Experiences of young people with harmful sexual behaviors in services: a qualitative study.

Abstract

Young people are responsible for a significant number of the sexual offences that are committed every year against children, same-age peers and adults. These young people, once detected, are generally referred to specialist services for treatment. This article explores the health characteristics and service experiences of 117 young people with sexual behavior problems, and the issues that services face when working with them. The study is based on analysis of 117 case files, identified from nine specialist services in the UK. These files were purposively identified to be representative of the entire sample of young people that these services deal with. The case files were thematically analysed. Case files provided information on the following topics: the reasons why the young people were referred to harmful sexual behavior services; the young people's personal characteristics; their medical and mental health problems; the young people's interests and aspirations; their attitudes towards services and interventions; continued problematic sexual incidents in services; progress in services; and post-service experiences. Overall, the findings of the study indicate that these young people have a number of strengths, but often have problems across a range of personal and health domains. A number of them continue to remain sexually and generally violent in services, particularly in residential settings, which has risk management implications for staff. Some of these young people's treatment costs significant amounts of money, which is an issue in a post-austerity world where the state is retreating from supplying public services in many countries.

Introduction

Young people are responsible for a significant number of the sexual offences that are committed every year against younger children, same-age peers and, to a lesser extent, adults (Hackett, Phillips, Masson & Balfe, 2013; Grady, Cherry, Tallon, Tunney & O' Reilly, 2018). Vizard, Hickey, French & McRory (2007) for example estimates that as much as a third of all sexual offences against children may be perpetrated by other young people. There is now a clear understanding that young people can engage in a wide variety of serious and harmful sexual activities (Hackett, Masson & Phillips, 2006; Somervell & Lambie, 2009), ranging from non-contact to violent contact offences. These young people are often vulnerable themselves, for example often being from difficult family and social backgrounds, experiencing high rates of physical or sexual violence or general neglect (Hackett et al., 2013), and many of them have serious comorbid physical and mental health problems (Vizard et al., 2007).

Young people who display harmful sexual behaviors, and who are detected, are generally referred to 'tertiary' services for 'treatment' (McKibbin, Humphreys & Hamilton, 2017). In the public health model of violence prevention, tertiary services are services that focus on responses to sexual abuse after it has occurred. These services can be community-based (Worling & Curwen, 2000) or residential (Edwards, Whittaker, Beckett, Bishopp & Bates, 2012). Some focus on victims and offenders, others on just one of these categories, and some are still further specialized, for example focusing on young people who have sexual behavior problems as well as comorbid and complex needs (Edwards et al., 2012). Interventions in tertiary services often concentrate on these young people's general needs, as well as their sexual behavior issues (Edwards et al., 2012). This is because, as noted, these young people

often present with a range of developmental, social and interpersonal problems, such as anger management issues and substance abuse (Print & O' Callaghan, 2004; Greaves & Salloum, 2015). Specialist services carry out detailed clinical assessments, documenting the nature of the young person's offending but also gathering important supplementary information such as their personality characteristics and health issues, and develop targeted treatment plans for the young people who are referred to them (Efta-Breitbach & Freeman, 2004; Worling & Curwen, 2000; Lawson, 2003). Services also work with young people on issues such as relapse prevention and effective decision-making (Lawson, 2003), and young people often take modules on topics such as taking responsibility for their actions, pornography usage, victim empathy and social and communication skills (Flanagan & Hayman-White, 2000; McKibbin et al., 2017). It is now widely recognized by practitioners that services for young people who sexually abuse should be driven by developmentally-sensitive approaches, and that these young people should not be treated as irredeemable 'sex offenders'— an approach which may well be counter-productive and increase risk (McKibbin et al., 2017; Yoder & Ruch, 2015).

Developmentally appropriate tertiary intervention has been linked with a decreased risk of recidivism in young people with harmful sexual behaviors (Letourneau & Bourdin, 2008; Edwards et al., 2012; Halse et al., 2012). This also challenges the previously held belief that people who commit sexual offences are fixated individuals who cannot be prevented from reoffending. Sexual recidivism rates for these young people are generally around 10% if the young people work with effective and appropriate services, though the precise rate of reoffending across outcome research varies from study to study (Caldwell, 2002; Letourneau & Bourdin, 2008). Additionally, it is well established that recidivism for non-sexual offences is

generally higher than it is for further sexual offences in juveniles (Veneziano & Veneziano, 2002).

While services are a crucial element in these young people's rehabilitation, and in their chance of living a normal life free of abusive behaviors, little is known about the experiences of young people with sexual behavior problems in tertiary services (Grady et al., 2018; Campbell, Booth, Hackett & Sutton, 2018). Grady et al. (2018), for example, found that they could only identify five qualitative studies on this topic. From the research that has been conducted, tertiary interventions appear to have a number of positive effects for these young people, such as increasing their sense of self-confidence and self-efficacy (Halse et al., 2012; Draper, Errington, Mar and Makhita, 2013). Many young people with sexual behavior issues appear to value interventions by tertiary services (though they may also be challenged by them), especially when these are undertaken with professionals who employ non-judgemental approaches and avoid labelling (Campbell et al., 2018). The development of a positive therapeutic relationship is especially appreciated; these young people often struggle with emotional loneliness and lack social support (Grady et al., 2018). Young people also appreciate intercessions that are targeted at particular areas of their lives, such as educational interventions that provide insight into their behavior (Grady et al., 2018).

This article explores the characteristics and experiences in tertiary services of 117 young people with sexual behavior problems, and the issues which services face when working with them. The study is based on qualitative thematic analysis of service case files; it thereby helps to address the lack of research on the young people who attend these services, and helps to give 'voice' to the young people's experiences (Grady et al., 2018; McCuish & Lussier, 2017). The article builds on the important

limited prior work in this area (e.g. Grady et al., 2018; Vizard et al., 2007) and extends it by examining the experiences of a large number of young people in a wide number of geographically dispersed tertiary settings. The article highlights that many of these young people have social, personal and health problems that they continue to need help with while they are in services, beyond their sexual behavior problems. It also identifies that a substantial minority of these young people may remain potentially risky while they are being treated, and that services need to think carefully about the risk management protocols that they use when working with this group.

Methodology

Details about our methods have been reported elsewhere (Hackett, Masson, Phillips & Balfe, 2015) so for space reasons we will only briefly recap them here. As part of a United Kingdom Economic and Social Research Council (ESRC) grant (reference RES-062023–0850), we collected data from nine services in England and Wales in the UK offering help to children and young people with harmful sexual behaviours. We analysed all cases which had been referred to those services in a nine-year timeframe. Four of these services were residential, five worked with young people on a community (out-patient) basis. Out-patient services generally provided weekly treatment sessions that could last up to six months. Young people who attended these services generally stayed with their families or relatives while they attended the services, though in some cases they were provided with accommodation by social services. Residential services usually treated young people on a long-term basis, in some cases for a period of years. Young people in residential services were provided with individual and group interventions (or both), internal and external educational opportunities, and if the length of stay was long enough, preparation for independent

living. We identified 700 cases from all the services, giving a total population sample. Prior to data collection, ethical approvals were sought from and granted by the authors' respective universities and the services themselves.

We previously published baseline demographic information on the entire sample of 700 cases (Hackett et al., 2013). However we also felt that it would be useful to extract more complex, less demographically orientated information from the cases as well. We therefore used a stratified purposeful sampling strategy to identify 117 cases from the 700 for detailed qualitative analysis, sampling these 117 cases on the basis of gender, ethnicity, disability, age at referral, victim characteristics, offence characteristics and family background. These 117 cases were broadly representative of the 700 cases from which they were drawn. Approximately 95% of the 117 cases were male and 'White British'. The majority, 63%, were between 13 and 16 years of age.

We read and made detailed notes on each of the 117 cases. Most of the original files of these 117 individuals were about 30-60 pages in length and these files routinely contained large amounts of information about the children's life circumstances and their experiences in services. We summarised each case file as a 2-4 page summary document (totalling about 400 pages of narrative information) outlining the child's background and sociological/family context; their offence characteristics; and their experiences in the services and personal issues. It took two researchers (the first and last authors), working fulltime, several months to collect this information. For the purposes of this article, we focused on the data collected on these young people's experiences in services and their personal and health characteristics. The specific themes that we identified, and which formed the organising sections of this article were: reasons for referral to services; the young person's personal

characteristics; medical and mental health problems; interests and aspirations; attitudes towards services and interventions; sexual incidents in services; progress in services; and post-service experiences. Illustrative quotes from the original case files are used to give readers insight into the children's background and experiences; these quotes were chosen from across the entire samples of 117 cases. After each quote is a bracketed number: this is the young person's age at referral for treatment. We employ basic quantification where necessary to give further insight into overall patterns within the data. We have slightly altered some of the details in the quotes (without changing the original meaning) to protect individuals' identities.

Results

Reasons for referral to services

Sixty-four (55%) of the files contained information describing why young people were initially referred to harmful sexual behavior services. Three (3%) of these cases were because other services were not seen to be helping the young person; sixteen (14%) were for sexual behavior interventions; thirty-nine (33%) were for risk assessments; and six (5%) were re-referrals following re-offending. Young people were referred to residential services for a number of reasons including the perceived high risk that they posed to children; the fact that they may have offended against a brother or sister and it was thought as a result that they should be removed from the family home; because they needed to develop inter-and intrapersonal skills and awareness; and because practitioners felt that parents would be unable to manage their risk successfully at home. In a very small number of cases, it was felt that the young person was at risk for fulfilling the criteria to become an adult 'paedophile', and

thereby needed to access specialist residential placements. Two of the young people stayed in residential services for more than six years.

Personal characteristics

The personal characteristics of the young people were described in detail in the files. Sixteen young people (14%) were noted to seek attention and approval from other young people and from adults. Sometimes wanting approval was noted in a positive context-"he liked to be liked"- and sometimes in a more negative one. More problematically, a minority (n=15, 13%) of young people were identified as having issues with power, and could desire to dominate and exert authority over people, especially girls and women. Services said about one young man:

> "He was verbally and physically aggressive towards his family. He talked to his mother like she was 'rubbish', and he perceived women to be 'his servants, beneath him'. He felt that women were there to be dominated and to submit to men. His mother felt that his behaviour was 'in his genes, just like his father'." (14).

As this quote indicates, some of these young men (n=11, 9%) were said by services to have particularly negative attitudes towards women. One young person believed that men provided "leadership and women had authority in the home". Another classified women into 'respectable' and 'disrespectable' groups, and felt that disrespectable women were responsible for what 'happened' to them. Five young people were noted to admire toughness, and emulate figures such as Deadpool from the X-Men or serial killers. Three were described as having 'hidden selves':

> "The service practitioner said that X presented a false, compliant self to the world and he kept his true self hidden. His true self was associated with his sense of grievance, anger and his abusive behaviour." (15).

About a third (n=40, 34%) of the young people were described as being aggressive and violent, which could manifest itself in a range of behaviors ranging from staring down service practitioners to rampaging around services, to attacking or threatening people. Some young people in the residential services were considered to be so dangerous that staff considered referring them to custodial settings. It was noted about one 14 year old young man that he "could become very violent very quickly, on occasions throwing knives at people". Another boy started fires and threw glass.

About a fifth of the young people (n=24, 20%) were observed by services to have problems with empathy, particularly with understanding victims' experiences. Over a third (n=39, 33%) were said to have self-esteem problems, seeing themselves as beings of little worth. One boy viewed himself as "ugly, boring and stupid". Five of the young people (4%) were also described as having problems with food and being obese. It is perhaps unsurprising, therefore, that an important minority (n=24, 21%) of these young people were described by services as being emotionally "damaged", either functioning at a very young age emotionally or being disconnected from their feelings (disconnection was described in a number of cases as a response to the young person's own trauma or abuse). One boy was described as an "emotional mess". Fourteen of the young people (12%) were also noted by staff to be immature, functioning emotionally at the level of much younger children. Problems with poor

social boundaries were noted (n=11, 9%), as was a general lack of control amongst some young people over their own behavior (n=8, 7%).

Finally problems with sex and sexuality were identified. Nineteen (16%) of the young people were described as having issues with their sexual or gender identity, unsure whether they were gay or not (these feelings could be triggered or accentuated if the young people had been abused themselves, or if they had abused younger boys). One thirteen year old was described as "very anxious about the thought of being gay or having gay feelings". A minority of the young people (n=11) were said to have poor or distorted knowledge about sex and sexuality, though others were noted to have inappropriate sexual knowledge. Some of the young people had very negative attitudes towards sex, expressing disgust at it. One twelve year old said "that's dirty, I'll not talk about it", and another told a service that "masturbation was an unhealthy activity and a waste of bodily energy" whereas others were described as having a "total sex syndrome" (a 'total sex syndrome' was a non-DSM recognized diagnosis that some practitioners used to describe young people who they felt were obsessed with sex). Twelve (10%) of the young people were noted to have paraphilic behaviors, the most common of which was wearing women's clothes, though two had zoophilic interests, and one boy was known to have engaged an animal in sexual behavior.

Medical, health and learning problems

Nine (8%) of the young people were said to have developmental problems, ranging from delays in speech or walking to autism. Three had sleeping disturbances and two suffered from fetal alcohol syndrome. A number of the young people had mental health problems:

> “Services indicated that he had significant psychological problems stemming from a background of emotional neglect and physical abuse.” (11).

Eight (7%) of the young people suffered from depression. Although in some cases this was longstanding, in others the depression occurred only in the aftermath of the harmful sexual behavior and during the interventions offered by the services, for example, because they felt that their parents had abandoned them. Eleven of the young people had suicidal ideation (9%). One boy had attempted to hang himself twice by the time he was twelve, another had swallowed bleach and three boys had jumped in front of cars. ADHD was noted in seven cases, and dissociation in six:

> “When he was interviewed he said that his mind and his body were different people. He called his mind ‘Ramsey’ and said that at times Ramsey took him over and made him do things. X said that when Ramsey was in charge X would experience a loss of time and would find himself in different places, unsure of how he got there. The practitioner thought that X might dissociate.” (15).

Three of the children were said to hear voices in their heads (one girl heard her own abuser’s voice telling her to do sexual things) and one young person was noted to be psychotic and “increasingly out of touch with reality”). Four were noted to suffer from PTSD:

> "He suffered frequent flashbacks to his abuse, images that were triggered by darkness and by seeing trees and bushes." (15).

Although many of the young people were said to be academically bright, or at least academically average, twenty (17%) had some degree of learning disability. One file noted that the young person was of "limited intellectual ability but had some degree of native cunning". Thirteen (11%) of the young people were noted by services to have significant learning problems and complex learning needs. One young person, for example, had an IQ of 45, and the other twelve had very low IQs as well. Sixteen (14%) of the young people were noted to have significant cognitive problems, such as problems with their concentration or with their memories. Several of the children mixed up past and present:

> "Frequently his thoughts were in the 'way back when' rather than the 'here are now', reflecting his preoccupation with his highly damaging, traumatic childhood. He also had a very poor concept of time and a very restricted memory." (15).

Interests and aspirations

Seventeen files (15%) noted that the young person had strong interests in some activity. These interests were diverse including, for example, karate, snooker, motor-biking, pokemon, gardening, fishing, boxing, cricket, football, music, playing with pets, dinosaurs, swimming and riding bikes.

Twenty-four (21%) of the files also noted the young people's long-term aspirations. Many of them said that they wanted to be normal teenagers and adults and

meet someone who loved them. They wanted children and a place of their own. They wanted successful careers, such as joining a company or the military or going to university. Given the nature of their offending behaviours and their own abuse experiences, on occasions some service personnel felt that these aspirations were "an escape into a fantasy". One girl noted what she wanted when she grew up:

> "I want to go to a theme park in New York, win millions of pounds, get loads of new clothes, bring my friend to the theme park, go to a hotel, have my friend moving in with me so the two of us can get up to mischief and brain people who call us names, my stepfather would die because I hate him, limousine for mum, have a big house, funfair in the garden, friends not use me, lots of sweets, mum doesn't shout at me". (12).

Young person's attitude towards services and interventions

Given the young people's wide range of inter- and intrapersonal problems, services undertook an equally wide range of interventions with them. Understandably the focus in most interventions was on the young person's abusive sexual behavior, victim empathy and sexual knowledge and relationships, but services also focused on family relationships, gender and sexual identity, feelings and emotions, self-esteem, social skills, body image problems, general problem solving and life skills. Some of the services used psychiatrists to help the children with mental health issues. All services were therefore holistic in their approaches.

Most of the files indicated that the young people responded positively to services' efforts. Perhaps understandably, these young people were often initially wary of service interventions and, as noted, some were aggressive by disposition, and

could be confrontational with service staff. However, many of them eventually cooperated with the intervention and understood why the service was working with them. The reasons for cooperation varied: some young people wanted to understand themselves; others felt that they had a problem that was too big for them to handle alone. One psychiatrist's report said that "I think in some senses he is really quite amazed by the situation he finds himself in"; others were worried that they would end up in prison if they did not receive help. Young people who had themselves been abused could see the service as a protective space and form a "deep attachment" to the institution and those who worked there. One twelve year old who progressed well in treatment said that the service had:

> "Made me a better person at home. Helped mum to see that I am a good person".

In fact, even young people who were considered to be fairly high risk could exert a positive influence. A practitioner said about one such young person who took part in group therapy:

> "He is one of the group members who contributes the most and is able to share his past experiences as well as support others" (14).

At the same time though, it is important to highlight that even young people who positively engaged with their service could find the work difficult or upsetting at times. Furthermore, an important minority of young people (n=19, 16%) responded negatively to service interventions or were hostile towards them. In eight of these

cases, the young person found it very difficult to talk about their harmful behavior, and could become angry or resistant when the topic was brought up. One file, for example, noted that the young person was "uncompromising in his unwillingness to discuss any aspect of his sexual behavior". Another seventeen year old said that it had "killed him to go to the service as it gave him nightmares". One young person was very worried about what could be discovered about his family by the service. There were other reasons for non-engagement. Several of the young people, for example, had chaotic or unstable living arrangements at the time of their intervention, a situation which services said "was not conducive to implementing a successful assessment process".

Sexual incidents in services

Continued sexual incidents in services occurred in 29 (25%) cases. Ten of the young people perpetrated aggressive sexual acts against female staff members, including making false sexual allegations against them, propositioning them, imprisoning them and in one case conspiring to rape them. There were several cases of voyeurism on the part of young people whilst in the service context. While these incidents could happen at residential and community services, they appeared to be more serious at residential services, possibly reflecting increased proximity with staff, and the more disturbed nature of the young people being treated in such settings:

> "On one occasion X locked a female staff member in a room with him, turned off the light and said 'nice ass'. He asked another female member of staff if she would lick his penis." (15).

> “He bored holes in the walls between his bedroom and the staff shower so that he could observe female staff members while they washed”. (13).

> “X enjoyed hurting female staff members and became sexually excited at the thought of hitting them. He carried a kitchen knife around. On one occasion he was charged with assault after he stroked a female staff member’s arm while telling her what he had done to boys and girls in the past.” (15).

It was also the case that some of these young people attempted to make or maintain surreptitious sexual contact with children or young people either outside or inside of the service. One young person began grooming a young girl who was herself the victim of sexual abuse and had a history of self-harming. Concerningly, he also began meeting an adult sex offender who told him that his behavior was normal. In another case it as noted that:

> “The programme came to an abrupt halt when further allegations came up that he had continued to systematically abuse his cousins, even while he was attending the service. It emerged that while attending the service he regularly threatened one cousin to let him abuse her and groomed and befriended the other.”

Progress in the service

Eighteen (15%) of the young people were considered to be at low risk at the end of their time in the service. These young people displayed no evidence of continued inappropriate sexual behaviors or thoughts. Furthermore, services felt that they had

developed empathy for their victims. One young person "told his sister that he had not appreciated how much he had hurt her". These young people also indicated that they felt ashamed about their actions, and appeared to have developed an internal locus of control and an ability to take responsibility for their own actions. They had committed to their work with the service and were considered to be honest and open. One young person said that he had worked with service because he did not want to become a "wife beater" when he grew up. Additionally, in a number of these cases, parents undertook their own therapeutic work, and had assumed responsibility for their own influence on the young person's actions. In one case for instance parents acknowledged that "their heavy drinking had a negative impact" on the young person.

Additionally, in another eighteen cases, (15%) of services felt that the young person had made good progress in the service, though they needed more work at the point that the intervention ended. In particular, many of these young people were described as needing help on assessing interpersonal boundaries, managing their feelings and improving their interpretations of social situations. As noted, services worked with a wide variety of these young people's problems, not just their sexual behavior, and these problems could continue to manifest themselves. One young person for example "could not manage timetable changes and changes to platforms if his train or bus were moved". Another case worker said of a young person:

> "While X would probably take care to avoid breaking the law, he would cynically and ruthlessly exploit opportunities to exploit [financially/emotionally] more vulnerable young people where such opportunities presented themselves" (15).

Finally, four of the young people considered to be a low risk of further sexual behavior problems were considered to be at risk of becoming sexual victims themselves in the future.

Twenty six (22%) of the young people, on the other hand, were considered to be at an elevated risk of continued sexual behavior problems; and ten of these twenty-six were considered to be high risk:

> "His case workers felt that not only was his risk of reoffending quite high, the severity of his offences could also be high" (precise age unknown-teens).

The most common reason (n=17, 14%) for an assessment of elevated risk was that the young person was not considered to be emotionally resilient, and could become dominated by negative emotions such as anger and depression. Lack of empathy, often manifesting itself as victim blaming, (n=8) was also a factor. Continued aggression, impulsivity and volatility were identified in 14 (12%) cases. Lack of control over their own behavior was noted in 16 (14%) cases:

> "During his last week in [the service] he kicked in the front door of the apartment that he was in and demanded food. It was decided that his situation in the service had become untenable and he was removed. His case worker felt that the person that was emerging in X was extremely dangerous, uncontained and damaged." (15).

In n=12 (10%) cases it was felt that social network factors, such as lack of support from family members, contributed to elevated risk. In several of these cases

parents were felt to be unable to control the young person, and in several others they attempted to minimize risk (for example because they wanted things to go back to 'normal'). Additionally, serious mental health problems, such as possible psychosis, and drug use problems were associated with increased risk in a handful of cases. Eight of the young people were considered to have what in adults would be considered to be paedophilic inclinations:

> "When X left [the service] he was considered, on balance, to be very high risk. He was described as a fixated paedophile that had little internal motivation to change his behaviour. He had detailed fantasies about abducting and abusing younger girls. After leaving [the service] X started texting former service users and signing his messages with the name of his younger sister [who he wanted to have sex with]. He also bought a mobile phone that could take pictures. [The service] referred to him as a 'high risk sexual predator', a phrase they rarely used" (15).

Parents could display a continuing disregard for their child and their child's future. One mother told a young person that "he would not be in her plans for the future", which led him to drop out of the service. In fact 14 (12%) of the young people ultimately did not complete treatment. The most common reason for this was the young people themselves refused to cooperate because they found working with the service to be too difficult. Many were simply described as becoming resistant and defiant as time went on.

Additionally in nine (8%) extra cases the young person's work with the service was terminated early for financial reasons, even if the young people were

making good progress. The costs of the young people's care could be very large. For example, one local authority spent over half a million pounds sterling on one young person's placement in a residential setting. Another local authority "was unhappy about X's referral to the service, principally because of the amount of money it cost them".

Finally, it is worth noting that there could be disagreement amongst case workers about how much of a risk a particular young person posed at the end of their treatment:

> "One of his therapists said that X had been able to construct coping strategies, and that he had made huge strides forward given how troubled he was when he first came to the service. Another therapist thought that X's behaviour was indicative of an individual who was likely to pursue his paedophilic tendencies despite having a full understanding of the possible negative consequences for either himself or for his potential victims." (15)

Post-service experiences

Following interventions by services, eight of the young people moved back to their family home. One of these young people said that leaving his residential service and returning home was like "moving from a village in Asia to London". Living circumstances could be dynamic - one young person's mother had a baby after he returned home and the young person was then removed from the house as he was felt to pose too great a risk to the child. Another young person was called a name (i.e. 'paedophile') by someone in the local neighbourhood, which made him question his long-term future in his hometown. Sixteen (14%) of the young people returned to the

area where they had grown up, but lived independently from their families. Nine (8%) of the young people were referred to secure or residential units. Some of these ended up in prison, others in mental health units. The potential for non-sexual violence was a concern in relation to many of the young people:

> "X was placed in a secure unit after leaving the service. Staff in the unit were informed that male staff should work with him where possible -though it was noted that X was also dismissive of men he regarded as being weak. X also asked for some female members of staff from the service to keep in touch with him, which they did not do." (15).

Eleven (9%) of the young people were noted to have sexually reoffended after leaving the service. As these young people were now older, the motivation and nature of the offences could change compared to what they had been when services first started working on them:

> "It was noted that his second round of offences were planned and premeditated and were wholly driven by a need for sexual gratification. The offences were committed at night to reduce his risk of being caught and he picked a site where he knew women would always be waiting on their own." (Precise age unknown at time of reoffending).

Some of the young people moved to new areas and began, or attempted to begin, entirely new lives after leaving the service. Some of these young people appeared to make positive transitions; however others experienced more stuttering

transitions, with the transition going well for a while and then deteriorating, or going well in one aspects of the young person's life and not so well in others. The young people could be chaotic in their approach to their transition to regular life, for example getting drunk or taking drugs and not showing up for work or job/accommodation placements, and then finding themselves in a particularly bad and precarious situation with few good options for a way out.

Discussion

This article has discussed the personal and health characteristics of a sample of young people with sexual behavior problems, as well as the experiences of these young people in services. Several key issues emerge.

The first of these relates to the potential for young people with sexual behavior problems to remain violent, or continue to engage in harmful sexual behaviors-or both, while attending services. Despite the evidence of longer-term low rates of recidivism, it is surprising and concerning that about a quarter of these young people continued to engage in problematic sexual activities while they were being treated, especially in residential settings. It was also highly concerning that a small proportion of these young people were sexually aggressive towards female staff members, and in rare cases towards men who they considered to be 'weak'. This might reflect the strength of the young person's sexual deviance, a sign of their own trauma, or an act of resistance to adult authority (Timmerman & Schreuder, 2014). Wylie & Griffin (2013) note that it is crucial that while services work holistically with these young people, they do not forget that some of these young people do pose serious risks - and that forgetting about this risk would be both unsafe and unethical. Appreciating this risk while also working with these individuals on their issues and needs is central to

good practice (Hackett et al., 2006). The results here suggest that in relation to certain dangerous young people, perhaps especially in residential settings, staff members should engage in careful risk management practices, such as working in pairs and avoiding situations where they might find themselves alone and at risk, particularly where there are opportunities for service users to quickly access weapons such as knives.

The prevalence of mental health and personal problems in the sample, ranging from aggression to suicidality was also a concern, and the findings support previous work in this area. The fact that these problems were routinely being documented in the case files is more positive, as it demonstrates that the services in the study were clearly not focused exclusively on these young people's harmful sexual behaviors, and were in fact considering a broad range of issues which could impact them. Some studies have in fact detected even higher rates of mental health issues than we discovered. Boonman et al. (2015) for example found that seven out of ten young people with sexual behavior problems meet the criteria for at least one mental disorder, and Vizard et al. (2007) found very high rates of aggression and anti-social behaviors in their study of these young people. Problems with ineffective management of emotion have also been noted in this group (Gerhard-Burnham et al., 2016; Print & O' Callaghan, 2004), and our study found that poor emotional resilience was the factor that professionals documented most often when considering recidivism risk factors. The degree of identity crisis in these young people (e.g. the young people's worries about their sexual identity) has been reported less often, and probably reflects at least in part the fact that a substantial proportion of the young men in the sample were either sexually abused by men or might themselves have sexually abused younger boys. This abuse would have come at a point in their lives,

adolescence, where the young people were developing their own independent identities, so it not surprising that it could have a significant psychological impact.

Lack of funding for residential placements was an issue in a minority of cases and was associated with dropout from services. Dropout is concerning as is linked to a greater risk of recidivism, and itself has wide-ranging financial implications if the young people reoffend (Edwards & Beech, 2004). The enormous financial cost of some of these young people's treatment was documented, with some costing their local authority over half a million pounds (the equivalent of $1.3m). It is clearly an issue in a post-austerity world, where the state is retreating from supplying public services in many areas, how to balance the cost of long-term residential treatment for high risk young people against the threat that they can potentially pose. Some local authority areas in the UK are currently experiencing funding crises that in large part are being created by the significant costs of providing accommodation for high risk young people in specialist residential provision away from their home areas.

The findings suggest the need for additional social and psychological supports for these young people after they leave services and transition back to the community-that is, if such support is not already being offered. While some of the young people in this study managed this transition well, others clearly had difficulties with it. Some of them moved very quickly between situations where they had very intensive supervision over a long period of time, to more decompressed situations where they had much less help and support. While any such post-service support will have cost implications, it does not necessarily make sense for young people to experience support in a binary fashion-i.e. either they have it intensively, or they have very little of it. Related to this there is also a possible need for services to continue to work with and support family members, including young family members and parents, after the

young person with sexual behavior problems has left services and returned to the community. It is possible that many families could struggle with this situation, in terms of reconfiguring their relationship with the young person, understanding their own feelings about the young person's 'release', and managing risk in an everyday, unsupported context.

This study has a number of limitations. It is based on uncontrolled, retrospective review of service case files- although Edwards & Beech (2004) note that the contribution of this type of study design should not be underestimated. Because service files were for the personal use of practitioners, it is not the case that they would have documented all information that is of interest to this article. As such, the true prevalence of conditions such as suicidality and aggression that were identified in this study may in fact be even higher. It is also the case that there is a tension between seeking to give voice to these young people's experiences, while relying on professional interpretations and recordings of those voices as baseline data. Finally, the vast majority of the young people examined in this study were male. While there is increasing research on young women who engage in harmful sexual behavior problems, overall the work on this group, particularly their experiences in services, is limited (Oliver & Holmes, 2015). Young women may have different experiences in services than men. It would be useful if future studies attempted to document their lives in treatment.

Conclusion

Young people with sexual behavior problems commit a significant number of sexual offences against children every year. Tertiary services must then step in to manage the risk that these young people present, and in many cases to provide support to help

them deal with psychological and sociological trauma. It is difficult work that is not itself without risk. It is also important and necessary. As one young person said: working with services helped him to "be on the right path" - the alternative was "awful and terrible".

Acknowledgements

We would like to sincerely thank the services and organisations that took part in and supported this study.

References

Boonman, C., van Vugt, E., Jansen, L., Colins, O., Doreleijers, A., Stams, G. & Vermerien, R. (2015). Mental disorders in juveniles who sexually offended: a meta-analysis. *Aggression and Violent Behaviour, 24*, 241-249.

Caldwell, M. (2002). What we do not know about juvenile sexual re-offense risk. *Child Maltreatment, 7, 4*, 291-302.

Campbell, F., Booth, A., Hackett, S. & Sutton, A. (2018). Young people who display harmful sexual behaviours and their families: a qualitative systematice review of their experiences of professional interventions. *Trauma, Violence and Abuse*. Retrieved from: https://doi.org/10.1177/1524838018770414

Draper, C., Errington, S., Mar, S. & Makhita, S. (2013). The therapeutica benefits of sport in the rehabilitation of young sexual offenders: a qualitative evaluation of the fight with insight programme. *Psychology of Sport and Exercise, 14*, 519-530.

Edwards, R. & Beech, A. (2004). Treatment programmes for adolescents who commit sexual offences: dropout and recidivism. *Journal of Sexual Aggression, 10,* 1, 101-115.

Edwards, R., Whittaker, M., Beckett, R., Bishopp, D. & Bates, A. (2012). Adolescents who have sexually harmed: An evaluation of a specialist treatment programme, *Journal of Sexual Aggression, 18, 1,* 91-111.

Efta-Breitbach, J. & Freeman, K. (2004). Treatment of juveniles who sexually offend: an overview. *Journal of Child Sexual Abuse, 13,* 125-138.

Flanagan, K. & Hayman-White, K. (2000). An australian adolescent sex offender treatment program: Program and client description. *Journal of Sexual Aggression, 5, 1,* 59-77.

Gerhard-Burnham, B., Underwood, L., 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.

Grady, S., Cherry, J., Tallon, M., Tunney, C. & O' Reilly, G. (2018). An exploration of the treatment expectations and experiences of adolescents who have sexually abused. *Journal of Sexual Aggression, 24, 1,* 80-98.

Greaves, J. & Salloum, A. (2015). Evaluation of a youth with sexual behavior problems outpatient treatment program. *Child and Adolescent Social Work, 32, 2,* 177-185.

Hackett, S., Masson, H. & Phillips, S. (2006). Exploring consensus in practice with young who are sexually abusive: findings from a Delphi study of practitioner views in the United Kingdom and the Republic of Ireland. *Child Maltreatment, 11, 2,* 146-156.

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

Hackett, S., Phillips, J., Balfe, M. & Masson, H. (2014). Family responses to young people who have sexually abused: anger, ambivalence and acceptance. *Children & Society,* 28, 128-139.

Halse, A., Grant, J., Thornton, J., Indermaur, D., Stevens, G. & Chamarette, C. (2012). Intrafamilial adolescent sex offenders' response to psychological treatment. *Psychiatry, Psychology and Law, 19, 2,* 221-235.

Lawson, L. (2003). Becoming a success story: how boys who have molested children talk about treatment. *Journal of Psychiatry and Mental Health Nursing, 10,* 259-268.

Letourneau, E. & Borduin, C. (2008). The effective treatment of juveniles who sexually offend: an ethical imperative. *Ethics and Behaviour, 18, 2/3,* 286-306.

Masson, H., Hackett, S., Phillips, J. & Balfe, M. (2015). Developmental markers of risk or vulnerability? Young people who sexually abuse-characteristics, backgrounds, behaviours and outcomes. *Child and Family Social Work, 20,* 1, 19-29.

McCuish, E. & Lussier, P. (2017). Unfinished stories: From juvenile sex offenders to juvenile sex offending through a developmental life course perspective. *Aggression and Violent Behaviour, 37,* 71-82.

McKibbin, G., Humphreys, C. & Hamilton, B. (2017). "Talking about child sexual abuse would have helped me": Young people who sexually abused reflect on preventing harmful sexual behavior. *Child Abuse and Neglect, 70, 1,* 210-221.

Oliver, B. & Holmes, L. (2015). Female juvenile sexual offenders: understanding who they are and possible steps that may prevent some girls from offending. *Journal of Child Sexual Abuse, 24, 6,* 698-715.

Print, B. and O' Callaghan, D. (2004). Essentials of an effective treatment programme for sexually abusive adolescents: offence specific treatment tasks. Ed. O' Reilly, G., Marshall, W., Carr, A. & Beckett, R. The Handbook of Clinical Intervention with Young people with harmful sexual behaviours.

Somervell, J. & Lambie, I. (2009). Wilderness therapy within an adolescent sexual offender treatment programme: a qualitative study. *Journal of Sexual Aggression, 15, 2,* 161-177.

Timmerman, M. and Schreuder, P. (2014). Sexual abuse of children and youth in residential care: an international review. *Aggression and Violent Behavior, 19,* 715-720.

Veneziano, C. & Veneziano, L. (2002). Adolescent sex offenders: a review of the literature. *Trauma, Violence and Abuse, 3, 4,* 247-260.

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.

Worling, J. & Curwen, T. (2000) Adolescent sexual offender recidivism: success of specialized treatment and implications for risk prediction. *Child Abuse and Neglect, 24, 7,* 965-982.

Wylie, L. & Griffin, H. (2013). G-map's application of the Good Lives Model to adolescent males who sexually harm: a case study. *Journal of Sexual Aggression, 19, 3,* 345-356.

Yoder, J. & Ruch, D. (2015). A qualitative investigation of treatment components for families of youth who have sexually offended. *Journal of Sexual Aggression, 22, 2,* 192-205.