The Experiences of Youth with Problem Sexual Behaviour: Barriers and Facilitators to Treatment

by

Rebecca Watson

Paper submitted in partial fulfillment of the requirements for the degree of

Master of Counselling
in the
Division of Arts and Sciences

City University of Seattle
2022

Abstract

This paper is an analysis of 10 qualitative, peer-reviewed studies exploring the aspects of the experience of youth with problem sexual behaviour (PSB) that act as barriers and facilitators to treatment. PSB is defined as sexual behaviour in children and youth under the age of 18 years that is outside expected development. Youth with PSB are a heterogenous group, though the influence and prevalence of insecure attachment has been recently recognized in this population. While effective, evidence-based treatment exists, there is no clear path of referral from identification to treatment. The results indicate that presently, youth are subject to inconsistent and varied responses, hindered by misconceptions. Four primary themes emerged from the experience of youth with PSB: caregiver impact, system response, treatment factors, and stigma. A further seven subthemes were identified as barriers, and four as facilitators. These findings allow therapists greater understanding into the experience of youth with PSB and how treatment currently exists within the systemic response to these behaviours. Additionally, these insights may inform more thorough education for therapists around child and adolescent sexual development. Therapists are also encouraged to reflect on and enhance their role within the multi-disciplinary systems and teams that support youth with PSB. In this paper, the author provides a methodological analysis, discusses ethical considerations, and makes recommendations for future research.

Keywords: *problem sexual behaviour, harmful sexual behaviour, juvenile sexual offenders, child advocacy centre, attachment theory, systemic response*

Acknowledgements

Dr. Galick, thank you for the necessary push to get this paper done. Your feedback and guidance produced a capstone I am proud of. Sorry it took so long!

To my family, I cannot quite put into words my gratitude for you. Sam, you felt every moment of these past four years with me and picked up every bit of slack I dropped. Thank you. Shea, Jules and Van, thank you for the perspective you provided me and the constant reminder to be present. You get all my evenings and weekends again! Mum and Dad, you not only instilled in me the drive to do this, but you stepped in to support this dream whenever I needed it.

To my friends, you checked in on me, dealt with an endless barrage of memes, and showed up when I needed you. And finally, Nasim and Karlee, you kept me sane, focused and I'm quite sure I wouldn't have completed this without you.

Contents

List of Tables and Figures

The Experiences of Youth with Problem Sexual Behaviour: Barriers and Facilitators to Treatment

In the field of counselling psychology, effective treatments for children and youth with problem sexual behaviours (PSB) are well-researched, however, they do not appear to be consistently offered or accessed. These youth represent approximately a third of those arrested in child sexual abuse cases across North America and the United Kingdom (UK) (Finkelhor et al., 2009; Hackett, 2014; Varma & Leroux, 2019). However, there may be jurisdictional inconsistencies in the systemic response for some children and youth displaying PSB (Silovsky, et al., 2019; Tener et al., 2020). It is being increasingly recognized that punitive measures, often based on adult models, have been shown to be developmentally inappropriate yet continue to persist as the standard in many countries and regions (Chaffin, 2008). Overall, the literature shows an increased understanding of PSB and treatment for these youth, however, models of response that fail to integrate this new knowledge. It is important for therapists to understand the barriers youth with PSB and their families must overcome to access treatment.

Research problem

It is unclear how treatment is systematically accessed by youth with PSB and their families. Youth with PSB make up about a quarter of all sexual offenders known to police in North America and just over one-third of sexual offenders of child sexual assault across America, Canada and the UK (Finkelhor et al., 2009; Hackett, 2014; National Children's Alliance [NCA], 2017; Varma & Leroux, 2019). Despite knowing numbers of youth involved in the criminal justice system, the prevalence of PSB in the general population is unknown (Chaffin et al., 2008; Finkelhor et al., 2009; National Society for the Prevention of Cruelty to Children [NSPCC], 2021). This may be in part because incidents of PSB without legal involvement are

not systematically tracked (Silovsky, et al., 2019). Furthermore, PSB not involving victimization, such as excessive masturbation, may still have detrimental effects on youth though may never come to the attention of systems.

Several treatments have been found to be effective for youth with PSB, including cognitive behavioural therapy (CBT) and multi-systemic therapy (MST). These treatments report low recidivism rates ranging from 2-15% (Chaffin, 2008; Dopp et al., 2017; NCA, 2017). These outcomes reflect future offending rates as low as non-PSB peers in some cases (Chaffin et al., 2008; Silovsky et al., 2019). However, it is unclear how these treatments are offered, accessed, or systematically made available to youth and their families. As a preventative measure for child sexual abuse, as well as improving children and youths' ability to effectively regulate emotions and manage their behaviours, it is important that the field of counselling is aware of the factors that play a role in the youths' access to treatment.

As researchers continue to investigate and uncover new information about children and youth with PSB and recommend leading evidence-based practice in their treatment (Dopp et al., 2017; Hackett et al., 2013; Leppink et al., 2016), it is imperative that therapists and other professionals working alongside these children and youth understand how youth experience intervention after the identification of their PSB. The NCA, the American body of accreditation for Child Advocacy Centres, recently recommended that CACs play a role in case management of PSB cases: facilitating collaboration and referrals for youth with PSB, their families, and involved professionals. Due to their specialized expertise in serving children and youth, CACs' multi-disciplinary team (MDT) and community focus are well suited to address the recommended multi-systemic and community-based interventions for these youth. However,

CACs traditionally only offer treatment to young victims, not those children and youth traditionally identified as offenders

Significance

Though the prevalence rate in the general population is unknown, it is being increasingly understood through research that children and youth with PSB benefit from age-appropriate intervention and treatment. However, there remains a gap in knowledge around where this treatment is offered and how youth with PSB and their families access it. Knowledge around what and how these youth experience responses to PSB from disclosure to treatment, may give us insight into how access to treatment for youth with PSB and their families can be improved. This study seeks to answer the following question: "how can the experiences of youth with problem sexual behavior (PSB) help us understand treatment barriers and facilitators?".

Problem Sexual Behaviours

To understand youth's experience of PSB, it is important to understand what PSB is. First, it is necessary to recognize that there exists developmentally appropriate sexual behaviour at every age. These expected sexual behaviours in children and youth are typically characterized as spontaneous, curious, easily redirected, and depending on stage of development, consensual and occurring with equal-ability peers (True Relationships & Reproductive Health [True], 2019). PSB is then defined as sexual behaviour outside expected development, that may occur frequently, is considered coercive or aggressive, and/or is considered harmful to self or others (Fonagy et al., 2015; NCA, 2017; Shields et al., 2018; Silovsky et al., 2019). This behaviour occurs on a continuum, with coercive victimization, such as an older child offering treats for sexual acts or non-consensual intercourse with a peer, representing the most severe end (Hackett,

2014; Shawler et al., 2020; True, 2019). It seems generally accepted in literature that youth with PSB can include anyone under the age of 18 years, though individual studies may focus on smaller age ranges either above or below a country's criminal age of responsibility, or due to the availability of participants.

The term *youth with PSB* is used intentionally in this study. PSB is referred to by many different labels in the literature, such as illegal sexual behaviour, sexual offending, and sexual abuse. Additionally, both children and youth are often labelled as juvenile sexual offenders (JSOs) or perpetrators. A shift in literature in the last ten years reflects the use of person-first language when referring to this population as children and youth with PSB, something that is also widely recommended by child abuse advocates (Chaffin, 2008; Hackett, 2014; NCA, 2017). Regionally, it is sometimes referred to as harmful sexual behaviour (HSB) which still reflects the use of person-first language in an effort to distance practice from stigmatizing, harmful labels (Hackett, 2014).

Characteristics of Youth with PSB

Though prevalence in the general population is unknown, research in criminal and clinical populations shows youth with PSB are a heterogeneous population (Dopp et al., 2017; Fonagy et al., 2015; Silovsky et al., 2019; Worling & Langton, 2012) with few common characteristics. They differ in risk factors, demographic features, and familial history (Silovsky et al., 2019). Some known risk factors include exposure to sexual content, childhood trauma, and poor parental supervision (Shawler et al., 2020). Additionally, specific attachment characteristics and social isolation seem to be linked with acting out sexual behaviours on others, hypothesizing that this behaviour could be an attempt by the youth to meet their psychosexual needs with non-peers, such as younger children (Keiley et al., 2015; Sitney & Kaufman, 2020; Yoder et al.,

2018). Several gaps remain in the literature, including that most studies involving youth with PSB almost exclusively studied male populations, though it is speculated that in early childhood behaviours may be more prevalent in females (Chaffin et al., 2008; Finkelhor, 2009). Authors Robson and Lambie (2013) argued that the lack of reported incidence of girls and women acting out sexually could be in part due to societal disbelief that women can offend sexually.

Leading Evidence-Based Treatments

Several evidence-based treatments appeared in literature on children and youth with PSB, including CBT and MST. CBT interventions range from PSB-specific CBT with group and caregiver sessions (CBT-PSB) to models originally developed for adult offenders. It is increasingly recognized that treatment programs for adults do not address the inherent differences between adult offenders and youth with PSB; these include youth often having fewer victims, and the incidents being more impulsive and situational in nature (Shawler et al., 2020). MST for PSB is described as a family- and community-based treatment that seeks to address youth with serious behavioural problems on a multisystem level, with interventions aimed at individual, family, peer, and school settings by a multidisciplinary team (Letourneau et al., 2013). Several follow-ups on the original randomized controlled trial have evaluated the long-term treatment gains of the intervention. These papers expound the success of enhancing parenting abilities and overcoming logistical barriers with pragmatic solutions, such as conducting therapy at the youth's home and therapist availability 24/7 to accommodate schedules and crises (Letourneau et al., 2013). Furthermore, a published proposal described a large-scale trial to be conducted in the UK, the first to be done outside America by researchers not involved in MST's development (Fonagy et al., 2015). Another treatment published was Keiley et al. (2015)'s long-term intervention used in male juvenile correctional institutions in Alabama,

multiple-family group intervention (MFGI). While youth were in residential settings, family were involved at great effort and expense as the intervention sees attachment and affect regulation at the heart of sexual behaviours. For younger children, there exist play therapy groups, such as the Boundary Project: an attachment-focused therapy utilizing CBT, mindfulness, emotional regulation strategies and other interventions (Gil Institute of Trauma Recovery & Education, n.d.). Finally, research has shown that children and youth with PSB need not access only PSB-specific programs, comparable outcomes have also been found in evidence-based, developmentally appropriate programs like trauma-focused CBT (Chaffin, 2008; NCA, 2018).

Themes of Best Practice

Two main themes emerge as it relates to best practice within treatment of youth with PSB: community-based treatments and caregiver involvement (Chaffin, 2008; Dopp et al., 2017; Keiley et al., 2015; Silovsky et al., 2019; Worling & Langton, 2012; Yoder et al., 2018). While it has long been assumed that lengthy, restrictive therapy was needed to address PSB, research shows significant support for youth remaining in their communities (Chaffin, 2008; Silovsky et al., 2019; Worling & Langton, 2012). Worling and Langton (2012) made a strong case for why institutionalizing youth has potentially detrimental effects on attachment, while also being counter-productive to reducing reoffending. Locking up youth with PSB in secure settings away from their caregivers and communities at a developmentally-sensitive period risks aggravating a youth's existing attachment difficulties (Worling & Langton, 2012). Also, in support of community-based treatment, Silovsky et al. (2019) concluded that it resulted in overall improvements to the family's wellbeing.

The importance of caregiver involvement was stated in nearly all research around treatment of PSB. Chaffin (2008) found that the clinical literature for PSB reflected that youth's current caregivers must be included in treatment; this is theorized to be for several reasons, including how the home environment contributed to the development of PSB and the role caregivers play in day-to-day support. Dopp et al.'s (2017) comprehensive literature review of evidence-based treatment for youth with PSB showed the most successful treatments involved caregivers, likely due to their focus on parenting skills and relationship. As Yoder et al. (2018) proposed that attachment deficits are the root of the development of PSB, they believed that family involvement in responding to the behaviours is crucial to effective treatment. Additionally, other authors illustrated the need to include family to strengthen attachment bonds and emotional regulation, resulting in longer lasting psychosocial and behavioural success for the population (Keiley et al., 2015; Worling & Langton, 2012).

Theoretical Framework

Insecure parent-child attachment relationships have been theorized to play a role in both the etiology of PSB, as well as the treatment. Attachment theory is a developmental theory of personality that assumes that one's earliest close relationships are the context of development; affecting how one experiences and regulates emotions, as well as how one adapts behaviourally (Bowlby, 1969; Johnson, 2019; Sitney & Kaufman, 2020). The theory suggests that early attachment with key caregivers not only influences one's behaviour and affect, but how one views themselves and the world (Keiley et al., 2015). Consistent and predictable emotional and physical connection by central caregivers fosters secure attachment, which is connected to virtually all positive measures of wellbeing, including stress resilience, self-esteem, and effective emotional regulation (Johnson, 2019). Adolescents with secure attachment relationships to their

caregivers are found to have greater ability to perceive, label, express, manage and regulate their emotions (Mónaco et al., 2019). In addition, they were found to have lower levels of stress and higher life satisfaction (Mónaco et al., 2019).

When these consistent conditions and attachment needs are not met, insecure attachment can develop. Insecure attachment is characterized by emotional dysregulation and loss of openness; these individuals may experience frequent feelings of fear, helplessness, and distress when connection to their attachment figure is threatened (Johnson, 2019). This can lead to anxious and avoidant patterns of regulating emotions and engaging with others, ranging from vigilant to dismissive strategies (Johnson, 2019). It has been theorized that problematic behaviour in children and youth, such as PSB, may develop through parent's ineffective affect regulation and the insecure quality of the attachment relationship (Keiley et al., 2015). Furthermore, experiences of abuse can contribute to these insecure or disorganized attachment styles, resulting in children with inadequate means of managing emotional dysregulation (Keiley et al., 2015; Robson & Lambie, 2013; Sitney & Kaufman, 2020). Unlike their secure peers who seek out connection as a means of managing stress, children with insecure attachment are often unable to manage their affect and may develop habitual fight or flight behaviours, of which inappropriate sexual behaviour can fall in either category (Keiley et al., 2015). Finally, findings of a recent study showed that indeed youth with PSB were found to have poorer quality relationships with their caregivers than other incarcerated youth, this was theorized to be exacerbated by the potential rejection by parent due to the stigmatized nature of PSB (Sitney & Kaufman, 2020). Thus, it seems imperative for attachment relationships and behaviours to be considered in responses to PSB.

Researcher's Position

The inception of this study began several years ago during my time working within a CAC. One case arose in which a young adolescent disclosed historical sexual abuse during their interview as the "offender" on a case. As a result, their own interview as a child that had experienced sexual abuse was booked at police headquarters, rather than the child-friendly environment of the CAC. There had been several previous instances where a child had experienced sexual abuse, then had a subsequent file as an "offender"; our team would get creative to ensure that child was supported through the court case as the victim. However, a newer member of our MDT expressed their discomfort with the idea that this youth, due only to the timing of their disclosure, would not be provided the supportive services they deserved. We gathered information and assembled as an MDT to begin advocating for a shift in practice. Furthermore, as an agency we frequently dealt with sibling sexual abuse cases and had limited and restrictive resources to refer to. Despite the NCA's recommendation that CACs play a role in providing services for youth with PSB, and the growing number of CACs in Canada, few resources or examples exist on how the MDT may serve children and youth with PSB in the Canadian context. I hope this paper can provide knowledge and evidence-based recommendations to help organizations begin these conversations.

Research Methodology

To better understand the experience of youth with PSB accessing treatment, 10 empirical studies were chosen (Table 1). Ultimately, research studies were included that explored how children and youth experience intervention from identification of PSB through to treatment. The purpose of this section is to critique and synthesize the research methodologies of the 10 chosen studies. The process of selection will be detailed, followed by discussion of research paradigms, sampling methods, participants, data collection, and data analysis procedures of the 10 studies.

To choose the best 10 research studies, City University of Seattle and the University of Alberta's online libraries were searched, providing access to a number of academic databases, such as Taylor & Francis, EBSCO, and SAGE Knowledge. The search started with two keywords *problem sexual behaviour* and *youth*, as well as their variations and combinations: *harmful sexual behaviour*, *juvenile sexual offenders*, *children, teen,* and *adolescents*. The search was refined to scholarly, peer-reviewed journal articles published in the previous five years. This primary search returned an abundance of material exploring the characteristics of the population, treatment outcome studies, comparison of sexual and non-sexual offending, and several qualitative explorations. Prior to beginning the search, the original intention had been to look for studies exploring how youth first accessed treatment, though upon familiarization with the available research, it became obvious there was a gap in addressing these processes. Thus, an expansion of the area of interest was necessitated to include a broader timeline of the experience of children and youth with PSB: from identification through to treatment. Eventually, the timeline was expanded to 10 years to ensure the inclusion of a foundational study on participant perspectives of treatment with a strong focus on cultural needs oft-cited in other research (Geary et al., 2011). Studies that were ultimately excluded were studies outside the timeline of interest, such as those addressing prevention and exploring prior childhood experience. Moreover, those focusing on population characteristics, professionals' knowledge of PSB, treatment outcomes, and funding or training to implement PSB treatment programs did not provide insight into how children and youth with PSB experienced intervention and so, were excluded.

The 10 articles chosen (see Table 1) provide an international selection of qualitative explorations of the identification, post-disclosure and treatment experiences of youth with PSB; they include the voice of the youth themselves, their caregivers and the professionals providing

intervention. These articles will be critically analyzed to better understand how the knowledge of youth with PSB's experience is constructed. Studies will be examined by paradigms; sampling, recruitment, and participants; data collection; and data analysis.

Table 1

Summary of Research Articles

Author(s)	Title	Year	Research Method and Paradigm	Research Inquiry and Relevance to Current Paper
Balfe, M., Hackett, S., Masson, H., & Phillips, J.	Experiences of Young People with Harmful Sexual Behaviors in Services: A Qualitative Study	2019	Qualitative Constructivist	Study explored the characteristics and experience of youth with PSB in treatment and the issues treating professionals face when working with them. Treatment experience.
Geary, J., Lambie, I., & Seymour, F.	Consumer perspectives of New Zealand community treatment programmes for sexually abusive youth	2011	Qualitative Constructivist	Study sought to identify consumer perspectives of strengths and weaknesses of program delivery for community treatment programs for sexually abusive youth. Treatment experience.
Gervais, C.L. & Romano, E.	Safeguarding child rights and enhancing caregiver responsibilities among Canadian parents of youth who sexually offend	2018	Qualitative Constructivist	Study explores caregivers' sense of responsibility in situations where their child has engaged in sexual offending behavior. Post-disclosure experience.
Kelley, A., Shawler, P., Shields, J.D., & Silovsky, J.F.	A qualitative investigation of policy of youth with problematic sexual behavior	2019	Qualitative Constructivist	Study explores the community's perceptions of policies and policy reforms within systems addressing PSB of youth. Post-disclosure experience.
Kjellgren, C. (2019)	Perspectives of young adult males who displayed harmful sexual behaviour during adolescence on motive and treatment	2019	Qualitative Constructivist	Study explores how young adults remember their sexually abusive behaviour during their adolescence, how this behaviour was disclosed, how they experienced interventions, and how these memories affect their adult life. Identification, post-disclosure, and treatment experience.

Shawler, P., Silvis, V.G., Taylor, E.K., Shields, J., Beasley, L., & Silovsky, J.F.	Early identification of youth with problematic sexual behavior: A qualitative study	2020	Qualitative Constructivist	Study examines how disclosure and identification of youth with PSB occurs and reaches professionals. Identification experience.
Shields, J.D., Coser, A., Beasley, L.O., & Silovsky, J.F.	A qualitative examination of factors impacting family engagement in treatment for youth with problematic sexual behavior	2020	Qualitative Constructivist	Study examines facilitators and barriers to engagement of families in an evidence-based practice for youth with PSB. Treatment experience.
Shields, J.D., Klinkebiel, C.M., Taylor, E.K., Espeleta, H.C., Beasley, L.O., & Silovsky, J.F.	A qualitative analysis of family perspective on treatment services for youths with problematic sexual behavior	2018	Qualitative Constructivist	Study examines how treatment impacts family members thoughts, feelings, and behaviours. What strategies and processes are helpful/problematic and what their perspective is regarding how to improve treatment process. Treatment experience.
Tener, D., Newman, A., Yates, P., & Tarshish, N.	Child Advocacy Centre intervention with sibling sexual abuse cases: Cross-cultural comparison of professionals' perspectives and experiences	2020	Qualitative Constructivist	Study aimed to compare staff perspectives and experiences of working with sibling sexual abuse cases across two Child Advocacy Centres in different cultural and legal contexts. Post-disclosure experience.
Yoder, J.R. & Brown, S.	Challenges Facing Families of Sexually Abusive Youth: What Prevents Service Engagement?	2015	Qualitative Constructivist	What circumstances, situations, and contexts prevent families from becoming engaged in treatment? Treatment experience.

Research Paradigms

The authors of all 10 studies used a qualitative research design, rooted in a constructivist paradigm. Constructivism acknowledges that multiple realities and lived experiences shape our understanding of the world and seeks to explore the complexity of views to explain a particular phenomenon (Creswell & Poth, 2018). The following section will examine how paradigms

influence research and, what this paradigm tells us about the knowledge presented on the experiences of children and youth with PSB.

Constructivism

Constructivism rejects the idea that there is singular truth or objective reality to be discovered; rather that understanding of phenomena comes from understanding how humans have made meaning of their experience. A noteworthy tenet of constructivism is the desire to explain the phenomenon through the lens of those experiencing it (Costantino, 2008). Six of the 10 studies examined sought to introduce the voice of the youth with PSB and their families; the other four consisted of professionals reflecting the experience of youth and families. Furthermore, all but one study gathered these perspectives through semi-structured interviews with open-ended questions, allowing, as constructivism asserts, opportunity for participants to make meaning of their own experience (Creswell & Poth, 2018). Constructivism does not require researchers to distance themselves from their data, but rather to recognize how their backgrounds mold their interpretation (Creswell & Poth, 2018). As such, most of the authors of the chosen 10 studies worked in close proximity to youth with PSB and/or the systems that respond to them. Additionally, the researchers took on varyingly active roles in recruitment, data collection and data analysis. Tener et al. (2020), in particular, not only conducted their focus groups but also included a reflexive writing practice into their research design in order to remain aware and cognizant of how their ideas and feelings developed during the analysis process.

Another notable commonality within the 10 research studies was the presence of an intent to inform change to systems through their research. This is in line with more recent acknowledgement that research can advance social justice issues and that constructivism is in a position to do so through its production of knowledge and particular attention paid to the

researcher-participant relationship (Mertens, 2019). The research, and language, of youth with PSB is transformational in its attempt to challenge long-held and harmful beliefs, assumptions, and practices around children and youth as "sexual offenders". It is unsurprising then, that research about these young people looks to inform policy and practice. Geary et al. (2011) and Kelley et al. (2019) were explicit in their intent for their research to inform change to specific national programs, while Gervais and Romano (2018) made considerable efforts to engage parents by ensuring a handout would be co-created with their input to provide education to other Canadian parents. Finally, at least four of the studies were participating in a larger study, funded by an American branch of government, in which participating sites were funded based on a "commitment to a system-wide change effort for youth with PSB" (Kelley et al., 2019, p.1349).

Summary

The prevalent use of the constructivist paradigm in the study of children and youth with PSB suggests that researchers conceptualize this population's experience as socially-constructed, understood through the participants' lived experience, and holding the potential to inform change. A benefit of this conceptualization includes that knowledge of youth with PSB and how they access treatment is collaboratively constructed by researchers and those participating in the experience, identification, and treatment of PSB. Additionally, that tapping into the experience of vulnerable and marginalized youth with PSB is not merely to document and comment, but rather to inform necessary change and improvements to the systemic response to their behaviours. However, the exclusive use of constructivism in research on youth with PSB creates gaps, such as, a lack of information on prevalence, as well as the inability to show statistical relationships that may improve the facilitation of treatment for these young people.

Much of the research in the field of youth with PSB does not emerge from a postpositivist paradigm, that is, that there exists an objective reality in their experience. The quantitative methodology provides some hurdles to studying a high-risk, vulnerable population of unknown size. Random sampling would be difficult given the sensitive nature of the inquiries and the requirement of mandatory reporting. Furthermore, accessibility to criminal and clinical populations make it difficult to explore large numbers. Despite this, there is a great deal of knowledge to be gained from the postpositivist paradigm. Firstly, there appears to be overwhelming consensus that the true prevalence of PSB behaviour is unknown, leading to a great difficulty in assessing the magnitude and impact of research in this field. The postpositivist desire to use standardized tools and language may be of great benefit in creating some clear language around PSB; moreover, the postpositivist researcher often creates distance between themselves and the participants which could be appealing to this highly stigmatized population of caregivers and youth. Furthermore, quantification and statistical relationships are often important and deemed necessary in justifying systemic change; exemplified in showing relationships between current punitive practices and outcomes.

Examining how the constructivist paradigm influenced the 10 research studies allows for a greater understanding of the influence of the research findings. A predominant perspective was that participant experience could help inform change within the systems responding to youth with PSB. In the following section, the sampling, recruitment, and participant characteristics of the selected studies will be examined.

Sampling, Recruitment, and Participants

It is difficult to study large samples of youth with PSB because of accessibility to these vulnerable and often criminalized youth, in addition to relatively small numbers of youth with

PSB known to the systems (Finkelhor et al., 2009). Utilizing qualitative approaches allows for an in-depth examination of the experiences of youth with PSB with smaller samples that are easier to obtain. The researchers of all 10 qualitative studies used purposive sampling to identify youth with PSB, their caregivers, and professionals who could provide perspective on the experience of PSB. This recruitment was largely done at sites involved in the 'systemic response' and treatment of this behaviour, reflecting the experience of youth who had disclosed and engaged in some form of intervention. Systemic response includes the multi-disciplinary agencies that respond to PSB after disclosure by law or mandate; these include , but not limited to, education, child welfare, law enforcement, and criminal justice systems. Sample sizes of the 10 studies ranged from 12 to 293 participants. In this section, types of sampling, recruitment of participants, sample sizes, and participant characteristics of the studies will be discussed (see Table 2 for summary).

Table 2

Summary of Sampling Procedures

Study reference (Methodology)	Sampling strategy	Recruitment strategy	Participants
Balfe et al., 2019 (Qualitative)	Stratified purposeful	A stratified sample was taken from all cases sampled from nine services in the United Kingdom offering services to youth with HSB, falling in a nine-year timeframe.	n = 117 cases 95% male 95% White British 63% between 13-16 yo
Geary et al., 2011 (Qualitative)	Stratified purposeful	Staff approached all participants, (1) adolescents and (2) caregivers at three of 10 PSB-serving sites in New Zealand: SAFE Network (Auckland), WellStop (Wellington), STOP (Christchurch). Participants were then chosen to ensure diverse categories were sampled.	*(1) Adolescents:* n = 24 23 male, 1 female 25% Maori 80% between 13-17yo *Sampling categories:* 25% therapy resistant; 62% out of home caregiving; 33% intellectual disabilities; 21% conduct disorder; 17% substance abuse problems; 12% ADHD; 4% autism *(2) Caregivers:* n = 23

			33.3% male 33.3% Maori 50% "family members" (of range: parent, extended family member, step-parent, placement caregiver)
Gervais & Romano, 2018 (Qualitative)	Purposive	Hospital SW approached families attending a hospital-based unit in Ontario, Canada providing intervention for PSB.	n = 16 caregivers from 10 families 34-50 years 90% White, 10% mixed ethnicity *Relationship to youth with PSB:* 75% biological parents; 12.5% step-parents; 12.5% adopted parents 1-5 children per family 68.8% employed outside the home *Education:* 18.8% high school education; 50% college; 25% undergraduate studies; 6.2% graduate studies *Household income* $55,000-$200,000
Kelley et al., 2019 (Qualitative)	Purposive	An administrator at each site acted as a recruiter, contacting potential participants. The eight American sites were chosen through their participation in a OJJDP-funded project to establish evidence-based, MDT-led treatment programs for youth with PSB.	n = 219 professionals *Role:* 21.9% treatment agency administor; 29.7% treatment providers; 48.4% community stakeholders (ie: often MDT members) *No further demographics were shared*
Kjellgren, 2019 (Qualitative)	Purposive	Invitation letters sent to participants who had been referred for assessment after an incident of PSB involving another person in Sweden.	n = 22 young adults 12-18 years old at assessment of PSB 4-8 years had passed since assessment 17-26 years old at interview *Treatment received:* 50% specialized treatment; 36% general treatment for anti-social behavior; 14% no intervention 73% employed or studying 68% close relationship with FOO and frequent contact with friends 32% in relationship 14% were parents 41% engaged in formal counselling in past year
Shawler et al., 2020 (Qualitative)	Purposive	Site staff initially reached out to local professionals and caregivers; the research team then contacted to explain study and schedule interview. The eight American sites were chosen through their participation in a OJJDP-funded project to establish evidence-based,	n = 100 professionals and caregivers *Role:* 19 agency administrators; 27 treatment providers; 38 community stakeholders; 16 caregivers with children and youth with PSB *No further demographics were shared*

		MDT-led treatment programs for youth with PSB.	
Shields et al., 2020 (Qualitative)	Purposive	The clinical lead of each program approached caregivers, connecting them to the research team. The five American sites were chosen through their participation in a OJJDP-funded project to establish evidence-based, MDT-led treatment programs for youth with PSB.	n = 12 caregivers 36-67 years old 83.3% female 66.7% White; 25.0% African-American; 8.3% Hispanic *Youth with PSB relationship to caregiver:* 58.3% bio-children; 16.7% grandchildren; 8.3% adopted; 8.3% nephew *Education:* 8.3% some high school; 8.3% GED; 25% high school diploma; 25% some college; 25% associate's degree; 8.3% doctorate *Referral from:* 33.3% MH professional; 25% child welfare; 25% self-referral; 16.7% police; 8.3% juvenile justice; 8.3% court order
Shields et al., 2018 (Qualitative)	Purposive	Program exit survey was filled out by all exiting participants (1), while agency staff approached current and past caregivers for qualitative interviews (2). The seven American sites were chosen through their participation in a OJJDP-funded project to establish evidence-based, MDT-led treatment programs for youth with PSB.	*(1) Youth*: n = 144 10-14 years old 92.4% male 42.4% African American; 32.6% Hispanic; 15.3% Caucasian; 1.4% Asian; 6.9% mixed racial or ethnic heritage; 1.4% missing data *Referral source:* 31% child welfare; 21% CACs; 12% juvenile justice; 9% parent; 7% behavioural agencies; 5% law enforcement;14% other agencies (ie: school or medical) *Court status:* 32% charged with sexual offense; 14% adjudicated; 41% mandated to receive treatment *Caregivers:* n = 149 75.8% female 77% biological parent; 17% foster or kinship caregivers 29.5% Hispanic; 28.2% African American; 20.8% Caucasian; 2.0% Asian; 1.3% mixed racial heritage; 18.12% missing data *(2)* n = 30 caregivers 73.3% female 56.7% Caucasian; 20% African American; 6.7% Hispanic; 3.3% Asian; 13% missing data *No further demographics were shared*

Tener et al., 2020 (Qualitative)	Purposive	In Israel, the first author introduced the study and invited participation at a staff meeting (1). In America, the second author sent an email invitation to CAC staff requesting voluntary participants (2).	*(1) Israel:* 7 focus groups of 5-18 participants/each *Roles:* social workers, child investigators, police, a doctor, prosecutors, a case coordinator, and a secretary *(2) America:* 7 focus groups of 4-18 participants/each *Roles:* mental health professionals, law enforcement professionals, child welfare, CAC staff (including advocates, ED, forensic interviewers)
Yoder & Brown, 2015 (Qualitative)	Purposive, followed by snowball	Initially, efforts were made to contact all treatment providers on a list maintained by an American state sex offender management board. To increase numbers, participants used "word of mouth" to gather more participants.	n = 19 professionals (treatment providers) 68% female 84% white 84% urban 63% outpatient Average 44.7 years old and 13.90 years of service

Note. Purposeful and purposive sampling are used interchangeably depending on region.

Sampling Type and Recruitment

Purposive sampling was used in all 10 studies to reach youth with PSB, their caregivers and professionals involved in the systemic response to PSB. This type of nonprobability sampling enables the recruitment of participants that are closely involved with youth with PSB, thus able to provide in-depth knowledge about aspects of their experience (Elo et al., 2014). It does, however, exclude the perspective of those youth with PSB in the community who have not yet disclosed or engaged with interventions. Likely due to the limited numbers and vulnerability of youth with PSB, caregivers and professionals were also utilized as participants. Both these peripheral populations were in close proximity to youth with PSB, thus likely able to speak knowledgably to aspects of their experience.

Participants were primarily sampled through treatment sites. Sampling youth with PSB presents several challenges. The ability to approach these young people is often limited by consent procedures and legal restrictions. Due to stigma and the subjection to punitive measures, it is unlikely youth and caregivers would self-identify when approached in the community. This echoes previously identified limitations that state research has largely drawn from clinical populations out of necessity (Finkelhor et al., 2009). Recruiting through treatment sites ensured researchers access to the vulnerable population of youth with PSB and their consenting caregivers. For example, half the studies recruited participants through CACs, which also provided the researchers access to peripheral populations for sampling; in this case, the caregivers and professionals who can also speak to the youth's experience (Kelley et al., 2019; Shawler et al., 2020; Shields et al., 2020; Shields et al., 2018; Tener et al., 2020). However, a potential drawback of recruiting at intervention sites is the uncertainty, for youth and caregivers, of the effects of research participation on their treatment assessment. In six studies, site staff were used to recruit youth with PSB, their caregivers and professionals (Geary et al., 2011; Gervais & Romano, 2018; Kelley et al. 2019; Shawler et al., 2020; Shields et al., 2020; Shields et al., 2018). If youth or caregivers perceived any possible negative influence on their success or completion of treatment, it is possible they may have been more inclined to participate or share positive feedback only. Of those six studies, four approached their participants after the completion of interventions, thus likely minimizing this concern (Kelley et al. 2019; Shawler et al., 2020; Shields et al., 2020; Shields et al., 2018).

Four studies purposefully sampled youth with PSB in search of their perspective on how they experienced interventions (Balfe et al., 2019; Geary et al., 2011; Kjellgren, 2019; Shields et al., 2018). Two studies employed stratified purposeful sampling capturing additional layers of

the diverse realities of youth with PSB (Balfe et al., 2019; Geary et al., 2019). For example, Geary et al. (2011) sought to ensure their sample of youth with PSB included specific representation from Maori youth, engaged and resistant participants, young people with intellectual disabilities, and females. The inclusion of youth with delays and psychiatric comorbidities is important to ensure the knowledge created reflects and addresses the needs of the PSB population. A large-scale study (n=700) of youth with PSB (Hackett et al., 2013) found that 38% had a learning disability, compared to just 2% of the larger adolescent population. Leppink et al. (2016) found that young adults with PSB have higher prevalence of psychiatric disorders than a control group. Ultimately, seeking to represent and reflect the experience of diversity within the PSB population ensures that the policies, procedures, and treatments are informed by this knowledge and effectively meet the needs of the youth with PSB they serve.

Five studies sampled caregivers of PSB (Geary et al., 2011; Gervais & Romano, 2018; Shawler et al., 2020; Shields et al., 2018; Shields et al., 2020). All caregivers had navigated a portion of the youths' experience alongside them, predominantly treatment, and thus were likely able to credibly describe aspects of the youths' experience. Most of the caregiver samples also triangulated their participants, with two studies also sampling youth with PSB alongside (Geary et al., 2011; Shields et al., 2018) and one, professionals (Shawler et al., 2020). This too gives readers confidence that the findings speak credibly to the experience as it is reflected through two voices.

The professionals sampled were drawn largely from MDTs: agency staff, administrators, social workers, law enforcement, medical professionals, prosecutors, forensic interviewers, and treatment providers (Kelley et al., 2019; Shawler et al., 2020; Tener et al., 2020; Yoder & Brown, 2015). The only apparent requirement was that they may have had contact with youth

with PSB and/or an administrative function in the systemic response. Only Yoder & Brown (2015) specified a particular amount of experience, purposefully seeking out a portion of their sample to include treatment providers with 20 years, or more, experience to ensure a depth to the data shared. In contrast, two studies sought out professionals connected to CACs, resulting in a variety of MDT and community roles included (Kelley et al., 2019; Tener et al., 2020). The challenge is that some CAC roles, such as child advocates and forensic interviewers, may only have brief, one-time interactions with these youth and families, or possibly, only have supported victims of PSB and not the youth themselves. Thus, there is no assurance that the samples that did not specify a measure of experience can truly provide in-depth knowledge on youth with PSB. In summary, as knowledge of PSB is constructed, the inclusion of professionals can be valuable in providing expertise on the more formal aspects of the systemic experience of the youth. However, it may be important to articulate the level of experience or degree of proximity to the youths' experience.

Despite the well-chosen samples, only the voice of youth with PSB that are already involved in interventions is heard, as all three sampled populations were recruited through intervention sites. Stigma and the unique vulnerability of youth with PSB continue to play a restrictive role in sampling. Additionally, there is an absence of probability sampling techniques. These would give insight into incidence of PSB and further the possibility of representational findings in the future, however, there remains significant systemic and societal factors to overcome to do this. And so, qualitative exploration, and its constructivist roots, is decidedly compatible with the purposeful identification of youth with PSB and those in close proximity to them.

Sample Size

Unlike quantitative research, there is no pre-determined sample sizes that assure representation or saturation. In qualitative research, sample size should be determined by data saturation, where novel insights have dissipated, and findings are well-grounded in data (Hennink & Kaiser, 2022). Samples in the 10 included studies ranged from 12 to 293 participants (see Table 2). Those with smaller sizes consisted of in-depth explorations with participants. The larger sample sizes largely consisted of survey data supplementing the interviews. Only four of the studies included in this paper suggested data saturation was considered and gave at least some reference as to the point at which it was reached (Kjellgren, 2019; Shields et al., 2020; Shields et al., 2018; Yoder & Brown, 2015). By failing to speak to data saturation, the remaining six studies do not allow the reader to determine if the ideas that arose adequately encompass the participants' insights.

Participant Characteristics

Youth with PSB, their caregivers, and professionals related to the systemic response to PSB were sampled. Transferability speaks to how relevant a study's findings are to the population to which they are applied. This suggests that the heterogeneity of the known PSB population should be reflected in order to speak confidently to the transferability of this study's findings. In this case, caregiver and professional characteristics provide contextual information on the youth, giving readers confidence that these sampled populations are proximal enough to the youth with PSB to be able to accurately describe aspects of their experience. However, it is more meaningful that the description of the youth that the caregivers and professionals approximate is provided to determine transferability. The samples of youth with PSB reflected regional and racial diversity across samples, however, were overwhelmingly male and all were involved in the systemic or therapeutic systems of response to PSB. Caregivers were primarily

female, biologically related to the youth and racially diverse. In the case of the caregiver samples, the studies also provided sufficient information on the youth they approximate allowing readers some insight into the transferability of the studies. Studies with professional samples were largely American and included large numbers of MDT roles, such as police, child welfare, CAC staff, justice staff, and therapists. Some significant gaps were the perspective of youth not already in contact with the systems and that of female youth offenders. In contrast, American youth and males appeared excessively. Overall, a diverse representation of youth and their experience was provided across the 10 studies.

Youth with PSB

While some individual studies had relatively homogenous samples, diversity was reflected across all 10 studies. This included representation in age, race, ethnicity, region, and intellectual abilities (see Table 2). Males were overly represented, with the four studies reporting 95% of participants being male (Balfe et al., 2019; Geary et al., 2011; Kjellgren, 2019; Shields et al., 2018). Overall, race and ethnicity information was inconsistent or absent, leaving questions about whether these findings can be confidently applied to diverse racial and cultural groups. Ages ranged from 10 to 19 years old, which includes children and youth above and below the age of criminal responsibility in their respective countries. Regionally, the four samples of youth with PSB spanned four international countries (UK, New Zealand, Sweden, and America) providing global diversity in experience. While this geographical diversity requires the acknowledgement of variation in laws, responses, and culture, it provides the opportunity to highlight similarities and consistencies in the youths' experiences.

Caregivers and Professionals

The caregiver samples utilized in five of the studies were largely female (~62%-83%), racially diverse, and mostly reporting a biological relationship to the youth with PSB (~50%-83%) (Geary et al., 2011; Gervais & Romano, 2018; Shawler et al., 2020; Shields et al., 2018; Shields et al., 2020). The professional samples mostly provided the roles, though a range of MDT roles were represented: agency administration, child welfare, law enforcement, medical, prosecutors, and treatment providers. While demographic information on the caregivers and professionals is important contextual information, information on the youth with PSB whose experience these adults are describing is particularly relevant to transferability. Two studies sampled equal numbers of youth and caregivers, providing adequate contextual insight (Geary et al., 2011; Shields et al., 2018). Gervais & Romano (2018) sought to reflect the experience of the families of 10 male youth, between the ages of 10 and 15 years old, also providing us information on the victims and their relationship. This allows readers insight into the transferability of their findings to their own populations. Geographical diversity within the caregiving samples was also reflected with three studies emerging from the US, one from Canada, and one from New Zealand, again allowing us to draw conclusions about similarities across regions. However, the professional samples saw an overrepresentation in American voices, perhaps limiting the findings with a predominantly professional voice from relevancy in other regions.

The samples appear to reflect the heterogenous population of youth with PSB, however it is difficult to determine because the characteristics of the population are generally unknown. Therefore, it is important to use caution in applying the results to certain groups that are not well represented, such as females and indigenous populations as only one study intentionally sought this representation (Geary et al., 2011). This will likely make it difficult to apply these findings

to those already marginalized and underrepresented populations. Moreover, the samples all reflect the experience of youth with PSB who had accessed interventions or treatment. This presents a significant absence of the voice of youth who have yet to disclose, are unable to access services, or struggle to engage with treatment. It is unmistakable that those youth, and their families, could provide a much-needed perspective on what they required in order to access treatment.

Summary

The researchers of all 10 studies used non probability sampling to purposefully seek out relevant participants. This recruitment was primarily done at treatment sites, due to the challenges in accessing this population. Three distinct populations were utilized, all credibly able to speak to a part of the experience and systemic response to PSB. The strength in these samples is the triangulation of the data, using data from different groups, times, and places. Together the 10 studies provided a diverse reflection of youth with PSB in age range, race and ethnicity, and geographical location. However, ultimately there remained gaps, the most significant of which may be that youth with PSB who have yet to disclose or be identified are not represented in the samples. Their perspective would provide valuable insight into the barriers to treatment. Furthermore, transferability could have been bolstered had further contextual information, by way of additional demographics of participants and the youth with PSB served, been provided by the researchers who sampled professionals. Although the samples cannot possibly be considered representative of a broader population that is, yet unknown, purposive sampling is valuable in the study of youth with PSB.

Data Collection

The researchers of the ten studies used qualitative methods based in constructivism to gather their data. In this section, the timing and the methods of data collection will be discussed. The choice of collection method is important in relation to the information sought. As the researchers in the 10 studies pursued in-depth perspective on the experiences of youth with PSB, interview-based methods are a compatible choice. Furthermore, it is important that details on how information was obtained from participants are provided in order to make determinations about the narratives that were subsequently shared. All researchers utilized a cross-sectional design, extracting data either during or after treatment. This suggests participants likely had more insight into PSB and shared language with the researchers. The primary means of data collection were semi-structured interviews, calling attention to the importance of interview guides and protocol. These procedures provide insight into the efficacy of the questions and whether they were able to facilitate relevant information. Additionally, the ways in which participants' comfort and safety was addressed is especially important given the stigmatized and potentially difficult nature of sharing PSB experiences.

Timing

All studies used cross-sectional design, collecting data at a single point in time in the experience of the youth with PSB. This does not allow researchers to speak to causal relationships between elements of the experience of youth with PSB and how those may have affected their access to and/or engagement in therapy. However, the open exploration of the youths' experience facilitates the emergence of themes, discovery of new variables, and enables the collection of information on multiple aspects of the youth's experience at the same time. Cross sectional design allows for the creation of new perspective on the youth's experience, allowing for potentially new insights into the barriers and facilitators to treatment.

Two studies collected data from youth with PSB and caregivers during treatment (Geary et al., 2011; Gervais & Romano, 2018), while four studies collected data from youth with PSB and caregivers after the conclusion of their interventions (Balfe et al., 2019; Kjellgren, 2019; Shields et al., 2020; Shawler et al., 2020). Finally, the professionals sampled in three studies were concurrently working in the systems of intervention that address PSB (Kelley et al., 2019; Shawler et al., 2020; Tener et al., 2020; Yoder & Brown, 2015). A strength in all three of these cross-sectional timings is that all populations were sampled after some contact with systems and treatment. This implies that the sampled populations and the researchers shared some common language around interventions and treatment, likely minimizing the need for explanation or suggestion by the interviewers. In addition, the youth and caregivers would have improved understanding of systemic interventions and their PSB experience and thus, able to speak more confidently to the exploration at hand. However, there's an obvious gap in longitudinal timing, preventing the studies from being able to speak to experience across time. Furthermore, important information on treatment barriers and facilitators could be gathered from youth and caregivers before treatment were to occur.

Collection Methods

The majority of the 10 qualitative studies utilized semi-structured interviews and focus groups as the primary means of data collection. Interactive methods are well-suited to collecting in-depth information in an exploratory way. Researchers would do well to provide thorough understanding into their interview protocol. Due to the sensitive nature of PSB, the attention to language and comfort utilized within the interview is important to allow readers insight into how this may have affected the knowledge shared by participants. Additionally, exit surveys and case file review were also utilized in three studies.

Semi-Structured Interviews and Focus Groups

Eight of the ten cross-sectional qualitative studies utilized semi-structured interviews to explore the service experience, family involvement, and systemic response to youth with PSB (Geary et al., 2011; Gervais & Romano, 2018; Kelley et al., 2019; Kjellgren, 2019; Shawler et al., 2020; Shields et al., 2018; Shields et al., 2020; Yoder & Brown, 2015). Additionally, Tener et al. (2020) utilized focus groups. Both these types of data collection rely on interaction, are facilitated by a member of the research team, and are semi-structured using guiding themes of inquiry while also allowing for free narrative by participants. An important difference is that focus groups emphasize the creation of knowledge through dialogue between participants, while semi-structured interviews utilize interactions between an interviewer and single participant. Sharing interview protocol, such as what questions were asked, as well as who and where the interviews were conducted, is important to provide insight into how the data was obtained from participants. This includes considerations such as efficacy of the interview guide, the role of stigma, and the comfort of the participants.

Two studies utilized reference groups in the creation of their interview guides (Geary et al., 2011; Yoder & Brown, 2015). For example, Geary et al. (2011) consulted a critical reference group consisting of program staff, child welfare professionals, and Maori advisors to create their interview guides. These guides focused on program strengths, weaknesses and facilitated suggestions for improvement from youth with PSB and their caregivers; in addition, Maori participants were asked questions specific to met and unmet cultural needs in their experience. By engaging people with knowledge and expertise in the areas of PSB and/or culture to inform and review interview protocol beforehand, the researchers ensured their questions displayed

knowledge and understanding of PSB, cultural awareness, and elicited information relevant to their study.

The majority of the studies provided whole or partial sections of their interview guides, allowing readers insight into the interactions (Geary et al., 2011; Gervais & Romano, 2018; Kelley et al., 2019; Shawler et al., 2020; Shields et al., 2018; Shields et al., 2020; Tener et al., 2020; Yoder & Brown, 2015). Strengths in these interview guides were the open-ended language used like "please describe" and "tell me about", as well as, the intentional prompts for positive and negative influences on experience. The specific use of language helps to prevent leading and suggestive answers, while also giving the participants the ability to voluntarily share their unique perspective on what aspects of their experience are most relevant. A weakness that stands out in some interview guides is the use of stigmatizing language for PSB: sexual offending behaviour/youth (Gervais & Romano, 2018), sexually abusive youth (Yoder & Brown, 2015), and offenders (Geary et al., 2011). As previously discussed, this introduces bias and stigma by labelling the youth and behaviour in a developmentally inaccurate and/or perceptually-negative way. Youth and caregivers may feel stigmatized by the interviewer, thus affecting the information they share, whether intentionally or subconsciously.

Markedly, only one study explicitly acknowledged the ways in which they built rapport with their participants, acknowledging the difficulty for the caregivers to reflect on their sensitive personal experiences related to their child's PSB (Gervais & Romano, 2018). These intentional methodological additions likely nullified any perceived stigma for the participating caregivers in the researchers' choice of language (ie: sexual offending youth). Particular attention was paid by the researchers to limit traceable correspondence, assure confidentiality, and establish comfort "in safe, non-stigmatizing, and non-marginalizing ways" (p. 506) through activities such as

discussing matters via phone rather than email, delivering materials in-person and allowing caregivers to choose the location of the interview. They also exemplified prolonged engagement in a particularly involved way: facilitating feedback on the interview process, providing updates on dissemination, consulting before conferences and workshops, and most notably, the creation of a pamphlet for parents that interpreted their experience into informed practice. This likely allowed their caregivers a sense of purpose in their participation in this research, allowing them an active role in how this information could impact others.

Given the emotionally difficult and stigmatized nature of PSB, it was notable that the majority of researchers did not report the decision-making process as to the ways in which comfort, containment, and psychological wellbeing were accounted for during data collection. One way this may have been acknowledged was through logistics, such as assurances of confidentiality and explanation of secure data storage. Perhaps more importantly, the researchers could have referenced interviewer competency and/or psychological supports offered to participants. It would be important to know these were accounted for to determine if youth, caregivers, and professionals felt safe and able to share truthful and accurate accounts of their experience without fear of dysregulation, re-traumatization, and/or judgment.

Exit Survey and Case File Review

Survey and case file review were utilized in three of the qualitative studies (Balfe et al., 2019; Kjellgren, 2019; Shields et al., 2018). Two of these studies incorporated these as a second means of data collection in addition to interviews; this triangulation in data provides the reader confidence that the data likely accurately reflects aspects of the youth's experience.

Shields et al. (2018) utilized the YPSB Program Evaluation Survey, an exit survey created to aid in the evaluation of the CBT-PSB treatment program. The exit surveys provided the opportunity for youth and their caregivers to provide feedback on specific aspects of their service experience: knowledge change, amount of help received, and satisfaction with services. Most of the answers were provided on a 5-point Likert scale, while several open-ended questions at the end allowed for the youth and caregivers to share any other information not previously prompted. The researchers reported a p-value of <0.001, though this means very little as no null hypothesis is shared and very little information on the measure can be found. Regardless of this, by collecting data through exit surveys and semi-structured interviews, the researchers strengthened the credibility of the data collected through data triangulation, the survey capturing the breadth of youth and caregiver experience in treatment, and the interviews exploring the depth of these service experiences.

Two studies utilized the extensive case files of youth with PSB to gather data related to interventions (Balfe et al., 2019; Kjellgren, 2019). Balfe et al. (2019) provided broad categories such as sociological context, their offense characteristics, and personal issues. It can be assumed that Kjellgren (2019) was likely looking for specifics to corroborate participants' recollections of in the interviews, though this was never explicitly stated. The lack of decision-making and procedure details leave the reader unable to determine what aspects of the youth's experience was deemed relevant by the researcher, and which were left out.

Summary

As the researchers sought to explore the relatively unknown, diverse realities of participants' experiences, in-depth data collection methods are an appropriate choice. Furthermore, the cross-sectional timing utilized in all 10 studies allowed for the exploration of

multiple factors at one time, conducive to the exploratory nature of these studies. The semi-structured, open-ended nature of the interviews and focus groups allowed for participant-led narrative and suspends the assumption that researchers know all the variables and themes that will arise in the experience of youth with PSB. Many studies would have benefitted from explicitly referencing the steps taken to ensure the comfort and safety of the participants while recalling potentially distressing and/or stigmatizing experiences. The use of more than one method of data collection allowed for catching both breadth and depth of the youths' experiences.

Data Analysis

Researchers use data analysis to make meaning of the vast amounts of information they have collected. The 10 qualitative studies utilize thematic analysis and content analysis, both approaches analyzing data in search of themes and patterns. Data analysis speaks to how accurately the authors interpreted their participants' narratives into meaningful knowledge on the experience of youth with PSB. This is done through processes such as demonstrating logic and transparency in their analysis through description, investigator triangulation, and member checking (Creswell & Poth, 2018). This section will explore how the researchers utilized these in the analysis of their data.

Qualitative Analysis

Qualitative data analysis relies heavily on researcher interpretation and thus it is important that measures of trustworthiness are put in place to ensure that the meaning derived from the analysis accurately reflects the participants' views. All ten studies utilize thematic analysis and content analysis, approaches that are non-linear, in search of patterns, and

commonly used for the analysis of text-based data (Vaismoradi et al., 2013). Both require transparency in the description of process to show the logic of the researchers in reaching their findings, something nearly all the included studies detailed. Due to the significant reliance on researcher interpretation in qualitative data analysis, many of the studies spoke to the inclusion of multiple personnel in coding and analysis, also known as researcher triangulation, to demonstrate that independent researchers understood the depictions of the youth's experience in similar ways (Elö et al., 2014). Finally, three studies used member checking to confirm the accurate interpretation of their participants' perspectives.

Detailed description of the analysis process helps the reader to assess if the researchers made sufficient effort to ensure that their participants' realities are reflected in their findings. While this is important to both thematic and content analysis, it is especially critical in the thematic approach due to the descriptive nature and high level of influence the researcher has in coding and deriving themes. Nine of the 10 included studies detailed the steps taken in deriving meaningful conclusions from their data (Geary et al., 2011; Gervais & Romano, 2018; Kelley et al., 2019; Kjellgren, 2019; Shawler et al., 2020; Shields et al., 2018; Shields et al., 2020; Tener et al., 2020; Yoder & Brown, 2015). These studies exemplify transparency in their comparable descriptions of the data analysis processes undertaken: transcription of audio recordings, familiarization with the texts, coding, deriving themes and subthemes, seeking agreement, and further defining through discussion. Additionally, five studies named the exact methods of thematic analysis they followed (Kelley et al., 2019; Shawler et al., 2020; Shields et al., 2018; Shields et al., 2020; Yoder & Brown, 2015) and five shared the analysis software employed (Kelley et al, 2019; Shields et al., 2018; Shields et al., 2020; Tener et al., 2020; Yoder & Brown) leaving a clear audit trail for readers to follow. Unlike the other nine studies chosen, Balfe et al.

(2019) failed to describe the steps they undertook to make meaning from the 400 pages of narrative data they began with, leaving readers unable to determine how, or if, their themes reflected the youth's experience they sought to describe.

Researchers may also achieve trustworthiness by engaging in researcher triangulation (Elo et al., 2014; Nowell et al., 2017). This activity looks to demonstrate a kind of objectivity in the interpretation of the data by having two or more team members independently arrive at the same meaning (Elo et al., 2014). This is most effectively demonstrated during the coding process when two or more coders independently code the transcripts, compare their codes and report the agreement in simple percentage. Eight studies mention the use of multiple coders strengthening the trustworthiness of their findings (Geary et al., 2011; Gervais & Romano, 2018; Kelley et al., 2019; Kjellgren, 2019; Shields et al., 2018; Shields et al., 2020; Yoder & Brown, 2015). Furthermore, three studies report 80% or higher intercoder agreement, showing consistency in the way codes were used and increasing the likelihood that the participants' narratives were accurately reflected in the findings.

Member checking also helps to ensure research reflects the participants' perspectives in the final stages of analysis. This is done by presenting the findings to some or all of the research participants to elicit feedback as to whether they believe their perspectives were adequately expressed. Four studies detailed their engagement in these processes, ultimately providing readers with the sense that their findings meaningfully describe the experience of youth with PSB (Gervais & Romano, 2018; Kelley et al., 2019; Tener et al., 2020; Yoder & Brown, 2015).

Summary

The majority of the ten included studies demonstrated strong use of transparent description and researcher triangulation in their efforts to demonstrate accuracy in their qualitative data analysis. Several studies provided further assurance of trustworthiness by naming the specific thematic analysis processes used and reporting their intercoder agreement. However, there were far fewer studies that utilized later means of assessing accuracy, such as member checking. Overall, the use of these validating activities gave confidence to the reader that the researchers accurately conveyed the views of their participants on the experience of youth with PSB.

Ethical Considerations

Due to the particular vulnerability of youth with PSB, adherence to ethical guidelines is important to ensure their vulnerable positions are not exacerbated and their confidentiality is not compromised in the course of research (Canadian Institutes of Health Research [CIHR], 2018). Table 3 summarizes the ethical considerations in each study, highlighting those impacting vulnerability and confidentiality. All 10 studies spoke to institutional research board approval which implies that they met their respective institution and/or country's ethical requirements.

Table 3

Summary of Ethical Considerations

Study Reference (Population sampled)	Appropriate Institutional Approval(s)	Informed Consent	Vulnerability	Confidentiality
Balfe et al., 2019 (Youth files)	Approvals granted	Yes from agencies; No from youth in files	No discussion	No discussion
Geary et al., 2011 (Youth and caregivers)	Approvals granted	Yes	No discussion	No discussion

Gervais & Romano, 2018 (Caregivers)	Approvals granted	Yes	"Methodological sensitivities" built into procedure: rapport, feedback, long-term engagement, and member checking	Explicit mention of activity during recruitment, correspondence, informed consent, analysis and reporting
Kelley et al., 2019 (Professionals)	Approvals granted	Yes	No discussion	De-identification during transcription
Kjellgren, 2019 (Former youth with PSB)	Approval granted	Unknown	No discussion	No discussion
Shawler et al., 2020 (Professionals and caregivers)	Approvals granted	Yes	No discussion	No discussion
Shields et al., 2018 (Youth and caregivers)	Approvals granted	Unknown (surveys); Yes (interviews)	Brief mention of sensitivity of data sought	De-identified survey data was stored on secure, encrypted database; interview transcripts were de-identified and specific assurance given to interview participants about separation of agency and research staff
Shields et al., 2020 (Caregivers)	Approvals granted	Yes	No discussion	Brief mention of activities in correspondence, informed consent and storage
Tener et al., 2020 (Professionals)	Israeli approval granted; American approval unknown	Yes	Recognition given to comfort of participants in session	Anonymity of participants (no identifying information collected)
Yoder & Brown, 2015 (Professionals)	Approvals granted	Yes	Identified during informed consent	Brief mention of storage and use of aliases for participants

Ethical Guidelines

In Canada, ethical guidelines for research are set in the *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans* (CIHR, 2018). This document sets out three

main principles: respect for the persons, concern for welfare, and justice. As nearly all the participants were approached in treatment settings, it is also necessary to consider the professional standards of psychologists as set out by the *Canadian Code of Ethics for Psychologists* (Canadian Psychological Association [CPA], 2017). This guideline has four ordered principles: respect for the dignity of persons and peoples, responsible caring, integrity in relationships, and responsibility to society. While the majority of the studies were not conducted in Canada, these documents will be utilized to navigate the discussion around ethical considerations for the 10 included studies.

Vulnerability

Vulnerability is explicitly referenced in all principles of the CIHR's Tri-Council Policy Statement (2018) and the CPA's Code of Ethics for Psychologists (CPA, 2017). The CIHR (2018) dedicate an entire chapter to the importance of appropriate inclusion, particularly of children. Considerations include whether or not the research can be conducted without them, that only minimal risk is incurred, and if the benefits are in proportion to the risks (CIHR, 2018). While it is paramount in the guidelines, only four of the included studies referenced the particular vulnerability of youth with PSB (Gervais & Romano, 2018; Shields et al., 2018; Tener et al., 2020; Yoder & Brown, 2015) (see Table 3). Many of the youth exist in the intersections of several vulnerable positions, such as age, impaired cognitive and/or emotional functioning, members of historically-oppressed groups, and economic disadvantage; these positions result in limited capacity to consent, limited decision-making capacity, and limited capacity for self-determination (CPA, 2017; CIHR, 2018). In turn, the sampled caregivers must be considered both in recognition of the potential of risk for their own vulnerabilities and for their children's, in accordance with the CIHR's concern for welfare consideration (2018). This is especially

significant given nearly all caregivers identified as female and a significant portion identified as racialized, both intersecting, historically-oppressed groups (Gervais & Romano, 2018; Shields et al., 2018; Shields et al., 2020). Only two studies elaborated on their consideration for the vulnerability of the caregiver and their youth (see Table 3). Gervais and Romano (2018) provided extensive detail on how they built validation and collaborative goal setting into their research methodology. They did so by engaging the caregivers in meaningful output, review and confirmation of the findings, and ongoing input into how the participants' stories would be presented at conferences and in publication. This was intentional on the part of the researchers to allow the caregivers the sense that they were respected and that their input was being meaningfully put into practice. This thorough and prolonged engagement closely aligns with psychologists' ethical principle I.8, providing the opportunity for research participants to safeguard their own dignity, as well as principle IV.25, directing psychologists to take care in reporting information on vulnerable groups to ensure it is not misrepresented (CPA, 2017).

Nine of the 10 included studies briefly referenced having conducted informed consent for the research (see Table 3). Neither the CPA (2017) or CIHR (2018) dictate a particular age of consent, though the age of majority in Canada is 18 years. Individual provincial practice guidelines differ; psychologists in Alberta are encouraged to seek parental consent under 18 years or the determination of mature minor status (College of Alberta Psychologists, 2019). Interestingly, of the four studies that sampled youth under the age of 18 years and/or accessed their information, none referenced any consent or assent considerations around age (Balfe et al., 2019; Geary et al., 2011; Kjellgren, 2019; Shields et al., 2018). Furthermore, Balfe et al. (2019) failed to acknowledge how the youth in the case files had been either previously informed of how their information could be utilized or what steps may have been taken to de-identify the files

before researchers accessed them. This leaves readers unable to gauge the youth's understanding of their participation, how that may have influenced the information shared, and ultimately, their well-being for having participated.

Confidentiality

Due to the sensitive nature of PSB, and the potential for social and legal consequences in the event of a breach, confidentiality must be considered at nearly every stage of the research. Six of the studies shared some insight into how confidentiality was approached (see Table 3), including de-identification of data encrypted correspondence and data storage. Confidentiality is explicitly mentioned in the first three principles of the CPA (2017)'s guidelines, with emphasis on informed consent, right to privacy, offsetting harm, and openness. The research guidelines also emphasize informed consent and the ongoing ability to control how the information is utilized (CIHR, 2018). Both guidelines highlight the need to review limits of confidentiality and explicitly reference the ways in which confidentiality will be addressed through recruitment, raw data storage, and publishing. The most common consideration referenced in the studies was the de-identification of the data in the early steps of analysis. This ensured that while several researchers and assistants may review the transcripts over the course of analysis and writing, the participants information will not be freely available. Assuming this was communicated to participants during the informed consent procedures (CPA, 2017), participants likely felt confidence that their identities would be protected throughout the research.

Summary

As Table 3 summarizes, the majority of the studies spoke to ethical considerations only in the acknowledgement of institutional approval and informed consent. This left the reader

questioning how the researchers considered the dynamics of vulnerability and confidentiality within the research process. By acknowledging measures were taken, like the thorough example of Gervais and Romano (2018), the reader is left with confidence that the participants likely felt comfortable and valued, allowing them to share more honestly and openly knowing the information would be utilized to the benefit of other youth with PSB and their caregivers. Perhaps the biggest, and most surprising, weakness was the lack of acknowledgement as to the vulnerability of youth with PSB and their caregivers in many of the studies.

Findings

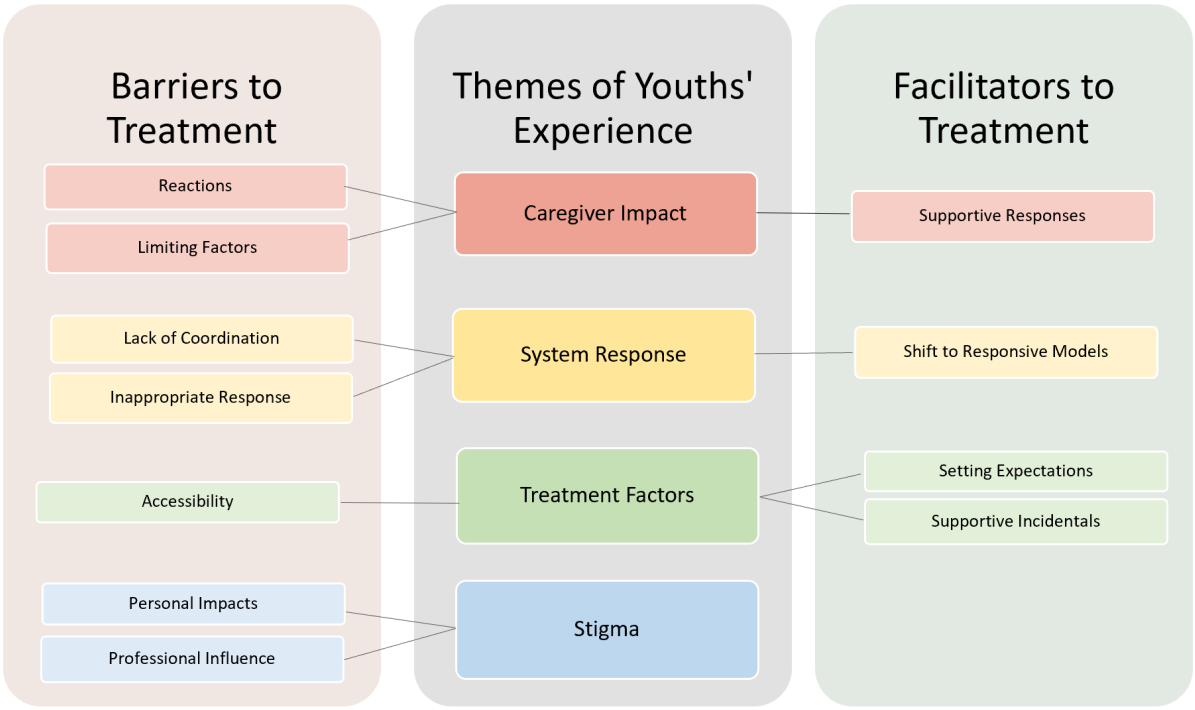
The studies' findings were analyzed to identify themes in youth with PSB's experience that may act as facilitators and/or barriers to their treatment. This process began with the creation of a table, in which each studies' findings were summarized in bullet points. Upon initial review, an additional column was utilized to jot down basic themes that arose. Next, the themes were reviewed for commonalities, grouped accordingly, and assigned a colour. The summarized bullet points were then colour-coded. For example, references to how official and community agencies responded to PSB appeared frequently, were highlighted yellow, and titled "System Response". A finding would sometimes speak to more than one theme and would be highlighted and subsequently underlined in both colours to capture this duality, such as examples of stigmatizing language falling to the theme of system response, as well as, stigma. After separating findings into themes, it became obvious that most themes could be categorized as both barriers and facilitators. Thus, each theme was then analyzed for subthemes, which emerged quite readily (see Figure 1).

Four main themes emerged as persistent elements of youth with PSB's experience: caregiver impact, system response, treatment factors, and stigma. A further 12 subthemes

developed as barriers or facilitators to treatment. Through the lens of attachment reference, the barriers reflect qualities of insecure attachment: inconsistent, unpredictable, reactive. In contrast, the facilitators display qualities of secure attachment: responsive, consistent, developmentally-appropriate. Caregiver impact recognizes the ways in which caregivers may impact youth accessing treatment. All 10 studies spoke to the crucial role that caregivers play in how youth with PSB interact with treatment. System response captures multi-disciplinary agencies and the systemic roles they play in responding to PSB. Most responses were found to be barriers, exacerbating difficulties within families and their ability to seek treatment. Treatment factors arose as an element of the PSB experience that can be considered both a barrier and facilitator onto itself. Lastly, stigma captures the roles of PSB misconceptions, shame, and the social consequences of these as barriers to treatment. Figure 1 was developed as a visual to demonstrate how the themes function as both barriers and facilitators.

Figure 1

Summary of Findings



Caregiver Impact

This theme looks at how variables related to caregivers, such as emotional reactions, living situations, and parental motivation, impact youths' experience accessing treatment. Research evidence has recognized the child-parent attachment relationship as fundamental in both the development of PSB behaviours, as well as their treatment. It is logical to explore how this attachment may impact youths' experience between the identification of their PSB and their access to treatment. The complexity of the interactions between youth with PSB and their caregivers was mentioned in all studies. Subthemes that arose as barriers were reactions and limiting factors, while supportive responses emerged as a facilitator.

Difficult emotional and behavioural reactions by caregivers upon learning of their child's PSB featured as a predominant idea in several studies (Gervais & Romano, 2018; Kelley et al., 2019; Shawler et al., 2020; Yoder & Brown, 2015). Caregivers and professionals in these

samples reported largely negative emotions, such as anger, shock, distress, fear, and grief. The behavioural reactions noted give insight into how the caregivers navigated these difficult emotions, and more importantly, how the youth experienced these. Gervais & Romano (2018) reported caregivers reacting in anger and judgement, often not talking to their child for some time after the PSB was discovered and asking them to move out. Yoder & Brown (2015) found families were unprepared to manage the multitude of emotions, evidenced by reactions like blaming the other parent, isolating from social supports, and turning away from systems. Furthermore, all four studies spoke to parental fear of reporting that prevents parents from accessing intervention for their child. These emotional and behavioural reactions suggest a barrier to accessing treatment for PSB. Parents appear less likely to access treatment due to fear, while youth may be less able to engage as they fear similar emotional or behavioural reactions from the therapist.

While the subtheme of reactions demonstrates interpersonal difficulties navigated by youth in their PSB experiences, limiting factors speak to external circumstances that influence caregivers' impact on accessing treatment for their youth with PSB. These factors include unstable or disrupted living situations and lack of logistical resources to navigate legal demands. For example, just over half of the studies reported unstable or ruptured living arrangements as having presented difficulties for youth, including removal from caregivers' homes, residential treatment settings, and incarceration (Balfe et al., 2019; Geary et al., 2011; Gervais & Romano, 2018; Shields et al., 2020; Tener et al., 2020; Yoder & Brown, 2015). Additionally, several studies spoke to how caregivers were required to meet the inflexible demands of the legal system, leaving no time, resources, or attention for therapeutic participation. Limiting factors

suggests that caregivers' impact on their child's path to treatment was often restricted by factors outside their control.

As a facilitator to treatment, supportive responses illustrate the ways in which caregivers effectively responded to their child's PSB and/or engaged with treatment. For example, Shields et al. (2020) noted that caregivers overwhelmingly spoke to their own motivation to help their child, as well as extended familial encouragement and support, as having been fundamental to overcoming numerous systemic and logistical barriers to treatment. Gervais & Romano (2018) similarly reported caregiver responsibility, through the establishment of safety plans and push for system involvement despite opposition, as having had positive impact on the youth with PSB's access to treatment. Additionally, Geary et al. (2011) and Shields et al. (2018) reflected on the benefits of the family and extended network support for the youth. These findings together suggest that youth are able to access and engage in treatment successfully when their caregiver is able to respond in supported and supportive ways.

The theme of caregiver impact emerges from all three sampled populations (youth, caregivers, professionals) and across all sampled countries. This consistency suggests that this element of youth with PSB's experience plays a role globally, and is important to facilitate youth's access to treatment. The subthemes highlighted the importance of parental support and regulation for youth with PSB and the impact that external circumstances can play on caregivers ability to do provide those.

System Response

The second theme describes the multi-disciplinary agencies that play a systemic role in responding to PSB after disclosure; these include education, child welfare, law enforcement, and criminal justice systems. Overwhelmingly, it was noted that youth and caregivers currently

experience a wide variety of systemic responses, within and across regions (Balfe et al., 2019; Gervais & Romano, 2018; Kelley et al., 2019; Kjellgren, 2019; Shawler et al., 2020; Shields et al., 2018; Shields et al., 2020; Tener et al., 2020; Yoder & Brown, 2015). The subthemes of lack of coordination and inappropriate response were identified as barriers to treatment, and shift to responsive models as a facilitator.

The lack of coordination in systemic response emerged across all sampled populations and nearly all countries. Caregivers and professionals in the American studies highlighted the lack of clear policy at all levels as contributing to inadequate communication, coordination, and understanding of agency responsibility (Kelley et al., 2019; Shawler et al., 2020; Shields et al., 2018; Shields et al., 2020). A common example of this was families reporting PSB to child welfare, only to receive no response, no connection to other resources and/or no support in notifying other authorities (Kelley et al., 2019; Gervais & Romano, 2018; Shawler et al., 2020). Other difficulties caregivers reported were the inability of MDTs to coordinate concurrent services and the seeming lack of knowledge by authorities within the system as to what treatment was available. The Swedish experience of PSB echoed this lack of standardization, finding youth with PSB experienced a multitude of interventions, with unclear reasoning as to why (Kjellgren, 2019). This evidence suggests that even when PSB is identified, the lack of clarity and siloed efforts of responding agencies prevent youth and families from accessing treatment in many cases.

Many studies also described systemic responses that could be defined as developmentally inappropriate. The most prevailing examples were the language and punitive measures utilized by professionals responding to PSB. Shawler et al. (2020) reported caregivers fear of reporting was often reinforced by their experiences with law enforcement; feeling alienated by the

language used to describe their young children, such as ‘perpetrator’ and ‘sex offender’. Furthermore, one caregiver shared a situation in which a child under the age of 10 was subject to an aggressive interrogation (Shawler et al., 2020). Studies often described children and youth being treated as criminals and adult offenders. Overall, these inappropriate responses show a lack of understanding as to the developmental capacities of children and youth; moreover, shows little awareness of the research evidence around PSB. As treatment can be seen as an extension of these systemic responses, youth and families may be less likely to access or engage in treatment after initial system contact, a finding echoed by Yoder & Brown (2015).

While the barriers of system response were prevalent, three studies spoke to the subtheme of shift to responsive models. Geary et al. (2011) spoke to how New Zealand requires a national response to PSB that incorporates both a culturally responsive, holistic health model and a PSB treatment framework that recognizes varying cognitive abilities. Similarly, Tener et al. (2020) reported on Israel’s 2008 law that mandated CACs in response to child sexual abuse, which inevitably encompassed a great deal of the response to PSB. In addition, the authors spoke to a cultural focus on family in response to PSB and an option to treat therapeutically instead of criminally (Tener et al., 2020). Finally, Kelley et al. (2019) spoke to a slow shift in the American response to PSB, with the NCA advocating for less prosecution of youth with PSB and more MDT collaboration. These international examples show promising alternatives to punitive responses, directing clear paths to treatment for youth with PSB and their families.

System response were found to be barriers to treatment across most populations and international borders. However, there is much to learn from the inclusive, cultural-focused models used in New Zealand and Israel.

Treatment Factors

The included studies primarily collected data during and after treatment, there was considerable knowledge accrued on elements of the treatment itself that act as barriers and facilitators. Three subthemes arose: availability as a barrier, and setting expectations and supportive incidentals as facilitators.

The subtheme of availability encompasses how treatment is made available to children, youth and families, something mentioned in most of the studies. Sampled professionals and caregivers predominantly reported the limited availability of these treatment programs (Gervais & Romano, 2018; Kjellgren, 2019; Shawler et al., 2020; Shields et al., 2020). Common logistical barriers were no regional availability, long commutes, restrictive program hours, childcare, and cost. Two studies highlighted the lack of referrals to treatment after reporting (Kelley et al., 2019; Shawler et al., 2020). These findings suggest that without accessible services, youth and families are unable to engage in treatment even if they were motivated to do so.

For youth with PSB and caregivers who had experienced treatment, setting expectations emerged as a facilitator. Most evidence-based treatments for PSB have clear skill-building goals for both the youth and the parents. Most treatment participants reported to have found benefit from psychoeducation on sexual behaviours and boundaries, as well as emotional regulation, communication and routine setting. Both caregivers and youth identified that having this information prior to commencing treatment was beneficial in understanding the purpose of accessing therapy. The young men who had experienced variations of treatment in Sweden after their own PSB retrospectively emphasized the importance of treatment that directly acknowledged their sexual behaviour (Kjellgren, 2019). Overall, this suggests that youth and caregivers may be more motivated to participate in treatment if the goals and benefits were more widely known.

While not widely mentioned, several secondary factors emerged as noteworthy qualities of treatment. These supportive incidentals included details like how information was presented, environment, and staff characteristics. A welcoming environment underscored the importance of attention to the physical surroundings, refreshments offered, and friendly staff (Geary et al., 2011; Shields et al., 2020). Moreover, specific therapist characteristics were expounded upon as a key factor to treatment engagement. For example, Geary et al. (2011) reported a multitude of therapist features that were seen as influential: understanding, challenging, respectful, non-judgmental, humorous, and taking a genuine interest in the youth. These findings suggest that providers could reap big rewards from a relatively small investment in the environmental details of therapy to facilitate and maintain engagement.

The accessibility of treatment must recognize the ways in which the treatment itself encourages or prevents participation. The subthemes of expectations and supportive incidentals found that overall, caregivers and youth reported a positive experience with treatment, having benefitted from proven outcomes and a felt sense of being welcomed in the process. However, the availability of treatment for youth with PSB and their caregivers is hindered by systemic logistics and lack of resources.

Stigma

Stigma surrounding misconceptions about PSB was prevalent in nearly all the studies. The language used to describe children and youth with PSB illustrates the misconceptions that fuel this stigma: pedophiles, criminals, perpetrators, sex offenders, and perverts (Balfe et al., 2019; Kelley et al., 2019; Shawler et al., 2020; Tener et al., 2020; Yoder & Brown, 2015). As discussed previously, research evidence refutes these assumptions and labels. These

misconceptions act as barriers in the youth's experience in two ways, as personal impacts and professional influence.

Personal impacts encompasses youth with PSB and caregivers' individual feelings of shame, fear and guilt. Several studies suggest these feelings led many families to fail or delay reporting, participating in interventions, and accessing treatment (Gervais & Romano, 2018; Kelley et al., 2019; Shawler et al., 2020; Yoder & Brown, 2015). Kjellgren (2019) demonstrated long lasting impacts of this stigma, reporting that these feelings still stood in the way of young adults seeking treatment years later.

Stigma demonstrated through professional influence also stood out as a barrier to treatment of youth with PSB. Kelley et al. (2019)'s findings spoke to the history of treating children with PSB as criminals, and acknowledged that the professional and political use of stigmatizing labels and language plays a role. Perhaps the most striking examples of how stigma influences professional attitudes and actions emerge from Tener et al. (2020)'s cross-cultural MDT focus groups on sibling sexual abuse by youth with PSB. One American CAC professional shared the opinion that youth with PSB should be registered as lifetime sex offenders and subsequently implied they do not endorse or refer to treatment as a result. An Israeli professional showed profound bias when they suggested that therapeutic alternatives to criminal procedures take away the victim's right "to punish or take revenge" on the sibling with PSB (as cited in Tener et al., 2020, p.10). These examples illustrate how misconceptions about PSB by professionals within the system act as very real barriers to treatment for youth with PSB.

Summary

Four prevailing themes emerged from the experience of youth with PSB: caregiver impact, system response, treatment factors, and stigma. Variables within each of these themes

acted as barriers and facilitators to treatment. The facilitators - supportive responses, shift to responsive models, setting expectations, and supportive incidentals - exemplify consistency, responsivity, and predictability. Youth are then provided conditions that foster emotional regulation, connection, and meet their individual needs; facilitating both the ability to access and engage in treatment. On the other hand, the barriers that emerge from youth's experience work quite adversely to these secure conditions. The seven barriers have in common inconsistent, unpredictable, and reactive responses. As PSB has been theorized as a maladaptive means of managing insecure attachment, it would then follow that these responses would exacerbate those patterns in youth. To improve access to treatment for youth with PSB, conditions of secure attachment must be fostered.

Clinical Applications

To ensure youth with PSB and their caregivers have consistent access to treatment, we must find ways to expand upon the facilitators discussed and address the barriers. Attachment theory provides a lens for this discussion. By addressing the insecure qualities of the treatment barriers, we can ensure that caregivers, systems, treatment, and the societal perception of PSB consistently meet the needs of the youth they purport to serve. Clinical applications will address three areas of relevance for therapists: education, membership in the MDT, and attention to systems.

Therapist Education

Several of the findings suggest that even professionals working regularly with PSB operate on misconceptions and emotional feedback, rather than research evidence. Barriers discussed above, such as reactions, limiting factors, inappropriate responses, and stigma, show this common thread of reactivity and lack of knowledge, leading to the inability to meet the

needs of the youth. Therapists unfamiliar with PSB may work off some of these same assumptions and be quick to assume their own level of competency in this field. This may lead to responses such as adherence to potentially harmful systems, a tendency to refer out to scarce and/or overburdened treatment resources and providing misinformed direction to families.

The American Psychological Association (APA) and the CPA recognize the importance of bias management for therapists (Britton, 2009; CPA, 2001); this can be facilitated through writing assignments and discussions with peers and supervisors. Encouraging future therapists to reflect on their own reactions to and understanding of PSB is crucial in building competency in this area (APA, 2009). In these reflective discussions, it may be necessary to use more common terms, such as juvenile sex offender, to ensure the topic is recognized and the responses that follow relevant. These reflections may begin with questions like "what do you know about youth who sexually offend?" or "when you hear the term *juvenile sex offender*, what comes up for you?". These explorations may open the examination around misconceptions, level of knowledge, and emotional reactions. Furthermore, it is important for one to reflect on how these internal processes show up in the therapeutic relationship. Questions such as "if you were working with a young person and found out they had been charged with child sexual assault, how might that change the way you worked with them?" or "if your client had displayed PSB, would their age affect your perspective?". More experientially, the use of case studies and case conceptualization can facilitate the exploration of counter-transference and its' role in interventions. Introducing theoretical clients, such as parents enquiring about their child's sexual behaviour or a young person with PSB mandated to attend therapy, can facilitate the identification of strong feelings or reactions that may impact a therapist's ability to provide

treatment (CPA, 2017). This allows therapists the opportunity to address these challenges in discussion with peers, supervisors, or their own therapist.

Further promoting therapist education in PSB requires a solid foundation in child and adolescent sexual development and behaviour. Educational programs should be encouraged to include sexual development within their courses on child and adolescent mental health and/or sexuality. This will promote the understanding that sexual behaviours do exist in children and young people, on a spectrum of typical to concerning. Furthermore, it is important for adults to understand how child sexual behaviour often differs from adults in motivation; behaviours typically prompted by curiosity and enjoyment in childhood rather than sexual gratification (Chaffin et al., 2008; True, 2019). According to a 2008 report from the Association for the Treatment of Sexual Abusers (ATSA) Task Force, assessment of PSB can be done by registered mental health professionals that have competency in child and adolescent mental health; particularly, familiarity with typical child sexual development, differential diagnosis of common childhood problems, and knowledge of current evidence-based treatment approaches (Chaffin et al., 2008). The ATSA Task Force also echoed the significance of the caregiver-child relationship in treatment.

Therapist education as a clinical application focuses on addressing barriers in the youths' experience linked to reactivity and denial of attachment needs. Through this lens of attachment, security is fostered through the teaching and modeling of healthy emotional regulation strategies, including seeking out support when needed (Johnson, 2019). In addition, one must have some knowledge of the required needs of youth with PSB in order to respond to them. The clinical applications suggested in this section emphasize these strategies. Through reflection and bias management, therapists become aware of emotional reactivity and the management of this

through connection to their supportive network. Moreover, increased education around child development and typical sexual behaviours ensures that there is recognition of the needs to be met.

Therapist as a Member of the MDT

Several of the findings in this paper indicate a lack of communication and connection between the systems that respond to PSB, thus creating barriers to treatment for youth with PSB (Balfe et al., 2019; Kelley et al., 2019; Tener et al., 2020). Limiting factors, lack of coordination, accessibility, and the professional influence of stigma emphasize the often-siloed nature of agency work that can prevent youth from accessing treatment. It is possible that MDT members feel restricted by their respective mandates and guidelines. In some cases, it also appears that MDT members may fail to see how they are perceived collectively as 'the system'. On the other hand, the subthemes of shift to responsive models and supportive incidentals highlight the positive impacts of system coordination on youth with PSB's access to treatment. This can include a sense of 'borrowed' rapport from one profession to the next.

Therapists must adhere to rigorous ethical standards around confidentiality which may prevent them from engaging with other MDT members. In Canada, the ethical guidelines for psychologists (CPA, 2017) contain considerable guidelines around confidentiality and the assurance within the therapeutic relationship that clients' information is kept private for their dignity and benefit. In strict adherence to these, a therapist cannot even confirm or deny that a client is seeing them in most cases. However, the findings argue that in the case of youth with PSB and caregivers concurrently navigating several systems, logistical information sharing may be in the client's benefit. This reiterates existing recommendations that emphasize collaboration throughout services and suggests the development of supporting policy to allow this (Chaffin et

al., 2008). In the province of Alberta, as an example, the *Children's First Act* (2014) prioritizes information sharing between service providers if determined to be in the best interests of the child. This legislation was created to facilitate the coordination of services to address children's health and safety and encourage collaboration between agencies to enhance the delivery of services (Government of Alberta, 2014). While this act does not override the CPA's guidelines for psychologists, it should encourage therapists to consider how they participate in MDT communication for the benefit of their client. Practically, this may first be a reflection or risk-benefit assessment, followed by consultation with supervisors or peers. Therapists could consider the creation of a consent to release form specific to multi-disciplinary collaboration. This form would elicit ongoing conversation with the youth and caregiver to determine risks and benefits and promote coordination with the MDT. This too is in line with previous recommendations encouraging the inclusion of caregivers and youth as part of the MDT decision-making process to determine shared goals, and clarity as to the responsibility of each member in reaching those (Chaffin et al., 2008). Understanding that communication as a member of the MDT can address several barriers to treatment should motivate therapists to improve their participation in the MDT.

The subtheme of lack of coordination for systemic response highlighted that some agencies did not see themselves as part of a larger response model, made clear by the examples of child welfare receiving reports of PSB outside their mandate and not ensuring follow-up to the appropriate authorities or resources. Furthermore, under the theme of stigma, more than one professional declared their bias against therapy, which determined their decisions not to refer youth with PSB to treatment in sibling sexual abuse cases (Tener et al., 2020). These examples spotlight the fragmented response that acts as a barrier to treatment for youth with PSB.

Therapists may react to these responses by distancing themselves from these agencies. As Yoder & Brown (2015) found though, many families consider the therapist and treatment as part of the bigger system, their distrust playing out in therapy dynamics. With this in mind, 'therapist as a member of the MDT' can be a powerful reflection for therapists, checking in on their own biases of the system. While this bias management is important in session with clients, it may be equally important at the multi-disciplinary table. As MDTs increasingly become the standard response, particularly in the form of CACs, each member must consider how the others may affect youths' relationship to the MDT. There must be recognition that a punitive or inappropriate response by one MDT member may act as a barrier for the professionals that closely follow. While this erosion of the youth with PSB's relationship to the system was illustrated in the findings, so too was the building. The subtheme of supportive incidentals highlighted the ways in which effective interpersonal qualities facilitated treatment, mostly describing therapist characteristics. Therapists may play a role in the MDT in educating the team on these potential positive effects of shared rapport. Therapists can not only challenge their own biases but facilitate the opportunity for the MDT to challenge theirs.

Therapist as a member of the MDT seeks to address barriers to treatment associated with lack of communication and safety. Trust, communication, and connection foster security in attachment relationships (Mónaco et al., 2019). The clinical applications in this section first address how a therapist might ethically participate in connection through communication, before addressing how trust is fostered within those multi-disciplinary relationships.

Therapist Attention to Systems

The final clinical application addresses the role therapists play in addressing the barriers to treatment at a higher level. Barriers such as lack of coordination, inappropriate response,

accessibility and stigma reflect inflexibility in thinking and behaviour on the part of the system as a whole. This calls for recognition of the research on PSB and advocating for system change. The code of ethics for psychologists (CPA, 2017) promotes therapists' responsibility to society in increasing societal knowledge and promoting the welfare of all humans. While the guidelines recommend respecting consensus in relation to social structures, they also advise the duty to contend those policies that ignore or oppose these ethical principles in advocating for change. Chaffin (2008) published a call to action from the American field of PSB that opposed the increasingly harmful responses to children and youth with PSB and asked the larger field of child abuse and child protection advocates to join the public educational efforts against the misinformation on PSB. Many of these same punitive responses are in practice here in Canada, including a criminal age of responsibility below that recommended by the 2007 meeting of the United Nation's Convention on the Rights of the Child and disproportionately high rates of youth arrests for sexual crimes (Varma & Leroux, 2019). In 2017, the NCA answered this call in a significant way. They developed several evidence-based, educational materials, including handouts and an online course. Perhaps most significantly, as an international leader in child sexual abuse, the NCA also called on CACs to consider leading the response to and the coordination of treatment for youth with PSB and continues to fight for national standardization (NCA, 2017). As psychologists are often looked to as leaders in the community, they play a role in advocating for systemic change for youth with PSB.

While advocating for systemic change may seem like an overwhelming task, this can be approached from a personal, organizational, and local level. Attention to systems at a personal level may look like a therapist familiarizing themselves with their regional system of response to PSB. This may begin with an online search of resources, such as provincial policy. It may also be

helpful to see what direction is recommended by their local CAC, sexual assault centres, child welfare, and policing agencies. At an organizational level, therapists can call attention to systems by supporting the use of person-first language and facilitating learning opportunities. Suggesting their clinic or agency use terms, such as children and youth with PSB, can encourage awareness in coworkers and the creation of policy for long-lasting change. In some agencies, education may be required before a change in language and understanding can be facilitated. For example, therapists within CACs may require a multi-disciplinary committee to allow for conversation and education around person-first language. These educational opportunities could be facilitated through informal 'lunch and learns' on key aspects of child sexual development, PSB, and the role that parenting and attachment plays. There are several helpful resources to facilitate this, such as True's Traffic Lights: Sexual behaviours in children & young people (2019), as well as Hackett's Children and young people with harmful sexual behaviours: research in review (2014). Finally, at a local level, therapists can look at system navigation and creating a network. This could entail creating a consultation list, not only with clinicians who serve children and youth with PSB, but MDT members that help in the navigation of systems of response.

Attention to systems addresses the barriers to treatment that are characterized by rigidity in response and unpredictability. While these qualities may seem contradictory, it is through the repeated experience of being unable to predict the response of others that one can become inflexible in their own patterns of thinking and behaving (Johnson, 2019). When an individual's energy is consumed in anticipation, there is little energy to take in new information and revise ways of thinking and behaving. The clinical applications in this section encourage addressing the systems' rigidity by introducing new information and revising the current patterns of response.

This can be done by creating some stability in the navigation of the systems and more advocacy for flexibility in responses.

Summary

The clinical applications developed from this study's findings include therapist education, therapist as a member of the MDT, and therapist attention to systems. Specific recommendations within these applications include building child sexual development into training, increasing MDT participation and communication for the youth's benefit, and familiarizing oneself with local resources. The clinical applications seek to utilize secure attachment strategies to facilitate youths' access to treatment; managing emotional reactivity, seeking connection, and increased flexibility are examples of these.

Conclusion and Recommendations for Future Research

This paper sought to identify barriers and facilitators to treatment for youth with PSB. The findings of this study show four common themes that arise within the experience of youth with PSB (see Figure 1 for summary). A review of the literature shows that several evidence-based treatments have been shown to be effective in improving behavioural outcomes, as well as familial functioning (Dopp et al., 2017; Chaffin, 2008). Further, there is increasing evidence to support more short-term, community-based interventions, over the more long-term, restrictive interventions that are often assumed to be necessary (Chaffin et al., 2008). However, less was reported about how youth access these treatments. In this study, subthemes emerged from the four themes of youth's experience that help understand treatment barriers and facilitators for these youth. The barriers had in common emotional reactivity, inconsistency, and lack of understanding as to the needs of youth with PSB and their families. In contrast, the facilitators suggested common elements of communication, consistency and predictability. Overall,

developmentally uninformed myths and assumptions about PSB and a system focus on the well-being of the victim leaves youth with PSB and their families with inconsistent access to treatment.

The researchers of all 10 qualitative studies used a constructivist paradigm. From the constructivist perspective, interactions between interviewer and participant are where knowledge is created (Creswell & Poth, 2018). This allowed for deep examinations of the participants' experiences. This also provided participants the opportunity to identify relevant aspects of their experience, reinforcing the idea that participants are experts in their own experience.

Given the prevalence of stigma, reinforced by inappropriate system response, there is a need to ensure increased education on PSB. Chaffin (2008) published a call to action to address these harmful rhetoric and policies, directed towards government, professionals, and child abuse advocates; it is still widely referenced and yet, appears to have been largely ignored by the two former addressees. For therapists themselves, this would involve self-reflection on biases, and training on child and adolescent sexual development. Moreover, therapists may then play a role in educating and challenging biases within MDTs and the larger systems. These findings hope to inform a shift in the way children and youth with PSB are responded to. Systemic response and interventions should be informed, consistent and regulated to meet the youths' needs.

There are limitations to the findings and their application. Most of the knowledge in this field comes from America and the UK. While the inclusion of international studies allowed for the exploration of commonalities across the global experience of PSB, it limits the consideration of differences. This results in Canadian agencies needing to make a great deal of assumptions about the relevancy of this material to their populations, policies, and laws. Additionally, only two studies provided insights into the role of culture, suggesting it has significant influence on

the experience of youth with PSB and their treatment. This highlighted an important gap of knowledge on cultural consideration and influence. Finally, there is growing extant literature around the clinical and legal population of youth with PSB, but there is an evident gap in what we know about PSB in the community. This includes prevalence, identification, system notification, and systematic tracking of PSB.

Considering these gaps, I would recommend future qualitative research expand upon the Canadian experience of PSB. Geary et al. (2011) brings attention to the importance of consistent, nationwide models that simultaneously consider inclusivity and culture. As a geographically vast country with varying levels of government, Canada has unique challenges to implementing federal consistency. Another area of future expansion would be on cultural influence and consideration. Tener et al. (2020)'s study highlights how culture can play a mediating role on stigma and system response. Furthermore, tools for identifying and assessing PSB often highlight that culture should be considered (Hackett, 2014; True, 2019), however, cultural discussion and application is rarely emphasized in research. Finally, I hope that future quantitative research can find ways to explore the prevalence of PSB in general populations. This should include who and how PSB is identified within the community, and further, how it comes to the attention of responding systems. This may require some examination of the systemic tracking of PSB, given the gaps highlighted in this study.

In this analysis, I explored the experience of youth with PSB and identified treatment barriers and facilitators. I recognize a need for considerable change within our current systems. I believe that therapist education and advocacy will allow for youth with PSB's needs to be met in secure and responsive ways, thus facilitating treatment access.

References

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. DOI:10.1080/10538712.2019.1573390

Bowlby, J. (1969). *Attachment (Second Edition).* Basic Books.

Britton, P.J. (2009). *Teaching tip sheet: Counselor attitude bias.* American Psychological Association. https://www.apa.org/pe/aids/resources/educaiton/counselor-bias

Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, & Social Sciences and Humanities Research Council of Canada (2018). *Tri council policy statement: Ethical conduct for research involving humans*. https://ethics.gc.ca/eng/documents/tcps2-2018-en-interactive-final.pdf

Canadian Psychological Association. (2017). *Canadian code of ethics for psychologists: Fourth Edition.* https://cpa.ca/docs/File/Ethics/CPA_Code_2017_4thEd.pdf

Canadian Psychological Association. (2001). *Guidelines for non-discriminatory practice.* http://cpa.ca/cpasite/UserFiles/Documents/publications/NonDiscPractrev%20cpa.pdf

Chaffin, M. (2008). Our minds are made up – Don't confuse us with the facts: Commentary on policies concerning children with sexual behavior problems and juvenile sex offenders. *Child Maltreatment, (13)*2, 110-121. DOI: 10.1177/1077559508314510

Chaffin, M., Berliner, L., Block, R., Johnson, T.C., Friedrich, W.N., Louis, D.G., Lyon, T.D., Page, I.J., Prescott, D.S., Silovsky, J.F., & Madden, C. (2008). Report of the ATSA Task Force on children with sexual behavior problems. *Child Maltreatment, 13*(2), 199-218. DOI: 10.1177/1077559507306718

College of Alberta Psychologists. (2019). *Practice guideline: Informed consent.* https://www.cap.ab.ca/Portals/0/pdfs/New%20Guidelines/Practice%20Guideline-%20Informed%20Consent.pdf?ver=2019-08-20-102058-527

Constantino, T.E. (2008). Constructivism. In L.Given (Ed.), *The SAGE encyclopedia of qualitative research methods* (pp. 117-120). SAGE Publications, Inc. http://dx.doi.org/10.4135/9781412963909.n64

Creswell, J.W. and Poth, C.N. (2018). *Qualitative inquiry and research design choosing among five approaches* (4th Edition). SAGE Publications, Inc.

Dopp, A.R., Borduin, C.M., Rothman, D.B., & Letourneau, E.J. (2017). Evidence-based treatments for youths who engage in illegal sexual behaviors. *Journal of Clinical Child & Adolescent Psychology, 46*(5), 631-645. DOI: 10.1080/15374416.2016.1261714

Elo, S., Kääriäinen, M., Kanste, O., Pölkki, T., Utrianinen, K., & Kyngäs, H. (2014). Qualitative content analysis: A focus on trustworthiness. *SAGE Open, 4*(1), 1-10. DOI: 10.1177/2158244014522633

Finkelhor, D., Ormrod, R., & Chaffin, M. (2009). *Juveniles who commit sex offenses against minors.* US Department of Justice. https://www.ojp.gov/pdffiles1/ojjdp/227763.pdf

Fonagy, P., Butler, S., Baruch, G., Byford, S., Seto, M.C., Wason, J., Wells, C., Greisbach, J., Ellison, R., & Simes, E. (2015). Evaluation of multisystemic therapy pilot services in services for teens engaging in problem sexual behaviour (STEPS-B): Study protocol for a randomized controlled trial. *Trials, 2015*(16), 1-19. DOI: 10.1186/s13063-015-1017-2

Geary, J, Lambie, I. & Seymour, F. (2011). Consumer perspectives of New Zealand community treatment programmes for sexually abusive youth. *Journal of Sexual Aggression 17*(2), 181-195. DOI: https://doi.org.10.1080/13552601003778693

Gervais, C.L. & Romano, E. (2018). Safeguarding child rights and enhancing caregiver responsibilities among Canadian parents of youth who sexually offend. *Child Abuse & Neglect, 2018*(76), 502-514. https://doi.org/10.1016/j.chiabu.2017.12.005

Gil Institute for Trauma Recovery and Education. (n.d.). Boundary Project. Retrieved December 8, 2020 from http://www.gilinstitute.com/services/treatment/boundary.php

Government of Alberta. (2014). *Guide to information sharing under the Children First Act.* https://open.alberta.ca/dataset/fd829a24-7877-4dba-9beb-e433da0e9699/resource/812e6646-dfa6-4e3b-b367-1b4f21b6f08d/download/guide-to-information-sharing-under-the-children-first-act.pdf

Hackett, S. (2014). *Children and young people with harmful sexual behaviours.* 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., Masson, H., Balfe, M., & Phillips, J. (2013). Individual, family and abuse characteristics of 700 British child and adolescent sexual abusers. *Child Abuse Review, 2013*(22), 235-245. DOI: 10.1002/car.2246

Hennink, M. & Kaiser, B.N. (2022). Sample sizes for saturation in qualitative research: A systematic review of empirical tests. *Social Science & Medicine, 292*(2022), 1-10. https://doi.org/10.1016/j.socscimed.2021.114523

Johnson, S.M. (2019). *Attachment theory in practice: Emotionally focused therapy (EFT) with individuals, couples, and families.* The Guilford Press.

Keiley, M.K., Zaremba-Morgan, A., Datubo-Brown, C., Pyle, R., & Cox, M. (2015). Multiple family group intervention for incarcerated male adolescents who sexually offend and

their families: Change in maladaptive emotion regulation predicts adaptive change in adolescent behaviors. *Journal of Marital and Family Therapy, 41*(3), 324-339. DOI: 10.1111/jmft.12078

Kelley, A., Shawler, P. Shields, J.D., & Silovsky, J.F. (2019). A qualitative investigation of policy of youth with problematic sexual behavior. *Journal of Community Psychology, 2019*(47), 1347-1363. https://doi.org/10/1002/jcop.22187

Kjellgren, C. (2019). Perspectives of young adult males who displayed harmful sexual behaviour during adolescence on motive and treatment. *Journal of Sexual Aggression, 25*(2), 116-130. https://doi.org/10.1080/13552600.2018.1563647

Leppink, E.W., Chamberlain, S.R., Redden, S.A., & Grant, J.E. (2016). Problematic sexual behavior in young adults: Associations across clinical behavioral and neurocognitive variables. *Psychiatry Res, 2016*(246), 230-235. DOI: 10.1016/j.psychres.2016.09.044

Letourneau, E.J., Henggeler, S.W., McCart, M.R., Borduin, C.M., Schewe, P.A., & Armstrong, K.S. (2013). Two-year follow-up of a randomized effectiveness trial evaluating MST for juveniles who sexually offend. *Journal of Family Psychology, 27(6)*, 978-985. DOI: 10.1037/a0034710

Mertens, D.M. (2019). *Research and evaluation in education and psychology: Integrating diversity with quantitative, qualitative, and mixed methods* (5th Edition). SAGE Publications, Inc.

Mónaco, E., Schoeps, K., & Montoya-Castilla, I. (2019). Attachment styles and well-being in adolescents: How does emotional development affect this relationship? *International Journal of Environmental Research and Public Health, 2019*(16), 1-17. DOI: 10.3390/ijerph1642554

National Children's Alliance. (2017). *What we can do: Understanding children and youth with problematic sexual behaviors.* https://www.nationalchildrensalliance.org/wp-content/uploads/2018/03/2017-PSB-Fact-Sheet-Overview-3.pdf

National Children's Alliance. (2019). *Effective treatment for youth with problematic behaviors.* https://www.nationalchildrensalliance.org/wp-content/uploads/2019/10/YPSB-Effective-Treatment-Fact-Sheet-2019_web.pdf

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

Nowell, L.S., Norris, J.M., White, D.E., & Moules, N.J. (2017). Thematic analysis: Striving to meet the trustworthiness criteria. *International Journal of Qualitative Methods, 16*(2017), 1-13. DOI: 10.1177.1609406917733847

Robson, M. & Lambie, I. (2013). Psychological and behavioural characteristics of females who sexually offend: Insights from psychotherapeutic work in New Zealand. *Sexual Abuse in Australia and New Zealand, 5*(1), 33-39. Retrieved from https://search-proquest-com.proxy.cityu.edu/docview/1355441812/abstract/83F8D02DEDA441C8PQ/1?accountid=1230

Shawler, P., Silvis, V.G., Taylor, E.K., Shields, J., Beasley, L., & Silovsky, J.F. (2020). Early identification of youth with problematic sexual behavior: A qualitative study. *Child Abuse & Neglect, 105*(2020), 1-10. https://doi.org/10.1016/chiabu.2019.104317

Shields, J.D., Coser, A., Beasley, L.O., & Silovsky, J.F. (2020). A qualitative examination of factors impacting family engagement in treatment for youth with problematic sexual

behavior. *Children and Youth Services Review, 108*(2020), 1-8. https://doi.org/10.1016/j.childyouth.2019.104597

Shields, K.D., Klinkebiel, C.M., Taylor, E.K., Espelata, H.C., Beasley, L.O. & Silovsky, J.F. (2018). A qualitative analysis of family perspective on treatment services for youths with problematic sexual behavior. *Victims & Offenders, 13*(7), 955-973. https://doi.org/10/1080/15564886.2018.1506853

Silovsky, J.F., Hunter, M.D., & Taylor, E.K. (2019). Impact of early intervention for youth with problematic sexual behaviors and their caregivers. *Journal of Sexual Aggression, 25*(1), 4-15. DOI: 10.1080/13552600.2018.1507487

Sitney, M. & Kaufman, K.L. (2020). The impact of disrupted caregiving for juvenile sexual offenders. *Journal of Sexual Aggression, 26*(2), 274-287. DOI:10.1080/13552600.2019.1618933

Te Kāwanatanga o Aotearoa - New Zealand Government. (2017, May 18). *Māori health models – Te Whare Tapa Whā.* Manatū Hauora – Ministry of Health. https://www.health.govt.nz/our-work/populations/maori-health/maori-health-models/maori-health-models-te-whare-tapa-wha

Tener, D., Newman, A., Yates, P., & Tarshish, N. (2020). Child Advocacy Centre intervention with sibling sexual abuse cases: Cross-cultural comparison of professionals' perspectives and experiences. *Child Abuse & Neglect, 2020*(105), 1-13. https://10.1016/j.chiabu.2019.104259

True Relationship & Reproductive Health. (2019). *Sexual behaviours in children and young people: A guide to identify, understand and respond to sexual behaviours.*

United Nations Convention on the Rights of the Child. (2007). *Committee on the rights of the child: Forty-fourth session.* https://www2.ohchr.org/english/bodies/crc/docs/CRC.C.GC.10.pdf

Vaismoradi, M., Turunen, H., & Bondas, T. (2013). Content analysis and thematic analysis: Implications for conducting a qualitative descriptive study. *Nursing and Health Sciences, 2013*(15), 398-405. DOI: 10.1111/nhs.12048

Varma, K.N. & Leroux, E.J. (2019). Understanding the nature and scope of adolescent sexual offending across Canada. *Annual Review of Interdiscilplinary Justice Research, 120*(8), 1-144. https://www.canlii.org/en/commentary/doc/2019CanLIIDocs4530#!fragment/zoupio-_Tocpdf_bk_6/BQCwhgziBcwMYgK4DsDWszIQewE4BUBTADwBdoAvbRABwEtsBaAfX2zhoBMAzZgI1TMAbAEoANMmylCEAIqJCuAJ7QA5KrERCYXAnmKV6zdt0gAynlIAhFQCUAogBl7ANQCCAOQDC9saTB80KTsIiJAA

Wellstop. (n.d.). *The Good Way model & enquiry form.* Retrieved September 20, 2022, from https://www.wellstop.org.nz/the-good-way-model-and-enquiry-form.html#:~:text=The%20Good%20Way%20model%20proposes,Way%E2%80%9D%20to%20meet%20our%20needs

Worling, J.R. & Langton, C.M. (2012). Assessment and treatment of adolescents who sexually offend. *Criminal Justice and Behavior, 39*(6), 814-841. DOI:10.1177/00938548124393780

Yoder, J.R. & Brown, S. (2015). Challenges facing families of sexually abusive youth: What prevents service engagement? *Victims & Offenders, 2015*(10), 29-50. DOI: 10.1080/15564886.2013.875969

Yoder, J.R., Leibowitz, G.S., & Peterson, L. (2018). Parental and peer attachment characteristics: Differentiating between youth sexual and non-sexual offenders and associations with sexual offense profiles. *Journal of Interpersonal Violence, 33*(17), 2643-2663. DOI: 10.1177/0886260516628805