	Semi-structured interviews Psychometric measures	Critical Discourse Analysis (CDA)

Table 2.3

Critical Appraisal (CASP)

Study	Statement of aims?	Appropriate methodology?	Appropriate design?	Appropriate research strategy?	Appropriate data collection?	Considered researcher & participant relationship?	Considered ethical issues?	Rigorous data analysis?	Clear statement of findings?	Valuable research?
1.	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
2.	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
3.	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
4.	Yes	Yes	Yes	Yes	Can't tell	Can't tell	Yes	Can't tell	Yes	Yes
5.	Yes	Yes	Yes	Yes	Yes	Can't tell	Yes	Yes	Yes	Yes
6.	Yes	Yes	Yes	Can't tell	Yes	Can't tell	Yes	Yes	Yes	Yes
7.	Yes	Yes	Yes	Can't tell	Yes	Can't tell	Yes	Yes	Yes	Yes

1-Gerhard-Burnham et al. (2016); 2- Reis (2015); 3- Thurston (2005); 4-Tidefors & Skillback (2014); 5- Vincent (2010); 6- Zaniewski et al. (2020); 7- Zaniewski et al. (2023)

As is congruent with thematic synthesis methodology, analytical themes were created through a process of identifying overt and inferred connections between related phenomena within the data (Thomas & Harden 2008). No data was privileged, and coded data included in analytical themes included the perspectives of both study participants and authors.

In total 29 descriptive themes were identified, which highlights the varied content of the studies (see Table 8.2, provided as Appendix 2). In the second stage of analysis these descriptive themes were explored in more depth to create analytical themes. Four major analytical themes were elicited, which captured the perspective of the young people in relation to their attachment experiences, *paternal relationships; maternal relationships; broken attachments; links to harmful sexual behaviours*. Within each major theme, sub-themes were created to allow in depth analysis of the rich data available in the studies. The contribution of each study to the themes is provided are provided in Table 2.4.

Table 2.4

Study Contribution to Themes

Theme	**Gerard-Burnham et al. (2016)**	**Reis (2015)**	**Thurston (2005)**	**Tidefors & Skillback (2014)**	**Vincent (2010)**	**Zaniewski et al. (2020)**	**Zaniewski et al. (2023)**
Paternal Relationships	√		√	√	√	√	√
Violent Fathers	√		√	√	√	√	√
Absent Fathers	√		√	√	√	√	√
Fear of Father			√		√		
Positive Fathers				√	√		
Maternal Relationships	√		√	√	√	√	√
Positive Mothers	√		√	√	√	√	
Negative Mothers	√		√			√	
Emotionless Care	√		√	√	√	√	√

Broken Attachments	√	√	√	√	√	√	√
Loss	√			√	√		√
Rejection	√	√	√	√	√	√	√
Trust		√			√	√	√
Links to Harmful Sexual Behaviours	√	√	√	√	√	√	√
Anger	√		√	√	√	√	√
Toughness			√	√	√	√	√
Troublemaker				√		√	
Emotional Dysregulation	√	√	√	√	√	√	√

Theme 1: Paternal Relationships

A strong theme elicited related to the relationship between the young people and their fathers. Six of the seven studies (Gerhard-Burnham et al., 2016; Thurston, 2005; Tidefors & Skillback, 2014; Vincent, 2010; Zaniewski at al., 2020; Zaniewski et al., 2023) revealed some form of difficulty in the young people's relationships with their father, with this being a key theme within some studies, as exemplified in the excerpt below:

> *"None of the participants (n=O, 0%) viewed their paternal relationships as good or nurturing."* (Thurston, 2010, p. 107)

Since the inception of Bowlby's attachment theory, there has often been focus on attachments to 'primary caregiver', often the child's mother, arguably to the detriment of considering the importance and relevance of attachment to fathers. What this theme identifies is that six studies identified difficulties and disruption in relationships between participants and their fathers with abandonment and harm both common features as highlighted by Tidefors & Skillback (2014):

> *"Pictures of fathers being cruel in an active manner were also present. Some told of a father who either was absent, did not care or was abusive. Fatherhood seemed to be associated with violence and abuse" (p.58)*

This theme was so prevalent that four subthemes were created to reflect the difficulties in relationship with fathers, *violent fathers; absent fathers; fear of father*. To ensure balance,

a final subtheme was identified, *positive fathers* which, whilst less evident, highlights examples of more positive child-father relationships.

Violent Fathers

This subtheme was present within six studies (Gerhard-Burnham et al., 2016; Thurston, 2005; Tidefors & Skillback, 2014; Vincent, 2010; Zaniewski at al., 2020; Zaniewski et al., 2023), highlighting participants experiences of both domestic abuse within paternal relationships, and the young people being the direct victim of aggression and physical harm from their father (and in some cases, also from subsequent father figures). This provides insight not only in terms of the impact of violence on attachment formation, but also in terms of the male 'role models' these young people had during their early years.

A prominent theme within the studies was violence from fathers to mothers exemplified by Gerhard-Burnham et al. (2016) who explained that in their study domestic abuse most commonly featured, *"father figures being verbally and physically abusive to participants' mothers*" (p.103). Violence was described by participants as frequent and / or extreme, such as in the following accounts provided by young people:

> *"Dad'll mostly yell, especially when he's drunk ... he'll just start yellin' and cussin' and throwin' things at ya. [frustrated] He was always beating up on my mom when I was little. Like, when we was little, I remember they was always fightin ' really loud. Once Dad pulled her by the hair and pulled her down the hallway. She was kickin' and screamin', beggin' him to get off of her. We was all hiding crouched down in the living room scared and cryin' [excited tone, angry]'.*
> (Thurston, 2005, p.116)

> *"When my mom was married before, he was very abusive to her .... Yea, I hated him. He had an anger problem and once he took my mom against the wall and threw her legs over her head and then after a while my mom pulled a knife on him for defense till the police came. It was pretty scary. [excited tone, raising hands]'.*
> (Thurston, 2005, p.110)

> *"Aggressive, because he, he gets like, like he just starts hitting people actually, it's kind of like the mean example, for like something he could just work it out on himself. The example is like, he, he, he was looking for his pills and like my stepmom, he asked her where are my pills and she didn't know and he just started grabbing and hitting her for that."*
> (Vincent, 2010, p.124)

There were examples of participants beginning to make sense of the impact of experiencing domestic abuse, with some, such as the participants below, beginning to consider links to their own harmful behaviour:

> *"I think that, like, my parents always fighting may have led to my offense. I mean, I'm totally responsible for my choice, but in counseling I learned that I have emotions from my family and their fighting always made me feel bad and stuff. I was always angry and looking to take it out on something. Plus, I didn't feel real good about myself. [sad, looking down]'.*
> (Thurston 2005, p.138)

Accounts of being physically abused by fathers also included examples of high frequency and high severity aggression.

> *"Dad used to beat me. Once, I was four and he told me not to touch something and I didn't obey ... [he] hit me on my back so I had bruises".*
>
> *"He was firm .. . harsh and egoistic. ... I wasn't used to getting beaten, but he beat us a lot. He used a lot of violence .. . It was almost like men were supposed to use more violence than women. He was quiet; never said anything about mum."*
> (Tidefors & Skillback, 2014, p.58)

Zaniewski et al, (2023) noted a normalising or perhaps even dismissive element to participants narratives of physical abuse and domestic violence, perhaps indicating that for some young people it was intolerable to place themselves in a position of vulnerability when speaking about their experiences of harm from their father.

> *"Journalistic and dry narrative was also evident in Noah description of domestic abuse and physical abuse from his father. … I tried to open the door, caught a seat-belt half undone and he grabbed it around my neck and pulled me back to the car. And that's why I hate him for that for what he is like and what he's done. But we had ups and downs say. And we do have laugh and giggles…"*
>
> "Noah talked about volatile relationship with his mother and a physical abuse from his father, but he concluded: …they never hurt my feeling… "
> (Zaniewski et al., 2023, p.14)

Fear of Fathers

Unsurprisingly, in the context of narratives of families characterised by violence from fathers, there were examples of participants describing memories of being fearful of their fathers:

> *"We was all hiding crouched down in the living room scared and cryin' . [excited tone, angry]"*
> (Thurston, 2005, p.116)
>
> *"My dad would hit me in the head if I smack my food or talk with my mouth full. After dinner we watch TV if I can stop myself from talking. My dad would tell me all the time, Shut up or go to your room!" .... [yelling] Yea, I'm afraid of my dad. He acts like he hates me and I'm always screwing up". [tearful]*
> (Thurston 2005, p.108)

The accounts of the young people demonstrate not only what they had been exposed to, but the impact on them in terms of a fearful existence during their childhoods. These accounts add a depth to the existing understanding of the impact of domestic abuse on children, when it is considered that for these children a person that should have been a source of care, was in fact a source of fear.

Absent Fathers

This subtheme was strongly present in six studies (Gerhard-Burnham et al., 2016; Thurston, 2005; Tidefors & Skillback, 2014; Vincent, 2010; Zaniewski at al., 2020; Zaniewski et al., 2023) and includes young people's accounts of separation, loss, rejection, and abandonment specifically in relation to their fathers. Author analysis identified the absence of fathers as having a profound impact on the young people as highlighted by the comments below:

> *"The most significant common experience expressed to the researcher was an intense, deeply felt personal loss of their father figures through death or abandonment…The absence of a responsible father figure was devastating".*
> (Gerhard-Burnham et al., 2016, p.100)

> *"Underneath the façade of bravado appeared to be a deep sense of rejection and being a victim. Regarding his father, he said he felt:" "Upset for the fact that he chose his marriage over me (…) his flesh and blood."*
> (Zaniewski et al., 2020 p.414)

As highlighted within the above quotes of researcher analysis, this subtheme, provides further evidence of the use of masking by some young people, with the use of 'bravado' to cover the likely painful impact of perceived paternal rejection.

Positive Fathers

There were fewer accounts of positive relationships with fathers within the studies, however two studies (Tidefors & Skillback, 2014; Vincent, 2010) did contain examples of positive recollections of fathers / father figures as outlined in the excerpt below:

> *"It was completely different. Um, he was always the fun or funny one. He had his times where he was kinda, where mom would have to tell him to punish me, but he, I don't know how to explain it, he seemed normal. It seemed like a normal relationship between me and him than it did with my mom."*
> (Vincent, 2010, p. 153)

Whilst the comments relating to positive paternal relationships were less prevalent within the accounts of the young people, the presence, albeit limited of this subtheme is important to consider as research begins to consider positive childhood experiences and the extent to which these may buffer the impact of adverse childhood experiences. This is of relevance here when specifically considering the attachment experiences of these young people as the presence of a positive male caregiver may go some way to reduce the internalised sense of males as harmful or abandoning as evidenced in the previous subthemes.

Theme 2: Maternal Relationships

The second key theme relates to the young people's relationship with their mothers which identified much more nuanced and varied narratives of participants experiences of maternal relationships. Studies detailed more positive references to mothers when compared to comments about fathers, however there was also evidence of fractured, harmful, and complex relationships with mothers.

Subthemes of *positive mothers, negative mothers* and *emotionless care* were elicited from the six studies that contributed to this theme (Gerhard-Burnham et al., 2016; Thurston, 2005; Tidefors & Skillback, 2014; Vincent, 2010; Zaniewski at al., 2020).

Positive Mothers

There was specific reference to positive relationships with mothers within four studies (Gerhard-Burnham et al., 2016; Thurston, 2005; Tidefors & Skillback, 2014; Vincent, 2010; Zaniewski at al., 2020). This was explicitly explored by Thurston (2005) as reported in the following excerpt:

> *"The majority of the participants (n=14, 70%) described their relationships with their mothers as positive."*
> (Thurston, 2005, p.105)

Rather than simply labelling relationships with mothers as positive, narratives provided insight into what the young people viewed as positive attributes relationships, with heavy focus on aspects of care and nurture. Also present in a number of accounts was refence to material benefits such as being bought things by mothers. Also, of note was occasional comparisons to more negative relationships with fathers, suggesting that it was within this dyad that mothers were spoken of with comparative positivity.

> *"My mom is awesome. She buys me lots of things and gives me money when I need it".*
>
> *"My mom's great. We get along good .... She's usually the one who takes care of me and makes me feel good when I'm down".*
>
> *"My mom's very sweet, very Christian. Believes in everyone. My mom's a hard worker, unlike my dad".*
> (Thurston, 2005, p.105)
>
> *"When asked to recall memories describing their mothers, some could remember when mother was caring and loving."*
> *"I did get candy kind of quite often, and that sort of things. And I guess I didn't get grounded as much as some kids did".*
> (Tidefors & Skillback 2014, p.58)

There was also evidence of some young people experiencing their mother's care as perhaps going some way to buffer the impact of other more negative family experiences, which again provides insight into the potential relevance of positive childhood experiences occurring alongside adverse childhood experiences.

> *"We're very loving and affectionate, especially my mom. She gives lots of hugs. Tries to make us feel better when dad was mean. [calm, nonchalant tone] "*
> (Thurston, 2005, p.112)

> *"Kind, because she is really nice to me. And so, I remember when she got really mad at her boyfriend and I was like annoying her and she didn't take her anger out on me."*
> (Vincent, 2010, p.124)

Negative Mothers

There were fewer accounts which directly referenced young people having a negative relationship with their mother, however there were more frequent accounts of negative elements of the relationships being inferred, which is captured within the next theme '*emotionless care'*.

This subtheme captures some of the more general negative comments about mothers, to provide depth to the existing understanding that justice-involved youth experience difficulties from an attachment perspective.

There were examples of feeling blamed and not being 'good enough', examples of abonnement by mothers, and also examples of volatile and aggressive relationships with mothers as outlined below:

> *"…. most sons and mothers shouldn't have a relationship like my mum and like me have you know, we have big monthly fights throughout the year we have big monthly fights you know where there's been arguing, and I'd call her a fucking whore and shit like this. She's called me all sorts of names and referred me to my dad and…"*
> (Zaniewski 2023, p.14)

> *"Usually she complains about most things and nothing seems to go her way. She' s pretty critical and insulting; wants everything perfect or she'll make you feel real small. [angry tone]"*
> *"Mom's always telling me how good she did and so did my dad and that she doesn't understand why I can' t get it. She gets really mad at me, makes me feel bad. I wish she could be supportive of me and know that I try my best. [sad, embarrassed expression, shrugging shoulders, looking down]"*
> *(Thurston, 2005, p.106)*

The accounts in which mothers are portrayed more negatively appear to have a focus on the child lacking a sense of being important to their mother, perhaps suggesting an absence of unconditional positive regard (Rogers, 1956), as illustrated in the account below:

> *"The message he received was that sex was the most important thing to his mother and that he was not important. This boy experienced deep feelings of anger, loneliness, and grief."*
> (Gerhard-Burnham at al., 2016, p.101)

Although there was notably less direct reference to violence from mothers than accounts of violent fathers, there were examples of young people describing aggression and violence from mothers and step-mothers:

> *"Young people often dismissed the importance of event or its impact on them and showed no protest or sadness about it. For example, Jamie repeatedly described violence from his mother but in a 'journalistic' style with little emotion or resentment at his beatings: …Well, she (mother) just like she grabs me by the hair and drags me upstairs (…) They wouldn't do it violently like just a clip across the head and stuff… "*
> (Zaniewski et al., 2023, p.13)

> *"Man, my mom' s crazy. She's always yellin' and screamin' and she'll beat yo' ass. Just start a-whalin' on ya. [smiling, laughing, slapping hands]".*
> (Thurston, 2005, p.117)

The evidence of violence from mothers, whilst less prevalent in the accounts, provides further insight into the overwhelming exposure to, and experience of violence in the lives of these young people that were all connected by their own display of behaviour that harmed others.

Emotionless Care

A subtheme which was elicited within six of the studies was that of '*emotionless care'* in which participants described feelings of being unloved, and relationships which lacked nurture, acceptance or comfort. Thurston (2005) reported*, "eight (40%) participants described their mothers as unloving and showing no affection"* (p.111).

Accounts from the young people provide insight into the extent of emotionless care in their relational experiences, providing further depth to the understanding of attachment experiences of these young people:

> *"There's not much love and affection. In my family there's mainly pain. We sure know how to express that! [sarcastic] My family doesn't know how to show love".*

> *"There's never any affection whatsoever. I never feel loved or special, more like a slave. [angry, calm]"*
> (Thurston, 2005, p.111)

Authors including Zaniewski et al. (2020;2023) and Vincent (2010) commented upon experiences and impact of the young people describing an absence of nurture and comfort:

> *"Although he yearned for a family and the love of his mother and father, he learned as a child that he could not expect emotional comfort or protection from his caregivers, so he knew he would have to live on his own as an adaptation to abandonment."*
> (Vincent, 2005, p.142)

> *"There was little evidence of having received or expecting to receive comfort in Matt's interview. He employed a self-reliant strategy and indicated no expectations to receive care or comfort".*
> (Zaniewski 2020, p.415)

These accounts highlight that whilst mothers may have been more physically present in the lives of many participants in these studies, what lacked was emotional connection and nurture from primary attachment figures. There was some insight into factors which may have impacted parents including their own traumatic experiences, substance use, and mental health difficulties, with clear evidence of intergenerational trauma in the accounts provided.

It is evident from the rich data pertaining to maternal and paternal relationships that the young people in these studies have displayed harmful behaviours in the context of disrupted and harmful attachments, with a particular prevalence of violence and unmet emotional needs.

Theme 3: Broken Attachments

Whilst the two previous themes include elements of the physical or emotional absence of an attachment figure, an issue which warranted recognition as a key theme in its own right was that of '*broken attachments'*. It was apparent within the studies that the young people had experienced broken and disrupted attachments for a variety of reasons and in a range of ways, with the commonality being some form of loss or rejection. Within this theme, three subthemes were created, *loss*; *rejection; trust*.

Loss

A number of young people within the studies described loss that was not related to rejection or abandonment, but rather as a result of death. There was reference to death of a mother in four studies, with a likelihood of a complex grief response in each example for reasons including a young person witnessing the shooting of his mother, death of a mother whilst she was in custody after a lifetime of substance use, and instability of care following a mother's death. These experiences of extreme adversity are likely to have had a profound

impact on the young people's attachment formation, in addition to their more general emotional wellbeing.

> *"Mum was killed ... Don't remember, myself. They say that I stood in front of her when she was shot like, stood there and she was killed".*
> (Tidefors & Skillback, 2014, p.59)

> *"Todd's mother died of AIDS at the age of 36 while she was in prison".*
> (Vincent, 2010 p.135)

> *"…would recall vivid images such as 'black ambulance' or her 'shut eyes'. His speech would become erratic, and he would often go into a dialogue with himself as he was re-living the event but at the same time mocking his responses. He showed extreme sense of guilt and responsibility for her death. But he also said that it was his sister who lost a mother and claimed that he was not affected by this. Furthermore, he would frequently conclude with a phrase 'it was well funny'".*
> (Zaniewski, 2023 p.16)

The extract above provides a further example of the narrative account being incongruent with the response of the young person as observed by the researcher. This evidences the crucial role of the researcher in qualitative research as the quote alone may suggest a complete disconnect or even callousness when this young person described his mother's death. The analysis of the researcher provides depth to the account, with the potential for dissociation and 'bravado' to mask the likely pain experienced by this young person in relation to the loss of his mother.

Rejection

Perceptions of rejection, or fear of rejection (likely as a result of previous rejection) were evident in the narratives of young people in all seven studies. This is a key subtheme to consider in the context of later themes such as 'trust' and 'toughness' as the narratives provide insight into these young people's anticipation of rejection.

> *"Rejection has most likely contributed to Mark's deep sense of loss, emptiness, and rage. Mark's comment about his mother seemed to sum up their relationship: "She was just there."*
> (Vincent, 2010, p.160)

> *"Ah, Dad'll cut you off. He' s quit talking to me right now and won't have anything to do with me. He' s started doing all this stuff for my little brother and is ignoring me, like birthdays and goin' fishin' and stuff. Hurts a lot. [serious expression, looking down, frustrated tone]*
> (Thurston, 2005, p.109)

> *"Sometimes it might take a while [to get very close to others]. I would like to get to know them first. It is quite hard to make a judgment if you don't know the person. If I get to know the person quite well I am not afraid they will reject me."*
> (Reis, 2015 p.117)

What is of note is that rejection is often inferred in participant accounts rather than explicitly stated or described. This could be linked to the young people not having the language to describe their experiences as being 'rejecting' but could also be linked to the potential that vocalising this would be too painful. Zaniewski et al. (2020;2023) noted suppressed and dismissed feelings of rejection within the accounts of young people in their studies,

> *"Another example is Matt's trauma regarding rejection from his mother. Initially, Matt described his 'childhood with his mum as very good' and her as 'reliable, but there were indicators of suppressed feelings of rejection related to his mother's decision leaving him in the care of his father where he experienced physical and sexual abuse:"*
>
> *"…I was about 3, I moved away from my mum because she was ill and what not and she was, couldn't handle me because of her illness, she couldn't take proper care of me, so she gave me away to my dad, well not that she gave me away, but you know she still handed me over to my dad…"*
> (Zaniewski 2023, p.13)

Trust

This subtheme reflects participants narratives of struggling to trust others, with rich accounts of feeling let down resulting in a reluctance to let people be close to them. There were examples of young people explicitly linking their difficulties in trusting others to experiences of harm or rejection, whilst for others this connection was inferred by the researchers. Reis (2015) reported, "*Nine of the twelve participants mentioned how they found it difficult to trust people and get close to people because they had negative past experiences in interpersonal relationships*" (p.113). Further depth to this finding is provided in the accounts below:

> *"I don't really trust anyone (...) It is difficult to ask for help (...) There is quite a few people I wouldn't go to for help. I just never allowed them to get close to me."*
> (Reis, 2015, p.112)
>
> *"Just I always live in fear because you put your life in other people's hands. It is so hard to trust people because I have been so let down. You always feel you're being plotted against. It has been the case numerous times in the past."*
> (Reis, 2015, p.113)
>
> *"It's just panic. If I get too close then what are they gonna do? When you're too close to someone, you're the most vulnerable then so it's easier for them to hurt you."*
> (Reis, 2015, p.118)

Researchers also hypothesised about the origins of the difficulties in trusting and how the struggle to trust others could impact on the future of the young people. This raises important considerations in relation to the support and intervention needs of the young

people, and how difficulties in trusting others could be barriers to future relational connection in terms of future personal relationships, but also relationships with professionals.

> *"For others this was related to inability to develop trusting relationship as result of abuse or rejection they have experienced from their parents/carers, but which was not validated."*
> (Zaniewski, et al., 2023, p.19)

> *"Though outwardly social and cooperative, Todd has a pervasive lack of trust in others and is wary about other peoples' motives. This lack of trust will likely prevent him from developing close interpersonal relationships in the future."*
> (Vincent 2010, p)

Theme 4: Links to Harmful Sexual Behaviours

The final key theme, evident in all seven studies relates to the impact of the young people's attachment experiences, with consideration of associations to the young person's harmful sexual behaviour. There is overlap, but subtle difference in the subthemes, *anger; toughness; troublemaker;* and *emotional dysregulation*. There are commonalities within the subthemes in terms of under-controlled emotion and bravado which can be hypothesised to have some association to the harmful behaviours displayed by the young people, as outlined in the following account:

> *"This boy also learned to use sexual touching as an emotional coping skill especially in the case of feeling anger and jealousy toward others."*
> (Gerhard-Burnham et al., 2016, p.101)

Anger

Anger was a feature in the narratives within the majority (n=6) of the studies with the young people and researchers making associations between anger and both participants life experiences and the harmful sexual behaviour they had displayed (Gerhard-Burnham et al., 2016; Thurston, 2005; Tidefors & Skillback, 2014; Vincent, 2010; Zaniewski at al., 2020; Zaniewski et al., 2023). One study explicitly explored this with participants and reported, *"Two (10%) participants attributed their family anger, chaos, and hostility to their offending, contributing to the emotional needs, poor social skills, and low self-esteem."* (Thurston, 2005, p.151). Providing depth to this perceived association, one participant commented:

> *"They didn' t teach me to offend, that was all my choice. But through counselling I know I was pretty lonely and was pretty angry. I think this had a part. I also learned to keep secret and hide lots of things".*
> (Thurston, 2005, p.138)

In the accounts provided to Zaniewski (2020;2023), anger was perceived to be used as a means to avoid intolerable feelings of vulnerability and maintain a sense of control.

> *"…and rejection of vulnerability and angrily expressing a wish to be emotionally self-reliant."*
> (Zaniewski et al., 2020, p.410)

> *"Matt appeared to justify and minimise violence within a framework which placed himself as strong and in control and also normalised violence. In the previous quote, he portrayed himself as a perpetrator of violence and justified it by being "angry".*
> (Zaniewski et al., 2020, p.414)

As has been identified in previous themes, the above accounts demonstrate that for some of the young people anger was an emotion they could identify with and felt able to speak about whereas other feelings were perhaps suppressed in order to avoid presenting in a position of vulnerability. When considering the prevalence of experiences of aggression and violence in the lives of these young people, it is perhaps unsurprising that anger was an emotion that was more familiar to them.

Bravado / Toughness

A theme within four of the papers was expression of 'bravado' or 'toughness' by the young people (Thurston, 2005; Tidefors & Skillback, 2014; Vincent, 2010; Zaniewski at al., 2020; Zaniewski et al., 2023). Zaniewski et al. (2023) described a theme within their study of, "*Power discourses encompassing entitlement, male superiority, toughness, bravado and denial of vulnerability*" (p.19). Further depth linking this to harmful sexual behaviour was provided:

> *"Participants also demonstrated a sense of entitlement and superiority as males… Matt's transcript included a very strong gender polarisation which contained an emphasis on males as needing to show physical strength, aggression and sex. A male was seen as needing to be strong and aggressive therefore respected as opposed to females who are 'too soft which is not as scary as men'.*
> (Zaniewski et al., 2020, p.415)

> *"A part of these boys' "tough attitudes" to life was that they did not need anybody, and even expressed feeling superior to others. There was no reflection that the statement "you can't understand who I am" also is an expression of loneliness."*
> (Tidefors & Skillback, 2014, p.59)

> "I'm the man of the house to take care of things now. My mom has always counted on~~ to be the man .... she depends on me to be the man of the family".
> (Thurston, 2005, p.107)

It is through accounts such as these that links between the attachment experiences of these young people and their own behaviours can begin to be made. Views of needing to 'be tough' and of male entitlement fit with the exposure to males which many of these

young people have had. Previous themes have also identified a lack of nurture, care and comfort for young people in these studies and so it can be seen that for many they have come to view self-reliance and 'toughness' as preferable, or perhaps as the only way to survive.

Troublemaker

This theme is closely linked to the previous subtheme, however a crucial difference is the inference that being a 'troublemaker' had seemingly become an identity for some participants, exemplified in the excerpt below:

> *"Many seemed to view themselves as troublemakers and roughnecks, though some stressed that they also were nice and calm. However, for a majority, the role of a rowdy boy and a young troublemaker almost seemed to function as an identity. They presented stories of getting into trouble their whole lives through, starting as little unruly boys in kindergarten. Anton told of the admiration he gained through fighting in school." "I skipped school, made a fucking mess. It was like people looked up to me when I was a real troublemaker, and I wanted to be the centre of attention. (Anton, 16)"*
>
> *"A part of these boys' "tough attitudes" to life was that they did not need anybody, and even expressed feeling superior to others. There was no reflection that the statement "you can't understand who I am" also is an expression of loneliness"*
> (Tidefors & Skillback, 2014, p.59)

The notion of being a troublemaker appeared within the narratives of the young people to be associated with the sense of bravado highlighted previously, likely developed from their experiences of males as identified in key theme one. Zaniewski at al. (2023) concluded that for some young people in their study, *"The power to disrupt and get self into trouble is "empowering*" (p.10). The excerpt below highlights how this could be linked to the display of harmful sexual behaviour:

> *"Matt then employed bravado (as with his mother), mixed with a sense of injustice and this appeared to fuel a "justifiable" aggression towards females including harmful sexual behaviour."*
> (Zaniewski et al., 2020, p.417)

Emotional Dysregulation

In addition to uncontained anger, there was evidence of more general emotional dysregulation in participant accounts, as concluded by Gerhard-Burnham et al. (2016), *"In the participants' related experiences and histories, emotional dysregulation emerged as a theme*" (p.101)

The potential for emotional dysregulation to be associated with the harmful sexual behaviours displayed by participants was considered within the following excerpts:

> "*Todd's responses also indicate that he frequently experiences dissociative symptoms corroborating the link between dissociation and trauma." "In order to cope with his traumatic past, Todd experiences dissociative states and self-destructive thoughts and behaviours in an attempt to modulate or soothe negative internal states*."
>
> *"For Todd, sexuality seems to validate his need to be special in someone's eyes and fulfils his desire to be contained emotionally."*
> (Vincent, 2010, p.138)

These accounts of dysregulated emotion are important to consider not only in relation to harmful sexual behaviour, but also in terms of the potential for this to impact on other behaviours, and particularly on the future relationships of the young people in these studies. This theme is likely to be associated with previous themes of *'loss', 'rejection' and 'emotionless care'* in that the development of emotional regulation requires co-regulation as an infant. If as it seems, this was not consistently available from a safe, predictable carer in the developmental histories of many of these young people, poor emotional regulation in adolescence could be anticipated.

2.5 Discussion

The seven studies included in this QES add depth to the existing research relating to harmful and disrupted attachment experiences for young people who have displayed harmful sexual behaviour (HSB). This review has outlined four key themes with rich data to illustrate the perceptions of the young people in relation to their attachment experiences. The stories of the young people are coupled with the views of the study authors who had the opportunity to meet with participants and gather non-verbal information which can be difficult to extract in written data.

Each study contained the voice of the young people which led to the creation of the four key themes: *Paternal Relationships; Maternal Relationships; Broken Attachments; Links to Harmful Sexual Behaviour,* thereby addressing the original aims of this QES and adding to the growing qualitative research base in this area.

A prominent key theme relates to the relationship between the young people and their fathers, overwhelmingly evidencing physical and psychological harm through violence, and emotional harm through rejection, abandonment, and broken relationships. Whilst there was some evidence of positive paternal relationships, the negative experiences were pervasive, with evidence of childhoods characterised by fear and loss. Experiences in which a child's "*haven of safety is also the source of their fear and distress*" (Benoit, 2004, p.543) have been found to potentially have a profound impact on attachment formation as the child begins to experience their parent as fear inducing, either alongside providing care, or in the absence of care and nurture (Benoit, 2004; Crittenden, 2006; Van Ijzendoorn et al.,

1999). The findings in this theme support previous research which has found that some individuals with a sexual offence have been more likely to report attachment disruption relating to fathers than mothers (Smallbone & Dadds, 1998; Smallbone & Wortley, 2000). These findings also provide depth to research which has identified a prevalence of exposure to domestic abuse in adolescents with HSB (Ogilvie, 2022).

There was more nuance in the theme relating to maternal relationships, with more evidence of positive experiences of relationships with mothers, including narratives which suggested this relationship may buffer the impact of negative experiences within the child's life. There is increased interest in Positive Childhood Experiences (PCEs) which emerging research suggests have the potential to mediate the relationship between Adverse Childhood Experiences (ACEs) and negative outcomes including offending behaviour (Baglivio et al., 2020). It could by hypothesised that a positive attachment figure could be one such PCE, evidencing an area for future research.

There was however also evidence of negative maternal relationships including rejection and loss, with a particularly prominent subtheme of experiencing emotionally disconnected care, leaving young people feeling unloved and unimportant. A lack of nurture and what Rogers (1954) termed 'unconditional positive regard' has potential to significantly impact on the attachment formation and development of the internal working model of these young people, arguably with the potential for the impact to be as profound as the violence and abandonment from fathers. Of course, for some of these young people, difficulties within both maternal and paternal relationships will have been their reality, evidencing the extent of attachment trauma some will have experienced.

The young people's experiences of parental relationships can be viewed as setting the scene for relational difficulties which are important to consider in the context that all these young people had displayed harmful sexual behaviours. Overwhelmingly, participants had witnessed and experienced harm from an attachment figure and many also had limited experiences of stability, consistent care, and nurture. As such, for some the harmful behaviours may have been acting out their own experiences of force, harm, or coercion, whilst for others there may have been elements of desperately seeking attachment and connection, albeit in maladaptive and harmful ways.

The third key theme emphasises the extent of broken attachments through death, rejection and abandonment and the profound impact this unsurprisingly has on the young people's ability to trust others. The findings in this theme support the shift away from referring to young people such as these having an 'attachment disorder'. Rather than being a disordered response, the young people having difficulties in trusting others is congruent with their experiences of loss, rejection, and harm from caregivers, all of which can be

viewed as factors that can disrupt and distort attachment formation (Harrelson et al., 2017; Shilkret & Shilkret, 2011).

The final theme focussed on the impact of the attachment experiences as described by the young people with an overwhelming presence of emotional dysregulation, be that externalising (such as anger and toughness) or internalising (supressing and masking emotions), all likely to be strategies to avoid feelings of vulnerability. Regulation difficulties have been evidenced to be prevalent for adolescents who have displayed HSB (Hunter et al., 201; Miner et al., 2016; Yoder et al., 2020), and so this theme provides further support for this as an area for support and intervention for young people with HSB, with a need to see beyond the 'bravado' of these young people in order to recognise the vulnerability many of them seek so desperately to hide.

These core findings provide insight in to the association between attachment disruption and adolescent harmful sexual behaviour, with a range of hypotheses which could be developed from the narratives of the young people, when considered alongside the existing research and clinical understanding in this area. For example, there is evidence of young people having coercive and aggressive behaviours modelled, particularly by father figures; the young people have learnt not to trust others and so may develop harmful means of keeping people close and meeting care and intimacy needs; emotional dysregulation could lead to aggressive outbursts or the use of sexual touch for comfort and to cope with difficult emotions. What these narratives demonstrate is that whilst there are common themes which have been elicited, there are of course individual differences, emphasising the importance of formulation within assessment of these young people, thus allowing them space to 'tell their stories' in order to ensure bespoke, rather than 'one size fits all' support and intervention.

Practice Implications

This QES not only adds to the research base but can also be used to inform clinical practice with young people who have displayed HSB, through capturing and synthesising their voices. There is growing recognition of the need to move beyond a purely 'offence focussed' approach to a 'whole child approach' with a crucial need to consider the relational aspect of working with these children (Campbell et al., 2020). This review emphasises the need to not only consider 'what' has happened to child and 'what' they have done (their behaviour), but also to consider 'how' and 'why' these are linked. This in-depth, complex and often nuanced interplay can only be understood by seeing the world through the eyes of the young person, further reinforcing the need for safe, therapeutic connection within assessments and interventions.

Harrelson et al. (2017) highlighted that experiences of disrupted attachments can perpetuate for adolescents, with the potential to negatively impact on the formation of relationships with professionals, in the context of the difficulties in trusting others as highlighted in this QES. There is a move towards attachment and trauma informed practice in the work with justice-involved youth (Grady et al., 2022; Levenson et al., 2017) and the need for this progression is highlighted by the voices of the children within this review.

The view that relational trauma requires relational repair (Treisman, 2016) is also supported by this review, as attachment trauma cannot be healed in isolation. Young people such as those within these seven studies may well require individualised therapy, however they also need exposure to positive attachment relationships, support to repair ruptured and disrupted attachments, and/or to process the trauma and pain that comes from broken attachments. The importance of involving families in systemic intervention is well documented (Archer et al., 2022; Campbell et al., 2020; Hackett et al., 2016; Letourneou & Borduin, 2008) and this review adds support for this to be seen as an integral element in responses to harmful sexual behaviour, rather than being viewed as an 'added extra'. Systemic intervention with parents and family members requires knowledge, skill and sensitivity, taking into account factors in their own histories which may have impacted on their attachments to their child, alongside the potential difficulties in coming to terms with their children's behaviours (Campbell et al., 2020).

Limitations

This review only synthesised data included within the results/findings sections of the studies due to the time limitations of this QES. There is therefore potential that data has been missed that was provided in other sections of the studies that may have contributed to this review.

From a theoretical perspective, qualitative syntheses have been criticised due to the risk of missing nuance within participant accounts through relaying on what the author chose to include as opposed to accessing original data. Decontextualsation of the qualitative data, which is required for a qualitative synthesis leaves the potential to obscure the complexities of individual accounts (Finfgeld-Connett, 2010; Lachal et al., 2017). This may be a particular limitation of this QES as the included studies are exploring the inherently personal, nuanced, and arguably abstract concept of attachment which leaves potential for researcher bias and differing interpretations of the accounts given. The setting of each study, along with the study title has been captured in the 'Table of Included Studies' (Table 2.2) with the aim of supporting the reader to discern the context of included studies, however it is acknowledged that without access to the full interview schedule or interview transcripts, the QES relies on the data chosen for inclusion by the author, alongside the meaning afforded to the data by the researcher(s). Weed (2005) postulates that there has

to be trust in the original researcher analysis within the QES, and within this study the use of quality appraisal provided an additional layer of scrutiny of the quality and aims of included studies.

A further factor to consider is that qualitative syntheses use third-order interpretation through the use of data that contains not only participant accounts (first-order interpretations), but also the analytical views and conclusions of researchers (second-order interpretations). This is inherent in a QES, positioning this methodology as 'meta-research' (Duden, 2021), and Weed (2005) highlights that the very concept of the QES is to go beyond first and second-order interpretation and it is this third-order interpretation that is central to the synthesis. The way this was addressed within this QES was to code researcher comments and analysis separately to the account of the participant, ensuring that assumptions were not made that participant and researcher views were the same. It is however again acknowledged that the participant accounts provided within the paper would have been selected to evidence and support the researcher analysis and without access to the full transcripts it is not possible to include other data within the QES.

In terms of the content of the studies, there is always the potential for socially desirable responding and impression management within interview data and this has been reported to be more prevalent in studies exploring sensitive issues (Bergen & Labonte, 2020). The published studies had limited researcher reflexivity and minimal explicit consideration of the impact of factors such as impression management and the potential for shame to influence responses.

2.6 Conclusion

The voices and lived experience of the young people within the studies in this review illustrate the need to explore the attachment experiences of young people who display harmful sexual behaviours, and to consider the relevance of these experiences in the behaviour which has been displayed. This will ensure that support and intervention is tailored to the needs of the young person, considering their vulnerabilities alongside risk, and crucially, formulating the potential for a complex interplay between the two. Primary and secondary prevention strategies sould be influenced by the growing evidence base for the impact of disrupted attachment across the life-course. This review also supports the need for tertiary and quaternary prevention strategies to be not only trauma and attachment 'informed', but trauma and attachment 'responsive' in order to address the needs and vulnerabilities of these young people if the aim of reducing risk and preventing further victimisation is to be met.

3. CHAPTER THREE: PRIMARY RESEARCH STUDY (QUANTITATIVE)

Associations between Polyvictimisation, Trauma, Attachment Disruption and Adolescent Harmful Sexual Behaviour

3.1 Abstract

This study explores the Adverse Childhood Experiences (ACEs) in a sample (n=43) of UK adolescents in custody for a sexual offence. Developmental histories characterised by adversity, trauma, and attachment disruption were found in the sample, with rates of ACEs far exceeding those within the general population. Associations were identified between specific ACEs and offence detail and a key finding was that ACE score (indicating polyvictimisation) predicted an early onset of harmful sexual behaviours. The study aims to improve understanding of the 'harmed' to 'harming' trajectory of these youths that present with high rates of both vulnerability and risk. Implications of the findings for prevention and intervention are discussed.

3.2 Introduction

Research highlights the high prevalence of adversity and trauma for justice-involved youth in comparison to the general population (Baglivio et al, 2014; HMIP, 2023; Thomsen at al., 2023). It is therefore unsurprising that young people in youth custody with serious or prolific offending present with particularly high rates of adversity and trauma (Liddle et al., 2016).

Although young people who have displayed harmful sexual behaviour (HSB) are recognised as a heterogenous group, research has evidenced that a commonality is the prevalence of adversity in the developmental histories of these young people, with this prevalence found to be even greater than for other justice involved youth (Levenson et al., 2017; Ogilvie et al., 2022, Thomsen et al., 2023).

As outlined in a review of the literature, studies have shown that trauma is potentially the factor linking Adverse Childhood Experiences (ACEs) to increased risk of offending (Malvaso et al., 2022). It is however important that ACEs and trauma are not conflated but are seen as independent although often interlinked constructs. Finklehor (2018) made important distinctions, by highlighting that not all individuals with ACEs will necessarily be traumatised and not all individuals with trauma will become involved in offending behaviour.

Young people who have displayed HSB have also been found to have increased likelihood of experiencing disrupted attachment (Malvaso, 2017). Studies have begun to explore links

between these adverse experiences, trauma and attachment disruption and the risk of displaying HSB, with early indications that increased risk of HSB is linked to increased levels of adversity (Craig & Zettler, 2021; DeLisi, 2017).

Early adversity and trauma has been found to be associated with a range of mental health, psychosocial and behavioural outcomes in childhood and across the lifespan (Creedon, 2009; Levenson et al., 2017, Thomsen et al., 2023) which highlights the importance of attending to these needs within the general population but also specifically for justice involved youth who are more likely to have experienced what Judith Herman (1997) termed 'complex trauma'.

An over representation of neurodevelopmental conditions such as learning disability, autism and ADHD have also been found in adolescents who have displayed HSB (Hackett et al., 2013, Rutten et al., 2022, Liddle, 2016) which highlights the need to understand characteristics of this group of young people beyond their life experiences to assist with understanding both developmental risk factors and vulnerabilities associated with adolescent sexual offending.

Whilst the research base has clearly evidenced the presence of adversity and trauma within the population of adolescents with HSB, McCuish and Lussier (2017) identified that research has tended to focus on the person, with limited exploration of the nature and context of the behaviour, evidencing a gap in the literature, which this study hopes to address. Additionally, Faure-Walker & Hunt (2022) highlighted that whilst adversity has been measured within previous studies, specific types are not always specified. Increased understanding of connections between being harmed and harming others is required to develop prevention strategies and to inform risk management (Grady et al., 2017).

Aims of the current study

Whilst ACEs have been shown to be prevalent in the histories of young people with HSB, research is now beginning to explore differences or similarities in particular cohorts of these youth (Thomsen at al., 2023). Furthermore, few studies have specifically explored polyvictimisation in adolescents with sexual offences (Alexander et al., 2021; Harrelson et al., 2017; Marini et al., 2014). The aim of the current study was to add to the research base for the characteristics and developmental histories of adolescents who have sexually offended (ASOs) and specifically those whose behaviour has resulted in a custodial sentence. The aim of this study was to move beyond the prevalence of adversity, trauma and attachment disruption and consider the nature, extent, and cumulative impact of adverse experiences, with exploration of relationships with offending behaviour.

It is hoped that by adding to the evidence base and improving understanding of these children with particularly high-risk behaviours, both policy and clinical practice can be

enhanced. This will help develop interventions (tertiary prevention) but crucially will also add to the research base to support the development of primary and secondary prevention strategies.

3.3 Method

This study explored data from a sample of adolescents (N=43) serving a custodial sentence at a UK Youth Offenders Institute (YOI) or Secure Children's Home (SCH) between January 2020 and October 2022. All had been convicted of a sexual offence.

A Forensic Child and Adolescent Mental Health Service (FCAMHS) was commissioned to provide assessment and interventions for adolescents convicted of a sexual offence within the two youth custody establishments. Data was extracted from a dataset held by this service which included information from a range of sources. The dataset was originally created for clinical and audit purposes and was not developed specifically for this study. Data was provided by the clinician allocated to each young person and was entered into the dataset by a member of the psychology team. The clinician providing the information was a registered practitioner (including psychologists, psychiatrists, social workers, and nurses) who had access to official records for the young person, and in most cases had regular clinical contact with the young person.

Participants

The 43 adolescents in the sample were all male and had a mean age of 16.6 years at the time of being referred to the service. Whilst females with a sexual offence could be referred to the service, there were no referrals for females with a sexual offence during the time-period of the study.

Within the sample, 74.4% (n = 32) of participants had their ethnicity recorded as 'White British' with the other 26.6% (n=11) made up of small numbers from a variety of ethnic backgrounds including 'Black African', 'Asian British' and 'Mixed Ethnicity', with no over-representation in any one group.

Nearly half, (46.5%) of the sample (n=20) had been in the care of the local authority (a 'child in care') at some point prior to their time in custody.

Variables Measured

Offending information

Offence detail was extracted from official records including FCAMHS referral form, and social care and youth justice reports. This included offence type, location of offence, victim detail (including age and gender of victim).

The dataset also included whether participants presented with or had convictions for non-sexual offending behaviours. The non-sexual offending behaviours (violence and aggression; fire setting, animal cruelty) were rated from 0-2 (0=not present, 1=conviction, 2= present but no conviction).

'Other criminal behaviour' included any other behaviour that would constitute a criminal (non-sexual) offence that was not included in the coding outlined above. This included behaviours such as criminal damage, stealing cars, drug offences, and burglary.

Substance use was also included relating to the participants use of use of alcohol or non-prescribed drugs. This was rated 0-1 (0=not present, 1=present).

Adverse Childhood Experiences (ACEs)

11 ACEs were rated as part of this study: physical harm, sexual harm, emotional harm, neglect, domestic violence, bullying, caregiver instability, parental mental health difficulties, parental substance misuse, family criminality, and other.

The ACEs were based on Felitti et al.'s original ACE framework, although there were some differences. For example, in this study 'neglect' focussed on physical neglect, whilst emotional neglect was captured within 'emotional harm'. Caregiver inconsistency was used rather than parental separation/divorce to capture whether inconsistency in care was experienced, as opposed to focussing on the relationship status of the parents.

As an addition to Felitti's original ACEs, bullying was included as an ACE to capture peer related adversity, on the basis that adverse experiences outside the family environment can also have a profound impact on children (Finklehor at al., 2015).

There was also the inclusion of an 'other' item. This captured any other significant adverse experience which was not included in the 10 ACEs listed. The coding guidelines were clear that this had to be a significant event or experience, rather than simply a difficult or sad experience. A range of adverse experiences were included within the 'other' item, including witnessing the death of a friend, the death of a parent, and war trauma.

Detailed item descriptions are provided as Appendix 3.

Presence of the ACE was judged by the clinician allocated to work with the young person, who therefore had a thorough knowledge of the individual and access to relevant documentation (e.g., health records, professional reports). For the ACE to be rated as present, there had to be evidence that the adversity had occurred prior to the offence, not as a result of the offence, or during time in custody.

In order to rate an ACE variable as present there had to have been a disclosure and/or documented evidence of the occurrence of that specific adversity. Professional suspicion of a type of adversity was not included within the rating. It is important to highlight that the inclusion of suspicion of an ACE would have increased the rating for each of the variables. This was particularly relevant for 'sexual abuse' which was suspected by the rating clinician for a number of young people, although there was insufficient evidence to rate as present.

Presence or absence of an ACE was initially coded from 0-3. 3 represented a disclosure from the young person that they had experienced that particular adversity, 2 was official documentation that the ACE had occurred, 1 was both disclosure and official documentation, and 0 was either no evidence or insufficient evidence of that ACE. Items were subsequently re-coded for analysis, with items rated from 1-3 being re-coded as 1 to indicate the presence of the ACE and 0 remaining as the ACE not being present, or insufficient evidence to rate.

A total ACE score was calculated by summing the number of adverse experiences rated as present, with a resultant score from 0-11.

Trauma and disrupted attachments

For the purposes of this study, 'trauma' was coded as present if the individual was considered to have been traumatised by any or all their ACEs. The trauma variable was rated by the allocated clinical with a score of 0 or 1. A score of 1 was assigned if the adolescent was considered to have experienced developmental trauma as a result of adverse experiences. A score of 0 was assigned if there was insufficient evidence to rate, or if the adolescent was considered not to present as having been traumatised by their experience. The rating for this item included the presence of an official diagnosis of PTSD, although diagnosis was not required to code the item as present. Factors which were included in rating this item as present were: professional consensus that the adolescent was traumatised by their experiences, professional reports which referred to the child

being considered traumatised and psychometric assessment that had been undertaken with the young person.

In relation to attachment disruption, a score of 1 was assigned if there was evidence of attachment disruption or attachment related harm. A score of 0 was assigned if there was insufficient evidence to rate, or if the adolescent was considered not to present with any attachment related difficulties.

As outlined above, the presence of developmental trauma or attachment disruption were rated by the allocated clinician. This rating relied on evidence based clinical opinion considering a range of information (e.g., direct work with the young person, access to professional documentation, documented clinical opinion of other professionals).

Mental health

Mental health diagnoses were captured within the dataset however these were not used in subsequent analysis as it was not possible to establish from the data whether a mental health condition was present prior to/at the time of the offence. As such, it was not possible to establish whether conditions such as depression, anxiety or Post-Traumatic Stress Disorder (PTSD) could be linked to the commission of the offence, or whether they occurred later, for example as a result of the criminal justice process or experience in custody.

Neurodevelopmental conditions

Neurodevelopmental conditions (learning disability, autism and ADHD) were only rated as present only if there was a diagnosis. As such, these conditions were either rated as present (1) or absent (0). A rating of 0 was given in the absence of diagnosis even if the condition was suspected and awaiting assessment.

'Low cognitive functioning' was also included in the dataset (separately to learning disability). This was rated as present if the participant had completed a cognitive assessment and had an IQ score in the 'borderline' range.

Treatment of Data

A chi-squared analysis was conducted on the data using cross-tabulations to explore associations between ACEs and offence detail. Due to the number of chi-squared tests carried out (93), to reduce the risk of a type 1 error, a Bonferroni correction was applied and rounded up ($p< 0.05/93 = 0.00053$), with an accepted significance level of $p<0.001$ for the analysis. A Mann Whitney U-Test was conducted to explore relationships between ACE

score and offence detail, with a Bonferroni correction again applied and rounded up ($p< 0.05/7 = 0.007$), with an accepted significance level of $p<0.01$ for the analysis.

Finally binary logistic regression was undertaken with variables reaching the accepted significance level as predictor variables. All analyses were undertaken using SPSS version 27.

3.4 Results

Descriptive statistics

ACEs

Regarding the prevalence of ACEs, Table 3.1 shows that emotional harm had the highest prevalence with 95.3% of the sample having had this experience, followed by bullying (81.4%) and caregiver instability (79.1%). A previous history of sexual victimisation had the least prevalence (27.9%) within this sample, however this figure this still represents five times the prevalence observed for boys in high income countries (Gilbert et al., 2010).

Table 3.1 provides the ACEs measured, with the percentage of participants who experienced each ACE. Table 3.2 shows that all the young people in the sample had experienced at least one Adverse Childhood Experience (ACE) and two of the young people had experienced all 11 ACEs. A total of 79.2% of the sample had experienced 4+ ACEs In terms of the mode for the ACE score data, the most frequent number of ACEs experienced by one individual were 3, 5 and 10, each with a value of six participants (meaning the data was tri-modal and six participants had 3 ACEs, six participants had 5 ACEs, and 6 participants had 10 ACEs).

Table 3.1

Prevalence of Each Adverse Child Experience (ACE)

ACE	Number of Participants (N=43)	Percentage
Physical harm	17	39.5%
Sexual harm	12	27.9%
Neglect	27	62.8%
Emotional harm	41	95.3%
Caregiver instability	34	79.1%
Domestic abuse	26	60.5%
Bullying	35	81.4%
Parental mental health difficulties	25	58.1%
Parental substance misuse	13	30.2%
Family criminality	19	44.2%
Other	19	44.2%

Table 3.2

Prevalence of Adverse Child Experience Scores (Number of ACEs)

Number of ACEs	Number of Participants (N=43)	Percentage
1	2	4.7%
2	1	2.3%
3	6	14%
4	5	11.6%
5	6	14%
6	3	7%
7	4	9.3%
8	5	11.6%
9	3	7%
10	6	14%
11	2	4.7%

Trauma and attachment disruption

Overall, 95.3% of the sample (n=41) were rated as having experienced trauma as a result of the adversity they had experienced and 95.3% (n=41) were rated as having experienced attachment disruption.

Offence Detail

Table 3.3
Offence Type

Offence Type	Number of participants (N=43)	Percentage
Offence(s) included rape / penetration	33	76.7%
Non-penetrative sexual offence	10	23.3%

Of the participants with a non-penetrative sexual offence, there were aggravating factors that had resulted in a custodial sentence. This included, multiple pre-pubescent victims (n=1), stranger victim (n=4), multiple non-contact sexual offences (n=1), other offending alongside non-penetrative sexual offence (n=3), and breach of community order (n=2)

Just over half of offences (53.5%) took place solely in a home environment, usually the home of the ASO and/or the home of the victim. Some ASOs had more than one offence location which included both within and outside home offences. Of those offences that did not take place in a home environment, the majority took place in an outside location within the community, evidencing community-based risk in addition to sexual abuse taking place within the home.

Victims

Regarding age of the victim, 48.8% (n=21) of the participants had at least one prepubescent child among their victims. Almost half of these (n=11) had solely pre-pubescent victim(s), with the remainder (n=10) having a mixed victim group, which included a prepubescent child. Of the remaining 52.2%, 34.9% (n= 15) had only adolescent victim(s) and 16.3% (n=7) had adult victim(s).

With regard to victim gender, 79.1% (n=34) had female victims, 2.3% (n=1) had male victims, and 18.6% (n=8) had both male and female victims.

In terms of the relationship to the victim, 32.6% (n=14) had a victim that was related to them (intrafamilial victim). 67.4% (n=29) did not have an intrafamilial victim. Within the sample, 18.86% (n=8) had only a stranger victim, 74.4% (n=32) had a victim that was known

to them prior to the offence (usually peer acquaintances or an intimate partner), and 7% (n=3) had both a stranger and a known victim in their offence history.

Offence Related Variables

Overall, 41.9% (n=18) were known to have accessed pornography below the age of 13.

The age at which HSB was first reported to have occurred ranged from 6-16 years, with a mean age of onset of 14.37 years. 20.9% (n=9) had an early onset of HSB (began before the age of 13).

Other Presenting Behaviours

Over half the sample 65.1% had some form of non-sexual offending behaviour recorded, although not all had resulted in charges or conviction. 34.9% had no non-sexual offending behaviour recorded and so exclusively presented with sexual offending behaviour.

Over half the sample (58.1%) were known to have displayed non-sexual aggression, with smaller numbers being reported to have other concerning forensic behaviours; fire-setting (16.3%) and animal cruelty (7%). 39.5% had other criminal behaviours recorded.

In addition, 55.8% (n=24) of the sample were recorded as having problematic substance use, meaning that substance use was not an issue for 44.2% of ASOs in this study.

Table 3.4
Non-Sexual Offending Behaviours

Behaviour	Number of Participants (N=43)	Percentage
Violence and aggression	25	58.1%
Fire setting	7	16.3%
Animal cruelty	3	7%
Other criminal behaviours	17	39.5%

Neurodevelopmental variables

Two participants had two neurodevelopmental diagnoses, all other participants had either one diagnosis (n=21) or zero neurodevelopmental diagnoses (n=20).

Table 3.5

Neurodevelopmental Diagnoses

Neurodevelopmental diagnosis	Number of participants (N=43)	Percentage
Learning disability	4	9.3%
Autism	9	20.9%
ADHD	12	27.9%

A further 23.3 % of participants (n=10) were considered to have low cognitive functioning.

Bivariate analysis

Chi square tests were used to explore relationships between ACEs and offence detail. 10 associated trends and four significant associations are reported, with the significant results provided separately for clarity. As the sample size is small (N=43), there is the possibility of a Type 2 error (false negative) where an association between two variables is omitted for failing to reach the accepted level of significance and so those approaching significance are reported. These associations approaching significance are reported (referred to as 'associated trends') due to being deemed to potentially have clinical significance in the field of adolescent harmful sexual behaviour, and also to inform future research with the potential to explore these variables with larger sample sizes.

Associated Trends

ACEs

Table 3.6

Chi Square Associated Trends for ACEs and Offence Detail

ACE Variable	Offence Variable	$\chi 2$	Two Tail P value
Physical harm	Victim age	5.324	0.021
Sexual harm	Victim age	7.927	**0.005**
Sexual harm	Onset age	*F.E	0.088
Neglect	Onset age	6.745	**0.009**
Neglect	Early onset of pornography use	5.592	0.018
Domestic abuse	Victim age	4.246	0.039
Domestic abuse	Onset age	F.E	**0.007**
Caregiver instability	Victim age	F.E	0.021

*Fisher's Exact (FE) is reported where >20% of expected cell counts are less than 5.

Although not reaching the required level of significance, these associated trends show that those with a pre-pubescent victim were more likely to have experienced sexual abuse, physical abuse, caregiver instability and domestic abuse. Those with an early onset of harmful sexual behaviour (age 13 or under) were more likely to have experienced sexual abuse, domestic abuse and neglect. Those with an early onset of pornography use (below the age of 13) were more likely to have experienced neglect. These associated trends have clinical utility when considering relationships between particular types of adversity and harmful sexual behaviour.

As onset age, victim age and non-sexual violence appeared to be relevant variables, there was further exploration in relation to their association with other offence details. Two associated trends were found, provided below:

Table 3.7

Chi Square Associated Trends for Offence Variables

Variable	Variable	$\chi 2$	Two Tail P value
Onset age	Victim gender	8.246	**0.004**
Non-sexual violence	Victim age	6.776	**0.009**

Although not significant, these associated trends indicate that those with an early onset of HSB were more likely to have a male victim and those with co-morbid non-sexual violence were more likely to have a post-pubescent victim.

Significant findings

Table 3.8

Significant Relationships Between ACE and Offence Detail Variables

Variable	Variable	$\chi 2$	Two Tail P value
Early onset of HSB (below 13)	Victim age (pre-pubescent victim)	F.E	0.001
Victim gender	Victim age (post-pubescent victim)	F.E	0.001
Extra-familial victim	Victim age (post-pubescent victim)	11.495	0.001
Extra-familial victim	Non-sexual violence	11.924	0.001

These findings demonstrate that those with an onset of HSB below the age of 13 were significantly more likely to have a prepubescent victim. All those (n=9) with an early onset of HSB had a prepubescent victim.

There were also significant findings in the opposite direction relating to victim age. Those with only post-pubescent victims were significantly more likely to only have female victims, and significantly more likely to have a victim outside the family. This indicates that younger victims are more likely to be family members.

Those with victims outside the family were also significantly more likely to present with comorbid non-sexual violence.

Independent-Samples Mann-Whitney U-Test with ACE score

Mann-Whitney U-Test was used to explore associations between ACE score and offence detail. One significant finding and two associated trends were found, as outlined below. All results are provided as Appendix 6.

Table 3.9
Mann Whitney U-Test

Variables	Sample size	U	Significance level
ACE score & onset age	43	246.500	**0.004**
ACE score & victim age	43	127.000	0.011
ACE score & early onset of pornography use	43	305.500	0.046

These results show that higher ACE scores were significantly associated with an early onset of HSB and having a pre-pubescent victim. Although not reaching the required significance level, an associated trend was that those with higher ACE scores were more likely to have an early onset of pornography use.

ACE score was not related to the following variables: stranger victim, intrafamilial victim, victim gender, offence severity. Co-morbid (non-sexual) violence did not have a relationship to ACE score.

Logistic Regression

As outlined above, for the purposes of regression Chi Square and Mann Whitney tests were carried out looking at associations between the offence factors being investigated, and the component variables making up the ACE score.

Logistic regression was undertaken to explore factors predicting an early onset of harmful sexual behaviour. As onset age had significant associations (with ACE score and victim age) and had an associated trend (with victim gender), these were used as predictor variables.

As there were less than 50 participants in the study (n=43), the model was underpowered, however, the correct classification of the model which contains three variables was 90.7%. The model had a false positive rate of 5.9% and a false negative rate of 22.2%.

The logistic regression model shows that ACE score is the strongest predictor of an early onset of harmful sexual behaviour (below the age of 13). ASOs with a high ACE score were 1.6x more likely to begin displaying HSB under the age of 13. ASOs with a male victim were 0.25% more likely to begin displaying HSB under the age of 13. Victim age loses predictive value as it was so strongly associated with ACE score.

Table 3.10

Logistic Regression Classification Table

Observed	13+	Under 13	Percentage correct
13+	32	2	94.1
Under 13	2	7	77.8
Overall percentage			90.7

Table 3.11

Variables in the Equation

Step 1	B	S.E.	Wald	df	Sig.	Exp(B)
ACE score	0.485	0.258	3.538	1	0.060	1.623
Victim age	-19.817	7829.194	0.000	1	0.998	0.000
Victim gender	-1.376	1.109	1.539	1	0.215	0.253
Constant	19.971	7829.195	0.000	1	0.998	63775290.4

3.5 Discussion

Summary of Findings

It is widely recognised that the complex interplay of factors leading to adolescent sexual offending differs within this heterogenous group. However, this study supports the emerging research base relating to the high prevalence of ACEs for justice involved youth in general and ASOs in particular (Baglivio et al., 2014; Harrelson et al., 2017; Levenson et al., 2017; Faure-Walker & Hunt, 2022; Thomsen at al., 2023). The ACEs in this sample were well above ACEs reported in the UK general public. For example, Bellis (2013) reported that 47% of individuals in England had experienced at least one ACE, compared to 100% of participants in this study; and 8.3% of individuals had experienced 4+ ACEs, compared to 79.2% in this study. The high prevalence of co-occurring ACEs therefore adds to the evidence base for higher rates of polyvictimisation in ASOs (Harrelson et al., 2017). These results therefore highlight the importance of attending to the cumulative impact of adversity.

This study found emotional harm, caregiver instability, neglect and bullying to be the most frequently occurring ACEs. Each ACE has the potential to impact differently on the psychological, social and sexual script of the young person, with further variation in the cumulative impact of co-occurring ACEs. This is perhaps the best way to conceptualise the complex 'harmed' to 'harming' trajectory of many ASOs. Rather than necessarily being a direct modelling of something they have experienced themselves, the impact of the ACEs can be wide reaching, for example, sexual touch could become a way to cope with intolerable emotions such as fear or distress (Levenson et al., 2016). Feeling unloved, unnoticed or rejected, could result in feelings of inadequacy which may result in difficulties in the formation of age-appropriate relationships. Attitudes and perceptions can become distorted through exposure to harmful attitudes and behaviours of others and these attitudes can go on to influence behaviours.

Although it is important to not conflate adversity and trauma, it is widely recognised that ACEs can result in developmental trauma. It can be hypothesised that the chronicity of the adversity in this sample would result in complex trauma (Herman, 1997) for these young people, evidenced by the high rates of trauma captured within this sample.

Childhood trauma can lead to attachment insecurity (Grady et al., 2017) and this study adds to the compelling body of research demonstrating the high prevalence of attachment disruption in those that offend generally and specifically those that sexually offend (Beech & Mitchell, 2005; Grady et al., 2016, Levenson et al., 2017, Harrelson et al., 2017). The prevalence of attachment disruption in this sample (95.3%) alongside the high levels of co-occurring ACEs support previous findings (Murphy, 2014; Harrelson et al., 2017) that

suggest it is the cumulative impact of ACEs which specifically impacts on attachment formation. Of particular note, as emotional harm was the most frequently occurring ACE in the current study, emotional abuse has specifically been linked to the development of insecure attachments (Taussig & Culhane, 2010; Grady et al., 2017).

It is important to next consider the nuance of the apparent relationship between ACEs, trauma and attachment and how this may link to sexual offending. It has been suggested that the link between ACEs and attachment formation is that children develop attachment insecurity when they experience inconsistent, unresponsive, abusive, or neglectful care (Shilkret & Shilkret, 2011, Grady et al., 2017). Within this context interpersonal relationships could come to be viewed as threatening and so the young person may develop patterns of behaviour to avoid being hurt or abandoned or may come to see coercion and force as the only way to ensure their needs are met. If attachment disruption is viewed as a form of relational trauma, it becomes evident that this can impact on the social and emotional development and internal working model of a child, potentially skewing the way they view themselves, others, and the world. This then has the potential to impact significantly on the way they relate to themselves and others creating and underlying vulnerability from a relational perspective. It is hypothesised that harmful behaviours and sexual offences take place in the context of these potentially chronic relational difficulties.

Although research strongly indicates that ACEs and attachment issues are correlated, it is important not to view this as causation and to consider the potential bi-directional relationship (Grady et al., 2017). For example, a child that has experienced harm may display behaviours that present challenges for caregivers, not just at home, but in other settings such as school and this has the potential to impact on attachment formation. Similarly, harm at home may result in behaviours which impact on the child's behaviour in school, which in turn has the potential to impact on the child's ability to form and maintain friendships, thus furthering their relational difficulties.

Whist the high rates of trauma and attachment within this study are compelling, it is important to consider the 'outliers' – the ASOs that did not present with trauma or attachment disruption. Some similarities were noted in the small number (n=3) of these ASOs, for example two of them had neurodevelopmental diagnoses and two had experienced bullying in the absence of other forms of adversity. It could therefore be hypothesised that whilst bullying is clearly an adverse experience which does have the potential to be traumatic, perhaps for these children, the presence of healthy attachments buffered the impact, reducing the likelihood of this becoming traumatic. Although too small a number to generalise, the presence of neurodevelopmental conditions in the absence of trauma/attachment disruption in these ASOs is worthy of further exploration.

This study highlights the importance of the inclusion of social trauma such as bullying and peer rejection as an ACE. It is again important to consider the cumulative impact of adversity as within this study, bullying was identified for 81.4% of the sample, almost always co-occurring with family-based adversity. It is perhaps the combination of harm and rejection within and outside the home environment that leads to the development of distorted core beliefs and in turn problematic and harmful behaviours in these young people. These findings echo those of Thomsen et al. (2023) who also explored peer related harm and found 60.7% of youths that sexually harmed siblings had experienced bullying at school and 62.3% had experienced social exclusion or peer rejection. Again, bullying often co-existed with family-based adversity / abuse meaning the child did not experience safety or acceptance in either of these key childhood environments. The cumulative impact of this dual-harm (from family and peers) is worthy of further exploration.

Statistical analysis demonstrated associations between specific adverse experiences and detail of the offence, particularly in relation to victim characteristics. Whilst not statistically significant, ASOs with a pre-pubescent victim were more likely to have experienced sexual abuse, physical abuse, caregiver instability and domestic abuse, whilst those with an early onset of pornography use (below the age of 13) were more likely to have experienced neglect.

There were also significant findings in the opposite direction relating to victim age. Those with only post-pubescent victims (adolescent and/or adult victims) were significantly more likely to only have female non-family member victims and were also significantly more likely to present with non-sexual violence. Although the small scale of this study cannot allow generalisations, this may support in the development of a typology whereby ASOs with peer age or adult victims are more likely to offend outside the family and present with comorbid non-sexual violence.

There were several findings relating to the early onset of HSB. Firstly, bivariate analysis demonstrated that the higher the number of ACEs, HSB was significantly more likely to begin below the age of 13. When then considering specific ACEs associated with this early onset, neglect, domestic abuse and sexual abuse were the most strongly correlated (with neglect and domestic abuse being significantly associated). Those with an early onset were also more likely to have a male victim and a prepubescent victim. This corresponds with the above findings indicating that those with male victims were also likely to have pre-pubescent victims. Multivariate analysis revealed that high ACE score (polyvictimisation) significantly predicted the likelihood of an early onset of harmful sexual behaviour.

Although there is limited insight into younger children displaying HSB (Allardyce & Yates, 2013, Hackett, 2004), these findings are in support of previous literature which has

highlighted more chronic adversity in the developmental experiences of younger children with HSB (Gray et al., 1999; Taylor, 2003, Yates, 2012).

Considering the specific ACEs that were associated with an early onset of HSB, several postulations can be made relating to why children who have been harmed may go on to cause harm. It is important again here to highlight the extremely high prevalence of co-occurring ACEs, causing overlap in the impact of each. It is relevant to note that domestic abuse and neglect were more strongly associated with an early onset than sexual abuse, highlighting that the 'harmed to harmer' trajectory is not linear and will not always involve a re-enactment of the type of adversity experienced. It is well documented that experiencing sexual abuse as a child can cause physical and psychological harm and distorts the sexual script of the child. Those children who go on to sexually harm others do so in the context of what they have witnessed and experienced and the impact of this on their own behaviours and views of relationships and intimacy.

The relationship between domestic abuse and an early onset of HSB could be hypothesised to be linked to several factors. Firstly, domestic abuse is recognised to include sexual violence (Holt & Devaney, 2015), with British Crime Survey data suggesting that intimate partner rape makes up potentially half of all rapes (Hester and Lilley, 2016). As such, exposure to domestic violence could include the witnessing of sexual violence, which would impact on the developing sexual script of a child and could be re-enacted by young children who do not have the capacity to understand that this is not a healthy or acceptable way to treat others. It may be that in the context of living in a fearful environment, sexual behaviour (such as that between siblings) is an attachment-based behaviour, in which the behaviour is a source of comfort. Finally, in line with theories of social learning (Bandura, 1979), being exposed to domestic abuse has the potential to reinforce the use of coercion and aggression in relationships (McDonald & Martinez, 2017).

It could be hypothesised that children growing up in neglectful environments have reduced levels of supervision and may also be exposed to decreased boundaries which would increase opportunity to display harmful behaviours without detection or adult intervention as behaviours begin to present as problematic. Additionally, although not significant there was a positive correlation between neglect and an early onset of pornography use, again likely linked to opportunity to do this through reduced boundaries and supervision often present in neglectful households. Early exposure to pornography use should be viewed as psychologically harmful to the child, with the potential to skew their developing sexual script, therefore being hypothesised as a key precipitating factor in displays of harmful sexual behaviour.

Implications for Practice

If, as Masson et al., (2015) propose, ACEs are viewed as markers of vulnerability as opposed to developmental risk factors, the finding of this study strongly indicate that early intervention to prevent children experiencing ACEs and trauma, and to help and support children and families where ACEs are occurring, has the potential to reduce sexual abuse (Faure-Walker & Hunt, 2022; Ogleive et al., 2022). Knowledge of developmental pathways to HSB will support services in designing the most effective tertiary interventions but could also assist practitioners and policy makers in developing primary and secondary prevention strategies to reduce offending before it happens (Grady et al., 2017).

This study supports the growing evidence base highlighting the importance of attending to developmental and relational trauma in interventions with ASOs considering their levels of vulnerability and risk. Whilst health and social services are beginning to recognise the need for trauma informed care (Levenson et al., 2017), this research highlights that services working with ASOs must be both trauma-informed but also trauma-responsive, with an expectation that the majority accessing the service will have experienced adversity and trauma.

The need for this to begin at the point of assessment is clear, highlighting the need for developmentally sensitive assessments which consider a range of adversities, in addition to the risk behaviour. What may seem relatively typical experiences may have a traumatic impact when the cumulative impact of adversity is explored (Harrelson et al., 2017). This confirms the fundamental importance of formulation to ensure that interventions are tailored to the needs of the young person, to have the best hope of addressing both vulnerability and risk.

Attachment disruption has the potential to impact on all relationships, including those outside the family and so could impact on relationship with therapist (Harrelson, 2017) highlighting the importance of stabilisation and safety within attachment/ trauma-based therapy (Levenson et al 2014; Harrelson et al., 2017).

The extent of ACEs which directly relate to difficulties and behaviours of parents / family (domestic abuse; parental substance misuse; parental mental health and family criminality) adds to the evidence base for the key importance of a systemic approach to support and intervention following incidents of HSB, (Archer et al.,2020; Campbell, 2018; NICE, 2016).

The high rates of bullying highlight that out of family harm should be included within an ACE framework. This supports the concept of contextual safeguarding (Firmin 2017) and the need for systemic interventions not only for families but within the wider system in which the child exists including school. There is limited literature relating to trauma-informed schools (Cafouleas et al., 2016; Maynard et al., 2019), however this study indicates that the implementation of trauma-informed and trauma responsive care within

an education environment would be another area in which primary and certainly secondary prevention could take place.

Limitations and Future Research

As identified for many studies of this population (Hackett, et al.,2013), the sample size is potentially a limitation of this study. UK youth custody rates have fallen over recent years (YJB, 2023) and so there are fewer young people sentenced to immediate custody. The relatively small sample size and the specific cohort being ASOs that have reached the custody threshold impacts on the generalisability of these study findings.

In terms of methodological limitations, this study required evidence rather than suspicion of an ACE for inclusion. This may have resulted in an underestimation as it is recognised that there are many barriers to children reporting abuse, due to factors such as stigma, family loyalty, shame, or fear. Moreover, there can be a delay in recognising adverse or harmful experiences in childhood if the behaviour taking place is the norm within the child's family.

Any study involving exploration of ACEs and the impact of adversity is complicated by the fact there are different conceptualisations and definitions of ACEs. The same ACE could be defined very differently, for example neglect could incorporate physical or emotional neglect, with some frameworks combing the two, and others extrapolating into two or more categories of neglect. Moreover, there is potential for ACEs to be interconnected with the most obvious example being emotional harm which can of course occur independently but is perhaps more likely to be a feature or by-product of all other types of adversity.

Using different definitions of ACEs and not adhering rigidly to Fellitti's framework complicates comparisons between studies. As Fellitti's ACE framework was developed to explore health outcomes in adults as opposed to having a direct focus on youth offending behaviour, it would be helpful to develop a framework for measuring childhood and adolescent adversity, taking into account increased knowledge and research with justice involved youth. It would be important to consider the inclusion of contextual factors such as poverty, social exclusion, and racism which are adverse experiences likely to be over-represented in populations of justice involved youth (Finkelhor, 2018; Skinner, 2021; Thomsen et al., 2023).

Whilst this study expands the research base in relation to the cumulative impact of ACEs for ASOs, it was not possible to explore the impact of the timing of the adversity which is proposed to be of relevance (Hawes et al, 2021; Schroeder et al, 2018). Other detail of the ACE was also not captured such as chronicity or who caused the harm, both of which could have relevance for impact. Nor did this research capture the presence or absence of

protective factors which early exploration has indicated may mediate the impact of ACEs (Davis et al., 2019; Moore & Ramirez, 2016). It may be that in addition to higher incidence of ACEs, this population have a reduced number of protective factors than those that also experience adversity and trauma but do not go on to harm others.

A further limitation of this study is that most participants were White British. Whilst this was the reality of the sample, there is the possibility that the experiences of a more diverse population of justice involved youth may yield different results.

Whilst not a focus of this study, it is important to highlight the over-representation of adolescents with neurodevelopmental disability. Estimates in the UK are that 1 in 100 people (1%) are autistic (O'Nions, et al., 2023) compared to 20.9% in this study. This is an issue worthy of further research.

3.6 Conclusion

This study outlines the high prevalence of polyvictimisation in a sample of ASOs which illustrates the need for thorough assessment of the developmental experiences of young people who display harmful sexual behaviour to ensure interventions that are trauma and attachment informed. Polyvictimisation was found to predict an early onset of harmful sexual behaviour further emphasising the need for early intervention responses, which have the potential to disrupt the 'harmed to harming' trajectory of these young people.

4. CHAPTER FOUR: PRIMARY RESEARCH STUDY (QUALITATIVE)

"It is what it is": An Interpretive Phenomenological Analysis of the accounts of adolescents in custody for a sexual offence

4.1 Abstract

The aim of this study was to explore narratives of adolescents with a sexual offence (ASOs). Semi-structured interviews were undertaken with six adolescents and analysed through Interpretive Phenomenological Analysis (IPA). Four superordinate themes emerged; 'No Safe Base'; 'Angry Child'; 'Learning to Cope' and 'My Normal'. Participants also completed self-report measures which offered further insight into trauma symptoms and experiences of warmth and safety in relationships. The richly detailed interview and psychometric data in this study provides results which highlighted that these ASOs have experienced harm and disrupted attachments including family and school rejection, with wide ranging impact from an early onset of emotional dysregulation and aggression to dissociation, normalisation, and acceptance. The interviews include adolescents' perspectives on their life experiences in the hope that the voices of these young people will aid clinical practice and intervention strategies and add depth to research in this area.

4.2 Introduction

Whilst the research base pertaining to adolescent harmful sexual behaviour (HSB) is growing, there are a lack of qualitative studies in this area (Balfe et al., 2020, Grady, 2018, McCuish & Lussier, 2017). Balfe et al. (2020) note that much of the research in this field is quantitative and therefore lacks the depth of analysis which would be available within qualitative research. Vizard, Hickey, French, & McCrory (2007) offer insight into why these gaps in research exist, citing issues such as difficulties in researchers being able to access the services which work with this population, along with the complexities of the young people being able to speak about their behaviours.

To address the dearth of qualitative research, Balfe et al. (2020) undertook a study in which detailed case files were analysed. However, whilst providing valuable insight into the lived experiences of the families, as the study involved retrospective review of case files, the contemporaneous 'voice of the child' remained largely absent.

There has been increased credibility afforded to qualitative research methods in social scientific research (Willing & Stainton Rogers, 2008). Moreover, there is increased interest in involving children in qualitative research and the importance of children's voices being heard within research is recognised (Huang et al., 2014). Kirk (2007) highlights that the inclusion of children within qualitative research should be framed in a children's rights

perspective with increased recognition within health and social sciences of children as 'active agents' rather than 'passive objects' within studies.

There is a growing evidence base relating to the prevalence of adversity, trauma, and attachment disruption in the developmental histories of adolescents who have displayed harmful sexual behaviour (Fox et al., 2015; Hackett, et al., 2013; Levenson, 2017; Malvaso et al., 2022; Miner et al., 2016). It is however important that the research base now explores the '*how*' and '*why*' of the relationship between early adversity, attachment disruption and trauma and adolescent harmful sexual behaviour and this will require the richness and depth of qualitative research. Eatough & Smith (2006) postulate that when people narrate personal events they also "*imbue these events with meaning so that they come to form part of their past, present and future lived experiences*" (p. 118)

The aim of the current study was to explore the narratives of six adolescents convicted of a sexual offence (ASOs) serving a custodial sentence in a UK secure establishment with the hope of addressing the lack of qualitative research in this area. Whilst quantitative research evidences the high prevalence of ACEs and trauma for ASOs, this study aims to progress the understanding of 'why' this may be the case through providing rich, idiographic, qualitative data.

Research Question:

What are the narratives of adolescents with a sexual offence (ASOs) about their life experiences, and how can these assist in understanding their pathway to offending and their intervention needs?

4.3 Method

Ethical Approval and Consent

Ethical approval for the study was granted by the University of Nottingham, and through Integrated Research Application System (IRAS) which included NHS and HMPPS ethical approval (IRAS ID: 300627). A copy of the Research Ethics Committee Approval letter is provided as Appendix 8. The British Psychological Society (2010) code of conduct for human research ethics was followed in the undertaking of the study, in addition to following guidance outlined by Farrel (2005) in 'designing ethical research with children'.

Ethical approval was granted to undertake interviews lasting a maximum of one hour, followed by a further hour for the participant to complete the self-report measures. This relatively limited time requested for interviews and psychometric completion was to take into account factors such as concentration levels and overall impact on the young person's

well-being. Psychometric measures were chosen that were brief enough to complete in this timescale.

All participants provided informed consent to take part in the study and relevant professionals agreed to the young person's involvement prior to them taking part. Participants were made aware that entry into the study was entirely voluntary and that their Care Plan / Sentence Plan would not be affected by their decision. It was also explained that they could withdraw from the study at any time. The consent form and participant information sheet were developed in collaboration with a young person in custody (who did not take part in the study). These are provided as Appendix 9 and Appendix 10.

In line with the BPS (2010) code of conduct, within the application for ethical approval both risk to participant and risk to researcher were considered. Risk to researcher was deemed to be low and was assessed as manageable as all interviews were undertaken in a secure establishment which the researcher was familiar with. Although there was no-one else present in the room, HMPPS staff were close by. Potential risk to the researcher was discussed with the care team when considering each individual's participation in the study.

The well-being of participants was paramount when planning the study. The questions were given careful consideration and whilst entirely possible that a question could unexpectedly cause distress, questions were kept as open as possible, with participants made aware that they could choose not to answer any question and that the study could be ended at any time (interview schedule is provided as Appendix 11). The purpose of the research was not to explore the offending behaviour and so this was not an area that participants were specifically asked about during the interview, with recognition that this can be an emotive subject. It was agreed from the outset that the interview would be terminated if there was any evidence of distress, with support arranged for the young person if this was required, however there were no overt signs of distress from participants who took part in the study.

A key factor in obtaining ethical approval was the researchers background as a qualified social worker with many years of clinical experience. It was therefore anticipated that any adverse impact on participants would be recognised and attended to within the interview, with confidence that the researcher would seek support for the young people following the interview, should this be deemed necessary.

Participant Recruitment

Purposive sampling was used, and participants were recruited through Forensic Child and Adolescent Mental Health Service (FCAMHS; the in-reach service delivering assessment and intervention within the secure establishment). Discussion took place with the

allocated FCAMHS clinician prior to approaching participants to take part in the study to ensure that no issue was identified which would prevent them taking part (such as concern about impact on their immediate well-being). If the young person met the eligibility criteria (outlined below), the FCAMHS clinician then spoke to the young person to ask if they would consider taking part in the study, following which, if the young person agreed, the researcher arranged to meet the young person to explain the study and provide the consent form and participant information sheet. All those spoken to by the researcher consented to take part. Relevant members of the young person's care team were contacted to advise of the planned participation in the study and were contacted again following completion of the interview, to ensure support could be provided if this was needed. Recruitment for the study ended when interviews had been completed with six young people.

In order to have as representative a sample as possible, there was minimal exclusion criteria. Young people with neurodevelopmental difficulties and those with mental health difficulties were not automatically excluded. The young person could be included in the study if adults in their care team believed they had capacity to consent, and that taking part would not be detrimental to them. Participants for whom English was not a first language were also not excluded from potential inclusion in the study and access to an interpreter would have been arranged if required, however all participants who took part spoke English as their first language.

Table 4.1

Inclusion & Exclusion Criteria

Inclusion Criteria	**Exclusion Criteria**
Male aged 15-18 years	Female
Residing within youth custody that has accessed the FCAMHS Harmful Sexual Behaviour Pathway.	Young people deemed by care team to be too vulnerable to take part.
Convicted of a sexual offence OR allegations of a sexual offence for which there is no further legal action, and which are admitted by the young person.	Young people on remand that have not yet been convicted or that have entered / plan to enter a not-guilty plea.
Able to give informed consent. Parental consent will be sought for young people under 16 and the young person will be asked to assent.	

Participants

The participants in the study were six adolescent males who had been convicted of a sexual offence and were in UK youth custody. Participants all identified as White British with a mean age of 16.8 years. The sample size of six is ostensibly modest, but appropriate for the purposes of Interpretive Phenomenological Analysis (IPA), the chosen methodology (Smith & Osborn, 2008). Alase (2017) suggests that for the phenomenological research tradition, the sample size should be between two and 25. Further, Clarke (2010) suggested that between four and 10 participants is advised for professional doctorates using IPA.

Data collection

All participants were interviewed on a one-to-one basis with interviews conducted in a private room within the secure setting. As far as could be achieved within a custody environment, this was a respectful and private environment for participants to "*tell their stories*" (Waldram, 2007, p. 963). The interviews were recorded on a Dictaphone and transcribed semi-verbatim, with the only information removed being that which may identify participants, their families, or victims. Participants were debriefed after interview and given the opportunity to ask questions.

All participants were asked whether they would like a copy of the study when written up, however all declined this. Whilst this may suggest a level of disinterest in the study, this was not how participant's responses were perceived by the researcher. One participant specifically commented that he struggles to read things he has said when they are written down due to distressing reports he has read about himself previously. There is potential that this was also an issue for other participants in that they may have come to anticipate that documents written about them may have emotive information or reflect them in a negative way. Another factor which was considered relevant is the prevalence of literacy difficulties in young people within youth custody environments, with links to issues such as cognitive difficulties, but also environmental issues including low school attendance / school exclusion. A final factor to consider is the nature of the offences of the young people in this sample. Young people in custody for a sexual offence can face significant difficulties in terms of stigmatisation, but also threat to their safety through verbal and physical assaults if it becomes known that they are convicted of a sexual offence. Young people go to significant efforts to ensure their offence does not become known amongst peers. As such, being provided with a document that makes any reference to sexual offending, or any risk of peers knowing they had taken part in such a study would cause understandable anxiety for these young people and may have impacted on their wish not to have a written account of the research.

The data were collected through semi structured interviews which lasted between 17 and 51 minutes (mean = 28.9 minutes). Semi-structured interviewing was selected for its flexibility, and open-ended questions were used in the hope of a more considered response by participants, with insight into their views and lived experience of the subject area. Byrne (2004) highlights that (qualitative interviewing) "*when done well is able to achieve a level of depth and complexity that is not available to other, particularly survey-based approaches*" (p.167). As Smith and Eatough (2012) outline, semi-structured interviews also allow the researcher to follow up important and possibly unexpected issues which may emerge during the interview.

Participants also completed two self-report measures, the Trauma Symptom Checklist for Children (Brierre, 1996) and Early Memories of Warmth and Safety Scale (Richter, Gilbert & McEwan, 2009). Permission was given by the publishers of each measure to use within this study.

The Trauma Symptom Checklist for Children (TSCC) is a 54-item measure of post-traumatic distress and related psychological symptomology in children. The TSCC is a well evaluated measure of trauma symptoms in children, with good results reported in relation to the reliability and validity of the tool (Briere, 1996; Kretschmar et al.,2018; Ohan & Collett, 2002). The TSCC has been shown to have high internal consistency with a Chronbach's alpha range from α= .78 to .89 for the clinical scales (Briere, 1996; Nilsson et al., 2008) Nilsson et al. (2008) reported good test-retest reliability for the TSCC (total scale *r*=.81, clinical scales *r*=.67-.81). The concurrent validity for justice-involved youth was explored with the results evidencing that the TSCC was able to differentiate between children with and without DSM diagnoses relevant to the scales (Kretschmar et al., 2018).

Studies of the psychometric properties of the TSCC have been undertaken in samples of community, inpatient and justice involved youth (Briere, 1996; Butcher et al., 2015; Kretschmar et al., 2018; Sadowski & French; 2000; Saunders, 1999). Although the TSCC was designed for use with children aged 8-16, the author reports that validation studies support the TSCC being utilised with young people aged 17 years, and there is evidence to support the utility of the tool with this age group (Briere, 1996; Finklehor et al., 2007; Stathis et al., 2005). The psychometric properties, general clinical utility, and the use of the TSCC within a custody population are explored further in Chapter 5.

The Early Memories of Warmth and Safety Scale (EMWSS) is a 21-item measure of personal memories of feeling warmth, safe and cared for during childhood. Excellent internal consistency (α = .97) and good test–retest reliability (*r* = .91) has been reported for the use of the EMWSS with adults (Richter et al., 2009). Use with adolescents was tested using the Portuguese version of the tool with excellent internal consistency (α = .95) and good test–retest reliability (*r* = .92) again reported (Cunha et al., 2014), and measurement invariance across sex and groups, including community and youth justice samples (Vagos et al., 2017).

When consenting to participate in the study, participants also consented for the researcher to access to their data held within the service dataset. This contained coded information relating to diagnoses, adverse childhood experiences, and offence detail (as outlined in Chapter 3). This data was not accessed until after the interviews had taken place in order that this information did not contaminate the interview at a conscious or unconscious level. Any information relevant for the interview such as that which may relate to risk to researcher, risk to participant, or adaptations required for the participant was shared by the FCAMHS clinician prior to the interview taking place.

Participant detail is provided in Table 4.2. This information is brief to prevent identification of participants.

Table 4.2

Participant Information (N=6)

Participant	Neurodevelopmental conditions	Number of ACEs	Index offence	Other offending behaviour
P1	N/A	9	Rape (peer age)	Yes
P2	ADHD	1	Rape (peer age)	Yes
P3	ADHD	9	Sexual assault (child and adult)	Yes
P4	ADHD Low cognitive functioning	10	Rape (adult)	Yes
P5	N/A	7	Rape (younger child)	No
P6	Autism	8	Rape (younger child)	No

Analysis

The research utilised the analytic method of Interpretative Phenomenological Analysis (IPA) since, as Reid, Flowers and Larkin (2005) promulgate, "*participants are recruited because of their expertise in the phenomenon being explored*" (p.20). IPA examines how participants make sense of their personal and social worlds (Smith & Osborn, 2008), and its central concern is with the subjective experiences of individuals (Eatough & Smith, 2006). IPA is a double hermeneutic method where participants seek to explain and interpret their own experiences, and researchers subsequently re-interpret participants' interpretations of their accounts of these experiences. As such, IPA can be seen to move beyond merely

describing individual responses and provides a more abstract, theoretical insight into the area of interest.

Analysis was guided by previous precedents (Smith, 2015) and entailed: Stage one – listening to the audio recordings of each interview several times in order to recall the atmosphere of each interview. At this point notes, reflections and thoughts were noted. Stage two involved the detailed reading, re-reading, and analysis of each transcript individually, with comments and observations recorded on content, language used, metaphors, and emotional reactions of the participant.

Stage three involved the re-reading of each transcript, with further notes added linking concepts and emerging themes intra and inter-transcripts. The use of the term 'emerging' themes refers to what Williams (2008) described as the process by which the narratives of the views and experiences of participants are captured through interactive reading and re-reading of the complex and nuanced data. It is through this inductive analysis that themes can be described to 'emerge', with similarities and patterns noted and consideration given to differing and conflicting narratives. It is recognised in the use of this term that the researcher plays a crucial role in the construction of these themes, evidencing the crucial role of considering researcher reflexivity within qualitative research.

In stage four, those themes that were identified in at least half of the transcripts were selected (Dickson, Knussen & Flowers, 2008). Emergent themes were subsequently clustered under superordinate headings. The researcher endeavoured to counterbalance the capture and presentation of rich idiographic data against the extraction and reporting of recurring themes across the data set. During this data organisation process, the researcher engaged in a continual iterative process, moving between themes and transcripts to ensure that the themes selected were representative of participants' accounts and that extracts highlighted the essence of the theme and the lived experience of an individual.

An example of a coded interview transcript and final themes are provided as Appendix 12 and Appendix 13.

Reflexivity

A critique of qualitative research is the potential for subjectivity and reduced rigor. One way to address this is through reflexivity (Teh & Lek, 2018). Within IPA the researcher becomes a co-constructor of meaning as they both gather and interpret the data (Smith, Flower, & Larkin, 2009). As such, it is essential that there is a process for the researcher to consider their personal perspectives, biases, and factors which may influence their interpretation. Reflexivity supports the credibility of qualitative research through transparently documenting the researcher's personal beliefs, values, and knowledge (Berger, 2015).

Researchers need to be able to demonstrate reflexive awareness about their own ontological (nature of reality) and epistemological (nature of knowledge) assumptions (Willig, 2012). This research has been undertaken from a critical realist ontological and epistemological stance. Critical realist ontology suggests that both objective and subjective realties exist. In terms of epistemology, critical realism rejects the notion of 'absolute truths', in favour of the view that truths exist which have not yet been uncovered (Westhorp, 2016).

During the study period, the researcher completed a reflexive journal and discussed the research within clinical and academic supervision. Walsh (2003) distinguishes between 'personal' and 'interpersonal' reflexivity both of which were considered within this study. A reflexive statement is provided as Appendix 14.

4.4 Results

The themes that emerged during the IPA analysis are detailed in Table 4.3. The results section will explore the four superordinate themes and the subordinate themes within them, following which there will be discussion in terms of their pertinence in attempting to understand adolescent harmful sexual behaviour. The contribution of participants to each theme is provided as Table 8.16 (Appendix 15).

Table 4.3

IPA Themes

Superordinate theme	Subordinate theme
1. No Safe Base	1.1 Disrupted Attachments
	1.2 Total Rejection
	1.3 Transitions
	1.4 Violent Fathers
2. 'Angry Child'	2.1 'Fight Club'
	2.2 School Exclusion
	2.3 Trouble with Friends
3. Learning to Cope	3.1 Surviving – Being Strong
	3.2 Loyalty
	3.3 No-one Helps
	3.4 Every Interaction Matters
4. 'My Normal'	4.1 Holding It In
	4.2 Acceptance: 'It is what it is'

Superordinate Theme 1: No Safe Base

A prominent theme, echoed by all participants was the lack of a 'safe base', highlighted by the extract below from P3 who, like others struggled to recall a sense of safety during his childhood.

> *I: Can you tell a time in your life that you've felt safe?*
> *P3: No.*
> *I: No? Have you ever felt safe?*
> *P3: Not that I can remember no.*

For some this was not feeling safe at home for a variety of reasons including experiences of chaotic home lives and domestic abuse. This theme also incorporates the lack of a 'safe base' in terms of broken attachments, transitions in care, and experiencing parental rejection.

P1 highlighted the complexity of identifying what is meant by feeling 'safe' and how this concept could be interpreted differently. In the excerpt below he gave insight into what this meant for him.

> *P1: Yeah I wouldn't really say I've felt safe in my own house. 'Cos my mum was there.*
> *I: Ok. So, you didn't feel safe at home?*
> *P1: No, but safe is a very lose term, I don't think it's very definitive, like you know I don't think I'm gonna bloody get shot or something, but you know, is it safe from arguments? Safe from, you know, feeling like shit? No.*

1.1 Disrupted Attachments

Five participants described experiences of disrupted and broken attachments through loss, separation, or harm from a parent or carer. Five participants described parental separation, with periods of separation from one or both parents as a result.

P1 described a complex relationship with his mother in which he was clear that he loved her, and she was important to him, but he also gave a compelling account of his fear of her at times and a sense of not always being loved. Throughout the interview P1 fluctuated between speaking of his sense of love, co-existing with a sense of confusion and fear about his mother.

> *P1: Erm, there's a lot of problems where like you know, like the, what's it called? Like the unconditional love part. That never really fit with my mum.*

When asked who was important in his life, P3 initially replied, "*My sister. Apart from that, my niece. That's it"*. He went on to describe a negative relationship with his parents and was clear that they were not important to him.

1.2 Total Rejection

Three participants spoke of complete rejection from a parent, with an absence of any relationship with them at the time of interview. For two participants this rejection occurred prior to their offence, whilst for one participant rejection was post-offence, which perhaps indicates the fragility of the attachment and the conditional nature of the care afforded to them. P6 gave a powerful account of complete rejection and spoke of the profound impact this had on him whilst P3 and P4 appeared to try to minimise impact of rejection through negative comments about their fathers and presenting with a sense of 'bravado'.

> *P6: So yeah, losing my mum. Not having that contact with my mum anymore, that hurt really bad 'cos I love my mum to bits. When she tells me she hates me…to go kill myself, that hurt, cos my mum's like my best mate.*

P3 described an incident in which he and his father had argued resulting in a physical altercation, following which he shared that his parents "*put me in care".*

> *P3: …my dad took the phone off me, so I told him to give it back, and he pushed me up the stairs, so I pushed him back and he said I strangled him. Then he said he didn't want me back.*

P4 recalled his father being in and out of his life and then described the last time his father left, which he said was the last contact he had with him.

> *P4: …he chose his girlfriend over me. He chose his mates over me.*

1.3 Transitions

Five of the six participants spoke of experiencing a number of transitions in their lives. For P5 this was transitions between his parent's care, impacting on his time with the other parent and his siblings, for the remaining four participants the transitions were either frequent and/or extreme, often at times of crisis and abuse. P3 and P6 had spent time as a 'child in care' and P1 and P4 both described times (prior to the age of 16) that they were "*homeless".*

P1 described a relationship with his mother in which they would frequently argue, which he explained was in the context of her mental health difficulties. P1 shared that arguments invariably led to him having to find somewhere else to sleep.

> *P1: Erm, but yeah, pretty much always ended up me going back to hers [mum's] cos you know, it's her house or being homeless.*
> *I: And where did you go when you left?*
> *P1: Anywhere. Erm, mate's houses, family houses, ex-girlfriends family houses. Erm sometimes the park bench (laughs).*
> *I: So sometimes it was so tough at home it was better to just sleep anywhere else?*
> *P1: Yeah there's no threat, erm being stabbed with a screwdriver in my sleep on a park bench, so erm…*

P4 also described himself as "homeless" following arguments with his mother and like P1 there was a sense of normalisation about this experience of having nowhere to sleep following an argument with a parent.

> *I: What would make you fight with your mum, what sorts of things?*
> *P4: Constantly talking, telling me to do stuff and like slap me if I didn't do it. Arguing with me.*
> *I: So your mum would slap you?*
> *P4: Yeah.*

I: And would you argue back with her?
P4: She'd just kick me out and that innit.
I: And where would you go when she kicked you out?
P4: I'd have to find a car innit.
I: Would you sleep in a car?
P4. Yeah.

1.4 Violent Fathers

As outlined above, although there was reference to physical harm from mothers from P1 and P4, three participants described home lives characterised by domestic violence from their fathers, with one of the three also sharing accounts of extreme physical abuse from his father. A further two participants described experiencing physical aggression from their fathers. This is important when considering the next superordinate theme in which participants described their own anger and aggression.

P4 expressed intense anger towards his father and circled back to his view that he "*hates*" his father on several occasions during the interview, concluding several times, "*He can fuck off"*. P4 described domestic violence from his father to his mother and expressed a wish to "*smash his* [father's] *head in"* in retaliation for the violence his father had displayed towards his mother.

P4: Him and my mum they had a fight and he kicked her…..He'd come home pissed as a fart and he'd try to sit on my mum and that, hit her and that.

P6 was one of the participants that described domestic violence and physical abuse from his father. He described domestic abuse during the time his parents were in a relationship and then physical abuse, to the extent of sustaining injuries during times he was in the care of his father.

P6: There's been a lot of incidents in front of me and my brother where they got into a big fight. Police were called, my dad was arrested in front of me. Erm, on several occasions. He was arrested in front of me on several occasions.

Superordinate Theme 2: Angry Child

This theme focuses on participants descriptions of themselves as being angry during childhood which was again relevant for most participants (n=5). This was exemplified by P1 who, when asked what his life was like as a young child replied, "*Erm, I was a very angry child"*.

The same five participants experienced school exclusion which is further explored within this theme, along with the relevance of friendship difficulties.

2.1 'Fight Club'

The titular quote for this subtheme comes from P1 who described his school life as "…*like fight club*…" Like other participants, P1 presented with a normalised view of violence which was congruent with his experience of violence at home. P1 described a fight in which he defended his friend at around the age of 13.

> *P1: And then I just went black. You know when you just go black. I put my head down and started swinging and before you know it about eight people are knocked out on the floor and I'm just stood there like…blood covering me and I realise it's not my blood. And I'm like shit...Erm so yeah it was like either get kicked out of school or they were gonna ring the police, they were gonna get the police involved.*

Like P1, other participants described an early onset of violence which all participants linked to feelings of anger. P2 described anger and fighting for as long as he could remember.

> *P2:* Well, my first primary school I got kicked out from year 2.
> *I: What had happened?*
> *P2: Just fighting all the time. Always angry and that.*
> *I: And what sorts of things would make you angry?*
> *P2: Everything.*

Similarly, P3 and P4 described an early onset of violence which both described continuing throughout their lives, including their time in custody.

> *I: What about, do you remember primary school?*
> *P3: All I remember is fights. I got in fights.*
> *P4: I used to run away, have fights, get into trouble, steal cars and that.*
> *I: Did you? And how old were you when you started doing stuff like that?*
> *P4: About 11 innit.*

2.2 School Exclusion

Five of the six participants shared that they had been excluded from school, with all five moving to alternative provision during their time at secondary school. Three of the five were not attending any form of education or employment at the time of their index offence.

Below P3 provides insight into his behaviour within education and how violence resulted in his school exclusions. P3 laughed as he described incidents of aggression and disruption in school.

> *P3: I was at school until…start of year nine. I got kicked out for taking a BB gun and trying to shoot the headteacher with it (laughs).*
> *I: Did you? And where did you go then? Were you sent to a…*
> *P3: I went to one of them thingys. Erm, I was there for a couple of weeks. Oh, and then I went to a PRU but I got kicked out of there cos I threw a chair at someone. And then I went to this sports centre, and I went to another school for one day, then I climbed over the fence and I just started going out all day.*

Whilst P3 spoke of continued difficulties within alternative provision, P1 described his preference for attending a Pupil Referral Unit.

> *P1: Yeah I went to [name of PRU]. Yeah, really nice. I loved it. I wish I would have went there sooner.*

It is of note however that P1 later explained that he rarely attended the PRU and was later moved again to another provision. P1 identified that whilst attending the PRU, a factor which helped him was being able to leave and go to his grandparents where he described feeling calmer, evidencing that the school environment was not a space in which he felt safe or contained.

> *P1:…so yeah whenever I used to get like stressed out or anything like that, any like loud noises or anything like that I get really stressed out. That's when I start getting angry and shit. Erm (pause), whenever shit would kick off there and they'd be like P1 out for a bit, I'd go to my nans.*

2.3 Trouble with Friends

Four participants gave accounts of having friends who were also involved in aggression, criminal and anti-social behaviour. Of note is the strength of the bond to these friends described by participants. Most smiled and became animated when they spoke of their friends and the behaviours they would be involved in together.

> *I: And when you were getting into trouble, was that with your friends?*
> *P2: Yeah, never on my own. I have never been on my own.*
> *I: And you said you were getting into trouble with the police? What was that for?*
> *P2: Like shooting rockets at cars. Setting fires. Not in houses or anything like that. You know when you go down river with your pals, make little fires when it's cold or summat. Motorbikes. Flying around on motorbikes.*

I: And what about friends? Tell me about your friends.
P3: When I was in [hometown] 'til I was 14, I had loads of mates. All sound and that. We'd be robbing people, going round in cars.
I: When did you start doing things like that? Robbing?
P3: 12.
I: Ah ok, and that was with your mates?
P3: Yeah, it's just messing about.

Here, P2 and P3 provide accounts in which early involvement in antisocial and criminal behaviour appears normalised. P3's use of the term "*messing about*" for describing robberies and stealing cars emphasises the extent to which he views this as being nothing out of the ordinary.

When considering friendships, it is of note that information contained within the dataset showed that five participants had experienced bullying, although only three participants mentioned this within the interview. Additionally, one participant spoke of difficulties in making friends and one participant described difficulties in maintaining friendships which indicates that friendships were a relevant issue to consider for all participants.

Superordinate Theme 3: Learning to Cope

Participants provided some insight into ways they had learnt to cope, and the extent to which they were helped by others.

3.1 Surviving – Being Strong

Several of the participants (n=4) described premature autonomy, in terms of looking after themselves and looking after parents or siblings. This seemed to be coupled with a desire to be seen as strong and not needing the support of others. A sense of 'bravado' and wanting to be viewed as 'tough' was particularly present for P1, P2, P3 and P4.

P1: I wouldn't say necessarily look after my mum. It's more look after myself. Like I had to do a lot of shit for myself. Erm, which I don't necessarily think is a bad thing.

P6: I had to grow up quite quickly from being quite young. 'Cos when my mum went out, I'd have to make food for my brother and my sister. I'd have to look after my sister, look after my brother even if my parents were there. I'd always be with them, couldn't get away from them. That kinda thing.

Exemplifying the sense of learning from a young age to only rely on himself, P3 described his parents placing him in local authority care and downplayed any impact.

> *P3: I'm not really arsed. I only need myself.*

Later when describing being bullied which he said was "*horrible*", P3 shared that he did not tell his parents this was happening and again expressed the view that he did not need care or protection.

> *P3: I just prefer to look after myself.*

P4 also described a need to be strong, describing himself as "*not scared of anything"*. P4 spoke of looking after his mum at times of domestic abuse:

> *P4: I'd look after me mum innit, but erm, now that I'm older I know that I wouldn't have done that [been violent to a woman].*

P4 seemed to be troubled by a sense that he had not protected his mum and spoke several times of a desire to now be violent to his father. When speaking about his sense of '*not being scared of anything'*, P4 was asked if that had always been the case and his reply provides further insight into his perception of the need to be '*strong*'.

> *P4: When my dad hit my mum, that changed me.*
> *I: How do you think it changed you?*
> *P4: It just did. I started going to boxing and all that. To stand up to him. Then I'm not scared anymore.*

Similarly, when discussing physical abuse from his father, P6 expressed his regret about not being '*strong enough'* to defend himself.

> *P6: I just wish that I was strong enough and big enough to go, to stop it when I was younger.*

Interestingly, providing insight at a more systemic influence, P1 also reflected on living in an impoverished and high-crime area and the influence this had on him learning to "*survive*" from a young age.

> *P1: So, it's like you've gotta survive. You've gotta literally survive. Erm, it's quite hard to live where I'm from unless you've got a load of money. There's not a lot of shit to do and that's probably why there's a lot of crime and everything you know. Why everyone used to fight at*

school and everything, cos there's nothing else to do. Erm, yeah that's probably it.

3.2 Loyalty

With the exception of P2 and P5, four participants recalled negative elements of their relationships with one or both of their parents an\or of their parent's behaviours. However, there was also a tendency to display loyalty to their parents and to try to explain or excuse their parent's behaviour.

P1: Erm yeah I love my mum. She's my mum. She has problems sometimes, but I've always been able to stick up for myself. There haven't been many occasions, I can count on my hand how many occasions there've actually been where she's actually gone, tried to hurt me or physically hurt me or anything. It's more mentally you know. She's just screaming and shit.

Later, when describing learning to look after himself, P1 paused and provided further explanation for his mother's behaviour, seemingly to ensure she was not viewed in a negative light.

P1: I'm kinda making out my mum didn't do shit. My mum did a lot of things. You know she paid the bills, put a roof over my head. Erm, you know she paid for the food and everything. So, you know…it's not that bad. Erm, yeah, so I've learnt a few things from my mum.

Similarly, P6 made efforts to highlight his love for his parents and to attempt to explain the behaviours which he had earlier indicated had harmed him emotionally and/or physically.

P6: Erm, and I love my dad and I didn't want to ever get him into trouble. And I was also scared of my dad… My mum was young when she had me…she don't know how to look after a kid. She was still a kid herself, do you know what I mean?

P1 and P6 went on to defend their parent's behaviours towards them through making negative comments about themselves, with P6 describing himself as "*quite a demanding child"* and P1 commenting, "*I was a bit more of a twat too back then to be honest"*.

3.3 No-one Helps

A number of participants (n= 4) expressed a perception of not being helped by professionals. Some shared specific negative experiences of professionals, whilst others (n=2) presented with an ambivalence about professional involvement with them and their family.

P4 did not distinguish between family members or professionals, and simply said that no-one had helped him.

I: Has anyone ever helped you P4?
P4: No.
I: Do you think people can help you in here?
P4: They try to. It's just hard.

P6 had spent time as a 'child in care' and had significant involvement with professionals. P6 expressed feeling let down by professionals and particularly expressed frustration at frequent changes of the person working with him.

P6: But my social worker, sometimes I wish he'd have just listened to me a bit more…Sometimes I wish that he would have listened and would have been like, 'he needs this help'.

P6: Erm, I mean it's difficult with social workers cos I've had quite a few. When you make a good relationship with one person, they kind of move and you have to meet another one. And then you get another one, it's kind of like repeating the thing…You just get to the point where you can trust them and then they leave….And then I was supposed to do sessions with a psychologist, erm, but my psychologist changed like four or five times in the space of two years….I made a good relationship with one person, then they left and I'd have to do it again.

Here, P6 gives a compelling account of the impact of changes in professionals and his difficulties in then forming trusting connections with them, which is unsurprising given that P6 had also experienced a number of transitions in caregiver during his life.

P1 and P5 had also had social workers but struggled to identify how they had helped them. P1 spoke of practical help such as his social worker '*getting me a B&B'*, but he did not seem to know the role of the social worker beyond this. Similarly, P5 did not seem to be clear on the role of a social worker, other than saying that he had social workers at different stages in his life.

P3 expressed negative views of professionals and spoke of negative experiences. His view of professionals was one of separating rather than supporting families.

P3: They work for the system for a start.
I: Right, and what does that mean to you, for them to work for the system?
P3: Er, they can take you away from families, do this, do that.

3.4 Every Interaction Matters

As outlined above, there seemed to be confusion about professional roles, with some negative experiences of professionals and a perception of not being helped, however,

importantly there were also examples of participants speaking of professionals and family members that made a difference in their lives.

When discussing something they were proud of, P2 and P5 both spoke of helping their grandparents, indicating a relational connection involving compassion and empathy. Both smiled when they spoke of their grandparents. This was particularly relevant for P2 whose interview was otherwise dominated by descriptions of his anger and antisocial behaviours.

> *P2: I used to always help my grandad, 'cos for a while he couldn't cope on his own.*
> *P5: Every day I'd like go to my great grandma's and make her drinks every day, like when she couldn't do it herself.*

P1 also mentioned his grandparents as important people in his life and described them as "…*the definition of unconditional love*", which is interesting as this was something he perceived as lacking from his mother.

P1 described a positive experience with a staff member when he moved to a PRU:

> *P1: Yeah they helped me. So, you know instead of looking at me as the problem, they were looking, trying to work their way around, find the route of it, which helped massively. Erm, and we went go-karting like every two weeks (laughs).*

P2 described professionals as a '*pain in the arse'* and said he felt like he had been treated "*like* shit", however he was able to identify one person that was different:

> *P2: Yeah [name] he's different. He's definitely one of the best. He actually cares.*
> *I: How can you tell he cares?*
> *P2: Cos he's always helping us out. He's always getting us things, getting things done for us. Always coming to check on us and make sure we're doing alright. He speaks on the phone to my family. He speaks to them about things.*

Superordinate Theme 4: "My Normal"

Whilst some participants (n=3) were able to reflect on the impact of their life experiences, others struggled to do so, which is perhaps unsurprising given the complexity of making sense of your own life and making links, especially at such a young age. One participant that was able to articulate his view that his life experiences had impacted on him was P1:

> *P1: Yeah, I think every experience in your childhood and your teenage years is like, it's just building blocks into your personality and everything…*

4.1 Holding It In

An important theme to highlight is the sense that some participants (n=3) were holding back on sharing potentially traumatic memories, either because they could not recall them, or that they understandably did not feel safe enough to share them within a relatively brief discussion with a person not known to them.

To provide context to this theme, it is important to draw attention to the number of ACEs each participant was reported to have had (see Table 4.2), most of which were not spoken about within the interview. The mean number of ACEs in this sample (n=6) was 7.3, with one participant (P4) having experienced 10 of the 11 ACEs which were measured (see Chapter 3 for detail of ACEs). Additionally, all participants had elevated TSCC scores (see Table 4.4 and Appendix 16). A further relevant factor to consider was the high rates of dissociation participants presented with, as measured by the TSCC, with all participants scoring in the 'elevated' or 'clinically significant' range for at least one of the dissociation scales (see Table 4.4 and Appendix 16).

Of interest P3 and P5 both spoke of having no memory of their early childhood and this was particularly relevant for P5 who had the shortest interview and shared minimal information about his life experiences. P5's dataset information shows that he has experienced 7 ACEs, and he was considered by the clinician working to be traumatised by his life experiences.

P5 did make reference to "*things that have happened"* as outlined below, however he did not go on to speak of these life experiences and as he looked away and then looked down, it was evident that this was not something he wanted to discuss further.

> *I: And so, how do you think your life experiences have impacted on you?*
> *P5: Just like things that have happened to me when I was a kid. Just….*

The issue of participants not feeling safe enough within a research interview to speak openly about their life experience was recognised from the outset and care was taken to ensure that all participants knew to only speak about things they felt comfortable to ensure the process was not traumagenic. The issue of not yet feeling safe to speak was articulated by P4 who indicated that he had more to share but did not feel able to.

> *I: Is there anything else you think it would be helpful for me to know?*
> *P4: Yeah.*
> *I: Go on…*
> *P4: Just things that have happened to me.*
> *I: What sorts of things?*
> *P4: I don't want to say.*

I: You don't want to say. Ok, that's ok. Does anybody know these things?
P4: Mum.
I: I'm not asking you to tell me, but do you think you would be able to tell anyone else?
P4: Dunno, it's hard to trust.
I: Ok, I get that. P4, I hope you find someone that you can trust and someone that can help you.

4.2 *Acceptance – "It is what it is"*

There was a sense of acceptance and normalisation of difficult and adverse experiences amongst most (n=4) participants, with an expectation that life would remain difficult. Participants overwhelmingly lacked a sense of hope for a better future.

P3 replied, "*It is what it is"* on several occasions when speaking about things that had happened in his life. For example,

P3….and then he [father] said he didn't want me back.
I: Oh ok, and how did that make you feel?
P3: It is what it is.

P1 used the same phrase when discussing difficulties, he had experienced. P1 spoke of not getting birthday presents, but then reflected that this has taught him a lesson in a life to "*work for your own presents"*.

I: Do you think things in your life have been fair?
P1: No. Not at all. But life ain't fair is it, so it is what it is.

P1 used this phrase again when describing feeling unsafe at home and in the community, due to having been a victim of a mugging and being stabbed. When reflecting on this lack of a sense of safety, P1 commented:

P1: It is what it is though innit. It's kind of like it's normal. That's pretty fucked up to say like, but it's my normal.

This extract from P3 highlights the importance of a person's lived experience. Experiences that to other's may be described as 'adverse' or 'traumatic' are to him 'normal', captured with his use of the powerful words, "*it's my normal"*.

Psychometric Data

Analysis of the self-report measures completed by each young person was undertaken and this data supported the themes outlined above. The outcomes of the measures for each participant are provided as Appendix 16.

Trauma Symptom Checklist for Children (TSCC)

The TSCC measures for 'under-score' and hyper-score' which can invalidate results, however all results were valid for all participants in the study. All six participants had some elevated scores within the TSCC, and four of the six had scores within the 'clinically significant' range.

Table 4.4

Trauma Symptom Checklist for Children (TSCC) Scores

TSCC Item	Number of participants with scores in 'normal' range	Number of participants with scores in '*elevated*' range	Number of participants with scores in '*clinically significant*' range	Total number of participants with scores above the 'normal' range for this item
Anxiety	1	5	0	5
Depression	0	4	2	6
Anger	1	4	1	5
Post-Traumatic Stress	1	2	3	5
Dissociation	0	2	4	6
Dissociation-Overt	0	3	3	6
Dissociation - Fantasy	3	1	2	3
Sexual Concerns	5	N/A	1	1
Sexual Preoccupation	5	N/A	1	1
Sexual Distress	5	N/A	1	1

The TSCC indicated a high prevalence of trauma symptoms for participants with elevated scores across all items measured.

Early Memories of Warmth and Safety Scale (EMWSS)

Table 4.5

Early Memories of Warmth and Safety Scale (EMWSS) Scores

Participant	Score	Descriptor
P1	33	Somewhat low feelings of warmth in childhood
P2	82	High feelings of warmth in childhood
P3	8	Low feelings of warmth in childhood
P4	56	Average feelings of warmth in childhood
P5	51	Average feelings of warmth in childhood
P6	41	Somewhat low feelings of warmth in childhood

Results for the EMWSS were varied. P3 had the lowest score of 8 (low experience of warmth in childhood). This was congruent with P3's comments in interview. Of note, when speaking of his parents within the interview, P3 commented, "*…I don't like them…I chat to them for money".*

P2 had the highest score of 82 (high feelings of warmth in childhood) which was congruent with his comments in interview about having a positive childhood and close relationship with his parents (particularly his father).

Of note, item 14 of EMWSS ('I felt loved even when people were upset about something I'd done') was endorsed 0 (never) or 1 (yes but rarely) by five of the six participants. This indicates that five young people did not experience what Rogers (1951) termed 'unconditional positive regard' which is characterised by the child feeling consistently loved and cared for despite their behaviours.

4.5 Discussion

The aim of this study was to explore the narratives of male adolescents in custody for a sexual offence in the hope that their voices and lived experienced could assist in understanding associations between adversity and offending behaviour. The themes which were elicited support and add depth to existing research which highlights experiences of adversity, attachment disruption, and trauma in this population (Hackett et al., 2013; Malvaso et al., 2022). Through allowing the young people to 'tell their stories', what becomes apparent is that these young people do not consider themselves 'traumatised', though the rich depth of their narratives provides insight into their perspective of their life experiences and their relationships with others.

Outlined below is analysis of each of the superordinate themes, with suggested implications for clinical practice arising from each.

No Safe Base

The evidence of disrupted attachments through harm, rejection, loss, separation, and transitions of care supports previous literature of a prevalence of these experiences within those that have sexually offended and specifically ASO's (Gerhard-Burnham et al., 2016; Grady et al., 2017; Hackett et al., 2012; Zaniewski et al., 2020). Participants overwhelmingly spoke of experiences and events that could be hypothesised to disrupt attachments and skew their view of relationships.

Although participants did not use the adult/professional language of adversity or trauma, the majority described incidents which would be considered emotionally and/or physically harmful, and analysis of their dataset information evidences polyvictimisation for the vast majority of the sample (n=5), with the mean number of ACEs being 7.3. Crucially, participants described not feeling safe in their homes, suggesting that either the harm was caused within the home, and/or they did not have care and protection to buffer harm they experienced.

Of note are the varied outcomes of the EMWSS in which young people indicated experiences of warmth and safety ranging from 'very low' to 'high'. What this measure does not detail is where the sense of warmth and safety came from for those that experienced it, however, as outlined in the *'learning to cope'* theme, there is the potential that secondary attachments are relevant to consider in addition to considering warmth and safety from parents. This theme particularly highlights the importance of qualitative data to support the quantitative research base.

One key finding from the EMWSS was the apparent lack of a sense of unconditional positive regard (Rogers, 1951), as judged by participants response to the item of not feeling loved when they did something wrong. Not feeling consistently cared for and accepted has the potential to have a profound impact on attachment formation and on the child's sense of self.

In terms of implications for clinical practice, this theme supports previous research which highlights the need for interventions with this population to be attachment focussed, highlighting the importance of individuals being afforded time and space to feel safe, by forming a trusting relational connection before moving to what is often termed 'offence focussed' intervention (Campbell et al., 2020; Hackett et al., 2022).

Angry Child

Anger was a prevalent feature in the narratives of the majority of participants and what was of note was their sense of being angry from being a young child. From the view of the participants it seems anger was very much linked to aggressive behaviours. The angry outbursts described by participants evidence the level of emotional dysregulation they experienced even as very young children. It can be hypothesised that this early onset of emotional dysregulation and aggression is linked to the adversity and traumatic experiences described by participants, along with the evidence of high levels of adversity contained within the dataset.

When viewing the early onset of aggression through a developmentally informed, trauma and attachment lens, this early onset of what would be considered 'behavioural difficulties' in fact evidences the level of vulnerability of these children, highlighting the need for early intervention and support rather than punitive responses and school exclusions. An additional factor to consider is that three participants were diagnosed with ADHD, and one had autism. The timing of their diagnoses is unknown but responses to hyperactive or dysregulated behaviours may have been in the absence of an awareness of neurodevelopmental conditions.

The TSCC scores evidence that anger was a continued difficulty, with elevated anger scores for five participants. Four of these adolescents are what Seto & Lalumiere (2010) termed 'generalist offenders' whose sexual offending is part of a wider pattern of criminal and anti-social behaviour, with a particular theme of aggression and violence. Echoing findings of Tidefors & Skillback (2014), it seems that for these participants, anger and aggression had become part of their identity which could be hypothesised to be linked to a subsequent theme of the need to '*be strong'* in a world which they believe they need to survive alone.

A crucial factor to consider in the early onset and continuation of aggressive behaviour is the evidence of experience of domestic abuse for five of these participants. Whilst formulation of violent behaviour is complex, with a number of potentially relevant underlying factors, an early onset and continuation of violence in these young males highlights the relevance of Social Learning Theory (Bandura, 1979) in the context of the intergenerational transmission of violence. Previous research has identified a link between exposure to violence and anger (Cecil et al., 2014; Flannery et al., 2004). Holt (2008) highlights that those exposure to domestic violence as a child may experience difficulties forming healthy relationships in adolescence which is crucial to consider both in terms of the offending behaviour but also the peer relationships described below.

The extent of school exclusion experienced by these participants is worthy of explicit consideration, in the context of the 'school-to-prison pipeline' (Mallett, 2016; Muniz,

2020). The disruptive and aggressive behaviour displayed by participants in school resulted in exclusion rather than the behaviour being interpreted as likely being a symptom of their adverse and traumatic experiences. Additionally, bullying was a further form of adversity and a factor which has potential to impact on the disengagement with education identified within this study (Baiden at al., 2020). As may be expected from these young people who appeared to desperately try to suppress vulnerability and appear 'tough', most did not mention experiences of bullying that were reported to have taken place during their childhoods.

It is unsurprising in the context of the '*disrupted attachments'* and '*angry child'* theme that participants described either an absence of social bonds, or bonds to peers also involved in anti-social behaviours. It can be hypothesised that in the context of relational trauma and disrupted attachments that these participants sought connection and belonging outside the family, increasing the likelihood of bonding with other young people with similar experiences involved in anti-social behaviours.

Findings within this theme have a number of implications for clinical practice including the need for recognition that high levels of aggression in early childhood are a potential indicator of adverse or traumatic experiences, highlighting the need for trauma informed schools. Intervention with ASOs should include much wider focus on relationships and relational trauma, including consideration of peer relationships.

Learning to Cope

This theme provided insight into participant's perception of the need to 'be strong' with insight into premature autonomy and a developing sense of learning to cope alone. It is hypothesised that this can in part be explained by the first theme of '*disrupted attachments'* as participants perceptions of the safety of self-reliance can be viewed as congruent with experiences of being harmed, let down and not being protected by significant others at times in their lives.

From information shared within interviews, but also information within the dataset, there is evidence that five participants had experienced domestic abuse. Although some spoke in negative terms about their father's violence, it remains that they have been exposed to male coercion and aggression which has the potential to shape their developing sense of self and in particular their sense of what it is to be a male. This is particularly relevant as aggression has been a feature for the majority of participants.

Rogers (2021) highlights that within the critical period of development that is adolescence, males can be impacted by perceptions of masculinity. Furthermore, Epstein & Ward (2011) postulate that there can be perceived pressure from parents for boys to be viewed as

'tough' and this appears more likely in families where violence is the norm. Zaniewski et al. (2020;2023) also found themes relating to 'bravado' and 'power' in their qualitative study, with similar findings to the current study of participants seeking hegemonic masculinity and suppressing feelings or behaviours they believe would challenge this.

Participants spoke of times they felt they had not been helped, and comments highlight the importance of consistency, with the ability to build trust as a crucial factor in relationships with professionals. Considering the transitions in care and disrupted attachments experienced by these young people it is unsurprising that transitions in professional relationships were experienced as problematic, as this is likely to reinforce an internalised sense of being unimportant and not worthy of time and care.

Conversely, participants also spoke of people who have had an impact on their lives. There were examples of connection to extended family members, which emphasises the importance of secondary attachments (Bowlby, 2007; Harrelson et al., 2017). Others spoke of positive relationships with professionals, some of which may not have been recognised by the professional at the time that they had made a lasting impact. This emphasises the notion that 'every interaction matters' and that relational trauma is healed through relational connection, not simply through formal 'therapy', with even seemingly inconsequential positive interactions having the power to heal (Bethell et al., 2019). The importance of each relational interaction is delineated by Bruce Perry, "*Just as a traumatic experience can alter a life in an instant, so too can a therapeutic encounter"* (p.308). This is particularly important as Hackett et al. (2022) found in a follow up study with adults that had sexually offend as adolescents, that relationships with professionals were impactful in influencing outcomes, and that this impact was not confined to specific intervention that was undertaken.

Impact

Five of the six participants in this study were considered by professionals to have been traumatised as a result of early adversity, and the TSCC outcomes supported this, with evidence of elevated and clinically significant trauma symptoms for these five participants (with elevated symptoms to a lesser extent for the remaining adolescent). However, what was of note was that the majority of participants gave minimal, or in some cases no account of the adversity they had experienced. Where adversity was spoken about, this was normalised, often with efforts to defend or explain their parent's behaviour.

There are many factors relevant to consider that may have impacted on what the participants included in their narratives. Young people need to feel safe to tell their stories and this is unlikely to have been achieved within a time-limited research interview, undertaken by a person they may recognise but did not have an existing relationship with.

The issue of family loyalty is also relevant to consider as outlined in the '*learning to cope'* theme and it can be hypothesised that participants sought to protect their family members. The issue of normalisation and acceptance is also highlighted within this theme. Participants are all adolescents, with many leaving the environments in which they experienced adversity at the time of coming to the arguably traumagenic environment of custody. As such, these young people may not have had time or opportunity to process their life experiences or even recognise them as adverse, harmful or traumatic, as exemplified by the theme of '*it is what it is'* and also by P1's comment '*…It's my normal*'.

A further consideration is the potential that some participants experience dissociation which is defined by the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V, American Psychiatric Association, 2013) as the "*disruption of and/or discontinuity in the normal integration of consciousness, memory, identity, emotion, perception, body representation, motor control, and behaviour*" (p. 291). Dissociation is known to be a common response to trauma (MIND, 2023) as it is, "*the mind's way of putting unbearable experiences and memories into different compartments*" (Lyons, 2020, p.3).

Evidence in support of the potential for dissociation to impact on the young people's narratives are P3 and P5 explicitly saying that they struggled to recall early memories and also the TSCC scores which evidenced that all participants had elevated and/or clinically significant scores on the dissociation scales.

The key implications for practice with this theme is that whilst services working with ASOs undoubtedly need to be trauma informed and trauma responsive, it is important to 'meet the child where they're at' and consider timing and sequencing of intervention needs, with the need for stabilisation and connection being viewed as fundamental. If a young person does not consider themselves 'traumatised' and/or presents as dissociated from traumatic experiences, it may be for example that a somatic approach is indicated in the first instance, as outlined by polyvagal theory (Porges, 2011). Additionally, these findings suggest that a move away from only viewing trauma within a traditional 'PTSD' framework may be too narrow and limited a way to conceptualise complex trauma.

Limitations

The themes elicited in this study were based on a sample of adolescents in youth custody and so it is not possible to state whether this sample is representative of adolescents whose harmful sexual behaviour (and/or other offending behaviour) has not met the threshold for custody.

It is recognised that by its very nature, this study was primarily reliant on the self-report of participants, however rather than be deemed a limitation it is suggested that the narratives

of the participants have provided novel insights which would not be achieved through other methodologies.

There is always the possibility of socially desirable responding within qualitative research. However, as highlighted previously, there was evidence of downplaying rather than exaggerating adversity. Despite a question which asked them to consider links between their life experiences and their life at the time of interview, none attempted to use experiences of adversity to justify their offence.

Participants did not have an existing relationship with the researcher which has clear potential to impact on their sense of trust and safety within the interview. However, whilst recognising this as a potential limitation, there is also the possibility that the discussion being contained to a research interview, may have allowed them to speak more freely in the knowledge that the researcher would not share information with other professionals or family members (other than in the event of a safeguarding concern).

In terms of methodological limitations, it is important to highlight that there is limited evidence to support the use of trauma measures, including the TSCC with young people in custody (O'Rourke et al., 2022). When considering the elevated scores on the TSCC there are a number of potentially confounding variables to consider, including the potential that the criminal justice process, separation from family and time in the potentially traumatising environment of custody could all impact the scores. There is also no evidence of validation study of the EMWSS in a custody population.

4.6 Conclusion

This study enhances psychological understanding of the experiences of ASOs, adding to the existing research base that this is a population that present with both risk and vulnerability. Analysis revealed how these young people have begun to make sense of their life experiences alongside the implications of their survival strategies. The findings highlight the fundamental need for early intervention and support for children experiencing adversity who may show the impact through 'behaviours that challenge', resulting in punitive rather than supportive responses. Furthermore, this research demonstrates the need for services working with these young people to consider their needs in relation to adversity, trauma and attachment disruption, alongside neurodevelopmental conditions, rather than focussing on only addressing the offending behaviour.

5. CHAPTER FIVE: METHODOLOGICAL CRITIQUE

Appraisal of the Trauma Symptom Checklist for Children (TSCC) with Consideration for Use Within a Youth Custody Population

5.1 Abstract

This methodological critique provides an overview of the Trauma Symptom Checklist for Children (TSCC; Briere, 2006) as a tool for assessing trauma in children and adolescents, with consideration of the psychometric properties and clinical utility of the tool. There is specific exploration of the use of the TSCC with young people in custody, leading to the conclusion that further research is required in relation to the use of the TSCC with this population.

5.2 Introduction

Defining trauma has both conceptual and clinical complexities, in addition to challenges from an empirical perspective (Isobel, 2021). However, as the understanding of the impact of early life experiences increases, there is a growing interest in the concept of trauma, with a move towards trauma-informed care in health and social care settings (Grady et al., 2022; Harris & Fallot, 2001; Levenson et al., 2017).

Following a review of the literature, a holistic definition of trauma was provided by the Substance Use and Mental Health Services Administration (SAMHSA, 2013): '*Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as psychically or emotionally harmful or life threatening and that has long lasting adverse effects on the individual's functioning and mental, social, emotional, or spiritual wellbeing'* (p,7).

There is an overwhelming body of research which indicates that childhood trauma can have significant and wide-ranging impact throughout the lifespan (Felliti and Anda, 1998; Finklehor et al., 2015), which highlights the importance of screening and assessment to allow the required support and intervention to aid recovery. One such impact reported in the literature is increased likelihood of involvement in anti-social and criminal behaviour for individuals that have experienced trauma (Farrell & Zimmerman, 2017; Kretschmar et al., 2017; Levenson et al., 2017). Justice involved youth are increasingly recognised to have higher rates of poly-victimisation (Ford et al., 2013; Levenson et al., 2017; Thomsen et al., 2022) and children who have experienced multiple forms of trauma have been reported to be more likely to endorse symptoms of post-traumatic stress (Finklehor et al., 2009).

There are recognised challenges in assessing and diagnosing childhood trauma (Cooke et al., 2005), however there is key importance in doing so, as early identification is crucial in preventing and reducing detrimental impact of traumatic experiences.

Assessment of Trauma in Children

There are a number of tools to assist in identifying childhood trauma symptoms, such as Children's Revised Impact of Event Scale (CRIES; Perrin et al., 2005); Child and Adolescent Trauma Screen (CATS; Berliner & Goldbeck, 2014); and Child Report of Post-Traumatic Symptoms (CROPS, Greenwald, 1999). Some tools are rated by the child, whilst others require parent/carer responses.

O'Rourke, et al. (2023) highlighted that there is a dearth of research in relation to trauma assessment for youth in custody in the UK, highlighting the need for further exploration of use within this cohort of young people, particularly with recognition of the prevalence of trauma in this group.

Trauma Symptom Checklist for Children (Briere, 2006)

The Trauma Symptom Checklist for Children (TSCC) is a self-report measure developed to assess post-traumatic stress and related psychological symptomology (Briere, 1996). The TSCC was designed for use with children (males and females) aged 8-16, however the author reports that validation studies support the TSCC being utilised with those 17 years of age, and there is evidence to support the utility of the tool with this age group (Briere, 1996; Finklehor et al., 2007; Stathis et al., 2005). Briere (1996) cautions that the wording may be too simple for this older age group and recommends a 2-point downward anger scale adjustment for females aged 17 years.

The TSCC is reported to have utility in the evaluation of children who have experienced traumatic events, including physical and sexual harm, victimisation by peers, experiencing significant loss, witnessing violence, and natural disasters (Briere, 1996).

The TSCC includes two validity scales (Under- response and Hyper-response), six clinical scales (Anxiety, Depression, Anger Post-traumatic Stress, Dissociation, and Sexual Concerns) and eight 'critical items' which consider situations that may require follow-up, such as suicidality and desire to hurt others (Briere, 1996; Hunter et al., 2003).

The TSCC presents respondents with a list of symptoms to which they are asked to indicate how often they have experienced each of the items in the past two months. Each item is rated on a four-point scale anchored at 0 ('never') to 3 ('almost all of the time'). This tool

requires approximately 15-20 minutes for administration. The TSCC has been translated into a number of languages including Spanish, Chinese and French Canadian.

Following development and testing of the TSCC there was concern that the Sexual Concerns items may be distressing for some children. This resulted in the development of an alternative version of the TSCC (TSCC-A) which is a 44-item measure with the sexual items omitted. There is also a version for younger children (aged 3-12), the Trauma Symptom Checklist for Young Children (TSCYC; Briere, 2005) which can be rated by the child's parent or the child dependent on age and ability.

The TSCC is recognised as a widely used measure of trauma symptomology in children (Kretschmar et al., 2018), including being used in the National Survey of Children's Exposure to Violence (NatSCEV) in the USA (Finklehor et al, 2005;2018).

It is outlined within the TSCC manual that the measure is not intended to be used as a diagnostic tool (Briere, 1996), rather it is regarded as an assessment of trauma which can be completed relatively quickly to gather information about trauma symptomology (Strand, Sarmiento & Pasquale, 2005). This information can then be used to establish whether diagnostic assessment is warranted (Briere, 1996).

5.3 Psychometric Properties

The standardisation of TSCC was based on a non-clinical sample of 3008 school children from different parts of the USA, however studies have since been undertaken to assess the psychometric properties of the tool in both clinical and non-clinical samples, including samples of justice-involved youth (Butcher et al., 2015; Kretcshmar et al., 2018) and children in psychiatric inpatient settings (Sadowski & Friedrich, 2000). The TSCC has been standardised on a large sample of children with racial and socio-economic diversity, with males and females of different ages (Strand, 2005).

Reliability

The TSCC is considered a psychometrically reliable measure as evidenced in a number of studies (Evans et al, 1993; Elliot & Briere, 1994; Lanktree et al, 1991). Lanktree and Briere (1995) reported high reliability in a repeated measures study of children who had experienced sexual abuse.

Internal consistency measures the extent to which an item within a tool measures different aspects of the same construct (Revicki, 2014). The TSCC has been shown to have high internal consistency with a Chronbach's alpha range from α= .82 to .89 for five of the six clinical scales (Briere, 1996). The Sexual Concerns scale has been reported to have

moderate internal consistency, with a α of .77 (Briere, 1996). Good internal consistency was also reported by Nilsson et al., 2008 who reported αs =.78-.83 in the clinical scales and α= .94 for the total scale, and by Gallito et al., 2017 who reported αs = .78 (sexual concerns) and .83. (anger) for welfare-involved youth.

Test-retest reliability is measured by administering the same test twice over a period of time to same group, with scores subsequently correlated at 'time 1' and 'time 2'. Nilsson et al. (2008) found the TSCC to have good test-retest reliability (total scale *r*=.81, clinical scales *r*=.67-.81). Within this study it was the dissociation scale which had the lowest test-retest score (*r*=.67). The authors outlined that comparable data was not available from previous studies.

Reliability within an inpatient setting was explored by Sadowski & Friedrich (2000) who reported '*very adequate'* (p.371) coefficient alphas (αs .71-.97) and also positive inter-scale correlations, with all correlations significant at p<.001. This indicates that each scale of the TSCC was measuring a closely related element of a larger scale.

Validity

Face validity is the extent to which a tool is effective in measuring the intended variable or construct. The TSCC has been found to have good face validity (Ohan, Myers, & Collett, 2002).

Criterion validity considers how well a test measures the outcome it was intended to measure. The TSCC has been reported to have good criterion validity (Diaz, 1994), whilst Nilsson et al. (2008) concluded that the TSCC has satisfactory criterion validity.

Construct validity is the extent to which the measure accurately assesses the concept it is intended to. The construct validity of the TSCC has been explored in terms of the extent to which it measures traumatic impact in both normative samples (Singer et al., 1995; Evans et al, 1994) and samples of children who have experienced sexual abuse (Elliott & Briere, 1994; Elliott et al., 1995; Lanktree & Briere, 1995; Wherry et al., 2008) with both suggesting that the TSCC has strong construct validity. Nillson (2008) performed a confirmatory factor analysis of the TSCC with Swedish youth and reported similar findings. The authors found the 'Anxiety' scale to have the weakest construct validity.

Butcher et al. (2015) also conducted a confirmatory factor analysis of the factor structure of the TSCC conceptualized as a total score with results indicating that a 'total' score did not fit the data. The authors suggested the TSCC could be conceptualised as comprising two factors, with subscales combined into two groups (anxiety, dissociation, and PTS in one group and anger and depression in the other).

Concurrent validity refers to a comparison between an instrument or measure and an outcome assessed at the same time (Kretschmar et al., 2018). The TSCC has been found to have concurrent validity with the Child Behavior Checklist and Children's Social Desirability Questionnaire (Nelson-Gardell, 1995; Lanktree, et al., 1991).

Nilsson et al. (2008) explored the concurrent validity of the Dissociation scale through comparison to the Dissociation Questionnaire, with results showing good concurrent validity, which gave support for the validity of this specific scale within the TSCC.

Kretschmar et al. (2018) explored the concurrent validity of the TSCC using corresponding DSM diagnoses in a population of justice-involved youth in Ohio (n= 2,544). Of note was the relative ethnic diversity of the youth in the study sample (52.3% White, 39.3% Black, 6.3% multi-racial). The authors concluded that the TSCC subscales were generally able to differentiate between youth with and without relevant DSM diagnoses.

Convergent validity relates to the extent to which a tool that measures a particular construct is correlated with other tests measuring the same (or similar) constructs. Discriminant validity measures whether two tests that should be unrelated have no relationship to each other. The TSCC has been found in several studies to have convergent and discriminant validity (Briere, 1996; Lanktree & Briere, 1995; Evans et al., 1994; Friedrich & Jaworski, 1995). Discriminant validity was also found in relation to children with and without sexual abuse histories (Elliott & Briere, 1994; Atlas & Ingram, 1998). Further support was found for the convergent and discriminant validity of the TSCC by Crouch, Smith, Ezzell, & Saunders (1999) who undertook comparison to the Children's Impact of Traumatic Events Scale–Revised.

In their comparison of TSCC scores between clinical and non-clinical population, Nilsson et al. (2008) reported that although significant differences were found between the 'normal' and 'clinical' group on the total scale and the majority of the clinical scales, there was no difference on the 'sexual preoccupation' scale. The authors postulated that the questions for the sexual preoccupation scale may not be sensitive enough to discriminate between a high level of interest in sex that would be typical in adolescence and a clinically elevated level of preoccupation.

Nilsson et al. (2008) also reported significantly higher means among those adolescents who self-reported having experienced trauma compared to those who did not report any trauma, however in line with their other findings, no difference was found in the Sexual Concerns scale.

Validity in an inpatient setting was explored by Sadowski & Friedrich (2000). In terms of concurrent validity, the Dissociation scale was found to correlate with the Adolescent-Dissociative Experience Scale (*r* = .79). The Depression scale was found to correlate with the Beck Depression Inventory (*r* =.8).

Sadowski & Friedrich (2000) reported that discriminative validity was not found to be significant (F=1.9 {6,107}, Wilks' lambda =.91, c2=10.8, p=.10) in a sample of abused and non-abused children in a psychiatric inpatient setting. However, the PTS scale was able to discriminate between the abused and non-abused group. The authors suggested a range of reasons for these findings including the issue of co-morbidity of psychiatric diagnoses and the reduced variance in symptomology in a psychiatric inpatient sample.

Clinical Utility

Several studies have confirmed the clinical utility of the TSCC with a range of children in clinical, non-clinical and diverse samples (Nillsson, 2008; Kretschmar et al., 2018; Sadowski & Friedrich, 2000).

Ohan et al. (2002) specifically commented upon the ease of use of the TSCC. A key factor in the clinical utility of the tool is ease of the use of the measure, which allows for not just an initial assessment, but repeat assessment to measure potential change in trauma symptomology over time (Kretschmar et al., 2018). This is particularly useful in treatment settings to allow clinicians to consider the effectiveness of support and intervention which is being provided to the child and/or family.

A unique feature of the TSCC are the validity scales which provide information as to whether the child may be downplaying (under-response) or exaggerating (hyper-response) symptoms. Helpfully, in the manual (Briere, 1996) provides support in the analysis of atypical response patterns, encouraging clinicians to hypothesise about the meaning of the way the child has responded, rather than simply using the scales to validate, or invalidate the measure. This is particularly important when viewing children in a developmentally sensitive way, moving from a position of reporting that a child has been dishonest, to considering why they may under or over report symptoms.

There are always limitations of self-report measure as a child could deny or under report symptoms for a variety of reasons, including fear, not wanting to appear vulnerable, or being disconnected from symptoms. This could be to some extent captured by the validity scales within the TSCC, however it remains that self-report is by its very nature a completely subjective measure of any symptoms. Briere, (1996) highlighted that the TSCC should be used as part of a wider assessment and so information such as that from parents, school staff, and other collateral information should be used to inform clinical decision

making alongside the use of a tool such as the TSCC. The use of a standardised tool such as the TSCC ensures that the child's views of their own difficulties are taken into account, alongside the other information available.

Ohan, Myers & Collett (2002) emphasised the importance of the TSCC not being used as a diagnostic tool and reiterated that it should be used as a tool to explore the existence of trauma symptoms, which is the intended use set out by Briere (1996). Ohan, Myers & Collett (2002) highlight that a limitation is that the PTS scale primarily contains 'intrusion' symptoms which is only one element of PTSD diagnosis using the DSM-V.

A key consideration when administering a trauma measure to children is that the measure itself is not traumagenic. The development of the TSCC-A with the Sexual Concerns scale removed offers an alternative tool if it is anticipated that the sexual questions could cause distress. When considering the clinical utility of the TSCC, Feindler et al. (2003) concluded, '*It does not orient respondents to their abuse experiences and is appropriate for children who have not disclosed abuse, as well as those who have'* (p. 210).

5.4 Use within Custody

There is some evidence to support the clinical utility of the TSCC in adolescents detained in secure settings. Calleja (2020) used the TSCC to measure trauma symptomology in a sample of adolescents (N=117) in secure treatment facilities in the USA. The adolescents had a range of offences, with only 1% adjudicated for a sexual offence. The TSCC was used pre- and post-delivery of Trauma Focussed Cognitive Behavioural Therapy (TF-CBT) and through the use of the tool, a significant reduction in trauma symptomology could be evidenced.

A further study using the TSCC in a sample of detained youth was undertaken by Alexander et al., (2021). The young people in the study were a residential correctional facility in the USA, with a combination of adolescents adjudicated for a sexual offence (n=76) and what the authors termed 'general adolescent population' (n=72) who were youths adjudicated for a non-sexual criminal offence. With similar results to those outlined in chapter three of this thesis, 93% of those in the sample had experienced at least one form of maltreatment during childhood.

Alexander et al. (2021) reported that of the adolescents with a sexual offence (ASOs), 29% were considered to have high levels of polyvictimisation and these young people had clinical levels of trauma related symptomology, using the TSCC as the trauma measure. The young people with low polyvictimisation had sub-clinical scores on the TSCC. Although the scores for the TSCC are not provided in the paper, and so detailed comparison cannot take place, the findings of clinical scores on the TSCC for those with high levels of

polyvictimisation, and subclinical scores for those with lower levels of polyvictimisation reflect the findings in the quantitative study in Chapter 3 of this thesis.

A further parallel finding are the low scores on the Sexual Concerns scale within both the study by Alexander et al. (2021) and the study in Chapter 3. Previous studies by Ruiz (2016) and the study by Calleja (2020) also found sub-clinical scores on the Sexual Concerns scale for adolescents accessing trauma intervention. Alexander et al. (2021) posited that these findings could be due to a number of factors including: an absence of sexual preoccupation or atypical sexual thoughts and feelings; participants not experiencing the reactive sexual behaviours that may be more associated with younger victims of trauma; participants being aware of the potential inferences that could be drawn from sexual related questions when in a residential facility due to sexual offending; hesitance to indicate sexual abuse symptomology due to the stigma of this.

Alexander et al. (2021) concluded by highlighting the importance of comprehensive psychological assessments for justice-involved youth, with the TSCC being used as part of this assessment. The authors refer to an 'abuse to prison pipeline' and emphasise the importance of early intervention approaches including trauma-focussed interventions to mitigate the impact of childhood trauma.

Whilst there is evidence to support the reliability and validity of the TSCC with justice-involved youth (Butcher et al., 2015; Kretschmar at al., 2018) and within an inpatient setting (Sadowski & Friedrich, 2000), there is less research into the psychometric properties of the TSCC in a youth custody environment.

O'Rourke et al. (2023) reviewed the use of a range of trauma assessments, including the TSCC to explore their clinical utility with adolescents in (UK) custody. The review concluded that there is a dearth of empirical evidence for the use of each trauma measure within a youth custody population, however, the authors concluded that the evidence is '*limited but promising'* (p.1).

O'Rourke (2023) found limited statistical evidence for the reliability of the TSCC in a custody sample, with '*limited positive evidence'* (p.8) reported for internal consistency. There was evidence for content validity of the TSCC, but no evidence reported for construct validity. The review by O'Rourke et al. (2023) outlines a number of critical findings and practice, policy and research implications including for the use of these tools (including the TSCC) in custodial settings, including:

'Critical findings'

- None of the trauma measures were found to account for trauma exposure as both a 'victim' and a 'perpetrator'.
- The tools do not account for the potential that being in custody is itself traumagenic, especially at such a young age.
- Many of the measures were identified to limit focus on the PTSD model of trauma which the authors postulate may be too narrow a way to conceptualise trauma for this group.

'Practice, policy and research implications'

- The authors concluded that further research on the reliability and validity of trauma measures is required, with specific focus on the extent of diversity in young people in custody.
- It was suggested that future research should consider differences between cumulative trauma and single-incident trauma, alongside the potential relevance of the developmental stage of the young person (at the time of the assessment and at the time of traumatic incident(s).

Adding to the findings of O'Rourke et al. (2023), consideration for the use of the TSCC or indeed any trauma measure within a youth custody sample is the previously discussed issue of the potential for trauma to be induced by the measure, which is arguably more relevant in a custody setting. Children in UK youth custody typically have increased periods of time on their own, given that they are detained in individual cells with little choice over their movements or when they will have contact with important people in their lives. As such, there is increased potential for being isolated at times of distress or ruminating on difficult thoughts than in community sample of youth. This highlights the need for planning prior to the administration of any assessment or intervention, with thought as to how the child may be impacted, and how to mitigate any potential detrimental impact.

Finally, a further consideration relates to the interpretation of TSCC results for a youth in custody, in terms of the potential traumatic impact of the young person's own behaviour (their offence), and their subsequent experiences of the criminal justice process. Elevated symptoms on the TSCC may be erroneously assumed to relate only to earlier childhood or adolescent experiences, if the person administering and analysing the results does not consider the potential impact of factors such as these, along with the potentially traumatising environment of youth custody, as noted by O'Rourke et al. (2023). Thus, elevated scores may relate as much to the young person's offence and/or current circumstances as they do to pre-existing experiences.

5.5 Conclusion

The TSCC is a well evaluated measure of trauma symptoms in children, with generally good results in relation to the reliability and validity of the tool. The evidence supports the conclusion that despite some limitations with 'total score' and the Sexual Concerns scale, the TSCC offers a relatively brief, but holistic, and standardised measure of trauma symptoms in children which can support in clinical decision making.

As identified by O'Rourke et al. (2023) there is limited validation of the use of trauma measures with young people in custody and so this is a key area for further research, to consider the psychometric properties and clinical utility in this cohort of young people. There is evidence to support a move away from a purely 'PTSD' model of trauma, taking into account increased knowledge of developmental trauma, with the potential for this to present differently to more traditional conceptualisations of post-traumatic stress. There is growing recognition that justice-involved youth are likely to present with complex, cumulative trauma, with elevated prevalence of poly-victimisation (Levenson et al., 2017; Thomsen et al, 2023) and thus there is an argument for trauma measures used within a youth custody environment to be nuanced enough to capture a particularly complex trauma presentation.

6. CHAPTER SIX: DISCUSSION

6.1 Summary of Key Findings

The systematic review provided a qualitative evidence synthesis (QES) of seven relevant studies in chapter two. This revealed four key themes (*Paternal Relationships, Maternal Relationships, Broken Attachments, and Links to Harmful Sexual Behaviour*) which provided depth to the understanding of the attachment experiences of adolescent that have displayed harmful sexual behaviour (HSB). The qualitative data within the studies included in the review highlights a prevalence of attachment disruption through loss, rejection, harm, and fractured parental relationships. A prominent finding supporting previous qualitative research (Ogilvie et al., 2022) was the pervasiveness of violent fathers both through experiences of domestic violence and direct physical harm, with this often co-occurring with a level of emotional detachment from mothers.

The results of the quantitative study in chapter three echo findings of previous studies which highlight a prevalence of polyvictimisation in the sample of adolescents with a sexual offence (Baglivio et al., 2014; Faure-Walker & Hunt, 2022; Levenson et al., 2017; Thomsen et al., 2023). The entirety of the sample (N=43) had experienced at least one ACE with 95.3% having experienced two or more ACEs, illustrating the importance of considering the cumulative impact of ACEs within an attachment and complex trauma framework. Emotional harm, caregiver instability, neglect, and domestic violence were the five most frequently occurring ACEs (with prevalence rates of 95.3% to 60.5%). When exploring association between adverse experiences and offending behaviour, the most prominent finding was that polyvictimisation significantly predicted an early onset of harmful sexual behaviour, with domestic violence and neglect significantly associated with HSB beginning under the age of 13. Overall, these findings support the conclusion of Masson et al., (2015), in terms of ACEs being a marker of vulnerability for children and adolescents to display HSB.

In chapter four, the voices of the participants in the qualitative research study elicited four superordinate themes which provide depth to the understanding of the lived experiences of these young people. Of note is the similarity in the findings to those of the QES with commonality in terms of the prevalence of attachment disruption through rejection abandonment and transitions of care, violence (particularly from fathers) and a presentation of toughness, bravado and learning to cope alone. Key findings within this study were the high levels of polyvictimisation in the sample, clearly indicating the need for early intervention and support for children experiencing these types of interpersonal traumas. However, normalisation and acceptance of adverse experiences were also prevalent, with evidence of factors such as family loyalty and dissociation relevant to consider. Emotional dysregulation was evident in the sample with descriptions of both explosions and suppression of emotion within the accounts provided by participants.

Findings which offer hope from a relational perspective were the importance of secondary attachments and the potential influence of positive relationships with professionals.

The methodological review within chapter five demonstrates that the Trauma Symptom Checklist for Children (Briere, 1996) is a tool for measuring childhood trauma symptoms which is well researched in terms of psychometric properties and clinical utility. The TSCC shows generally good reliability, with psychometric properties explored within community and inpatient samples (Briere, 1996; Sadowski & Friedrich, 2000) and also specifically for use with justice-involved youth and welfare-involved youth (Butcher et al., 2015; Kretcshmar et al., 2018). The review of the TSCC identified that there has been limited research of the use of the TSCC within a youth custody population, although a recent systematic review by O'Rourke et al. (2023) highlights the general dearth of research regarding the use of trauma assessment tools within a youth custody population. The conclusion of this chapter is that whilst there is good evidence for the psychometric properties of the TSCC and evidence of the clinical utility of the tool, further research is needed in terms of the use of TSCC and indeed other measures within a youth custody population.

Overall, the findings within each chapter of this thesis add to the compelling research base demonstrating associations between adverse experiences/trauma/attachment disruption and adolescent harmful sexual behaviour, with novel findings of polyvictimisation predicting the onset of this behaviour in earlier childhood. As such, these findings add support to the integrated theory developed by Grady et al. (2017) in which ACEs are proposed to lead to insecure attachment formation, which is in turn associated with the development of criminogenic needs which underpin sexual offending. This model has a focus on adult sexual offending but could be considered equally, if not more relevant for adolescents who are demonstrably closer to the childhood adversity at the time of their offending.

6.2 Implications for clinical practice

The findings of this thesis support the call for a public health approach to the prevention of sexual harm and so implications for clinical practice will be considered in the context of each of the levels of prevention as recommended by McCarten & Kemshall (2023). An effective prevention approach includes responses and interventions that target presentations and behaviours both before and after sexual harm has occurred.

Primary Prevention

Primary prevention efforts relating to sexual harm could include approaches such as public awareness campaigns, education for parents, and access to high quality training for professionals (Kemshall & Moulden, 2015). The findings of this thesis support previous research (Baglivio et al., 2014) which highlighted the need for a change in policy and clinical

practice whereby ACEs are recognised as creating a vulnerability not only to detrimental outcomes for the child, but also the potential for involvement in offending behaviour.

Secondary Prevention

Findings of this thesis along with the wider research base support the view that ACEs, trauma, and attachment disruption are viewed as indicators of vulnerability for harmful sexual behaviour, alongside other wide ranging detrimental impact of these experiences. As such, secondary prevention efforts for those 'at risk' or with increased vulnerability to display HSB should be targeted towards children experiencing adversity. Policy and practice aimed to reduce the risk of children experiencing adversity and trauma, would have the secondary gain of also having the potential to reduce harmful sexual behaviours displayed by adolescents. Put simply, the prevention of childhood adversity could also be considered a form of prevention of sexual harm.

Findings within this thesis show that domestic abuse and neglect are significantly associated with an early onset of HSB and so this indicates that children experiencing these forms of harm are an 'at risk' population for beginning harmful sexual behaviours during earlier childhood. These findings therefore suggest that early detection and intervention for children experiencing adversity would be a form of secondary prevention of sexual harm.

Whilst the prevention of children experiencing adversity in the first place would be the main goal, secondary prevention of sexual harm could also be construed as the efforts to support children to recover after adverse experiences, as safety and therapeutic repair could assist in mitigating the impact of the adverse experiences.

Another area which could be considered secondary prevention is through focus on the education system. The quantitative research study in this thesis demonstrates high rates of bullying (81.4%), echoing findings of Thomsen et al., (2023) who also reported high rates of bullying and peer rejection in their sample of adolescents who had displayed HSB. These high rates of out of family interpersonal trauma, often co-existing alongside familial interpersonal traumas provide support for the widening of the conceptualisation of ACEs and the need to consider the cumulative impact of this harm. Whilst schools cannot eradicate bullying alone, there is a recommendation for support to school staff to recognise and respond to bullying and to understand the pervasive impact of this, way beyond the confines of the school environment, particularly in the context of the toxicity of cyber as well as 'face to face' bullying. Moreover, within the qualitative study, five participants had experienced school exclusion, indicating that their behaviours had been viewed as challenging and harmful, which they undoubtedly were, but perhaps there was an absence of considering the 'root cause' of these behaviours. These findings provide support for the

concept of a school to prison pipeline (Mallett, 2015; Muniz, 2021) highlighting the need for a trauma informed education system.

Tertiary Prevention

The growing strength of evidence of polyvictimisation in this group indicates more pervasive and enduring trauma for this population, evidencing the need for services that work with these young people to not just be trauma informed but to be trauma responsive. Collaboration between professionals will be required to ensure a multiagency response in the context of the complexity of the vulnerabilities and risk associated with this group. It is important to highlight that responding to the traumatisation of these young people does not mean that risk cannot also be attended to (Hackett et al., 2006). It is suggested that trauma informed practice and risk reduction are inextricably linked. They can and should co-exist.

These findings highlight the need for trauma and attachment informed, developmentally sensitive assessments, which balance assessment of vulnerability with assessment of risk. It is recommended that assessment is viewed as an integral part of the tertiary response, to allow a bespoke package of care to be identified. Assessments should be undertaken therapeutically, with this phase of work beginning the formation of therapeutic alliance. The use of formulation as recommended in the NICE guidelines (2016) should be viewed as the lynchpin to understand links between vulnerability and risk. This is exemplified in the definition of formulation provided by Johnstone et al., (2018), "*Formulation can be defined as the process of co-constructing a hypothesis or best guess about the origins of a person's difficulties in the context of their relationships, social circumstances, life events, and the sense they have made of them"* (p. 32).

As has been identified in previous studies, in the context of relational trauma and the potential for this to impact on trust, forming a relational connection within intervention should be viewed as fundamental. The benefits of this are well established, with evidence of the need for a patient, compassionate approach, with recognition of the potential for attachment experiences to impact on the young person's therapeutic journey (Campbell et al., 2020; Hackett et al., 2022; Harrelson et al., 2017).

The complexity of the needs of these young people as highlighted within this thesis demonstrate the need for a multi-agency response with multi-modal therapeutic interventions. As highlighted by Grady et al. (2017) there has historically been an overemphasis on cognitive based programmes, however if trauma is a fundamental underlying factor in the behaviour, then the use of cognitive approaches alone are unlikely to be beneficial. The sequencing of intervention will also be important to consider, in order to not necessarily begin with the 'offence focussed' element of the work but ensuring a

period of stabilisation. A model such as the Trauma Recovery Model (Skuse & Matthew, 2015) provides a framework for this type of approach.

It is suggested that 'intervention' should not be viewed as being confined to formalised therapy, but should be viewed systemically, taking into account that "*every moment and interaction can be an intervention"* (Treisman, 2016). Additionally, when considering research relating to positive childhood experiences (PCEs) and protective factors (Baglivio et al., 2014; Bethell et al., 2019; Skrivankova et al., 2023) the importance of strengths based, recovery focussed intervention cannot be overstated.

A further element of tertiary prevention indicated by this thesis is the involvement of families which should be viewed as crucial, as recommended by NICE (2016), the HSB Framework (Hackett at al., 2019) and within previous literature (Archer et al., 2020).

Working with these young people and their families in this way will only be possible with staff training and support, considering factors such as vicarious trauma. If clinical practice is to effectively balance vulnerability and risk as outlined above, it should be recognised that clinicians will be exposed to 'dual traumatisation', frequently working with young people who have suffered significant harm, but who have also caused harm to others. These findings therefore have implications for training and supervision that will be required within both universal services (at a secondary prevention level) and specialist services (at a tertiary prevention level). This is particularly important not just for staff care, but in recognition of the key role professionals can play in the journey to recovery and change (Blagden et al., 2016, Gannon et al, 2019, Hackett et al., 2022)

Quaternary Prevention

Quaternary responses are concerned with re-integration into communities and society as a whole, or for some young people who have experienced harm, isolation and rejection pre-offence, this is perhaps best understood as simply 'integration'. McCarten & Richards (2021) outline that, "*Successful desistance from sexual offending is as much about the community and society as it is about the individual*" (p.51).

Consideration of quaternary prevention is a particularly important area to think about for the participants in the primary research studies who face the challenges of re-integration at the time of release from custody, which can add further complexities to this process (Winder, 2022). Responses to young people with a conviction for sexual offence can prevent reintegration and have the potential to create factors which may increase risk such as isolation and emotional dysregulation. Quaternary prevention efforts would therefore require societal shift and would involve longer term support for the young people to maintain offence free lifestyles, to assist them to be an accepted member of society.

6.3 Implications for Future Research

The QES and qualitative research study highlight the importance of the inclusion of children in research, viewing them as experts in their own experiences. Further research exploring factors such as attachment and trauma in this population would also benefit from the involvement of parents and secondary attachment figures.

Continued research in this area would benefit from more nuanced exploration of factors such as frequency and timing of adversity, alongside considering factors that buffer impact, or support recovery.

The use of trauma measures within a youth custody population would benefit from further research, in terms of the psychometric properties and clinical utility of existing tools and also to potentially consider whether a tool specific to a youth justice and/or youth custody population is warranted. The evidence of complex, interpersonal trauma within all chapters of this thesis indicates a need to perhaps re-conceptualise trauma, moving from the traditional PTSD framework to a more nuanced approach, taking into account the potential that an absence of care could potentially be as traumatising as the commission of harm, when considering the impact of experiences such as rejection, abandonment, and disrupted attachments which may not be typically recognised within a PTSD framework.

An area which was not the focus of this thesis is the role of pornography in adolescent HSB. As outlined in the study in chapter three, 41.9% of the sample were reported to have pornography use which began below the age of 13, with the potential that this is an underestimate for reasons such as pornography use not always being known by parents/carers, and young people being invested in adults not knowing what they have accessed online, especially in the context of wider sexual behaviour concerns. Within the study in this thesis, although not statistically significant, associations were found between an early onset of pornography use and experiencing neglect, and also between polyvictimisation and an early onset of pornography use, highlighting this as an area worthy of further research.

6.4 Limitations

The small sample size in the quantitative element of this mixed methods research limited the statistical analysis somewhat and restricts the extent to which the results can be generalised. Additionally, the sample was adolescents in youth custody who by the nature of having a custodial sentence imposed present with risker behaviours (more likely to be at the 'violent' domain of the continuum proposed by Hackett (2014), potentially further impacting on the generalisability to adolescents who may be closer to the 'problematic' end of this continuum.

An area which was not explored in any depth within this thesis is the impact of o neurodivergence. Within the sample of young people in the quantitative study (N=43), over half (n=23) had at least one neurodevelopmental diagnosis. Of the sub-sample of participants within the qualitative study (N=6), two thirds (n=4) had a neurodevelopmental diagnosis. The relevance of these diagnoses to the offending behaviour are worthy of further exploration in their own right, in addition to consideration of the potential impact of neurodivergence co-existing with polyvictimisation, trauma, and attachment disruption which was the case for many participants within this study sample.

Whilst it is important to highlight that conditions such as autism and learning disability should not be viewed as 'risk' factors for offending, the prevalence of neurodivergence in forensic samples (including adolescent that have displayed HSB) is indicative that these conditions may create a vulnerability to involvement in offending behaviour which is worthy of further exploration in research and clinical practice (Al-Attar, 2021; Allely, 2015;22; Allely & Faccini, 2020; Balfe et al., 2019) Furthermore, there is evidence that autistic individuals are at elevated risk of exposure to ACEs and particularly interpersonal trauma and that trauma may be present and be experienced differently within this autistic population (Allely & Faccini 2020; Dodds, 2021; Fuld, 2008; Roberts et al., 2015).

6.5 Conclusion

This thesis is aimed to advance understanding of the developmental histories of adolescents who have displayed harmful sexual behaviours and explore association between their life experiences and their harmful behaviours. The 'harmed to harmer' trajectory is complex and nuanced, however the research base demonstrates compelling evidence that polyvictimisation, trauma, and attachment disruption are key underlying factors in adolescent HSB. This supports the growing recognition that prevention efforts must be both trauma informed and trauma responsive, with exploration of adversity, trauma and attachment disruption being undertaken in way which recognises the complex interplay of a vulnerability and risk factors.

7. REFERENCES

Abram, K. M., Teplin, L. A., Charles, D. R., Longworth, S. L., McClelland, G. M., & Dulcan, M. K. (2004). Posttraumatic stress disorder and trauma in youth in juvenile detention. *Archives of general psychiatry*, *61*(4), 403-410. doi:10.1001/archpsyc.61.4.403

Alase, A. (2017). The interpretative phenomenological analysis (IPA): A guide to a good qualitative research approach. *International journal of education and literacy studies*, *5*(2), 9-19. *: http://www.journals.aiac.org.au/index.php/IJELS/index*

Allardyce, S., & Yates, P. (2013). Assessing Risk of Victim Crossover with Children and Young People who display Harmful Sexual Behaviours. *Child Abuse Review.* Vol.22: 255–267. DOI: 10.1002/car.2277

Al-Attar, Z. (2021). Autism spectrum disorders and terrorism: how different features of autism can contextualise vulnerability and resilience. In *Violent extremism* (pp. 121-144). Routledge.

Alexander, A. A., McCallum, K. E., & Thompson, K. R. (2021). Poly-victimization among adolescents adjudicated for illegal sexual behavior: A latent class analysis. *Journal of Aggression, Maltreatment & Trauma, 30*(3), 347-367. https://doi.org/10.1080/10926771.2020.1774692

Allely, C. S. (2015). Experiences of prison inmates with autism spectrum disorders and the knowledge and understanding of the spectrum amongst prison staff: a review. *Journal of Intellectual Disabilities and Offending Behaviour*, *6*(2), 55-67. https://doi.org/10.1108/JIDOB-06-2015-0014

Allely, C. S. (2022). *Autism spectrum disorder in the criminal justice System: A guide to understanding suspects, defendants and offenders with autism*. Routledge.

Allely, C.S., & Faccini, L. (2020). The importance of considering trauma in individuals with autism spectrum disorder: considerations and clinical recommendations. Journal of Forensic Practice, 22(1), 23-28. DOI 10.1108/JFP-11-2019-0049

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). https://doi.org/10.1176/appi.books.9780890425596

Archer, E., Nel, P. W., Turpin, M., & Barry, S. (2020). Parents' perspectives on the parent–child relationship following their child's engagement in harmful sexual behaviour. *Journal of sexual aggression*, *26*(3), 359-371. https://doi.org/10.1080/13552600.2019.1649479

Atkinson, M., & Hollis, C. (2010). NICE guideline: attention deficit hyperactivity disorder. *Archives of Disease in Childhood-Education and Practice*, *95*(1), 24-27. https://doi.org/10.1136/adc.2009.175943

Atlas, J.A., & Ingram, D.M. (1998). Betrayal trauma in adolescent inpatients. *Psychological Reports*, 83, 914-915, 2. https://doi.org/10.2466/pr0.1998.83.3.914

Baglivio, M. T., Epps, N., Swartz, K., Huq, M. S., Sheer, A., & Hardt, N. S. (2014). The prevalence of adverse childhood experiences (ACE) in the lives of juvenile offenders. *Journal of Juvenile Justice*, *3*(2). http://www.journalofjuvjustice.org/JOJJ0302/article01.html

Baglivio, M. T., Wolff, K. T., DeLisi, M., & Jackowski, K. (2020). The role of adverse childhood experiences (ACEs) and psychopathic features on juvenile offending criminal careers to age 18. *Youth Violence and Juvenile Justice*, *18*(4), 337-364. https://doi.org/10.1177/1541204020927075

Baglivio, M. T., & Wolff, K. T. (2021). Positive childhood experiences (PCE): Cumulative resiliency in the face of adverse childhood experiences. *Youth violence and juvenile justice*, *19*(2), 139-162. https://doi.org/10.1177/1541204020972487

Baiden, P., LaBrenz, C. A., Okine, L., Thrasher, S., & Asiedua-Baiden, G. (2020). The toxic duo: Bullying involvement and adverse childhood experiences as factors associated with school disengagement among children. *Children and Youth Services Review*, *119*, 105383. https://doi.org/10.1016/j.childyouth.2020.105383

Baker, E., Beech, A., & Tyson, M. (2006). Attachment disorganization and its relevance to sexual offending. *Journal of Family Violence*, *21*, 221-231. https://doi.org/10.1007/s10896-006-9017-3

Balfe, M., Hackett, S., Masson, H., & Phillips, J. (2019). Experiences of young people with harmful sexual behaviors in services: a qualitative study. *Journal of Child Sexual Abuse*, *28*(6), 649-666. https://doi.org/10.1080/10538712.2019.1573390

Balfe, M., Hackett, S., Masson, H., & Phillips, J. (2019). The disrupted sociologies of young people with harmful sexual behaviours. *Journal of Sexual Aggression, 25*(2), 177-192. https://doi.org/10.1080/13552600.2019.1589003

Balfe, M., Hackett, S., Masson, H., & Phillips, J. (2021). Young men with harmful sexual behaviour problems: a qualitative exploration of the nature and characteristics of their violence. *Journal of sexual aggression*, *27*(2), 139-152. https://doi.org/10.1080/13552600.2020.1752834

Bandura, A. (1979). *Social Learning Theory*. Englewood Cliffs, NJ: Prentice Hall.

Barnett-Page, E., & Thomas, J. (2009). Methods for the synthesis of qualitative research: a critical review. *BMC medical research methodology*, *9*, 1-11. https://doi.org/10.1186/1471-2288-9-59

Beech, A. R., & Mitchell, I. J. (2005). A neurobiological perspective on attachment problems in sexual offenders and the role of selective serotonin re-uptake inhibitors in the treatment of such problems. *Clinical Psychology Review*, 25, 153–182. https://doi.org/10.1016/j.cpr.2004.10.002

Bellis, M. A., Hughes, K., Leckenby, N., Perkins, C., & Lowey, H. (2014). National household survey of adverse childhood experiences and their relationship with resilience to health-harming behaviors in England. *BMC medicine*, *12*, 1-10. https://doi.org/10.1186/1741-7015-12-72

Benoit, D. (2004). Infant-parent attachment: Definition, types, antecedents, measurement and outcome. *Paediatrics & child health*, *9*(8), 541-545. https://doi.org/10.1093/pch/9.8.541

Bergen, N., & Labonté, R. (2020). "Everything is perfect, and we have no problems": detecting and limiting social desirability bias in qualitative research. *Qualitative health research*, *30*(5), 783-792. https://doi.org/10.1177/1049732319889354

Berger, R. (2015). Now I see it, now I don't: researcher's position and reflexivity in qualitative research. *Qualitative Research, 15*(2), 219-234. https://doi.org/10.1177/1468794112468475

Berliner, L., & Goldbeck, L. (2014). Child and Adolescent Trauma Screening Questionnaire (CATS). *Zugriff am*, *2*(09), 2016.

Bethell, C., Jones, J., Gombojav, N., Linkenbach, J., & Sege, E. (2019). Positive Childhood Experiences and Adult Mental and Relational Health in a Statewide Sample. Associations Across Adverse Childhood Experiences Levels. *JAMA Pediat*rics, 173(11). doi:10.1001/jamapediatrics.2019.3007

Blagden, N., Winder, B., & Hames, C. (2016). "They treat us like human beings"—Experiencing a therapeutic sex offenders prison: Impact on prisoners and staff and implications for treatment. *International journal of offender therapy and comparative criminology*, *60*(4), 371-396. https://doi.org/10.1177/0306624X14553227

Booth, A. (2016). Searching for qualitative research for inclusion in systematic reviews: a structured methodological review. *Systematic Reviews*, 5(1), 1-23. DOI 10.1186/s13643-016-0249-x

Boullier, M., & Blair, M. (2018). Adverse childhood experiences. *Paediatrics and Child Health*, *28*(3), 132-137. https://doi.org/10.1016/j.paed.2017.12.008

Bretherton, I. (2013). The origins of attachment theory: John Bowlby and Mary Ainsworth. In *Attachment theory* (pp. 45-84). Routledge.

Bowlby, J. (1944). Forty-four juvenile thieves: their characters and home-life. *The International Journal of Psychoanalysis, 25,* 19–53.

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

Bowlby, J. (1973). Attachment and loss: Vol. 2. Separation: Anxiety and anger. New York: Basic Books.

Bowlby, J. (1977). The making and breaking of affectional bonds: II. Some principles of psychotherapy: The Fiftieth Maudsley Lecture (expanded version). *The British Journal of Psychiatry*, *130*(5), 421-431. doi: 10.1192/bjp.130.5.421

Bowlby, J. (1982). Attachment and loss; Vol 1 (2nd Edition). Attachment. New York: Basic Books.

Bowlby, J. (1988). Developmental psychiatry comes of age. *The American journal of psychiatry*, *145*(1), 1-10. https://doi.org/10.1176/ajp.145.1.1

Bowlby, R. (2007). Babies and toddlers in non-parental daycare can avoid stress and anxiety if they develop a lasting secondary attachment bond with one carer who is consistently accessible to them. *Attachment & Human Development*, *9*(4), 307-319. https://doi.org/10.1080/14616730701711516

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology*, *3*(2), 77-101. DOI: 10.1191/1478088706qp063oa

Briere, J. (1996). Trauma Symptom Checklist for Children (TSCC), Professional Manual. Odessa, FL: Psychological Assessment Resources.

Briere, J. (2005). Trauma symptom checklist for young children (TSCYC). *Odessa, FL: Psychological Assessment Resources*.

Briere, J. (2006). Dissociative symptoms and trauma exposure: Specificity, affect dysregulation, and posttraumatic stress. *The Journal of nervous and mental disease*, *194*(2), 78-82. *DOI:* 10.1097/01.nmd.0000198139.47371.54

Burk, L. R., & Burkhart, B. R. (2003). Disorganized attachment as a diathesis for sexual deviance: Developmental experience and the motivation for sexual offending. *Aggression and Violent behavior*, *8*(5), 487-511. https://doi.org/10.1016/S1359-1789(02)00076-9

Butcher, F., Kretschmar, J. M., Singer, M. I., & Flannery, D. J. (2015). Confirmatory factor analysis of the Trauma Symptom Checklist for Children in an at-risk sample of youth. *Journal of the Society for Social Work and Research*, *6*(2), 251-268.

Byrne, M. (2004). In: Silverman D, (2011). *Interpreting Qualitative Data*. 4th ed. London: Sage

Calleja, N. G. (2020). Assessing and treating trauma in detained adolescents: A pre-post within subjects evaluation. *Journal of Child and Family Studies*, *4*(29), 934–941. https://doi.org/10. 1007/s10826-019-01564-9

Campbell, F., Booth, A., Hackett, S., & Sutton, A. (2020). Young people who display harmful sexual behaviors and their families: A qualitative systematic review of their experiences of professional interventions. *Trauma, Violence, & Abuse, 21*(3), 456-469. https://doi.org/10.1177/1524838018770414

Capinha, M., Matos, M., Pereira, M., Matos, M., & Rijo, D. (2021). The early memories of warmth and safeness scale: dimensionality and measurement invariance. *Journal of affective disorders*, *280*, 228-235. doi.org/10.1016/j.jad.2020.11.033.

Cecil, C. A., Viding, E., Barker, E. D., Guiney, J., & McCrory, E. J. (2014). Double disadvantage: The influence of childhood maltreatment and community violence exposure on adolescent mental health. *Journal of Child Psychology and Psychiatry*, *55*(7), 839-848. https://doi.org/10.1111/jcpp.12213

Chafouleas, S.M., Johnson, A.H., Overstreet, S., & Santos, M.N. (2016). Toward a Blueprint for Trauma-Informed Service Delivery in Schools. *School Mental Health*, 8 144-162. DOI 10.1007/s12310-015-9166-8

Children Act (1989). https://www.legislation.gov.uk/ukpga/1989/41/contents

Children Act (2004). https://www.legislation.gov.uk/ukpga/2004/31/contents

Clarke, V. (2010). Review of the book "Interpretative phenomenological analysis: Theory, method and research". *Psychology Learning & Teaching*, *9*(1), 57-56.

Cohen, J. R., & Choi, J. W. (2022). Is ACEs screening for adolescent mental health accurate and fair?. *Prevention Science*, *23*(7), 1216-1229. DOIhttps://doi.org/10.1007/s11121-022-01391-3

Craig, J. M., & Zettler, H. R. (2021). Are the effects of adverse childhood experiences on violent recidivism offense-specific?. *Youth violence and juvenile justice*, *19*(1), 27-44. https://doi.org/10.1177/1541204020939638

Creeden, K. (2009). How trauma and attachment can impact neurodevelopment: Informing our understanding and treatment of sexual behaviour problems. *Journal of Sexual Aggression, 15*(3), 261-273. https://doi.org/10.1080/13552600903335844

Craig, J. M., Malvaso, C., & Farrington, D. P. (2021). All in the family? Exploring the intergenerational transmission of exposure to adverse childhood experiences and their effect on offending behavior. *Youth violence and juvenile justice*, *19*(3), 292-307. https://doi.org/10.1177/15412040211003648

Critical Appraisal Skills Programme. (2013). *CASP Qualitative Studies Checklist.* http://www.casp-uk.net/casp-tools- checklists

Crittenden, P. M. (2006). A dynamic-maturational model of attachment. *Australian and New Zealand Journal of Family Therapy*, *27*(2), 105-115. https://doi.org/10.1002/j.1467-8438.2006.tb00704.x

Crouch, J.L., Smith, D.W., & Ezzell, C.E. (1999). Measuring reactions to sexual trauma among children: Comparing the Children's Impact of Traumatic Events Scale and the Trauma Symptom Checklist for Children. Child Maltreatment. *Journal of the American Professional Society on the Abuse of Children*, 4, 255-263. https://doi.org/10.1177/1077559599004003006

Cunha, M., Xavier, A., Martinho, M. I., & Matos, M. (2014). Measuring positive emotional memories in adolescents: Psychometric properties and confirmatory factor analysis of the early memories of warmth and safeness scale. International Journal of Psychology and Psychological Therapy, 14, 245-259.

Davis, J.P., Ports, K.A., Basile, K.C., Espelage, D.L., & David-Ferdon, C.M. (2019). Understanding the buffering effects of protective factors on the relationship between adverse childhood experiences and teen dating violence perpetration. Journal of Youth and Adolescence, 48, 2343-2359. doi.org/10.1007/s10964-019-01028-9

DeLisi, M., Alcala, J., Kusow, A., Hochstetler, A., Heirigs, M. H., Caudill, J. W., & Baglivio, M. T. (2017). Adverse childhood experiences, commitment offense, and race/ethnicity: Are the effects crime-, race, and ethnicity-specific?. *International journal of environmental research and public health*, *14*(3), 331. https://doi.org/10.3390/ijerph14030331

De Vries Robbé, M., Mann, R. E., Maruna, S., & Thornton, D. (2015). An exploration of protective factors supporting desistance from sexual offending. *Sexual Abuse, 27*(1), 16-33. https://doi.org/10.1177/1079063214547582

Dierkhising, C.B., Woods-Jaeger, B., Briggs, E.C., Lee, R. & Pynoos, R.S. (2013). Trauma histories among justice-involved youth: findings from the National Child Traumatic Stress Network, European *Journal of Psychotraumatology*, 4:1, 20274. DOI: 10.3402/ejpt.v4i0.20274

Diaz, J. (1994). *The impact of sexual abuse on adolescent females: factors influencing subsequent psychological adjustment and sexual behaviour*. Unpublished doctoral dissertation. Columbia University, New York. Cited in Briere, J. (1996) Trauma *Symptom Checklist for Children: Professional Manual.* Florida: Psychological Assessment Resources Inc.

Dickson, A., Knussen, C., & Flowers, P. (2008). 'That was my old life; it's almost like a past-life now': Identity crisis, loss and adjustment amongst people living with Chronic Fatigue Syndrome. *Psychology and Health*, *23*(4), 459-476. https://doi.org/10.1080/08870440701757393

Dodds, R.L. (2021) An Exploratory Review of the Associations between Adverse Experiences and Autism, *Journal of Aggression, Maltreatment & Trauma*, 30:8, 1093-1112, DOI: 10.1080/10926771.2020.1783736

Duden, G. S. (2021). Challenges to qualitative evidence synthesis–Aiming for diversity and abstracting without losing meaning. *Methods in Psychology*, *5*, 100070.https://doi.org/10.1016/j.metip.2021.100070

Eatough, V., & Smith, J. (2006). "I was like a wild person": Understanding feelings of anger using interpretative phenomenological analysis. *British Journal of Psychology,* 97, 483-498. https://doi.org/10.1348/000712606X97831

Elliot, A.N., Alexander, A.A., Pierce, T.W., Aspelmeir, J. E., & Richmond, J.M. (2009). Childhood victimization, poly-victimization and adjustment to college in women. *Child Maltreatment.* https://doi.org/10.1177/1077559509332262

Elliott, D.M., & Briere, J. (1994). Forensic sexual abuse evaluations of older children: Disclosures and symptomatology. *Behavioral Sciences and the Law*, 12, 261-277. https://doi.org/10.1002/bsl.2370120306

Elliot, D.M., & Briere, J. (1995). Posttraumatic stress associated with delayed recall of sexual abuse: A general population study. *Journal of Traumatic Stress*, 8, 629-647. https://doi.org/10.1007/BF02102892

Epstein, M., & Ward, L. M. (2011). Exploring parent-adolescent communication about gender: Results from adolescent and emerging adult samples. *Sex roles*, *65*, 108-118. https://doi.org/10.1007/s11199-011-9975-7

Evans, J.J., & Briere, J., Boggiano, A.K. & Barrett, M. (1994) *Reliability and validity of the Trauma Symptom Checklist for Children in a normative sample.* Paper presented at the San Diego Conference on responding to Child Maltreatment. Cited in Briere, J. (1996) *Trauma Symptom Checklist for Children : Professional Manual.* Florida: Psychological Assessment Resources Inc.

Evans, J., Skuse, T., Kennedy, D., & Matthew, J. (2023). Desistance, adversity and trauma: Implications for practice with children and young people in conflict with the law. HMIP. https://www.justiceinspectorates.gov.uk/hmiprobation/wp-

content/uploads/sites/5/2023/09/Academic-Insights-Desistance-adversity-and-trauma-Implications-for-practice-with-children-and-young-people-in-conflict-with-the-law-.pdf

Fallot, R., & Harris, M. (2009). Creating cultures of trauma-informed care: A self- assessment and planning protocol. *Community Connections*. https://doi.org/10.13140/2.1.4843.6002.

Farrell, C., & Zimmerman, G. M. (2017). Does offending intensify as exposure to violence aggregates? Reconsidering the effects of repeat victimization, types of exposure to violence, and poly-victimization on property crime, violent offending, and substance use. *Journal of Criminal Justice*, *53*, 25-33. https://doi.org/10.1016/j.jcrimjus.2017.09.004

Faure-Walker, D. & Hunt, N. (2022). The Prevalence of Adverse Childhood Experiences Among Children and Adolescents Who Display Harmful Sexual Behaviour: A Review of the Existing Research. The Journal of Child & Adolescent Trauma, 15:1051–1061. doi.org/10.1007/s40653-022-00444-7

Farrell, A. (2005). *Ethical research with children*. McGraw-Hill Education (UK).

Feindler, E. L., Rathus, J. H., & Silver, L. B. (2003). General Issues in the Assessment of Family Violence.

Felitti, V.J., Anda, R.F., Nordenberg, D., Williamson, D.F., Spitz, A.M., Edwards, V., Koss, M.P., & Marks, J.S. (1998). Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventative Medicine*, 14 (4) 245-258. https://doi.org/10.1016/S0749-3797(98)00017-8

Felizzi, M. V. (2015). Family or caregiver instability, parental attachment, and the relationship to juvenile sex offending. *Journal of child sexual abuse*, *24*(6), 641-658. https://doi.org/10.1080/10538712.2015.1057668

Flemming, K., & Noyes, J. (2021). Qualitative evidence synthesis: Where are we at? *International Journal of Qualitative Methods, 20*, 1-13. https://doi.org/https://doi.org/10.1177/1609406921993276

Fingfeld-Connett, D. (2010). Generalizability and transferability of meta-synthesis research findings. Journal of Advanced Nursing, 66(2), 246-254. https://doi.org/10.1111/j.1365-2648.2009.05250.x

Finkelhor, D. (2018). Screening for adverse childhood experiences (ACEs): Cautions and suggestions. *Child abuse & neglect*, *85*, 174-179. https://doi.org/10.1016/j.chiabu.2017.07.016

Finkelhor, D., Turner, H., Hamby, S. L., & Ormrod, R. (2011). Polyvictimization: Children's Exposure to Multiple Types of Violence, Crime, and Abuse. *National survey of children's exposure to violence*. https://scholars.unh.edu/cgi/viewcontent.cgi?article=1024&context=ccrc

Finkelhor, D., Ormrod, R. K., Turner, H. A., & Hamby, S. L. (2005). Measuring poly-victimization using the Juvenile Victimization Questionnaire. *Child abuse & neglect*, *29*(11), 1297-1312. https://doi.org/10.1016/j.chiabu.2005.06.005

Finkelhor, D., Ormrod, R. K., & Turner, H. A. (2007). Poly-victimization: A neglected component in child victimization. *Child Abuse & Neglect, 31*(1), 7-26. https://doi.org/10.1016/j.chiabu.2006.06.008

Finkelhor, D., Turner, H., Ormrod, R., & Hamby, S. L. (2009). Violence, abuse, and crime exposure in a national sample of children and youth. *Pediatrics*, *124*(5), 1411-1423. https://doi.org/10.1542/peds.2009-0467

Finklehor, D., Shattuck, A., Turner, H., Hamby, S. (2015). A revised inventory of Adverse Childhood Experiences. *Child Abuse & Neglect* 48 13-21. https://doi.org/10.1016/j.chiabu.2015.07.011

Firmin, C. E. (2015). Peer on peer abuse: Safeguarding implications of contextualising abuse between young people within social fields. https://uobrep.openrepository.com/handle/10547/565790

Firmin, C. E. (2017). Contextual safeguarding: an overview of the operational, strategic and conceptual framework. https://uobrep.openrepository.com/handle/10547/624844

Flannery, D. J., Wester, K. L., & Singer, M. I. (2004). Impact of exposure to violence in school on child and adolescent mental health and behavior. *Journal of community psychology*, *32*(5), 559-573. https://doi.org/10.1002/jcop.20019

Flemming, K., & Noyes, J. (2021). Qualitative evidence synthesis: where are we at?. *International Journal of Qualitative Methods*, *20*, 1609406921993276. https://doi.org/10.1177/1609406921993276

Ford, J. D., Grasso, D. J., Hawke, J., & Chapman, J. F. (2013). Poly-victimization among juvenile justice-involved youths. *Child abuse & neglect*, *37*(10), 788-800. https://doi.org/10.1016/j.chiabu.2013.01.005

Fox, B. H., Perez, N., Cass, E., Baglivio, M. T., & Epps, N. (2015). Trauma changes everything: Examining the relationship between adverse childhood experiences and serious, violent and chronic juvenile offenders. *Child abuse & neglect*, *46*, 163-173. https://doi.org/10.1016/j.chiabu.2015.01.011

Friedrich, W. N., & Jaworski, T. M. (1995). Pediatric abdominal disorders: Inflammatory bowel disease, rumination/vomiting, and recurrent abdominal pain. *Handbook of pediatric psychology*, 479-497.

Friedrich, W.N., Jaworski, T.M., Huxsahl, S.E., & Bengtson, B.S. (1997). Dissociative and sexual behaviors in children and adolescents with sexual abuse and psychiatric histories. *Journal of Interpersonal Violence*, 12, 155-171. https://doi.org/10.1177/088626097012002001

Fuld, S. (2018). Autism spectrum disorder: The impact of stressful and traumatic life events and implications for clinical practice. *Clinical social work journal*, *46*(3), 210-219. https://doi.org/10.1007/s10615-018-0649-6

Gallitto, E., Lyons, J., Weegar, K., & Romano, E. (2017). Trauma-symptom profiles of adolescents in child welfare. *Child Abuse & Neglect*, 68, 25-35. http://dx.doi.org/10.1016/j.chiabu.2017.03.011

Gannon, T, Olver, M. E., Mallion, J. S., & James, M. (2019). Does specialized psychological treatment for offending reduce recidivism? A meta-analysis examining staff and program variables as predictors of treatment effectiveness. *Clinical Psychology Review*, *73*, 1-18. 101752–101752. https://doi.org/10.1016/j.cpr.2019.101752

Garrett, L. (2010). A phenomenological explanation of the reflections on lived space by child sexual abusers. Issues in Mental Health Nursing, 31, 758–762. doi:10.3109/ 01612840.2010.506253

Gerhard-Burnham, B., Underwood, L. A., Speck, K., Williams, C., Merino, C., & Crump, Y. (2016). The lived experience of the adolescent sex offender: A phenomenological case study. *Journal of child sexual abuse*, *25*(1), 93-109. https://doi.org/10.1080/10538712.2016.1111965

Giarratano, P., Ford, J. D., & Nochajski, T. H. (2020). Gender differences in complex posttraumatic stress symptoms, and their relationship to mental health and substance abuse outcomes in incarcerated adults. *Journal of Interpersonal Violence*, *35*(5-6), 1133-1157. https://doi.org/10.1177/0886260517692995

Gilbert, L. K., Breiding, M. J., Merrick, M. T., Thompson, W. W., Ford, D. C., Dhingra, S. S., & Parks, S. E. (2015). Childhood adversity and adult chronic disease: an update from ten states and the District of Columbia, 2010. *American journal of preventive medicine*, *48*(3), 345-349. https://doi.org/10.1016/j.amepre.2014.09.006

Gough, D., Thomas, J., & Oliver, S. (2012). Clarifying differences between review designs and methods. *Systematic reviews*, *1*, 1-9. https://doi.org/10.1186/2046-4053-1-28

Grady, M. D., Levenson, J. S., & Bolder, T. (2017). Linking adverse childhood effects and attachment: A theory of etiology for sexual offending. *18(*4), 433-444. https://doi.org/10.1177/1524838015627147

Grady, M. D., Levenson, J. S., Glover, J., & Kavanagh, S. (2021). Is sex-offending treatment trauma-informed? Exploring perspectives of clinicians and clients. *Journal of Sexual Aggression*, 28*(1),* 60-75. https://doi.org/10.1080/13552600.2021.1942572

Grady, M. D., & Shields, J. J. (2018). The relationship between attachment dimensions and emotion regulation in individuals who have committed sexual crimes. *Journal of Sexual Aggression*, *24*(1), 51-65. https://doi.org/10.1080/13552600.2017.1391630

Grady, M. D., Levenson, J. S., Glover, J., & Kavanagh, S. (2022). Is sex-offending treatment trauma-informed? Exploring perspectives of clinicians and clients. *Journal of sexual aggression*, *28*(1), 60-75. https://doi.org/10.1080/13552600.2021.1942572

Grady, M. D., Levenson, J. S., Glover, J., Kavanagh, S., & Carter, K. (2022). "Hurt people hurt other people": The link between past trauma and sexual offending. *Sexual Offending: Theory, Research, and Prevention*, *17*, 1-28. https://doi.org/10.5964/sotrap.7361

Gray, A., Pithers, W. D., Busconi, A., & Houchens, P. (1999). Developmental and etiological characteristics of children with sexual behavior problems: Treatment implications. *Child Abuse & Neglect*, *23*(6), 601-621. https://doi.org/10.1016/S0145-2134(99)00027-7

Greenwald, R., & Rubin, A. (1999). Assessment of children's post-traumatic symptoms: Development and preliminary validation of parent and child scales. *Research on Social Work Practice*, 9, 61-75. https://doi.org/10.1177/104973159900900105

Hackett, S. (2004). *What works for children and young people with harmful sexual behaviours?*. https://durham-repository.worktribe.com/output/1128135

Hackett, S (2010). Children, young people and sexual violence. In chapter. C. Barter & C. Berridge (Eds,). *Children behaving badly? Exploring peer violence between children and young people*. (pp. 121-135). London: Blackwell Wiley.

Hackett, S. (2014). Children and young people with harmful sexual behaviours: Research Review. *Research in Practice.* https://tce.researchinpractice.org.uk/wp-content/uploads/2020/05/children_and_young_people_with_harmful_sexual _behaviours_research_review_2014.pdf

Hackett, S., Branigan, P., & Holmes, D. (2016/2019). *Harmful Sexual Behaviour Framework: an Evidence-Informed Operational Framework for Children and Young People Displaying Harmful Sexual Behaviours.* NSPCC. https://learning.nspcc.org.uk/media/1657/harmful-sexual-behaviour- framework.pdf

Hackett, S., Darling, A. J., Balfe, M., Masson, H., & Phillips, J. (2022). Life course outcomes and developmental pathways for children and young people with harmful sexual behaviour. *Journal of Sexual Aggression*, 1-21. https://doi.org/10.1080/13552600.2022.2124323

Hackett, S., & Masson, H. (2006). Young people who have sexually abused: What do they (and their parents) want from professionals. *Children and Society, 20*(3), 183-195. https://doi.org/10.1002/CHI.873

Hackett, S., Masson, H., & Phillips, S. (2005). Services for young people who sexually abuse. *A report on mapping and exploring services for young people who have sexually abused others. London: Youth Justice Board for England and Wales*.

Hackett, S., Masson, H., Balfe, M., & Phillips, J. (2013). Individual, family and abuse characteristics of 700 British child and adolescent sexual abusers. *Child Abuse Review, 22*(4), 232-245. https://doi.org/10.1002/car.2246

Hannes, K., & Macaitis, K. (2012). A move to more systematic and transparent approaches in qualitative evidence synthesis: Update on a review of published papers. Qualitative Research, 12, 402–442. https://doi.org/10.1177/1468794111432992

Harrelson, M.E., Alexander, A.A., Morais, H.B., Burkhart, B.R. (2017). The effects of polyvictimizationn and quality of caregiver attachment on disclosure of illegal sexual behaviour. *Journal of Child Sexual Abuse*, 26:5, 625-642. https://doi.org/10.1080/10538712.2017.1328474

Harris, M., & Fallot, R. D. (2001). Envisioning a trauma-informed service system: A vital paradigm shift. *New directions for mental health services*, *2001*(89), 3-22. https://doi.org/10.1002/yd.23320018903

Hawes, D.J., Lechowicz, M., Roach, A., Fisher, C., Doyle, F.L., Noble, S., & Dadds, M.R. (2021). Capturing the Developmental Timing of Adverse Childhood Experiences: The Adverse Life Experiences Scale. *American Psychologist*, 76 (2) 253-267. DOI: 10.1037/AMP0000760

Harris, M. E., & Fallot, R. D. (2001). *Using trauma theory to design service systems*. Jossey-Bass/Wiley.

Herman, J. L. (1992). Complex PTSD: A syndrome in survivors of prolonged and repeated trauma. *Journal of traumatic stress*, *5*(3), 377-391. https://doi.org/10.1002/jts.2490050305

Herman, J. (1997). *Trauma and recovery: The aftermath of Violence - from Domestic Abuse to Political Terror*. New York: Basic Books.

Hester, M., & Lilley, S-J., (2016). Rape investigation and attrition in acquaintance, domestic violence and historical rape cases. *Journal of Investigative Psychology and Offender Profiling*, 14 (2). https://doi.org/10.1002/jip.1469

Holt, S., Buckley, H., & Whelan, S. (2008). The impact of exposure to domestic violence on children and young people: A review of the literature. *Child abuse & neglect*, *32*(8), 797-810. https://doi.org/10.1016/j.chiabu.2008.02.004

Holt, S., & Devaney, J. (2015). Understanding domestic abuse and sexual violence. In The Routledge Handbook of Irish Criminology. Routledge.

Huang, X., O'Connor, M., & Lee, S. (2014). Ethical and methodological issues in qualitative health research involving children: A systematic review. *Nursing Ethics*, 23 (3). doi.org/10.1177/0969733014564102

Hunter, W. M., Cox, C. E., Teagle, S., Johnson, R. M., Mathew, R., Knight, E. D., & Smith, J. B. (2003). Measures for assessment of functioning and outcomes in longitudinal research on child abuse. Volume 2: Middle childhood.

Hunter, J.A., Figueredo, A.J., & Malamuth, N.M. (2010). Developmental pathways into social and sexual deviance. *Journal of Family Violence*, 25, 141-148. https://doi.org/10.1007/s10896-009-9277-9

Hurren, E., Stewart, A., & Dennison, S. (2017). Transitions and turning points revisited: A replication to explore child maltreatment and youth offending links within and across Australian cohorts. *Child Abuse & Neglect*, *65*, 24-36.https://doi.org/10.1016/j.chiabu.2017.01.002

Irons, C., Gilbert, P., Baldwin, M. W., Baccus, J. R., & Palmer, M. (2006). Parental recall, attachment relating and self-attacking/self-reassurance: Their relationship with depression. *British Journal of Clinical Psychology*, *45*(3), 297-308. https://doi.org/10.1348/014466505X68230

Isobel, S. (2021). The 'trauma' of trauma-informed care. *Australasian Psychiatry, 29*(6), 604-606. https://doi.org/10.1177/10398562211022756

Johnstone, L., & Boyle, M. (2018). The Power Threat Meaning Framework: An Alternative Nondiagnostic Conceptual System. *Journal of Humanistic Psychology*, *0*(0). https://doi.org/10.1177/0022167818793289

Kemshall, H., Moulden H. M. (2017). Communicating about child sexual abuse with the public: Learning the lessons from public awareness campaigns. *Journal of Sexual Aggression*, 23, 124–138. https://doi.org/10.1080/13552600.2016.1222004

Kirk, S. (2007). Methodological and ethical issues in conducting qualitative research with children and young people: A literature review. *International Journal of Nursing Studies*, 44 (7), 1250-1260. https://doi.org/10.1016/j.ijnurstu.2006.08.015

Kisiel, C., Fehrenbach, T., Liang, L. J., Stolbach, B., McClelland, G., Griffin, G., & Spinazzola, J. (2014). Examining child sexual abuse in relation to complex patterns of trauma exposure: Findings from the National Child Traumatic Stress Network. *Psychological Trauma: Theory, Research, Practice, and Policy*, *6*(S1), S29. https://psycnet.apa.org/doi/10.1037/a0037812

Kretschmar, J.M., Butcher, F., Tossone, K., & Beale, B.L. (2018). Examining the Concurrent Validity of the Trauma Symptoms Checklist for Children. *Research on Social Work Practice*, 28(7) 882-890. DOI: 10.1177/1049731516677065

Lachal, J., Revah-Levy, A., Orri, M., & Morro, M.R. (2017). Metasynthesis: An original method to synthesize qualitative literature in psychiatry. Frontiers in Psychiatry, 8(269), 1-9. https://doi.org/10.3389/fpsyt.2017.00269

Lanktree, C., Briere, J., & Zaidi, L. (1991). Incidence and impact of sexual abuse in a child outpatient sample: The role of direct inquiry. *Child Abuse & Neglect*, *15*(4), 447-453. https://doi.org/10.1016/0145-2134(91)90028-C

Lanktree, C.B., & Briere, J. (1995). Outcome of therapy for sexually abused children: A repeated measures study. *Child Abuse and Neglect*, 19, 1145-1155. https://doi.org/10.1016/0145-2134(95)00075-J

Lanktree, C.B., Gilbert, A.M., Briere, J., Taylor, N., Chen, K., Maida, C.A., & Saltzman, W.R. (2008). Multi-informant assessment of maltreated children: Convergent and discriminant validity of the TSCC and TSCYC. *Child Abuse & Neglect,* 32, 621-625. https://doi.org/10.1016/j.chiabu.2007.10.003

Laws, D. R. (2000). Sexual offending as a public health problem: A North American perspective. *Journal of Sexual Aggression*, *5*, 30–44. https://doi.org/10.1080/13552600008413294

Lawson, D. M., & Quinn, J. (2013). Complex trauma in children and adolescents: Evidence-based practice in clinical settings. *Journal of clinical psychology*, *69*(5), 497-509. https://doi.org/10.1002/jclp.21990

Letourneau, E. J., & Borduin, C. M. (2008). The effective treatment of juveniles who sexually offend: An ethical imperative. *Ethics & Behavior*, *18*(2-3), 286-306. https://doi.org/10.1080/10508420802066940

Levenson, J. (2014). Incorporating trauma-informed care into evidence-based sex offender treatment. *Journal of Sexual Aggression*, *20*(1), 9-22. https://doi.org/10.1080/13552600.2013.861523

Levenson, J. S., Willis, G. M., & Prescott, D. S. (2016). Adverse childhood experiences in the lives of male sex offenders: Implications for trauma-informed care. *Sexual Abuse*, *28*(4), 340-359. https://doi.org/10.1177/1079063214535819

Levenson, J. S., Baglivio, M., Wolff, K. T., Epps, N., Royall, W. C., Gomez, K. C., & Kaplan, D. (2017). You learn what you live: Prevalence of childhood adversity in the lives of juveniles arrested for sexual offenses. *Advances in Social Work, 18*(1), 313-334. https://doi.org/10.18060/21204

Liddle, M., Boswell, G., Wright, S. and Francis, V. (2016). *Trauma and young offenders: A review of the research and practice literature*. London: Beyond Youth Custody.

Lyons, S., Whyte, K., Stephens, R. & Townsend, H. (2020) Beacon House Therapeutic Services and Trauma Team (www.beaconhouse.org.uk/useful-resources)

Main, M. (2000). The organized categories of infant, child, and adult attachment: Flexible vs. inflexible attention under attachment-related stress. *Journal of the American Psychoanalytic Association*, *48*(4), 1055-1096. https://doi.org/10.1177/00030651000480041801

Mallett, C. A. (2016). The school-to-prison pipeline: A critical review of the punitive paradigm shift. *Child and adolescent social work journal*, *33*, 15-24. https://doi.org/10.1007/s10560-015-0397-1

Malvaso, C. G., Cale, J., Whitten, T., Day, A., Singh, S., Hackett, L., & Ross, S. (2022). Associations between adverse childhood experiences and trauma among young people who offend: A systematic literature review. *Trauma, Violence, & Abuse*, *23*(5), 1677-1694. https://doi.org/10.1177/15248380211013132

Malvaso, C. G., Delfabbro, P. H., & Day, A. (2016). Risk factors that influence the maltreatment-offending association: A systematic review of prospective and longitudinal studies. *Aggression and violent behavior*, *31*, 1-15. https://doi.org/10.1016/j.avb.2016.06.006

Malvaso, C. G., Delfabbro, P. H., & Day, A. (2017). The child protection and juvenile justice nexus in Australia: A longitudinal examination of the relationship between maltreatment and offending. *Child abuse & neglect*, *64*, 32-46. https://doi.org/10.1016/j.chiabu.2016.11.028

Marini, V. A., Leibowitz, G. S., Burton, D. L., & Stickle, T. R. (2014). Victimization, substance use, and sexual aggression in male adolescent sexual offenders. *Criminal Justice and Behavior*, *41*(5), 635–649. https://doi.org/10.1177/0093854813507567

Marshall, W. L., & Marshall, L. E. (2000). The origins of sexual offending. *Trauma, Violence, & Abuse*, *1*(3), 250-263. https://doi.org/10.1177/1524838000001003003

Masson, H., Hackett, S., Phillips, J. and Balfe, M. (2015). Developmental markers of risk or vulnerability? Young females who sexually abuse – characteristics, backgrounds, behaviours and outcomes. *Child & Family Social Work,* 20(1):19–29. https://doi.org/10.1111/cfs.12050

Maynard, B. R., Farina, A., Dell, N., Kelly, M.S. (2019). Effects of trauma-informed approaches in schools: A systematic review. *Campbell Systematic Reviews*. doi: 10.1002/c12.1018

McCartan, K. F., Kemshall, H., & Tabachnick, J. (2015). The construction of community understandings of sexual violence: Rethinking public, practitioner and policy discourses. *Journal of Sexual Aggression*, *21*(1), 100-116. https://doi.org/10.1080/13552600.2014.945976

McCarten, K.F. & Kemshall, H. (2023). Incorporating Quaternary Prevention: Understanding the Full Scope of Public Health Practices in Sexual Abuse Prevention. International Journal of Offender Therapy and Comparative Criminology, 67 (2). https://doi.org/10.1177/0306624X21104920

McCarten, K.F., Merdian, H.L., Perkins, D.E., & Kettleborough, D. (2018) Ethics and Issues of Secondary Prevention Efforts in Child Sexual Abuse I*nternational Journal of Offender Therapy and Comparative Criminology*. DOI: 10.1177/0306624X17723951

McCarten, K.F., & Richards, K. (2021). The Integration of People Convicted of a Sexual Offence into the Community and Their (Risk) Management. Current Psychiatry Reports, 23:52. https://doi.org/10.1007/s11920-021-01258-4

McCartan, K., Uzieblo, K., & Smid, W. J. (2021). Professionals' understandings of and attitudes to the prevention of sexual abuse: An international exploratory study. *International journal of offender therapy and comparative criminology*, *65*(8), 815-831. https://doi.org/10.1177/0306624X20919706

McCuish, E. C., & Lussier, P. (2017). Unfinished stories: From juvenile sex offenders to juvenile sex offending through a developmental life course perspective. *Aggression and violent behavior*, *37*, 71-82. https://doi.org/10.1016/j.avb.2017.09.004

McDonald, C., & Martinez, K. (2017). Victims' retrospective explanations of sibling sexual violence. *Journal of child sexual abuse*, *26*(7), 874-888. https://doi.org/10.1080/10538712.2017.1354953

McLaughlin, K. A., Colich, N. L., Rodman, A. M., & Weissman, D. G. (2020). Mechanisms linking childhood trauma exposure and psychopathology: A transdiagnostic model of risk and resilience. *BMC medicine*, *18*, 1-11. https://doi.org/10.1186/s12916-020-01561-6

McPherson, L., Vosz, M., Gatwiri, K., Hitchcock, C., Tucci, J., Mitchell, J., & Macnamara, N. (2024). Approaches to assessment and intervention with children and young people who engage in harmful sexual behavior: A scoping review. *Trauma, Violence, & Abuse*, *25*(2), 1585-1598. https://doi.org/10.1177/15248380231189293

MIND (2023). Dissociation and dissociative disorders. https://www.mind.org.uk/information-support/types-of-mental-health-problems/dissociation-and-dissociative-disorders/about-dissociation/

Miner, M. H., Swinburne Romine, R., Robinson, B. B. E., Berg, D., & Knight, R. A. (2016). Anxious attachment, social isolation, and indicators of sex drive and compulsivity: Predictors of child sexual abuse perpetration in adolescent males?. *Sexual abuse*, *28*(2), 132-153. https://doi.org/10.1177/1079063214547585

Mitchell, I. J., & Beech, A. R. (2011). Towards a neurobiological model of offending. *Clinical psychology review*, *31*(5), 872-882. https://doi.org/10.1016/j.cpr.2011.04.001

Moher, D., Liberati, A., Tetzlaff, J., & Altman, D. (2009). Preferred Reporting Items for Systematic Reviews and Meta- Analyses: The PRISMA Statement. *PLoS Med, 6*(7). https://doi.org/doi:10.1371/journal.pmed1000097

Moore, K.A., & Ramirez, A.N. (2016). Adverse childhood experience and adolescent well-being: Do protective factors matter? *Child Indicators Research*, 9 (2), 299-316. DOI 10.1007/s12187-015-9324-4

Muñiz, J. O. (2021). Exclusionary discipline policies, school-police partnerships, surveillance technologies and disproportionality: A review of the school to prison pipeline literature. *The Urban Review*, *53*(5), 735-760. https://doi.org/10.1007/s11256-021-00595-1

Murphy, A., Steele, M., Dube, S. R., Bate, J., Bonuck, K., Meissner, P., & Steele, H. (2014). Adverse childhood experiences (ACEs) questionnaire and adult attachment interview (AAI): Implications for parent child relationships. *Child abuse & neglect*, *38*(2), 224-233. https://doi.org/10.1016/j.chiabu.2013.09.004

National Institute for Health and Care Excellence [NICE]. (2016). *Harmful sexual behaviour among children and young people*. NICE. www.nice.org.uk/guidance/ng55

National Society for the Prevention of Cruelty to Children [NSPCC]. (2021). *Statistics briefing: harmful sexual behaviour.* https://learning.nspcc.org.uk/media/1661/statistics-briefing-harmful-sexual- behaviour.pdf

Nelson-Gardell, D. M. (1995). *Child report of sexual abuse treatment effectiveness: development of a rapid assessment instrument*. The Florida State University.

Nilsson D, Wadsby M, Svedin C. G. (2008). The psychometric properties of The Trauma Symptom Checklist for Children (TSCC) in a sample of Swedish children. *Child Abuse & Neglect*, 32, 627-36. https://doi.org/10.1016/j.chiabu.2007.09.009

Noyes, J., Booth, A., Flemming, K., Garside, R., Harden, A., Lewin, S., & Thomas, J. (2018). Cochrane Qualitative and Implementation Methods Group guidance series—paper 3: methods for assessing methodological limitations, data extraction and synthesis, and confidence in synthesized qualitative findings. *Journal of clinical epidemiology*, *97*, 49-58. https://doi.org/10.1016/j.jclinepi.2017.06.020

Noyes, J. and Lewin, S. In J. Noyes, A. Booth, K. Hannes, A. Harden, J. Harris, S. Lewin and C. Lockwood (2011) *Supplementary Guidance for Inclusion of Qualitative Research in Cochrane Systematic Reviews of Interventions*. https://methods.cochrane.org/qi/supplemental-handbook-guidance

Oates, J., Carpenter, D., Fisher, M., Goodson, S., Hannah, B., Kwiatowski, R., & Wainwright, T. (2021). BPS code of human research ethics. British Psychological Society.

Ohan, J.L., Myers, K., & Collett, B.R. (2002). Ten-Year Review of Rating Scales. IV: Scales Assessing Trauma and Its Effects. *American Academy of Child & Adolescent Psychiatry* 41(12). https://doi.org/10.1097/00004583-200212000-00012

Ohashi, K., Anderson, C. M., Bolger, E. A., Khan, A., McGreenery, C. E., & Teicher, M. H. (2019). Susceptibility or resilience to maltreatment can be explained by specific differences in brain network architecture. *Biological psychiatry*, *85*(8), 690-702. https://doi.org/10.1016/j.biopsych.2018.10.016

O'Nions, E., Petersen, I., Buckman, J. E., Charlton, R., Cooper, C., Corbett, A., & Stott, J. (2023). Autism in England: assessing underdiagnosis in a population-based cohort study of prospectively collected primary care data. *The Lancet Regional Health–Europe*, *29*. https://doi.org/10. 1016/j.lanepe.2023. 100626

Ogilvie, J., Thomsen, L., Barton, J., Harris, D. A., Rynne, J., & O'Leary, P. (2022). *Adverse childhood experiences among youth who offend: Examining exposure to domestic and family violence for male youth who perpetrate sexual harm and violence* (Research report, 13/2022). ANROWS.

O'Rourke, R., Marriot, M., & Trigg, R. (2023). What Measures are Effective in Trauma Screening for Young Males in Custody? A COSMIN Systematic Review. *Trauma, Violence & Abuse*, 1-14. Doi i1.o1r7g/71/01.15127478/135820428381022139121591251

Page, M. J., McKenzie, J. E., Bossuyt, P. M., Boutron, I., Hoffmann, T. C., Mulrow, C. D., & Moher, D. (2021). The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. *BMJ*, *372*. https://doi.org/10.1136/bmj.n71

Perrin, S., Meiser-Stedman, R., & Smith, P. (2005). The Children's Revised Impact of Event Scale (CRIES): Validity as a screening instrument for PTSD. *Behavioural and Cognitive Psychotherapy*, *33*(4), 487-498. https://doi.org/10.1017/S1352465805002419

Perry, B. D. (2001). The neurodevelopmental impact of violence in childhood. Textbook of Child and Adolescent Forensic Psychiatry.

Perry, B.D., & Szalavitz, M. (2017). *The boy who was raised as a dog* (2nd Edition). New York: Basic Books.

Porges, S.W. (2011). The polyvagal theory: *Neuropsychological Foundations of Emotions, Attachment, Communication and Self-Regulation*. WW Norton & Co.

Reid, K., Flowers, P., & Larkin, M. (2005). Exploring lived experience. The Psychologist, 18 (1), 20–23. *https://goo. gl/9ScDxi*.

Reis, M. (2015). Exploring the Attachment Style of Sex Offenders [Doctoral Dissertation, University of Birmingham].

Revicki, D. (2014). Internal Consistency Reliability. In Michalos, A.C. (eds) *Encyclopaedia of Quality of Life and Well-Being Research*. Springer.

Rich, P. (2006). From theory to practice: the application of attachment theory to assessment and treatment in forensic mental health services. *Criminal Behavior. & Mental Health*, *16*, 211.

Ritcher, A., Gilbert, P., & McEwan, K. (2009). Development of an early memories of warmth and safeness scale and its relationship to psychopathology. *Psychology & Psychotherapy: Theory, Research and Practice*, 82(2), 171-184. https://doi.org/10.1348/147608308X395213

Roberts, A.L., Kerestan, C.K., Lyal, K., Robinson, E.B., & Wiesskopf, M.G. (2015). Association of autistic traits in adulthood with childhood abuse, interpersonal victimization, and posttraumatic stress. *Child Abuse & Neglect,* 45 (2015) 135–142. http://dx.doi.org/10.1016/j.chiabu.2015.04.010

Rogers, A.A., Nielson, M.G., & Santos, C.E., (2021). Manning Up While Growing Up: A Developmental-Contextual Perspective on Masculine Gender-Role Socialization in Adolescence. *Psychology of Men & Masculinities*, 22(2), 354-364. https://doi.org/10.1037/men0000296

Rogers, C. R. (1951). *Client Centered Therapy*. Boston, MA: Houghton Mifflin.

Ruiz, E. (2016). Trauma symptoms in a diverse population of sexually abused children. *Psychological Trauma: Theory, Research, Practice, and Policy*, *8*(6), 680–687. https://doi.org/10.1037/tra0000160

Rutten, A.X., Kempes, M., Bongers, I.J., Vermeiren, R., Nieuwenhuizen, C. (2022). Offence type and neurodiversity: A comparison of 12-17-year-old boys charged with a criminal offence by diagnosis of autism spectrum disorder, attention deficit hyperactivity disorder or both. *Criminal Behaviour and Mental Health*, 32 (6). DOI: 10.1002/cbm.2267

Sachser, C., Berliner, L., Holt, T., Jensen, T. K., Jungbluth, N., Risch, E., & Goldbeck, L. (2017). International development and psychometric properties of the Child and Adolescent Trauma Screen (CATS). *Journal of affective disorders, 210*189-195. https://pubmed.ncbi.nlm.nih.gov/28049104/

Sadowski, C.M., & Friedrich, W.N. (2000). Psychometric properties of the Trauma Symptom Checklist for Children (TSCC) with psychiatrically hospitalized adolescents. *Child Maltreatment*, 5(4), 364-372. https://doi.org/10.1177/1077559500005004008

Substance Abuse and Mental Health Services Administration, [SAMHSA]. (2013). SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. https://ncsacw.acf.hhs.gov/userfiles/files/SAMHSA_Trauma.pdf

Saunders, E. A., & Edelson, J. A. (1999). Attachment style, traumatic bonding, and developing relational capacities in a long-term trauma group for women. *International Journal of Group Psychotherapy*, *49*(4), 465-485. https://doi.org/10.1080/00207284.1999.11490964

Sawyer, S. M., Azzopardi, P. S., Wickremarathne, D., & Patton, G. C. (2018). The age of adolescence. *The lancet child & adolescent health*, *2*(3), 223-228. https://doi.org/10.1016/S2352-4642(18)30022-1

Savage, J. (2014). The association between attachment, parental bonds and physically aggressive and violent behavior: A comprehensive review. *Aggression and violent behavior*, *19*(2), 164-178. https://doi.org/10.1016/j.avb.2014.02.004

Schroeder, A., Slopen, N., & Mittal, M. (2018). Accumulation, Timing, and Duration of Early Childhood Adversity and Behavior Problems at Age 9. *Journal of Clinical Child & Adolescent Psychology*, 49 (1). doi.org/10.1080/15374416.2018.1496440

Seto, M. C., & Lalumiere, M. L. (2010). What is so special about male adolescent sexual offending? A review and test of explanations through meta-analysis. *Psychological Bulletin, 136*(4), 526-575. https://doi.org/http://dx.doi.org/10.1037/a0019700

Sharma, A., & Newberg, A. (2015). Mind-body practices and the adolescent brain: Clinical neuroimaging studies. *Adolescent Psychiatry*, *5*(2), 116-124.

Shilkret, R., & Shilkret, C. J. (2011). Attachment theory. *Inside out and outside in: Psychodynamic clinical theory and contemporary multicultural contexts*, 186-207.

Siegal, D. J. (2001). Toward an interpersonal neurobiology of the developing mind: Attachment relationships, "mindsight," and neural integration. *Infant Mental Health Journal, 221*(1-2), 67-94. https://doi.org/10.1002/1097- 0355(200101/04

Singer, M.I., Anglen, T.M., Song, L.Y., & Lunghofer, L. (1995). Adolescents' exposure to violence and associated symptoms of psychological trauma. *Journal of American Medical Association*, 273(6), 477-482.

Skinner, G. (2021). *Offending, Physical Health and Premature Mortality: Associations Derived from Longitudinal and Meta-Analytic Evidence* (Doctoral dissertation).

Skřivánková, P., Páv, M., Faberová, K., Perkins, D., Adam, D., Mazouchová, A., & Anders, M. (2023). Violence risk and personality assessment in adolescents by Structured Assessment of Violence Risk in Youth (SAVRY) and high school personality questionnaire (HSPQ): Focus on protective factors strengthening. *Frontiers in psychiatry*, *13*, 1067450. https://doi.org/10.3389/fpsyt.2022.1067450

Skuse, T., & Matthew, J. (2015). The Trauma Recovery Model: Sequencing Youth Justice Interventions for Young People with Complex Needs. *Prison Service Journal*, 220, 16-25. https://jonnymatthew.com/wp- content/uploads/2018/08/3.-TRM-published-paper-July-2015.pdf

Smallbone, S. W. (2006). Social and psychological factors in the development of delinquency and sexual deviance. In H. E. Barbaree & W. L. Marshall (Eds.), The juvenile sex offender (2nd ed., pp. 105–127). New York: Guilford Press.

Smallbone, S. W., & Dadds, M. R. (1998). Childhood attachment and adult attachment in incarcerated adult male sex offenders. *Journal of Interpersonal Violence*, *13*(5), 555-573. https://doi.org/10.1177/088626098013005001

Smallbone, S. W., & Dadds, M. R. (2000). Attachment and coercive sexual behavior. *Sexual Abuse: A Journal of Research and Treatment,* 12, 3-15. https://doi.org/10.1023/A:1009555619323

Smallbone, S., Rayment-Mchugh, S., Crissman, B., & Shumack, D. (2008). Treatment with youth who have committed sexual offences: Extending the reach of systemic interventions through collaborative partnerships. *Clinical Psychologist*, *12*(3), 109-116. https://doi.org/10.1080/13284200802520839

Smallbone, S., & Wortley, R. K. (2000). *Child sexual abuse in Queensland: Offender characteristics and modus operandi*. Brisbane: Queensland Crime Commission and Queensland Police Service.

Smith, J.A., & Etaugh, V. (2012). Interpretive Phenomenological Analysis. In Breakwell, G. M., Smith, J. A., & Wright, D. B. (ed), *Research Methods in Psychology*. 4th ed. London: Sage.

Smith, J., & Osborn, M. (2008). Interpretative Phenomenological Analysis. In J. Smith. (Ed.), Qualitative Psychology: A Practical Guide to Research Methods.

Smith, J. A., & Osborn, M. (2015). Interpretative phenomenological analysis as a useful methodology for research on the lived experience of pain. *British journal of pain*, *9*(1), 41-42. https://doi.org/10.1177/2049463714541642

Somervell, J., & Lambie, I. (2009). Wilderness therapy within adolescent sexual offender treatment programme: A qualitative study. Journal of Sexual Aggression, 15(2), 161–177. doi:10.1080/13552600902823055

Stathis, S., Martin, G., & McKenna, J.G. (2005). A Preliminary Case Series on the Use of Quetiapine for Posttraumatic Stress Disorder in Juveniles Within a Youth Detention Center. *Journal of Clinical Psychopharmacology*, 25 (6). *DOI:* 10.1097/01.jcp.0000186901.79861.e2

Strand, V. C., Pasquale, L. E., & Sarmiento, T. L. (2005). Child and adolescent trauma measures: A review. http://hdl.handle.net/11212/1771

Substance Abuse and Mental Health Services Administration, [SAMHSA]. (2013). SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. https://ncsacw.acf.hhs.gov/userfiles/files/SAMHSA_Trauma.pdf

Taussig, H. N., & Culhane, S. E. (2010). Impact of a mentoring and skills group program on mental health outcomes for maltreated children in foster care. *Archives of pediatrics & adolescent medicine*, *164*(8), 739-746. doi:10.1001/archpediatrics.2010.124

Taylor, J. F. (2003). Children and young people accused of child sexual abuse: A study within a community. *Journal of sexual aggression*, *9*(1), 57-70. https://doi.org/10.1080/1355260031000149154

Teh, Y. Y., & Lek, E. (2018). Culture and reflexivity: Systemic journeys with a British Chinese family. *Journal of Family Therapy, 40*(4), 520–536. https://doi.org/10.1111/1467-6427.12205

Tidefors, I., & Skillbäck, S. (2014). The picture of me: Narratives about childhood and early adolescence by boys who have sexually abused. Nordic Psychology, 66(1), 53-67. https://doi.org/10.1080/19012276.2014.886906

Thomas, J., & Harden, A. (2008). Methods for the thematic synthesis of qualitative research in systematic reviews. *BMC medical research methodology*, *8*, 1-10. https://doi.org/10.1186/1471-2288-8-45

Thomsen, L., Ogilvie, J., & Rynne, J. (2023) Adverse childhood experiences and psychosocial functioning problems for youths who sexually harm siblings, *Journal of Sexual Aggression*, DOI: 10.1080/13552600.2023.2223234

Thurston, S. C. (2005). *An exploration of family interactions and male juvenile sexual offending: A qualitative study*. (Doctoral Dissertation, Texas Woman's University).

Treisman, K. (2017). *Every Interaction is an Intervention.* Safe Hands Thinking Minds. http://www.safehandsthinkingminds.co.uk/wp- content/uploads/2016/03/evey-itneraction-is-an-intervention.pdf

United Nations. (1989). Convention on the Rights of the Child. Treaty Series, 1577, 3.

Vagos, P., Silva, D.R., Brazao, N., Rijo, D., & Gilbert, P. (2017). The early memories of warmth and safeness scale for adolescents: Cross-sample validation of the complete and brief versions. Clinical Psychology and Psychotherapy, 24, 793-804. https://doi.org/10.1002/cpp.2059

Van der Kolk, B. A. (2015). *The body keeps the score: Brain, mind, and body in the healing of trauma*. Penguin Books.

Van ijzendoorn, M.H., Schuengel, C., Bakermans-Kranbeurg, M.J. (1999) Disorganised attachment in early childhood: Meta-analysis of precursors, concomitants and sequelae. Developmental Psychopathology, 11, 225-249. https://doi.org/10.1017/S0954579499002035

Vincent, R. (2010). *Case Studies on the Attachment Origins of Adolescent Sexual Offending* [Doctoral Thesis, Pacifica Graduate Institute].

Vizard, E., Hickey, N., French, L., & McCrory, E. (2007). Children and adolescents who present with sexually abusive behaviour: A UK descriptive study. *The Journal of Forensic Psychiatry & Psychology*, *18*(1), 59-73. https://doi.org/10.1080/14789940601056745

Waldram, J. B. (2007). Everybody has a story: Listening to imprisoned sexual offenders. *Qualitative Health Research*, *17*(7), 963-970. https://doi.org/10.1177/1049732307306014

Walsh, R. (2003). The methods of reflexivity. *The Humanistic Psychologist*, *31*(4), 51-66. https://doi.org/10.1080/08873267.2003.9986934

Weed, M. (2005). Meta Interpretation: A Method for the Interpretive Synthesis of Qualitative Research. In *Forum Qualitative Sozialforschung/Forum: Qualitative Social Research*, 6, 1. https://doi.org/10.17169/fqs-6.1.508

Westhorp, G., Stevens, K., & Rogers, P. J. (2016). Using realist action research for service redesign. *Evaluation*, *22*(3), 361-379. https://doi.org/10.1177/1356389016656514

Wherry, J. N., Graves, L. E., Rhodes, H. M. (2008). The convergent validity of the Trauma Symptom Checklist for Young Children for a sample of sexually abused outpatients. *Journal of Child Sexual Abuse*, 17(1), 38-50. https://doi.org/10.1080/10538710701884441

Williams, J. P. (2008). Emergent themes. In Given, L. M. (Ed.). (2008). *The Sage Encyclopaedia of Qualitative Research Methods*. Sage Publications.

Willig, C. (2012). Perspectives on the epistemological bases for qualitative research. In H. Cooper, P. M. Camic, D. L. Long, A. T. Panter, D. Rindskopf, & K. J. Sher (Eds.), *APA handbook of research methods in psychology, Vol. 1. Foundations, planning, measures, and psychometrics* (pp. 5–21). American Psychological Association. https://doi.org/10.1037/13619-002

Willig, C., & Stainton-Rogers, W. (2008). *The SAGE Handbook of Qualitative Research in Psychology*. SAGE Publications Ltd, https://doi.org/10.4135/9781848607927

Winder, B. (2022). Reducing reoffending and increasing community (re)integration: effective practice when people have a sexual conviction. Mildenhall: Clinks.

Winnicott, D.W. (1973). The Child, the Family, and the Outside World. London, Pelican Books.

World Health Organisation. (2022). Prevention of sexual exploitation, abuse and harassment. Prevention of sexual exploitation, abuse and harassment (who.int)

Yates, P., Allardyce, S., & MacQueen, S. (2012). Children who display harmful sexual behaviour: Assessing the risks of boys abusing at home, in the community or across both settings. *Journal of sexual aggression*, *18*(1), 23-35. https://doi.org/10.1080/13552600.2011.634527

Youth Justice Board. (2024). Youth Justice Statistics: 2022 to 2023. https://www.gov.uk/government/statistics/youth-justice-statistics-2022-to-2023

Yoder, J.Y., Grady, M.D., Brown, A., & Dillard, R. (2020) Criminogenic Needs as Intervening Factors in the Relation Between Insecure Attachments and Youth Sexual Violence. Sexual Abuse 32(3) 247-272. https://doi.org/10.1177/1079063218821108

Zaniewski, B., Dallos, R., Stedmon, J., & Welbourne, P. (2020). An exploration of attachment and trauma in young men who have engaged in harmful sexual behaviours. *Journal of sexual Aggression*, *26*(3), 405-421. https://doi.org/10.1080/13552600.2019.1678688

Zaniewski, B., Dallos, R, Jacqui Stedmon, J., & Welbourne, P. (2023). Boys don't cry: Trauma, trauma narrative and masculine practice among young males who engaged in harmful sexual behaviour. *Human Systems: Therapy, Culture and Attachments*, 3(1), 3-26. DOI: 10.1177/26344041221127693

8. APPENDICES

8.1 CHAPTER TWO APPENDICES

Appendix 1

Search Strategy – PsychInfo

Table 8.1.
Example Search Strategy

Research question:

What are the perceptions of young people who have displayed harmful sexual behaviours in relation to their attachment experiences?

Electronic database:

APA PsychInfo

Date of search	Search strategy	Total number of results	Comments
10th September 2023			
	1. Population Construct 1. "young offender*".ti,ab - 1448 2. (adolescen* adj3 "sex* offen*").ti,ab - 679 3. (juvenile* adj3 "sex* offen*").ti,ab - 800 4. (you* adj3 "sex* offen*").ti,ab - 238 5. exp Juvenile Delinquency/ or exp Juvenile Justice/ or "juvenile delinquen*".ti,ab - 23911	**47220**	

	6. young male*.ti,ab - 3711 7. young men.ti,ab - 6277 8. youth*.ti,ab - 118596 9. young people.ti,ab - 34713 10.young person*.ti,ab 3097 11. adolescen*.ti,ab - 269533 12.teenager*.ti,ab - 9402 13. Juvenile*.ti,ab - 27522 14. Minor*.ti,ab - 92724 **15. 1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10 or 11 or 12 or 13 or 14**		
	2. HSB Construct 16. harmful sex* behavio*.mp - 128 17. inappropriate sex* behav*.mp - 299 18. atypical sex* behav*.mp - 33 19. exp Sex Offenses/ or "sex* offen*".tw - 43604 20. sex* violence.mp – 6735 21. sex* aggress*.mp – 2415 22. illegal sex* behav*.mp - 55 23. abusive sex* behav*.mp - 30	**48361**	

	24. sexual adj2 behav* adj2 problem*.mp - 736 25. sex* molest*.mp - 284 26. aggressive sex* behav*.mp - 78 27. sex* abus* behav*.mp - 286 28. coercive sex* behav*.mp - 81 29. sex* harm.mp – 94 **30. 16 or 17 or 18 or 19 or 20 or 21 or 22 or 23 or 24 or 25 or 26 or 27 or 28 or 29**		
	3. Attachment Construct 30. attachment*.tw - 49536 31. bond*.tw – 24546 32. (parent adj3 child adj3 relationship).tw – 6041 33. (mother adj3 child adj3 relationship).mp – 2400 34. (father adj3 child adj3 relationship).mp – 636 35. Maternal relationship.mp - 176 36. Paternal relationship.mp - 62 37. (caregiver adj2 relationship).mp - 1073 38. (relationship adj2 mother).mp - 4969 39. (relationship adj2 father).mp - 1626	**81382**	

	40. (relationship adj parent*).mp – 357 **41. 30 or 31 or 32 or 33 or 34 or 35 or 36 or 37 or 38 or 39 or 40 or 41**		
	42. 15 and 30 and 42	**390**	

Appendix 2

Descriptive Codes

Table 8.2.
Inductive Descriptive Codes

Broken attachments	Rejection	Sex to cope
Absent fathers	Too grown up	Emotional dysregulation
Positive mothers	Poor relationships with fathers	No boundaries
Positive fathers	Emotionless care	Defending parents
Domestic violence	No time together	Troublemaker
Violent fathers	Links to HSB	Dissociation
Fear of father	Anger	Bravado / toughness
Poor relationship with mother	Early sexualisation	Trust
Bullied	Trauma	Loss
Violent mothers	Positive attachments	

8.2 CHAPTER THREE APPENDICES

Appendix 3
ACE Variable Definitions

Table 8.3.
ACE Definitions

Adverse Childhood Experience	Definition
Physical harm	The use of physical chastisement or punishment towards the child by a parent, carer, or someone else in a position of trust (e.g., another relative) and which results in the child being harmed.
Sexual harm	Direct sexual abuse of the child.
Emotional harm	Emotional / psychological harm of the child through cruel or humiliating treatment by a parent, carer, or someone else in a position of trust (e.g. another relative). Also includes persistent failure to meet the child's emotional needs such as not providing them with emotional warmth or nurture (omission of care). Must be considered to have had a harmful impact on the child such as impacting their self-esteem or self-worth.
Neglect	Failure to meet the physical or medical needs of the child. May include failure to provide appropriate levels of safety, warmth, food, stimulation, or cleanliness.
Caregiver instability	Changes in caregiver that were either unpredictable or permanent. *Do not score as present if parents separated but remained amicable, with both involved in the child's life.
Domestic abuse	Directly witnessing (visual or auditory) verbal physical or sexual abuse within the child's immediate family. Also includes being aware of a parent being the victim of domestic abuse (e.g., witnessing the after effects such as injuries or property damage).
Parental mental health difficulties	Parent or carer has a history of mental health difficulties which are deemed to have impacted on the child.
Parental substance misuse	Parent or carer has a history of substance misuse which impacted on their functioning and/or their parenting.
Family criminality	Immediate family member (e.g., parent, sibling) or extended family member that the child has a close relationship (e.g. aunt, uncle, grandparent) has had involvement in criminal behaviour. May include time in custody.
Bullying	Significant verbal or physical abuse from peers outside the family environment - within school and/or the local community. AND/OR Significant peer rejection (such as persistent peer rejection or peer rejection deemed to have a profound impact).

Other	Any other significant adverse experience that is viewed as being harmful to the child. *Do not score as present for a single slightly sad or upsetting event.

Appendix 4

Offence Detail Definitions

Table 8.4.

Offence Detail Definitions

Offence detail	Definition
Offence type	Whether the offence was a penetration or non-penetration sexual offence. In the case of multiple offences, this was coded 'penetration' if there was any penetration offence.
Victim age	Whether the victim was prepubescent (12 or under) or post pubescent (13+). In the case of multiple victims this was coded 'prepubescent' if there was any prepubescent victim.
Victim gender	Whether the victim was male or female. In the case of multiple victims, this was coded 'male' if there was any male victim'.
Stranger victim	Whether the victim was known to the ASO more than 24 hours prior to the offence. In the case of multiple victims this was coded as 'stranger' if there was any stranger victim.
Intrafamilial victim	Whether the victim was biologically related to the ASO. This included a parents, grandparents, sibling, cousin, aunt or uncle. Half-siblings were included as they are biologically related, but step-siblings were excluded. In the case of multiple victims this was coded 'intrafamilial' if there was any related victim in the victim pool.
Age at onset of harmful sexual behaviour (HSB)	The age at which HSB was first documented to have taken place. This behaviour should fall within the 'abusive' or 'violent' domains of Hackett's continuum.

	If this is the first sexual offence / known incident of harmful sexual behaviour, then age at onset would be the age of the index offence. If a prior incident of HSB is recorded, the young person must have admitted this, been given a caution/conviction, or there must be professional consensus that the HSB took place.
Location of offence	Location in which the offence took place.

Appendix 5

Chi Square Tables

*Fisher's Exact (FE) is reported where >20% of expected cell counts are less than 5.

Table 8.5.

ACEs and Offence Type

ACE variable	Offence variable	$\chi 2$	Two Tail P value
Physical abuse	Offence type	FE	1.000
Sexual abuse	Offence type	FE	0.698
Emotional abuse	Offence type	FE	0.415
Neglect	Offence type	FE	1.000
Domestic abuse	Offence type	FE	1.000
Bullying	Offence type	2.978	0.084
Caregiver instability	Offence type	FE	1.000
Parental mental health difficulties	Offence type	FE	0.717
Parental substance misuse	Offence type	FE	0.696
Family criminality	Offence type	3.091	0.079
Other	Offence type	FE	0.470

Table 8.6.

ACEs and Victim Gender

ACE variable	Offence variable	$\chi 2$	P value
Physical abuse	Victim gender	1.222	0.269
Sexual abuse	Victim gender	1.547	0.214
Emotional abuse	Victim gender	0.854	0.356
Neglect	Victim gender	1.094	0.296
Domestic abuse	Victim gender	1.427	0.232
Bullying	Victim gender	2.602	0.107
Caregiver instability	Victim gender	3.013	0.083
Parental mental health difficulties	Victim gender	0.031	0.860
Parental substance misuse	Victim gender	0.052	0.820
Family criminality	Victim gender	0.544	0.461
Other	Victim gender	0.000	0.986

Table 8.7.

ACEs and Victim Age

ACE variable	Offence variable	$\chi 2$	Two Tail P value
Physical abuse	Victim age	5.324	0.021
Sexual abuse	Victim age	7.927	0.005
Emotional abuse	Victim age	FE	0.233
Neglect	Victim age	3.154	0.076
Domestic abuse	Victim age	4.246	0.039
Bullying	Victim age	FE	0.698
Caregiver instability	Victim age	FE	0.021
Parental mental health difficulties	Victim age	1.226	0.268
Parental substance misuse	Victim age	3.101	0.078
Family criminality	Victim age	0.029	0.864
Other	Victim age	0.029	0.864

Table 8.8

ACEs and Intrafamilial Victim

ACE variable	Offence variable	$\chi 2$	Two Tail P value
Physical abuse	Intrafamilial victim	2.692	0.101
Sexual abuse	Intrafamilial victim	FE	0.160
Emotional abuse	Intrafamilial victim	FE	1.000
Neglect	Intrafamilial victim	0.663	0.416
Domestic abuse	Intrafamilial victim	0.127	0.722
Bullying	Intrafamilial victim	FE	0.240
Caregiver instability	Intrafamilial victim	FE	0.231
Parental mental health difficulties	Intrafamilial victim	0.322	0.570
Parental substance misuse	Intrafamilial victim	FE	0.292
Family criminality	Intrafamilial victim	0.604	0.437
Other	Intrafamilial victim	0.285	0.594

Table 8.9

ACEs and Stranger Victim

ACE variable	Offence variable	$\chi 2$	P value
Physical abuse	Stranger victim	0.217	0.642
Sexual abuse	Stranger victim	0.696	0.405
Emotional abuse	Stranger victim	1.109	0.292
Neglect	Stranger victim	0.625	0.429
Domestic abuse	Stranger victim	0.930	0.335
Bullying	Stranger victim	0.883	0.347
Caregiver instability	Stranger victim	0.067	0.795
Parental mental health difficulties	Stranger victim	0.184	0.668
Parental substance misuse	Stranger victim	0.263	0.608
Family criminality	Stranger victim	0.643	0.423
Other	Stranger victim	0.643	0.423

Table 8.10

ACEs and Early Onset of Pornography Use

ACE variable	Offence variable	$\chi 2$	P value
Physical abuse	Pornography use	3.324	0.68
Sexual abuse	Pornography use	0.453	0.501
Emotional abuse	Pornography use	0.96	0.756
Neglect	Pornography use	5.592	0.018
Domestic abuse	Pornography use	1.790	0.181
Bullying	Pornography use	0.077	0.782
Caregiver instability	Pornography use	1.804	0.179
Parental mental health difficulties	Pornography use	0.925	0.336
Parental substance misuse	Pornography use	2.965	0.085
Family criminality	Pornography use	1.623	0.203
Other	Pornography use	0.001	0.977

Table 8.11

ACEs and Age at Onset of Harmful Sexual Behaviour

ACE variable	Offence variable	$\chi 2$	Two Tail P value
Physical abuse	Age at onset	FE	0.122
Sexual abuse	Age at onset	FE	0.088
Emotional abuse	Age at onset	FE	1.000
Neglect	Age at onset	6.745	0.009
Domestic abuse	Age at onset	FE	0.007
Bullying	Age at onset	0.422	0.516
Caregiver instability	Age at onset	3.013	0.083
Parental mental health difficulties	Age at onset	1.804	0.179
Parental substance misuse	Age at onset	3.460	0.063
Family criminality	Age at onset	2.332	0.127
Other	Age at onset	FE	1.00

Table. 8.12.

Age at Onset of Harmful Sexual Behaviour and Offence Detail

Offence variable	Offence variable	$\chi 2$	P value
Age at onset of HSB	Offence type	3.449	0.063
Age at onset of HSB	Victim gender	8.246	0.004
Age at onset of HSB	Victim age	11.924	0.001
Age at onset of HSB	Intrafamilial victim	0.732	0.392
Age at onset of HSB	Stranger victim	0.359	0.549
Age at onset of HSB	Early onset of pornography use	2.878	0.090

Table. 8.13.

Victim age and Other Offence Details

Offence variable	Offence variable	$\chi 2$	P value
Victim age	Offence type	0.407	0.523
Victim age	Victim gender	11.924	0.001
Victim age	Intrafamilial victim	11.924	0.001
Victim age	Stranger victim	2.751	0.097
Victim age	Early onset of pornography use	1.867	0.172

Table. 8.14.

Non-Sexual Violence and Offence Detail

Offence variable	Offence variable	$\chi 2$	P value
Non-sexual violence	Offence type	0.150	0.698
Non-sexual violence	Victim gender	0.877	0.349
Non-sexual violence	Victim age	6.776	0.009
Non-sexual violence	Intrafamilial victim	11.495	0.001
Non-sexual violence	Stranger victim	3.405	0.065

Appendix 6
Mann Whitney Table

Table 8.15.
ACE Score and Offence Details

Variables	Sample size	U	Significance level
ACE score & onset age	43	246.500	0.004
ACE score & victim age	43	127.000	0.011
ACE score & offence type	43	211.500	0.825
ACE score & victim gender	43	111.000	0.220
ACE score & intrafamilial victim	43	257.500	0.155
ACE score & stranger victim	43	208.000	0.386
ACE score & early onset of pornography use	43	305.500	0.046

Appendix 7: Mann Whitney Graphs

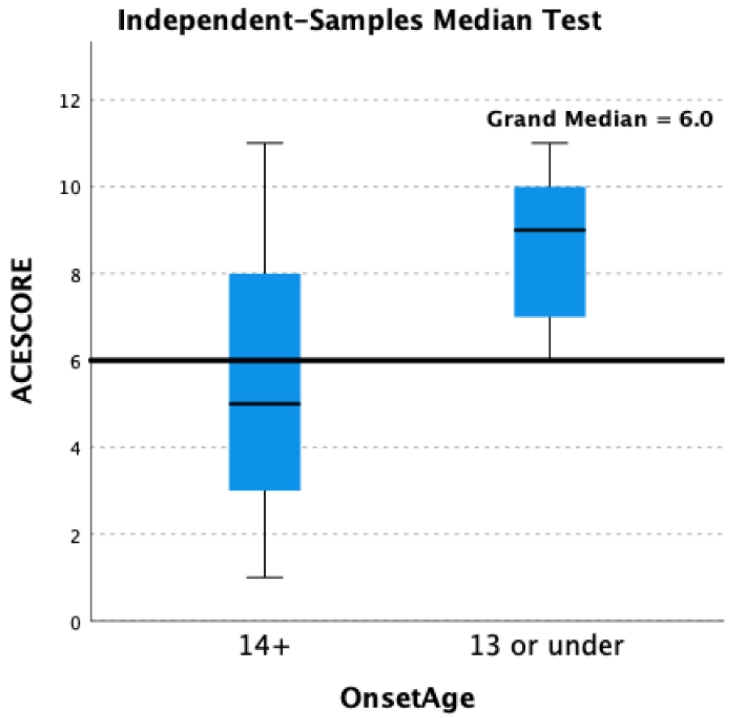


Figure 8.1. Onset Age & ACE Score

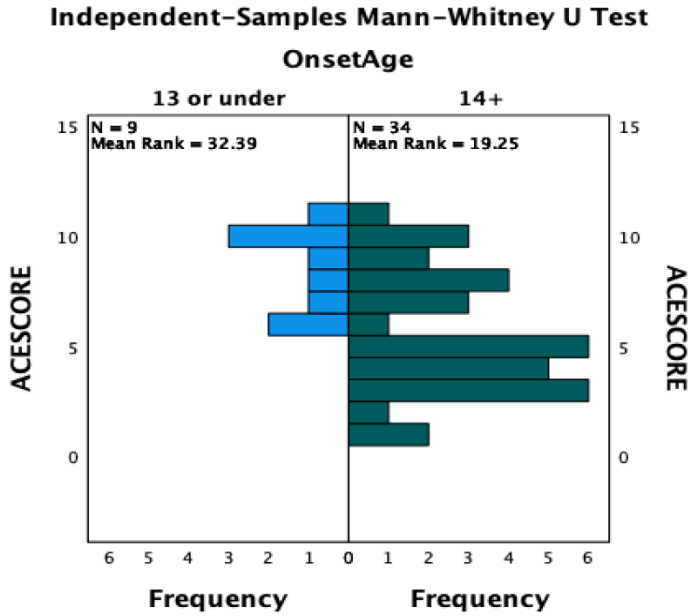


Figure 8.2 Onset Age & ACE Score

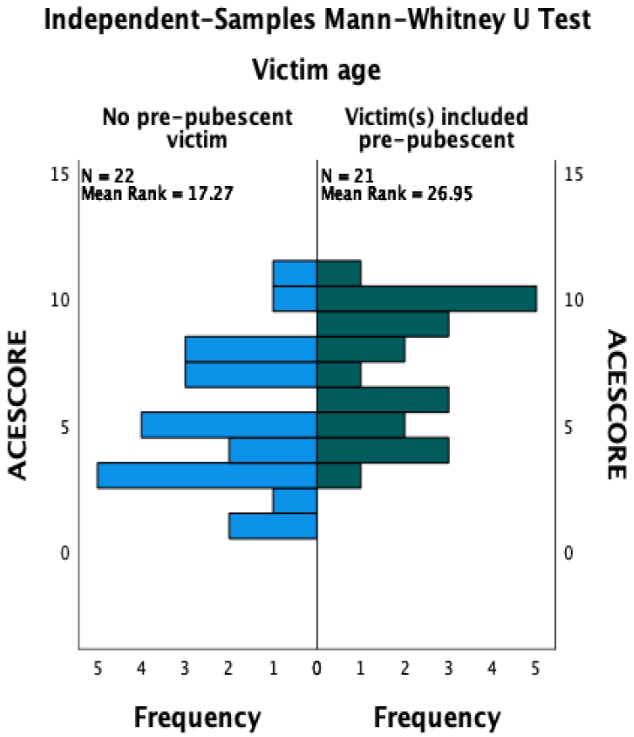


Figure 8.3. Victim Age & ACE Score

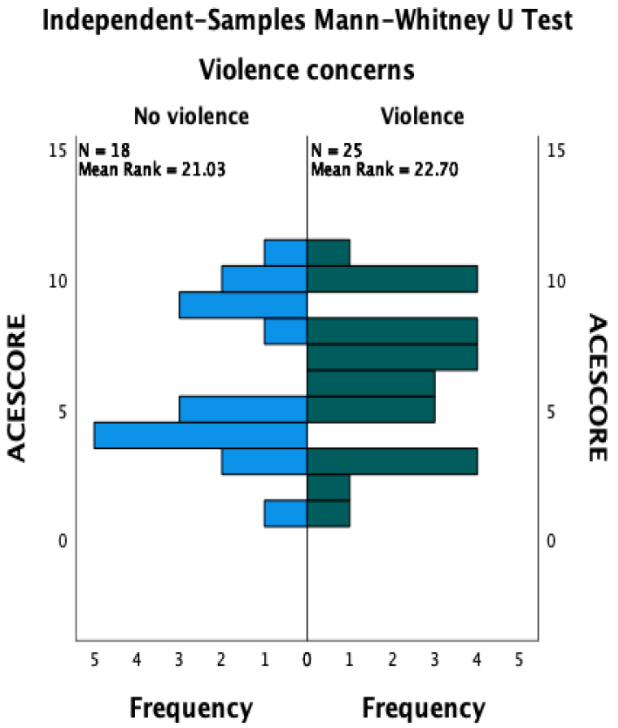


Figure 8.4. Violence & ACE Score

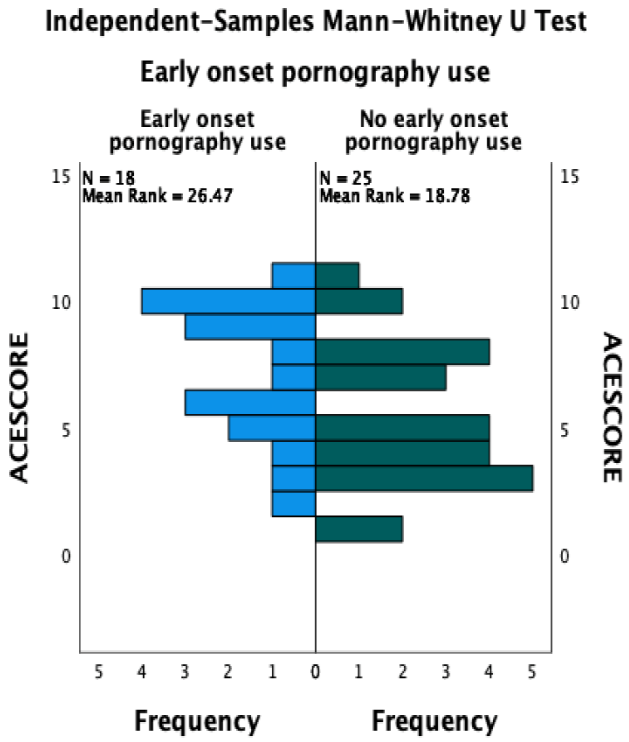


Figure 8.5. Early Onset Pornography Use & ACE Score

8.3 CHAPTER FOUR APPENDICES

Appendix 8
Research Ethics Committee Favourable Opinion Letter

NHS
Health Research Authority
London - South East Research Ethics Committee
Equinox House
City Link
Nottingham
NG2 4LA

Please note: This is the favourable opinion of the REC only and does not allow you to start your study at NHS sites in England until you receive HRA Approval

21 April 2022

Miss Jennifer Allotey

Doctoral Student (University of Nottingham) / Harmful Sexual Behaviour Lead (NHS Forensic CAMHS)
South West Yorkshire Foundation NHS Trust
Newton Lodge
Ouchthorpe Lane
Wakefield
WF1 3SP

Dear Miss Allotey,

Study title:	**EXPLORING THE LINK BETWEEN ADVERSITY, TRAUMA AND HARMFUL SEXUAL BEHAVIOUR: WHAT ARE THE CHRACTERISTICS OF MALE ADOLESCSENTS IN CUSTODY FOR A SEXUAL OFFENCE AND HOW CAN THEIR LIFE EXPERIENCES ASSIST IN UNDERSTANDING THEIR BEHAVIOUR?**
REC reference:	**22/LO/0109**
Protocol number:	**21059**
IRAS project ID:	**300627**

Thank you for your response that was received on 8th April, responding to the Research Ethics Committee's (REC) request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair and other named Committee members.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Good practice principles and responsibilities

The UK Policy Framework for Health and Social Care Research sets out principles of good practice in the management and conduct of health and social care research. It also outlines the responsibilities of individuals and organisations, including those related to the four elements of research transparency:

1. registering research studies
2. reporting results
3. informing participants
4. sharing study data and tissue

Conditions of the favourable opinion

The REC favourable opinion is subject to the following conditions being met prior to the start of the study.

Confirmation of Capacity and Capability (in England, Northern Ireland and Wales) or NHS management permission (in Scotland) should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).

Guidance on applying for HRA and HCRW Approval (England and Wales)/ NHS permission for research is available in the Integrated Research Application System.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of management permissions from host organisations

Registration of Clinical Trials

All research should be registered in a publicly accessible database and we expect all researchers, research sponsors and others to meet this fundamental best practice standard.

It is a condition of the REC favourable opinion that **all clinical trials are registered** on a publicly accessible database within six weeks of recruiting the first research participant. For this purpose, 'clinical trials' are defined as:

- clinical trial of an investigational medicinal product
- clinical investigation or other study of a medical device
- combined trial of an investigational medicinal product and an investigational medical device
- other clinical trial to study a novel intervention or randomised clinical trial to compare interventions in clinical practice.

Failure to register a clinical trial is a breach of these approval conditions, unless a deferral has been agreed by the HRA (for more information on registration and requesting a deferral see: Research registration and research project identifiers).

If you have not already included registration details in your IRAS application form you should notify the REC of the registration details as soon as possible.

Publication of Your Research Summary

We will publish your research summary for the above study on the research summaries section of our website, together with your contact details, no earlier than three months from the date of this favourable opinion letter.

Should you wish to provide a substitute contact point, make a request to defer, or require further information, please visit:

https://www.hra.nhs.uk/planning-and-improving-research/application-summaries/research-sum maries/

N.B. If your study is related to COVID-19 we will aim to publish your research summary within 3 days rather than three months.

During this public health emergency, it is vital that everyone can promptly identify all relevant research related to COVID-19 that is taking place globally. If you haven't already done so, please register your study on a public registry as soon as possible and provide the REC with the registration detail, which will be posted alongside other information relating to your project. We are also asking sponsors not to request deferral of publication of research summary for any projects relating to COVID-19. In addition, to facilitate finding and extracting studies related to COVID-19 from public databases, please enter the WHO official acronym for the coronavirus disease (COVID-19) in the full title of your study. Approved COVID-19 studies can be found at:

https://www.hra.nhs.uk/covid-19-research/approved-covid-19-research/

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

After ethical review: Reporting requirements

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study, including early termination of the study
- Final report
- Reporting results

The latest guidance on these topics can be found at https://www.hra.nhs.uk/approvals-amendments/managing-your-approval/.

Ethical review of research sites

NHS/HSC sites

The favourable opinion applies to all NHS/HSC sites taking part in the study, subject to confirmation of Capacity and Capability (in England, Northern Ireland and Wales) or management permission (in Scotland) being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Non-NHS/HSC sites

I am pleased to confirm that the favourable opinion applies to any non-NHS/HSC sites listed in the application, subject to site management permission being obtained prior to the start of the study at the site.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [UoN insurance certificate]		
GP/consultant information sheets or letters [Professional Letter]	1.0	10 December 2021
Interview schedules or topic guides for participants [DRAFT INTERVIEW SCHEDULE -Adversity, Trauma & Sexual Behaviour- Final version 1.0 10.12.21]	1.0	10 December 2021
IRAS Application Form [IRAS_Form_12012022]		12 January 2022
IRAS Checklist XML [Checklist_12012022]		12 January 2022
Letter from sponsor [21059 Sponsor Letter HRA REC]		10 December 2021
Other [PARENT INFORMATION SHEET Adversity, Trauma & Sexual Behaviour - Final version 1.0 10.12.21]	1.0	10 December 2021
Other [PARENT CONSENT FORM- Adversity, Trauma & Sexual Behaviour - Final version 1.0 10.12.21]	1.0	10 December 2021
Other [PROFESSIONAL LETTER Adversity, Trauma & Sexual Behaviour - Final version 1.0 10.12.21]	1.0	10 December 2021
Other [APPENDIX - EARLY MEMORIES OF WARMTH & SAFENESS SCALE Adversity, Trauma & Sexual Behaviour - Final version 1.0 10.12.21]	1.0	10 December 2021
Other [APPENDIX - TSCC Adversity, Trauma & Sexual Behaviour - Final version 1.0 10.12.21]	1.0	10 December 2021
Other [APPENDIX- TSI-2 Adversity, Trauma & Sexual Behaviour - Final version 1.0 10.12.21]	1.0	10 December 2021
Other [Additional insurance document (TWIMC Professional		
Indemnity Insurance)]		
Other		
Participant consent form	1.1	27 March 2022
Participant consent form [CONSENT FORM WITH CHNGES HIGHLIGHTED]	1.1	27 March 2022
Participant information sheet (PIS)	1.1	27 March 2022
Participant information sheet (PIS) [PARTICIPANT INFORMATION SHEET WITH CHANGES HIGHLIGHTED]	1.1	27 March 2022
Research protocol or project proposal [PROTOCOL - Final Version 1.1 27.03.22]	1.1	27 March 2022
Research protocol or project proposal [Protocol]	1.1	27 March 2022
Summary CV for Chief Investigator (CI) [Kevin Browne CV-Adversity, Trauma & Sexual Behaviour- Final version 1.0 10.12.21]	1.0	10 December 2021
Summary CV for student [CV Jennifer Allotey Adversity, Trauma & Sexual Behaviour- Final version 1.0 10.12.21]	1.0	10 December 2021

Validated questionnaire [Trauma Symptom Checklist for Children (TSCC)]		
Validated questionnaire [Trauma Symptom Inventory (TSI-2)]		
Validated questionnaire		

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.
User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website:
http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/

HRA Learning

We are pleased to welcome researchers and research staff to our HRA Learning Events and online learning opportunities– see details at:
https://www.hra.nhs.uk/planning-and-improving-research/learning/

IRAS project ID: 300627 Please quote this number on all correspondence

With the Committee's best wishes for the success of this project.

Yours sincerely

pp. Owain Richardson

Dr Anthony Fox
Chair

Email:londonsoutheast.rec@hra.nhs.uk

Appendix 9
Study Consent Form

University of Nottingham
UK | CHINA | MALAYSIA

CONSENT FORM

Title of Project: Adversity, Trauma and Sexual Behaviour

IRAS Project ID: 300627

Project Lead: Jennifer Allotey

Name of Participant: XXXXX

Please initial box

1. I have read and understood the information sheet version number XXX dated XXX and have had chance to ask questions. ☐

2. I know that it is my choice whether I take part in the study and I can change my mind at any time without giving a reason. I know that if I don't take part nothing will change about my care at *XX / *XX and that nothing will change in my Sentence Plan. ☐

3. I know that if I say I want to take part and then change my mind that my information might still be used in the study (if I change my mind more than 7 days after I have taken part). ☐

4. I understand that some of the information I give as part of the study might be looked at by authorised people from the University of Nottingham teams that check studies have been done properly. I give permission for these people to have access to the study records and to save, look at and write about the information taken from me as part of the study. I understand that my personal details will not be shared. ☐

5. I agree to FCAMHS sharing the information they have from when I was referred to them including my offence and background information. I understand that my personal details will be kept private. ☐

6. I know that the interview will be recorded and that things I say might be written in the study report. I understand that this will be done without using my name or anything else to show that it is me. ☐

7. I know that the interview will be recorded and that things I say might be written in the study report. I understand that this will be done without using my name or anything else to show that it is me. ☐

8. I know that my Care Team will be informed that I have taken part in the study. ☐

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

_____	_____	_____
Name of Participant	**Date**	**Signature**
_____	_____	_____
Name of Person taking consent	Date	Signature

3 copies: 1 for participant, 1 for the health notes and 1 for the project notes

Appendix 10
Participant Information Sheet

University of Nottingham
UK | CHINA | MALAYSIA

Participant Information Sheet

IRAS Project ID: 300627

Title of Study: Adversity, trauma and adolescent sexual behaviour

Chief Investigator (person leading the study): Professor Kevin Browne
Local Researcher (person that will do the interviews): Jennifer Allotey

This is Jennifer that will meet you if you do take part in the study.

We would like to invite you to take part in our study. Before you decide we want to make sure that you understand why the study is being done and what you would be asked to do.

Jennifer will go through the information sheet with you and answer any questions you have. You can talk to your parent/carer if you want to, or anyone in your care team at *XXX / *XXX

What is the study about?

The study is to help to understand teenage sexual behaviour. It is hoped that the information you share will help services like Forensic CAMHS (FCAMHS) to help young people that have been in trouble.

Why have I been asked to take part in the study?

You have been asked because the study is about boys that are working with FCAMHS at *XXX/ *XX

Do I have to take part?

You do not have to take part in the study, and nothing will change on your Care Plan or Sentence Plan if you say you don't want to do it. You don't have to give a reason if you don't want to take part.

If you say that you will take part and then change your mind, that's ok as well. Just tell Jennifer at any time and we can stop the interview. If you do that, anything you have said will be deleted and won't be used in the study. If you decide you don't want to take part more than 7 days after the interview, we would use the things you said as part of the study.

If you do agree to take part and then change your mind, the study team will keep a record that you had said you would take part. No one else would see this.

What will happen if I take part?

If you agree to take part, Jennifer will come and see you at *XX / *XX and will ask you some questions about your life. This will be audio recorded so that Jennifer doesn't have to take notes when you are talking. The audio will be deleted straight after Jennifer has typed up the things you said. You will also be asked to fill in two questionnaires.

The interview will last for 2 hours at the most and will take place in a private room at *XX/*XX.

After the interview, Jennifer will be sent some information about you from your worker at FCAMHS. This will include some background information and the detail of your conviction. This means that you don't have to speak about your offence during the interview if you don't want to. The information shared by FCAMHS will be kept private and will be used to help understand links between your life experiences and your behaviour.

Will what I say be kept private?

Everything you say in the study will be kept private (confidential). The only time we would not keep what you say private is if we think you or someone else is at risk. If we think someone is not safe, then Jennifer will speak to a member of staff or other professionals such as social workers. This would happen if there was a worry that you are not safe or that someone else might not be safe such as someone in your family or someone else at *XX/ *XX.

Your CAMHS and FCAMHS worker will know that you have taken part in the study, but they will not know what you have said.

What bad things might happen if I take part?

You will be asked some questions about your life and so it could be that something you are asked, or something you talk about, makes you feel sad or angry. You only have to answer questions you want to and you can ask for the interview to stop at any time. If you do feel upset, we will make sure that we speak to someone in your Care Team to make sure you have some support.

What is good about taking part?

Taking part in the study lets you tell your story about your life and what has happened to you. This might help services like FCAMHS work with other young people like you in the future.

What happens when the research study stops?

After the study has ended, we will type up what you said and this will be saved on a private computer. We will then write up a study report. You can have a copy of this if you would like one. The report might be written in a journal which is a paper book or an online book that can be read by other people. The report will not have anything in to show that you took part in the study.

There is some more information on the next sheets which explains the study in lots more detail. You can read this yourself or ask Jennifer or someone in your care team to read it to you or with you if you want.

Thank you for reading or listening to this information and thank you for taking part in the study.

Additional Information

Expenses and payments

You will not be paid anything to take part in the study.

How will we use information about you?

We will need to use information from you and from FCAMHS as part of the study. This will be stored using a code number that will be assigned to you when the study starts. Your personal details such as your NHS number / date of birth will not be accessed. We will keep all information about you safe and secure.

What are your choices about how your information is used?

You can stop being part of the study at any time without giving a reason, but we will keep the information about you that we already have.

Where can you find out more about how your information is used?

You can find out more about how we use your information:

-at www.hra.nhs.uk/information-about-patients/
-by asking Jennifer
-by asking someone in your care team to arrange for you to call or email us on: 07881561219 / Jennifer.allotey@nottingham.ac.uk

What if there is a problem?

We hope that you don't have any worries about taking part, but if you do you can ask to speak to Jennifer or Kevin. The researcher's contact details are given at the end of this information sheet. You can ask someone in your Care Team to make contact for you. If you are still unhappy and want to make a complaint, you or someone in your Care Team can do this by contacting PALS on 0113 2066261. The normal National Health Service complaints mechanisms will still be available to you.

After the study

Your information will be kept by the University of Nottingham for 12 months after the end of the study so that we are able to contact you about the findings of the study and possible follow-up studies (unless you tell us you don't want to be contacted). All other anonymous data will be kept securely for 7 years. After this time your data will be disposed of securely.

Who is organising and funding the research?

This research is being organised and funded by the University of Nottingham.

Who has reviewed the study?

All research in healthcare is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed by IRAS Research Ethics Committee and it was agreed that the study can go ahead.

Further information and contact details

You can contact us using the details below:
Professor Kevin Browne:
0115 8232210
Kevin.browne@nottingham.ac.uk

Jennifer Allotey
07881561219
Jennifer.allotey@nottingham.ac.uk

Appendix 11
Interview Schedule

INTERVIEW SCHEDULE

1. Could you tell me a bit about your family or who is most important in your life?
   -Parents
   -Siblings
   -Carers

2. I'm interested in where you lived before you came here.
   -Were you happy there?
   -What was good / not good about living there?

3. What can you tell me about your early childhood?
   -School
   -Home
   -Friends

4. What about your time as a teenager?
   -School
   -Home
   -Friends
   -Relationships

5. Can you tell me about professionals you have worked with?
   -How have you found this?
   -How do you think you have been treated by professionals

6. How easy do you think you find it to make friends?
   -Why do you think this is?
   -What is that you find easy/ difficult?

7. I'm interested in how you think your life experiences have impacted on the person you are today.

8. Do you think things have been fair in your life?
   -In what way?
   -(If unfair) – how does that make you feel?

9. Can you tell me about a time you have felt safe in your life?

10. What about a time you have felt unsafe?

11. Can you tell me about a time you have felt happy in your life?

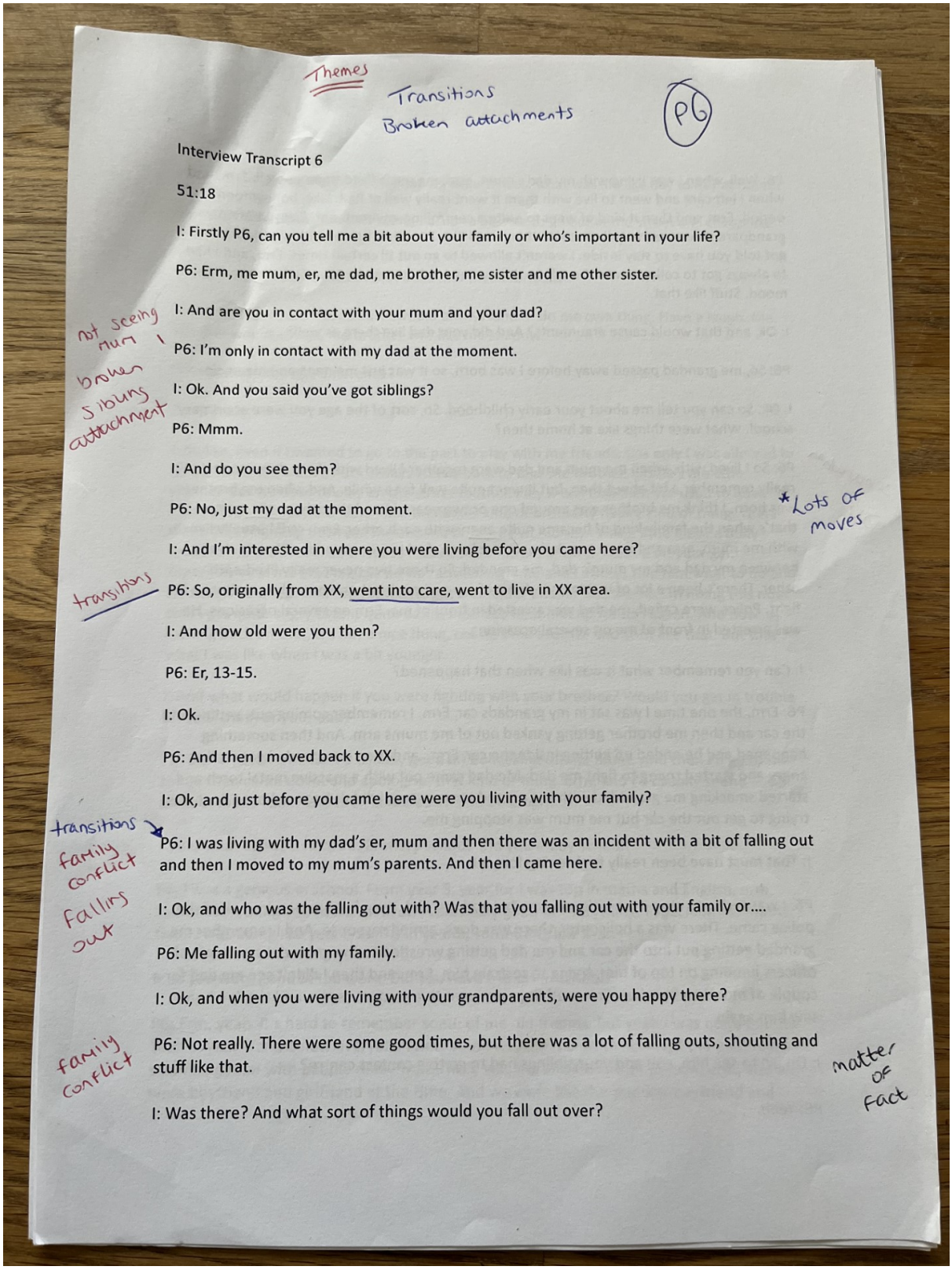
12. Now about a time you have felt sad?

13. Is there anything you have dine in your life that you are really proud of?

14. What about anything you're not proud of?

15. Is there anything else you think it would helpful for me to know about you and your life?

Appendix 12
Example of Coded Transcript



Themes
Transitions
Broken attachments
P6

Interview Transcript 6

51:18

I: Firstly P6, can you tell me a bit about your family or who's important in your life?

P6: Erm, me mum, er, me dad, me brother, me sister and me other sister.

not seeing mum / broken siblings attachment

I: And are you in contact with your mum and your dad?

P6: I'm only in contact with my dad at the moment.

I: Ok. And you said you've got siblings?

P6: Mmm.

I: And do you see them?

P6: No, just my dad at the moment.

*Lots of moves

I: And I'm interested in where you were living before you came here?

transitions

P6: So, originally from XX, went into care, went to live in XX area.

I: And how old were you then?

P6: Er, 13-15.

I: Ok.

P6: And then I moved back to XX.

I: Ok, and just before you came here were you living with your family?

transitions family conflict falling out

P6: I was living with my dad's er, mum and then there was an incident with a bit of falling out and then I moved to my mum's parents. And then I came here.

I: Ok, and who was the falling out with? Was that you falling out with your family or....

P6: Me falling out with my family.

I: Ok, and when you were living with your grandparents, were you happy there?

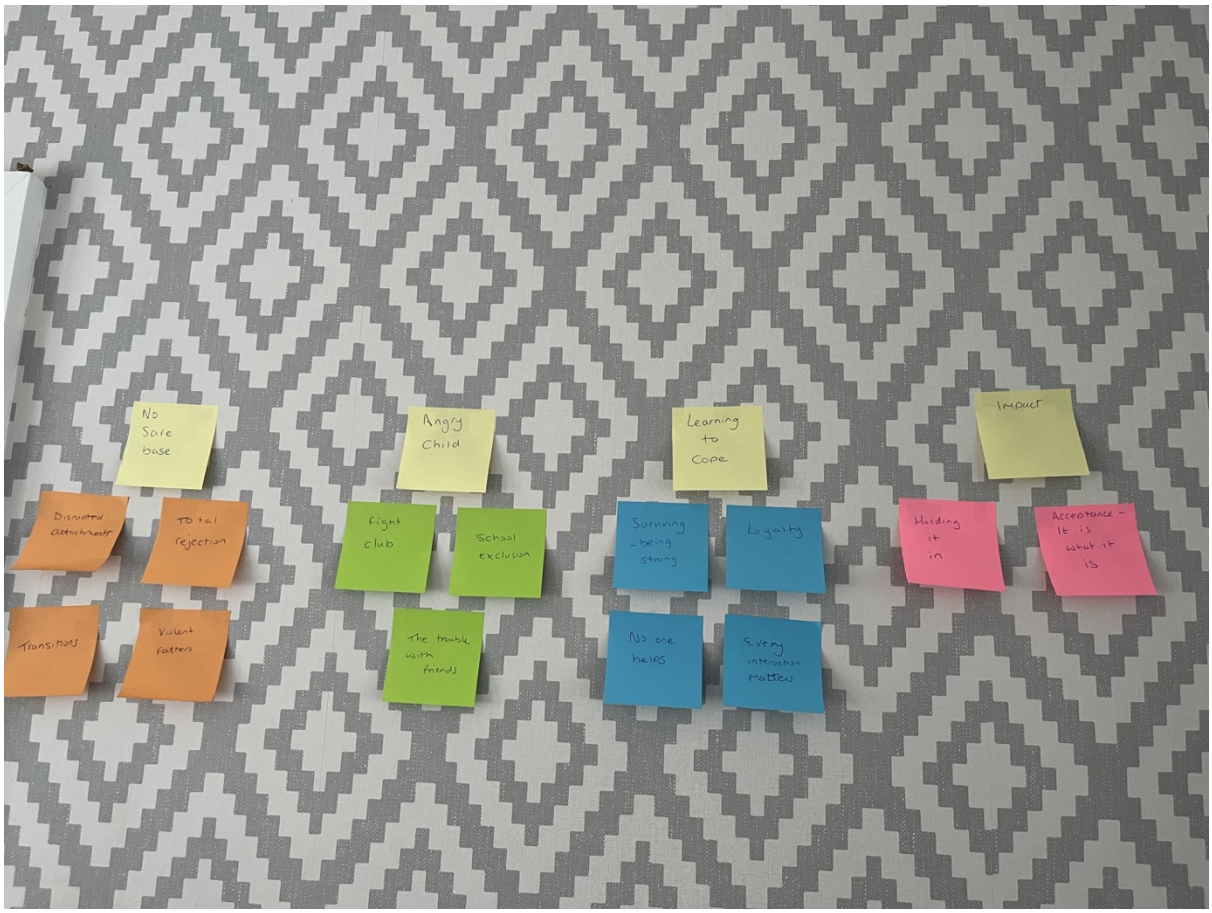
family conflict

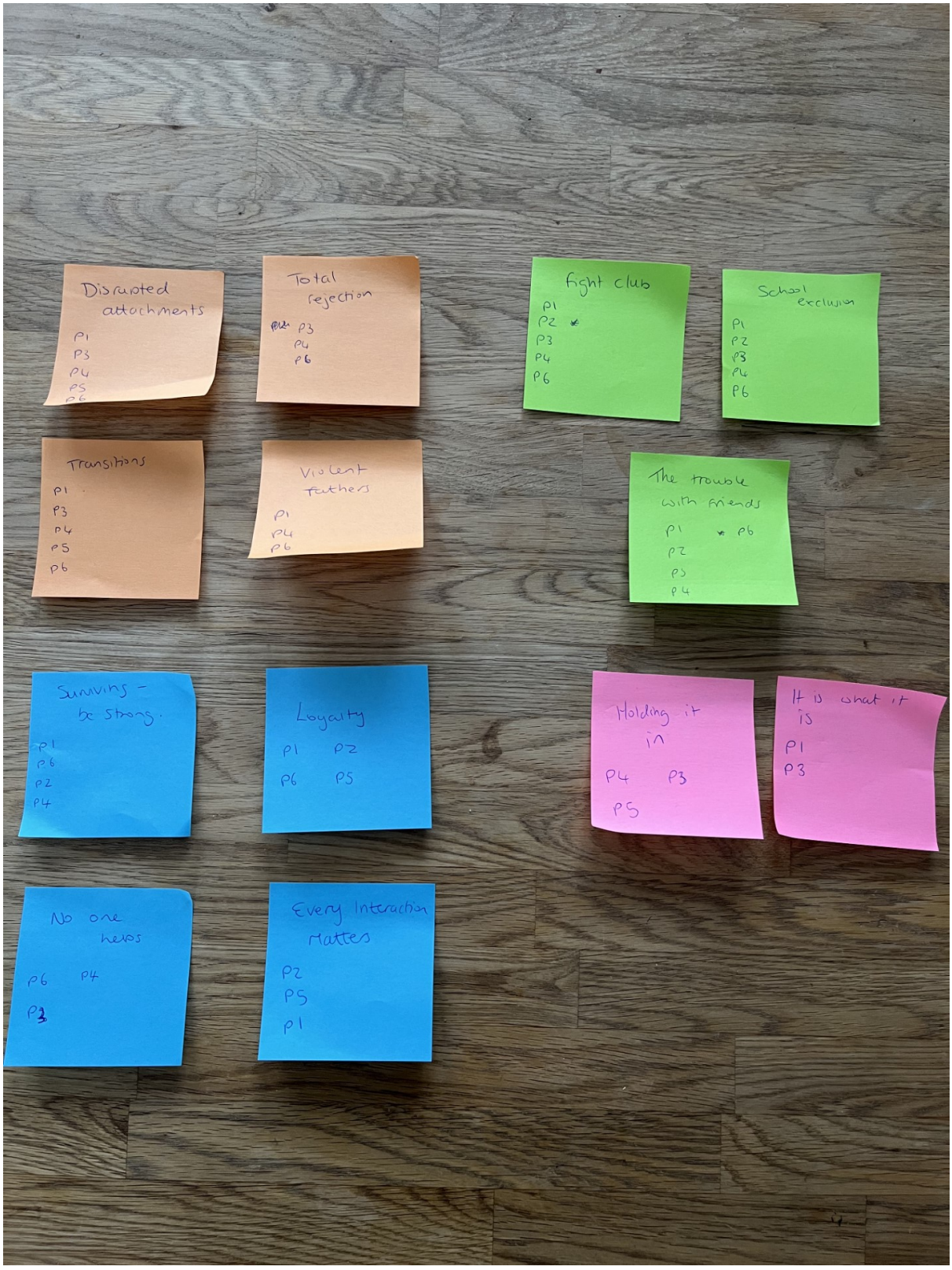
P6: Not really. There were some good times, but there was a lot of falling outs, shouting and stuff like that.

matter of fact

I: Was there? And what sort of things would you fall out over?

Appendix 13
IPA Themes




Disrupted attachments
P1
P3
P4
P5
P6
Total rejection
P3
P4
P6
Fight club
P1
P2
P3
P4
P6
School exclusion
P1
P2
P3
P4
P6
Transitions
P1
P3
P4
P5
P6
Violent fathers
P1
P4
P6
The trouble with friends
P1
P6
P2
P3
P4
Surviving - be Strong.
P1
P6
P2
P4
Loyalty
P1
P2
P6
P5
Holding it in
P4
P3
P5
It is what it is
P1
P3
No one helps
P6
P4
P3
Every Interaction Matters
P2
P5
P1

Appendix 14
Reflexive Statement

I am a female forensic psychology trainee from mixed ethnic origin. I am a qualified social worker with many years of experience in child protection and forensic settings. I am also a mother of two children. I have significant experience in working with children and young people who have displayed harmful sexual behaviour, with professional roles in the community and in youth secure settings. As such, I have pre-existing insight into the life experiences of young people who have displayed harmful sexual behaviour.

Through the use of a reflexive journal and discussion within supervision, I have sought to maintain a reflexive stance on how my personal and professional experiences, alongside my theoretical positionings have influenced this study. This has assisted me to be aware of, and attend to my biases whilst undertaking data collection and analysis.

When considering my ontological and epistemological perspectives I considered a range of positions, before deciding that critical realism best fits my values and beliefs. Whilst I believe in the existence of 'truths' I also place significant value on the way an individual interprets a situation, with their sense of meaning and 'reality' shaped by their own values, beliefs and experiences.

I believe this epistemological stance was the best fit for both my own values and beliefs, and also for this study, as the main aim was to explore the perspectives and narratives of the young people who agreed to take part, to add to the quantitative element of this thesis. The belief from the outset of this study was that the participants are experts in their own lives.

IPA was chosen as the most appropriate methodology to interpret the data due to the epistemology of this qualitative research method, in which the purpose is to allow the participant to make sense of their own lived experience, in line with the central focus of this study.

Appendix 15
Participant Contribution to Themes

Table 8.16

Participant Contribution to Themes

Theme	P1	P2	P3	P4	P5	P6
No Safe Base	√	√	√	√	√	√
Disrupted attachments	√		√	√	√	√
Total rejection			√	√		√
Transitions	√		√	√	√	√
Violent fathers	√	√		√		√
Angry Child	√	√	√		√	√
Fight club	√	√	√	√		√
School exclusion	√	√	√	√		√
The trouble with friends	√	√	√	√		√
Learning to Cope	√	√	√	√	√	√
Surviving – being strong	√	√	√	√		√
Loyalty	√	√			√	√
No one helps			√	√		√
Every interaction matters	√	√			√	
Impact	√		√	√	√	√
Holding it in			√	√	√	
Acceptance – It is what it is	√		√	√		√

Appendix 16
Outcome Measures

Participant 1

Trauma Symptom Checklist for Children (TSCC)

Table 8.17

P1 TSCC scores

Domain	Raw Score	T-Score	Descriptor
Under-Score	0	39	Valid
Hyper-Score	1	67	Valid
Anxiety	8	59	Elevated range
Depression	10	64	Elevated range
Anger	12	56	Elevated range
Post-Traumatic Stress	19	74	Clinically significant range
Dissociation	19	76	Clinically Significant range
Dissociation - Overt	12	73	Clinically Significant range
Dissociation- Fantasy	7	76	Clinically Significant range
Sexual Concerns	4	51	Normal range
Sexual Preoccupation	4	52	Normal range
Sexual Distress	0	45	Normal range

Early Memories of Warmth and Safeness Scale

Total: **33**

Items Rated 0 (No, never)
3. I felt understood
19. I had a sense of belonging
21. I felt at ease

Items Rated 1 (yes, but rarely
1. I felt safe and secure
5. I felt comfortable sharing my feelings and thoughts with those around me.
7. I knew that I could count on empathy and understanding from people close to me when I was unhappy
8. I felt peaceful and calm
14. I felt loved even when people were upset about something I had done
17. I knew I could rely on people close to me to console me when I was upset

Items Rated 4 (yes, most of the time)
None

Participant 2

Trauma Symptom Checklist for Children (TSCC)

Table 8.18.

P2 TSCC scores

Domain	Raw Score	T-Score	Descriptor
Under-Score	0	39	Valid
Hyper-Score	1	67	Valid
Anxiety	3	46	Normal range
Depression	5	51	Elevated range
Anger	15	61	Elevated range
Post-Traumatic Stress	3	43	Normal range
Dissociation	7	52	Elevated range
Dissociation - Overt	6	56	Elevated range
Dissociation- Fantasy	1	43	Normal range
Sexual Concerns	4	51	Normal range
Sexual Preoccupation	4	52	Normal range
Sexual Distress	0	45	Normal range

Early Memories of Warmth and Safeness Scale

Total: **82**

Items Rated 0

None

Items Rated 1 (yes, but rarely)
None

Items Rated 4 (yes, most of the time)
All but one question

Participant 3

Trauma Symptom Checklist for Children (TSCC)

Table 8.19.

P3 TSCC scores

Domain	Raw Score	T-Score	Descriptor
Under-Score	0	39	Valid
Hyper-Score	1	67	Valid
Anxiety	8	59	Elevated range
Depression	6	54	Elevated range
Anger	17	64	Elevated range
Post-Traumatic Stress	21	78	Clinically Significant range
Dissociation	16	70	Clinically Significant Range
Dissociation - Overt	14	78	Clinically Significant range
Dissociation- Fantasy	2	49	Normal range
Sexual Concerns	7	60	Normal range
Sexual Preoccupation	7	61	Normal range
Sexual Distress	0	45	Normal range

Early Memories of Warmth and Safeness Scale

Total: **8**

Items Rated 0 (No, never)

3. I felt understood

4. I felt a sense of warmth with those around me
5. I felt comfortable sharing my feelings and thoughts with those around me
9. I felt that I was a cherished member of the family
10. I could easily be soothed by people close to me when I was unhappy
11. I felt loved
13. I felt part of those around me
14. I felt loved even when people were upset about something I had done
16. I had feelings of connectedness

17. I knew I could rely on people close to me to console me when I was upset
18. I felt cared about
19. I had a sense of belonging
20. I knew that I could count on help from people close to me when I was unhappy

<u>Items Rated 1 (yes, but rarely)</u>
1. I felt safe and secure
2. I felt appreciated the way I was
6. I felt people enjoyed my company
7. I knew that I could count on empathy and understanding from people close to me when I was unhappy
8. I felt peaceful and calm
12. I felt comfortable turning to people important to me for help and advice
15. I felt happy
21. I felt at ease

<u>Items Rated 4 (Yes, most of the time)</u>
None

Participant 4

Trauma Symptom Checklist for Children (TSCC)

Table 8.20.

P4 TSCC scores

Domain	Raw Score	T-Score	Descriptor
Under-Score	0	39	Valid
Hyper-Score	0	47	Valid
Anxiety	9	62	Elevated range
Depression	12	69	Clinically significant range
Anger	19	68	Clinically significant range
Post-Traumatic Stress	10	56	Elevated range
Dissociation	15	68	Clinically significant range
Dissociation - Overt	8	61	Elevated range
Dissociation- Fantasy	6	70	Clinically significant range
Sexual Concerns	6	57	Normal range
Sexual Preoccupation	6	58	Normal range
Sexual Distress	1	56	Normal range

Early Memories of Warmth and Safeness Scale

Total: **56**

Items Rated 0 (No, never)
14. I felt loved even when people were upset about something I had done

Items Rated 1 (yes, but rarely)
None

Items Rated 4 (Yes, most of the time)
1. I felt safe and secure
2. I felt appreciated the way I was
3. I felt understood
4. I felt a sense of warmth with those around me
6. I felt people enjoyed my company
7. I knew that I could count on empathy and understanding from people close to me when I was unhappy
10. I could be easily soothed by people close to me when I was unhappy

Participant 5

Trauma Symptom Checklist for Children (TSCC)

Table 8.21.

P5 TSCC scores

Domain	Raw Score	T-Score	Descriptor
Under-Score	0	39	Valid
Hyper-Score	0	47	Valid
Anxiety	5	51	Elevated range
Depression	6	54	Elevated range
Anger	7	48	Normal range
Post-Traumatic Stress	12	60	Elevated range
Dissociation	8	54	Elevated range
Dissociation - Overt	6	56	Elevated range
Dissociation- Fantasy	2	49	Normal range
Sexual Concerns	3	48	Normal range
Sexual Preoccupation	3	48	Normal range
Sexual Distress	0	45	Normal range

Early Memories of Warmth and Safeness Scale

Total: **51**

Items Rated 0 (No, never)
14. I felt loved even when people were upset about something I had done

Items Rated 1 (yes, but rarely)
2. I felt appreciated the way I was
8. I felt peaceful and calm

Items Rated 4 (Yes, most of the time)
6. I felt people enjoyed my company
11. I felt loved
12. I felt comfortable turning to people important to me for help and advice
18. I felt cared about
19. I had a sense of belonging
20. I knew that I could count on help from people close to me when I was unhappy

Participant 6

Trauma Symptom Checklist for Children (TSCC)

Table 8.22.

P6 TSCC scores

Domain	Raw Score	T-Score	Descriptor
Under-Score	0	39	Valid
Hyper-Score	0	47	Valid
Anxiety	9	62	Elevated range
Depression	11	66	Clinically significant range
Anger	9	51	Elevated range
Post-Traumatic Stress	17	70	Clinically significant range
Dissociation	14	66	Clinically significant range
Dissociation - Overt	11	70	Clinically significant range
Dissociation- Fantasy	3	54	Elevated range
Sexual Concerns	17	90	Clinically significant range
Sexual Preoccupation	14	84	Clinically significant range
Sexual Distress	5	99	Clinically significant range

Early Memories of Warmth and Safeness Scale

Total: **41**

Items Rated 0

None

Items Rated 1 (yes, but rarely)

5. I felt comfortable sharing my feelings and thoughts with those around me
6. I felt people enjoyed my company
9. I felt that I was a cherished member of my family
14. I felt loved even when people were upset about something I had done

Items Rated 4

None.