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Doctoral Thesis

The experience of professionals working with children and young people who display harmful sexual behaviours

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Statement of Total Word Count

Section	Main Text	Appendices (including abstracts. tables, figures and references)	Total
Thesis abstract	**274**	**-**	
Literature review	**7,964**	**9,381**	**17,345**
Empirical paper	**8,000**	**5,345**	**13,345**
Critical appraisal	**3,573**	**615**	**4,188**
Ethics section	**3,260**	**8,111**	**11,371**
Total	**23,071**	**23,452**	**46,523**

Abstract

This thesis explored the experiences of professionals who work with children and young people who have displayed harmful sexual behaviours.

The systematic literature review addresses the question "what are the experiences of professionals who provide therapeutic intervention to CYP who have displayed HSB?" A systematic search of seven electronic databases was undertaken with inclusion and exclusion criteria applied. This resulted in eight papers whose data were extracted and synthesised using a meta-ethnographic approach. Three overarching themes are reported: (1) Counter-cultural beliefs; (2) Professional self-confidence; (3) Altered experiences of the world, which contains the subtheme: Positive experiences emerging from the work. Findings are discussed and clinical implications at the service and organisational level are suggested.

Next, the empirical paper explores the impact of working with children and young people who have displayed harmful sexual behaviours on residential care workers. The data were analysed using thematic analysis. Four themes were reported: 1) "In theory you should hate them" – The impact of personal beliefs; 2) "You learn why they behaved like they did" - Developing alternative understandings of HSB; 3) "We are here to care" - Purpose of the role; and 4) "I didn't feel safe, he made my skin crawl" - The impact of threat. Themes are discussed in relation to relevant literature and clinical implications for residential care services are discussed.

The critical appraisal provides a brief outline of the findings of the empirical paper before discussing reflections on key parts of the research process including; reflections on the researcher's relationship with HSB; an exploration of the decision to use thematic analysis methodology; and finding the balance between the dual roles of researcher and clinician.

Declaration

This thesis records the work undertaken for the Doctorate in Clinical Psychology at the Division of Health Research at Lancaster University from August 2018 to June 2019. The work presented within this thesis is the author's own, except where due reference is made. The work has not been submitted for the award of a higher degree elsewhere.

Name: Kristian Glenny

Signature:

Date:

Acknowledgments

I would like to thank the nine people who gave up their time and agreed to be the participants in this study without whom none of this would have been possible. I also would like to extend a huge thank you to those staff members who recruited on my behalf, I am so grateful for how enthusiastic and organised you were.

To my supervisors Anna and Jane, thank you. I could not have asked for a more supportive and compassionate set of supervisors.

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Section One: Systematic Literature Review

Providing therapeutic input to children and young people who have displayed harmful sexual behaviour

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Abstract

Providing therapeutic input to children and young people who have displayed harmful sexual behaviours may lead to professionals experiencing negative impacts related to their role, impacting the client, the professional and the organisation. A systematic review of qualitative literature was therefore conducted to answer the question "what are the experiences of professionals who provide therapeutic intervention to CYP who have displayed HSB?". A systematic search of seven electronic databases was undertaken with inclusion and exclusion criteria applied. This resulted in eight papers whose data were extracted and synthesised using a meta-ethnographic approach. Three overarching themes are reported: (1) Counter-cultural beliefs; (2) Professional self-confidence; (3) Altered experiences of the world, which contains the subtheme: Positive experiences emerging from the work. Findings are discussed and clinical implications at the service and organisational level are suggested.

Keywords: Harmful sexual behaviour, professional experiences, burnout, compassion fatigue, compassion satisfaction, Youth offending

Children and young people (CYP) display a range of sexual behaviours, many of which are appropriate and consensual (Hackett, 2010). However, some sexual behaviours are harmful, either to the CYP or others. Whilst acknowledging the difficulty of gathering accurate data regarding the prevalence of sexual offences (Biehal, 2014), reports estimate that one in four sexual offences in the United States of America (USA) are perpetrated by CYP (Finkelhor, Ormrod, & Chaffin, 2009), as is approximately one third of all reported child sexual abuse in the United Kingdom (UK; Hackett, 2014), suggesting that acts of sexual harm displayed by CYP are not a rare phenomenon.

Attempts to define HSB have proven difficult with legal, societal and cultural contexts introducing a range of biases in relation to HSB specifically and sexual behaviour more generally. For example, homosexual behaviour is condemned by multiple religions, judged morally "wrong" in many cultures and is currently defined as illegal in 72 countries worldwide ("Human Dignity Trust," n.d.), whilst across western (north America and western Europe) cultures such behaviours are accepted and protected by law.

Despite these limitations, attempts have been made to define HSB. Informed by the argument that "it is not the sexual behaviour that defines sexual abuse but, rather, it is the nature of the interaction and the relationship" (Ryan, 1999, p.424), Ryan and Lane's (1997) definition of HSB was considered: "a sexual activity that takes place against a victim's will, without consent or in an aggressive, exploitative, manipulative or threatening manner". Whilst this definition captures the role of consent, control and power within HSB, it fails to address behaviours which may be harmful to the self and does not explicitly describe who may be the victim of such behaviours. Therefore the following definition of HSB was used during this study: "sexual behaviours expressed by children and young people under 18 years of age that are developmentally inappropriate, may be harmful towards self or others, or be abusive towards another child, young person or adult" (Hackett, Branigan, & Holmes, 2019,

p.13). This definition captures a potentially broad range of behaviours and reflects the need to acknowledge that both CYP and adults may be the victim of HSB. However it is also limited, particularly by its assumption that individuals possess knowledge of what is developmentally appropriate, or that such knowledge can even exist.

Authors including Lovell (2002) and Tolman and Mcclelland (2011) have argued that there is a general lack of knowledge regarding adolescent sexual behaviour and thus what "normal" sexual development is, making claims that a behaviour is developmentally inappropriate difficult to justify. Furthermore, as argued above, understandings of what constitutes "normal" sexual behaviour vary between cultures (Bearinger, Sieving, Ferguson, & Sharma, 2007) suggesting that the understandings held by professionals are likely to be culturally biased.

Aetiology

It is widely accepted that there is no one-size-fits all pathway of development which leads CYP to display HSB, rather, it is a multi-faceted process involving a wide variety of factors including socioeconomic status and culture (Caldwell, 2002; Hackett, 2014; Rich, 2011). However, a growing body of evidence does suggest that CYP who have displayed HSB are more likely to have been raised in problematic or abusive home environments and to have experienced disadvantage, adversity and abuse (Hackett, Phillips, Masson, & Balfe, 2013; Hall, Mathews, & Pearce, 1998; Hutton, 2007). This correlation suggests attachment theory (Bowlby, 1969, 1988) may offer a beneficial lens through which to understand the aetiology of HSB. More specifically, a number of authors have theorised that insecure and disorganised attachment styles may be a factor involved in predisposing CYP to display HSB (Creeden, 2013; Rich, 2006; Smallbone, 2005; Zaniewski, 2016).

Attachment theory posits that behaviours observable in the present are a reflection of the quality of the individual's early years and in particular their relationship and interactions

with their caregivers (Bowlby, 1969, 1988). Through early relational experiences attachment theory argues that infants form "internal working models" which inform their perception of themselves and their expectations of others (Bowlby, 1988; Golding, 2007). These internal working models are theorised to quickly become distinct and persistent responses to the external world, categorised as: secure, when the infant is nurtured through warm, sensitive and responsive parenting; insecure (ambivalent or avoidant) when the caregiver is unable to consistently identify and respond to the infant's needs; or disorganised, when the infant's source of care is also a source of threat (Main & Solomon, 1990).

In relation to the role of attachment in the development of HSB, a number of theories have been suggested. Based upon observations that secure attachments promote the development of emotional awareness, empathy and self-regulation (Music, 2011), Smallbone (2005) proposes that insecure attachment styles may lead to difficulties in the development of behavioural restraint, which in turn contributes to the development of HSB. Marshall, Serran and Cortoni (2000) suggest insecure attachment styles may make individuals vulnerable to sexual abuse which may, when combined with poor-self regulation skills, lead to the use of sexual behaviours to self-regulate. Burk and Burkhart (2003) suggest HSB represents an extreme attempt to control interpersonal relationships, used by individuals with insecure and disorganised attachment styles who have not been able to internalise self-regulatory skills and thus rely on external strategies (i.e. HSB) to avoid disorganised self-states at times of high stress.

Despite a number of theories existing which link attachment to HSB, it is important to emphasise that there is currently a lack of empirical evidence for any of the above theories (Rich, 2006; Creeden, 2013; Hackett, 2014). Furthermore, it is evident that a far larger number of CYP will develop insecure/disorganised attachment styles than will go on to display HSB. This suggests that attachment style alone should not be thought of as the cause

of HSB. Perhaps instead, attachment may be best understood as a predisposing factor, which when exacerbated by other factors (e.g. social environment) may lead to HSB (Rich, 2006).

The context of HSB services

Organisational responses to HSB vary at both international and national scales. Responses to HSB in the USA and Australia are reported to focus on punishment rather than rehabilitation (Letourneau & Caldwell, 2013), whilst contemporary approaches in the UK are argued to take a more holistic approach. In a largely positive step, the UK has recently published national practice guidelines regarding HSB (National Institute for Health and Care Excellence [NICE]; 2016). These guidleines emphasise the importance of including the CYP's family and accounting for their social context when conducting interventions (Campbell et al., 2016) as well as promoting a number of HSB specific intervention packages including the Good Lives Model (Ward & Gannon, 2006) and the AIM project (Print, Morrison, & Henniker, 2001). Whilst practice guidelines are beneficial insofar as they ensure individuals receive high quality care based on available evidence, they are also limited by the quality and scope of said evidence. In relation to HSB, whilst the evidence base has greatly increased since the 1990's (Wareham, 2016), it has disproportionately focused upon male CYP (Epps & Fisher, 2004) thereby unrepresenting populations including black and minority ethinic groups (Hackett, 2014), females (Righthand & Welch, 2001; Wareham, 2016) and indiviuals with learning disablities (Fyson, 2007; Hackett, 2014). Therefore, whilst practice guidelines can benefit CYP, services and practitioners the field, they must be applied with an understanding of their limitations and in particular the communities with whom there is little evidence for their effectiveness.

The current structure of UK approaches to HSB involves multiple professional agencies including general mental health services, specialist HSB providers (both NHS and

third sector), social services and youth justice. Whilst this does allow the flexible provision of input in line with the needs of the CYP, it also increases the risk of CYP falling between the gaps (Farooq, Stevenson, & Martin, 2018), a risk further exacerbated by frequently observed poor communication between professional bodies (NCH, 1992; Masson & Hackett, 2003; Smith et al., 2013). Role confusion, a lack of clarity among professional agencies regarding their roles and responsibilities, is argued to further complicate the current system, reducing commitment and investment of professionals (Hackett et al., 2019). In an effort to address these limitations, recent UK government initiatives have proposed merging health and youth justice services (NHS England, 2016; NICE, 2016). Whilst this may potentially close the gaps in the system, investigations into attempts to merge services report that such endeavours are difficult, with differing organisational aims, structures and cultures leading to staff employing self-protective strategies when working with those from "other" agencies (Hudson, Hardy, Henwood, & Wistow, 1997; Hvinden, 1994). Farooq et al. (2018) argue that in order to overcome such challenges, organisations, must nurture positive relationships, with one potential method being the provision of reflective spaces where difficulties can be identified, addressed and relationships given space to grow.

The experience of professionals

Central to the role of professionals (this term will be used throughout this study to describe those who provide interventions to CYP who have displayed HSB) who provide intervention to CYP who have displayed HSB is bringing about behavioural change, whether that be within a holistic intervention framework, or a more punitive system. It is therefore necessary to acknowledge the body of literature which suggests it is the characteristics of the professional, and their therapeutic relationship with the client, which contributes most to such change (Horvath, Del Re, Flückiger, & Symonds, 2011; Wampold, 2015; Yalom, 1995).

Given this, it is pertinent to explore the factors which enable or inhibit professional's ability to form such relationships.

Three concepts are frequently discussed in relation to the negative impact that caring for another can have on the carer/professional: burnout (Maslach, 1982); compassion fatigue (CF; Figley, 1995); and secondary traumatic stress (STS; Figley, 1983). A large body of evidence reports on the experiences of professionals who work with adults who have sexually harmed others, reporting professionals to be vulnerable to STS and burnout (Farrenkopf, 1992; Moulden & Firestone, 2007; Way, VanDeusen, & Cottrell, 2007) as well as psychological distress i.e. anxiety, intrusive images and low mood (Moulden & Firestone, 2010). Higher levels of burnout/ CF/STS have also been associated with a lessened ability to display those characteristics which develop the therapeutic alliance (Willemsen, Seys, Gunst, & Desmet, 2016) such as respect, warmth, sincerity (Marshall, Anderson, & Fernandez, 1999).

Alongside these negative impacts, there exists a smaller body of literature, often under-reported (Hardeberg Bach & Demuth, 2018), describing the experiences of professionals who report positive impacts from their work. Termed compassion satisfaction, a limited number of studies have reported on such experiences among professionals working with those who have sexually harmed others, with such experiences suggested to be a protective factor against burnout/CF (Stamm, 2002). Carmel and Friedlander (2009) report low levels of stress and high levels of compassion satisfaction in their study of 109 therapists, whilst a study of 90 professionals who work with CYP who have displayed HSB found that compassion satisfaction was negatively correlated to CF and burnout (Kraus, 2005). Factors which have been associated with the development of compassion satisfaction include: being a part of a multidisciplinary team, seeing clients "recover", receiving supervision and

experiencing peer support (Maslach, Schaufeli, & Leiter, 2001; Moulden & Firestone, 2007; Willis et al., 2018).

Conscious of the need to avoid conflating work with adults who have sexually harmed others and CYP who have displayed HSB, it is important to drawn on the literature exploring the experiences of professionals working with CYP who have committed non-sexual offences. Indeed it has been argued that CYP who have displayed HSB have more in common with the latter population than the former (Hickey, Vizard, McCrory, & French, 2006). Souhami (2007) reports professionals to experience negative factors such as divisions within services and pressure to achieve targets, alongside positive experiences including unified attitudes and perspectives amongst professional peers. Briggs (2013) reports that whilst professionals working in youth justice services feel a sense of unity among their peers, they feel challenged by society, which is felt to perceive their methods as too lenient and insufficiently effective in reducing recidivism.

The current review

Extant literature suggests professionals providing intervention to CYP who have displayed HSB may have similar experiences to their peers working with adult who have sexually harmed others, however these two populations should not be assumed to be equivalent. An initial scoping review was therefore conducted exploring the experiences of professionals working with CYP who have displayed HSB, revealing an emerging evidence base. The significant majority of these studies utilised qualitative methodologies, with only the above mentioned study conducted by Kraus (2005) utilising quantitative methods. As there have been no qualitative systematic literature reviews published in this area, a systematic meta-synthesis of qualitative investigations was felt to be suitable.

Meta-syntheses of qualitative studies allows for the findings of various studies exploring a related topic to be collated, reinterpreted and fresh insights developed (Walsh & Downe, 2005), with the aim of generating deeper insights into the data set and increasing the accessibility and utility of findings (Sandelowski, Docherty, & Emden, 1997).

By conducting a systematic search of the literature using multiple databases, the aim of this systematic meta-synthesis is to examine and synthesise the available qualitative literature necessary to answer the question: "what are the experiences of professionals who provide therapeutic intervention to CYP who have displayed HSB?"

Materials and Methods

Prior to data extraction and synthesis, a comprehensive search strategy was implemented to identify all studies relevant to the research questions. Reporting guidelines as outlined by the "Enhancing transparency in reporting the synthesis of qualitative research" (ENTREQ) statement (Tong, Flemming, McInnes, Oliver, & Craig, 2012) were followed.

Literature search

To aid the development of the research questions and a thorough search strategy, the "Context, How, Issues and Population (CHIP)" tool (Shaw, 2010) was utilised (appendix 1-A). A brief scoping search of the literature using the PSYCHINFO database and Google Scholar was then used to develop keyword search terms in relation to the four CHIP criteria (CYP; HSB; qualitative methodology; and professionals).

A comprehensive and systematic search of seven electronic databases of international peer-reviewed papers was conducted on 22nd March 2019 using: Scopus, Medline, Cumulative Index to Nursing and Allied Health (CINAHL), Academic Search Ultimate, SocINDEX, Social Care Online and PsychINFO. A complete search strategy can be located in appendix 1-B. Databases were chosen due to their coverage of a range of professions

identified as working with CYP who display HSB. Searches were not limited by date. Six of the seven databases were searched individually using a combination of free text search terms and subject headings/thesaurus/medical subject headings (where available), associated with the four concepts identified using the CHIP tool. The remaining database, Social Care Online, was searched without the use of the qualitative criterion due to limitations of the database. Keyword search terms were limited to the title and abstract (where possible) of papers to reduce the likelihood of irrelevant results. Boolean operators "AND" and "OR" were implemented, as were truncations through use of the wildcard function (*). In their description of qualitative literature search strategy, Shaw et al. (2004) describe a tension between sensitivity and comprehensiveness. Within this review, a comprehensive strategy was adopted due to the heterogeneity of terms used to describe HSB and variety of professions who engage in therapeutic work with CYP. A specialist academic librarian was consulted regarding the search strategy, with it deemed sufficiently rigorous. Following implementation of the search strategy 13,936 papers were identified. Using the reference management software Endnote, 3472 duplicate references were identified and removed, resulting in 10,464 unique papers.

The inclusion criteria for this study were as follows: (i) The study was published in English (due to lack of funding for translation). (ii) The study was published in a peer-reviewed journal, as a basic indicator of quality and rigour. (iii) The study adopted qualitative methodology and analysis as described by Sandelowski & Barroso (2003), with this definition chosen for its ease of use and continued use within qualitative literature e.g. (Colvin et al., 2018) . (iv) The study reports on the experiences of professionals providing therapeutic intervention to CYP who have displayed HSB.

Studies were excluded based on the following criteria: (i) Qualitative data could not be extracted from mixed methodology studies. (ii) The study reported on the experiences of

caregiving professionals (e.g. foster carers). (iii) Data could not be extracted related specifically to CYP who have displayed HSB. (iv) The study reports a secondary analysis (e.g. review of the literature, opinion piece). (v) The study reports upon treatment of HSB rather than experiences of providing treatment. Studies were not excluded based on publication date in recognition that despite potentially reflecting a different historical context of HSB understandings and approaches, exclusion of studies may result in significant contributions to the literature being omitted (Bondas & Hall, 2007; Sandelowski & Barroso, 2002).

Following application of these criteria, eight papers remained and were included in this meta-synthesis. Additional references were searched for using the "cited by" feature of Google Scholar as well as searching the reference list of each paper, no additional papers were identified (See figure 1 for a flow chart illustrating this process).

Characteristics of selected papers

The key characteristics of the included papers are described in table 1-A. The eight papers, henceforth referred to by study numbers S1 – S8, were published between 1996 and 2017. 82 participants (study samples ranged from 5 - 18) participated in the eight separate studies. Studies were conducted in the UK, Israel, Australia and USA. The professions of the sample were reported to be: youth justice practitioners & qualified social workers (S1, S3); social workers (S4, S5), youth justice practitioners (S6, S7), qualified therapists (S8) and counsellors (S2). Six studies reported the minimum number of years' experience working with CYP who have displayed HSB their sample had, with one study reporting a minimum of one year (S6); three studies reporting a minimum of two years (S1; S2; S8) and one study reporting a minimum of three years' experience (S7). S3 reporte their sample to have no prior experience with this client group whilst studies S4 and S5 did not report on experience. Data

were collected via semi-structured interview in the majority of studies, with only S3 utilising alternative methods, collecting data via the minutes of the supervisory group. Methods of data analysis were reported to be: thematic analysis (S4, S6, S8), Grounded theory (S2), interpretive phenomenological analysis (S7) and framework analysis (S1). Two papers did not report their method of analysis (S5, S3).

Quality appraisal

The Critical Appraisal Skills Programme (CASP; 2018) qualitative research checklist was used to assess the quality of the included studies (see table 1-B). The CASP is a widely used and clear checklist comprising 10 criteria considered important in qualitative research including methodology, design and ethical practice. Quality appraisal was conducted prior to data extraction as recommended by Harden and Thomas (2005). Each study was assigned a score based on the fulfilment of CASP criteria using the three-point rating system developed by Duggleby et al. (2010). A score of (1) indicated a lack of evidence relating to the criterion; (2) indicated partial evidence; and (3) indicated evidence the full criterion had been met.

The initial two items of the CASP are screening questions assessing the clarity of research aims and appropriateness of qualitative methodology. All included papers met these criteria. Duggleby et al's, (2010) scoring criteria were subsequently applied to the latter 8 items of the CASP, with scores ranging from 10-20 out of a possible 24. To add rigour to this process three papers were appraised by a peer experienced in qualitative synthesis and use of the CASP with no discrepancies between scores reported.

The utility of quality assessment within qualitative research is disputed given the differing methodologies employed which necessarily give rise to differing flaws (Dixon-Woods, Shaw, Agarwal, & Smith, 2004). Guidance therefore states that quality appraisal findings can be used to exclude lower quality studies or to include them but give more weight

to those appraised as higher quality (Hannes, 2011). Within this study, the latter approach was taken, with scores used as a medium for reflection (Barbour, 2001) rather than as a basis for exclusion, once more reflecting recognition that exclusion of studies based on quality may result in important contributions to the literature being omitted (Bondas & Hall, 2007; Sandelowski & Barroso, 2002).

Data abstraction and synthesis

A meta-ethnographic (Noblit & Hare, 1988) approach to meta-synthesis was utilised, in recognition of guidance that where research questions aim to explore a body of literature rather than answer a specific question, meta-ethnography may be well suited (Thomas & Harden, 2008). Noblit and Hare's (1988) seven step process for abstracting and synthesising data were followed: "(1) getting started; (2) deciding what is relevant to the initial interest; (3) reading the studies, (4) determining how the studies are related; (5) translating the studies into one another; (6) synthesising translations; (7) expressing the synthesis" (Noblit & Hare, 1988, p. 26-29). This methodology was utilised with the goal being to translate related qualitative studies into each other to develop concepts embodying the data set as a whole (Campbell et al., 2003).

Having identified relevant papers, the results and discussion sections of each were read repeatedly, with themes/metaphors relevant to the research question extracted (column 2, appendix 1-C). Recognising that authors selectively report participant quotations to support their interpretations, participant quotations were synthesised with corresponding author interpretations and used to illustrate themes reported in this synthesis, but were not analysed in isolation (France et al., 2019).

Extracted themes were then analysed to determine how they were related. This was achieved through a process of grouping similar concepts reported across studies, as

recommended by Noblit & Hare (1988), whose description of this stage identifies two separate processes which can occur: reciprocal translation and refutational translation. Reciprocal translation is the process of translating concepts from individual studies into each other, thereby creating overarching concepts (Noblit & Hare, 1988), whilst refutational translation involves comparing contradictory themes, conclusion and underlying ideologies within and across studies (Campbell et al., 2011). Contemporary accounts of meta-ethnography argue that both forms of translation can be present within the same synthesis (Campbell et al., 2011; France et al., 2019) and this approach was therefore adopted and achieved by creating a table of all extracted themes, placing themes alongside each other and then making connections between them. These groups were then renamed to establish key themes (column 3, appendix 1-C).

Finally these key themes were then synthesised to create over-arching themes (column 5, appendix 1-C) recognised as a "lines-of-argument" synthesis (Noblit & Hare, 1988, p.62) in order to move beyond simple collation of results reported across papers and instead "discover a 'whole' among a set of parts" (Noblit & Hare, 1988, p.63).

Results

Quality appraisal

All studies met the initial two screening questions. Three studies; S3, S4 and S5 were assessed to be of significantly lower quality than the remaining five, failing to report their research design or methods of data collection appropriately. Furthermore these three papers failed to appropriately report the ethical approval process, or consideration of ethical issues during the research process. Therefore these three papers were used to provide supporting evidence to themes already established, but were not drawn upon in absence of higher quality papers.

Analysis and Synthesis of data

Three over-arching themes were identified: (1) Counter-cultural beliefs (2) Professional self-confidence (3) Altered experiences of the world, which contains the subtheme: Positive experiences emerging from the work.

Theme 1: Counter-cultural beliefs. A difference was reported between the beliefs surrounding HSB held by society and wider professional networks (i.e. legal, judicial) and those held by participant professionals. Wider networks and society at large were reported to perceive CYP who had displayed HSB as 'different' from those who had committed non-sexual offences:

> "there's a real strong message that if you are sexually harmful. . . there's something wrong with you and you need to be helped, fixed, locked up, in a hospital, whatever it is. . . whereas if you've just, if you've gone and beaten someone up. . . you can come back from that" (S6, p.13)

These perceptions were linked to a sense of panic (S6), horror and anxiety: "The participants felt that the sexualised behaviour created huge anxiety, horror and fear amongst the networks around the child" (S8, p. 66), which participant professionals' could then feel pressured to manage in addition to their work with the CYP (S3; S8). In contrast to the stigmatising views of wider networks, participant professionals reported viewing CYP with hope and compassion:

> "staff who took part in this research did not express any negative views towards the group of young people they worked with and thought that experience in the job had contributed to the de-stigmatising views of young people… rather than seeing their client group as "other" they saw them as young people who were in need of support" (S7, p.197).

Professionals were also aware of the impact prevailing societal narratives could have upon the CYP:

> "Hannah addressed the issue of the impact and harm of labelling a young person as a "sexual predator" and the idea of self-fulfilling prophecy by explaining "labels stick and there's the other side to it; those labels can contribute towards people becoming something they're actually not"" (S7, p.197).

The conflict between the beliefs and approaches of participant professionals and the wider networks they existed within could lead to feelings of stigmatisation and isolation: "I see myself as a pioneer, but my colleagues think I'm different. Some even think I must be a pervert if I chose to work in this field." (S3, p.60). Further examples of this conflict between professionals and wider society were apparent in reports from professionals that they could feel uneasy or unable to discuss their work in their personal lives (S1; S8):

> "The majority of respondents (N=14) said they did not discuss work with family/friends and those who did kept content to a minimum; the main reasons being confidentiality, others finding the work hard to comprehend or it being a "conversation stopper" in social situations" (S1, p.343).

The experiencing of compassionate and counter-culture beliefs were not unanimously reported among professionals, indeed one paper reported professionals feeling that they should not have to work with these CYP: "Some felt that assessment was better undertaken by juvenile justice because 'society had already indicated needs for sanctions when individuals offend norms" (S5, p.58). However, as indicated in the quality appraisal, this study was not reported at a very high standard making it problematic to attach too much interpretive power to the findings. Furthermore, having been conducted in 1999, the context of the era, where denial and minimisation of HSB (NCH,1992) and punitive intervention

approaches prevailed, must be acknowledged, making this finding potentially less applicable to more contemporary approaches to HSB treatment.

Theme 2: Professional confidence. Multiple papers reported professionals to feel under-skilled or incompetent to deliver HSB interventions (S4; S5; S6; S8):

> "I'd be quite happy to, to work with somebody who's committed a violent robbery or a violent burglary, whereas somebody's committed a sexual offense, oooooerrr, yeah, I've, I've still got those feelings of, I actually wouldn't know what to do with you" (S6, p.9).

Such beliefs appear to lead professionals to feel they need more knowledge, more support and more training to work with HSB: "Practitioners felt an urgent need to be updated generally on the knowledge currently available from research and practice experience" (S5, p.59). This urgency appears to be linked, for some professionals, to a sense of responsibility for the actions of the CYP they were working with (S3; S6): "The risk of further sexual harm by the young person is internalized by practitioners, who may feel a sense of professional responsibility for any further offenses in the future" (S6: p.10).

For other professionals, their anxiety about working with this population appeared linked to both a perceived lack of skill, and beliefs regarding recidivism rates of CYP who have displayed HSB.

> I think because I'm more aware of my deficiencies in my own training needs that I would actually do more harm than good and wouldn't be able to sufficiently manage the risk . . . and actually get somebody to gravitate from what would be perhaps a low level sexualized behaviour to somebody who gravitates to the more serious ones" (S6 p.10)

It is notable that such beliefs around incompetence were not universal, in other studies professionals were reported to feel competent and able to fulfil their role (S1; S7). These professionals were reported to recognise that whilst HSB and non-sexual offences were different, their experience and skills were transferable:

> "it's two areas of work and they're not too dissimilar in the fact that both will have committed some kind of offence, and yes you'll be dealing with it probably in a slightly different way […] but […] I probably deal with things pretty similarly" (S7, p.196).

And to also feel confident in their abilities: "I feel because of my knowledge and experience I'm doing it …doing some really complex stuff…that takes real skills"" (S1, p. 341).

Theme 3: Altered experiences of the world. Professionals reported experiencing a number of negative changes to their perceptions of themselves, others and the world due to their work with CYP who have displayed HSB. Some professionals expressed an increased feeling of vulnerability (S1; S2), manifesting in a reduced sense of personal safety and lessened trust in others: "I think there is an element of me trusting people less than before." (S8, p. 62), whilst for others there was a reduced belief that the world was a safe or fair place (S8). Other papers report professionals to have experienced preoccupation, isolation, intrusive thoughts, flashbacks and horrifying dreams (S2; S3; S8): "I had dreams of actually abusing children. and umm became quite shocked by that" (S8, p.62).

Professionals were also reported to experience troubling beliefs about themselves in relation to counter-transference experiences and the content of HSB work. Some professionals felt they were invited to take either an "abuser" role during sessions:

> Another counsellor discussed having a passing identification with an adult sexual offender, where he was able to imagine sexually abusing his young client. This

> reaction was followed by a "repulsion of that notion." He was sometimes troubled by dreams, stating, "I'm constantly having nightmares, I'm either the victim or I'm the perpetrator, usually the perpetrator. So in that way I'm identifying with the abusers that I sit with day in and day out (S2, p. 272).

Whilst for other professionals they could feel victimised and powerless: "He very much pushed into me his feelings of powerlessness…their intention is to control you so that they are safe … Making me feel physically watched … I sometimes felt powerless and used" (S8, p.59).

Professionals could experience strong, internally directed negative emotions in relation to experiencing sexual arousal during therapeutic work with CYP. Two papers discussed this theme (S2; S8), with some professionals reported to feel disgust and horror towards themselves for experiencing such feelings: "I did get this twinge of arousal myself and I was horrified. The horror and worry was about what that meant about me as a therapist, as a person – you know feeling this sexual twinge" (S8, p.61). However, other professionals described experiencing sexual arousal as a natural response to the sexual content of the work "We're sentient beings and so if we're touching erogenous parts of our body, our body's gonna respond. If we're talking about things that are sexual, I think that our bodies are gonna respond" (S2, p.272).

Subtheme: Positive experiences emerging from the work. Importantly, not all papers reported professionals to feel that negative personal impacts were inevitable, or that they were due specifically to working with HSB. One study reported professionals to believe that whilst there was a negative impact associated with providing therapeutic input to others generally, working with HSB did not increase the likelihood of this happening:

> "The vast majority of respondents (N=15) believed that impact of some sort was inevitable. However, feedback suggested that the nature and content of HSB work did not correlate with negative impact to a high degree. Whilst some did identify more serious levels of physical and emotional impact at certain points in their career (such as depression, anxiety and stress), they did not attribute these symptoms directly to the work involving HSB." (S1, p. 341).

The same study then goes on to reports some professionals to have experienced positive effects due to their work with HSB, including: "increased self-awareness/self-reflection, being less reactive to people/situations, being "more tolerant (and) less judgemental" (respondent 3) and having optimism that "I'll keep changing in a good way" (respondent 9) from doing the work" (S1, p.342).

Clinical supervision was reported to have a central role in determining how professionals experienced their work and the impact it had upon them. Beneficial characteristics of supervision included space for reflection (S1; S6) and provision of an ongoing supportive relationship (S1; S2; S8; S7) with an accessible, open and experienced practitioner (S1; S4). Within such relationships professionals felt their practice could develop (S1; S2; S4; S8), for instance through developing a more "empathetic approach" (S6, P.11). However, when clinical supervision was not offered, was didactic (S6), or focused on organisational targets, it was felt to increase professionals' negative experiences:

> "the organisation is becoming more target this, target that; supervision is 'have you done this, have you done that in these timescales'…I don't think I would feel confident to sit down with my manager…and just cry…if you don't feel supported and contained that's what makes it so incredibly scary…(Supervision by) someone who is experienced in HSB…would make me feel held and safe (S1, p.344).

Training (S4; S8) and the support of professional peers were both also reported to positively influence professionals' experiences of their work. Training was understood to be a medium through which professionals' perceived lack of skill (see theme two) could be addressed, whilst peer support helped professionals derive a personal sense of value and worth (S2; S7).

Discussion

This review aimed to answer the question: "what are the experiences of professionals who provide therapeutic intervention to CYP who have displayed HSB"? The synthesis of eight papers derived three overarching themes: (1) Counter-cultural beliefs (2) Professional self-confidence (3) Altered experiences of the world, which contains the subtheme: positive experiences emerging from the work. That only eight papers were identified after application of inclusion/exclusion criteria to the results of a systematic search is surprising given the international relevance of such investigations. Nonetheless, given the comprehensive search strategy and hand searching of both reference lists and citations of included papers, it is likely that the findings reported have been based on all available evidence.

That the views of society and wider professional networks were negative in relation to CYP who have displayed HSB aligns with literature which describes the unfavourable and polarised media portrayal of individuals who have sexually harmed others, for example as "incurable human predators" (Magers, Jennings, Tewksbury, & Miller, 2009, p.133), and how this in turn has led to the current climate of unfavourable opinion towards both these individuals and those that work therapeutically with them (Sahlstrom & Jeglic, 2008). The latter point also relates to the findings of Briggs (2013) that youth justice professionals can be viewed by society as being too lenient and ineffective. The danger of such attitudes is multi-faceted, having been argued to lead to self-fulfilling prophesies where CYP respond to labels

by living a life corresponding to the identity they are assigned (Muncie, 2009). Furthermore, the stigmatisation and isolation reported by professionals can lead to the experiencing of burnout and a reduction of their ability to enact change (Hardeberg Bach & Demuth, 2018; Moulden & Firestone, 2007). Furthermore it may deter professionals from entering this area of work, limiting resource availability (Hardeberg Bach & Demuth, 2019).

The finding that professionals could experience negative changes to their perception of the world, others and themselves due to their work suggests a similar experience to that reported among professionals working with adults who have sexually harmed others (Costantino & Malgady, 1996; Farrenkopf, 1992; Hardeberg Bach & Demuth, 2018; Moulden & Firestone, 2007). That professionals also reported experiencing stigmatisation and isolation due to their roles, both personally and among wider professional networks, indicates that the development of social support, reflective spaces and secure supervisory relationships may be beneficial (Maslach et al., 2001). Providing further support for such support structures are the findings reported by literature exploring the experiences of professionals working with adults who have sexually harmed others, where collegial support and reflective supervision are reported to be the primary means by which professionals receive support (Moulden & Firestone, 2007; Scheela, 2001; Willis et al., 2018).

The responsibilities an individual feels in relation to their role has been reported to strongly influence the impact of their role upon them (Seti, 2008). More specifically, role conflicts and role ambiguity can lead to professionals experiencing negative impacts from their work. Role conflicts emerge when the work expected of a professional is incompatible with their perceived abilities, values and/or beliefs, whilst role ambiguity emerges when professionals are not provided clarity regarding expectations placed on them (Harrison, 1980; Holloway & Wallinga, 1990). Professional's identified lack of confidence in their ability to provide HSB interventions may be understood to be a consequence of role conflict, where

professionals feel they lack the ability to fulfil their role. It has been reported that professionals working with CYP who have displayed HSB are often undertrained. For example, a recent inquiry into UK HSB service provision concluded that the level of understanding of among professionals in the UK varied greatly, with some professionals having an insufficient understanding of what HSB was or what to do when it was recognised (Barnardo's, 2016). It therefore appears important to improve consistency with which professionals are provided training, particularly as knowledge was identified within the findings of this meta-synthesis to be a source upon which professionals drew a sense of confidence.

Professionals may also experience role ambiguity due to the expectation upon them to be both guardians against risk and compassionate therapists providing holistic intervention (Barnardo's, 2016). Termed the dual identity problem, this experience has been well explored in a number of clinical and forensic populations (Greenberg & Shuman, 2007; Ward, 2013). It is theorised to emerge from a fundamental conflict between therapeutic values such as alleviating suffering and increasing quality of life, and forensic values which require the needs of the public are prioritised over the individual (Adshead & Sarkar, 2005; Ward, 2013). The fundamental conflict between these roles is argued to make fulfilling the requirements of both an impossible task, and one which professionals should not attempt, nor services require of their employees, instead splitting the responsibilities into two distinct roles (Greenberg & Shuman, 1997, 2007).

The finding that these negative changes within professionals were in some cases related to them experiencing sexual arousal within therapeutic sessions is notable. Acknowledgment of sexual arousal is argued to be taboo among professionals who provide therapeutic intervention (Pope, Sonne, & Greene, 2006), and in relation to CYP may be doubly taboo. Some authors have emphasised the importance of professionals having an awareness of the

potential for such experiences (Gil, 2006; Rymaszewska & Philpot, 2006), due to findings that where such feelings are denied or avoided this can lead the professional to become emotionally distant, punitive or even act out sexually towards the client (Tansey, 1994). It is therefore important for professionals providing therapeutic intervention to CYP who have displayed HSB to be informed that sexual arousal can be a normal response to working with sexual content (Pope, Sonne, & Holroyd, 1993) and that coping strategies such as avoidance may leave them emotionally detached from clients (Pope et al., 1993). Additionally, given the crucial role of supervision, particularly when reflective and where normalisation of these feelings occur, supervisors must be made available for these professionals (Pope et al., 1993).

Finally, the finding that the impact of the work on professionals could be positive provides an important perspective and addresses criticisms around failure to report positive experiences and compassion satisfaction (Hardeberg Bach & Demuth, 2018). Such findings are in keeping with those of Hardeberg Bach and Demuth (2019) and Scheela (2001), both of whom report professionals working with individuals who have sexually offended to experience a range of rewarding and positive impacts. That such experiences were reported in S1 may be related to the "sense of purpose and direction" (S1, p.341) and high quality supervision and support that participants in this study were reported to experience, as these align with those factors associated with developing compassion satisfaction (Maslach et al., 2001; Moulden & Firestone, 2007; Willis et al., 2018).

Clinical implications

The clinical recommendations which follow focus on two levels of the system surrounding CYP who have displayed HSB, the service level and the organisational level. This reflects a conscious choice to avoid making recommendations about what individual professionals may do differently, based on two related findings. First, Seti (2008) reports on a

consensus within the literature that the negative impact of one's role (burnout/CF/STS), is more a function of the service and organisational levels than it is a result of the individual. Second, Holloway and Wallinga (1990) suggest that interventions focused at the level of individual practitioners "tend to place the focus of blame on the individual who is experiencing burnout" (p.10). It is therefore hoped that the implications below will avoid the scapegoating of individuals and instead highlight the wider systemic change required.

In relation to the dual identity problem, a division of responsibility where one team member can focus fully on the therapeutic aspects of the role whilst the other takes the forensic component would appear to achieve two beneficial outcomes. First it would allow professionals to escape the conflict which currently is a defining feature of their role, and second it would facilitate a closer working relationship with peers, thereby increasing the chance for peer support and joint decision making, both of which have been found to reduce stress/negative impact of the role. Recognising that economic limitations may make this change unlikely, services should consider providing access reflective style supervision a priority alongside developing joint decision making forums where professionals can consult with peers and reach a shared consensus. Both of these factors have been found to be beneficial in reducing the negative impact of the role on professionals (Moulden & Firestone, 2007, 2010; Scheela, 2001).

In relation to supervision more widely, a key finding of this meta-synthesis has been the multiple benefits professionals experience through provision of regular, reflective supervision. Therefore, whilst recognising that supervision serves multiple purposes, particularly across the range of professions who may be involved in provision of therapeutic input, services should prioritise regular supervision which allows space for personal reflection. This is particularly pertinent when considering that a significant proportion of participants the studies in this sample drew upon were qualified social workers. McGregor (as

cited in Almond, 2014) reports that that over one third of UK social workers do not receive supervision and that over a third of social workers felt it was not regarded as an organisational priority.

This study highlights the impact that negative cultural beliefs regarding those who sexually offend against CYP can have on professionals, whether that be from direct communication with professional colleagues or wider societal attitudes. Whilst it is not the aim of the author to minimise the consequences of such behaviours, developing a discourse within society where more holistic understandings of CYP who display HSB can be shared would be beneficial. Through developing more holistic cultural understandings of why individuals may act as they do, more professionals may feel able to work within the field and experience lower levels of stress/negative impacts related to the role. This would particularly be beneficial in countries such as the USA, where punitive approaches predominate.

Strengths, limitations and future research

This is the first paper to systematically identify, appraise and synthesise qualitative literature exploring professionals' experiences of working with CYP who have displayed HSB. It has adhered to ENTREQ guidelines and included the use of an established quality appraisal tool. Undertaking qualitative research requires the researcher to become intimately involved in data analysis and to present their interpretation of the results (Geertz, 1973), a fact which is doubled in meta-synthesis where the research interprets others' interpretations. Therefore, Noblit and Hare (1988) argue the values and experiences of the researcher should be explicitly reported. The author has previously provided therapeutic input to two CYP who had displayed HSB, experiencing a personal reaction of reluctance and self-doubt, reflecting some of the beliefs reported in theme two of this study.

Epistemologically, the author identifies themselves as holding a social constructionist stance, believing that the realities, truths and meanings humans develop are shaped by their contexts and are consequently varied and multiple (Creswell, 2003). The author therefore recognises that their personal context will have unavoidably influenced the analysis presented within this meta-synthesis. Despite this inevitability, supervision was used to reduce the potential impact of such bias. The presence of potential bias is recognised as a necessary part of the meta-ethnography approach and thus is not strictly a limitation. It should however be acknowledged that the findings of this meta-synthesis are just one potential interpretation of the eight included studies.

All included studies were published in the English language and report on culturally "western" populations, a decision based on a lack of funding for translation and a sparsity of literature exploring HSB within diverse cultures. As such, participants' views are likely influenced by dominant "western" cultural narratives of childhood and sexuality and the findings presented should not be applied to the experiences of professionals from wider cultural backgrounds without first conducting further research.

A notable limitation of the studies included in this meta-synthesis is their failure to report the gender of the CYP participants reflected upon. Only two included studies, S3 and S5, describe such information with male adolescents comprising the majority (S5), or entirety (S3), of included CYP. This finding supports claims that the literature base is not representative of female CYP (Hackett, Branigan, & Holmes, 2019). Whilst it is understandable that the design of studies such as those included in this review, which ask professionals to reflect on a career's worth of experience, may be limited in how they are able to capture concrete data regarding CYP demographics, the literature base would benefit from investigations explicitly exploring the experiences of professionals in relation to the subgroups of CYP who at present are underrepresented.

It is notable that this study has made reference to research conducted with adults who have committed sexual offences. This may be perceived as a limitation by those who feel this fails to address the numerous differences that exist between adult and CYP populations and potentially contributes toward an evidence base for CYP who have displayed HSB being influenced by the attitudes of professionals towards adults who have committed sexual offences, which may be more punitive (Hackett, 2014). Indeed Hackett's (2014) widely accepted argument, that responses derived from work with adult sexual offenders are inappropriate for work with CYP who have displayed HSB, suggests such references must be made very carefully. However, within this study, where reference has been made to research with adult populations it has been done so in a thoughtful manner, with the findings of this meta-synthesis being compared to extant literature, rather than in the above described manner.

Finally, it may be perceived as a limitation that this meta-synthesis has not drawn explicit links between the experiences of professionals which are reported and terms such as burnout, CF and STS. The choice not to do so was deliberate, reflecting the focus of this investigation being on exploring the experiences of professionals rather than categorising them.

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Table 1-A: Characteristics of included studies

Study number	Author(s) & Year	Research Aims	Service type	Location	Sample & years of experience working with CYP who have displayed HSB	Data Collection	Data Analysis	Key Findings
S1	Almond (2014)	To explore the issues of impact and support in the context of working with CYP with HSB	HSB specialist services.	UK	16 specialist HSB practitioners (qualified social workers). Minimum 2 years' experience	Semi-structured interviews	Framework analysis	3 superordinate themes: Impact; support; supervision
S2	Chassman, Kottler & Madison (2010)	To explore the impact of working with adolescents with sexual behaviour problems	Various places of employment (Private practice, outpatient clinics, residential treatment programs).	USA & Australia	18 counsellors. Minimum 2 years' experience	Semi-structured interviews	Grounded Theory	Findings reported: counsellors' own histories of abuse, their feelings regarding sexual information, their sexual and emotional responses to clients and the importance of self-care and self-monitoring
S3	Etgar (1997)	To explore parallel processes in two group settings: groups of adolescent sex offenders and their counsellors' training and supervision group	Israel's Youth Probation Service	Israel	14 youth justice practitioners (qualified social workers). No prior experience.	Minutes of group supervision	Not reported	4 parallel processes: Feelings of isolation; The burden of responsibility; self-control - control of thoughts & deeds
S4	Hall (2006)	To explore what helped and hindered social workers in their work with CYP with HSB	Social Services Department	UK	14 social workers. Experience not reported	Semi-structured interviews	Thematic analysis	"Social workers described what helped them most in their work… " "Data were analysed to identify what social workers found the most difficult I their work"
S5	Ladwa-Thomas & Sanders	To explore: definitions of HSB; views regarding the cause of HSB; social work	Three specialist child protection teams.	Not stated	7 social workers Experience not	Interviews	Not reported	Findings reported personal resources needed to work with young abusers

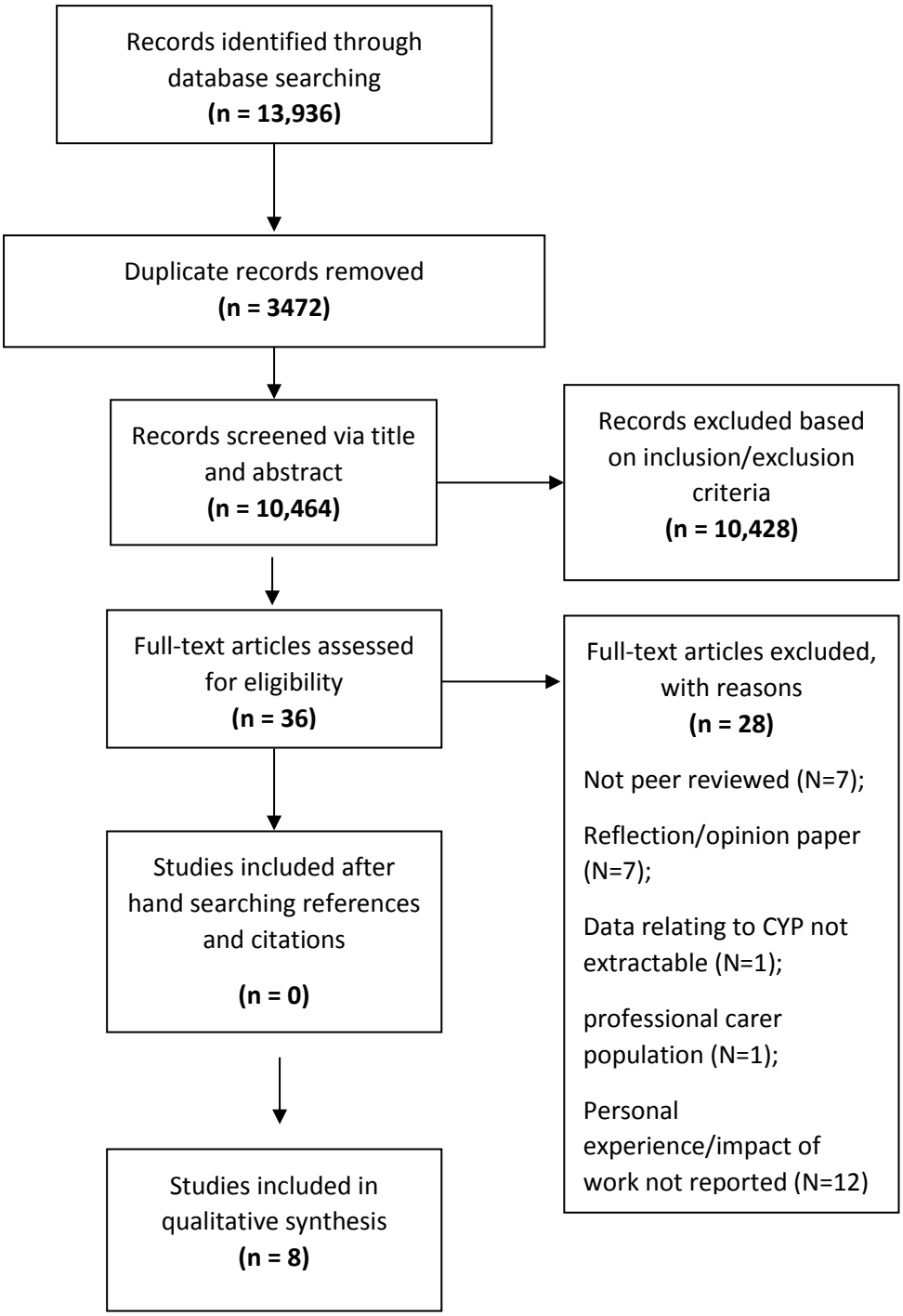
	(1999)	intervention and personal resources need to work with young abusers			reported			
S6	Myles-Wright & Nee (2017)	To explore the lived experiences of youth justice practitioners supervising CYP displaying HSB	Two youth offending services	UK	5 youth justice practitioners. Minimum one year of experience	Semi-structured interviews	Thematic Analysis	Overarching theme of: "systemic unease" which contained subthemes: "unease with the self, and wider YOS personnel" and "unease working with partner agencies".
S7	Russell & Harvey (2016)	To explore the psychosocial experience of staff working with adolescents displaying sexually harmful behaviour	One youth offending team and attached sexual behaviour specialist service	UK	8 youth justice practitioners. experience ranged from <3 – 10+ years	Semi-structured interviews	Interpretative Phenomenological Analysis (IPA)	3 superordinate themes: client-focused; challenges within the role; looking after the self
S8	Shevade, Norris & Swann (2011)	To explore the reactions of therapists working with children with HSB and how these reactions can be managed	Various places of employment (Specialist service for young offenders, private practice, CAMHS)	UK	9 qualified therapists. 2-16 years' experience.	Semi-structured interviews	Thematic analysis	4 major themes: "therapist reactions in the session", "systemic anxieties and the effect on the therapist", "personal effect on the therapist" and "management of therapist reactions".

Table 1-B: CASP checklist results

Study	Research aims	Qualitative methodology appropriate	Research design	Sampling	Data collection	Reflexivity	Ethical issues	Data analysis	Findings	Value	Total
Almond (2014)	Y	Y	3	3	2	3	3	1	2	2	19
Chassman, Kottler & Madison (2010)	Y	Y	2	2	3	2	1	3	3	2	18
Etgar (1996)	Y	Y	1	2	1	1	1	1	2	1	10
Hall (2006)	Y	Y	1	2	2	1	2	1	2	2	13
Ladwa-Thomas & Sanders (1999)	Y	Y	1	1	1	1	1	1	2	2	10
Myles-Wright & Nee (2017)	Y	Y	3	2	2	2	3	2	3	3	20
Russell & Harvey (2016)	Y	Y	3	2	3	1	3	3	2	3	20
Shevade, Norris & Swann (2011)	Y	Y	3	2	2	1	3	2	3	2	18

Note: Weak/lacking evidence = 1; Moderate/partial evidence = 2; Strong/full criteria = 3

Figure 1-A: Flowchart of paper selection based on Moher, Liberati, Tetzlaff, Altman, & The PRISMA group's (2009) four phase flow diagram



Appendix 1-A: CHIP Tool

Context	**What contexts are of interest?** **Children/young people who display harmful sexual behaviour:** Looked after children's services / youth offending services / child & adolescent therapeutic services / fostering & adoption services /social care services
How	**What research methods are of interest?** Qualitative research methods
Issues	**What issues related to working in these settings are of interest?** Professional's experiences of working with children/young people who display harmful sexual behaviours. The impact of this work upon the individual i.e. emotional wellbeing, beliefs, behaviour, mood, relationships. The coping strategies utilised by individuals
Population	**Which groups are of interest?** Professionals who work with children/young people who display harmful sexual behaviours.
	Identified research questions • What are the experiences and personal impacts of professionals who work with children/young people who display harmful sexual behaviours? • How do professionals make sense of and manage these experiences?

Appendix 1-B: Search Strategy

Database: SCOPUS

	CHIP term 1 - Children & Young people	**Where searched & number of results:**
1	Child* OR Adolescent* OR teenager* OR juvenile* OR boy* OR girl* OR young people OR childhood OR youth*	Title, abstract, keyword: 701,960
2		
3	**CHIP Term 2 – Harmful sexual behaviours**	
4	"Harmful sex* behavi*" OR "sexual* harmful behavi*" OR "sex* abusive behavi*" OR "abusive sex* behavi*" OR "sex* reactive behavi*" OR "problem* sex* behavi*" OR "sexual* problem* behavi*" OR "sex* behavi* problem*" OR "sexual* aggress*" OR "sex* violen*"	Title, abstract, keyword: 9,684
5		
6	**CHIP term 3 - qualitative**	
7	Interview* OR qualitative OR interpretive OR "focus group" OR "grounded theory" OR hermeneutic OR narrative OR them* OR "interpretative phenomenological analys*" OR "IPA" OR "content analys*" OR ethnolog* OR "case stud*" OR experience* Or perspective OR survey OR phenomenol* OR attitude* OR view*	Title, abstract, keyword: 7,064,984
8		
9	**CHIP term 4 - Professionals**	
10	Professional* OR clinical OR staff OR practitioner* OR worker* OR "youth offending team" OR psychologist* OR personnel OR therapist* OR "mental health professional*" OR psychiatrist* OR "treatment provider*" OR "social service*" OR "behavi* analyst*" OR counsel* OR "social care service*"	Title, abstract, keyword: 10,554,132
11		
12	1 AND 4 AND 7 AND 10	430
12	1 AND 4 AND 7 AND 10	430

Database: Medline

	CHIP term 1 – Children & Young people	**Where searched & number of results:**
1	Child* OR Adolescent* OR teenager* OR juvenile* OR boy* OR girl* OR young people OR childhood OR youth*	Title: 906,262
2	Child* OR Adolescent* OR teenager* OR juvenile* OR boy* OR girl* OR young people OR childhood OR youth*	Abstract: 1,271,952
3	(MH "Child") OR (MH "Adolescent") OR (MH "Minors")	MH exact subject heading: 2,649,753
4	1 OR 2 OR 3	3,282,831
5		
6	**CHIP term 2 – Harmful sexual behaviours**	
7	"Harmful sex* behavi*" OR "sexual* harmful behavi*" OR "sex* abusive behavi*" OR "abusive sex* behavi*" OR "sex* reactive behavi*" OR "problem* sex* behavi*" OR "sexual* problem* behavi*" OR "sex* behavi* problem*" OR "sexual* aggress*" OR "sex* violen*"	Title: 1,297
8	"Harmful sex* behavi*" OR "sexual* harmful behavi*" OR "sex* abusive behavi*" OR "abusive sex* behavi*" OR "sex* reactive behavi*" OR "problem* sex* behavi*" OR "sexual* problem* behavi*" OR "sex* behavi* problem*" OR "sexual* aggress*" OR "sex* violen*"	Abstract: 3,360
9	(MH "Child Abuse, Sexual") OR (MH "Sex Offenses") OR (MH "Rape")	MH exact subject heading:

		21,913
10	7 OR 8 OR 9	23,752
11		
12	**CHIP term 3 – Qualitative**	
13	Interview* OR qualitative OR interpretive OR "focus group" OR "grounded theory" OR hermeneutic OR narrative OR them* OR "interpretative phenomenological analys*" OR "IPA" OR "content analys*" OR ethnolog* OR "case stud*" OR experience* Or perspective OR survey OR phenomenol* OR attitude* OR view*	Title: 708,935
14	Interview* OR qualitative OR interpretive OR "focus group" OR "grounded theory" OR hermeneutic OR narrative OR them* OR "interpretative phenomenological analys*" OR "IPA" OR "content analys*" OR ethnolog* OR "case stud*" OR experience* Or perspective OR survey OR phenomenol* OR attitude* OR view*	Abstract: 2,708,808
15	(MH "Qualitative Research")	MH exact subject heading: 43,573
16	13 OR 14 OR 15	3,113,518
17		
18	**CHIP term 4 – professionals**	
19	Professional* OR clinical OR staff OR practitioner* OR worker* OR "youth offending team" OR psychologist* OR personnel OR therapist* OR "mental health professional*" OR psychiatrist* OR "treatment provider*" OR "social service*" OR "behavi* analyst*" OR counsel* OR "social care service*"	Title: 953,220
20	Professional* OR clinical OR staff OR practitioner* OR worker* OR "youth offending team" OR psychologist* OR personnel OR therapist* OR "mental health professional*" OR psychiatrist* OR "treatment provider*" OR "social service*" OR "behavi* analyst*" OR counsel* OR "social care service*"	Abstract: 3,301,967
21	(MH "Psychology") OR (MH "Social Workers") OR (MH "Counselors") OR (MH "Social Work, Psychiatric")	MH exact subject heading: 25,659
22	19 OR 20 OR 21	3,820,980
23		
24	4 AND 10 AND 16 AND 22	**2,158**

Database: CINAHL

	CHIP term 1 - Children & Young people	**Where searched & number of results:**
1	Child* OR Adolescent* OR teenager* OR juvenile* OR boy* OR girl* OR young people OR childhood OR youth*	Title: 327,896
2	Child* OR Adolescent* OR teenager* OR juvenile* OR boy* OR girl* OR young people OR childhood OR youth*	Abstract: 366,373
3	(MH "Adolescence") OR (MH "Child") OR (MH "Minors (Legal)")	MH exact subject headings: 660,503
4	1 OR 2 OR 3	855,208
5		
6	**CHIP term 2 – Harmful sexual behaviours**	
7	"Harmful sex* behavi*" OR "sexual* harmful behavi*" OR "sex* abusive behavi*" OR "abusive sex* behavi*" OR "sex* reactive behavi*" OR "problem* sex* behavi*" OR "sexual* problem* behavi*" OR "sex* behavi* problem*" OR "sexual* aggress*" OR "sex* violen*"	Title: 1,040
8	"Harmful sex* behavi*" OR "sexual* harmful behavi*" OR "sex* abusive behavi*" OR "abusive sex* behavi*" OR "sex* reactive behavi*" OR	Abstract: 1,875

	"problem* sex* behavi*" OR "sexual* problem* behavi*" OR "sex* behavi* problem*" OR "sexual* aggress*" OR "sex* violen*"	
9	(MH "Sex Offenders") OR (MH "Sexual Abuse") OR (MH "Child Abuse, Sexual") OR (MH "Incest") OR (MH "Rape")	MH exact subject headings: 15,591
10	7 OR 8 OR 9	16,491
11		
12	**CHIP term 3 – Qualitative**	
13	Interview* OR qualitative OR interpretive OR "focus group" OR "grounded theory" OR hermeneutic OR narrative OR them* OR "interpretative phenomenological analys*" OR "IPA" OR "content analys*" OR ethnolog* OR "case stud*" OR experience* Or perspective OR survey OR phenomenol* OR attitude* OR view*	Title: 269,854
14	Interview* OR qualitative OR interpretive OR "focus group" OR "grounded theory" OR hermeneutic OR narrative OR them* OR "interpretative phenomenological analys*" OR "IPA" OR "content analys*" OR ethnolog* OR "case stud*" OR experience* Or perspective OR survey OR phenomenol* OR attitude* OR view*	Abstract: 771,371
15	(MH "Qualitative Studies+") OR (MH "Content Analysis") OR (MH "Discourse Analysis") OR (MH "Thematic Analysis") OR (MH "Interviews+") OR (MH "Focus Groups")	MH exact subject headings: 270,820
16	13 OR 14 OR 15	996,272
17		
18	**CHIP term 4 – professionals**	
19	Professional* OR clinical OR staff OR practitioner* OR worker* OR "youth offending team" OR psychologist* OR personnel OR therapist* OR "mental health professional*" OR psychiatrist* OR "treatment provider*" OR "social service*" OR "behavi* analyst*" OR counsel* OR "social care service*"	Title: 329,106
20	Professional* OR clinical OR staff OR practitioner* OR worker* OR "youth offending team" OR psychologist* OR personnel OR therapist* OR "mental health professional*" OR psychiatrist* OR "treatment provider*" OR "social service*" OR "behavi* analyst*" OR counsel* OR "social care service*"	Abstract: 848,053
21	(MH "Mental Health Personnel+") OR (MH "Social Workers") OR (MH "Correctional Facilities Personnel") OR (MH "Counselors")	MH exact subject headings: 19,164
22	19 OR 20 OR 21	1,048,170
23		
24	4 AND 10 AND 16 AND 22	**1,358**

Database: Academic Search Ultimate:

	CHIP term 1 - Children & Young people	**Where searched & number of results:**
1	Child* OR Adolescent* OR teenager* OR juvenile* OR boy* OR girl* OR young people OR childhood OR youth*	Title: 635,272
2	Child* OR Adolescent* OR teenager* OR juvenile* OR boy* OR girl* OR young people OR childhood OR youth*	Abstract: 1,438,226
3	DE "CHILDREN" OR DE "ADOLESCENCE" OR DE "TEENAGERS" OR DE "YOUNG adults" OR DE "YOUTH"	Subject term: 189,563
4	1 OR 2 OR 3	1,601,975
5		
6	**CHIP term 2 – Harmful sexual behaviours**	
7	"Harmful sex* behavi*" OR "sexual* harmful behavi*" OR "sex* abusive behavi*" OR "abusive sex* behavi*" OR "sex* reactive behavi*" OR	Title: 2,215

	"problem* sex* behavi*" OR "sexual* problem* behavi*" OR "sex* behavi* problem*" OR "sexual* aggress*" OR "sex* violen*"	
8	"Harmful sex* behavi*" OR "sexual* harmful behavi*" OR "sex* abusive behavi*" OR "abusive sex* behavi*" OR "sex* reactive behavi*" OR "problem* sex* behavi*" OR "sexual* problem* behavi*" OR "sex* behavi* problem*" OR "sexual* aggress*" OR "sex* violen*"	Abstract: 6,356
9	DE "CHILD sex offenders" OR DE "CHILDREN'S sexual behavior" OR DE "TEENAGE sex offenders" OR DE "RAPISTS" OR DE "SEX crimes" OR DE "SEX offenders"	Subject Term: 17,073
10	7 OR 8 OR 9	22,126
11		
12	**CHIP term 3 – Qualitative**	
13	Interview* OR qualitative OR interpretive OR "focus group" OR "grounded theory" OR hermeneutic OR narrative OR them* OR "interpretative phenomenological analys*" OR "IPA" OR "content analys*" OR ethnolog* OR "case stud*" OR experience* Or perspective OR survey OR phenomenol* OR attitude* OR view*	Title: 659,073
14	Interview* OR qualitative OR interpretive OR "focus group" OR "grounded theory" OR hermeneutic OR narrative OR them* OR "interpretative phenomenological analys*" OR "IPA" OR "content analys*" OR ethnolog* OR "case stud*" OR experience* Or perspective OR survey OR phenomenol* OR attitude* OR view*	Abstract: 3,935,062
15	DE "QUALITATIVE research" OR DE "CONVERSATION analysis" OR DE "EDUCATION -- Qualitative research" OR DE "FOCUS groups" OR DE "PHENOMENOGRAPHY" OR DE "INTERVIEWING" OR DE "QUALITATIVE research"	Subject terms: 109,853
16	13 OR 14 OR 15	4,208,931
17		
18	**CHIP term 4 – professionals**	
19	Professional* OR clinical OR staff OR practitioner* OR worker* OR "youth offending team" OR psychologist* OR personnel OR therapist* OR "mental health professional*" OR psychiatrist* OR "treatment provider*" OR "social service*" OR "behavi* analyst*" OR counsel* OR "social care service*"	Title: 416,996
20	Professional* OR clinical OR staff OR practitioner* OR worker* OR "youth offending team" OR psychologist* OR personnel OR therapist* OR "mental health professional*" OR psychiatrist* OR "treatment provider*" OR "social service*" OR "behavi* analyst*" OR counsel* OR "social care service*"	Abstract: 2,139,012
21	DE "SOCIAL services" OR DE "SOCIAL work with sex offenders" OR DE "PSYCHOLOGISTS" OR DE "BEHAVIOR analysts" OR DE "CHILD psychologists" OR DE "CLINICAL psychologists" OR DE "COMMUNITY psychologists" OR DE "COUNSELING psychologists" OR DE "FORENSIC psychologists" OR DE "PSYCHOTHERAPISTS" OR DE "SOCIAL workers" OR DE "ART therapists" OR DE "BEHAVIOR therapists" OR DE "CHILD psychotherapists" OR DE "FAMILY therapists" OR DE "FAMILY counselors" OR DE "MENTAL health counselors" OR DE "CHILD welfare workers" OR DE "PSYCHIATRIC social workers" OR DE "COUNSELORS" OR DE "YOUTH workers (Social services)"	Subject terms: 54,716
22	19 OR 20 OR 21	2,285,653
23		
24	4 AND 10 AND 16 AND 22	**980**

Database: SocINDEX

	CHIP term 1 - Children & Young people	**Where searched & number of results:**
1	Child* OR Adolescent* OR teenager* OR juvenile* OR boy* OR girl* OR young people OR childhood OR youth*	Title: 168,705
2	Child* OR Adolescent* OR teenager* OR juvenile* OR boy* OR girl* OR young people OR childhood OR youth*	Abstract: 326,980
3	DE "CHILDREN" OR DE "BOYS" OR DE "GIRLS" OR DE "ADOLESCENCE" OR DE "MINORS" OR DE "TEENAGERS" OR DE "YOUTH"	Subject terms: 48,243
4	1 OR 2 OR 3	353,209
5		
6	**CHIP term 2 – Harmful sexual behaviours –**	
7	"Harmful sex* behavi*" OR "sexual* harmful behavi*" OR "sex* abusive behavi*" OR "abusive sex* behavi*" OR "sex* reactive behavi*" OR "problem* sex* behavi*" OR "sexual* problem* behavi*" OR "sex* behavi* problem*" OR "sexual* aggress*" OR "sex* violen*"	Title: 1,378
8	"Harmful sex* behavi*" OR "sexual* harmful behavi*" OR "sex* abusive behavi*" OR "abusive sex* behavi*" OR "sex* reactive behavi*" OR "problem* sex* behavi*" OR "sexual* problem* behavi*" OR "sex* behavi* problem*" OR "sexual* aggress*" OR "sex* violen*"	Abstract: 3,452
9	DE "TEENAGE sex offenders" OR DE "SEXUAL aggression" OR DE "SEX crimes" OR DE "SEX offenders" OR DE "SEXUAL harassment"	Subject terms: 12,354
10	7 OR 8 OR 9	14,887
11		
12	**CHIP term 3 – Qualitative**	
13	Interview* OR qualitative OR interpretive OR "focus group" OR "grounded theory" OR hermeneutic OR narrative OR them* OR "interpretative phenomenological analys*" OR "IPA" OR "content analys*" OR ethnolog* OR "case stud*" OR experience* Or perspective OR survey OR phenomenol* OR attitude* OR view*	Title: 148,392
14	Interview* OR qualitative OR interpretive OR "focus group" OR "grounded theory" OR hermeneutic OR narrative OR them* OR "interpretative phenomenological analys*" OR "IPA" OR "content analys*" OR ethnolog* OR "case stud*" OR experience* Or perspective OR survey OR phenomenol* OR attitude* OR view*	Abstract: 705,776
15	DE "QUALITATIVE research" OR DE "CONVERSATION analysis" OR DE "FOCUS groups" OR DE "PARTICIPANT observation" OR DE "INTERVIEWING"	Subject terms: 29,692
16	13 OR 14 OR 15	750,096
17		
18	**CHIP term 4 – professionals**	
19	Professional* OR clinical OR staff OR practitioner* OR worker* OR "youth offending team" OR psychologist* OR personnel OR therapist* OR "mental health professional*" OR psychiatrist* OR "treatment provider*" OR "social service*" OR "behavi* analyst*" OR counsel* OR "social care service*"	Title: 68,257
20	Professional* OR clinical OR staff OR practitioner* OR worker* OR "youth offending team" OR psychologist* OR personnel OR therapist* OR "mental health professional*" OR psychiatrist* OR "treatment provider*" OR "social service*" OR "behavi* analyst*" OR counsel* OR "social care service*"	Abstract: 302,948
21	DE "YOUTH workers (Social services)" OR DE "SOCIAL workers" OR DE "FAMILY therapists" OR DE "COUNSELORS" OR DE "PSYCHOLOGISTS" OR DE "BEHAVIOR analysts" OR DE "POLICE psychologists" OR DE "PSYCHOTHERAPISTS"	Subject term: 24,179

22	19 OR 20 OR 21	319,993
23	4 AND 10 AND 16 AND 22	**974**

Database: Social Care online:

	CHIP term 1 - Children & Young people	**Where searched & number of results:**
1	Child* OR Adolescent* OR teenager* OR juvenile* OR boy* OR girl* OR young people OR childhood OR youth*	Title: 31,453
2	Child* OR Adolescent* OR teenager* OR juvenile* OR boy* OR girl* OR young people OR childhood OR youth*	Abstract: 50,462
3	"young people" OR "children" (include narrower terms)	Subject term: 38,992
4	1 OR 2 OR 3	59,922
5		
6	**CHIP term 2 – Harmful sexual behaviours –**	
7	"Harmful sex* behavi*" OR "sexual* harmful behavi*" OR "sex* abusive behavi*" OR "abusive sex* behavi*" OR "sex* reactive behavi*" OR "problem* sex* behavi*" OR "sexual* problem* behavi*" OR "sex* behavi* problem*" OR "sexual* aggress*" OR "sex* violen*"	Title: 475
8	"Harmful sex* behavi*" OR "sexual* harmful behavi*" OR "sex* abusive behavi*" OR "abusive sex* behavi*" OR "sex* reactive behavi*" OR "problem* sex* behavi*" OR "sexual* problem* behavi*" OR "sex* behavi* problem*" OR "sexual* aggress*" OR "sex* violen*"	Abstract: 2437
9	"harmful sexual behaviour" OR "young sex offenders" OR "sexual offences" (THIS TERM ONLY)	Subject terms: 984
10	7 OR 8 OR 9	2390
11		
12	**CHIP term 3 – Qualitative**	
13	Interview* OR qualitative OR interpretive OR "focus group" OR "grounded theory" OR hermeneutic OR narrative OR them* OR "interpretative phenomenological analys*" OR "IPA" OR "content analys*" OR ethnolog* OR "case stud*" OR experience* Or perspective OR survey OR phenomenol* OR attitude* OR view*	Title: 12,362
14	Interview* OR qualitative OR interpretive OR "focus group" OR "grounded theory" OR hermeneutic OR narrative OR them* OR "interpretative phenomenological analys*" OR "IPA" OR "content analys*" OR ethnolog* OR "case stud*" OR experience* Or perspective OR survey OR phenomenol* OR attitude* OR view*	Abstract: 65,530
15	"qualitative research" (THIS TERM ONLY)	Subject terms: 814
16	13 OR 14 OR 15	68,599
17		
18	**CHIP term 4 – professionals**	
19	Professional* OR clinical OR staff OR practitioner* OR worker* OR "youth offending team" OR psychologist* OR personnel OR therapist* OR "mental health professional*" OR psychiatrist* OR "treatment provider*" OR "social service*" OR "behavi* analyst*" OR counsel* OR "social care service*"	Title: 8,708
20	Professional* OR clinical OR staff OR practitioner* OR worker* OR "youth offending team" OR psychologist* OR personnel OR therapist* OR "mental health professional*" OR psychiatrist* OR "treatment provider*" OR "social service*" OR "behavi* analyst*" OR counsel* OR "social care service*"	Abstract: 39,384
21	"Care workforce" OR "Professionals" (include narrower terms)	Subject terms: 14,476

22	19 OR 20 OR 21	46,582
23		
24	4 AND 10 AND 16 AND 22	**21,658**
26	4 AND 10 AND 22 (qualitative criteria excluded)	**371**

Database: PsychINFO

	CHIP term 1 – Children & Young people	**Search location & results:**
1	Child* OR Adolescent* OR teenager* OR juvenile* OR boy* OR girl* OR young people OR childhood OR youth*	Title: 466, 981
2	Child* OR Adolescent* OR teenager* OR juvenile* OR boy* OR girl* OR young people OR childhood OR youth*	Abstract: 815,050
3	No relevant terms identified	DE Subjects: N/A
4	1 OR 2	876,765
5		
6	**CHIP term 2 – Harmful sexual behaviours**	
7	"Harmful sex* behavi*" OR "sexual* harmful behavi*" OR "sex* abusive behavi*" OR "abusive sex* behavi*" OR "sex* reactive behavi*" OR "problem* sex* behavi*" OR "sexual* problem* behavi*" OR "sex* behavi* problem*" OR "sexual* aggress*" OR "sex* violen*"	Title: 2,138
8	"Harmful sex* behavi*" OR "sexual* harmful behavi*" OR "sex* abusive behavi*" OR "abusive sex* behavi*" OR "sex* reactive behavi*" OR "problem* sex* behavi*" OR "sexual* problem* behavi*" OR "sex* behavi* problem*" OR "sexual* aggress*" OR "sex* violen*"	Abstract: 5,912
9	DE "Rape" OR DE "Child Abuse" OR DE "Incest" OR DE "Sex Offenses" OR DE "Sexual Abuse" OR DE "Sexual Harassment"	DE Subjects: 57, 493
10	7 OR 8 OR 9	59,819
11		
12	**CHIP term 3 – Qualitative**	
13	Interview* OR qualitative OR interpretive OR "focus group" OR "grounded theory" OR hermeneutic OR narrative OR them* OR "interpretative phenomenological analys*" OR "IPA" OR "content analys*" OR ethnolog* OR "case stud*" OR experience* Or perspective OR survey OR phenomenol* OR attitude* OR view*	Title: 352,411
14	Interview* OR qualitative OR interpretive OR "focus group" OR "grounded theory" OR hermeneutic OR narrative OR them* OR "interpretative phenomenological analys*" OR "IPA" OR "content analys*" OR ethnolog* OR "case stud*" OR experience* Or perspective OR survey OR phenomenol* OR attitude* OR view*	Abstract: 1,686,318
15	DE "Qualitative Methods" OR DE "Focus Group" OR DE "Grounded Theory" OR DE "Interpretative Phenomenological Analysis" OR DE "Narrative Analysis" OR DE "Semi-Structured Interview" OR DE "Thematic Analysis" OR DE "Mixed Methods Research" OR DE "Phenomenology"	DE subjects: 26,028
16	13 OR 14 OR 15	1,764,394
17		
18	**CHIP term 4 – professionals**	
19	Professional* OR clinical OR staff OR practitioner* OR worker* OR "youth offending team" OR psychologist* OR personnel OR therapist* OR "mental health professional*" OR psychiatrist* OR "treatment provider*" OR "social service*" OR "behavi* analyst*" OR counsel* OR "social care service*"	Title: 210,932
20	Professional* OR clinical OR staff OR practitioner* OR worker* OR "youth offending team" OR psychologist* OR personnel OR therapist* OR "mental	Abstract: 974,701

	health professional*” OR psychiatrist* OR “treatment provider*” OR “social service*” OR “behavi* analyst*” OR counsel* OR “social care service*”	
21	DE "Counselor Trainees" OR DE "Therapist Trainees" OR DE "Psychoanalysts" OR DE "Counseling Psychologists" OR DE "Clinical Psychologists" OR DE "Psychiatric Social Workers" OR DE "Psychiatrists" OR DE "Psychotherapists" OR DE "Psychologists" OR DE "Paraprofessional Personnel" OR DE "Professional Personnel" OR DE "Counselors" OR DE "Social Workers" OR DE "Therapists" OR DE "Mental Health Personnel" OR DE “Clinicians”	DE subjects; 106,871
22	19 OR 20 OR 21	1,037,770
23		
24	**4 AND 10 AND 16 AND 22**	**7,665**

Appendix 1-C: Extracts from Final Meta-Synthesis Table

Relevant Papers	Examples of Themes & Concepts from studies	Key Themes (Final Iterations)	Subtheme(s)	Over-arching Theme
S1 Almond, 2014 S4 Hall, 2006 S5 Ladwa-Thomas & Sanders, 1999 S6 Myles-Wright & Nee, 2017 S7 Russell & Harvey, 2016 S8 Shevade, Norris, & Swann, 2011	HSB different than other offences (Myles-Wright & Nee, 2017). Some feel they shouldn't have to work with these CYP (Ladwa-Thomas & Sanders, 1999). Negative societal labels of HSB not shared- Viewed CYP with compassion (Russell & Harvey, 2016).	Perception of HSB vs. other offending behaviours	N/A	**Counter-cultural beliefs**
	MDT as best practice (Ladwa-Thomas & Sanders, 1999) Feeling pressured, deskilled and uncomfortable with MDT role (Shevade, Norris & Swann, 2011) Agencies panic about HSB management (Myles-Wright & Nee, 2017)	Multi-disciplinary working		
S1 Almond, 2014 S3 Etgar, 1997 S4 Hall, 2006 S5 Ladwa-Thomas & Sanders, 1999 S6 Myles-Wright & Nee, 2017 S7 Russell & Harvey, 2016 S8 Shevade, Norris, & Swann, 2011	Sense of responsibility for the actions of client (Etgar, 1997) Feeling of responsibility for CYP's actions (Myles-Wright & Nee, 2017)	Feeling responsible for CYP's actions	N/A	**Professional self-confidence**
	Professionals do not feel they know how to work with HSB, or what to cover (Myles-Wright & Nee, 2017) Practitioners felt under skilled to fulfil requirements of the role (Ladwa-Thomas & Sanders, 1999) Participants question their ability (Shevade, Norris & Swann, 2011)	Feeling under-skilled		
S1 Almond, 2014 S2 Chassman, Kottler, & Madison, 2010 S4 Hall, 2006 S5 Ladwa-Thomas	Less trusting of the world and people in general (Shevade, Norris & Swann, 2011) Some professionals felt more vulnerable, suspicious and cautious (Almond, 2014)	Increasing vulnerability		**Altered experiences of the world**

& Sanders, 1999 S6 Myles-Wright & Nee, 2017 S7 Russell & Harvey, 2016 S8 Shevade, Norris, & Swann, 2011	Disgust, fear, feeling of vulnerability (Chassman, Kottler & Madison, 2010) Isolation & stigmatisation (Etgar, 1997) Identifying as an abuser (Chassman, Kottler & Madison, 2010) Participants felt powerless (Shevade, Norris & Swann, 2011)			
	Distress re: experiencing sexual arousal (Shevade, Norris & Swann, 2011) Disgust with self for experiencing sexual arousal (Chassman, Kottler & Madison, 2010) Acceptance of sexual arousal as natural response to the content of the work (Chassman, Kottler & Madison, 2010)	Experiencing sexual arousal		
	Personal growth due to HSB work (Shevade, Norris & Swann, 2011) Some professionals felt the work benefitted them personally (Almond, 2014) A sense of purpose (Almond, 2014)	Positive impact of HSB work	Positive experiences emerging from the work	
	Variety of personal resources help coping: exercise, creative activities, relaxation, prayer (Shevade, Norris & Swann, 2011) Activities external to work essential to replenishing emotional energy (Chassman, Kottler & Madison, 2010) Disconnecting from work (Russell & Harvey, 2016)	External support		

	Support of colleagues is an important coping resource (Russell & Harvey, 2016). Professional peers a valued source of support (Chassman, Kottler & Madison, 2010)	Support of professional peers		
	Training reflecting realties of role is helpful (Hall, 2006) Training increases coping resources (Shevade, Norris & Swann, 2011)	Training		
	Supervision a source of ongoing support, when available. (Chassman, Kottler & Madison, 2010) Reflective practice is valued highly (Almond, 2014) Reflection on personal feelings towards CYP used to manage unease felt about HSB (Myles-Wright & Nee, 2017)	Supervision		

Appendix 1-D : Journal of Sexual Aggression, Instructions for Authors

About the Journal

Journal of Sexual Aggression is an international, peer-reviewed journal publishing high-quality, original research. Please see the journal's Aims & Scope for information about its focus and peer-review policy.

Please note that this journal only publishes manuscripts in English.

Journal of Sexual Aggression accepts the following types of article: original articles.

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Structure

Your paper should be compiled in the following order: title page; abstract; keywords; main text introduction, materials and methods, results, discussion; acknowledgments; declaration of interest statement; references; appendices (as appropriate); table(s) with caption(s) (on individual pages); figures; figure captions (as a list).

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A typical article (Research and conceptual development) for this journal would usually be 6000 words (this limit does not include tables, figure captions or references), but longer papers are considered at the editor's discretion if they are reporting on a substantial body of work. A typical Review article for this journal should be no more than 8000 words; this limit does not include tables, references or figure captions. A typical Practice article for this journal should be no more than 6000 words; this limit does not include tables, references or figure captions. A typical Debate article for this journal should be no more than 5000 words; this limit does not include tables, references or figure captions.

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Between 6 and 6 **keywords**. Read making your article more discoverable, including information on choosing a title and search engine optimization.

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Section Two: Empirical Paper

Residential Care Worker Experiences of Caring for Children & Young People who display Harmful Sexual Behaviours

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Trainee Clinical Psychologist

Lancaster University

Word Count: 8000

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Prepared for: Journal of Sexual Aggression

Abstract

Relationships between residential care workers and looked after children and young people are recognised as important, but the impact of working with children and young people who have displayed harmful sexual behaviours is underexplored. Using qualitative methodology, nine residential care workers were interviewed. The data were analysed using thematic analysis. Four themes were reported: 1) “In theory you should hate them” – The impact of personal beliefs; 2) “You learn why they behaved like they did” - Developing alternative understandings of HSB; 3) “We are here to care” - Purpose of the role; and 4) “I didn’t feel safe, he made my skin crawl” - The impact of threat. Themes are discussed in relation to relevant literature and clinical implications for residential care services are discussed.

Keywords: harmful sexual behaviour; looked after children and young people; staff; residential care; relationship; organisation

This report will use the term children and young people (CYP) to avoid referring to all CYP as children, which would disregard the emotional, cognitive and relational differences between, for example, a 9 year old and a 17 year old. The term 'looked after child or young person' (LACYP) is commonly used within the literature to refer to CYP who are in the care of the local authority. Use of this term serves to continually highlight the "otherness" of these CYP, setting them apart from those who are not in care. Therefore, this report will use the term CYP, but, where necessary will refer to LACYP to distinguish information specific to this subset of CYP.

Residential Care

LACYP are cared for across a range of settings, with international guidance suggesting residential care be used only as a "last-resort" (Stockholm Declaration, 2003; United Nations General Assembly, 2009). Family oriented placements (i.e. kinship care, foster care) are preferred due to CYP's need "for secure attachments and to be cared-about, not just cared-for" (Hart, La Valle, & Holmes, 2015, p.22). Whilst some nations, including Japan, Germany and Denmark continue to place a high proportion of LACYP in residential care (Ainsworth & Thoburn, 2014) other nations, including the United Kingdom (UK) and Australia have reduced their use of residential care in recent years (Ainsworth & Thoburn, 2014). Within the UK, residential care is now most commonly used only after multiple family centred placements have broken down (Hart et al., 2015; NICE, 2015). It has been observed that a consequence of using residential care in this manner is the development of a narrative that residential care is a last resort, for only the most challenging CYP (Hart et al., 2015; Steels & Simpson, 2017). Despite this, multiple literature reviews have found residential care to provide beneficial outcomes for CYP (Hair, 2005; James, 2011; Knorth, Harder, Zandberg, & Kendrick, 2008) with these benefits suggested to arise from the interplay of a number of

factors including; the organisational context, the personal characteristics of the CYP and the staff providing care (McLean, 2015).

UK guidance describes the purpose of residential care as including: developing nurturing bonds between CYP and staff; meeting the CYP's physical, social and emotion needs and providing the CYP a safe environment (DfE, 2015a). Hart et al., (2015) expand on these purposes, arguing residential care may be used for temporary care, assessment or as preparation for long-term foster placements. Such a variety of purposes can create confusion for staff working within residential care settings; referred to as residential care workers (RCWs) within this report. RCW beliefs regarding the purpose of their role are heavily influenced by the perceived purpose of the organisation (Hart et al., 2015), which are often poorly communicated (Berridge, Biehal, & Henry, 2012). For example, RCWs have been reported to experience competing pressures to take both a "parental" nurturing role and a more distant "professional" role focused on risk management (Coyle & Pinkerton, 2012; Steels & Simpson, 2017). It has been argued that in the absence of organisational guidance RCWs draw upon alternate sources, such as cultural narratives, to help determine their role purpose, leading to a professional landscape fractured by multiple purposes (Smith, 2009) where some may focus on policing and controlling CYP rather than the relational components of the role (Green & Masson, 2002; Mainey & Crimmens, 2006).

Relationships between RCWs and CYP

Many authors have argued that RCWs are the primary agents of therapeutic change within residential care settings (Hart et al., 2015; Moses, 2000; Furnivall et al., 2007), with this importance stemming from the relationship formed between CYP and RCWs. These relationships have the potential to meet the attachment related needs of CYP, through the experiencing of interpersonal warmth and consistent boundaries (Hannon, Wood, &

Bazalgette, 2010) and are valued highly enough that many have called for relationally informed practice to be at the heart of every residential care service (Care Inquiry, 2013; Hackett, 2006; NICE, 2015). Within residential care, where such relationships have been formed and CYP experience their carers as warm, genuine and consistent (Houston, 2010), it has been claimed that these CYP experience more positive outcomes in adulthood than their peers who have not had such experiences (Cahill, Holt, & Kirwan, 2016; Hannon et al., 2010).

Despite recognition of the importance of RCW-CYP relationships, there is a notable absence of knowledge regarding the factors which may influence the formation and maintenance of these relationships (Brown, Winter, & Carr, 2018; Hart et al., 2015; McLean, 2015), with Moses (2000) arguing the processes involved had been relegated to a "black box" (p.474). Notwithstanding such claims, the literature surrounding residential care does offer some insight into factors that may potentially influence these relationships.

Residential care settings have been argued to facilitate the formation of beneficial RCW-CYP relationships due to the availability of multiple caregivers to which the CYP can form relationships with (Furnivall, 2011). However, such claims ignore the multitude of factors including shift working, high staff turnover and illness that perpetuate an inconsistent environment, which in turn limits the ability of RCWs to display characteristics such as consistency, held to underpin positive relationship formation (Holt & Kirwan, 2012). This suggests that the context of residential care itself may negatively impact the formation of beneficial relationships.

As discussed above, residential care placements can be commissioned for a number of reasons, leading to RCWs holding competing beliefs about the purpose of their role. This in turn may impact RCW-CYP relationships as individual RCWs work towards differing goals,

creating inconsistency in CYPs' experiences of caregivers (Barton, Gonzalez, & Tomlinson, 2012; Whittaker et al., 1998).

The perception RCWs have of CYP also influences their relationships with said CYP. Those perceived to be understandable, cooperative and easy to work with have been found to receive more individualised attention, whilst those seen as difficult to understand or dysfunctional experience depersonalised care focused on control (Moses, 2000). Thus, the understandings RCWs hold about the behaviours they encounter are crucial in regard to supporting RCWs to form beneficial relationships with CYP. Relatedly, it has been claimed that when RCWs perceived themselves to be at risk, they cope by withdrawing from and avoiding contact with the CYP evoking the threatened feeling (Heron & Chakrabarti, 2003; Lyth, 1988). This would suggest that in addition to understanding behaviours, RCWs must also feel safe in order to form positive and beneficial relationships with CYP.

A final factor which appears related to the formation of relationships in residential care settings is the frames of reference model (Ashurst, 2011). This proposes two frames of reference where the first, the external frame, is informed by organisational factors such as the principles and theory one uses to understand behaviours encountered and purpose of the role. The second frame, termed the subjective frame of reference relates to the RCWs' personal values, beliefs and responses to emotive situations. Ashurst (2011) proposes that it is the interplay between these two frames which influences the nature of relationships. Whilst an individuals' personal frame of reference cannot be removed and will influence their work, the external frame can be developed and will then potentially provide a counterweight to the personal frame of reference.

To summarise, whilst some claim there has been little empirical attention paid to factors impacting the therapeutic relationship in residential care settings, a number of factors

have in fact been explored. However, it is acknowledged that the factors above were not investigated in relation to specific behavioural presentations, including harmful sexual behaviour (HSB; Barter, 2006; McLean, 2015).

Harmful Sexual Behaviour

The term HSB is used throughout this paper in reference to "sexual behaviours expressed by children and young people under 18 years of age that are developmentally inappropriate, may be harmful towards self or others, or be abusive towards another child, young person or adult" (Hackett, Branigan, & Holmes, 2019, p.13), with this definition having been adopted by UK public health guidelines (NICE 2016) and third sector organisations (Hackett et al., 2019). Use of the term HSB acknowledges the need to move away from labels such as "juvenile sex offender", as this both stigmatises CYP and may increase the likelihood of recidivism (Hackett, 2014). Instead, the term HSB implies a shift towards recognising the child first and the offender second (Barnardo's, 2016).

At an organisational level, HSB was not recognised by the academic community until the early 1990's (Masson, 2000), with the National Children's Home committee report (NCH; 1992) recognised as the first attempt to understand the needs of CYP who display HSB and outline a coherent response strategy (Murphy et al., 2017). A range of concerns were identified by the NCH (1992) report including: a theme of denial and minimisation of HSB at both a societal and professional level; an absence of policy or practice guidelines to assist practitioners; and inadequate supervision and training for professionals (NCH, 1992). In the decades since, approaches to the management of CYP have developed considerably (Masson & Hackett, 2003), with an example being the development of understandings regarding why CYP display HSB. Worling (2013) outlines five assumptions argued to have defined the understandings held about HSB and the CYP who display them, namely that

these CYP were seen as; deviant; delinquent; disordered; deficit-ridden; and deceitful. Such understandings are argued to have underpinned approaches to HSB management in the UK, and to continue to underpin contemporary practice in countries including the United States of America and Australia where punitive approaches predominate and CYP are viewed as "mini-sex offenders" (Letourneau & Caldwell, 2013). Within the UK Hackett (2018) argues that understandings have evolved to recognise that sexual behaviour is a natural part of human development, whose expression is shaped by social factors (i.e. family/care environments) and this can encourage both positive and harmful expressions of sexual behaviour. With such understanding, HSB is argued to often be an indication of other developmental difficulties, such as social isolation, rather than an indication of personal moral flaws which require punishment (Rich, 2007; Hackett, 2018).

Harmful Sexual Behaviour and Residential Care

Many CYP who have displayed HSB are safely left in the care of their families where they receive input via community education, support and treatment (Erooga & Masson, 2006; Hackett, Branigan, & Holmes, 2019). However, a minority of CYP do require care in an out-of-home setting for a variety of reasons including: the risks posed to themselves or others, ongoing abuse within the home, and family breakdown (Hackett, Phillips, Masson, & Balfe, 2013; McKibbin, 2017). Such care may be provided in specialist, secure HSB services, but as provision of such services is limited, CYP who have displayed HSB are frequently placed in non-specialist residential care settings (Barnardo's, 2016; Hackett et al., 2019). A small body of literature has explored how RCWs' experience working with CYP who have displayed HSB. Findings from a study conducted by the Centre for Residential Child Care (as cited in Epps, 2006) report RCWs to feel uncomfortable discussing HSB, to feel threatened by the CYP and overwhelmed with the percieved responsibility to prevent future incidents of HSB.

Other investigations have observed similar responses, reporting RCWs to react with denial, fear, and their own moral values/beliefs (Christine Barter, 1997; Farmer & Pollock, 2003; Green & Masson, 2002b).

As intentified by Timmerman & Schreuder's (2014) review, since these studies conducted in the 1990's/early 2000's there has been a considerable gap in the literature pertaining to HSB and residential care, argued to be dangerous as it allows space for 'common sense' understandings of HSB to proliferate. In relation to the danger of such "common sense" understandings, the formation of beliefs is influenced by the social and cultural narratives one exists within (Ashurst, 2011; Bankes, 2006) making it necessary to identify what those narratives relating to HSB are in order to understand how they may impact beliefs about CYP.

Jenks (1996) identifies two primary narratives of childhood and sexuality; the Dionysian, where the CYP is innately evil, corrupt and in need of surveillance and restriction; and the Appollonian, where the CYP is innocent, untainted and in need of care and protection. Jenks argues that CYP who display HSB are either met with denial, avoidance and minimisation, to preserve the Appollonian conception, or with outrage, demonization and punishment as the CYP is placed within the Dionysian conception (Franklin & Horwath, 1996). These cultural narratives can also be seen to be reinforced through media portrayal, where those who commit sexual offences against children are portrayed as 'evil' (Edwards & Hensley, 2001; Soothill, 1997) and "incurable human predators" (Magers, Jennings, Tewksbury, & Miller, 2009, P. 133). This process can also be seen as occurring within residential care, where RCWs have been observed to place CYP in an "asexual vacuum of innocence and purity" (Green & Masson, 2002, p. 157) by refusing to acknowledge or address HSB.

The current study

The importance of the relationship between RCWs and CYP is well recognised, whilst the presence of HSB is acknowledged to impact these relationships. Extant literature exploring this impact is limited both by its age, with approaches towards, and understandings of HSB having evolved considerably from the early 2000's. Furthermore, approaches to sexuality in residential care settings has also evolved. Hackett (2018) observes that the publication of the Department for Education (2015a) document, "*Guide to the Children's Homes Regulations including quality standards"* has required residential care providers to emphasise sex and relationship education. This suggests that alongside potentially different understandings of HSB, RCWs may now work in an environment where sex and sexuality is more openly acknowledged and discussed. For these reasons, it appears that an investigation into the experiences of RCWs who care for CYP who have displayed HSB within residential care settings is warranted.

This empirical investigation will explore the following question "What factors do RCWs perceive as impacting their relationships with CYP who have displayed HSB?"

Materials and Methods

Design

A qualitative approach was taken in this study given the research question's focus on understanding process rather than outcome (Smith, 1996), and the suitability of qualitative methodology when exploring issues which have received little empirical focus (Smith, 2015). Data were gathered using semi-structured interviews with nine participants. Subsequently, Braun & Clarke's (2006) six stage model of thematic analysis was utilised to analyse and report patterns within and across the data, underpinned by a social constructionist epistemological position. Social constructionism suggests that the realities, truths and meanings humans develop are shaped by their contexts and are consequently varied and

multiple (Creswell, 2003). Thematic analysis was considered an appropriate methodology given its theoretical flexibility (Braun & Clarke, 2006), allowing the analysis to be firmly grounded within the data and for meaningful themes to emerge in an iterative process. Braun and Clarke (2013) describe how findings do not emerge within thematic analysis, but are co-constructed by the researcher and participants, and argument supported by Finlay (2009) who argues that some level of interpretation of participant narratives from the author is inevitable. This necessitates both the reporting of the researcher's own context and position (see ensuring quality section below) and displays congruence with the constructionist position held by the author.

Participants

Recruitment materials for this study were distributed across 20 residential care homes, operated in the Midlands and North-West of England by one residential care provider. Whilst CYP who had displayed HSB were cared for within said homes, the provider did not offer specialist provision for this population. Staff members were given basic training to aid understanding and identification of HSB, for instance being introduced to Brook's (2012) sexual behaviours traffic light tool but did not have access to more specialist HSB training i.e. the AIM project (Print, Morrison, & Henniker, 2001).

As a part of their standard provision, the care provider employed a multi-disciplinary therapeutic team including Clinical Psychologists, Psychotherapists and Drama Therapists to deliver therapeutic input into each home they operated. As well as providing direct therapeutic input to CYP where appropriate, the therapeutic team member allocated to a home was embedded within the staff team and available to staff members in order to help them better understand the issues they encountered relating to CYP, which in many instances included the co-construction of psychological formulations.

Following the granting of ethical approval from the Lancaster University Faculty of Health and Medicine Research Ethics Committee, the researcher met with members of the therapeutic team, who provide therapeutic input into each home operated by the provider. The initial stages of recruitment were carried out by the therapeutic team on behalf of the researcher, with their established relationships with the RCW teams they were embedded within judged to be an efficient means of recruitment. The study was explained and recruitment materials disseminated to the therapeutic team, including: a covering letter and expression of interest slip (appendix 4-B) and a participant information sheet (appendix 4-C). Using an opportunistic sampling strategy, members of the therapeutic team then disseminated recruitment materials within the residential homes they worked within, to staff members who had worked with CYP who had displayed HSB.

Participants were included in the study if:

1) They had been employed in a direct care role within the last 2 years.
2) Said role required them to work regularly with CYP (e.g. residential care worker or equivalent job title).
3) They had worked directly with CYP within the last 2 years who had displayed HSB.
4) They had been employed in the role for a minimum of 6 months prior to working with said CYP who had displayed HSB, aiding exclusion of experiences related to being new to the role.

Participants were excluded if:

1) They had received specialist training (additional to any in house training provided) regarding HSB
2) They had not been employed in a role where direct care was provided on a regular basis whilst working with the CYP who displayed HSB (e.g. registered manager)

Nine participants were recruited and interviewed. Participant ages ranged from 27-39, the number of years participants had worked with LACYP ranged from 3-15 years and the number of CYP who had displayed HSB participants had worked with ranged from 1-10. All participants chose a non-gender specific and culturally homogenous pseudonym to protect their anonymity prior to commencement of the interview (see appendix 2-A for full demographic information).

Procedure

Potential participants were invited, through the covering letter, to contact the researcher or register their consent to be contacted by the researcher with the recruiter. During the initial contact, the researcher checked potential participants met inclusion/exclusion criteria and organised a mutually convenient time to conduct an interview. Interviews were conducted either at the company's head office (n = 7), where a constant presence of staff members throughout the day suggested anonymity of participants could be maintained, or at the participants home address (n= 2) where the researcher followed relevant lone working procedures. Interviews were preceded by discussion of the participant information sheet, the limits of confidentiality and the participants' right to withdraw consent for up to two weeks following the interview. They were then asked to sign a consent form (appendix 4-E) and complete a demographic questionnaire (appendix 4-D).

Interviews were conducted adopting a semi-structured style, guided by the interview schedule (appendix 4-F) and recorded using an audio recording device. The interview schedule was developed to fully explore the research question and its design drew upon guidance provided in Braun and Clarke (2013) on constructing interview schedules in qualitative research. An initial draft was developed through multiple discussions between the researcher and research supervisor before a final draft was developed based on feedback from both a senior leader

within the care provider organisation and by the organisation's therapeutic governance committee, which contained members with personal experience of caring for CYP who have displayed HSB.

Consideration was given to questions which may have elicited emotional reactions from participants, with a precis given by the researcher reminding participants to only give as much information as they felt comfortable with (Oliver, 2010).

Following completion of the interview participants were debriefed and audio recordings were transferred to a password protected secure destination as soon as possible where they were then transcribed verbatim by the researcher.

Data Analysis

An inductive analysis was conducted at the semantic level of the data, following the six-stage method as described by Braun and Clarke (2006). This included:

1) Familiarising yourself with the data. Each transcription was read at least twice with initial observations and notes recorded.
2) Generating initial codes. Features of the data which were felt to relate to the research question were coded (see appendix 2-C for extract).
3) Searching for themes. All codes across the data set were grouped under similar codes and then collated into potential themes (see appendix 2-C).
4) Reviewing potential themes. Potential themes were examined against the data set to ensure they were adequately representative, and a thematic 'map' was developed (see figure 2-A).
5) Defining and naming themes. Titles and summaries of each theme were formed.
6) Producing the report. These themes are presented in the results section below.

Ensuring Quality

Yardley (2000, 2008) reports 4 criteria to be central to the production of high quality qualitative research:

1) Sensitivity to context
2) Commitment and rigour
3) Transparency and coherence
4) Impact and importance

These criteria were considered throughout the research process, for example through use of a field diary to enhance reflection (Ortlipp, 2008) and provision of an auditable trail of coding and analysis. Supervisory support was also provided through review of an early transcript with reflections provided on the researcher's style, and during the process of theme development.

Reflexivity, referring to a researcher's awareness of how their characteristics and assumptions may influence the research (Finlay, 2002), is central to the quality criterion of transparency (Yardley, 2000) and a brief statement is therefore presented here. The researcher was employed as an assistant psychologist by a residential child care provider for 18 months prior to beginning the Clinical Psychology training programme. Within this role they provided therapeutic input to two CYP who had displayed HSB as well as providing input to the staff team caring for them. The researcher formed very different relationships with the two young people, as did the staff team. The researcher was, and has remained, curious about what contributed to the difference in relationships between these two CYP, as the one who had arguably committed the more 'severe' HSB was related to in a much more compassionate way that the other CYP. The researcher also completed their specialist third year placement in a looked after children specialist service and was considering a future career in LAC

services. Consequently, the researcher had direct experience of the phenomena under investigation in this project and acknowledged this was likely to have impacted the research process.

Results

Analysis of the data led to the development of four inter-related themes: 1) "In theory you should hate them" – The impact of personal beliefs; 2) "You learn why they behaved like they did" - Developing alternative understandings of HSB; 3) "We are here to care" - Purpose of the role; and 4) "I didn't feel safe, he made my skin crawl" - The impact of threat. The relationship between themes is represented in figure 2-A.

Personal beliefs held by participants regarding HSB could negatively impact their relationships with CYP (1). The impact of these beliefs was related to the participant's access to alternative, more compassionate understandings of HSB (2) and the purpose participants' felt in relation to their professional roles (3). Impacting upon this triad of factors was the sense of threat participants experienced in relation to CYP (4).

Theme 1: "In theory you should hate them" – The impact of personal beliefs

This theme captures the impact of personal beliefs on RCW relationships with CYP who had displayed HSB. Some participants described experiencing a powerful cultural expectation to feel negatively towards CYP who had displayed HSB: "In theory you should hate them" (Alex). Descriptions from other participants illustrated how CYP who displayed HSB could be viewed as sex offenders, leading to negative appraisals of the CYP and avoidant coping responses by RCWs: "it's that word "sex offender"... It puts staff off. It makes them not want to work with those young people" (Chris). Avoidance could be enacted physically: "She [colleague] didn't like the lad, she didn't want anything to do with him"

(Alex), or by the participant cognitively separating the CYP from the HSB: "I had quite a positive relationship with him. I tried not to think about what he'd done…I could separate that quite well" (Charlie).

A connection between negative beliefs regarding CYP who display HSB was made to wider societal narratives about those who sexually harm others: "She would not accept that he was trying to change. Her understanding was "once a sex offender, always a sex offender" which is basically what you hear every time you turn on the telly or read the paper" (Tony).

The impact of societal narratives on an individual's beliefs were described as most powerful when staff were inexperienced:

> I think as a new starter with very little experience and very little training, I was a person who had them type of views about kids that have sexually harmed others, black and white, right and wrong, like you hear about in the news… anyone that tells you they don't label them in their early stages of employment, well they're a liar cos you do. You're inexperienced, you don't know how to respond. (Chris)

Holding an explanatory framework of HSB appears to have been important for participants. Participants described searching for meaning and drawing on the explanatory models available to them, even when these were simplistic or reductionist:

> I think its human nature to always have a reason why. If you don't, it's more difficult to understand them [CYP who have displayed HSB]. It's easier to say he's a rapist because he's a rapist, that's just who he is. (Sam)

RCWs new to the role and lacking training potentially lacked alternative explanatory frameworks of HSB and so were more likely to draw upon societal narratives which are categorical: "sometimes young people can have the best upbringing in the world and still

have sexualised behaviours… that's why they're thinking it could be a mental illness" (Jamie); "Is there something in their [CYP who have displayed HSB] brain that's not fused right?"(Alex). In contrast, where other participants could understand the CYP's actions, for example through linking past experiences to HSB, a more hopeful, recovery focused attitude towards the CYP was observed: "There's a link isn't there, from some sort of abuse in their past. That's where we can help them, or try to help them at least" (Tony).

Theme 2: "You learn why they behaved like they did" - Developing alternative understandings of HSB

This theme articulates and expands on the theme of Tony's above quotation, that being provided with explanatory models of both HSB generally, and CYP's behaviours specifically, enabled participants to challenge cultural narratives about HSB and develop more empathetic and hopeful attitudes towards CYP who had displayed HSB, which in turn positively impacted their relationships.

Being introduced to key theory related to HSB (i.e. attachment theory), through staff training initiatives was described by some participants as enabling them, and their wider staff teams, to recognise and overcome previously held frustrations towards CYP as well as developing alternative, more empathetic understandings of the CYP, their experiences, and their behaviours:

> That young person was really complex. Staff got really frustrated sometimes and would think, "Oh they're just on one again". But then they come to training and actually see the bigger picture. They actually start to understand why. The more knowledge you get the more you learn why they behaved like they did. (Jamie)

Psychological formulations also were recognised as beneficial, providing more individualised understandings of CYP than training sessions could offer. Jessie described

being able to utilise such a framework to understand a CYP and contrasted this with colleagues who relied on harsher, more judgemental understandings:

> One of the young people now has one [psychological formulation]. It explains so much. It's easier to understand why they do certain behaviours, why they might act more sexualised. Whereas, other people would just say "they're just naughty" or "they're sick". (Jessie)

Formulation also appeared to develop participants' understandings of HSB: "It helped me to see why you might do something like that [HSB], not that it's okay, but seeing it written down you get it, why they might do those behaviours because of what they learned in the past". (Alex)

The provision of tools specifically developed to aid identification of HSB were recognised by participants as having increased their understanding of what HSB is: "We have a traffic light system of sexual behaviours and what the young person was doing was in the green part of the chart. So that improved my understanding of what's appropriate for their age" (Sam). Additionally participants appeared to value the tool as a base from which they could ground their clinical decisions regarding HSB. In contrast, other participants, who did not report using similar tools appeared to confuse age appropriate, consensual sexual behaviours with HSB: "He sneaked a girl in, in the night without us knowing. She agreed to it, but still, I think it weren't right cos of what he's done before" (Ashley).

Theme 3: "We are here to care" - Purpose of the role

This theme explores what participants' perceived the purpose of their role to be and how this impacted their relationships with CYP who had displayed HSB. For some participants their role focused on prevention of further incidents of HSB: "We're here to hopefully stop the sexualised behaviours and try to educate them on what's appropriate and

what's not" *(*Ricky). When participants held such a role purpose it appeared that their relationships with CYP could suffer when they continued to display HSB: "staff can get really frustrated with the young person when it's ongoing sexual behaviours" (Jamie).

For other participants, they saw their purpose being to provide care:

> I find it easy [to work with HSB] because at the end of the day I know what my job role is regardless of what that child has done. Our aim is to support them, help them develop and grow. To care for them (Chris).

It did not appear as though participants needed to cognitively separate the CYP from the HSB, to provide this care. Rather, with their purpose being to care participants were able to hold both the CYP and HSB in mind together: "Yeah it's wrong what they've done… they've hurt that person, mentally and maybe physically. But, they are here to be looked after and to be cared for. We're here to care for them, we have the responsibility" (Ashley).

Theme 4: "I didn't feel safe, he made my skin crawl" - The impact of threat

This theme describes the impact perceived threat had on participants and their ability to form relationships with CYP. Some participants described being aware of the potential risks CYP posed and where these were felt to be threatening, described distancing from the CYP to protect themselves:

> Young people that have come in and been really aggressive or really sexualised, that's worrying. You don't want to put yourself in a scenario where you're open to being assaulted... so I'm gonna keep them a little bit over there [signals arms reach away]. (Charlie)

HSB was perceived to be particularly threatening to some due to their lack of familiarity with it: "in terms of harmful sexual behaviour, we don't get many cases" (Alex),

as opposed to physical violence with which they were more familiar: "We work with violent kids, we know the majority of them are gonna be violent, or can be. You don't go in and expect one could rape you though" (Tony). The impact of feeling vulnerable on participant's relationships with CYP is captured by Ashley where feelings of threat can be seen to lead to highly negative views about the CYP: "I didn't feel safe, he made my skin crawl".

Where participants did not feel threatened they did not report needing to rely on these avoidant safety behaviours, despite the presence of what could be perceived as HSB: "there was a young person… he'd say "I'll skull fuck you, I'm gonna rape your grandma" it wasn't nice to hear, but it wouldn't affect me because I knew he wasn't gonna rape my grandma" (Sam). It appeared that a reduced sense of personal threat felt by participants enabled them to form more compassionate, nurturing relationships. Consequently younger, physically smaller CYP were described to be easier to form relationships with than older CYP when both displayed HSB:

> He was in age 7-8 clothes, he was quite small. His behaviours was quite high, once he got into crisis he would do lots of sexualised things but, because he was younger, you dealt with it more maternally I think, you knew there was no real risk because you could manage him, it wasn't really hard to deal with him, whereas with a 15 year old lad… it's different (Charlie).

Discussion

The present study aimed to explore factors RCWs felt impacted their relationships with CYP who had displayed HSB. Four themes were reported: 1) "In theory you should hate them" – The impact of personal beliefs; (2) "You learn why they behaved like they did" - Developing alternative understandings of HSB; (3) "We are here to care" - Purpose of the

role; (4) "I didn't feel safe, he made my skin crawl" - The impact of threat. A diagram (figure 2-A) was developed to illustrate the proposed relationship between these themes.

The three themes at the core of the diagram can be understood to represent the interplay between the external and subjective frames of reference proposed by Ashurst (2011), where theme (1) "In theory you should hate them" – The impact of personal beliefs represents the subjective frame. This theme captures the importance of understanding behaviours for participants, as well as how participant's beliefs influenced their relationships with CYP who had displayed HSB. Within this theme findings indicate that for some RCWs, the professional system's shift away from pejorative and punitive approaches to this population of CYP (Smith et al., 2013) has not resulted in a lack of negative personal beliefs about those who display HSB within this sample of RCWs. This illustrates the ongoing influence of cultural narratives about "sex offenders" and a lack of differentiation between CYP and adult "offenders", as has been reported in multiple studies (Magers et al., 2009; Salerno et al., 2010).

Jenks' (1996) narratives of childhood sexuality provide a theoretical framework to understand how such negative attitudes towards HSB may develop, as they appear to align with the Dionysian conceptualisation of the "evil" CYP needing control and restraint. Reports of participants using avoidance, itself consistent with findings across the wider literature concerning RCW coping behaviours (Elliott, 2013; Heron & Chakrabarti, 2003; Jenks, 1996b; Lyth, 1988; Stovall-McClough & Dozier, 2004), can be understood to be an attempt to hold the CYP within the alternative 'innocent' Apollonian conceptualisation by separating the CYP from their actions or more simply by avoiding the disconfirming evidence. It would seem beneficial in this case for narratives and conceptualisations to be presented to RCWs which offer less polarised understandings, such as Hackett et al.'s (2019)

continuum of childhood of sexual behaviours, which explores how sexual behaviour can be viewed along a spectrum.

Returning to the diagram of themes, the impact of the participant's personal beliefs is proposed to be influenced by themes: (2) "You learn why they behaved like they did" - developing alternative understandings of HSB, and (3) "We are here to care" - Purpose of the role, which together can be seen as representing Ashurst's (2011) external frame of reference. The external frame is argued to balance the impact of personal beliefs through the knowledge and understandings gathered from the professional sphere. A number of findings demonstrate this balancing effect, for example in the reports that the impact of negative cultural narratives around HSB were strongest when staff were new to the role.

The central finding of theme (2), that participants felt being exposed to new ways of understanding HSB enhanced their relationships with CYP, supports the findings of various authors that increased training improves RCWs' ability to form positive relationships with CYP generally and with CYP who have displayed HSB specifically (Furnivall, 2011b; Masson, Hackett, Phillips, & Balfe, 2014; Moses, 2000b; Steels & Simpson, 2017), as well as the claim that RCW's understandings of HSB are core to their ability to form positive relationships with said CYP (Pollock & Farmer, 2002). By recognising this theme as being involved in the development of the external frame of reference, this study presents an understanding of the mechanism through which a holistic understanding of HSB impacts relationship formation.

Whilst the benefits of training have been discussed previously, to the best of the authors knowledge no study has yet reported on the benefits psychological formulations were reported to provide RCWs within this study. Formulation was described as separate and distinct from training, providing a more personalised understanding of individual CYPs

alongside a deeper understanding of what the function of HSB may be. For services who work with CYP who display HSB infrequently (i.e. non-specialist services) it may therefore be beneficial for organisations to develop/commission formulations in order to support and reinforce the more generalised training regarding HSB staff may receive, given that there may be a large temporal distance between receiving training and working with a CYP who has displayed HSB in non-specialist settings.

The impact of HSB specific tools on RCWs' perceived ability to understand HSB and feel confident doing is also an important finding emerging from this analysis. Use of such tools is in keeping with recommendations made by McKibbin (2017) that RCWs should be trained to distinguish HSB from age appropriate sexual behaviour and, when considered alongside Hackett's (2018) argument that professionals lack understanding about the nature of normal sexual development, which leads to pathologising sexual behaviours which may be healthy and "normal", suggests the implementation of such tools may provide RCWs with the knowledge necessary to not fall into such a trap.

Theme (3) explores the impact that differing perceptions of role purpose can have and appears to support Hart et al., (2015)'s claim that this is not always clearly communicated by managers and residential care providers. Clearly defined role purpose is particularly important in relation to CYP who have displayed HSB given cultural expectations to treat these CYP in punitive and restrictive ways. Two purposes were identified from the analysis. For those who saw their role being to prevent the reoccurrence of HSB, extant literature suggests this may negatively impact the relationship with CYP. As McLean (2015) observed, RCWs who did not notice a reduction in challenging behaviours felt their relationships with those CYP were negatively impacted. Therefore, whilst participants who shared this belief may have been able to develop positive relationships with CYP who did not display HSB

whilst in their care, this was dependant on the absence of HSB and so not truly the "unconditional positive regard" so vital to the formation of attachment relationships (Golding, 2007). Furthermore, when and if CYP did display HSB again, RCWs with a preventative role purpose may view these CYP as difficult or dysfunctional (Moses, 2000), or withdraw from them to protect their perceptions of themselves as capable and able to fulfil their role (Harhoff, 2006). It has also been reported in an investigation of adult sexual offenders that where beliefs were held by professionals that they were responsible for the prevention of their clients sexually reoffending, these professional were more likely to experience negative personal emotional experiences (Moulden & Firestone, 2007), making this perceived purpose potentially damaging to the RCW as well as the CYP.

The second role identified within this theme was centred not just upon provision of care, but recognition of the entire person rather than just the HSB they have displayed. By taking this broader, holistic view of CYP, participants were able to respond to the individual needs of the CYP which has been recognised to facilitate an identity that is free from 'sexual deviance' (Lawson, 2003), illustrating how such a purpose may feed into the development of an external frame of reference (Ashurst, 2011). Participant's expressed ability to meet both the parental 'nurturing' role and the professional 'risk focused' role, is also notable as it conflicts with the majority of the literature where finding this balance has been recognised as challenging for RCWs (Coyle & Pinkerton, 2012b; Epps, 2006; Farmer & Pollock, 2003; Hannon et al., 2010; Masson et al., 2014; Steels & Simpson, 2017).

Referring to the map of themes, theme (4): "I didn't feel safe, he made my skin crawl" - The impact of threat, is theorised to act upon themes (1), (2) and (3) as well as being influenced by them. That feelings of threat should influence RCWs' relationships with CYP is consistent with the findings of Heron & Chakrabarti (2003) who report that when RCWs

perceived themselves to be at risk they would cope by withdrawing from and avoiding contact with the CYP evoking the threatened feeling. Such responses are understandable given that RCWs experience high levels of physical assault and threatening behaviour within the work place (Alink, Euser, Bakermans-Kranenburg, & van IJzendoorn, 2014; Winstanley & Hales, 2008). It is also widely held that threat detection and prevention is a core survival strategy of all living beings and that avoidance is an innate mechanism to achieve this (Gilbert, 2009). Therefore, whilst avoidance should not be considered good practice, it may be viewed as a natural response to perceived threat rather than an indictment of the level of professionalism or commitment of the RSW (Wilson, 2006). The association between age and threat described by participants is also in keeping with wider literature where Salerno et al. (2010) reports that in addition to older CYP to be associated with higher levels of perceived threat.

It is however, notable that HSB was perceived to be more threatening than physical aggression due to a lack of familiarity with it. This suggests that RCWs may benefit from training which includes specific information around risk to staff, both to ensure safety of staff and to dispel assumptions that these CYP are somehow "worse". Furthermore, Seti (2008) proposes that RCWs' perceiving themselves to be surrounded by a supportive team and organisation experienced less threat related to their role and a greater sense of security.

Clinical implications

The findings of this study present an understanding of how multiple, interrelated factors impact on RCWs' ability to form positive relationships with CYP who have displayed HSB. Recognising the impact of negative cultural narratives, residential care providers would benefit from providing protected spaces and secure supervisory relationships, within which

RCWs can express and reflect upon their beliefs and the implications they have on their ability to form relationships with this population of CYP.

Residential care providers would benefit from drawing upon practice frameworks, such as that developed by Hackett et al., (2019) when developing their service delivery strategies for CYP who have displayed HSB. This would foster holistic understandings of HSB and therefore also a role purpose focused on providing care. Additionally, the availability of resources such as the traffic light tool (Brook, 2012) would appear to benefit RCWs both in terms of developing their knowledge of HSB, and as an aid which can reassure RCW's about their judgements of what is and is not harmful.

In relation to the role confusion participants report experiencing, RCWs may benefit from their roles and responsibilities being explicitly outlined (Seti, 2008), but recognising that the nature of HSB requires dual responsibilities of RCWs, to both guard against risk and develop therapeutic relationships, RCWs may benefit from the above mentioned protected spaces where the tensions between these roles can be discussed safely with peers and knowledgeable supervisors.

The benefit provided by psychological formulations were an important finding emerging from this study. Psychological formulation offers a medium through which staff teams can come to generate hypotheses regarding why CYP display the behaviours they do (Division of Clinical Psychology, 2011), leading to the development of appropriate and effective responses, much as is reported in the findings of this study. It therefore appears that access to psychological formulations may be an important factor in enabling RCW's to develop therapeutic relationships with CYP who have displayed HSB. It is noteworthy that current levels of staff access to therapeutic input is reportedly limited (Mulcahy, Badger, Wright, &

Erskine, 2014; Vostanis, 2010), suggesting that the experiences reported by participants in this study may not be representative of RCW's more generally.

Strengths and limitations

The aim of this study was to explore factors impacting RCWs formation of relationships with CYP who have displayed HSB. As a result, a number of factors were identified and a model is proposed to understand their interaction, contributing to a previously under explored and valuable area of knowledge. There were however a number of limitations to this study. The opportunistic sampling strategy used may have resulted in sampling bias, with RCWs who hold negative views about CYP who have displayed HSB less likely to volunteer to discuss it, potentially utilising avoidance of HSB as a coping strategy.

Hackett (2006) critiques the wider state of the literature regarding HSB, arguing there is a lack of investigation of CYP perspectives, undermining the validity of the literature, perpetuating the bias that CYP who have displayed HSB are unreliable and maintaining a power imbalance rather than developing a culture of empowerment. By investigating only the experiences of RCWs the present study is subject to these critiques. This study also is culturally bound, having only explored the experiences of participants working within a UK service and sampling participants exclusively from a white British background, although the latter was not a deliberate decision.

Future research

In order to preserve anonymity of participants and the CYP they care for, identifiers including gender were obscured during the transcription phase of analysis. While this decision was deemed ethically necessary it has subsequently not been possible to explore the impact of gender on the therapeutic relationship between RCWs and CYP who have

displayed HSB. This is noteworthy as gender has been argued to play an important role for both RCWs and CYP in relation to HSB. What limited information there is regarding RCW gender suggests that female RCWs feel more threatened by CYPs who have displayed HSB as compared to male RCWs (Harnett, 1997), a finding also reported in a study exploring carer relationships with adults with intellectual disabilities (Kleinberg & Scior, 2014).Drawing on the arguments of Heron and Chakrabarti (2003) and Lyth (1988), that RCWs experiencing threat may cope by withdrawing from CYP, it would therefore be beneficial for future research to explore whether RCW gender does indeed impact their relationships with CYP who have displayed HSB.

In relation to CYP gender, multiple studies report professionals to be more likely to deny or minimise HSB displayed by females (Denov, 2001; Mellor & Deering, 2010; Scott & Telford, 2006). As a consequence of this minimisation Ashfield et al. (as cited in Scott & Telford, 2006) found professionals were less confident working with females who had displayed HSB due to a lack of knowledge about how to work with females. Again this indicates that future research exploring the impact of CYP gender on therapeutic relationships would be beneficial.

Further areas which would benefit from further research include, for reasons discussed above, investigations from the perspective of CYP. Exploration of the experiences of direct care staff across a wider range of residential care settings would also benefit from further research, expanding and developing the generalisability of findings reported here. Finally, it would also be beneficial to explore the experiences of RCWs who care for CYP who have displayed HSB, where the CYP is a member of populations such as black and minority ethnic groups or having a learning disability which are known to be underrepresented by current literature.

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Introducing qualitative researc

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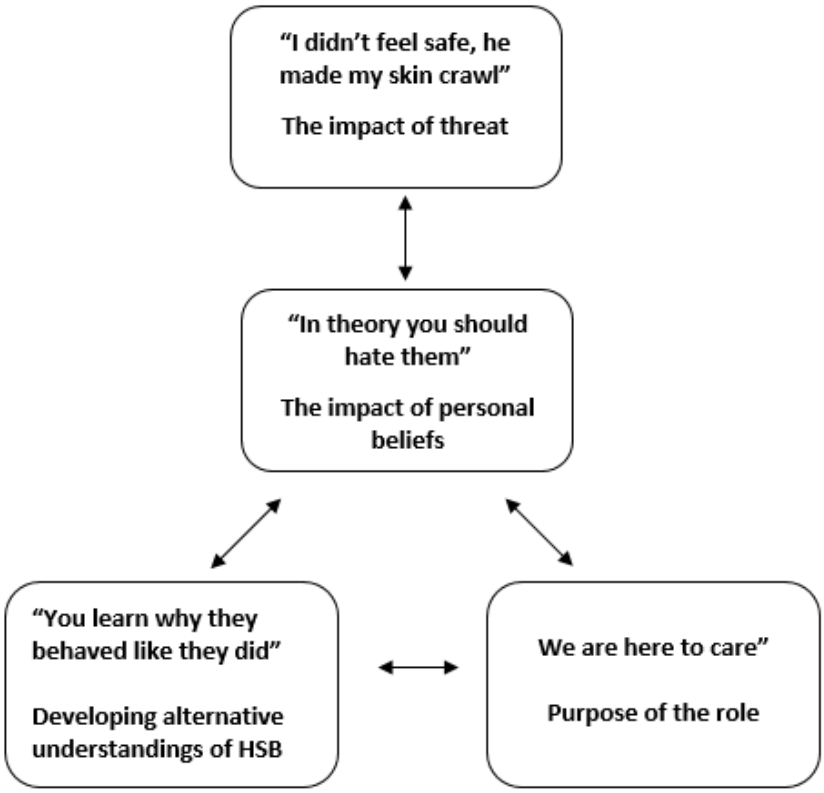
Figure 2-A: Diagrammatic representation of the interaction between themes



Appendix 2-A: Participant Demographic information

Participant alias	Age	Ethnicity	Yearsexperience in direct care roles	Years with current employer	Number of children with HSB cared for
Jamie	30	White British	8.5 years	8.5 years	1
Tony	28	White British	3 years	3 years	3
Charlie	34	White British	8 years	8 years	4
Alex	32	White British	8 years	7 years	2
Sam	33	White British	10 years	10 years	2
Jessie	28	White British	6 years	6 years	2
Ashley	39	White British	4 years	4 years	3
Chris	38	White British	15 years	3 years	10
Ricky	27	White British	3 years	3 years	2

Appendix 2-B: Example of transcript analysis, including initial notes and codes

Notes	Transcript	Codes
Agency staff not helpful, due to CYP's unfamiliarity with them. Organisational support: training and providing staff is important. Relating training to specific CYP helpful Therapists helpful for their work with CYP and with staff. Therapists facilitating reflective practice is beneficial Staff value that they know therapists are there for them Staff value deeper understandings of the CYP they care for	I: So what sort of factors impact on your job satisfaction? R: yeah so with the children placed with us, sometimes the kid's behaviours, the risk increases. So, we've had in the past where the staffing ratios increased from one to one to two to one… erm… sometimes staff will go off shift when they get burnt out so you end up in with agency staff which is never a good thing cos it loses that consistency for the young people, they don't know them. Erm… but sometimes they'll put in place agency that are specialised when we know we need them on a longer-term basis, like waking night staff. We get a lot of… specialised training and its individual to the young people. This morning's for example, erm… cos it was such a small group it was really, we were able to relate it to our young people rather than having a big room full of people it was more focused on the young people that we work with at the moment so it was more helpful really. We have like allocated therapists for the young people which is great because they're in the house quite a lot to work with the young people but also with the staff, so in like monthly team meetings they always attend and they'll say: "is there anything you're struggling with this month?" and they'll help put things in place, and we'll try it for a month erm… when young people move on we'll do a debrief with the therapist and talk about what worked well what didn't, what we'd do again moving forward… erm… and then the therapists are there just to ring if you're struggling erm, even as a manager they're brilliant like that. They just really have a deep understanding of the young people and their behaviours because they're all specialised therapists with a lot of training behind them so its always helpful	CYP's need relational continuity Organisation provide staff & training when needed Helpful training is specific to our CYP Therapists valued Therapists are there for CYP and staff Debriefs develop professional practice. Therapists are accessible. Therapists' understanding of CYP valued

Appendix 2-C: Example of theme development

Codes	Supporting evidence
Feeling threatened is a hard part of the role HSB seen as equally threatening as aggression Perceived threat from CYP dictates reaction to them Not feeling safe leads to negative views of CYP from staff The ability of the CYP to harm you impacts your relationship with them Aggression impacts the relationship rather than HSB Feeling vulnerable leads to staff distancing from CYP Staff are constantly aware of the risk inherent to their role Staff feelings of safety impact the relationship with CYP Invest less into CYP you feel threatened by Hard to look after CYP you feel unsafe with Potential HSB not seen as such in CYP who aren't threatening HSB is threatening to staff Unfamiliarity with HSB makes it threatening	"Young people that have come in and been really aggressive or really sexualised, that's worrying cos you don't want to put yourself in a scenario where you're open to being assaulted." (Charlie) I didn't feel safe, he made my skin crawl. He had had all these images, from babies up to any age. It was just everything about him, something about him, he was just sneaky. I've never looked after another like him. I wont lie, I found it hard (Ashley) "We work with violent kids, we know the majority of them are gonna be violent, or can be. You don't go in and expect one could rape you though" (Tony). "From the sexual side of it, I can always kind of put that where it is. Its more the aggression side of things that make it difficult with the young people" (Ricky). "In residential settings you're always aware of the risk, there's so much risk involved. You're living in homes with potentially dangerous young people." (Chris) "there was a young person… he'd say "I'll skull fuck you, I'm gonna rape your grandma" it wasn't nice to hear, but it wouldn't affect me because I knew he wasn't gonna rape my grandma" (Sam) If they are quite sexualised, and again it comes with aggression too, you end

RCW experiences of caring for CYP who have displayed HSB

Level of threat felt by staff about CYP influences if its HSB or not. Intensity of HSB doesn't determine attitude towards CYP, age and physical size does 'Innocence' of younger CYP who display HSB Younger CYP who display HSB don't produce same reactions as older CYP.	up having that relationship with them where you distance yourself more, distance yourself emotionally too. You skim around them a bit (Charlie) "When they're bigger its not a restraint, it's a fight. Its so much more dangerous. You have to protect yourself" (Charlie) He was in age 7-8 clothes, he was quite small. His behaviours was quite high, once he got into crisis he would do lots of sexualised things but, because he was younger, you dealt with it more maternally I think, you knew there was no real risk because you could manage him, it wasn't really hard to deal with him, whereas with a 15 year old lad… it's different (Charlie).

Appendix 2-D: Journal of Sexual Aggression, Instructions for Authors

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Chapter Three: Critical Appraisal

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This critical appraisal begins by providing a brief outline of the findings of the empirical paper presented in chapter two of this thesis. Following this, reflections are presented relating to the authors' relationship with HSB; an exploration of the decision to use thematic analysis (TA) methodology; and finding the balance between the dual roles of researcher and clinician.

The use of the first person within this paper is deliberate and used to facilitate the personal reflections of the author regarding their experiences throughout the process of conducting the research project described in chapter two of this thesis.

Research findings

The research paper, titled "Residential Care Worker Experiences of Caring for Children & Young People who display Harmful Sexual Behaviours" explored residential care workers' (RCW) experiences of providing care to children and young people (CYP) who have displayed harmful sexual behaviour (HSB). It is acknowledged that the relationship between RCWs and CYP living in residential care settings is vitally important to achieving beneficial therapeutic outcomes from the placement. Alongside this, HSB is known to evoke strong emotional reactions in people and that RCW reactions to HSB can be negative. This study therefore explored the area of overlap between these two factors in an attempt to understand what factors impact upon RCWs who care for CYP who have displayed HSB. Nine RCWs were interviewed with data analysed using thematic analysis and five themes reported. The first theme related to the negative impact that personal beliefs could have on the therapeutic relationship, the second and third themes explored how this negative impact could be countered by development of alternative, compassionate understandings of the CYP and an organising framework regarding the role of RCW which centred on provision of care. The fourth theme then explores how all three preceding themes are impacted by the level of

threat experienced by the professional. The findings of this paper provides both clinical and theoretical implications which can support service delivery through an understanding of the factors impacting RCWs' ability to provide care to CYP who have displayed HSB.

Personal reflections in relation to HSB

Reflexivity is a vital part of the qualitative research process, requiring researchers to critically self-reflect on their backgrounds, assumptions and behaviour in order to make the subjectivity of qualitative research visible (Braun & Clarke, 2013). However, Fine et al. (2003) argue that there is also a risk that overly verbose and deep reflections can make the researcher the "star" of the research project; "in the hands of relatively privileged researchers… the reflexive mode's potential to silence subjects is of particular concern" (Fine et al., 2003, p. 170). Reflecting on this balance I chose to include brief information within each of the two papers which would allow the reader to know I was not coming to the research from a neutral position but rather with personal experience. However I did not go into details beyond this as I wanted to preserve the focus of the research on its participants. Within this section, where there is space to more clearly engage in reflexivity without fear of "outshining" the participants, I will explore in greater detail how I feel the research reported in the two papers above may have been influenced by me.

Developing the thesis topic. Prior to my acceptance onto the clinical doctorate programme I was employed as an assistant psychologist by a residential care provider. Through the experiences I gained in this role I was able to observe the vulnerability of the CYP being cared for in this setting, due in part to the multiple traumas they frequently have experienced, as well as their frequent lack of experience of "good enough" parenting (Oakley, Miscampbell, & Gregorian, 2018). Those employed to care for these CYP, RCWs, were in my experience often passionate, dedicated and compassionate. However I also

witnessed how demanding the role could be, how it left individuals feeling frustrated, threatened and exhausted due to both the needs of the CYP and the structure of the care system as a whole. I also became aware that whilst CYP taken into care are widely acknowledged to experience more positive outcomes than they would were they not taken into care, they still experience considerably lower outcomes educationally, are more likely to enter the criminal justice system and are more likely to experience serious mental health issues than their peers who are not cared for by the local authority (Bazalgette, Rahilly, & Trevelyan, 2015; Department for Education, 2017). From these experiences one of the core lessons I learnt was that we as a society identify the most vulnerable CYP among us, take them out of their homes in order to care for them but then often fail to provide them, or those caring for them, with the resources necessary for them to fully heal and realise their potential.

I therefore knew, when it came time to develop a thesis proposal, that I would be passionate and genuinely interested in a project focusing on CYP placed in residential care as a population. Fortunately my thesis supervisor also had prior experience of working with this population and it was during a conversation about where my passion came from that I mentioned HSB and my observations of both how it had left me feeling and how I had seen it impact experienced and otherwise confident staff teams.

I had initially planned for the empirical investigation to explore the experiences of CYP directly, but had to alter these plans due to the lengthy process of receiving ethical approval when involving CYP in research and the tight deadline I had to work to for submission of the thesis. I therefore decided to instead focus on the experiences of RCWs in the empirical paper, as this related to my personal curiosity regarding what it was about HSB that impacted RCWs so strongly. Turning next to the literature review, I noted that there was a gap in the literature regarding how professionals who provide therapeutic input experience their work with CYP who display HSB and felt that this would be an appropriate topic.

However as well as being a pragmatic decision, I was also influenced by a personal interest in exploring the reactions I had to working with HSB and a desire to normalise/validate those responses.

Insider VS. Outsider status. I have had no experience of caring for CYP who have displayed HSB and so hold what is described as "outsider status" in relation to the participants of the empirical paper. Dwyer and Buckle (2009) discuss how outsider status may be detrimental to the collection of data, with participants potentially feeling less able to discuss aspects of their experience which aren't shared by the other party, particularly when taboo. Whilst it is of course possible for this to have been the case, I attempted to mitigate its effects by using my clinical skills to create an empathetic environment where I openly discussed with each participant, prior to the interview, that I did not know what their experience was like and that that was why this research was needed and that even had I had personal experience it would not necessarily reflect theirs. One potential area where my outsider status may have negatively impacted this study was the recruitment of participants. As staff did not know me, and because a senior organisational manager was my field supervisor, RCWs with particularly negative experiences or views about CYP who have displayed HSB may have feared negative reprisals despite my statements about confidentiality. In an attempt to mitigate such an impact I chose to recruit through members of the therapeutic team, who were insiders, with the theory that they may potentially reach those staff members who would not have responded had I conducted recruitment personally.

Personal experience of working with HSB. Reflecting on my experience working with CYP who have displayed HSB, I can clearly recall the strong, fearful reaction I had to first finding out I would be required to deliver therapeutic interventions. I felt a cloud of self-doubt regarding my ability to carry out such work, where would I even begin? Did I have any of the skills necessary? This reaction was very much outside of the norm for me. I had

previously always felt (relatively) competent to carry out the work required of me and had worked with a number of individuals with forensic histories and histories of high levels of aggressive behaviour. There seemed to be something different about HSB which had impacted me. This response resonates with a number of themes I have reported in the two papers above, but in particular it seems to relate to the "professional confidence" theme from the meta-synthesis, where professionals reported themselves to feel under-skilled and incompetent to deliver HSB interventions. Much like the professionals whose experiences are included in the meta-synthesis, my personal response to these feelings was to seek out knowledge and a sense of "what to do", believing myself to be incapable of working with individuals who had sexually harmed others. Some may argue this represents an instance of personal bias influencing analysis and I would agree, however I do not feel this reduces the validity of the findings. Rather I think my methodology and analysis were reported with sufficient rigour for it to be shown that these experiences were present within the data and that it was their presence combined with my experiences which led to me identifying them as salient.

Methodology and epistemology

I chose to collect data for the empirical paper from residential care workers (RCWs) who were not working within specialist HSB settings and had no HSB specific training beyond that which is provided internally by the care provider. In doing so I recognised that theoretically, few CYP who have displayed HSB should be placed in such settings, as organisational practice frameworks (Hackett, Branigan, & Holmes, 2019) recommend a tiered approach to the management of HSB, where those CYP requiring residential care are placed within specialist HSB residential care services. However, it is well documented that current practice does not meet these goals. Provision of specialist residential HSB specialist services is rare and those services with do exist set high thresholds for referrals to be

accepted. As such, there is an underrepresented population of CYP who have displayed HSB that are provided care by non-specialist residential care providers. It is this setting that I am interested in, with the hope that by developing a shared understanding of the factors influencing these RCW's ability to provide care, a greater recognition of the needs of this population can be achieved.

As I document in the empirical paper, the aims of this project were exploratory and focused upon process rather than outcomes, leading me to conclude that qualitative methods would most effectively meet these aims. Thematic analysis (TA) was chosen as the method through with I would analyse the data but I feel it is important to explore the other methodologies which were considered to further illustrate why TA was chosen.

Interpretive Phenomenological Analysis (IPA) was one methodology considered. This approach is epistemologically bound to phenomenology ("being" and experiencing), hermeneutics (interpretation) and symbolic–interactionism (how individuals construct meaning socially and personally; Larkin & Thompson, 2011). The aims of IPA informed research are therefore to understand people's everyday lived experience in relation to a phenomenon, which in turn improves understanding of the phenomena in question (Eatough & Smith, 2008). The interpretive role of the researcher is given central focus and a double hermeneutic is acknowledged, that being that the researcher makes interpretations based on the interpretations participants make of their experience. As such I felt the epistemology of IPA reflected my epistemological position of social constructionism due to its recognition of the impact that the researcher's lens has on the analysis. However, IPA's binding to phenomenology, which necessitates a prioritisation of lived experience (McLeod, 2001), made IPA unsuitable for my project. In essence I aimed to explore the factors which impacted RCW's experiences of providing care, rather than what these experiences were.

The second methodology I considered was Grounded Theory (GT). GT comes in a variety of versions, spread across the epistemological spectrum from positivism to constructivism (Birks & Mills, 2015; Tweed & Charmaz, 2012), but overarching these methodologies is the goal of creating a plausible and useful theory of the phenomena that is grounded within the data (McLeod, 2001; Tweed & Charmaz, 2012). GT is recognised as a particularly suitable methodology for studies exploring factors influencing a particular social process (Braun & Clarke, 2013). Theory building is an ongoing and recursive process which involves the researcher staying close to the data, developing an in-depth understanding and moving back and forth between different aspects of data collection and analysis (Howitt, 2010). Although the current study conducted a detailed exploration of factors impacting RCW's ability to care for CYP who have displayed HSB, its aim was to illustrate shared and converging patterns of experience across the participant pool, not to construct a theory of caring for CYP who display HSB. Furthermore, given that a defining feature of current HSB service provision within the United Kingdom is the variability of service at a national scale, attempting to develop a grounded theory of the underlying experiences/factors impacting non-specialist RCWs would require a far greater time and resource commitment than is possible for a research project of this scope. This is a common criticism of GT and I do recognise what Braun and Clarke (2006, 2013) term "grounded theory–lite" which addresses these concerns by placing a greater focus on the earlier stages of GT (i.e. initial coding and concept development). However, these "GT-lite" methodologies often still rely on processes such as theoretical sampling, constant comparative analysis and the concept of saturation. Many of these methods are acknowledged to be more achievable within "GT-lite" methodologies, but still require a considerable amount of time to complete appropriately. Therefore, given the reduced timescale of this project, it was felt that such methodology was not feasible.

TA was then decided upon as it isn't tied to a particular theoretical framework, which I considered to be a strength of the approach and a key difference which separates TA from the methodologies of IPA and GT. While this flexibility has been identified as a criticism of TA, with some authors arguing TA is a process contained within many qualitative methodologies rather than an approach in and of itself, these criticisms were addressed to some degree with Braun & Clarkes' (2006) publication accepted by many in the field as a distinct methodological approach to conducting TA in a systematic manner.

Balancing dual identities

One of the challenges I faced during the design and data collection stages of this research project was the risk that when exploring participants' experiences of providing care, incidents of poor practice or abuse may be disclosed. I understood that an exploration of this topic may have been perceived as interrogative and was therefore mindful that my tone, language and questions I asked did not suggest I had made an assumption about their practice or professionalism. Due to recognition of the risk that safeguarding concerns may emerge from interviews I developed explicit protocols for how I would manage such situations, and shared this explicitly with each participant prior to the beginning of their interview. Fortunately no such issues arose, but there were incidences during interviews where participants did experience heightened emotions. One particular experience stands out in my memory, where a participant disclosed they had been the victim of child sexual exploitation and how they felt this impacted their ability to fulfil their role. I later documented in my reflective diary that I was surprised at how equipped I had felt to manage this participant's distress:

> I'm not entirely sure how I feel coming out of this interview. We really connect and on one hand I feel so grateful that they felt able to share such

> personal experiences. But I also found it really hard to balance asking them to talk more about it and not wanting to make them overly distressed. I do feel okay with how I handled the disclosure and that we left things with them in an okay place. I think maybe that's the benefit of being both a researcher and a clinician, I have experience of being in such situations. Maybe it was a combination of feeling I could manage and knowing what I would do if I needed to. (Extract from reflective diary).

Similarly, because I was familiar with safeguarding procedures due to my clinical work I felt comfortable with potentially having to enact safeguarding procedures should concerns be raised during interviews. This reflects the observations made by some authors that researchers from non-clinical backgrounds may feel they lack the necessary skills or training to manage the more therapeutic elements of research such as working with emotions (Dickson-Swift, James, Kippen, & Liamputtong, 2006), whilst as (trainee) clinical psychologists we are trained and experienced in such areas and can therefore be of particular value when conducting research in potentially sensitive areas.

However, alongside experiencing benefits of my dual identify as a researcher and clinician there were also difficulties. Dickson-Swift et al. (2006) report that researchers with professional clinical training can feel a sense of conflict between the differing roles of researcher and clinician, whilst Orb, Eisenhauer, & Wynaden, (2001) discuss how practitioners may find the perceived passivity of the researcher's role difficult to adjust to. I am able to recognise elements of this conflict in the difficulty I had in finding the appropriate balance between enquiry and sensitivity to distress.

Engaging in reflexive practice, defined as "the capacity of the researcher to turn back on his or her experience, and then use this material to inform the process of

enquiry"(McLeod, 2001, p.48), helped me to consider the challenges associated with holding these dual roles. Alongside the use of a reflective diary, which helped me to bracket my own views and experiences, another particularly helpful process was having my research supervisor review an early interview transcript. Through this procedure it was pointed out to me that there were certain techniques I routinely used in my clinical practice that may steer the interview from a research focus (where the aim is to develop an understanding of the participant's perspective of the research question) to a clinical interview focus (where the aim is to develop an understanding of a client's experience to facilitate therapeutic change; Drury, Francis, & Chapman, 2007). From this observation I was then able take a more reflexive stance towards myself and the impact I might unwittingly have on the participants.

I was aware of additional processes which could have been implemented to potentially further enhance the reflexivity and quality of this piece of research. One such method is member checking, which if implemented would have enhanced the credibility of my analysis by checking with participants, the accuracy with which I had interpreted their data as well as whether the findings reported resonated with their experiences. Unfortunately a combination of logical issues and time demands upon the submission of this piece of work, mean I was unable to arrange such a meeting with participants, but I recognise the value member checking offers and will be mindful to attempt to include such processes in research projects I am involved with in the future.

I was also aware of bracketing interviews, which are argued to help researchers become conscious of their biases (Rolls & Relf, 2006) and then put them aside in order that their analyses are not automatically shaped by them (Braun & Clarke, 2013). Whilst recognising the value of bracketing interviews in so far as it is not possible to put aside biases which one is unaware of (Ahern, 1999), a combination of my social constructionist epistemological position and the arguments made originally by Heidegger (1962) that it is neither possible nor

desirable to bracket out one's preconceptions, and furthermore that such preconceptions are essential to the interpretive process, led me to question whether bracketing interviews would be appropriate for this project. Individuals influenced by Heidegger's work argue that rather than bracketing, one might instead understand, embrace and report the frames of reference (biases) they bring (Tufford & Newman, 2010). Indeed it has been argued that researchers are not disembodied, objective entities, but rather are humans trying to understand and cope with the research experience (Johnson, 2009). As such it cannot then be possible, nor is it even desirable to bracket or eliminate the researcher from the research (Perry, Thurston, & Green, 2004; Sword, 1999; Tillmann-Healy & Kiesinger, 2001). Feeling that this more closely aligned with the social constructivist epistemology guiding the research project I therefore decided not to conduct bracketing interviews and to instead focus upon reporting, within the reflexivity section of the paper, those frames of reference which will have influenced my analysis.

Conclusion

To conclude, this empirical paper has explored the factors experiences by RCWs that impact their ability to care for CYP who have displayed HSB. The findings illustrate an interplay of factors and suggests ways residential care providers may better support RCWs so they in turn can care for CYP. Alongside these outcomes, the process of conducting this research has imparted a number of lessons to me, amongst them an enhanced understanding of the impact of the researcher on their findings, a more nuanced understanding of some of the more popular qualitative methodologies and a more comprehensive understanding of my own epistemological position.

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Section Four: Ethics Section

Ethics Application for Empirical Paper

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Research Protocol

Title: Residential care workers' experiences of working with children & young people who display harmful sexual behaviour.

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Given the traumatic life experiences one must experience to be placed into the care of the local authority, it is unsurprising that looked after children and young people (LACYP) are consistently found to experience higher rates of mental health difficulties than the general population. Some studies report LACYP as four times more likely to experience mental health difficulties (Bazalgette, Rahilly, & Trevelyan, 2015) and others report almost half of all LACYP, and three quarters of those in residential care, as meeting the criteria for a psychiatric disorder (Ford, Vostanis, Meltzer, & Goodman, 2007; Luke, Sinclair, Woolgar, & Sebba, 2014; Meltzer, Gatward, Corbin, Goodman, & Ford, 2003).

Looked after children and young people (LACYP) are placed in residential care for a number of reasons, sometimes as a 'last resort' when no family or foster care placements are

found, whilst in other cases it is a response to behaviours displayed which are considered too challenging to be managed in other settings (Hart, La Valle, & Holmes, 2015). Whilst all LACYP present with more complex/challenging behaviour than the general population, those placed in residential care are consistently reported to display more challenging behaviour than their peers in foster care (Berridge, Biehal, & Henry, 2012; Delfabbro, Osborn, & Barber, 2005; Hart et al., 2015).

As is the case across childcare settings, it is theorised that when residential care provides beneficial placements to LACYP, it is enacted through the meeting of attachment related needs, such as developing a secure attachment and experiencing parenting styles which provide both warmth and consistent boundaries (Hannon, Wood, & Bazalgette, 2010). As these needs are enacted through relationships, direct care staff (referred to in this proposal as residential care workers [RCW]) are recognised as the primary agents of therapeutic change (Hart et al., 2015; Kahan, 1994; Moses, 2000).

Several factors negatively impact RCWs' ability to form positive therapeutic relationships with LACYP: poor training, a lack of understanding of behaviours LACYP present with and demands to deliver quality services with insufficient resources (Berridge et al., 2012; Cameron, 2004; Steels & Simpson, 2017). The therapeutic relationship is also impacted by the balance RCWs must find between nurturing a relationship which meets the attachment focused needs typically met by parents, and keeping a professional distance from the LACYP (Hannon et al., 2010).

Harmful sexual behaviour (HSB) is defined by the National Society for the Prevention of Cruelty to Children (NSPCC) as children or young people engaging in sexual behaviour that is developmentally inappropriate and problematic or abusive towards the self or others (NSPCC, 2019). It is acknowledged that gathering incidence rates regarding HSB is subject

to bias and any statistics must be viewed with caution (Allnock & Barns, 2011; Biehal, 2014). The nature of residential care means that LACYP displaying behaviours society deems most challenging are often placed there, leading to a higher concentration of individuals who display HSB (Euser, Alink, Tharner, van IJzendoorn, & Bakermans-Kranenburg, 2013; Hayden, 2010; McKibbin, 2017).

Studies investigating sexual abuse of any sort in residential care did not begin in earnest until the 1990's (Timmerman & Schreuder, 2014), but have increased in the last 3 decades, with the National Institute for Health and Care Excellence (NICE) recently publishing guidelines on recognition, assessment and reduction of HSB among children (NICE, 2016). Literature reviews have also recently been published exploring the nature and prevention of HSB in general (Campbell et al., 2016; Hackett, 2014) and in residential care settings specifically (McKibbin, 2017; Timmerman & Schreuder, 2014).

Studies investigating HSB in residential care have found that RCW responses to HSB are characterised by ignorance, prejudice, anxiety and denial (Baker et al., 2008; Barter, 1997; Farmer & Pollock, 2003), and that this is partially due to a lack of adequate support, training or guidance given to them (Green & Masson, 2002). Whilst these studies provide valuable information, their quantitative focus has failed to explore how RCWs experience working with HSB. The understandings, beliefs and attitudes RCWs hold will underpin how they respond to the LACYP displaying HSB and therefore also impact the therapeutic relationship (Moses, 2000).

As indicated above, there is a lack of research exploring the experiences of RCWs and how these impact and influence the therapeutic relationship they form with LACYP who display HSB. I therefore propose to explore these with the aim of deepening understandings

of how these internal experiences influence the therapeutic relationship as well as providing insight for service providers regarding areas of best practice and areas requiring development.

Aims of the study

Through exploration of the experiences of residential care workers, the aims of this study are to:

1) Gain an understanding of the experiences of residential care workers who work with children/young people who display harmful sexual behaviour by identifying recurring themes within the dataset.
2) Develop insight into how residential care worker understandings of harmful sexual behaviour impact the therapeutic relationship between themselves and the children/young people displaying them.

Methodology

Design

This project aims to explore RCWs' experiences of caring for LACYP who display HSB. Qualitative research methodology lends itself to such aims as it provides participants the opportunity to give rich and deep accounts of their personal experience, in their own words.

Semi-structured 1:1 interviews will be used to gather information from participants which will be analysed using thematic analysis (Braun & Clarke, 2006).

Prior to submitting ethical approval, the principal investigator has consulted on the appropriateness of the recruitment pathway and all recruitment material with a senior leader from [redacted], the residential care provider participants will be recruited from. The [redacted] Therapeutic Governance group were then consulted by the principal

investigator to gain further stakeholder feedback on the recruitment pathway, recruitment materials and interview schedule. The proposal submitted here has been updated to reflect the feedback received.

Participants

Participants will be recruited, in the first instance, through [redacted], a residential care provider employing over 180 staff across 20 residential homes in the North-West and Midlands. The study will aim to recruit between 8 and 12 participants.

Guidance on conducting thematic analysis sample sizes suggest 6-10 interviews are sufficient for small projects and 10-20 for medium projects (Braun & Clarke, 2013). Braun & Clarke (2013) further suggest research questions exploring the experiencing of a certain phenomenon are well suited to 'small or moderate' sample sizes. A sample size of between 8-12 participants will therefore be sought to ensure that theoretical sufficiency is attained whilst also being a realistic estimate of recruitment levels, given that whilst incidents of HSB are more concentrated in residential care than the general population, the number of incidents is still estimated to be low. As mentioned above, whilst estimates of HSB prevalence are flawed, an overview of sexual offending in England and Wales found that of 5,900 perpetrators guilty of sexual offences in 2011, 8% (491) were children or young people under the age of 18 (Ministry of Justice, 2013)

Individuals will be deemed suitable for recruitment if they meet the following criteria:

1. They are currently employed in a direct care role, within which they work regularly with LACYP (e.g. RCW or equivalent title e.g. residential support worker, senior RCW, team leader, deputy manager). Or they have worked within such a role within the last 2 years.

2. The home they work within must be an Ofsted-registered children's home, providing 24-hour residential care to LACYP aged 18 and under.
3. They must have been employed in this role for a minimum of 6 months, reflecting the length of time necessary to complete induction and probation within the service. This criterion will help exclude experiences related to being new to the direct care role.
4. They have worked directly with a LACYP in the last 2 years, who either have a history of displaying HSB, or have displayed HSB whilst in placement. This criterion reflects a balance between recognising the relatively low incidence rate of HSB within residential care settings and the need for the relationship and the RCWs experiences of it to be recallable.

Individuals will be excluded if they meet the following criteria:

1. They are employed by services offering specialist provision for LACYP who display HSB. The enhanced familiarity with HSB individuals working within these populations will have will be non-representative and non-generalisable to non-specialist services.
2. Those who have received specialist/enhanced training regarding HSB. The knowledge gained through such training would be unrepresentative of RCWs more widely and including their experiences could decrease the homogeneity of experiences in the sample.
3. Those employed in roles where provision of direct care to LACYP is not provided on a regular basis.

Procedure

Recruitment. A member of the research team will attend at least one meeting of the [redacted] therapeutic governance group, with [redacted] being the organisation participants will be recruited from. The study's aims, inclusion/exclusion criteria, recruitment

pathway and recruitment materials will be introduced and the governance group asked to give confirmation that staff members from [redacted] may participate.

The principal investigator will then introduce the study to the [redacted] therapy team, who provide a therapeutic case manager and therapeutic input to each home. Therapy team members will be provided with recruitment packs, consisting of a covering letter and expression of interest slip (appendix 4-A) and a participant information sheet (appendix 4-B) which they will disseminate to staff members of the homes they provide input to. The principal investigator will also be available to introduce the study to the staff of individual homes, if requested by the home manager or therapy team.

Potential participants interested in participating in the study will be invited, through the cover letter, to contact the principal investigator via email or telephone. Additionally, individuals will be able to register their interest and consent to be contacted by the principle investigator through leaving their contact details (email address and/or telephone number) with the recruiting member of the therapeutic team. These details will then be passed along to the principal investigator. Details passed along to the principal investigator will be disposed of in a secure manner (e.g. use of confidential waste disposal).

The principal investigator will then discuss the project in more detail with interested individuals with space given for them to ask any questions they may have. The principal investigator will also verbally check to ensure all inclusion and exclusion criteria have been met.

Sampling will be purposive with the principal investigator aiming to recruit from a range of residential care homes to minimise the possibility multiple participants talking about their experiences with the same child/young person, however should there be difficulties with recruitment, more than one participant may need to be recruited from each home. Potential

participants will be told that should recruitment targets already be met, they may not be invited to participate, but will have the results of the study shared with them should they wish, on completion of the project. Once the top end of the target sample size (12) has been recruited to, those who have expressed an interest in participation will be informed that recruitment has closed, and they will be thanked for their interest.

Participants will also be asked if they would consent to being contacted for a second interview. Second interviews will be considered if new topics, themes or questions emerge once data collection has begun, which it is deemed necessary to the project to explore with all participants.

Whilst this project will not feature direct contact with LACYP, the therapy team, within their recruiting role, will share the participant information sheet with the social worker of any LACYP currently under the care of Meadows Care who has displayed HSB. This will ensure clear and open communication is maintained between those legally responsible for the care of LACYP.

Interviews. For those invited to participate, a mutually convenient location and time will be agreed upon, with participants offered the choice of being interviewed at [redacted] head office, where permission has been given to use a bookable room, or their own home. Due to staff being present at head office for a variety of reasons throughout the day it is not expected that a participant's presence will compromise the anonymity of their participation in the proposed study.

Should it not prove possible to arrange a face to face interview and the potential participant wish to take part despite this, the principal investigator will offer a telephone interview.

The principal investigator will adhere to Lancaster University lone working policies if conducting interviews at participants' homes. The use of 'Sky guard' was discussed by the principal investigator and supervisory team. Due to the frequency of interviews conducted in participant's homes predicted to be low and logistical challenges concerning the use of equipment, a 'buddy' system will instead be used. A 'buddy' (a named colleague) will be notified before each interview where the interview is taking place and at what time. If the buddy does not hear from the principal investigator by a predetermined time, they will take steps to contact the principal investigator. If no contact can be made the buddy will next inform the police.

Each interview will begin with the principal investigator talking through the participant information sheet, answering any questions and the participant being asked to complete a demographic information sheet (appendix 4-C). The participant will then be asked to complete and sign the consent form (appendix 4-D) which will be signed by both the participant and the principal investigator. Two copies will be signed, with one being held by the principal investigator and the other held by the participant. The consent form will highlight the participant's right to withdraw at any point before or during the interview and that their data can be withdrawn at any point in the two weeks following the interview. After these two weeks it will be explained that withdrawal of their data will no longer be possible.

If interviews take place via telephone participants will be sent a consent form prior to the interview. The consent form will then also be read aloud before the interview begins and the potential participant will be asked if they agree to each item. This information will be audio recorded and transcribed and stored as electronic data.

Interviews will then be conducted, guided by the interview schedule (appendix 4-E), lasting approximately one hour. Interviews will be recorded using an audio recording device

which will not support encrypted recordings. Therefore, data will be moved from the recording device to the principal investigator ’s H: drive, a password protected secure destination hosted by Lancaster University, as soon as possible following completion of an interview and the recording deleted from the audio recording device. All access to the data for transcription and analysis will be conducted via the H: drive

After concluding the interview, the principal investigator will debrief the participant, focusing on managing any distress the participant is experiencing using their clinical skills and by signposting to the relevant agencies listed on the participant information sheet and relevant support offered by [redacted] e.g. supervision. Furthermore, the principal investigator will outline what will happen to the participant’s data and the process of withdrawing from the study. The principal investigator will also ask if the participant would like a summary of the findings on conclusion of the project.

Materials

Recruitment materials will include a participant information sheet, a covering letter and expression of interest slip, a consent form, a demographic information sheet and an interview schedule (see appendices).

All participants will be allocated a non-identifying pseudonym before transcription commences ensuring no personally identifying information exists within the research documentation.

The principal investigator will share at least the first audio recording with at least one supervising member of the research team to ensure interviews are conducted appropriately and to provide any corrective feedback for future interviews.

Proposed analysis

The interviews will be analysed using thematic analysis (Braun & Clarke, 2006). Thematic analysis is a flexible analytical approach with an established use in LACYP and residential care populations (Allan, 2006; Belton, Barnard, & Cotmore, 2014; Durka & Hacker, 2015; McLean, 2013). It will be used to identify and explore common themes across the experiences of participants to develop a better understanding of the experiences of RCWs who work with LACYP who display HSB.

The six-step method described by Braun & Clarke (2006) will be followed

1. Data transcription – conducted by the researcher, with initial ideas noted throughout
2. Initial coding – systematic coding of the data set
3. Theme generation – code and data collated into potential themes
4. Review – themes reviewed for consistency with coded extracts
5. Naming – themes defined and named
6. Report – final analysis, selection of extracts in relation to research aims.

Practical and Ethical Issues

Data protection and storage

Data from the interviews will be stored on the principal investigator ’s H: drive, a password protected secure destination hosted by Lancaster University and deleted from the audio recording device as soon as it is transferred. Following transcription, the audio recording will be deleted and only the interview transcript will remain. Transcripts will be stored on the principal investigator ’s H: drive.

Prior to submission of the project, all personally identifying information (e.g. consent forms and demographic information) will be stored separately to anonymised information (interview transcripts and codes emerging across transcripts). All information will be stored

securely, physical information will be kept in a locked cabinet and electronic data will be password protected and stored on the secure H: drive hosted by Lancaster University.

Following submission of the project, all paper consent forms will be scanned and saved in electronic format. Physical paper copies will be destroyed following this. Electronic data will then be encrypted and securely transferred to the DClinPsy programme research Coordinator, who will store the files on a server hosted by Lancaster University in a password protected file. Data will be held for 10 years after submission of the project at which point it will be destroyed by the Research Coordinator.

Consent and rights to withdraw

Participants will be informed of their right to withdraw from the study at any time before or during the interview. Following the interview participants will be informed that they may withdraw consent for up to two weeks after the interview has concluded. It will be explained that following these two weeks their interview will be anonymised, transcribed, coded and pooled with other data removing the possibility of extracting their data from this point onwards.

Confidentiality

To protect confidentiality participants will be allocated a pseudonym which will be used in the write up of the data. No identifiable information will be used or published. All data will be stored on a secure, password protected and encrypted device at all times.

The limits of confidentiality will also be explained. It will be explained that if information is disclosed which indicates safeguarding concerns or issues of malpractice then confidentiality may not be able to be maintained and a relevant professional will need to be informed. This would also be fed back to the academic and field supervisors.

Timescale

January 2019 = submit ethics to FHMREC

February - March 2019 = Data collection,

April – June 2019 = Analysis and write up of research paper

February – July 2019 = write systematic review

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Appendix 4-A: FHMREC Application Form

Faculty of Health and Medicine Research Ethics Committee (FHMREC)

Lancaster University

Application for Ethical Approval for Research

Title of Project: Residential care workers' experiences of working with children & young people who display harmful sexual behaviour.

Name of applicant/researcher: Kristian Glenny

ACP ID number (if applicable)*: n/a **Funding source (if applicable)** n/a

Grant code (if applicable): n/a

***If your project has *not* been costed on ACP, you will also need to complete the Governance Checklist [**link**].**

Type of study

☐ Involves existing documents/data only, or the evaluation of an existing project with no direct contact with human participants. **Complete sections one, *two* and four of this form**

☒ Includes *direct* involvement by human subjects. **Complete sections one, *three* and four of this form**

SECTION ONE

1. Appointment/position held by applicant and Division within FHM Principal investigator Clinical Psychologist, Division of Clinical Psychology

2. Contact information for applicant:

E-mail: k.glenny@lancaster.ac.uk **Telephone**: [redacted] (please give a number on which you can be contacted at short notice)

Address: Furness College, Lancaster University, Bailrigg, Lancaster LA1 4YW

3. **Names and appointments of all members of the research team (including degree where applicable)**

Dr Suzanne Hodge – PhD; Lecturer in Research methods, DClinPsy training programme

Dr Anna Daiches - DClinPsy: Clinical Director and Deputy Programme Director of the Doctorate in Clinical Psychology

Dr Jane Toner - DClinPsy: [redacted]

3. If this is a student project, please indicate what type of project by marking the relevant box/deleting as appropriate: (please note that UG and taught masters projects should complete **FHMREC form UG-tPG**, following the procedures set out on the FHMREC website

PG Diploma ☐ Masters by research ☐ PhD Thesis ☐ PhD Pall. Care ☐

PhD Pub. Health ☐ PhD Org. Health & Well Being ☐ PhD Mental Health ☐ MD ☐

DClinPsy SRP ☐ [if SRP Service Evaluation, please also indicate here: ☐]
DClinPsy Thesis ☒

4. Project supervisor(s), if different from applicant: Dr Anna Daiches & Dr Jane Toner

5. **Appointment held by supervisor(s) and institution(s) where based (if applicable)**:

Dr Suzanne Hodge – PhD; Lecturer in Research methods, DClinPsy training programme

Dr Anna Daiches - DClinPsy: Clinical Director and Deputy Programme Director of the Doctorate in Clinical Psychology at Lancaster University.

Dr Jane Toner - DClinPsy: [redacted]

SECTION THREE

Complete this section if your project includes *direct* involvement by human subjects

1**. Summary of research protocol in lay terms (indicative maximum length 150 words):**

This project will explore the experiences of residential care workers (RCWs) in child residential care settings, who work with children and young people who display harmful sexual behaviours. 1:1 semi structured interviews will be used to gather data which will then be analysed using thematic analysis.

Knowledge gained from this study will contribute to understandings of the factors impacting the development of therapeutic relationships, strategies used by direct care staff to cope and the understandings held about harmful sexual behaviour and the children/young people who display them.

It is hoped that these findings can influence how direct care staff are trained and supported in their work with this client group.

2. **Anticipated project dates (month and year only**)

Start date: February 2019 End date: October 2019

Data Collection and Management

For additional guidance on data management, please go to Research Data Management *webpage, or email the RDM support email:* rdm@lancaster.ac.uk

3. **Please describe the sample of participants to be studied (including maximum & minimum number, age, gender):**

Between 8-12 residential care workers, who have experience working with children/young people who display harmful sexual behaviours in residential care settings will be sought.

Inclusion criteria:

Individuals will be deemed suitable for recruitment if they meet the following criteria:

They are currently employed in a direct care role, within which they work regularly with LACYP (e.g. RCW or equivalent title e.g. residential support worker, senior RCW, team leader, deputy manager). Or they have worked within such a role within the last 2 years

The home they work within must be an Ofsted-registered children's home, providing 24-hour residential care to LACYP aged 18 and under.

They must have been employed in this role for a minimum of 6 months, reflecting the length of time necessary to complete induction and probation within the service. This criterion will help exclude experiences related to being new to the direct care role.

They have worked directly with a LACYP in the last 2 years, who either have a history of displaying HSB or have displayed HSB whilst in placement. This criterion reflects a balance between recognising the relatively low incidence rate of HSB within residential care settings and the need for the relationship and the RCWs experiences of it to be recallable.

Exclusion criteria:

Individuals will be deemed unsuitable for recruitment if they meet the following criteria:

They are employed by services offering specialist provision for LACYP who display HSB. The enhanced familiarity with HSB individuals working within these populations will have will be non-representative and non-generalisable to non-specialist populations.

Those who have received specialist/enhanced training regarding HSB. The knowledge gained through such training would be unrepresentative of RCWs more widely and including their experiences could decrease the homogeneity of experiences in the sample.

Those employed in roles where provision of direct care to LACYP is not provided on a regular basis.

4. **How will participants be recruited and from where? Be as specific as possible. Ensure that you provide the *full versions* of all recruitment materials you intend to use with this application (eg adverts, flyers, posters).**

A member of the research team will attend at least one meeting of the [redacted] therapeutic governance group, with [redacted] being the organisation participants will be recruited from. The study's aims, inclusion/exclusion criteria, recruitment pathway and recruitment materials will be introduced and the governance group asked to give confirmation that staff members from [redacted] may participate.

The principal investigator will then introduce the study to the [redacted] therapy team, who provide a therapeutic case manager and therapeutic input to each home. Therapy team members will be provided with recruitment packs, consisting of a covering letter and expression of interest slip (appendix 4-A) and a participant information sheet (appendix 4-B) which they will disseminate to staff members of the homes they provide input to. The principal investigator will also be available to introduce the study to the staff of individual homes, if requested by the home manager or therapy team.

Potential participants interested in participating in the study will be invited, through the cover letter, to contact the principal investigator via email or telephone. Additionally, individuals will also be able to register their interest and consent to be contacted by the principle investigator through leaving their contact details (email address and/or telephone number) with the recruiting member of the therapeutic team. These details will then be passed along to the principal investigator.

Sampling will be purposive with the principal investigator aiming to recruit from a range of residential care homes to minimise the possibility multiple participants talking about their experiences with the same child/young person, however should there be difficulties with recruitment, more than one participant may need to be recruited from each home. Potential participants will be told that should recruitment targets already be met, they may not be invited to participate, but will have the results of the study shared with them should they wish, on completion of the project. Once the top end of the target sample size (12) has been recruited to, those who have expressed an interest in participation will be informed that recruitment has closed, and they will be thanked for their interest.

Participants will also be asked if they would consent to being contacted for a second interview. Second interviews will be considered if new topics, themes or questions emerge once data collection has begun, which it is deemed necessary to the project to explore with all participants.

Whilst this project will not feature direct contact with LACYP, the therapy team, within their recruiting role, will share the participant information sheet with the social worker of any LACYP currently under the care of [redacted] who has displayed HSB. This will ensure clear and open communication is maintained between those legally responsible for the care of LACYP.

5. Briefly describe your data collection and analysis methods, and the rationale for their use.

For those invited to participate, a mutually convenient location and time will be agreed upon, with participants offered the choice of being interviewed at [redacted] head office, where permission has been given to use a bookable room, or their own home. Due to staff being present at head office for a variety of reasons throughout the day it is not expected that a participant's presence will compromise the anonymity of their participation in the proposed study.

Should it not prove possible to arrange a face to face interview and the potential participant wish to take part despite this, the principal investigator will offer a telephone interview.

The principal investigator will adhere to Lancaster University lone working policies if conducting interviews at participants' homes. The use of 'Sky guard' was discussed by the principal investigator and supervisory team. Due to the frequency of interviews conducted in participant's homes predicted to be low and logistical challenges concerning the use of equipment, a 'buddy' system will instead be used. A 'buddy' (a named colleague) will be notified before each interview where the interview is taking place and at what time. If the buddy does not hear from the principal investigator by a predetermined time, they will take steps to contact the principal investigator. If no contact can be made the buddy will next inform the police.

Each interview will begin with the principal investigator talking through the participant information sheet, answering any questions and the participant being asked to complete a demographic information sheet (appendix 4-C). The participant will then be asked to complete and sign the consent form (appendix 4-D) which will be signed by both the participant and the principal investigator. Two copies will be signed, with one being held by the principal investigator and the other held by the participant. The consent form will highlight the participant's right to withdraw at any point before or during the interview and that their data can be withdrawn at any point in the two weeks following the interview. After these two weeks it will be explained that withdrawal of their data will no longer be possible.

If interviews take place via telephone participants will be sent a consent form prior to the interview. The consent form will then also be read aloud before the interview begins and the potential participant will be asked if they agree to each item. This information will be audio recorded and transcribed and stored as electronic data.

Interviews will then be conducted, guided by the interview schedule (appendix 4-E), lasting approximately one hour. Interviews will be recorded using an audio recording device which will not support encrypted recordings. Therefore, data will be moved from the recording device to the principal investigator 's H: drive, a password protected secure destination hosted by Lancaster University, as soon as possible following completion of an interview and the recording deleted from the audio recording device. All access to the data for transcription and analysis will be conducted via the H: drive.

After concluding the interview, the principal investigator will debrief the participant, focusing on managing any distress the participant is experiencing using their clinical skills and by signposting to the relevant agencies listed on the participant information sheet and relevant support offered by [redacted] e.g. supervision. Furthermore, the principal investigator will outline what will happen to the participant's data and the process of

withdrawing from the study. The principal investigator will also ask if the participant would like a summary of the findings on conclusion of the project

Analysis:

The interviews will be analysed using thematic analysis (Braun & Clarke, 2006). Thematic analysis is a flexible analytical approach with an established use in LACYP and residential care populations (Allan, 2006; Belton, Barnard, & Cotmore, 2014; Durka & Hacker, 2015; McLean, 2013). It will be used to identify and explore common themes across the experiences of participants to develop a better understanding of the experiences of RCWs who work with LACYP who display HSB.

The six-step method described by Braun & Clarke (2006) will be followed: 1) Data transcription - conducted by the researcher, with initial ideas noted throughout; 2) Initial coding – systematic coding of the data set; 3) Theme generation – code and data collated into potential themes; 4) Review- themes reviewed for consistency with coded extracts; 5) Naming – these defined and named; 6) Report-final analysis, selection of extracts in relation to research aims.

6. What plan is in place for the storage, back-up, security and documentation of data (electronic, digital, paper, etc.)? Note who will be responsible for deleting the data at the end of the storage period. Please ensure that your plans comply with General Data Protection Regulation (GDPR) and the (UK) Data Protection Act 2018.

Data from the interviews will be stored on the principal investigator 's H: drive, a password protected secure destination hosted by Lancaster University and deleted from the audio recording device as soon as it is transferred. Following transcription, the audio recording will be deleted and only the interview transcript will remain. Transcripts will be stored on the principal investigator 's H:Drive.

Prior to submission of the project, all personally identifying information (e.g. consent forms and demographic information) will be stored separately to anonymised information (interview transcripts and codes emerging across transcripts). All information will be stored securely, physical information will be kept in a locked cabinet and electronic data will be password protected and stored on the secure H: drive hosted by Lancaster university.

Following submission of the project, all paper consent forms will be scanned and saved in electronic format. Physical paper copies will be destroyed following this. Electronic data will then be encrypted and securely transferred to the DClinPsy programme research Coordinator, who will store the files on a server hosted by Lancaster University in a password protected file. Data will be held for 10 years after submission of the project at which point it will be destroyed by the Research coordinator.

7. Will audio or video recording take place? ☐ no ☒ audio ☐ video

a. Please confirm that portable devices (laptop, USB drive etc) will be encrypted where they are used for identifiable data. If it is not possible to encrypt your portable devices, please comment on the steps you will take to protect the data.

The audio recording device used will not support encrypted recordings. Data will therefore be moved from the recording device to the principal investigator 's H: drive, a password protected secure destination hosted by Lancaster University, as soon as possible following completion of an interview and the recording deleted from the audio recording device. All access to the data for transcription and analysis will be conducted via the H: drive.

b What arrangements have been made for audio/video data storage? At what point in the research will tapes/digital recordings/files be destroyed?

Data from the interviews will be stored on the principal investigator 's H: drive, a password protected secure destination hosted by Lancaster University and deleted from the audio recording device as soon as it is transferred. Following transcription, the audio recording will be deleted and only the interview transcript will remain. Transcripts will be stored on the principal investigator 's H:Drive.

Prior to submission of the project, all personally identifying information (e.g. consent forms) will be stored separately to anonymised information (interview transcripts and codes emerging across transcripts). All information will be stored securely, physical information will be kept in a locked cabinet and electronic data will be password protected and stored on the secure H: drive hosted by Lancaster university.

Following submission of the project, all paper consent forms will be scanned and saved in electronic format. Physical paper copies will be destroyed following this. Electronic data will then be encrypted and securely transferred to the DClinPsy programme research Coordinator, who will store the files on a server hosted by Lancaster University in a password protected file. Data will be held for 10 years after submission of the project at which point it will be destroyed by the Research coordinator.

Please answer the following questions *only* if you have not completed a Data Management Plan for an external funder

8a. How will you share and preserve the data underpinning your publications for at least 10 years e.g. PURE?

Data will be held, managed and preserved on Lancaster University's PURE data repository for 10 years

8b. Are there any restrictions on sharing your data ?

Due to the small sample size there is a chance that participants could be identified even after full anonymisation. Therefore supporting data will only be shared with genuine researchers (e.g. those with email addresses ending in .ac.uk). Access to data will be made on a case by case basis by the research co-ordinator.

9. Consent

a. Will you take all necessary steps to obtain the voluntary and informed consent of the prospective participant(s) or, in the case of individual(s) not capable of giving informed consent, the permission of a legally authorised representative in accordance with applicable law? yes

b. Detail the procedure you will use for obtaining consent?

Once the principal investigator is contacted by a potential participant they will arrange a discussion about the project where a copy of the participant information sheet will be provided and discussed. Two printed copies of the consent form will then be provided to read and sign. One copy will be kept by the participant and the other by the principal investigator, who will also sign each form.

If interviews take place via telephone participants will be sent a consent form prior to the interview. The consent form will then also be read aloud before the interview begins and the potential participant will be asked if they agree to each item. This information will be audio recorded and transcribed and stored as electronic data.

Scanned electronic copies of all consent forms will be held by Lancaster University for 10 years after the submission of the project.

10. What discomfort (including psychological e.g. distressing or sensitive topics), inconvenience or danger could be caused by participation in the project? Please indicate plans to address these potential risks. State the timescales within which participants may withdraw from the study, noting your reasons.

Discovery of malpractice.

If during the interview information is disclosed suggesting malpractice occurring within the service, the researcher will contact either their research supervisor Anna Daiches or the field supervisor Jane Toner in the first instance and take the appropriate steps from there.

Fear of scrutiny

Participants may be reluctant to participate for fear that their practice will be scrutinised. Efforts will be made to address this directly in the recruiting information and in the conversation before the interview begins where participants will be reassured confidentiality would only be breached if there appears to be a threat to the themselves or another person and that in that case the disclosure would be discussed with the project supervisors before any action is taken.

Breaches of confidentiality are anticipated to be required in two scenarios. The first reflects a situation where the participant is deemed to present a risk to themselves or others, the second reflects a situation where it is felt that a young person is at risk. In either situation the principal investigator will follow the safeguarding protocol of [redacted], contacting their designated safeguarding professional (contactable 24 hours a day). The principal investigator will also contact the supervising members of the research team and inform them at the earliest possible opportunity.

Maintenance of anonymity

Participants will be informed that should they chose to be interviewed within their workplace their anonymity cannot be assured as others may be aware that the interview is taking place. Participants will be reassured that pseudonyms will be used throughout the project report and reminded that they may not want to disclose identifying information during the interview (e.g. name or other distinguishing information).

Participant Distress

Discussing sexually harmful behaviour can evoke strong emotional reactions and the principal investigator will draw on their clinical experience and training to support participants should they become distressed during the interview. The interview will also be followed by a debriefing where the researcher will be able to draw attention to the participant information sheet which lists contact details of support offered internally by [redacted] and by external agencies which can provide support if they continue to feel distressed (e.g. Samaritans, MIND).

Withdrawal from study.

Participants will be welcomed to withdraw from the study at any time before or during the interview. Following the interview, the participant will be informed they may request the withdrawal of their data in the next two weeks. It will be explained that following these two weeks withdraw of their data will no longer be possible because at this point data will be transcribed, coded and pooled with other data, making it's extraction no longer possible.

11. What potential risks may exist for the researcher(s)? Please indicate plans to address such risks (for example, noting the support available to you; counselling considerations arising from the sensitive or distressing nature of the research/topic; details of the lone worker plan you will follow, and the steps you will take).

Lone working

The researcher will follow Lancaster Care NHS foundation trust lone working policy when conducting interviews, for example contacting a supervisor prior to the interview beginning and again once it has finished.

12. Whilst we do not generally expect direct benefits to participants as a result of this research, please state here any that result from completion of the study.

Time spent participating in the study will be viewed as working time by [redacted]. The participant may also find it interesting to take part.

13. Details of any incentives/payments (including out-of-pocket expenses) made to participants:

n/a

14. Confidentiality and Anonymity

a. Will you take the necessary steps to assure the anonymity of subjects, including in subsequent publications? yes

b. Please include details of how the confidentiality and anonymity of participants will be ensured, and the limits to confidentiality.

To protect anonymity participants will be allocated a pseudonym which will be used in the write up of the data.

To ensure confidentiality data will be stored on a secure, password protected and encrypted device at all times. The limits of confidentiality will also be explained. Specifically that if information is disclosed which indicates safeguarding concerns or issues of malpractice then

confidentiality may not be able to be maintained and a relevant professional will need to be informed. This would also be fed back to the academic and field supervisors.

15. If relevant, describe the involvement of your target participant group in the *design and conduct* of your research.

Prior to submitting ethical approval, the principal investigator has consulted on the appropriateness of the recruitment pathway and all recruitment material with a senior leader from [redacted], the residential care provider participants will be recruited from. Documents have been updated to reflect feedback received.

The [redacted] Therapeutic Governance group and therapeutic team have since also been consulted to gain stakeholder feedback on the recruitment pathway, recruitment materials and the interview schedule. The research proposal has been amended to reflect this feedback.

16. What are the plans for dissemination of findings from the research? If you are a student, include here your thesis.

Results will be disseminated to the service participants were recruited from and individual participants who express an interest in the findings via a concise written summary of the project and potentially a presentation of findings at a senior staff meeting. This feedback will help to ensure the findings can contribute to improved practice at a service level.

Finding will also be disseminated via the submission of the thesis, and in a presentation of the study to other students on the DClinPsy training programme, as well as staff and members of the Lancaster University public engagement network (presentations are mandatory for all third-year trainee clinical psychologists).

Further dissemination may occur via publication of the study in a relevant academic journal and potentially through a presentation at a relevant conference.

17. What particular ethical considerations, not previously noted on this application, do you think there are in the proposed study? Are there any matters about which you wish to seek guidance from the FHMREC?

SECTION FOUR: signature

Applicant electronic signature: Kristian Glenny Date 21/01/2019

Student applicants: please tick to confirm that your supervisor has reviewed your application, and that they are happy for the application to proceed to ethical review ☒

Project Supervisor name (if applicable): Dr Suzanne Hodge, Dr Anna Daiches & Dr Jane Toner Date application discussed 21/01/2019

Appendix 4-B: Cover letter and Expression of Interest Slip

Hello,

My name is Kristian Glenny and I am a Trainee Clinical Psychologist at Lancaster University. I am writing to you to tell you about a research project I am doing as a part of my doctoral thesis.

I am interested in understanding how the relationship between professionals providing care and children is impacted when the child displays, or has previously displayed, harmful sexual behaviours.

I think this is an important area to explore because harmful sexual behaviours create strong reactions in us all. Understanding the experiences of direct care professionals and how they balance them with forming therapeutic relationships will provide important information about how to best support professionals and children/young people who display harmful sexual behaviours.

If you currently work in a **direct care role** (e.g. RSW; senior RSW, team leader) **and have worked with a child that displays harmful sexual behaviour**, either whilst in their current placement or **within the last 2 years** I would be very grateful if you would consider taking part in my research. I have included some further information about the project in the Participant Information Sheet.

Taking part would entail meeting with me for an interview lasting no more than one hour at a time suitable to you. [redacted] **will class this interview as working time.**

If you are interested in taking part in this research project or would like to speak to me about it before deciding, please complete the tear off strip below and return it **to the member of the therapy team** who gave you this letter. I will then contact you by your preferred means. You can also contact me directly **by email** at k.glenny@lancaster.ac.uk or **by telephone,** on [redacted]**.**

Alternatively, you can contact [redacted] if you would like more information.

Thank you for taking the time to read this information. I hope to hear from you soon.

Best wishes

Kristian Glenny
Trainee Clinical Psychologist

✂----------

Name: ……...
Tel:.....

Email address:
……
……..

Preferred method of contact: ☐ Telephone ☐ Email

Preferred times/days to contact you:
……..

Signed:……
…… Date:……..

Appendix 4-C: Participant Information Sheet

Lancaster University

Participant Information Sheet

Residential care workers' experiences of working with children & young people who display harmful sexual behaviour.

My name is Kristian Glenny and I am a trainee Clinical Psychologist studying at Lancaster University. You are being invited to take part in this research project which is being conducted as a part of my training. Before you decide if you would like to participate I will explain why the research is being done and what taking part would involve for you. Please feel free to ask any questions you may have and to talk to others about the study when making up your mind.

Please take as much time as you need to decide whether you would like to participate. Thank you for taking the time to read this.

What is the study about?

This study aims to explore the thoughts and feelings residential support workers (RSWs; or other similar titles referring to direct care staff) have about children and young people they care for who have displayed harmful sexual behaviours. We are also interested in understanding how RSWs make sense of this behaviour and how this impacts the relationship between RSW and child/young person.

It is known that one of the most therapeutically important parts of residential care is the relationship that RSWs and children/young people develop. Furthermore, the understandings RSWs have about behaviours children/young people display impacts the quality of these therapeutic relationships.

Harmful sexual behaviour understandably creates strong emotional reactions in people and it has been found that reactions of RSWs towards harmful sexual behaviours can, understandably, be negative. However, no study has yet investigated how RSWs experience working with harmful sexual behaviours, the understandings they have about the harmful sexual behaviour and the impact this has on the therapeutic relationship.

What is harmful sexual behaviour?

The term 'harmful sexual behaviour' encompasses a range of behaviours from sexualised language that is inappropriate given the child's age, to sexual penetration of another child or adult. The defining features of harmful sexual behaviour are that it is developmentally-inappropriate and problematic or abusive to the child themselves or the victim of their actions.

Why have I been approached?

All residential support workers, including senior RSWs and team leaders, employed by [redacted] are being asked if they would like to take part in this study if they:

- Have been employed by [redacted] in a residential support worker role for at least 6 months
- Work in a residential care home
- Have worked directly with a child or young person who displayed harmful sexual behaviours within the last two years, either in their current placement or a previous one.

Do I have to take part?
No. Taking part is a completely voluntary decision. If you agree to take part, you can withdraw at any time prior or during the interview. Following the interview, you will have a two-week period to decide if you would like to withdraw your data from the study. After these two weeks your data will be pooled with the other participants' data making withdrawal of an individual's data no longer possible.

What will I be asked to do if I take part?

If you decide to take part, you will be asked to meet with the researcher for an interview which will last no longer than an hour and will be 1:1. The interview will be arranged for a time suitable to you and around your shift pattern. Interviews can take place at [redacted] head office or your own home.

Whilst face to face interviews are ideal, if we are unable to find a mutually suitable time and you wish to participate, interviews can also be carried out via a telephone call.

Taking part in this study will be classified by [redacted] as working time.

During the interview you will be asked questions about your experiences of working with children or young people who display harmful sexual behaviours.

You may also be asked if you would agree to the research team contacting you after the interview has been completed. This would be to arrange a follow up interview, should new topics/ questions emerge which we think it would be helpful to get your views and experiences on.

All interviews will be audio recorded. Two weeks after the interview, the recording will be anonymised and transcribed.

Will my data be confidential?
The information you provide will be kept confidential. The data collected for this study will be stored securely and only the researchers conducting this study will have access to this data:

- The audio recordings of your interview will be destroyed once the project has been submitted and examined.
- All documents with identifying information will be encrypted (no-one other than the researchers will be able to access them) and stored on a password projected drive.
- The typed version of your interview will be made anonymous by removing any identifying information including your name. Anonymised direct quotations from your interview may be used in the reports or publications resulting from the study, so your name will not be attached to them.

- At the end of the study written transcripts will also be kept securely on a Lancaster University computer drive for ten years.

There are some limits to confidentiality. If what is said during the interview makes me think you or someone else is at significant risk of harm, I will break confidentiality and speak to an appropriate person about this (e.g. the [redacted] designated safeguarding person), to ensure that I follow the safeguarding policies of [redacted] and the British Psychological Societies code of conduct. If possible, I will tell you if I must do this.

For further information about how Lancaster University processes personal data for research purposes and your data rights, please visit: www.lancaster.ac.uk/research/data-protection.

What will happen to the results?
The results will be summarised and reported as a part of my Clinical Psychology qualification. Results from the study will be fed back to [redacted] to help inform the care provided to children/young people who display harmful sexual behaviours.
The study may also be submitted for publication in an academic or professional journal to share the knowledge we discover. If you would like a copy of the results, please ask me and I will provide a copy.

Are there any risks?
There are no anticipated risks to participating in this study. The interview is however about a subject with is understandably distressing for some people. Whilst the researcher will use their skills to reduce distress, if you are finding the interview difficult please let the researcher know and the interview can be paused for a break or stopped. If you experience distress following the interview you are encouraged to either contact the researcher or use the details of helpful organisations listed at the end of this document. It may also be helpful to speak to your supervisor/line manager.

Are there any benefits to taking part?
Your participation in this study will be classed as working hours. You may also find it interesting and helpful to discuss your experiences and understandings.

Who has reviewed the project?
This study has been reviewed and approved by Lancaster University (the Faculty of Medicine Research Ethics Committee).

How can I opt in to the study?
If you might be interested in taking part in the study, please complete the expression of interest slip at the bottom of the cover letter and return it to the member of the therapeutic team who gave you the information about this study.

Alternatively you can contact me, Kristian Glenny **by email** at k.glenny@lancaster.ac.uk or **by telephone,** on [redacted]

Complaints
If you wish to make a complaint or raise concerns about any aspect of this study and do not want to speak to the researchers, you can contact:

Professor Bill Sellwood Tel: (01524) 593998

Email: b.sellwood@lancaster.ac.uk
Programme Director
Division of Clinical Psychology
Lancaster University
Lancaster
LA1 4YG

If you wish to speak to someone outside of the Clinical Psychology Doctorate Programme, you may also contact:

Professor Roger Pickup Tel: (0)1524 593746
Associate Dean for Research Email: r.pickup@lancaster.ac.uk
Faculty of Health and Medicine
(Division of Biomedical and Life Sciences)
Lancaster University
Lancaster
LA1 4YG

Thank you for reading this information sheet.

Resources

It is not anticipated that taking part in this research will cause distress. However, should you feel distressed because of taking part you can contact:

The Samaritans www.samaritans.org
The Samaritans offer a non-judgemental listening service. Their phone number is 116 123 (free from any phone) or you can email them on jo@samaritans.org

MIND – www.mind.org.uk
MIND's info line service provides information on a range of topics including the experiencing of emotional distress and signposting where to get additional support. Their phone number is 0300 123 3393 (local rates apply) or text 86463.

The Survivors Trust – www.thesurvivorstrust.org
The survivors trust offers support, advice and information to survivors of rape and sexual violence. Their phone number is 0808 801 0818 or you can email them on info@thesurvivorstrust.org

Appendix 4-D: Demographic Information

Demographic Information Form

Please underline or circle the appropriate response.

1. What is your Gender?

Male Female Other (please specify)
…….

Please provide an answer for the questions below:

2. How old are you?

…….

3. What is your ethnicity?

…….

4. How long have you worked in a direct care role with looked after children/young people?

…….

5. How long have you worked for your current employer?

…….

6. What is your current job title?

…….

7. What post-16 qualifications do you hold?

…….

8. **How many looked after children/young people have you worked with who displayed harmful sexual behaviours?**

…….

9. **What support or training have you received to help you in your work with children/young people who display harmful sexual behaviours?**

_____
_____

_____
_____

-
_____
_____

Thank you for your time.

Appendix 4-E: Consent form

Lancaster University

Consent Form

Residential care workers' experiences of working with children & young people who display harmful sexual behaviour.

We are asking if you would like to take part in a study investigating the experiences of residential care workers (direct care staff) who have worked with children or young people who have displayed harmful sexual behaviour, in residential care settings, within the last 2 years.

Before you consent to participating in the study we ask that you read the participant information sheet and mark each box below with a tick if you agree. If you have any questions or queries before signing the consent form please speak to a member of the research team.

	Please tick box after each statement
1. I confirm that I have read the participant information sheet and fully understand what is expected of me within this study	
2. I confirm that I have had the opportunity to ask any questions and to have them answered.	
3. I understand that my participation is voluntary, that I am free to refuse to answer any question or withdraw from the interview at any time without giving any reason and without any personal or professional repercussions	
4. I consent to being contacted by a member of the research team in order to arrange a second interview, should additional questions or topics emerge which are deemed necessary to explore with participants.	
5. I understand that an audio recording of my interview will be taken and made into an anonymised written transcript, two weeks after the interview.	
6. I understand that the information from my interview will be pooled with the information of other participants and may be published.	
7. I understand that once anonymised and pooled it will not be possible for my information to be withdraw.	
8. I consent to the anonymised information and quotations from my interview, including demographic data, being used in reports, conferences and training events.	

9. I understand that any information I give will remain strictly confidential among the research team unless it is thought that there is a risk of harm to myself or others, in which case this information may need to be shared with appropriate persons.	
10. I consent to Lancaster University keeping written transcriptions from the study for up to 10 years after the study has finished	
11. I consent to take part in the above study.	

Name of Participant_____ Signature_____ Date _____

Name of Researcher _____Signature _____Date _____

Appendix 4-F: Interview Schedule

Interview Schedule

Introduction and Background

- Introductions - name and role. Confirm the participant meets the inclusion/exclusion criteria for the study
- Provide participant information sheet. Answer questions any questions arising.
- Explain confidentiality procedure, highlighting exceptions where confidentiality would have to be broken. Explain advice would be sought from supervisors/relevant professionals.
- Explain interview process. Interview will last approximately one hour, breaks can be arranged, the interview can be terminated at any point should the participant wish, the participant can choose not to answer any question and stop the interview at any time.
- Explain that the researcher is interested in their thoughts, feelings and understandings. There are no right or wrong answers. Also explain it is okay for there to be pauses whilst participant thinks about their answer.
- Check if participant still wishes to take part in the study. If no, thank participant for their time. If yes, provide participant with consent form (2 copies, one to be held by participant, one by researcher).
- Inform participant you are now starting the audio recorder

Interview

This schedule will be used to guide the exploration of participant experiences and understandings. Questions will be adapted based on participant responses with additional prompts used as necessary.

Understanding the context of the participant

Example questions:

- How long have you been an RSW (or equivalent role)?
- What led to you deciding to become a residential support worker (substitute for relevant job title e.g. residential care worker)?
- In your opinion, what is the purpose of residential care?
- In your experience, what are the rewards of the role?... What are the challenges?
    - What factors impact your job satisfaction?

Exploring the conceptualisation of harmful sexual behaviours

Example questions:

- What do you understand by the term “harmful sexual behaviour”?
- Have there been times you were unsure if something was a harmful sexual behaviour or not?
    - What did you do to help yourself understand what it was?

- How do you make sense of harmful sexual behaviours?
    - What causes these behaviours? /Why do you think some children/young people display these behaviours?
    - What triggers the harmful sexual behaviours?

Harmful sexual behaviour and the therapeutic relationship

Example questions:

Thinking back to a time when you may have worked with child/young person who displayed harmful sexual behaviours:

- How do you approach working with a child/young person displaying harmful sexual behaviour?
- What are your thoughts and feelings when you know a child who has previously displayed harmful sexual behaviours is being placed in your home?
    - What are your thoughts and feelings towards the child/young person whilst they are placed with you?
    - Do/did your thoughts and feelings towards the child change?
- If you have worked with more than one child/young person who displays harmful sexual behaviours, were your thoughts and feelings towards them different?
    - What do you think contributed to this difference?
- Are there things you would change about how you responded to harmful sexual behaviours in the past?
    - What stopped you from acting in this alternate way?
- Do your experiences and understandings of harmful sexual behaviour impact the thoughts and feelings you have towards the child/young person? How?
- What has shaped your relationship towards harmful sexual behaviours?
    - ***"please only share as much information as you feel comfortable with"***

Last question

- This research is about exploring the thoughts and feelings staff have about children/young people they care for who have displayed harmful sexual behaviours as well as the ways staff make sense of this behaviour. Is there anything else which you think would help us understand this?

Closing the interview

- Check on participant distress level. If there is evidence of distress signpost the participant to relevant support agencies listed on participant information sheet.
- Remind the participant of the two-week allotment within which they can withdraw their data for any reason and that after this point it will no longer be possible.
- Should the participant have disclosed information necessitating a confidentiality breach, the process of breaching confidentiality should be revisited (if appropriate).
- Inform participant of the timescale of the research project and thank them for their time.

Appendix 4-G – Faculty of Health and Medicine Research Ethics Committee (FHMREC) approval letter

Lancaster University

Applicant: Kristian Glenny
Supervisors: Suzanne Hodge and Anna Daiches
Department: Health Research
FHMREC Reference: FHMREC18050

21 February 2019

Dear Kristian

Re: Residential care workers' experiences of working with children & young people who display harmful sexual behaviour

Thank you for submitting your research ethics application for the above project for review by the Faculty of Health and Medicine Research Ethics Committee (FHMREC). The application was recommended for approval by FHMREC, and on behalf of the Chair of the Committee, I can confirm that approval has been granted for this research project.

As principal investigator your responsibilities include:

- ensuring that (where applicable) all the necessary legal and regulatory requirements in order to conduct the research are met, and the necessary licenses and approvals have been obtained;
- reporting any ethics-related issues that occur during the course of the research or arising from the research to the Research Ethics Officer at the email address below (e.g. unforeseen ethical issues, complaints about the conduct of the research, adverse reactions such as extreme distress);
- submitting details of proposed substantive amendments to the protocol to the Research Ethics Officer for approval.

Please contact me if you have any queries or require further information.

Tel:- 01542 593987
Email:- fhmresearchsupport@lancaster.ac.uk

Yours sincerely,

R E Case

Becky Case
Research Ethics Officer, Secretary to FHMREC.