# Towards a Typology of Youth Sexual Harmers in Aotearoa, New Zealand

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# ABSTRACT

Sixty seven characteristics, and demographic and offence data were used to explore patterns of similarity amongst a sample of 195 male youths aged 6-17 years who had been referred for treatment because of their sexually harmful behaviour. The overarching aim of the study was to investigate the possibility of developing a typology of youth sexual harmers in order to enhance assessment and treatment. Archival data were collected from three specialist treatment agencies providing services to nine locations across New Zealand. The characteristics were chosen to highlight a broad range of functioning and incorporated personality traits, social and family factors, education and developmental factors, mental health issues and antisocial behaviour as well as sexual behaviour and prior victimisation. Hierarchical cluster analysis was employed to determine whether certain characteristics and youth were similar and whether these similarities indicated clinically relevant profiles of youth were present within the sample. A review of the analysis suggested seven themes of characteristics were present: Sexual Deviancy and Delinquency, Trauma and Neglect, Sexual Abuse and Family Mental Health, Mood Disregulation, Personality and Social Deficits, Developmental Deficits, and Family Aggression and Abuse. A review of the analysis of the youth indicated four profiles of sexually harmful youth in this sample: Depressed Relationship Seeking, Trauma Reactive, Hostile/Versatile, and Controlling/Entitled. Demographic and offence data for each profile indicated within profile similarity, also. The analyses enabled a review of the inter-relationship of multiple characteristics and highlighted the way in which certain characteristics and life experiences can influence behaviour and learning. The results imply an inclusive typology of young sexual harmers is possible and this has implications for the assessment and treatment of these youth. Assessments that can define profiles may enhance treatment planning and delivery.

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# Chapter 1

## *Introduction*

The observed heterogeneity within youth sexual harmer (YSH) populations has challenged treatment providers in recent years (Burton, Smith-Darden & Frankel, 2006; Hackett, 2007; Hunter, 2006; Leversee, 2007). Veneziano and Veneziano (2002) suggested continued advancement in the assessment and treatment of YSH would be enhanced by the development of typologies. Such typologies may uncover subgroups within the population which have differing treatment needs. If assessment of these youth is able to successfully determine the subgroup into which a YSH best fits then treatment strategies could be implemented to target the inclusive needs of that young person. The purpose of this study is to explore the possibility of developing a typology of YSH, using hierarchical cluster analysis of a large number of variables. The results of this study offer an opportunity to promote discussion about how best to assess and provide treatment with YSH.

Research has shown that individual differences within YSH samples are found in personality traits (Burton, 2008; Worling, 2001), family factors (Blaske, Bourdin, Henggeler & Mann, 1989) intellect and educational needs (Fyson, 2007), social skills (Hunter, Figueredo, Malamuth & Becker, 2003), mental health issues (Kavoussi, Kaplan & Becker, 1988), behavioural difficulties (Hunter, 2004), prior victimisation (Burton, 2003), and versatility of sexual, general and violent behaviour (Bullens, van Wijk & Mali, 2006). Typology research, which has the primary goal of grouping types of objects, based on characteristics or traits which the objects have in common, has been utilised as a way of attempting to develop

homogeneous subgroups of YSH (Hunter, 2004; O'Brien & Bera, 1986; Richardson, Kelly, Graham & Bhate, 2004; Smith, Monastersky & Deisher, 1987; Veneziano & Veneziano, 2002; Worling, 2001). While typology research has improved knowledge about similarities within YSH populations, most studies, to date, have incorporated variables designed to highlight a particular problem issue, such as personality characteristics (Richardson et al., 2004; Worling, 2001), prior victimisation (Burton, 2003) and social skills deficits (Hunter et al., 2003). This type of approach has limitations when the development of within population subgroups is the aim, because it does not taken into account a broad range of problem life experiences or characteristics of YSH and the results of such studies have offered inadequate representations of YSH. This has meant the utility of typologically derived YSH profiles in terms of theory development, treatments, and assessment procedures have been limited.

In this researcher's clinical experience, in New Zealand there has been no shift to develop profile specific risk assessment, nor have the results of typology studies been used to incorporate treatment components designed specifically for the different needs of different profiles of YSH. The observed reticence may be rooted in the limited descriptions given of YSH within current typologies. Further, perhaps as a result of this, YSH typology researchers have not developed assessment instruments based on their results. In order for research such as this to have clinical value, clinicians must have an assessment instrument which classifies clients into profiles. Once this is achievable, appropriate treatments would become apparent – based on the strengths and needs of the client, as highlighted within the assessment.

On occasion, YSH typology researchers have discussed treatment strategies which might be useful for different profiles of YSH. Yet these have been brief offerings inserted into

the discussion section of typology research articles and, as such, they have done little to aid clinicians in their day to day work. The current research seeks to address the lack of synergy experienced as a clinician between typology research, risk assessment research, and analyses of efficacious treatment strategies. To advance the assessment and treatment of YSH, this study extends the potential for typology research by including a large number of variables covering a wide variety of issues to allow for a more inclusive representation of different profiles for YSH to be advanced.

## Research Context

### Underlying Social and Professional Issues

While the majority of sexually harmful behaviour is perpetrated by adult males, a concerning proportion is committed by adolescent males (Erooga & Mass, 1999). Adolescents and children do engage in a variety of experimental sexual behaviours (Lightfoot & Evans, 2000). However, a small percentage of these youngsters engage in sexual activities with others that are intrusive and unwanted by the other person. Between 2000 and 2005, New Zealand Police statistics indicate that 15 percent of all people convicted of sexual crimes were adolescents under the age of 17. Between 1991 and 2000, the percentage was 11 (Statistics New Zealand, 2005). These statistics emphasised a worrying increase over a period when the New Zealand Government set new protocols for dealing with crimes committed by adolescents (Child Youth & Family Services, 2001). These protocols are aimed at rehabilitating young sexual harmers and not on punishment or the incurrence of a criminal conviction.

In a British survey of the general population, four percent of male adolescents reported committing a sexual offence (Erooga & Mass, 1999). Although the prevalence of sexually

harmful behaviour for youth may be low, a substantial proportion of all sexual crimes can be attributed to them (Barbaree & Marshall, 2006). In the New Zealand Otago Women's Health Study, approximately 33 percent of women interviewed said they had experienced at least one unwanted sexual advance (contact and non-contact) before the age of 16. Further, 50 percent of the perpetrators were under the age of 25 and half of them were under 18 (Anderson, Martin, Mullen, Romans & Herbison, 1993). Lambie (1998 cited in Lambie & Seymour, 2006) found in a study of adolescent males who had been sexually abused as youngsters, that 35 percent reported their abuse had been committed by an adolescent. Similarly, another New Zealand study of 482 adolescent sexual harmers found that, for 42 percent of those sexually abused, the abuse was perpetrated by an adolescent (Lambie, 1998 cited in Lambie & Seymour, 2006).

In comparison, rates for YSH in North America estimate that 20 percent of all rapes and 30-50 percent of all child molestations are committed by adolescent males (Barbaree, Hudson & Seto, 1993). In the United Kingdom 32 percent of all cautions in 2005 (n = 6,400) for sexual offences were aimed at young people between the ages of 12 and 17; 19 percent were aged 12-14 years, and 13 percent were 15-17 years (Home Office, 2005). Erooga and Mass (1999) caution that official statistics for YSH only apply to reported offences and, in all likelihood, represent only a small portion of sexual abuse committed by children and young people, particularly as much sexual abuse goes unreported or is not recognised or dealt with as such. A consistent finding across international studies is that between 15 and 50 percent of all convicted sexual offenders are male adolescents. Further, retrospective studies have indicated that the percentage is much higher (Erooga & Mass, 1999).

Youth sexual harming places significant time and financial costs on the New Zealand criminal justice system and Child Youth and Families Services (CYFs), which must investigate and, on occasion, charge and adjudicate these young people. While youth justice teams within the police are supportive of non-punitive interventions for these youth, where this can be safely achieved, they require the support of CYFs to investigate the young person's background and refer them to specialist intervention programmes, primarily because in New Zealand CYFs is the major funder for specialist YSH treatment agencies. A common complaint of police is that CYFs has often appeared unwilling or unable to investigate the issues fully and, as such, the young person is not referred appropriately (personal correspondence, Sergeant Alan Potter, Youth Justice, New Zealand Police; 9th December 2008). In response, social workers within CYFs have cited funding constraints imposed by their managers as a reason many youth are not referred immediately for treatment (personal correspondence, M.D. retired CYFs social worker, 4th May 2009). This has potentially created a situation whereby these young people and their families receive an unspoken message that their inappropriate sexualised behaviour is not viewed as a serious problem. When this has occurred, the risk of further sexual harm to others is high and it may only be after the young person has sexually abused multiple people, or perpetrated a particularly serious crime, that they are finally referred for specialist treatment.

**Research Issues**

The goal of specialist sexual offender treatment programmes is to provide well informed, empirically-based assessment and treatment for YSH (Marshall, 1996). Despite the overwhelming evidence that supports the need for interventions to target the social, educational, developmental and familial difficulties experienced by YSH there are no

empirically derived treatment components that have specifically been shown to work with this population (Burton et al., 2006).

It is this researcher's contention that effective assessments and interventions with YSH require an understanding of diversity. Typology studies to date have described profiles of YSH within the population; however, the outcomes have been based on variables limited to a specific concept or problem issue, and researchers have often excluded some YSH because their characteristics or behaviours did not meet the inclusion criteria of the study (Bullens et al., 2006; Hunter et al., 2003; Langstrom, Grann & Lindblad, 2000). In addition, many of the published studies have been undertaken with relatively small samples. While differing methods have been used to analyse data, most researchers have used significance testing as a way to highlight seemingly prominent results. The typical number of participants in YSH typology studies to date has been around 100, with resulting profiles containing between three and 50 participants. Reporting significance is, therefore, somewhat troublesome because of the lack of statistical power.

It is also noted that community based treatment agencies in New Zealand have largely ignored the results of Northern Hemisphere typology research in the past ten years, continuing to deliver, more or less, a 'one size fits all' assessment and treatment regime. Determining a typology of New Zealand YSH is urgently needed to advance local clinical practice. Understanding the diversity of YSH has the potential to generate new ideas about the treatment needs of YSH, allowing a shift from 'one size fits all' treatment to be replaced by profile specific strategies. In this respect cluster analysis is a method which fits this objective because it promotes the middle ground – a shift away from stereotypical or idiosyncratic

treatment, both of which are problematic, either overly inclusive or very difficult to resource and implement. In 2007 this researcher undertook a study of 81 YSH using 62 variables (Dillon, 2007). The aims of that study were to see whether profiles of YSH could be detected. Cluster analysis was used to classify a large number of variables into seven themes. The variables grouped into themes, called characteristic themes, were based on the frequency with which certain variables occurred together. Cluster analysis was then undertaken with the participants by clustering them across the themes. The results indicated five profiles of YSH, within the sample. The profiles differed from each other in their collective life experiences and behaviours. While the results were encouraging, further investigation was required, with a larger sample and an amended variable list. The purpose of the amended variable list was to increase the amount of information available for the cluster analysis for the current study and improve item validity. The overarching purpose of the current study is to build upon the knowledge gained in the 2007 study and to develop profiles of YSH so as to encourage a review of assessment and treatment strategies with this population.

**Assessment and Treatment Issues**

Outcomes of many studies have contributed to the knowledge that clinicians and researchers have about sexual harming youth (Craissati, Webb & Keen, 2008; Fortune & Lambie, 2006; Hanson & Bussiere, 1998; Lightfoot & Evans, 2000; Prentky, Harris, Frizzell & Righthand, 2000; Smith et al., 1987; Starzyk & Marshall, 2003; Whitaker, Le, Hanson, Baker, McMahon, Ryan, Klein, & Donovan Rice, 2008; Wilcox, 2004; Worling & Curwen, 2000). Yet still there remain unanswered questions about how best to detect, describe, and provide

treatments for those who sexually harm so as to reduce the risk of subsequent sexually harmful behaviour (Veneziano & Veneziano, 2002).

During the early 1990s when New Zealand agencies began working with sexually harmful youth, there was a paucity of theory and clinical experience. Clinicians adopted methods from North America and utilised research outcomes with adults to inform their interventions. There has been criticism about the relevance of using methods developed for work with adults, and outcomes based on populations that are very different from our own culture. Myers (1998) argues that accepting models and research findings from North America means other countries have constructed a philosophical and clinical base that is constructed on both clinical and actuarial data in an 'offending' context resulting in models of assessment and treatment that are largely punitive where enforced treatment compliance is a result of legal processes.

This stance has seen many youth in New Zealand forced to attend treatment for long periods, and it could be argued that extending social and legal control over these youth and their families has not improved outcomes. Indeed, resources, both economic and clinical, that could have been put to better use with the most troubled YSH, may have been squandered on a 'one size fits all' treatment model. Lambie and Seymour (2006) argue that New Zealand needs to develop novel ways of working with YSH, and that the diversity within the population necessarily means that interventions need to be tailored to the needs of the young person and their family. To speak to these issues and develop efficacious assessment methods and treatments requires a resolute commitment to viewing the problem of YSH from developmental and socio-ecological perspectives, with an emphasis on both the individual

sexual harmer and the families and communities within which they are raised. The current study was designed to emphasise the interrelationship of individual and family characteristics in a way that addresses some of the limitations of typology research to date.

## Aims

The overarching aims of this study were to explore the presence and absence of problem characteristics and life experiences observed within a New Zealand sample of YSH using a method of analysis that enabled the inter-relationship of problem issues to be considered and that showed the similarity of YSH within profiles. It was hoped the results of this research would provide local and recent information about the young sexual harmers currently in treatment in New Zealand and contribute to our understanding of their, their family's, and their community's intervention requirements.

1. To explore how a large set of variables, encompassing YSH characteristics and life experiences may be classified into a number of themes using hierarchical cluster analysis of those variables.
2. To explore how a sample of YSH may be classified into a number of profiles using hierarchical cluster analysis of the participants, and to interpret these profiles in terms of both the participant characteristics and life experiences, and resulting themes.
3. To use YSH demographic and offence information to examine the relationship between profile membership and the types of offences committed by YSH
4. To discuss a new approach to assessing and treating YSH based on the emergent profiles.

# Chapter 2

## *Literature Review*

In order to carry out the first two aims of this study; which is to explore how a large set of characteristics and life experiences could be classified into a number of themes using cluster analysis and classify clients into profiles, it was necessary to review a large body of YSH literature. Throughout that review it became apparent many researchers had successfully highlighted problem characteristics, offence details, behaviours, pathways, and life experiences that were germane to YSH populations. However, what impressed was that little of the published research to date has attempted to integrate these issues within a single study so as to promote knowledge regarding how all these factors interrelate. Family factors, personality traits, behavioural problems, sexual behaviours, educational needs, prior victimisation, social deficits, and mental health issues may appear issues which are contextually diverse; some are inherent, some environmental, some are risk factors, and others are learned or modeled behaviours which may serve instrumental needs for particular YSH. However, it is the multiplicity of issues and the interplay between all those factors which will afford a far better understanding of the assessment and treatment needs of this population.

This chapter details a comprehensive list of the characteristics, behaviours, pathways and life experiences that have been researched thus far. The breadth of the issues clearly shows that, in order to further understanding about YSH, and to enable the development of population profiles all these factors have to be taken into account The variables used in this study were chosen by first examining the types of variables used in other YSH research to see

which were shown to be clinically relevant, secondly by reviewing past outcome research and recidivism data to see whether current treatments were successfully focusing on issues which would lower the risk of re-offending. Thirdly, the variables used in this study attempted to ensure that as a group they encompassed YSH functioning across primary environments young people typically encounter, such as school, home, social/peer relationships, and medical/psychological practices, and variables that highlighted emotional and personality functioning.

The latter part of the chapter relates to a review of typology studies and, as will be shown, these individual studies only focus on specific types of characteristics, limiting the utility of the results to aid assessment and treatment. The combined review of characteristic and typology research was used to inform this study's variable list, with the aim that combining these well researched characteristics, and interpreting the interrelationship of those characteristics, would advance knowledge and aid in the assessment and treatment of YSH.

## Problem Characteristics and Behaviours

Any advancement in understanding why young people sexually harm others requires both the identification of adverse developmental experiences that increase vulnerability, and elucidation of the manner in which such experiences might alter personality, cognitions and social behaviours (Hunter, 2004). Sexual offender research in the past three decades has unearthed a plethora of factors, characteristics, childhood experiences, social problems and developmental impairments that are commonly seen in YSH populations.

One of the difficulties in studies with YSH is that they appear to be a very diverse group of youngsters who display a wide variety of behaviours. They tend to come from all

socioeconomic backgrounds and cultural environs and have had an array of life experiences, both positive and negative. These young people are known to engage in diverse types of sexual harming; some have abused one person, some many, and frequently their harmful sexual behaviour has been multifarious. Within this observed heterogeneity there are, however, characteristics which seem common across the population. These characteristics and life experiences are detailed below. The purpose of this review was to ensure that the characteristics used in this study captured the breadth of those that had been previously researched, so as to explore new understanding of their interrelationship using hierarchical cluster analysis. This method enabled the aims of this study, with results allowing conceptually different characteristics to be interpreted based on their relative presence or absence.

**Pornography**

With the advent in recent years of widespread internet use, the issue of viewing pornography via the internet has become a subject of research (Alexy, 2003; Carr, 2004; Greenfield, 2004; Quayle & Taylor, 2002). The viewing of pornography, especially child pornography, which is a crime in New Zealand under the Films, Videos, and Publications Classification Act (1993), has been associated with the development of maladaptive schema about sexual relations, and repetitive viewing is said to aid the formation and enhancement of abnormal beliefs about sex. Further, accessing the internet is not a passive pastime; reductions in depressive thoughts, anxiety and loneliness have been reported by viewers (Holmes, Tewksbury & Holmes, 1998).

Carter, Prentky, Knight, Vanderveer and Boucher (1987) examined the use of pornography in the developmental trajectories of adult sex offenders and found that all

offenders in their sample had been exposed to pornography in childhood. Proulx, Perreult and Ouimet (1999) studied the role of pornography in contact sexual offences and found that, for non-coercive offenders, pornography was used as a part of the commission of their crime; meaning that they used the sexual arousal derived from viewing the material as a primer to their contact sexual offence.

Early viewing of child pornography has been shown to alter sexual arousal patterns, and perhaps evidences a new factor in the development of deviant sexual interest. Research has shown teenagers also seem to be accessing pornography using mobile phones (Quayle, 2007). One adolescent in the Dillon (2007) study had purchased videos of adult males and females having sexual intercourse via the internet connection on his mobile phone. Apparently for a small cost ($2.99NZ per minute) adult pornography is readily available for download to a mobile phone. For the most part, parents may be unaware of the technological capacities of their children's mobile phones, and so few would caution their children or take steps to safeguard against the adolescent viewing material that is inappropriate.

**Victim Selection**

While earlier research attempted to differentiate adolescent sexual harmers by the type of victim they targeted and the types of offences they committed, Worling (2001) argues that a commonly held assumption that adolescents sexually harm children rather than peers because of social deficits, fear of rejection, and intimacy are not borne out in empirical findings. While this may be true in some samples of YSH, Hunter (2004) found that many adolescent sexual harmers who targeted prepubescent children did have social skills deficits. A New Zealand study found that one subgroup of YSH sexually harmed male children more often

than YSH in other profiles. Youth within this profile were the youngest participants (12.5 years old), were more likely to have committed anal penetration offences and more likely to have sexually abused children within their family (Dillon, 2007). In the same study all of the adolescents in a different profile had sexually abused a child (<11) years and were more likely to have targeted non-family female victims. One further group sexually abused females, exclusively, and none had committed anal penetration offences. A limitation of the above study was the relatively small sample size (n = 81) and, as a consequence, there were between eight and 26 participants within any of the five profiles described.

The notion, therefore, of preferential victim targeting or offence type are tentative at best. It seems that the complex interrelationship between factors plays a part in how, why, and who young sexual harmers target as potential victims. As individuals, YSH may target different types of victims, be motivated to sexually harm in different ways, and have differing triggers that raise their susceptibility for sexually harming.

**Non-sexual Offending Behaviour**

As a cohort YSH are more likely than youth in a general population to have received sanctions for prior non-sexual offences against people and/or property. Ryan, Miyoshi, Metzner, Krugman and Fryer (1996) in their sample of 1600 adolescent sexual harmers from across North America, found that 63 percent had committed non-sexual offences prior to their index sexual offence (sexual offence for which they were first referred for specialist sex offender treatment). These offences included theft, assault, arson, vandalism, running away, and animal cruelty. France and Hudson (1993) extrapolated from a meta-analysis of studies that almost 50 percent of adolescent sexual harmers had a history of non-sexual offending.

Their results suggest the more serious the young person's sexual offence, the more serious their non-sexual offending.

Taylor's (2003) study of the backgrounds of YSH in a British study found that 58 percent had criminal convictions for non-sexual offending, with approximately half of these for violent crimes. An important limitation of these statistics is that the age of criminal culpability in Western countries is often higher than the actual age of the offending youth. Thus, many young sexual harmers may not have convictions for general offending, yet still commit such acts. A recent New Zealand study of YSH who had been referred for specialist sex offender treatment found that 30 percent had received sanctions for prior property offences and one tenth had been sanctioned for violent offences against people. Of this sample almost one fifth also had a history of cruelty to animals (Dillon, 2007).

In contrast to the above studies, Bullens et al. (2006) study of Dutch young sexual harmers found that many of them had sexually offended *before* going on to commit general and violent crimes. They noted that the rate of sexual offending in their sample decreased as the rate of non-sexual offending increased, and that these youth, with the exception of exhibitionists, tended to start their criminal careers at a slightly younger age. This contrast highlights that, for some young sexual harmers, sexual deviancy is probably not the cause of them choosing to sexually harm others. Bullens et al. (2006) outcome resonates with the notion that there are different determinants of sexual harming by youth. This again illustrates that different treatments may be required for certain YSH, and this may depend upon the reasons why they sexually harmed.

A review of recidivism studies by Fortune and Lambie (2006) indicates non-sexual re-offending by young sexual harmers ranges from eight to 52 percent. The researchers highlight the fact that official recidivism rates are conservative at best, and the actual rate of re-offending may be much higher. This is because official criminal recidivism rates are based on the number of successful prosecutions obtained in a court of law. The most recent recidivism data from a New Zealand survey of YSH referred for specialist sexual offender treatment (Lambie & Geary, 2007) found that at least 38 percent of them had re-offended non-sexually. This statistic evidences that general disregard for the rights of others and the law is a common feature for about 50 percent of the YSH population.

**Antisocial and Conduct Disordered Behaviour**

Many studies have focused on comparing antisocial characteristics in YSH and non-sexual adolescent offenders, and on the criminal versatility seen in recidivism studies (Huizinga & Jakob-Chien, 1998; Hunter, 2004; Ryan et al., 1996; van Outsem, Beckett, Bullens, Vermeiren, Van Horn & Doreleijers, 2006). Antisocial behaviour, or delinquency as it is called in other countries, entails actions which are socially, and sometimes legally, unacceptable within the society in which the person resides. Antisocial behaviours include vandalism of property, public nuisance behaviours, substance abuse, aggressive acts towards others, an inability to follow rules at home or school, and risk taking behaviour that has the potential to cause serious harm to self and others (Ishikawa & Raine, 2003).

Dillon (2007) in a sample (n = 81) of New Zealand young sexual harmers found that just over a third had antisocial behaviour histories and one fifth had been diagnosed with conduct disorder. While general antisocial and conduct problems have featured strongly in YSH

literature, there is little that distinguishes them from non-sexually offending youth on this dimension. Smallbone (2006) states that there is currently little evidence that YSH constitute a distinct subgroup within the antisocial population.

What is known, however, is that chronic antisocial behaviour is marked by a reliable developmental sequence of events (Patterson, DeBaryshe & Ramsey 1989). These researchers proposed a model of the development of antisocial behaviour. In early childhood, antisocially prone youngsters experience poor, or inconsistent, parental discipline and monitoring which may lead to aggressive and oppositional behaviour. In middle childhood, these youngsters may be rejected by healthy peer groups, and they tend to experience academic difficulties. These experiences may lead to social marginalisation, frustration and resentment. During adolescence, these youth gravitate to a deviant peer group and are at a higher risk for perpetrating crimes (Patterson et al., 1989). Perhaps for some antisocial youth, sexually harming another person is just one avenue for committing a crime.

**Victimisation**

Much of the research with YSH has focused on earlier victimisation in an effort to ascertain whether such experiences have placed young people at risk of perpetrating abuses against others (Burton, 2003). Findings from Hutton and White (2006) clearly show that young sexual harmers frequently suffer multiple forms of abuse. Their study of 139 adolescents found that 70 percent had experienced some form of abuse and/or neglect. Ryan et al. (1996) indicate 39.1 percent of their sample (n = 1,600) had been victims of sexual abuse. Neglect also featured, with 25.9 percent of the sample having such histories. Of the sexual abuse complaints, only 37 percent resulted in criminal proceedings for the perpetrator(s). Given

research has suggested most sexual abuse is perpetrated by a family member (Fanslow, Robinson, Crengle & Perese, 2007), it necessarily follows that these young people may have often lived in unsafe environments in which they believed they had no-one safe to disclose abuses to, and therefore they may have been subjected to the trauma effects of sexual victimisation. The impacts of which resonate with part of Lane's (1997) cycle of sexual offending, where repeated trigger events imbue a sense of hopelessness and helplessness for the future. For some youngsters, this may have led them to seek sexual compensatory ways to re-establish a feeling of power and autonomy.

Hackett (2002) posits prior victimisation contributes to the development of sexually harmful behaviour as some youngsters may attempt to re-enact their own abuse in an attempt to gain mastery over the resulting internal conflicts. A cycle may eventuate, by pairing alleviating negative affect states with sexual arousal and gratification (Becker & Stein, 1991). Hunter et al. (2003) reported that 75 percent of their sample had been sexually victimised. This is a much higher percentage than other research and raises the question about how the YSH in that sample were presented with the question(s) regarding victimisation, and at what point in treatment they were sampled.

Lambie (1998 cited in Lambie & Seymour, 2006) found that 39 percent of a New Zealand sample of adolescent sexual harmers reported experiencing childhood sexual abuse. Dillon (2007) found of a small sample of YSH (*n* = 81) half had histories of emotional abuse, just over one third had been sexually abused, and almost one third had grown up in homes where neglect was common.

Given that the prevalence rates for male child sexual abuse in a general population in New Zealand are approximately 17 percent (Ministry of Justice, 1999), it is clear that childhood sexual victimisation is a more common experience for many YSH. Further, Burton, Miller and Shill (2002) compared adolescent sexual harmers who had been sexually abused with adolescents who had been sexually abused but *had not* sexually harmed anyone. They found that young sexual harmers were more likely to have suffered severe sexual victimisation over several years, by both male and female perpetrators. They were also more likely to have been subjected to penetration abuses, have been abused by a family member, and that their victimisation was gained by force. This result suggests that not only are YSH more likely to have been sexually abused, but that their sexual victimisation is more likely to be of a serious nature.

While very few young people who have been sexually abused go on to sexually harm others, clearly some do and the violations they have suffered may contribute to the development of maladaptive schema that increases their vulnerability for acting in sexually problematic ways (Briere, 1992; Johnson & Knight, 2000; Richardson, 2005). Veneziano, Veneziano & Le Grand, (2000) using social learning theory, examined the offence histories of sexually abused adolescent sexual harmers. Their findings indicate that youth who had been anally penetrated were significantly more likely to anally penetrate a subsequent victim. There was also support for the notion that YSH learn from, and repeat, characteristics of their own abuse. While the studies cited differ in their sampling and methodological procedures, they offer valuable insights into how prior victimisation may contribute to an aetiological explanation for some youth sexual harming.

Emotional abuse in the histories of young people who sexually harm has received little research attention. However, studies have reported these youth often display a range of intrapersonal and social deficits that could be associated with experiencing emotional abuse. Becker and Abel (1985) found that YSH seem to suffer higher rates of low self-esteem, loneliness, poor social skills, and fears of intimacy and rejection. O'Callaghan and Print (1994) report YSH were more likely to be socially isolated, have fewer peer aged friends, and have underdeveloped social skills. These youngsters may have been bullied at school, have few supportive relationships, or lack the ability to recognise and use support networks (Lightfoot & Evans, 2000). Becker (1988) attested that some adolescents who lack the necessary skills to make and maintain healthy peer relationships may befriend younger children and subsequently sexualise that relationship.

The prevalence of physical abuse and exposure to domestic violence amongst YSH samples is substantially higher than general populations (Marshall & Holtzworth-Munroe, 2000; Sisco, Becker, Sanders & Harvey, 2007). Studies around the world have consistently found a disproportionate number of young sexual harmers have been subjected to violence; 41.8 percent (Ryan et al., 1996); 63 percent (Hunter et al., 2003); 44 percent Lambie (1998 cited in Lambie & Seymour, 2006); 58 percent (Dillon, 2007). Exposure to violence has major ramifications for the physical and psychological development of children. The negative effects of child abuse have proven to be amplified by exposure to additional trauma, such as domestic violence (Dobash & Dobash, 1979; Edleson, 1999; Ehrensaft, Cohen, Brown, Smailes, Chen & Johnson, 2003). Physically abused youngsters are more likely to behave in a violent manner

than their non-abused peers (Kaufman & Cicchetti, 1989; Dodge, Pettit & Bates, 1997; Koyabashi, Sales, Becker, Figueredo & Kaplan, 1995).

Further, children exposed to domestic violence are more likely to exhibit behavioural and emotional problems, including depression, anger, low self-esteem, and have deficits in social skills (Jaffe, Suderman & Reitzel, 1992; Schwartz, Cavanaugh, Prentky & Pimental, 2007). They are also more likely to experience developmental delay, including fewer language skills (McLaren & Brown, 1989), impeded emotional expression (Hunter et al., 2003) and lack competence in social situations (Katz, 1992). In addition, young people who have experienced violence are at an increased risk of educational failure, anxiety, suicidal ideation and early parenthood (Sisco et al., 2006). Male adolescents, in particular, may be more likely to carry out acts of aggression towards others and endorse negative gender stereotypes that embody subjugation of females and value masculine tactics (Hunter et al., 2003). Beliefs such as these are correlated with the perpetration of sexual crimes (Hanson & Bussiere, 1998).

**Comorbid Mental Health Issues**

Some young sexual harmers have been diagnosed with mental illness. Common diagnoses include conduct disorder, attention deficit hyperactivity disorder, substance abuse problems, attachment disorders, and post-traumatic stress disorder (Ryan et al., 1996). Research has also found YSH are more likely than young people in a general population to experience depression and chronic anxiety (Morenz & Becker, 1995). Using Beck's Depression Inventory (Beck, Ward, Mendelson, Mock & Erbaugh, 1961) with a sample of 246 youth, Becker, Kaplan, Tenke and Tartaglini (1991) reported mean scores of 14.3, a value higher than published norms for an adolescent population, indicating mild depression. Forty-two percent

of the sample had scores indicating substantial depressive symptomology, with a history of sexual and physical abuse being significantly correlated with high scores.

**Educational and Academic Problems**

As in a general population of adolescents, young people with special needs feature in YSH populations. These special needs are variously defined in the literature as intellectual disabilities (IQ <70), learning disorders, developmental delay and motor disorders. There is however, a paucity of reliable data and comparing studies has been problematic, primarily because of difficulties defining special needs, and the small sample sizes researchers have used (Fortune & Lambie, 2006).

British studies have identified between 30 and 50 percent of YSH have learning disabilities or serious educational problems requiring additional educational resources (Dolan, Holloway, Bailey & Kroll, 1996; Hawkes, Jenkins & Vizard, 1997). Ryan et al., (1996) reported 60 percent of their sample had problems at school (truancy, learning disabilities and behavioural problems). Frequencies for special needs issues were not recorded. The literature has consistently shown youngsters who experience learning difficulties are over-represented within YSH populations (Fyson, 2007). Dillon (2007) found that just over a third of New Zealand adolescent sexual harmers in specialist treatment had histories of educational difficulties, and just over half of those had been diagnosed with a learning disorder.

Notwithstanding educational problems, commonalities between all YSH have been observed (Gilbey, Wolf & Goldberg, 1989). Differences appear to lie in victim selection and the type of offences committed. Special needs YSH are more likely to target young children without a preference for gender, and more often display nuisance type behaviour, such as

exhibitionism, voyeurism, and public masturbation. Further, their sexually harmful behaviour appears less sophisticated, more opportunist, and they utilise fewer grooming tactics (Timms & Goreczny, 2002).

Special needs YSH seem to be concrete thinkers who may often become fixated on their sexual arousal and, because they lack the ability to comprehend the moral wrongfulness of using a non-consenting person to meet their sexual needs, they may become compulsive and indiscriminate harmers (Regan, Spidel, Gretton, Catchpole & Douglas, 2007). Further, these youngsters often misinterpret social dynamics and communications. They often perceive intimate relationships where none exist and often invade the personal space of others. They are more likely to be compliant and dependent, and use less force when sexually harming (Timms & Goreczny, 2002).

**Family Factors**

Young people who sexually harm others often come from dysfunctional, chaotic and abusive homes, regardless of their cultural or socioeconomic backgrounds (Dillon, 2007; Hutton & Whyte, 2006; Hunter et al., 2003; Hunter, 2004; Lakey, 1994; Lambie & Seymour, 2006; Ryan et al., 1996). Instability, lack of safety and negative communications are common characteristics of the families of YSH (Morenz & Becker, 1995). Loss of important caregivers or close family members may interrupt important bonding. Marshall, Hudson and Hodkinson (1993) assert that poor attachment, combined with parental abuse, are risk factors for adolescent sexual harming. Modeling of aggressive and violent acts by parental figures, combined with inappropriate sexual boundaries in the home, is more likely to teach youngsters that aggressive sexual behaviour is acceptable. It is also hypothesised YSH who are subjected to

ongoing abuse, dysfunction, and chaos within the family, may have few outlets for intimate interactions and, fearing rejection, they engage in inappropriate interactions with children or peers more vulnerable than themselves (Davis & Leitenberg, 1987).

Given that these youngsters are not autonomous, and that they exist within families, it could be argued families have the greatest influence upon the development of their children. It would not take a great conceptual leap to say the multitude of negative life experiences and behaviours disproportionately seen in this population are, in large part, attributable to their upbringing, yet studies that have spoken directly to the influence of family and the responsibility of parental figures for the disturbances seen in their children are rare.

Researchers of YSH have cited the negative life experiences and the damage that occurs for young people who have been abused, but they have been curiously silent when it comes to apportioning responsibility to the families of adolescents who sexually abuse others. Why? One theory is that clinicians need parental compliance and to openly criticise them would be counter-productive to the aim of therapy. Further, parents are influenced in multifactorial ways; the time they live in, their own upbringing, life experiences, economic stressors, mental health issues, government policies, media, other family members, and their own belief systems, morals and unique coping strategies. Therefore to apportion responsibility to parents might seem a futile engagement.

Within specialist agencies across the world, there has always been an understanding that therapy with the families of sexually abusive youth is important (Johnson, Scott & Telford, 2007); yet, time and time again this intervention appears as an adjunct to individual therapy with the young person. In New Zealand, therapy is available for families and parents within the

specialist agencies, but parental attendance is not a requirement to a youth being accepted for treatment. And even when families have attended therapy, the focus has been on improving understanding of their child's behaviour, or improving parent-child communication. In this researcher's clinical experience, little focus has been given to parental pathology, distorted thinking, poor parenting practices or the modeling of antisocial attitudes and behaviours in the home. Yet it could be easily surmised that young people who exhibit serious sexual, behavioural and emotional problems, in all likelihood exist in homes where parental problems are as serious.

If that is the case, any new theory regarding the determinant of sexually harmful behaviour in youth, the treatments required that will lessen their vulnerability of re-harming, and the promotion of educational material within society to lessen the occurrence of sexual abuse, needs to account for the interplay between multiple stressors within the family and societal influences.

**Summary of Characteristics**

This account shows the diversity of characteristics and life experiences and highlights the importance of exploring how each may influence and impact upon another. Family dynamics and early experiences may influence subsequent behaviour and beliefs for the YSH. These beliefs and the expression of certain behaviours may be influenced by the individual's intellectual ability, peer group or social skills. And these in turn may be influenced by the opportunities a young person has to learn and express themselves. Impairment or deficits of cognitive and emotional functioning can alter the manner in which people interact with others, and this is no different for YSH. The characteristics used for this study were chosen to explore

the presence of certain characteristics together and promote a better understanding of how these might influence beliefs and behaviours for certain YSH. Below are two theories that suggest multiple influences play a part in sexually harmful behaviour.

## Pathway Theories

The two most widely accepted models for understanding the development of sexually harmful behaviour in adolescents, are Finkelhor's (1979) four preconditions model, and the sexual abuse cycle developed by Lane (1997). Finkelhor's 1979 model was primarily developed in regard to adult sexual offenders but has been generally accepted as appropriate for use in an adolescent population (Erooga & Mass, 1999). Finkelhor proposed that four distinct preconditions needed to be met before a person could sexually abuse. The potential sexual harmer needed to be *motivated* in some way to abuse and have an ability to overcome any *internal inhibitions* against acting on their motivations. The person must then overcome any *external inhibitors* to committing sexual abuse and overcome or weaken a *victim's possible resistance* to the abuse.

According to this model there are a number of potential barriers for the sexual harmer to overcome prior to abusing. The first two relate to offender characteristics, such as personality, sexual arousal patterns and beliefs, and the last two relate to factors external to him or her, such as access to a potential victim and impaired parental or other person protection, or a victim's own personal vulnerability. This model offers a way of beginning to understand some of the dynamics of the sexual abuse process. The model also signals there are characteristics and life experiences which must be discovered so that motivating and disinhibiting factors can be better understood. Reflection about what characteristics and life

experiences an offender has that enable that person to overcome both internal and external inhibitors to committing a sexual offence requires an understanding of the interrelationship of those factors. While allowing this reflection Finkelhor's model does not promote understanding about the emotional states an offender may experience, or why a person would re-offend.

Lane (1997) developed a model of a cycle of sexual offending focusing on an offender's dysfunctional responses to problematic situations or interactions. The YSH responses in this model are based on distorted perceptions relating to power and control, which are then said to become sexualised by the offender, it also suggests the emotional states a YSH may experience before and after sexually harming. This model has been used in sex offender treatment programmes in New Zealand with adaptation concomitant on the age and intellectual ability of the sexual harmer. This said, the validity of the model has not been empirically established (Lane, 1999) and its use in clinical settings is waning because there is a recognition that Lane's cycle has assumed all offenders feel, behave and have thinking errors that are similar.

Research in recent years with YSH populations has suggested these young people have diverse reasons for sexually harming, are motivated by different needs and have differing predisposing attitudes and feelings about themselves and others (Burton, 2003). Lane's and Finkelhor's models have limitations, as stated, but they do encourage the exploration and bringing together of YSH characteristics and perhaps these models may be improved by this endeavour.

## Offence Variables

The third aim of this study was to examine the relationship between profile membership and the offences committed by YSH. These youth commit a variety of sexual offences and a review of the results of research with different samples of YSH provided a rationale for the types of offence variables used in this study. Taylor's (2003) sample of 227 British YSH revealed that 93 percent had committed contact offences (touching another person's genitals) and seven percent had committed hands-off type behaviours. One third of the sample had sexually violated another person by either vaginal or anal penetration, or both. Ryan et al. (1996) reported YSH commit a wide variety of sexual offences, 35.4 percent had penetrated their victim(s) anally and/or vaginally, and 14.7 percent were involved in oral/genital contact. Commission of the offence(s) included verbal coercion (57%), threats (24.5%) and physical force (31.7%). Many of the youth in that sample had prior sanctions or were known to have engaged in hands-off sexually abusive activities, and a substantial proportion of those referred for treatment were known to have sexually abused a child prior to referral for specialised sex offender treatment. Dillon (2007) reported that, for just over a third of a sample of YSH in New Zealand (n = 82), either statutory agencies and/or their families were aware that the youth had displayed sexually harmful behaviour long before referral for specialist treatment. In that sample, some youth had exhibited sexually harmful behaviour for many years (*m* = 15 months, range 1-72 months).

## Typologies

As has been shown, there is recognition that YSH are a heterogeneous population. With this awareness there is an acknowledgement that treatment and assessment should be tailored to YSH diverse developmental, social and intellectual needs (Worling, 2001). In an effort to understand within population similarity and emphasise important problem characteristics which could be focused on in treatment some researchers have developed typologies of YSH. These are intended to bring attention to the ways in which different YSH may present, based on certain characteristics, and therefore respond to their environment. Outcomes of typology research have potential implications for treatment with this population but only when the results offer information about how YSH may function within their primary environments and emotional and personality issues which might influence this functioning. Unfortunately, because most typology studies have only discussed subgroups in terms of specific issues, such as personality traits, social skills, or victim or offence characteristics the utility of the results for treatment is limited. A typology of YSH needs to address and make obvious characteristics which may be the focus of treatment, so that treatments can be tailored to be met the inclusive needs. The current study utilised results gained from past typology research in an effort to build upon the knowledge gained and improve the ability to describe resulting profiles.

O'Brien and Bera (1986) were among the first researchers to develop a typology of YSH. Their study utilised factors such as victim characteristics, offending history, antisocial behaviour, and personality variables. Outcomes of this study advanced six types of adolescent sexual harmers, described as: naïve experimenters, sexual aggressives, sexual compulsives,

disturbed impulsives, undersocialised child exploiters, and group influenced. While these subgroups have yet to be validated they have been widely used in clinical settings in the Northern Hemisphere (Worling, 2001).

In 1987, Smith et al. used the Minnesota Multiphasic Personality Inventory with a sample of 262 adolescent sexual harmers and, using cluster analysis, distinguished four subgroups based on personality profiles. These subgroups were: immature, personality disordered, conduct disordered, and social delinquents. The researchers found subgroup assignment was not related to victim characteristics and there was little difference between the groups or the type of offence committed, clinical presentation or historical variables. However, the authors did not indicate which historical variables were reviewed, rendering a full understanding of their YSH subgroups incomplete.

Worling (2001) attempted to replicate the Smith et al. study using the California Psychological Inventory with a sample of 112 adolescent sexual harmers in Canada. Cluster analysis revealed four distinct subgroups: antisocial/impulsive, unusual/isolated, overcontrolled/reserved, and confident/aggressive. Worling (2001) concluded there were similarities between the personality based subgroups in his study and those described by Smith et al.

The overcontrolled/reserved group resembled Smith et al. immature group, the unusual/isolated group resembled the personality disordered group, the confident/aggressive group was similar to Smith et al. socialized delinquent group, and the antisocial/impulsive group resembled the conduct disordered group. The latter group was more likely to have received a criminal conviction for their index sexual offence, and to have experienced physical

abuse during childhood. Along with the confident/aggressive group these adolescents were more likely to be living within a residential treatment setting. The antisocial/impulsive and unusual/isolated groups were more likely to have been charged with a subsequent offence, and more likely to have parents who were separated or divorced. There were no significant differences across the groups with regard to victim age or relationship to a victim (Worling, 2001).

Richardson et al. (2004) used the Millon Adolescent Clinical Inventory with a sample of 112 adolescent sexual harmers in England. Using cluster analysis, they determined five subgroups: normal, antisocial, submissive, dysthymic/inhibited, and dysthymic/negativistic. While some similarities were found between the subgroups of Smith et al. and Worling's, differences were apparent. These differences may have arisen because of the different personality inventories used, the different theoretical stances of the researchers, and differences in nomenclature (Richardson et al., 2004). The latter researchers found no significant differences between subgroup membership, with regard to victim characteristics and type of offence committed.

Thus, three studies found that adolescent sexual harmers could be assigned to a subgroup according to different personality characteristics, and that subgroup assignment had no correlation with victim characteristics or offence type. Broadly then, it would seem that four or five homogeneous subgroups of adolescents have been detected based on different personality profiles. While these findings have improved understanding of within population personality differences, the outcomes should be treated cautiously. Measuring personality

traits does not reveal the complexity of the interplay between many of the other characteristics and behaviours seen in these youngsters.

There are also noteworthy methodological limitations; the self-report nature of such inventories means outcomes are vulnerable to adolescents answering questions in a manner that they believe is socially acceptable. Similarly, none of these measures used in the three studies has been normed on adolescent sexual harmer populations. Further, research cautions that the inappropriate administration of psychometric measures can affect results (Millon & Davis, 1993; Groth-Marnat, 2003).

Valid results from these inventories relied on the ability of the respondent to read and understand each question, and then determine an answer that most represented their beliefs about themselves. None of the three studies mentioned the intellectual ability of their participants, or whether adolescents with lower intellectual abilities were excluded from the research. Given that rates of educational problems and intellectual impairment for this population are reportedly around 35-40 percent (Fyson, 2007), this is a curious omission. Only Richardson et al. (2004) mentioned that participants who were not able to read at the required level were read the questions on the Millon Adolescent Clinical Inventory.

Three important issues arise from these methodological problems - (1) studies have clearly shown many adolescent sexual harmers have learning problems and intellectual impairments; (2) if such youngsters were excluded from these studies then the resulting typologies were not representative of the whole population; (3) if impaired adolescents were included, did they understand what the questions meant and so answer them correctly? These points are not tabled as criticisms; these studies are valuable. However, typology research is

still in its infancy and further work is needed yet to fully understand how factors, personality traits, and other contextual issues are linked to behaviour, and the complex relationship that exists between each of these groups of variables needs further investigation.

Hunter et al. (2004) used cluster analysis with 256 adolescents; the results were based on the participant's scores across five constructs – pedophilic interests, hostile masculinity, egotistical-antagonistic masculinity, lifestyle delinquency, and psychosocial deficits. The study represented an attempt to identify three subgroups of YSH - life-style persistent offenders; adolescent onset offenders, non-paraphiliac; and early adolescent onset offenders, paraphiliac.

Hunter et al. study attempted to integrate Moffitt's (1993) typology theory of delinquent and aggressive youth. In the Hunter et al. study the lifestyle persistent YSH tended to engage in antisocial and oppositional behaviours in childhood and their developmental trajectory was seen as persistently negative, reflecting antisocial personality disorder-like traits and impulsivity. These youth were more likely to have sexually harmed pubescent and post-pubescent females, and had engaged in general offending.

The adolescent onset, non-paraphiliac subgroup was perceived as inappropriate sexual experimenters who lacked social confidence, and who found maintaining peer relationships difficult. It was hypothesised YSH with this profile would be more likely to sexually harm prepubescent girls and less likely to continue any type of offending beyond adolescence, unless influenced by antisocial affiliations. The final subgroup, the early adolescent onset, paraphiliac, was thought to represent youth who were developing pedophilic interests. These youth were more likely to sexually harm pre-pubescent male children, and may have continued to offend into adulthood.

The Hunter et al. study showed how family modeling of violence might contribute to the development of hostile masculinity attitudes in youth, the expression of which might include sexual offending. Further, this was one of the few studies that found different profiles of YSH may preferentially target different types of victims. The results of the Hunter et al. study encouraged this researcher to believe that if the interplay between large numbers of characteristics was thoroughly investigated the determinants of sexually harmful behaviour for different profiles of YSH could be explored.

One study brought together a large group of variables in an attempt to find subgroups. Almond, Canter and Salfati (2006), informed by research outlining the support for three dominant development themes found in the backgrounds of YSH – abused (Barbaree, Marshall & McCormick, 1998; Hackett, 2002; Ryan et al., 1996), delinquent (Becker, 1988; Butler & Seto, 2002; Malamuth, 1986; Ryan et al., 1996), and impaired (Timms & Goreczny, 2002) reviewed the clinical files of 300 YSH in treatment in England.

Using 41 characteristics (see Almond et al., 2006 for review) the researchers coded characteristics present or absent for each participant. To investigate whether three distinct themes (abused, delinquent and impaired) existed, they used smallest space analysis, an application of multidimensional scaling. It should be noted that the themes were bound and limited by the number and type of characteristics used, and cluster analysis was not performed. Cluster analysis would have informed the reader of what variables clustered together, based on co-occurrence. The results of the smallest space analysis also showed large gaps in the region of the graph assigned to the impaired theme. The researchers discussed the possibility that gaps in the structure probably indicated important variables were missing. The

percentages with which some characteristics were present for YSH in this study differed from other research outcomes. For instance, studies have shown the percentage of YSH who have experienced physical abuse is in the range of 30 to 60 percent (Dillon, 2007, Ryan et al., 1996; Veneziano & Veneziano, 2002); however, the Almond et al. study found 27 percent of the sample had suffered such abuse; similarly, low present rates appeared across many of the characteristics (Almond et al., 2006). The authors cautioned that data missing from client files may have influenced these results.

When the Almond et al. participants were assessed to see whether individuals could be assigned to one of the three themes (abused, delinquent or impaired) the results were somewhat mixed. Just less than three-quarters of the sample could be assigned thusly: 29 percent in the impaired theme, 28 percent in the abused theme, and 14 percent in the delinquent theme. Youth who had similar scores across two dominant themes occurred in seven percent of the cases. Six percent of the sample presented with none of the characteristics used in the study, and 16 percent had characteristics that were evenly distributed across all three themes.

While the results of the above study conveyed methodological limitations, hampering the clinical utility of the outcomes, it was cited here because it has been one of the few studies conducted with a YSH sample which used large numbers of conceptually different characteristics. The study shows that it is possible to classify conceptually different characteristics into themes.

The Almond et al. outcome encouraged this researcher to think about the ways in which certain life experiences and characteristics interrelate. If it was possible to detect

themes of characteristics, then it would be possible to classify YSH into profiles based on scores across themes - if the correct statistical method was used. Further, if a large enough number of characteristics was used then a comprehensive description of different profiles of YSH may be possible.

The research cited suggests YSH present with a variety of developmental, behavioural, family, personality, and social characteristics and life experiences. These can directly and indirectly influence the youth's response to treatment and potential for perpetrating further harmful behaviour. Hunter (2006) suggests these, and other characteristics, may cluster in a manner that is potentially diagnostically meaningful, and that assessments ought to be conducted in a way that highlights different developmental processes. The ability to assess how YSH function within their primary environments, and the strengths, limitations and resources available to them may assist the development of treatments. This process would be improved by advances in typology research (Veneziano & Veneziano, 2002).

The following chapter details the current YSH risk assessment methods and treatments available in New Zealand and overseas. Along with the problem characteristics detailed in this chapter, the inclusion of these topics affords an overall description of the important issues facing clients and treatment providers in New Zealand. This review paves the way for understanding current assessment and treatment limitations.

# Chapter 3

## *Assessment, Risk and Treatment Issues*

The fourth aim of this study is to discuss a new assessment approach for use with YSH in New Zealand, and suggest treatment strategies based on the needs of different profiles of clients. This chapter details the risk assessment methods and treatment options which have been adopted in New Zealand from Northern Hemisphere research. The results of these studies were used by this researcher to further develop the characteristic variable list, and inform the inclusion of specific demographic and offence variables for this study. It should be noted that some of the information and opinion advanced below is derived from this researcher's eight years clinical experience working for one of the specialist sex offender programmes in New Zealand, and as such some statements are not cited.

### Assessment

YSH are referred for assessment by CYFs, New Zealand Youth Courts, families, schools, or community agencies. Funding for YSH assessments is typically provided by the New Zealand Ministry of Social Development through contracts awarded to specialist sex offender treatment providers. On occasion, families may pay for a child's assessment or treatment, but this is rare.

Assessments typically include semi-structured interviews with the YSH and family members. These interviews are designed to obtain an overall understanding of the family, young person, living and relationship issues, educational difficulties, mental health issues, behavioural problems, safety, particulars of the sexually harmful behaviour, and to gain an idea

about the resources currently available to the YSH and their family to deal with problems. Additional information is gathered through the use of psychometric measures and a risk assessment scale. Collated information is then detailed in a written report, which is used by referrers and the agency to determine whether a YSH requires treatment, the approximate length of time a client might be in treatment and whether additional safety measures need to be taken to ensure the YSH is contained and safe. In addition, recommendations may include educational interventions and inter-agency social work aid.

Often the time taken to complete an assessment exceeds the funding allocation, potentially creating financial pressures for agencies, the flow-on effect of which may be less money available to train staff, and fewer resources with which to implement the types of interventions that may be most beneficial. Additionally, the 'one size fits all' treatment approach further erodes resources and clinician time.

The use in New Zealand of a risk assessment checklist which requires a clinician to use clinical judgment to allocate a level of risk of YSH sexual recidivism further creates a tension between 'real' YSH risk and the level of risk an agency is prepared to hold. Put simply, YSH may often be assessed at a higher risk of sexual recidivism than is empirically warranted – with the flow-on effect that some YSH receive treatment for longer than is necessary, thus, adding to the burden on staff and the financial resources of specialist agencies.

## Risk Assessment

Official recidivism studies indicate YSH re-offend sexually at low rates, which means that often there is limited information with which to aid the development of risk assessment measures. Additionally, the currently available researched recidivism rates have been

calculated using relatively short follow-up periods - only a few months in some studies (Fortune & Lambie, 2006). One of the longest follow-up studies in the world was completed in 2007 with a group of New Zealand YSH who had been referred for specialist treatment (Lambie & Geary, 2007). However, this study only had a median follow-up period of 4.5 years (range: 1-10 years). It could be argued that it will take some years yet to establish valid recidivism rates. Taylor (2003) succinctly stated that the low recorded recidivism rates may be erroneous because few longitudinal studies have been undertaken. Therefore, some YSH may cease offending completely and some may temporarily stop as a result of positive short term treatment benefits, close monitoring during treatment, and the relative lack of accessibility to suitably vulnerable victims during late adolescence and early adulthood.

Studying risk is inherently about studying safety - safety for the community and the young person. The typical question asked of clinicians by courts, parents and child protection agencies is: how likely is it the young person will sexually harm in the future? The answer given may have profound implications for the individual adolescent and their family as they may be removed from their home, incarcerated or sent to a residential treatment center.

Risk is not a dichotomous variable and so attempting to answer the question necessarily means grappling with an enormous array of individual and contextual factors. Only six factors have empirical support linked to sexual re-offending in adolescents. These are: deviant sexual interest in prepubescent children; prior criminal sanctions for sexual offences; sexually harming more than one person; sexually abusing a stranger; social isolation; and not completing specialist sex offender treatment (Worling & Langstrom, 2006). There is some empirical support for the notion that adolescents may be more likely to re-offend sexually if

they have a problematic relationship with their parents, and if they harbour attitudes supportive of sexual abuse. Less is known about the role of impulsivity, antisocial attitudes and friends, stressful home lives, aggression, sexual preoccupation, abusing a male victim, abusing a child, use of force/threats, or living in a home that supports sexual abuse. All 24 factors detailed above appear as individual items on the Estimate of Risk of Adolescent Sex Offender Recidivism (ERASOR) checklist; 16 of the items are dynamic in nature and nine relate to static, or historical, events (Worling & Curwen, 2000). The ERASOR is routinely used with most YSH who are treated within New Zealand specialist programmes.

While there is not enough follow-up research to establish and validate an actuarial tool for adolescents yet, the identification of relevant factors that increase an adolescent's vulnerability to re-offend is important. The use of the word 'vulnerability' is purposeful in this context – too often the word 'risk' seems misattributed and ill-defined. Further, as has been shown, many of the factors seen in the risk assessment measure used in New Zealand for YSH have yet to be validated for sexual re-offending. So, when clinicians are asked to define a young person's risk of sexually harming in the future, they are required to use an unsubstantiated measure, and define the presence or absence of a particular factor based largely on their subjective clinical opinion, then arrive at a risk point (low, moderate or high). It is noted that the ERASOR has been used almost exclusively by all the specialist sex offender treatment providers with YSH since 2004. To this researcher's knowledge, none of the agencies has audited the manner in which the ERASOR is being used with clients to ascertain (a) whether the measure is accurately measuring risk; (b) whether the 24 factors are being rated

consistently by different clinicians; (c) whether the use of the ERASOR has improved treatment delivery, and (d) whether clinicians are adequately trained to complete the checklist.

Too often YSH may be categorised as high risk, when the checklist used to define their risk has limited empirical validity. Using the word 'vulnerability' to describe a level of concern could alleviate the punitive perceptions conjured up when one hears the word 'risk'. Further, when a person is said to be vulnerable the perception gained is that the person is in need of support and help, not vilification. As has been shown, the array of characteristics and life experiences often seen in these adolescents do not appear in their personality or social behaviours by chance or pure genetics – they are present, primarily, because of the learning and interaction YSH have with families and the social worlds they inhabit. Therefore, punitive nomenclature may further marginalise already emotionally and psychologically damaged youngsters.

The issue of terminology aside, seeking factors that highlight vulnerability is important. The importance lays not only in society's concern regarding the potential for a young person to sexually harm again, but to highlight the characteristics and life experiences that the YSH has – so as to improve the delivery of treatment. Further, knowing how young people are vulnerable will aid the dissemination of educational material to child protection agencies so that early intervention can be accessed by the young person and their family.

The issue of early intervention, or lack of, was highlighted in Dillon (2007) where it was found that the median history of sexually harmful behaviour was 17.8 months (range: 1-72 months). The profile of adolescents in that study who presented as the most disturbed also abused the most victims, perpetrated the most serious sexual assaults, and all of them had

sexually abused a prepubescent child. Further, statutory agencies and family were aware of their sexually harmful behaviour long before the young person was referred for treatment (*M* = 34.3 months) (Dillon, 2007).

A 2007 outcome study of the SAFE, Wellstop and STOP programmes (n = 682 clients) indicates that, compared to other countries, New Zealand recidivism rates for successful treatment completers is low - two percent compared with 11 percent (Lambie & Geary, 2007). The median follow-up period for the study was 4.5 years (range: 1-10 years). Given that most adolescents are in their early teens when referred for treatment, and may be less than 16 years old when treatment ends, it could be argued that 4.5 years follow-up is too short a time to gather accurate recidivism data. Many males in their late teens and early twenties may not have ready access to potential victims because of social, educational or work related changes, and some may be involved in non-sexual offending. Given that the average age of onset of adult sexual offending is 24 years, there may exist a period of hiatus of sexual harming for some adolescents (Barbaree & Marshall, 2006). Further follow-up research should yield valuable data regarding recidivism rates.

The sexual recidivism rate for adolescents who did not complete treatment, in the New Zealand study, was 10 percent; those adolescents not taken into treatment had a sexual recidivism rate of six percent. Lambie and Geary (2007) found that re-offending for non-sexual crimes was concerning - 38 percent for successful treatment completers, 44 percent for those adolescents who did not receive treatment, and 61 percent for adolescents who dropped out of treatment. Re-offending was not found to be related to age, ethnicity, victim gender preference, number of previous sexual offences, or total number of previous offences. Higher

sexual and non-sexual re-offending was related to non-completion of treatment, with those most at risk of dropping out being older adolescents. The rate of non-sexual offending by YSH is concerning. It evidences that while treatment appears efficacious for some youth, current interventions lack the necessary treatment components to ameliorate general criminal behaviour, which in all likelihood is influenced by the inter-relationship of a number of factors.

## Treatment

Traditionally, specialist community based treatment programmes for YSH in North America have consisted of individual therapy, placement in group therapy with other youth, and family therapy. Group therapy typically involves providing the adolescents with social skills training, sexual education, correction of cognitive distortions, victim empathy, and teaching relapse prevention. Time spent during individual therapy sessions may focus on issues of self-esteem, relationship and communication with parents and peers and, to a lesser extent, work on trauma issues. While it is agreed that family therapy is important, all too often busy clinicians and parents find scheduling such sessions problematic. And it is only when a crisis arises that families seek out the support of their child's clinician.

Hunter, Gilbertson, Vedros and Morton (2004) argue that the approaches mentioned are based on implicit, but as yet empirically unfounded, assumptions. These include the assumption that the dynamics of sexual harming, and therefore the intervention needs, of the majority of YSH are the same. Simply put, all and any adolescent in treatment can be placed in any group of other adolescents and they will benefit from the intervention, and that treatment should focus on the sexually harmful behaviour and its presumed causes. Further, because the presumption is that sexually harmful behaviour is strongly influenced by deviant sexual

interests, cognitive processing errors and social skills training are most appropriately addressed by clinicians in a controlled therapeutic environment.

Again there is an assumption that learning in one environment will generalise to the youth's real world. It would seem that little focus is given to the cultural and social influences on the adolescent's behaviour, despite growing evidence that these influences are critical to understanding the origin and maintenance of sexually harmful behaviour (Eddy & Chamberlain, 2000). Although the above mentioned approach may benefit less troubled YSH, who also have good family support, it is inadequate in addressing the multitude of problems with which highly disturbed, traumatised, and antisocial YSH present with during treatment.

Further, there is a paucity of research related to treatment processes and outcomes with YSH. Fewer than 20 treatment evaluation studies have been completed so, not surprisingly, few meta-analyses studies have been attempted (Burton et al., 2006). Generally studies report effectiveness of current treatment with this population, in that recidivism rates are low (Worling & Curwen, 2000). However, outcome studies have yet to offer guidance as to which specific treatment components should be implemented and which have proved inadequate or harmful. This said, there is some agreement that placing relatively healthy adolescents in group therapy with highly disturbed youth is deleterious for them and may in fact increase the likelihood of further sexually harmful behaviour being committed (Hunter et al., 2004). Within treatment programmes there has been little differentiation of interventions in terms of the particular needs that different profiles of YSH may have. As a result, no evidence based treatment guidelines for this population are currently available (Burton et al., 2006).

In New Zealand most YSH referred for specialist treatment are seen in community based programmes. Three agencies; SAFE, Wellstop and STOP are resourced by government contracts to deliver services, in the community, to both adult and adolescent offenders. Only one specialist residential service exists for adolescents, Te Poutama Arahi Rangitahi. While the agencies are independent from one another, and deliver services in slightly differing ways, there has been a push in recent years to standardise assessment and treatment processes in New Zealand so that expertise and best practice models can be made available to all clients. The sharing and learning gained by regular combined training, conferences, and meetings, seeks to improve the quality of treatment, at the same time as supporting clinicians working with this population.

The community based programmes in New Zealand have traditionally utilised cognitive behavioural therapy as a means of addressing cognitive distortions, cycles of offending, deviant patterns of sexual interest, sex education, victim empathy, trauma work, and relapse prevention. Individual, group and family therapy are typically offered to all youth. While the model and components of therapy appear efficacious for most YSH, a concerning number of youth reoffend non-sexually (Lambie & Geary, 2007). Further, emerging research about the diversity within the population of YSH, and the possibility of specific profiles, with different treatment needs, has not influenced the delivery of interventions in New Zealand. Only one new approach appears to be gaining acceptance as suitable for clients with intellectual disabilities – Ayland and West's (2006) Good Way model. Research to explore the validity and clinical efficacy of the Good Way began in late 2009 (personal communication, Lesley Ayland, April 2009). This research is urgently needed because, while sexual recidivism rates for YSH

who complete treatment are low (2%) in New Zealand, a concerning proportion drop out of treatment, and many of them continue to experience problems (Lambie & Geary, 2007). In addition, some go on to perpetrate sexual and non-sexual offences.

Critical to ameliorating the host of life problems some of these youth present with, is developing an understanding of the determinants of their sexually harmful behaviour and other maladaptive behaviour. This understanding could then guide the formulation of individualised treatment plans and inform opinion about which treatment components are required. Case conceptualisation could also inform the development of treatment goals and decisions regarding who is best placed to deliver certain interventions (Hunter et al., 2004). The heterogeneity of the population necessitates the establishment of a continuum of care, in which all aspects of the young person's life, including personal characteristics, abusive behaviour, family, society, culture, educational needs, and life experiences are taken into account. The integration of these facets during assessment has the potential to improve provision of services to all YSH in treatment.

Research suggests socio-ecological models offer promise for understanding the diverse influences that work upon adolescents, and reciprocally the ways in which those youth alter their environments by their actions and attitudes. Socio-ecological theories allow for the transformation of ideas and perceptions as individuals learn about themselves in the context of the world they inhabit (Ronis & Borduin, 2007; Bronfenbrenner, 1974). The development of interventions for YSH requires a conceptualisation of how multi-layered influences produce and maintain harmful behaviour. The best known, and researched, application of this theoretical approach is multisystemic treatment (Henggeler, Schoenwald, Borduin, Rowland &

Cunningham, 1998). In clinical trials and outcome studies multisystemic treatment has consistently been found to be more effective than traditional interventions in attenuating antisocial and aggressive behaviour (Henggeler et al., 1998). An exploration of how socio-ecological factors may influence sexually abusive behaviour may offer a greater understanding of the treatment needs of this diverse population, and alert researchers and clinicians to specific treatment components that may be effective in improving the adolescent's quality of life and, in doing so lower the rate of sexual and non-sexual re-offending.

The research cited suggests YSH present with a variety of developmental, behavioural, family, personality, and social characteristics and life experiences. These directly and indirectly influence the adolescent's response to treatment, their vulnerability, and potential for perpetrating further harmful behaviour. As reviewed, the study outcomes cited indicate the importance of peer, cultural, social, and familial influences on a person's behaviour. These influences necessarily impact the adolescent's willingness and ability to engage with an intervention, and to benefit from treatment. Assessments and treatment therefore, need to focus on the systems in which the young person lives, the functioning of those systems, their beliefs, and values.

Attention will now turn to detailing the characteristic variables used in the hierarchical cluster analysis for this study. As stated these were chosen to represent the primary environments young people live in, and offer information about the ways in which YSH may function in those environments. A description of the coding criteria used to report the presence or absence of characteristic variables is also included. In addition the offence and demographic variables are described.

# Chapter 4

## *Characteristics Used in this Study*

The notion of combining a large number of conceptually diverse characteristics within one study is ambitious and novel. Yet it seems a logical progression that builds upon the results of YSH studies thus far. Further, Veneziano and Veneziano (2002, p. 253) in their review of adolescent sexual harmer literature advise, "…progress in the field will be significantly enhanced once reliable and empirically validated typologies emerge…and the use of multivariate statistical techniques and hierarchical cluster analysis is likely to be beneficial in this regard." Similarly, Lambie and Seymour (2006) state that, while typology research was still in the early stages, reliable typologies could be used to predict risk of re-offending and guide the manner in which interventions are applied. They advise that the role of families in the lives of YSH and other contextual information needs to be accounted for within any treatment strategy. This necessarily means that information about how YSH function within their primary environments has to be incorporated, and the variables used need to be able to provide that information.

This chapter details the characteristics that were used in the hierarchical cluster analysis to determine themes of characteristics and profiles of participants. The latter part of the chapter introduces the two demographic variables, and 15 offence variables which were coded as frequencies for the sample, and for profiles of YSH. These variables enhance the description of resulting profiles, and offer information about the types of sexually harmful behaviour committed, the YSH relationship to their victim(s), whether the victim was a child,

peer (or older), and information about ethnicity and age of YSH at the time of referral for specialist treatment.

## Rationale for Characteristics Inclusion

A review of 120 characteristics by the researcher, doctoral supervisors and fellow doctoral students was undertaken; this list was informed by a thorough search of YSH research, clinical experience, and a critical analysis of the utility of characteristics used in this researcher's 2007 study of YSH. The characteristic list was finalised when it was found that 81 characteristics adequately captured the multiplicity of problem issues seen in YSH populations.

Construct validity of each characteristic was assumed based on a review of characteristics used in other YSH studies (Almond et al., 2006; Richardson et al., 2004; Hunter, 2004; O'Brien & Bera, 1986; Smith, et al., 1987; Veneziano & Veneziano, 2002; Worling, 2001), and construct validity criteria for research purposes (Aiken, 2003). Considerable effort was extended to define the coding criteria used to rate a characteristic present or absent; this procedure ensured the content validity of each characteristic, and the parsimonious way each was described improved the face validity.

This study employs the use of archival data. This method has limitations in that the extracted data was not originally collected for the purposes of research, and the quality of that data was determined by the information gathered by a clinician. The majority of characteristics used in this study were those that are typically determined as present or absent during an initial assessment by a specialist sex offender programme. The remaining characteristics are usually highlighted in prior psychological, medical or school reports, which are typically supplied to the clinician by the referring agency or the family, when the youth is referred.

To reduce the possibility of incorrect classification of characteristics only information that was collected during a client's initial assessment with a specialist sexual offender programme was utilised in this study. This method negated temporal issues, whereby clients who might have been in treatment longer may have disclosed additional information, or their behaviour may have changed as a result of the treatments they had received.

**Characteristic Variables**

Family Factors

This category contained 15 characteristics. Studies suggest that many youth who sexually harm have often been exposed to significant forms of psychopathology, family dysfunction, disrupted parenting, parental drug and alcohol abuse, familial criminal offending, and family isolation (Righthand & Welch, 2004). The characteristics in the family factors category were developed to encompass these issues. Table 1 details each characteristic and the explanation used to delineate correct classification.

**Table 1: Family Factors Characteristics**

| Family Factors Category | Coding Criteria |
|---|---|
| In Child Youth & Family Services, or approved provider care | Young person living in statutory care at the time of referral for specialist treatment |
| Living with extended family | Young person living with extended biological family at time of referral |
| History of removal from home | Young person has history of removal by family or CYFs, placed in residential or foster care homes |
| History of sexual abuse in family | History of sexual abuse in family does not include the sexual abuse by or of the young person |
| Domestic violence | Young person has lived in a home where domestic violence has occurred |
| Maternal psychiatric | Biological mother has experienced mental illness |
| Paternal psychiatric | Biological father has experienced mental illness |
| Sibling psychiatric | Biological sibling has experienced mental illness |
| Familial drug/alcohol problems | Young person has parents/siblings/grandparents or aunt/uncle who have substance abuse problems |
| Parental offending | Young person has a biological parent who has been charged with a criminal offence |
| Absent mother | Young person's biological mother is absent from home at the time of referral, or has been absent in the past for more than six months at a time, and has had no contact during periods of absence |
| Absent father | As above |
| Death of a caregiver | Young person has experienced the death of a parent or parental figure |
| Death of a sibling | Young person has experienced the death of a sibling or step-sibling |
| Family isolation | Family of young person is isolated from society by choice or circumstance |

Personality

This category contained seven characteristics. The characteristics in this category were limited to observable negative traits. The rationale was that, without the benefit of using an already empirically validated personality measure, attempting to define personality constructs within this study would be vulnerable to subjective categorisation. Table 2 details the personality characteristics used and an explanation for each that guided classification.

**Table 2: Personality Characteristics**

| Personality | Coding Criteria |
|---|---|
| Egocentric | Young person displays egocentric or narcissistic behaviours or cognitions |
| Controlling | Young person regularly attempts to control and/or dominate situations and/or people |
| Dishonesty | Young person regularly tells lies, even when they would not get into trouble for telling the truth |
| Lacks remorse | Young person displays a lack of remorse for their sexually harmful behaviour |
| Injustice | Young person harbours beliefs that they are regularly treated unfairly |
| Envious | Young person harbours feelings of envy towards others |
| Dramatising | Young person often embellishes own narrative, making accounts appear more dramatic |

## Education

Research has established that many young people who sexually harm others also present with academic problems or have histories of being suspended or excluded from mainstream educational facilities (O'Callaghan, 2004). Table 3 details the six characteristics in this category, along with an explanation that guided correct classification.

**Table 3: Education Characteristics**

| Educational Factors | Coding Criteria |
|---|---|
| Reading difficulties | Young person has reading difficulties sufficient to receive extra educational aid (RTLB/Teacher Aid) |
| Mathematics difficulties | Young person has mathematical difficulties sufficient to receive extra educational aid |
| Writing difficulties | Young person has writing difficulties sufficient to receive extra educational aid |
| Diagnosed Intellectual Disability | Young person has a full IQ less than 70, must have been administered standardized test (Eg. WISC-IV) |
| School exclusion | Young person has a history of suspension or expulsion from school |
| Not at school | Young person not attending a registered school or educational training facility |

## Social Factors

Studies repeatedly document that YSH often have deficits in social competence (Knight & Prentky, 1993). Inadequate social skills, poor peer relationships and social isolation have been identified (Carpenter, Peed & Eastman, 1995). These youngsters tend to have fewer peer attachments and often feel less positive about their social desirability than either antisocial or untroubled youth (Miner & Crimmins, 1995). Three characteristics were chosen for the social factors category. Other characteristics deemed as social constructs were delineated into other categories for ease of coding. Table 4 detailed the characteristics in the social factors category along with the explanation that guided classification.

**Table 4: Social Factors Characteristics**

| Social Factors | Coding Criteria |
|---|---|
| Evidence of social isolation | Young person is described as being socially isolated and lacking close peer relationships |
| Poor social skills | Young person is described as lacking social skills to enable them to interact/maintain appropriate interpersonal relationships |
| Low self-esteem | Young person is described as lacking confidence in themselves across a range of situations |

DSM-IV-TR/Medical

Studies indicate some YSH may meet the criteria for a psychiatric disorder (Sheerin, 2004). The characteristics, 'medical problems' and 'head injury' were included in this category to explore the prevalence of those difficulties within the sample. Seventeen characteristics were chosen for this category. Table 5 details and describes classification criteria.

**Table 5: DSM-IV-TR/Medical Characteristics**

| DSM-IV-TR/Medical | Coding Criteria |
|---|---|
| Auditory/speech difficulties | Young person suffers from some form of speech impediment and/or has diminished hearing |
| Attachment difficulties | Young person presents with interpersonal difficulties consistent with attachment problems |
| Autistic diagnosis | Young person has been diagnosed |
| Asperger's Syndrome | Young person has been diagnosed |
| Oppositional Defiant Disorder | Young person has been diagnosed |
| Anxiety | Young person experiences regular anxiety difficulties |
| Post Traumatic Stress Disorder | Young person has been diagnosed |
| Obsessive Compulsive Disorder | Young person has been diagnosed |
| Attention Deficit Hyperactivity Disorder | Young person has been diagnosed |
| Conduct Disorder | Young person has been diagnosed (any specifier) |
| Mental Illness Not Otherwise Specified | Young person has been diagnosed with a DSM disorder not otherwise specified on this list |
| Hoardes items | Young person regularly hordes food or other items |
| Enuresis | Young person has a history of enuresis (nocturnal or diurnal) |
| Encopresis | Young person has a history of encopresis |
| Depression | Young person displays symptoms of a depressive disorder |
| Medical problems | Young person has ongoing chronic medical problems |
| Head injury | Young person has sustained a head injury requiring medical intervention |

Behaviour

Youth sexual harmers often exhibit a range of behavioural problems, for which they have received sanctions prior to referral for treatment of their sexually harmful behaviour. Characteristics chosen for this category included antisocial acts against property and others, prior non-sexual offending and impulsivity. Also included were acts of harm towards self, and substance abuse problems. Table 6 details the 12 characteristics and the explanation that guided classification.

**Table 6: Behaviour Characteristics**

| Behaviour | Coding Criteria |
|---|---|
| Previous property offence | Young person has committed an offence against property, including arson, burglary and theft; include youth who were not charged |
| Previous offence person | Young person has a prior sanction for an offence against a person, excluding sexual offence, but including physical assault, harassment, and verbal abuse, and youth not charged |
| Behaviour problems at home | Parents/caregivers report youth regularly displays disruptive/non-compliant behaviour at home but is not physically violent or verbally abusive |
| Behaviour problems at school | School reports indicate youth regularly displays disruptive/non-compliant behaviour while at school but is not physically violent or verbally abusive |
| Antisocial behaviour | Young person carries out acts of antisocial and general nuisance behaviour, not necessarily dealt with by police (Eg. Graffiti, vandalism, or gang affiliation) |
| Self-harm | Young person has deliberately hurt themselves |
| Suicide attempt | Young person has attempted suicide in the past |
| Alcohol/drug abuse | Young person has a history of drug and/or alcohol abuse |
| Animal cruelty | Young person has a history of physical cruelty towards animals |
| Fire setting | Young person has deliberately set fires in inappropriate and/or dangerous places |
| Impulsive | Young person regularly acts without thinking of the consequences of their actions, but behaviours do not meet the criteria for ADHD |
| Bully | Young person has/is regularly bullying others |

## Victimisation

Many youth who sexually harm have themselves experienced various types of victimisation (Burton, 2003). The eight characteristics chosen for this category describe the types of victimisation the youth may have suffered, and the relationship the perpetrator of that abuse had with the young person. Table 7 details the eight characteristics along with a description of the classification criteria.

**Table 7: Victimisation Characteristics**

| Victimisation | Coding Criteria |
|---|---|
| Victim of sexual abuse by family member | Young person has been sexually abused by a family member (include step-parent) |
| Victim of sexual abuse non-familial | Young person has been sexually abused by someone outside their biological or step family |
| Victim of physical abuse by family member | Young person has experienced physical abuse by a family member (include step-parent) |
| Victim of physical abuse non-familial | Young person has experienced physical abuse by someone outside their biological or step family |
| Victim of emotional abuse by family member | Young person has been emotionally abused by a member of their family (include step-parent) |
| Victim of emotional abuse non-familial | Young person has experienced emotional abuse by someone outside their biological or step family |
| Victim of neglect | Young person has experienced neglect (eg. inadequate food, shelter, clothing, nurturance or supervision) |
| Victim of bullying | Young person has experienced bullying at school |

Sexual Behaviour

The 13 characteristics chosen for this category encompass sexually harmful behaviour, the use of pornography, sexual interests, and prior exposure to inappropriate sexual material/acts within the young person's usual residence. Table 8 details these characteristics along with the explanation that guided correct classification.

**Table 8: Sexual Behaviour Characteristics**

| Sexual Behaviour | Coding Criteria |
|---|---|
| Previous sexual offence known | Young person's family and/or statutory agency was aware of prior sexually harmful behaviour but did not refer young person for specialised treatment |
| Previous sexual offence not disclosed | Young person had sexually harmed prior to index offence but this had not been disclosed prior to specialist assessment |
| Previous sexual offence non-specialist treatment | Young person had been to counselling for past sexually harmful behaviour; but was not referred to SAFE, Wellstop or STOP |
| Use of pornography | Young person has viewed or read pornographic material via internet, magazine or film |
| Use of pornography (mobile phone) | Young person has accessed pornographic material via a mobile phone |
| Paraphiliac behaviour | Young person has engaged in paraphiliac behaviour (eg. voyeurism, exhibitionism, frottage/fetishism) |
| Animal | Young person has engaged in sexual acts with animals |
| Inappropriate sexual boundaries at home | Young person has witnessed biological/step parents and/or siblings engaging in sexual acts. Parents/siblings must have been aware the youth may have seen them, and continued the act(s) regardless |
| Exposure to sexually explicit material | Young person lives/lived in a home where sexually explicit material (internet/magazine/film) is commonly accessible to them |
| Sexual interest in children | Young person, or collateral informant, reports the youth has a sexual interest in children |
| Confused about sexuality | Young person reports confusion about their own sexual orientation |
| Deviant sexual interest | Young person, or collateral informant, reports the young person is sexually aroused by thoughts of sex with a non-consenting person or person who cannot give informed consent |
| Consenting sexual experience | Young person has engaged in consenting sexual encounter (more than kissing) |

**Demographic and Offence Variables**

Listed below in Table 9 are the two demographic and 15 offence variables used in the study. The YSH age at the time of referral was seen as important as research suggests the older a YSH is when referred the more likely they may be to drop out of treatment (Lambie & Geary, 2007). Further, cross-referencing age and length of time since first sexually harmful incident was seen as important because prior research (Dillon, 2007) showed that youth who had perpetrated the most serious sexual abuse and who had sexually harmed the most victims were also those that were known to statutory agencies long before specialist referral for assessment and treatment.

The ethnicity variable was included because it was a mandatory requirement of ethics approval for this study. This researcher maintained some reservations about the validity of collecting ethnicity data from a secondary source (archival data inputted by clinicians) and, as such, the results should be treated cautiously by the reader, because their validity cannot be assured. The offence and demographic variables were used to enhance the descriptions of the clients within each of the profiles and to explore whether some profiles of YSH exhibited certain types of sexually harmful behaviour or tended to sexually abuse certain categories of victims.

**Table 9: Demographic and Offence Variables**

| Variables | Coding Criteria |
|---|---|
| 1. Age at referral | Age at which the person was referred for specialist assessment (years & months) |
| 2. Ethnicity | The ethnicity of the person as detailed in the specialist assessment |
| 3. Length of time offending | The length of time, in months, from the first sexual offence until referral for specialist assessment |
| 4. Number of victims | Number of people the person has sexually abused |
| 5. Male victims | If person has sexually abused a male |
| 6. Female victims | As above but for females |
| 7. Both gender victims | If person has sexually abused males & females |
| 8. Child victims | If person has sexually abused a child (<11) and the victim is at least four years younger than perpetrator. If YSH and victim are <11, victim is a peer, unless child is more than 4 years younger |
| 9. Peer victims | When victim and perpetrator are a similar age, where victim is an adult narrate answer |
| 10. Non-contact | If the person committed a non-contact sexual offence |
| 11. Internet pornography (objectionable) | If person has viewed internet material deemed illegal under the Objectionable Material Act |
| 12. Indecent assault | If person committed a contact offence that did not include penetration |
| 13. Vaginal penetration | If person vaginally penetrated a victim |
| 14. Anal penetration | If person anally penetrated a victim |
| 15. Family victim | If person sexually abused a family member |
| 16. Non-familial victims | If person sexually abused non-family victims |
| 17. Both family/non-family victims | If YSH has sexually harmed people within and beyond family |

## Summary

All 81 characteristics were chosen after a detailed review of the literature. While it may appear some characteristics commonly seen in a youth sexual harmer population are not included here, an arbitrary decision was made to *not include* certain characteristics, where their inclusion would have been redundant. For example, one such characteristic was 'hostile'; it was believed that youth who display severe behavioural problems are violent and lack remorse, are also expressively hostile and, as such, the characteristic is redundant. Clearly a

young person may appear hostile and not express this hostility physically or verbally; however, to correctly classify the presence or absence of the characteristic (without the accompanying behaviour) without using a valid measure would have been problematic and none of the agencies used such a measure when assessing these youth. The development of the characteristic list was a balance between ensuring the most clinically relevant characteristics were included while acknowledging the limitations of using archival data in the study.

A shift away from focusing on individual characteristics, or small groups of conceptually similar characteristics, to describing the inter-relationship of many characteristics has the potential to advance clinical interventions. However, this advancement can only take place if a typology of YSH is able to describe the population in such detail that clinicians feel confident allocating resources to develop new treatment strategies. And this will only happen if the typology is empirically driven, methodologically sound, and the resulting profiles resonate clearly enough with clients that clinicians work with every day.

# Chapter 5

## *Method*

This chapter begins with an overview of where the sample was derived from and the criteria used for including client data in this study. Ethical considerations regarding access and maintenance of the data are discussed. The information sources used to extract the required data are detailed. The analyses section relates information about the criteria used to code data and hierarchical cluster analysis. Data collection of demographic and offence variables, and inter-rater reliability is presented.

### Sample

The current study utilised archival data of 195 males under the age of 17 years who had been referred to one of the three specialist sex offender treatment programmes in New Zealand. One programme, SAFE, works with clients in the Auckland and greater area; although SAFE has outreach offices in Hamilton and Whangarei, it was not possible to collect data from those offices due to resource constraints. Wellstop works with clients in the lower North Island at four different sites (Hawkes Bay, Palmerston North, Lower Hutt and Gisborne). Data from all Wellstop offices was coded. STOP works with clients in Christchurch, and the agency also has outreach offices in Nelson, Dunedin and Westport. Data was collected from all STOP sites.

The criteria for inclusion in this study was that YSH had to be current clients of a community sexual offender treatment programme, and be under the age of 17 at the time of referral to the programme. Only two clients' data was not coded for this study; those files

contained insufficient assessment information at the time of coding. All other current clients' data at all three programme sites was coded.

Data from 195 files showed clients were aged between six years and four months and 17 years old (*m* = 13 years 11 months; *SD* = 1 year 11 months) at the time of their referral for specialist assessment. Clients less than 11 years old accounted for 7.1 percent of the sample, 23 percent were aged between 11 and 13, 37.4 percent were 13 to 15 years of age, and 32.2 percent were aged 15 to 17 years old at the time of their referral for specialist assessment. Sixty one percent of the sample were New Zealand European, 20.3 percent Maori, 8.6 percent Maori/NZ European, 5.3 percent Pacific Islanders, and 4.8 percent Other ethnic descent.

## Ethical Considerations

The file data required by this researcher in order to carry out the aims of this study were highly sensitive. Either the client or their guardian must have signed a form for release of confidential information for research purposes. Forms included a caveat that no information which could potentially identify a client could be used. No such information was collected for this study. These signed forms, which were similar in wording for each agency and formed part of an agreement between the client and the agency, were individually reviewed by the researcher prior to the collection of each YSH data. No client data was omitted because these forms had not been signed. This study was approved by the Massey Human Ethics Committee, Southern A, Application 08/45 on 22 October 2008.

Each of the three agencies who granted this researcher access to this data had to be assured that their client's information would be analysed by a person who was clinically knowledgeable in the field of YSH treatment, and that the results and opinions arising from the

analysis would have clinical utility for them. This researcher is a former clinician and regional manager of Wellstop. I have worked with YSH clients for the past eight years, assessing and treating YSH and working with their families. It was in this capacity that management of the three agencies agreed to allow me access to their clients' data. Confidentiality agreements were signed between this researcher and the agencies.

## Data Collection and Measurement

### Information Sources

Archival information from SAFE, Wellstop and STOP client files was reviewed to establish the presence or absence of the 81 characteristics and 15 offence variables for each client. The two demographic variables, age at time of referral and ethnicity, were also recorded. These client files contained information from a wide variety of sources, which included: (1) interview scripts with the young person, family members, schools, social workers, mental health professionals, and police; (2) past reports from social workers, police statements, past psychological reports, and past educational reports; (3) psychometric results from the Millon Adolescent Clinical Inventory (MACI), Childhood Trauma Questionnaire (CTQ), Youth Self Report (YSR), and the Child Behaviour Checklist (CBCL); (4) non-standardised checklists, the Adolescent Sexual Behaviour Inventory-Self Report and Parent Report; (5) risk assessment using the Estimate of Risk of Sexual Offence Recidivism (ERASOR); (6) comprehensive assessment report for the young person completed by clinicians at Wellstop, SAFE and STOP.

**Coding Criteria - Characteristics**

Each client's file was reviewed and the 81 characteristics (see chapter 4) were coded as present/absent dichotomies in preparation for analyses using SPSS for Windows, version 15. Using a dichotomous classification for data was chosen because the use of archival information made it impossible to ascertain the degree to which a characteristic was present.

Data was coded, based on evidence that more than one data source within the client's file concluded that a characteristic was present. Where file information appeared ambiguous regarding the presence or absence of a characteristic, the client's therapist was asked to classify the characteristic present or absent. The method of seeking collateral agreement ensured each client's data was correctly represented. Data coding was completed by the researcher and the research assistant at the agencies' offices. A research assistant was required to recode a number of client files, for the purposes of examining inter-rater agreement.

**Coding Criteria – Demographic and Offence Variables**

The demographic and offence data (see chapter 4) for each client was coded. Client's age at the time of referral was determined by cross-referencing their date of birth with the date of their referral to the agency. Ethnicity data was coded from a client's 'personal information page' which was located at the front of each client file. Ethnicity had been recorded by a clinician subsequent to the client being asked how they identified themselves ethnically. Five ethnic categories were determined from information seen in client files: Maori, New Zealand European, Maori/New Zealand European, Pacific Islander, and Other.

Sexual offence variables were coded present or absent based on information contained within client's specialist sex offender assessment reports, written by agency clinicians prior to the client entering treatment. Where clients were found to have committed more than one type of sexual offence against the same victim, 'the most serious offence' was coded. Informed by the literature, a decision was made to code sexual offence variables as: non-contact offences, indecent assault, vaginal penetration, and anal penetration, in ascending order of seriousness (Ryan et al., 1996; Veneziano & Veneziano, 2002; Worling & Curwen, 2000). The variable 'viewing child pornography via the internet' was included to explore the prevalence of such offending within a YSH sample in New Zealand.

Penetration offences, vaginal or anal, were coded when a client was reported as violating a victim orally, digitally, or with his penis or an object. Where clients had committed a range of sexual offences against different victims, all types of offences were coded. Clients who had sexually harmed family and non-family victims were only coded on the 'both relationships' offence variable.

**Inter-rater Data Coding**

Thirty percent of the files were re-coded by a trained research assistant to establish the degree of inter-rater agreement for the characteristics. The research assistant was a person who had 15 years experience working in the field of mental health and sexual abuse. Initially, a decision was made to re-code every fourth file that the researcher had coded. However, it was not possible to re-code the STOP client files and a decision was made to re-code 11 additional Wellstop files to ensure 30 percent of the data was re-coded.

To examine the degree of agreement between the two raters used in this study, Cohen's Kappa was used (Aiken, 2003). Kappa is appropriate for use when two raters are employed and the data is binary. Kappa is a robust measure of agreement that takes into account agreements that may occur by chance alone. Further, research indicates Kappa has a tendency to underestimate the level of agreement for a category, and therefore produces a conservative estimate of agreement (Aiken, 2003). The conservative nature of Kappa ensured that the results of the inter-rater reliability test in this study did not overestimate the level of agreement.

Kappa coefficients were calculated for the 66 characteristics used in the cluster analysis. A Kappa coefficient was not able to be calculated for the characteristic 'Head Injury (TBI)' because there were no 'present' ratings for either scorer on the 40 files. Forty-six characteristics achieved a Kappa coefficient of between 1.00-0.80, 14 characteristics were between .799 - 0.60, and 6 characteristics had Kappa coefficient of between .599 - -1.00 (see Appendix 1). The lower Kappa coefficients tended to occur with characteristics which represented mood and personality traits. Thus, 91 percent of the characteristics used in the cluster analysis for this study meet the research threshold for inter-rater reliability (>0.60), and 76 percent meet the threshold for clinical reliability (>0.80) (Aiken, 2003).

## Analysis

### Cluster Analysis

The primary aims of this study were to explore the possibility of classifying the characteristics into themes and the clients into profiles in a clinically meaningful way. These aims were best achieved statistically with a family of techniques called cluster analysis

(Romesburg, 2004). Within cluster analysis, a strategy called hierarchical agglomerative clustering seemed to fit the exploratory intent of the research problem as it required no prior specification of how many clusters may emerge, and offered a variety of methods for defining and forming clusters. The rationale for testing a variety of methods and distance measures available within hierarchical cluster analysis was *not* to seek convergent sets of results. Rather it was to find a strategy that produced the most clinically meaningful set of results.

Hierarchical clustering creates a hierarchy of clusters which may be represented in a tree like structure called a dendrogram. The root of the dendrograms consists of a single cluster containing all observations, and the branches correspond to individual observations. Algorithms for hierarchical clustering are generally either agglomerative, in which one starts at the branches and successively merges clusters together until a single one is formed; or divisive, in which one starts at the root and recursively splits clusters. As stated agglomerative clustering was used in this study.

In this study the characteristics were first clustered across the (cases) clients and the results yielded seven theme clusters. The clients were then clustered across the characteristics with the result that four profile clusters were formed. In order to interpret the profiles in a clinically meaningful way the characteristics were arranged in their themes. Then a theme score on a 10 point scale was calculated for each case on each theme. This process enabled the calculation of seven theme score means for each profile for the sample as a whole. These mean scores constituted the process by which the initial quantitative interpretation of the profiles took place. Thus, all the hierarchical cluster analyses was performed on clients and characteristics and the formed theme clusters were only interpreted qualitatively without

further analysis. However, the themes were used subsequently to generate theme scores so that client profiles could be reviewed from both a characteristic and theme level.

Similarity Measures

The task of clustering similar characteristics or similar clients requires a quantification of "similarity". Since the present data was dichotomous, the quantification was in terms of matches and mismatches. So, for example, two clients were more likely to appear in the same profile the more characteristics they shared (matches), and the fewer they do not share (mismatches).

Various measures were explored, based on different ways of combining matches and mismatches (Hair, Black, Babin, Anderson & Tatham, 2006). Squared Euclidean distance was a measure that was explored because of its utility with binary and interval data, and it is a commonly used measure within cluster analysis. However, this distance measure only takes account of the sum of the mismatches within a data set (dissimilarity) and, as such, the results would not have been appropriate for the aims of this study; which was within population similarity. Other dissimilarity measures, such as Dice, Hamann and Kulczynski 1, were reviewed as possible distance measures and were discarded on the same basis as squared Euclidian distance.

Three similarity measures were explored as being potentially more appropriate for the aims of the study: Jaccard, Russel and Rao, and Yule's Y. The measure that offered the most appropriate strategy for clustering characteristics and clients, and that produced the most meaningful clinical results was Yule's Y. Yule's Y is a similarity measure based on the cross-ratio for a two-by-two table of binary data. The similarity coefficient is defined as (sqrt(ad) –

sqrt(bc))/(sqrt(ad) + sqrt(bc)) where a is the sum of 1/1 matches across all characteristics, b is the sum of 1/0 mismatches, c is the sum of 0/1 mismatches, and d is the sum of 0/0 matches. The values of Y run from -1 (maximum dissimilarity) to 1 (maximum similarity) overall Yule's Y takes account of all the types of matches and mismatches, giving equal weight to these. The use of a square root transformation within Y reduces the problem of outliers by pulling in extreme values.

Cluster Methods

Hierarchical clustering allows for a variety of algorithms to be used to determine when a cluster should be formed. The choice of similarity measure precluded the use of some popular techniques such as Ward's. Within-groups linkage was chosen instead and this method calculates the average distance between all possible inter or intra-cluster pairs. The average distance between all pairs in the resulting cluster is made to be as small as possible. The method is therefore appropriate when the research purpose is homogeneity within clusters.

# Chapter 6

## *Results*

This chapter begins with a review of the characteristics and client sample used in this study. These sections detail which characteristics were used in the final hierarchical cluster analysis and which client data was discarded. The frequency of offence variables across the sample is then reported. The following section provides a description of the characteristic clusters and the client clusters. The final section reports the relationship between profiles of YSH and their demographic and offence attributes.

### Review of the Characteristics

The frequencies for which 81 characteristics were present across the total sample are presented in Table 10 as percentages in declining magnitude within the categories introduced in chapter four. Sixty seven of the characteristics were present at a rate of more than 10 percent for the sample. The frequencies with which these problem characteristics were present for this sample of YSH was similar to the frequencies found in other YSH research. These frequencies were also higher than general population rates for the same characteristics (Carr, 2006). This result highlighted the clinical relevance of using these characteristics to explore the assessment and treatment needs of this population, and how the frequencies of problem characteristics for YSH can differ from a general population of young people.

Cluster analysis strategies are highly dependent upon the data set used and a decision was made that the 14 characteristics which were present at a rate of less than 10 percent

should not be used in the cluster analysis. The rationale was that the low rates with which these 14 characteristics occurred meant they were not clinically relevant to this sample and, if included in the cluster analysis, they had the potential to skew the theme and profile results, and this had implications for the clinical interpretation of profiles. Thus, 67 of the 81 characteristics were used in the cluster analysis.

The 67 characteristics were correlated within a proximity matrix using Phi 4-point correlation coefficient. There was little evidence of multicollinearity (see Appendix 2) with coefficients ranging from -0.09 to 0.82; very few coefficients were above 0.5 and the small number above 0.64 related to the four characteristics used to describe learning difficulties. High multicollinearity would have been another reason to exclude certain characteristics from the cluster analysis because they would have given undue weight in the analysis (Hair et al., 2006).

**Table 10: Characteristics within Categories**

Frequency of Characteristics across the Sample (n = 195)

| Variable | % | Variable | % |
|---|---|---|---|
| **Family Factors** | | **DSM/Medical** | |
| Absent father | 65.1 | Attachment difficulties | 48.2 |
| Exposed to domestic violence | 46.2 | Anxiety | 28.2 |
| Familial alcohol/drug problems | 45.1 | Depression | 27.7 |
| Family isolation | 44.1 | ADHD | 22.6 |
| History of sexual abuse in family | 36.4 | Oppositional defiant disorder | 21.5 |
| History of removal from home | 34.9 | Traumatic brain injury | 18.5 |
| Maternal psychiatric problems | 34.4 | Post traumatic stress disorder | 16.9 |
| In care at assessment | 32.3 | Conduct disorder | 16.4 |
| Absent mother | 29.7 | Chronic medical problems | 11.8 |
| Parental criminal offending | 26.1 | Auditory/speech difficulties | 10.3 |
| Paternal psychiatric problems | 17.4 | Enuresis | 9.7 |
| Living with extended family | 16.9 | Encopresis | 7.2 |
| Death of a caregiver | 12.8 | Mental illness NOS | 5.6 |
| Sibling psychiatric problems | 9.2 | Obsessive compulsive disorder | 2.6 |
| Death of a sibling | 5.1 | Asperger's syndrome | 2.6 |
| **Personality Traits** | | Hordes items | 2.1 |
| Lacks appropriate remorse | 50.3 | Autistic diagnosis | 0.5 |
| Dishonest | 47.2 | **Behaviour** | |
| Controlling | 43.6 | Impulsive | 65.1 |
| Harbours feelings of injustice | 29.2 | Behaviour problems at home | 55.4 |
| Egocentric | 26.7 | Behaviour problems at school | 52.3 |
| Dramatic personality | 18.5 | Antisocial behaviour | 34.9 |
| Envious personality | 14.4 | Perpetrator of bullying | 31.8 |
| **Education** | | Previous property offence | 29.7 |
| Reading difficulties | 41.5 | Alcohol/drug problem | 21.0 |
| History of school suspension | 34.4 | Fire setting | 19.0 |
| Mathematics difficulties | 33.3 | Previous offence against person | 19.0 |
| Writing (spelling) difficulties | 22.6 | History of self-harm | 14.9 |
| Not in school/training | 14.9 | Animal cruelty | 10.3 |
| Diagnosed intellectual disability | 14.4 | Suicide attempt | 6.9 |
| **Social Functioning** | | **Sexual Behaviour** | |
| Lacks social skills | 73.3 | Viewing adult pornography | 52.3 |
| Social isolation | 61.0 | Prior sex offence known to family/CYFs | 30.3 |
| Low self-esteem | 48.7 | Deviant sexual interest | 28.7 |
| Consenting sexual experience | 18.5 | Sexual interest in children | 27.2 |
| **Victimisation** | | Exposure to sexual material at home | 25.6 |
| Victim of emotional abuse family | 57.4 | Prior undisclosed sex offence | 23.6 |
| Victim of physical abuse family | 48.2 | Inappropriate sexual boundaries at home | 22.6 |
| Victim of bullying | 40.5 | Paraphiliac behaviour | 21.5 |
| Victim of neglect | 33.8 | Prior sex offence (generic therapy) | 12.3 |
| Victim of sexual abuse non-family | 21.5 | Pornography via mobile phone | 8.2 |
| Victim of sexual abuse family | 19.5 | Confused about sexuality | 7.2 |
| Victim of emotional abuse non-family | 10.8 | Sex offence against an animal | 6.7 |
| Victim of physical abuse non-family | 8.7 | | |

## Review of the Clients

Because cluster analysis results are highly sensitive to the data used, a review of which client data to include was undertaken (Hair et al., 2006). Three of the 195 clients' data were not used for this study because none of the characteristics used in the cluster analysis were present for these three clients. The measure used in the cluster analysis, Yule's Y, requires at least one 'present' characteristic for each client in order to perform the calculation. No clients were excluded on the basis of their offence or demographic data.

## Offence Variable Frequencies across the Sample

The frequencies for which 13 of the offence variables were present for the sample were detailed in Table 11, as percentages. The average number of months clients in this study had been exhibiting sexually harmful behaviour was 19, and the median number of months was 12. On average, clients had sexually harmed two victims each.

**Table 11: Frequencies of Offence Variables across the Sample**

| | *N* | % |
|---|---|---|
| Male victim | 64 | 34.2 |
| Female victim | 134 | 71.7 |
| Both gender victims | 36 | 19.3 |
| Child victim (<11) | 154 | 82.4 |
| Peer+ victim | 74 | 39.6 |
| Non-contact | 45 | 24.1 |
| Internet | 7 | 3.7 |
| Indecent assault | 148 | 79.1 |
| Vaginal penetration | 46 | 24.6 |
| Anal penetration | 31 | 16.6 |
| Family victim | 79 | 42.2 |
| Non-family victim | 68 | 36.4 |
| Both family & non-family victim | 37 | 19.8 |

## Themes Derived from Cluster Analysis

The Yule's Y measure and within-group linkage method were used to generate solutions ranging between four and nine clusters. The use of a range of possible clusters allowed for an inspection of different cluster compositions. The final cluster membership was determined using three integrated strategies; an examination of the dendrogram (see Appendix 3) against the cluster membership table to determine which membership revealed the greatest distance between branches on the dendrogram. And in keeping with the aim of developing clinically useful profiles, a review of the characteristics within different cluster memberships to qualitatively assess whether a particular cluster of characteristics appeared conceptually similar. Using these criteria led to the choice of a seven cluster solution, that is a grouping of the characteristics into seven themes (Table 12). The themes were given titles that represented the core concept(s) of the theme.

The clusters derived from cluster analysis strategies may be affected by the order in which variables enter the calculation (Hair et al., 2006). To explore the effect of this phenomenon on the characteristic data set used in this study, the data set was first analysed in the order in which it had been coded and the output reviewed. The characteristics were then randomly ordered twice and cluster analyses again completed. The outputs were reviewed to ascertain the way in which cluster memberships might have changed. There was no change in cluster membership across the three trials for the 67 characteristics.

**Table 12: Seven Themes Derived from Hierarchical Cluster Analysis**

| Cluster | Characteristics | Cluster | Characteristics |
|---|---|---|---|
| Theme I | **Sexual Deviancy & Delinquency** | Theme V | **Personality & Social Deficits** |
| | Attachment difficulties | | Envious personality |
| | Inappropriate sex boundaries home | | Dramatic personality |
| | Consenting sexual experience | | Social isolation |
| | Deviant sexual interests | | Prior sex offence known to family/CYFs |
| | Sexual interest in children | | Dishonest |
| | Fire | | Lacks appropriate remorse |
| | Previous offence against person | | Lacks social skills |
| | Alcohol/drug problem | | Impulsive |
| | Behaviour problems school | | Victim of bullying |
| | Exposure to sexual material home | | Harbours feeling of injustice |
| | History school suspension | | Animal cruelty |
| | Conduct disorder | | Prior sex offence (generic therapy) |
| | Behaviour problems home | | Egocentric |
| | Viewing adult pornography | | Controlling |
| | Antisocial | Theme VI | **Developmental Difficulties** |
| | Perpetrator of bullying | | Reading difficulties |
| | Previous offence against property | | Mathematics difficulties |
| | Not in school/training | | Writing (spelling) difficulties |
| Theme II | **Neglect & Trauma** | | Diagnosed intellectual disability |
| | In care at assessment | | Low self-esteem |
| | History of removal from home | | Family isolation |
| | Absent mother | | Paraphiliac behaviour |
| | Victim of neglect | | ADHD |
| | Death of parent/caregiver | | Oppositional defiant disorder |
| | PTSD | | Chronic medical problems |
| | History of self-harm | | TBI (mild/moderate) |
| | Victim sexual abuse non-family | | |
| | Prior sex offence undisclosed | Theme VII | **Family Aggression & Abuse** |
| | Victim emotional abuse non-family | | Parental criminal offending |
| Theme III | **Sexual Abuse & Family Mental Health** | | Living with extended family |
| | History sexual abuse in family | | Victim physical abuse family |
| | Maternal psychiatric problems | | Victim emotional abuse family |
| | Speech/hearing problems | | Exposed to domestic violence |
| | Paternal psychiatric problems | | Family alcohol/drug problems |
| | Victim sexual abuse family | | Absent father |
| Theme IV | **Mood Disregulation** | | |
| | Anxiety | | |
| | Depression | | |

Theme I: Sexual Deviancy and Delinquency

Eighteen characteristics clustered together to create a theme which incorporated two key concepts: sexual deviancy and delinquency. This theme included five characteristics that represented problematic sexual interests, but it did not include paraphiliac behaviour or the three characteristics which were related to prior sexual offending. Cluster analysis showed paraphiliac behaviour was more likely to occur with developmental difficulties, undisclosed sexual offending was more likely to occur with trauma related characteristics, and prior therapy or prior disclosures of sexual offending occurred with problem personality characteristics. That deviant sexual behaviours and attitudes occurred more often with excessive antisocial behaviour problems indicated these two concepts were interrelated.

Both concepts incorporate socially inappropriate behaviours, the expressions of which would require a person to overcome internal and external inhibitors to the expression of the behaviour. It may be that, for some clients in the sample, sexual deviancy and delinquent behaviours were similar ways to express a versatile disregard for the rights of others.

Theme II: Neglect and Trauma

Ten characteristics clustered to create a theme of experienced neglect, loss of family members, and out of home care. These characteristics occurred more often with 'victim of sexual and emotional abuse by non-family member'. The inclusion of PTSD indicated the impact of such traumas for many youth. That 'prior undisclosed sexual offence' occurred with these characteristics indicated there was an inter-relationship between these characteristics.

Theme III: Sexual Abuse and Family Mental Health

This theme showed that, when one parent had experienced a mental health problem, the other was more than likely to be similarly afflicted. These characteristics occurred more often when there was a history of sexual abuse in the family, and when their child had been sexually abused by a family member. The inclusion of speech and/or hearing problems within this theme was conceptually unusual. It was hypothesised that, when there were significant mental health and sexual abuse issues in the home, adults within these homes may have lacked knowledge or insight into how to appropriately help their children overcome these difficulties.

Theme IV: Mood Disregulation

Anxiety and depression occurred more often between themselves than with any other characteristics. Research of mood and anxiety disorders indicates co-morbidity is common (Sadock & Sadock, 2003).

Theme V: Personality and Social Deficits

Personality and social deficits clustered more frequently together than with any other characteristics. Exhibiting serious personality problems was related to being socially isolated and lacking social skills. These issues were also related to a YSH being highly impulsive, the victim of bullying and perpetrating cruelty towards animals. It may be that personality problems moderated social acuity – in that YSH may have been disliked by peers because of their way of relating and this led to social isolation and therefore many YSH had fewer opportunities to develop social skills.

This theme included two of the characteristics related to prior sexual offending, 'prior sexual offence known to family/CYFs' and 'generic counseling for prior sexual offence', indicating that, for some YSH, interventions had been attempted. Research indicates that, without expert intervention, delivered within an empirically valid therapy model, personality difficulties can endure (Sadock & Sadock, 2003). Developmental psychology research shows that youth do change, often rapidly, prior to adulthood, and therefore personality traits for youth may not be stable (Groth-Marnat, 2003). However, it may also be that, for some YSH, the lack of social skills practice and a propensity to engage in impulsive acts actually aids the embedding of problem personality traits.

Theme VI: Developmental Difficulties

The 11 characteristics which occurred more frequently together generated a conceptual theme of learning difficulties that co-occurred more frequently with low self-esteem, family isolation and paraphiliac behaviour. Research indicates that YSH with intellectual difficulties may be more likely to engage in nuisance, non-contact sexually harming (Timms & Goreczny, 2002). This result evidenced support for this suggestion.

Oppositional defiant disorder (ODD) and ADHD were also more likely to be related to the above characteristics suggesting co-morbidity with learning difficulties. That chronic medical problems and head injuries (TBI) also occurred within this theme indicated brain and physical injuries were related to the development of learning difficulties, ADHD and ODD. Family isolation may have occurred as result of their child's difficulties or the child's difficulties might have been maintained because families were unwilling or unable to access community resources.

Theme VII: Family Aggression and Abuse

The seven characteristics co-occurring within this theme suggested a strong link between family violence and parental drug and/or alcohol problems. Criminal offending by a parent was also related to these characteristics, as was absentee fathers. Youth exposed to such violence and dysfunction were more likely to be living with extended family.

## Client Profiles Derived from Cluster Analysis

As with the characteristic cluster analysis, a range (3 to 7) of cluster numbers was used in the Within-groups linkage algorithm and Yule's Y, and the client data set was randomly ordered three times. Only a slight cluster membership change was found from the first to second ordering and none occurred between the second and third ordering. The different cluster compositions were reviewed to ascertain the number of client profiles. The final cluster membership was determined using the same strategies as for the characteristic clusters and final cluster membership determined upon the same basis (see Appendix 4): Initially five profile clusters were examined; however, one profile contained only five clients and a review of why these clients clustered together was undertaken to investigate whether the similarities they had constituted a profile that was clinically distinct from other profiles. A review of the cluster solutions indicated that if four profiles were chosen instead of five, then these five clients would join a profile which did not appear clinically or characteristically similar. This created a conundrum requiring further investigation.

Four of these YSH were clients of Wellstop and this researcher reviewed their original files again. A clinical interpretation followed which determined that these clients had characteristics and life experiences which were not recorded at the time of their initial

assessment with Wellstop (client disclosures during therapy were found within the file data). The clustering strategy correctly isolated them in one profile based on the characteristics that were recorded, but the missing data altered profile membership because relevant characteristics were not recorded as present. It was determined that these clients did not constitute a distinct profile and, if the missing data was available, these five clients would have met the criteria for inclusion in one of the four profiles. This data was discarded, resulting in 187 clients' data being used in the final analysis for this study.

Data from the 187 files showed the clients were aged between six years and four months and 17 years old (*m* = 13 years 11 months; *SD* = 1 year 11 months) at the time of their referral for specialist assessment. Sixty one percent of the sample were New Zealand European, 20.3 percent Maori, 8.6 percent Maori/NZ European, 5.3 percent Pacific Islanders, and 4.8 percent Other ethnic descent.

**Description for 4 Profiles across 7 Themes**

Four client profiles were determined subsequent to cluster analysis. Profile I included 29 (15.5%) clients, Profile II had 43 (23 %), Profile III had 63 (33.7%) clients, and Profile IV had 52 (27.8%). The average age of clients within profiles was similar across the four profiles, and clients aged 11 years or under were evenly distributed across the four profiles. A comparison of the profiles across the seven themes is detailed in Figure 1. Themes were used in this comparison, instead of characteristics, to highlight the relative strength of each theme for each profile. This process allows for easier understanding of profile difference. A description of the profiles is reported, along with each profile's mean age and ethnicity make-up. The profiles

were given titles which are intended to describe the primary characteristic constructs which were prominent for clients within the profile.

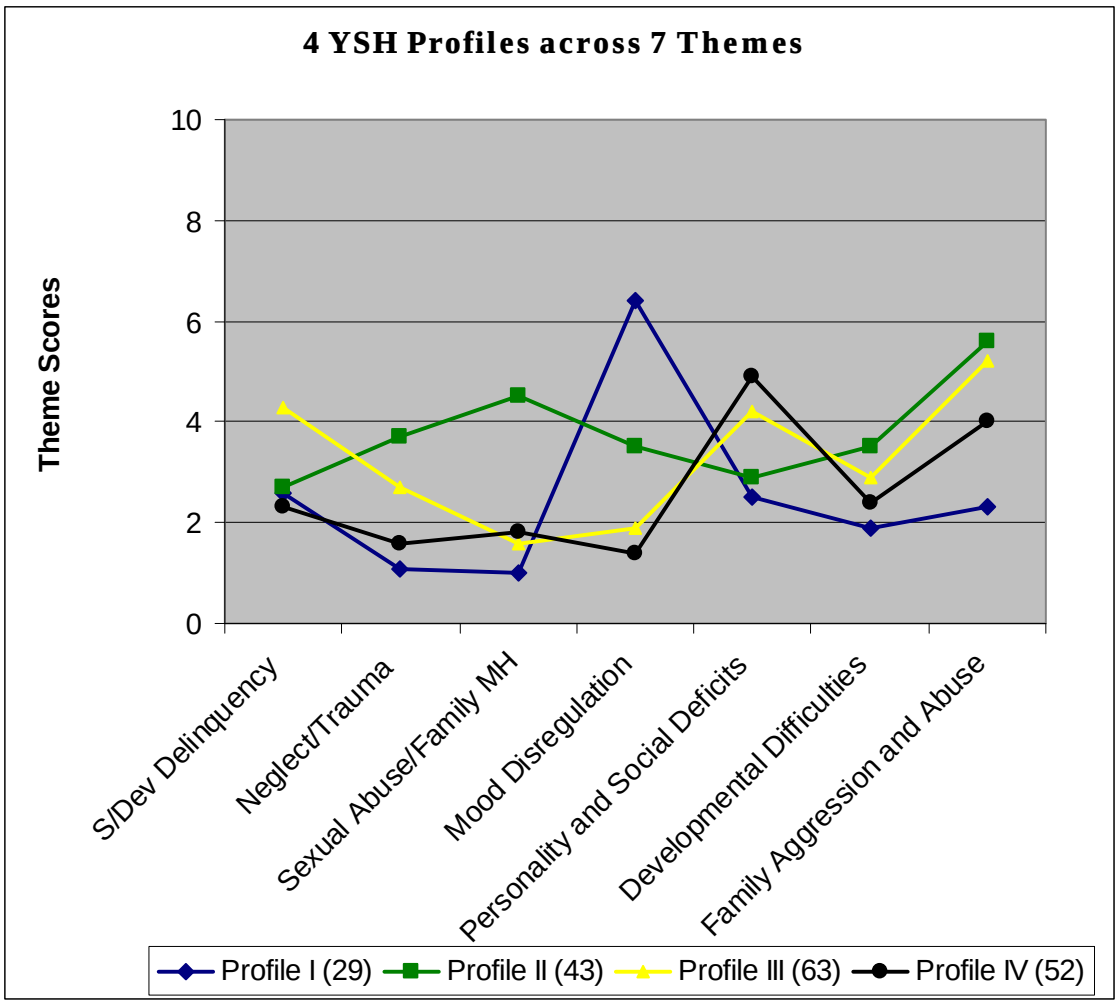


**Figure 1: 4 YSH Profiles across 7 Themes**

Profile I: Depressed Relationship Seeking YSH

There were Twenty-nine (15.5%) YSH in this profile. The average age of these YSH was 14 years and four months (*SD* = 1y8m). The ethnic composition of the profile was: Maori (6.9%), NZ European (62.1%), Maori/NZ European (10.3%), Pacific Islander (10.3%), and Other

(10.3%). Maori clients were under-represented in this profile, Pacific Islanders and Others were over-represented.

These YSH had low rates of neglect and trauma (1.1), and had few developmental difficulties (1.9). These clients were not likely to have had parents who had mental health issues, nor were they, or members of their family, likely to have experienced sexual abuse (1.7). Clients in this profile had experienced family aggression and abuse to a moderate degree (2.3). They also had moderate scores for sexual deviancy and delinquency (2.6) and personality and social deficits (2.5). These YSH differed markedly from other youth in the sample on the mood disregulation theme (6.4). Higher rates of depression and anxiety, and moderate rates of personality and social deficits meant these youth were more likely than others to be depressed and socially isolated.

In summary, these youngsters had low to moderate rates of problem characteristics except on the mood disregulation theme. The relative absence of many problem characteristics indicates these YSH have many protective factors which could be utilised in treatment development for them.

Profile II: Trauma Reactive YSH

There were Forty-three (23%) clients in this profile. The average age of YSH in this profile was 13 years and four months (*SD* = 2y3m). The ethnicity composition of the profile was: Maori (18.6%), NZ European (51.2%), Maori/NZ European (20.9%), Pacific Islander (4.7%), and Other (4.7%). Maori/NZ European clients were over-represented in this profile.

Scores across all seven themes showed moderate to moderate/high levels of problem characteristics were common for these clients. These YSH had the highest scores of all profiles

on four of the seven themes of characteristics. These YSH had the highest profile score on the neglect and trauma theme (3.4) and developmental difficulties theme (3.5). The interplay of these theme scores indicated Trauma Reactive YSH had experienced moderate levels of learning difficulties at school, which may have been influenced by the impact of neglect and trauma. These YSH had the highest scores on both themes that included sexual victimisation characteristics. These themes also included PTSD, a history of self harming, TBI and chronic medical problems.

These youngsters were more likely than any other clients to have experienced statutory care. Clients in this profile scored in the moderate/high range on the themes 'sexual abuse and family mental health' (5.4) and 'family aggression and abuse' (5.6). These scores were the highest for any profile. These YSH were more likely than any other profile to have experienced multiple types of abuse (sexual, physical and emotional). Their parents were more likely to have mental health problems and abuse alcohol and/or drugs. Families of clients in this profile were likely to perpetrate domestic violence and engage in criminal offending. The lowest score for these YSH occurred on the sexual deviancy and delinquency theme (2.7), indicating moderate levels of sexual pre-occupation and antisocial behaviour. YSH in this profile also had moderate personality and social deficits (2.9), suggesting their ability to develop and maintain social relationships was not overly impaired.

In summary, Trauma Reactive YSH were highly likely to have experienced multiple types of loss and abuse. It was hypothesised these distressing events impacted their ability to succeed academically. The interplay between all themes revealed these youngsters were more likely to be traumatised by the multiplicity of their life experiences.

Profile III: Hostile Versatile YSH

There were 63 (33.7%) YSH clients in this profile. The average age of clients in this profile was 13 years and 11 months (*SD* = 1y8m). The ethnic composition of this profile was: Maori (28.6%), NZ European (57.1%), Maori/NZ European (6.3%), Pacific Islander (6.3%), and Other (1.6%). Maori were over-represented in this profile and Other were under-represented.

These youngsters had theme scores in the low range for sexual abuse and family mental health (1.6) and mood disregulation (1.9). These clients had experienced a moderate degree of neglect and trauma (2.7) and developmental difficulties (2.9). Hostile Versatile YSH had the second highest score on the personality and social deficits theme (4.2) and the highest score on the sexual deviancy and delinquency theme (4.3). They had also experienced a moderate/high degree of family violence and physical and emotional abuse.

In summary, the interplay of theme scores indicated these youth were not likely to be depressed or to have experienced sexual abuse, nor did they have high rates of learning difficulties. Their scores suggested they were not socially isolated and that they had good self-esteem. Hostile Versatile YSH had experienced higher rates of violence, and were likely to have lived in homes where antisocial and abusive behaviours were common, however. These youth were more likely than any others to act out in antisocial and hostile ways towards others and to have problematic personality traits.

Profile IV: Controlling Entitled YSH

Twenty-seven percent (52) clients in the sample were in this profile. The average age of YSH in this profile was 14 years and seven months (*SD* = 1y11m). The ethnic composition of the profile was: Maori (19.2%), NZ European (73.1%), Maori/NZ European (0%), Pacific Islander

(1.9%), and Other (5.8%). NZ European was over-represented in this profile, and Maori/NZ European and Pacific Islander were under-represented.

These youngsters had experienced low levels of neglect and trauma (1.7) and were less likely than any other youth to be depressed or anxious (1.3). They also had a low score on the theme 'sexual abuse and family mental health' (1.8). Controlling Entitled YSH had experienced a moderate degree of learning difficulties (2.4) and were the least likely to act out in delinquent ways (2.3). Their score on the sexual deviance and delinquency theme was in the moderate range (2.3).

These clients had experienced a moderate/high degree of family aggression and physical and emotional abuse (4). They also had the highest score on the Personality and Social Deficits theme (4.9). This result indicated these youngsters were likely to experience social difficulties and their interaction style may have made them appear arrogant and aloof to others. These experiences did not negatively affect their self-esteem or mood, however.

In summary, Controlling Entitled youth were more likely than others to appear egocentric and unremorseful. Their profile results suggest a tendency to lack the social skills necessary to develop and maintain healthy peer relationships.

**Summary of Profile Results**

The results of the hierarchical cluster analysis of clients showed that the problem characteristics chosen were appropriate to the aims of this study. The presence and absence of characteristics for clients enabled profiles to be determined that appeared clinically amenable to a discussion about relevant ways these youth could be assessed and treated. The four profiles have good clinical face validity, and the composition of their problem characteristics

emphasised within profile similarity, which allows an examination of the diversity between profiles. These results suggest a new assessment instrument could be developed for YSH, one that can capture clinically pertinent characteristics so that treatments can be inclusively targeted to meet the diverse needs of this population.

## Description of Offence Variables Associated with the Four Profiles

The length of offending history, number of victims and types of offences committed by YSH in each profile is detailed in Figure 2. A description of the degree to which each profile of YSH was likely to commit a certain type of offence follows. These descriptions are intended to enhance the interpretation of the four profiles, and were used in the subsequent chapter during the interpretation of the four profiles.

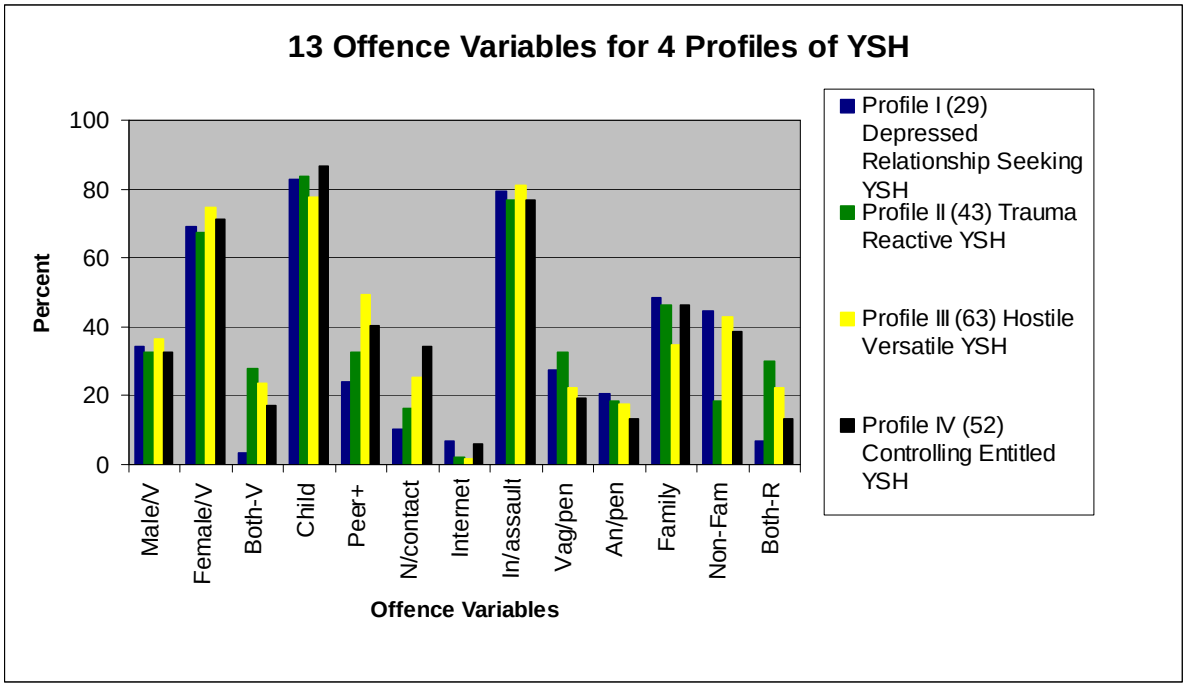


**Figure 2: 13 Offence Variables across 4 Profiles of YSH**

Depressed Relationship Seeking YSH

The Depressed Relationship Seeking YSH had exhibited sexually harmful behaviour for, on average, eight months prior to being referred for specialist treatment and this was less time than the other profiles. They were likely to have sexually harmed two victims. These were the lowest figures for all the profiles. These youth had the lowest frequency for sexually harming both males and females (3.4%), perhaps indicating gender preferential sexual interest. These YSH had the highest frequency for having viewed child pornography (10.3%) via the internet and sexually harming either a family member or non-family victim, not both. Depressed Relationship Seeking YSH were the least likely to commit non-contact sexual offences, or sexually harm a peer. These youth had the highest prevalence of committing anal penetration offences (20.7%).

Trauma Reactive YSH

The Trauma Reactive clients had exhibited sexually harmful behaviour for, on average, 20 months prior to referral for specialist treatment, during that period they were likely to have sexually abused two victims. These youth were the profile which had the highest prevalence for sexually harming both males and females (25.6%) and for committing vaginal penetration offences (32.6%). The results on the three victim relationship variables showed these youth had the second highest frequency for family victim (46.5%), the lowest for non-family victim (18.6%) and the highest for sexually harm victims within and beyond their family (32.6%). These results indicated Trauma Reactive YSH were more likely to sexually harm members of their own family.

Hostile Versatile YSH

The Hostile Versatile YSH had exhibited sexually harmful behaviour for, on average, 18 months prior to referral for specialist treatment. During that period, they were likely to have sexually abused three victims. These youth had the frequency for sexually harming a peer (49.2%), and committing indecent assaults (81%). They had the highest rate of male (36.5%) and female (74.6%) victims. Hostile Versatile YSH had the lowest frequency for viewing child pornography via the internet (1.6%).

Controlling Entitled YSH

Controlling Entitled YSH had exhibited sexually harmful behaviour for, on average, 24 months prior to referral for specialist treatment; this was the longest offence history. During that period, these YSH were likely to have sexually harmed three victims. These youth had the highest prevalence for child victims (86.5%) and they had the greatest frequency of non-contact offences (34.6%). Controlling Entitled YSH committed the fewest penetrative offences - vaginal (19.2%) and anal (13.5%).

**Summary of Profile Offence Histories**

The results of the offence data for the four profiles showed YSH within profiles tended to commit similar types of sexual offences. Depressed Relationship Seeking YSH had the shortest offence histories and the least victims. However, the results showed they tended to choose male or female victims, and those victims were likely to be children either within or beyond their family, not both. They were also more likely than YSH in other profiles to spend time viewing child pornography, and had the highest frequency for anal penetration offences.

The Trauma Reactive YSH were more likely to sexually harm both male and female children, and they tended to commit vaginal penetration offences against their female victims. The results suggested these youth targeted children within their families most often. Hostile Versatile YSH were sexual harmers who tended to target peers or older victims and these victims were more likely to be female. The results showed these youth were equally likely to sexually harm people within and beyond their families. These offences tended to be indecent assaults, and very few Hostile Versatile YSH spent time viewing child pornography via the internet. The Controlling Entitled YSH had been sexually harming longer than any other profile and their offences tended to be less serious. The results showed these YSH had the highest frequency for non-contact offences and the least for anal or vaginal penetration offences.

The degree to which the offence results might contribute to an understanding of YSH requires an interpretation of the interplay between profiles characteristic and offence data. This interpretation is detailed in the next chapter.

## Summary of Results

This chapter has reported the results of the analysis of the characteristics and clients, the two demographic and 13 offence variables. These results indicate profiles of YSH could be determined using cluster analysis with this sample of young people. The results depended upon the characteristics used in this study, and therefore other research using the same method but different characteristics may determine different types of profiles of YSH. However, the ways in which YSH between profiles differed allows exploratory discussion and interpretation of those differences and what that may mean for assessment and treatment.

Seven themes of characteristics were determined from the analysis of 67 characteristics, the grouping together of certain characteristics enables an exploration about why particular characteristics were similar and what this might mean for profile interpretation. The attributes of the four profiles of YSH found using hierarchical cluster analysis appear clinically adroit. Along with the theme scores and offence results for each profile this result paves the way for advancing an interpretation of the YSH within profiles.

# Chapter 7

## *Profile Interpretation*

Seven themes of characteristics were determined using hierarchical cluster analysis, these themes were utilised to display similar characteristics. Four profiles of YSH profiles were found by using hierarchical cluster analysis of 187 clients across the 67 characteristics. Themes for each profile were used to show how YSH in profiles differed from YSH in other profiles. This chapter interprets the results of the themes scores and characteristic percentages for each profile. The specific percentages for which the 67 characteristics were present for each profile are detailed in Appendix five. The results of the offence analysis for YSH within profiles showed there were no note-worthy differences between profiles for these variables, however there appeared to be trends, especially in the length of time certain profiles had been sexually harming before they were referred for specialist treatment. These trends are discussed for each profile.

An interpretation of the inter-relationship of characteristics and the clinical relevance for assessment is advanced for each profile. The results of this study suggest the characteristics used were able to successfully highlight functioning across a number of treatment relevant areas. However, treatment planning and the resources required to deliver treatment needs to be informed by assessment. Factually, all clients in this study sexually harmed, and the results showed within profile similarity and between profile difference. Therefore, the reasons why, or motivation to, sexually harm may occur as a result of multiple influences and these may be different for each profile of YSH. Without appropriate assessment these influences may not be

obvious and subsequently efficacious treatment components less likely to be identified. The purpose of this chapter is to emphasise within profile functioning so as to highlight assessment needs.

## Depressed Relationship Seeking YSH

Twenty-nine clients (15.5%) with an average age of 14 years and four months (*SD* = 1 year 8 months) were classified as Depressed Relationship Seeking YSH. Their score on the sexual deviancy/delinquency theme was influenced by the moderate present ratings of sexually deviant characteristics, especially 'viewing adult pornography', more of these YSH viewed pornography than clients in any other profile. General behavioural problems featured but these youth were less likely to be endorsed as antisocial, with their behavioural difficulties likely to occur at home and at school. Scores on the mood disregulation theme and specific characteristics percentages on the personality and social deficits theme suggest the difficulties in these environments occurred as a result of inter-personal relationship problems. These youth were more likely to withdraw from relationships and experience depressive symptoms and anxiety as a result of inter-personal conflict. Viewing pornography appears to be one way these youth sought to alleviate negative affect states.

On the neglect/trauma theme these youth scored far lower than the other profiles for each of the 10 characteristics, except 'victim of sexual abuse by a non-family person' and 'previously undisclosed sexual offence'. A low neglect/trauma theme score along with low scores on the sexual abuse and family mental health theme indicate these youth lived in homes which typically provided safety from experiencing sexual abuse. This was not so of physical and emotional abuse, or the experience of witnessing domestic violence, with one fifth of these

youth having these experiences. These youth were likely to live with their mothers, and if their father was not at home, most had regular contact with him. Thus, it may be their mood, anxiety, and relationship difficulties occur as a result of the inter-relationship of experiencing family aggression and emotional abuse. All of which influenced their self-esteem, almost 90 percent of these youth were seen as having low self esteem. The result of which are depressed anxious youth who have little confidence in themselves and few social skills with which to form and maintain healthy peer relationships. If these youth also live in family environments in which the adults may be preoccupied with their own difficulties these youth may feel very isolated, lonely and angry.

As a profile these youth were succeeding academically, none had been diagnosed with a learning disorder and they had very low present ratings on the personality characteristics used in this study, but this profile had the highest percentage by far of YSH who had been a 'victim of bullying'. When their sexually harmful behaviour was discovered they were seen as the most remorseful and honest. What then might have influenced these youngsters to sexually harm and what factors need to be highlighted during an assessment that would successfully target those influences?

As stated these youngsters were lonely, unskilled socially, and this meant they probably had few peer aged friends with whom they could interact and engage in age appropriate activities. Research indicates pornography viewing has the potential to alter sexual schema and aids the developmental of maladaptive beliefs about sex (Greenfield, 2004). In addition pornography is known to alleviate negative affect states, such as depression and anxiety (Carr, 2004). These youngsters were more likely to sexually harm either male or female children, not

peers, and they had the shortest offence history. While the results of the offence data did not indicate any significant differences between profiles there were trends in the nature of offending within profiles that seemed to be related to their characteristics and theme interpretation. These youth may have befriended children younger than themselves because they felt more comfortable and accepted – and subsequently sexually abused these children. Inappropriate sexual schema developed during periods of pornography viewing, paired with psycho-sexual development, and few skills with which to develop intimate peer relationship may be one reason these youth chose to sexually harm. Therefore, assessments need to determine the degree of inter-relationship between depression, anxiety, low self-esteem, social isolation, family violence, and the use of pornography, as these issues are a likely influence for the sexually harmful behaviour perpetrated by some YSH.

## Trauma Reactive YSH

Forty three clients (23%) in this study, with an average age of 13 years and four months (*SD* = 2 years 3 months), were classified as Trauma Reactive YSH. Their score on the sexual deviancy/delinquent theme was similar to the Depressed Relationship Seeking YSH however individual characteristic percentages revealed differences. These youth were more likely than any other profile to experience attachment difficulties, over two thirds. In addition, they were more likely than Depressed Relationships Seeking YSH to bully other people and more of them displayed behavioural problems at home and at school. For most their behaviour and presentation were unlikely to have resulted in a diagnosis of conduct disorder, nor were many seen as antisocial. It would seem their ability to appropriately regulate themselves in

interpersonal relationships was negatively influenced by prior learning within primary caregiver relationships.

These youth were far more likely than any other youngsters to have witnessed inappropriate sexual acts and to have been exposed to sexually explicit material within their homes, indicating a relationship, between family sexual pre-occupation and attachment difficulties.

Far more than any other profile within this study, Trauma Reactive YSH had experienced multiple types of abuse. Their scores on the three themes that included abuse characteristics were the highest of any profile. On the sexual abuse and family mental health theme these youth scored significantly higher than all others. Almost half had been sexually abused by a family member and over two thirds grew up in families where sexual abuse was common. Almost three quarters had mothers who had been diagnosed with a mental illness and over half had spent long periods of their life without seeing her. Almost two thirds had histories of neglect and physical abuse, and just fewer than 90 percent had been emotionally abused. Witnessing domestic violence was also common for two thirds of these youth, along with family drug and alcohol problems. The negative impact of these experiences was seen in the relationship between abuse and high percentages for social isolation and lack of social skills. In addition, Trauma Reactive YSH had the highest percentage of youth who had a diagnosis of PTSD and who had self-harmed.

Trauma Reactive YSH also experienced a higher rate of learning problems than others, and more of them, than any other profile, had chronic medical problems and head injuries. Over half these youngsters were in statutory care at the time of referral for specialist

assessment and approximately 50 percent had experienced prior multiple out of home placements, this was greater than any other profile. It would seem then that statutory agencies had been aware of the problems many of these homes posed, and had attempted interventions. However, it took on average almost two years (*m* = 20.3 months) for CYFs to refer Trauma Reactive YSH for specialist assessment and treatment. This may have occurred for a number of reasons; the families of these youth were observed to have multiple difficulties and the results indicated regular parental absences were common. Families with similar issues as those of the Trauma Reactive YSH are likely to have come to the attention of multiple agencies over a long period. There may be a reticence or fear on the part of the family to engage with services and this can make successful intervention very difficult to achieve. In addition, CYFs social workers may not fully understand the inter-relationship between multiple difficulties or which issues signal the need for specialist treatment.

These issues are highlighted for the Trauma Reactive youth in that they have experienced significant traumas, and lived in the family homes which were chaotic, dysfunctional, and abusive. The inter-relationship of these issues is seen in the far higher incidence of educational and health problems. Families who are marginalised in society may lack the capacity or knowledge of how to access help resources, the impact of which may be further isolation, ill health and poor mental health outcomes, with abusive behaviour within the family increasing victimisation and the potential for intergenerational dysfunction and violence.

It is likely the inter-relationship of multiple issues influenced their sexually harmful behaviour. Long term exposure to sexually inappropriate material, chronic victimisation within

the family, and the normalisation of abuse is likely to have offered these YSH few opportunities to learn about healthy relationships. These youth were more likely than other profiles to sexually harm indiscriminately – individuals within the profile were likely to have male and female victims, and to have sexually harmed family and non-family victims. Further, these YSH had the second longest average offence history indicating an established pattern of inappropriate sexual behaviour. Assessments would need to show the degree to which prior victimisation, educational difficulties, parental pathology, and sexual dysfunction within the family were present for different YSH. The inter-relationship of these factors was far more prominent for this profile than any other and may indicate a specific group of risk characteristics.

## Hostile Versatile YSH

Sixty three clients (33.7%) in this study, with an average age of 13 years and 11 months (*SD* = 1 year 8 months), were classified as Hostile Versatile YSH. These youth scored higher than other profiles on the sexual deviancy/delinquency theme, and as with the preceding two profiles specific characteristics percentages showed how these youth differed on this theme. In contrast to the other profiles the Hostile Versatile YSH displayed severe behavioural problems across multiple environments. Over a third had been diagnosed with conduct disorder and 61.1 percent were reported as being antisocial. Half had been sanctioned for a property offence and over a third had committed a violent offence against a person. These youth were more likely than any others to have set fires and to have been cruel to animals. Hostile Versatile YSH had the highest percentage of present ratings for all the delinquent behaviours used in this study.

Just over 20 percent of these youth were not attending school and more of them had been suspended from school than all other profiles, combined.

More youth in this profile were seen as sexually deviant, than in other profiles, and the interplay between characteristic and offence data suggested this deviancy was likely to be in the form of an endorsement of sexual contact with a non-consenting peer. Many of these youngsters had not witnessed inappropriate sexual acts at home, nor had many of them been exposed to sexually explicit material at home. In addition, on the sexual abuse and family mental health theme they were the least likely of all profiles to come from families who had a history of sexual abuse. Sexual victimisation was also not common for these youngsters; however, those who experienced such abuse were more likely to have been sexually harmed by a non-family person (33.3%), which was a higher rate than any other profile.

Results from the family aggression and abuse theme show many parents of Hostile Versatile YSH displayed serious antisocial and abusive behaviour. Just over 40 percent of these parents had been convicted of a criminal offence, over half had alcohol and/or drug problems, and they were more likely than the parents of any other profile to physically abuse their child (66.7%). Almost three quarters of these YSH had experienced emotional abuse from people within their families, and half had witnessed domestic violence. While one third of these youth had lived for extended periods without their mother, this group was the least likely to be living with extended family. Almost 70 percent of the fathers of these youth had been absent from their child's life, and it may be that parents were absent during periods of prison incarceration. However, Hostile Versatile YSH had a higher rate of parental death (15.9%) than any other youth, and this may have accounted for some parental absenteeism. Additionally,

approximately half of these YSH had a history of removal from home and many were in statutory care at the time of their referral for specialist treatment. It would appear CYFs were aware of the problems and safety issues for these youth and had attempted to intervene.

Many of the youth in this profile were seen as dishonest and impulsive, and they were more controlling in relationships than YSH in other profiles. Interestingly, as a cohort these YSH were the least socially isolated of any profile and they displayed more self-confidence than other youth. Very few of these YSH were depressed or anxious and they appeared to be the healthiest profile, with few medical problems. They did have the second highest rate of learning problems, behind the Trauma Reactive YSH but the inter-relationship of behavioural problems and an abusive home life indicated these YSH were experiencing academic difficulties as a result of entrenched antisocial attitudes and beliefs leading to conduct disordered behaviour, resulting in multiple school suspensions. A chaotic, violent home where parents may be permissive and preoccupied is suggestive of poor academic outcomes for these YSH.

The role modeling of antisocial attitudes and behaviours by parents also had a relationship with the degree of concern or empathy Hostile Versatile YSH displayed. Just over half showed little remorse for the sexually harmful behaviour and they were the profile most likely to have multiple victims, male or female. Their sexually harmful behaviour was of a long duration (*m* = 18.1 months) and statutory agencies or their families were aware they had sexually harmed long before a referral for specialist treatment was actioned. These YSH were also more likely than others to sexually harm a peer or older person. Given these YSH were also the most likely to have committed general and violent offences this evidences early criminal versatility, and assessments need to highlight the inter-relationship between parental criminal

behaviour, physical and emotional victimisation, antisocial behaviour, educational problems and versatile offending. For some YSH sexual offending may be only one of the ways they perpetrate criminal behaviour.

## Controlling Entitled YSH

Fifty two clients (27.8%) in this study, with an average age of 14 years seven months (*SD* = 1 year 11 months), were classified as Controlling Entitled YSH. On the sexual deviance/delinquency theme fewer of these youth were seen as having attachment difficulties than youth in other profiles and few displayed behaviour problems which might bring them to the attention of school authorities. While some did display behavioural problems these were likely to occur at home. As a cohort these clients were the least likely to have committed a property offence, very few had alcohol and/or drug problems and, along with the Trauma Reactive YSH, these clients were the most likely to be regularly attending school.

Few clients in this profile were viewed as having a sexual interest in children or were reported to harbour deviant sexual interests. The criteria for coding the latter characteristic present was that the client must be viewed as endorsing sexual acts with non-consenting people. Interestingly the Controlling Entitled YSH had the highest rate of sexual offences against children and more of them had paraphiliac interests (32.7%), which was a higher percentage than the other profiles, combined. Further, these youth had been sexually harming, on average, longer than any other profile (*m* = 24 months). For 40 percent of these youth, families and/or statutory agencies had been aware of their sexually harmful behaviour some two years prior to the YSH being referred for specialist assessment.

The Controlling Entitled YSH were the profile least likely to have been sexually abused by someone, either family or non-family. Approximately one third of them had experienced emotional and physical abuse, which was substantially lower than the Trauma Reactive or Hostile Versatile YSH. Half of these youth however, had lived in homes where domestic violence occurred and almost three quarters had not seen their father for long periods of their life. In addition one quarter of these youth had experienced periods when their mother was absent, and approximately one third had been neglected. This profile also had the second highest rate of maternal mental health problems. These experiences did not appear to negatively impact academic progress for most of these YSH, with most succeeding at school. Further, a negative family environment was not related to depression or anxiety for 86.5 percent of these youth, they were the profile least likely to experience chronic low mood, nor were they seen as the type of clients who were worriers.

The Controlling Entitled YSH were however, the most socially isolated (78.8%) and few had age appropriate social skills. More clients in this profile than any other displayed significant personality deficits across the seven personality characteristics used in this study. As a cohort they were more likely to be envious of others, behave dramatically, appear egocentric, and harbour a sense of injustice for perceived hurts. They had the second highest percentage of youth who were controlling and dishonest, just behind the Hostile Versatile YSH, but most of them (82.7%) had displayed little or no remorse for their sexually harmful behaviour, which was a far higher percentage than the Hostile Versatile YSH. While a negative family environment may not have affected many of these youth's mood or academic development

there appeared an inter-relationship between family violence and the development of serious personality problems for many in the profile.

The Controlling Entitled YSH were youth who possibly did not endear themselves to others. As a cohort they were socially inept and isolated, and many were the type of youth who tend to dominate verbal exchanges and wish to appear superior to others. They were likely to hold 'grudges' against others for perceived slights and these aspects of their personality might make them uncomfortable to be around. YSH with this profile were less likely than any others to show empathy for wrongdoings. These issues, coupled with long term sexual deviancy and few intellectual difficulties, mean many Controlled Entitled YSH might have the insight to know how to impression manage themselves during therapy. Assessments of YSH need to uncover and appreciate the potential relationship between family violence, problem personality characteristics, a lack of empathy, and long term sexually harming for YSH.

## Summary of Profile Interpretation

Classification using hierarchical cluster analysis of 187 YSH clients across 67 characteristics revealed the similarities of clients within profiles and demonstrated differences between each profile. Depressed Relationship Seeking YSH were youth who displayed few behavioural or academic problems, nor had many of them experienced serious abuse or lived in dysfunctional homes. However, the majority of these youngsters had clinical levels of depression and they were highly anxious. Being bullied and socially isolated had negatively impacted their self confidence and it is hypothesised these YSH experienced intense feelings of emotional loneliness.

Trauma Reactive YSH had experienced multiple types of abuse, however, in contrast to the Hostile Versatile YSH who also experienced severe physical abuse and high rates of exposure to domestic violence. Higher rates of sexual abuse, a higher rate of familial sexual abuse and living in homes where sexually inappropriate material was common was related to many having trauma related experiences (PTSD, self-harm).

Hostile Versatile YSH had lived in homes where violence and criminal offending was commonplace. These youth would have learnt early on that aggressiveness towards others was not only acceptable, it was normal. In order to protect themselves from perceived threats, these youth acted in hostile and antisocial ways. It was believed as a cohort these youth had good self-esteem and this may have been so, yet the veneer of a cocky attitude and nonchalance may hide an unhappiness and anger towards those who have hurt them.

Controlling Entitled YSH were youngsters who probably believed that the 'world owed them.' Many were narcissistic, forceful and jealous. As a cohort, these youth had experienced less dysfunction and abuse than either, the Traumatic Reactive and Hostile Versatile YSH, yet these youth had displayed behaviours and cognitions which indicated they harboured intense feelings of rage towards others. Exploiting others to achieve their needs appeared commonplace for many of these YSH, leading to social isolation and few peer-aged relationships.

The description offered for these profiles was developed from the results of the data analysis. Clearly not all clients presented with exactly the same life experiences or characteristics. However, the interpretation advanced was representative of each profile, and offered a way of discussing within population diversity. The purpose of this study was to

explore the possibility of developing a typology of YSH using a large number of problem characteristics. The results suggest the diversity in this sample of New Zealand YSH was able to be highlighted by cluster analysis. This has clinical and practical implications and paves the way to discuss the possibility of whether different types of assessment and treatment are required for different profiles of YSH.

# Chapter 8

## *Assessment and Treatment Considerations*

Chapter three outlined the usual procedures taken by specialist clinicians to assess YSH. Assessments typically take the form of interviews, reviews of past social work, school and psychological reports, reviews of police statements and the administration of psychometrics. In addition, most YSH referred to New Zealand community specialist sexual offending programmes in the past five years have been risk assessed using the ERASOR, with a risk level detailed within reports. Data gathered during assessments is collated into an assessment report which is used to highlight strengths and needs of clients. Referrers, the YSH and their families are appraised of the report's contents and recommendations. As discussed in Chapter three, often assessments can take considerable time to complete and are costly for agencies.

Specialist community sex offender programmes have been operating in New Zealand for approximately 15 years. During that period, management of the programmes has invested in staff training and there has been a consistent commitment to improving the delivery of service to YSH. This has taken the form of independent clinical auditing of programme components and outcomes, and internal programme development by senior staff. New procedures have been introduced regularly over the past five years in response to perceived needs of YSH.

A recent audit of the efficacy of New Zealand YSH programmes, which used data from the same agencies from which this researcher collected data, indicated interventions were effective at reducing the risk of future sexual harming (Lambie & Geary, 2007). However, 38

percent of clients who were seen as successfully completing treatment went on to re-offend generally and/or violently. Further, 61 percent of clients who did not complete treatment re-offended generally or violently, and 10 percent committed a subsequent criminally adjudicated sexual crime.

The outcomes of the Lambie and Geary audit indicate that the assessment methods and interventions being used with young sexual harmers have not been successful in ameliorating the multiplicity of problems experienced by YSH. Without appropriate assessment methods, clinicians are at risk of not appreciating the inter-relationship of problem factors, and therefore the development of formulations for clients may be inadequate. Without adequate formulations it may be very difficult to advocate for appropriate resources from referrers so clinicians can introduce treatments that target the multiple life difficulties of YSH.

The current study has suggested four profiles of YSH. The use of a large characteristic set enabled a description of clients within profiles, and problem characteristics which were prominent in each profile signpost the differing treatment needs of clients. As has been stated, in order for YSH typology results to have clinical utility, a researcher must go beyond merely interpreting profiles of YSH. Clinicians must be able to use assessment methods that classify YSH so as to: (1) clearly inform assessment reports; (2) provide evidence to referrers and funders the level and type of resources required to help the YSH; (3) inform clinicians of the issues that would require therapeutic focus in treatment.

The current study's results meant that a novel approach to assessing YSH can be discussed. In addition, the presenting life problems and characteristics seen for clients across the four profiles of YSH in this study indicate each profile requires differing treatment

strategies. Suggestions for treatment for specific profiles follows the assessment discussion, these are based on a review of efficacy studies of therapy models, and are related to the inter-relationship of problem characteristics described in Chapter 7 for each profile.

## Assessment Instrument for Sexual Harming Youth

It is intended that a new assessment instrument could be used by specialist clinicians to assess clients who had already sexually harmed, and who had been referred for specialist treatment. While not intended to entirely take the place of current assessment methods such an instrument may reduce the amount of time it takes to complete an assessment. This would occur primarily because fewer psychometric measures would be required, and interpretation of gathered information could be expedited because clients could be classified into profiles. Client, family and professionals would be interviewed and the instrument used as a checklist to highlight the presence or absence of problem characteristics and life experiences. The characteristic set used in this study appears to be able to classify clients appropriately and perhaps after further investigation, clinical trials and amendments, it could be used in the proposed assessment instrument. The primary clinical use of a new assessment instrument would be for treatment planning and as a reassessment tool throughout treatment to ascertain whether problem characteristics were being appropriately targeted. A reduction in 'present' characteristics would indicate treatment was improving the strength base of the client and their family, thereby reducing their risk of re-offending.

Risk assessment for future sexual harming for YSH was not focused upon in this study, nor is it intended that a new assessment instrument be utilised to assess risk of sexual recidivism. Few characteristics have been validated as risk factors for future youth sexual

harming (Worling & Langstrom, 2002). Further, the offence data coded for this study indicated little difference in the types of offences committed by YSH across profiles. It would seem that the majority of YSH are not preferential sexual offenders, some may never sexually harm again and others may, but it is unlikely that checklists such as the ERASOR would be able to determine the identity of those who were most susceptible.

There is no doubt that many YSH are at risk, but the question must be: what are they at risk from? Current risk assessment tools for YSH have been unable to answer that question. The results of a new assessment instrument may instead emphasise vulnerabilities, and it is multiple vulnerabilities which place a young person at risk for a host of future life problems.

## Profile Specific Treatment for YSH

Each of the four profiles classified in this study was found to have varying protective factors and vulnerabilities. The results suggest differing treatment needs and this researcher reviewed the efficacy of different types of psychotherapeutic interventions to promote discussion about the types of treatment components that may be beneficial for different profiles of YSH.

### Depressed Relationship Seeking YSH

Anxiety relates to fears about future events. For young people between the ages of eight and 18, research has shown these fears typically revolve around peer rejection and ridicule, and academic and sporting failure (Ollendick, King & Yule, 1994; Ost & Treffers, 2001; Westenberg, Siebelink & Treffers, 2001). Maladaptive fears involve inaccurate appraisals of potential threats, which can lead to adjustment difficulties and the use of avoidance strategies (Carr, 2006). These difficulties may be maintained by reinforcements. Parents of anxious youth

may themselves be anxious, and research has indicated these parents are more likely to have low self-esteem, poor coping strategies, and their interactions tend be problem and threat focused (Carr, 2006). YSH living in such environments may perceive the world as a dangerous place and use avoidance to lessen the threat of social rejection and ridicule.

Depressive symptoms manifest in youth as negative thoughts of themselves and the world. Youth may find it difficult to concentrate, and they may be irritable and harbour excessive, but ill-defined, guilt. Typically this can lead to a deterioration in family relationships, withdrawal from peers and poor performance in a range of activities (Achenbach & Rescorla, 2000; Weersing & Brent, 2003), all of which may exacerbate the youth's anxiety and depressed mood.

Focusing on ameliorating the negative impacts of excessive anxiety and chronic low mood would improve Depressed Relationship Seeking YSH perception of themselves, others and their future. This in turn would lead to greater social involvement and positive peer interactions. Adaptive cognitive and emotional changes would allow for a realistic re-appraisal of their beliefs about sex, and sexual education would offer these youngsters a model of appropriate psychosexual development. Family therapy with parents of these youth would have the goal of altering problem focused communications and improving social skills for all family members.

Depressed Relationship Seeking YSH may not require long term interventions. Research has indicated positive treatment outcomes for anxiety and depressive symptoms can be achieved in approximately 12 to 18 one-hour sessions (Lambert, 2004). These youth typically lived in reasonably well functioning homes and they displayed more remorse for their

sexualised behaviour than any other youth. Unless family relationships had deteriorated markedly since the sexually harmful behaviour had been committed and parents were unwilling to care for their child, then it would be disadvantageous to remove these children from their homes. One of the primary goals of treatment with these youth would be greater social involvement and an improvement in family relationships – to place these youth elsewhere would render that goal difficult to achieve.

**Trauma Reactive YSH**

Chronic and severe abuse, be it physical, sexual or emotional causes short and long term physical and psychological consequences, including scarring, neurobiological damage, visual and auditory problems, learning difficulties, attachment problems, and failures of growth (Carr, 2006).

Young people may develop negative self beliefs, fail to develop cognitive competencies, have difficulty with effective regulation and have excessive internalising and externalising behaviour problems (Cicchetti, 2004; Kolko, 2002). When homes are chaotic and unsafe, with parents exhibiting serious psychological and behavioural problems, children are at risk of developing anxious-avoidant or disorganised attachments, this can lead to later difficulties forming and maintaining relationships (Marshall et al., 1993)

Emotional abuse may take the form of persistent negative misattributions to the child, emotional unavailability of parents – or parents using children to meet their emotional needs, deviant socialisation and frequent attitudinal corruption by parents (Carr, 2006). Sexual abuse when perpetrated within the family transmits misconceptions about normal sexual behaviour and morality to a child (Burton et al., 2002). The violation of trust and lack of parental

protection may cause young people to feel powerless and ineffective. Over time the stressors experienced can lead to complex PTSD, self-harm, suicide attempts and social withdrawal (Burton et al., 2002).

Many children living with families who exhibit these problems have also experienced multiple out-of-home placements. While placement is utilised in an attempt to keep young people safe, these children are not usually able to easily integrate into a new family, because of early disrupted attachment. As such, they are likely to exhibit behaviours in placement which cause tension and interpersonal problems. Multiple placements can ensue with young people 'bouncing' from caregiver, to CYFs family home, back to biological parents, and then, when re-abuse occurs, the 'round' of placements begins again. This process is all too common with children such as the Trauma Reactive YSH. And because early sexualisation has imbued them with inappropriate sexual schema, these youth may be more likely to sexually harm vulnerable people during periods of placements and upon return to home. Sexual behaviour and the pleasure gained from arousal and orgasm may be one of the few ways these youngsters can soothe themselves, and because primary relationships in their lives have been sexualized, these YSH may believe it is a legitimate way to show love.

The interventions required for these YSH are considerable and multi-layered. The stability of a placement is paramount if any treatment is to be beneficial. All too often YSH with these profiles change placements during treatment and, because of their attachment difficulties and sexualised behaviour, it is difficult for CYFs to find appropriate caregivers. The geographical movements, sometimes long distances, and school changes, can only add to feelings of displacement and isolation. In this researcher's experience, secure long term

placements outside of these children's families do not eventuate for most Trauma Reactive YSH. The statutory and specialist community agency resources which are spent finding and training caregivers for these YSH, monitoring the placement, meeting with the caregivers regularly, and working with schools, may be money not well spent.

While a radical departure from current CYFs care and protection practices, it may be more beneficial for Trauma Reactive YSH, their families, and society, if CYFs were able to place specialist family mentors within the home for an extended period. The benefits of this type of intervention are: (1) Keeping families together would lessen the trauma for children and parents when children are removed; (2) Youth remain in the same school, which improves the possibility that specialist educational help would be beneficial, and allows youngsters the possibility of maintaining contact with friends, joining sports teams and participating fully in school activities safe in the knowledge that they would not be moved on; (3) Specialist family mentors would be able to help families develop routines, improve healthy living standards, help with budgeting, and model appropriate child-parent interactions; (4) Specialist family mentors could advocate and support parents to access community resources; (5) The constant presence of the specialist family mentor would be a highly protective factor for children and vulnerable people within the home; (6) Specialist family mentors would support specialist clinicians by ensuring the young person and their family attended therapy sessions – on occasion parents or caregivers have not brought their child to therapy simply because they did not have access to a vehicle or they had no money to put fuel in a car; these are simple difficulties to overcome, yet often families may feel ashamed and unwilling to discuss the

stressors they are experiencing, and having a specialist family mentor would allow them access to their own support person.

Clearly there would be obstacles to using this type of intervention; the financial burden to CYFs, recruitment, training and retention of specialist family mentors, and the size of homes may make introducing a new live-in person difficult, families may be highly resistant to the intrusive nature of the intervention and some professionals may believe this type of intervention compromises the privacy of individuals. Yet even though these difficulties and arguments might ensue, New Zealand must look at novel ways to help these family's lives and protect vulnerable youth.

Treatment with Trauma Reactive YSH and their families may be very intensive at the outset, with multiple sessions each week for the first two months. The Good Way, (Ayland & West, 2006) a narrative model of treatment that appears efficacious with clients who present with cognitive deficits and multiple difficulties is likely the best treatment option for Trauma Reactive YSH. Over time, session frequency could be reduced as autonomy for healthy family functioning is incrementally returned to parents. These families may require support for a long period, however.

**Hostile Versatile YSH**

Young people with this type of profile, but perhaps without the accompanying sexualised behaviour, are over-represented in referrals to clinical services (Burke, Loeber & Birmaher, 2002; Winters & Zera, 2000). Further, conduct disorder behaviours and attitudes are extremely unresponsive to treatment, with 60 percent of conduct disordered youth showing few or no behavioural or attitudinal changes in the long term (Carr, 2006).

These youth have significant difficulties regulating their emotional responses, and often display aggression and defiance when they perceive situations or people as challenging. This hostile attribution bias creates a situation where they have few social experiences in which to learn appropriate social skills. They have poor problem solving skills and are often too impulsive to implement non-aggressive solutions to problems. Attempts by families to discipline these youth are typically punitive or permissive, and parents are more likely to lack positive communication skills. There are likely to be poor intergenerational boundaries in the home with these youth often required to step into a parental role and look after the home and younger siblings. Parents may be absent, working or socialising, none of which allow for the monitoring of their children's behaviour.

Parental pathology is a significant impediment to successful treatment for YSH in this profile. Parents who are willing to enter treatment would need long term social support, education and therapy. This would include support to access community resources, help to increase pro-social networks, access to parenting programmes and family therapy. If parents are unwilling or unavailable to take an active part in the treatment these youth are likely to drop out of therapy, or make few positive changes. Social interventions and family therapy are required. Clearly, many of the youth in the profile live in highly dysfunctional and often violent homes. If parental agreement to enter therapy could not be obtained, this profile of youngsters may be best treated in a residential environment. The nature of such an environment, with close monitoring and modeling of acceptable behaviours would decrease antisocial behaviour and allow for the learning of pro-social skills.

Hostile Versatile YSH may be very challenging young people to work with and a multi-disciplinary team approach is required to decrease the likelihood of worker burn-out and increase supports for the family and young person. Interventions such as those described need long term financial resourcing and a consistent effort on the part of CYFs to support and acknowledge the specialist professionals involved.

**Controlling Entitled YSH**

Problematic personality traits can cause inter-personal difficulties and tend to isolate individuals from forming and maintaining healthy relationships. These traits consist of long-standing, inflexible, maladaptive inner experiences and behaviours that impair functioning (Neal, Davison & Haaga, 1996). Personality is a complex function of biological heritage, environmental experience, and how people perceive, process, and remember that heritage and experience (Phares & Chaplin, 1997). Problematic personality traits are therefore likely to develop in individuals at a relatively young age, and their continued presentation may be more likely if their primary environment supports or rewards their existence. Individuals with personality traits such as the Controlling Entitled YSH may be classified under the Dramatic/Emotional Cluster of personality disorders with the Diagnostic and Statistical Manual of Mental Disorders, fourth edition, revised text (APA, 2001).

While personality inventories have been used to develop typologies for YSH, little has been written about how to change negative personality patterns (Burton, 2008; Hunter, et al., 2003; Oxnam & Vess, 2008; Richardson et al., 2004; Worling, 2001). Only a tentative treatment solution can be advanced at this time. It would seem that, if their harmful sexual behaviour is maintained by the pleasure these YSH get from overpowering more vulnerable individuals and

that Controlling Entitled YSH do not care about the harm they cause others, then teaching them the concept of empathy is a futile undertaking.

Instead, clinicians need to understand the high 'value' these youth place upon feeling powerful and in control. Once clinicians know and accept the values these YSH have, they will be better placed to develop an experiential intervention. Cognitive-behavioural therapy alone is unlikely to change these YSH values and any challenge to their beliefs and attitudes is likely to be met with obstinate non-compliance and therapy drop-out. It is this researcher's tentative opinion that only through 'doing' and 'feeling' will this profile of youngsters change their beliefs and behaviour. If interventions can be organised in such a way that the YSH feels a measure of control in the way therapy is undertaken, and they believe their opinions are valued, they are likely to remain engaged.

Ronningstam (2010) reports that internal control is a psychological function that serves to maintain an inner sense of mastery, cohesiveness, power and self-sufficiency. Individuals with personality traits similar to the Controlling Entitled YSH fear loss of control, which is central to self-esteem regulation, tolerance of negative affect states, and the ability to manage interpersonal relationships. Closely related to internal control is self-disregulation and the associated states ranging from experiencing grandiose perfectionism to those of inferiority, insecurity, and worthlessness. Vulnerability and fluctuations in self-esteem cause intense fears of being perceived as incompetent, which the person attempts to overcome by overtly controlling their environment (Ronningstam, 2010).

Controlling Entitled YSH clients need to be shown pro-social ways to feel powerful. For example, if they feel powerful being kind to others they are more likely to act kindly; if they

gain a greater sense of accomplishment from helping others, they will help others. In short, this type of intervention would seek to use the instrumental needs being met by sexually harming, and change the behaviour of the Controlling Entitled YSH so these needs can be achieved without harming others.

This type of treatment is novel and untested with YSH, yet it would seem that healthy emotional attachment to others and feeling valued and powerful are not uncommon wishes for any human being. If these youngsters can be helped to feel important, and their pro-social skills develop, then their self-esteem should increase and their social isolation decrease. Given that three of the dynamic risk factors for adult sexual recidivism are poor social skills, social isolation and sexual deviancy this intervention may have benefits into the future.

## Summary

This chapter has advanced a suggestion for a complementary new assessment instrument to aid clinicians working with YSH. The types of characteristics which could be used in the instrument are based on the results of this study. If developed and utilised, this assessment instrument has the potential to decrease the amount of time clinicians spend gathering information, and improve understanding about the inter-relationship of problem factors so as to enhance clinical formulations. This information would inform clinicians and funders regarding the resources and types of intervention specific clients require.

The interventions offered for each profile of YSH have been a brief overview of the types of treatment strategies which may be beneficial. These were tabled after a careful review of therapeutic interventions for difficulties such as those experienced by the YSH in this study. Further research is required to explore the clinical applicability of the assessment

instrument and the profile specific treatment strategies suggested here. Future directions of such research and an overview of this study are detailed in the following discussion chapter.

# Chapter 9

## *Discussion*

The first two aims of this study were to explore how a large set of characteristics could be classified into a number of themes using hierarchical cluster analysis, and to explore how a sample of YSH could be classified into a number of profiles using hierarchical cluster analysis and to interpret the resulting profiles in terms of both, participant characteristics and the resulting themes. The third aim was to incorporate demographic and offence variables from individual YSH into profile descriptions to examine the relationship between profile membership and the types of offences profiles of YSH committed. The final aim of this study was to be able to discuss a new approach to assessing YSH, and suggest profile specific treatment components, based on the results of the emergent profiles uncovered in this study.

## Results

Hierarchical cluster analysis provided a method for allowing clinically meaningful clusters of characteristics and profiles of YSH to be determined. The frequencies with which characteristics were present or absent for this sample were similar to that other YSH research (Almond et al., 2006; Barbaree & Marshall, 2006; Blaske et al., 1989; Fyson, 2007; Hunter et al., 2003; Richardson, Kelly, Graham & Bhate, 1997; Ryan et al., 1996; Veneziano & Veneziano, 2002). The derived themes established a clinically meaningful framework within which to interpret the problem characteristics and strengths of YSH within profiles. The offence data collected from this sample, when examined within profiles, indicated trends for offending. It

seemed that the longer a YSH had been exhibiting sexually harmful behaviour the greater the likelihood of multiple victims, and for some, the greater the likelihood that more serious offences were committed. The longer a person spends engaging in a behaviour, for which there may be intrinsic rewards, the more likely that person is to continue with the behaviour. And if certain behaviours meet instrumental needs for the individual then cessation is unlikely to occur without external intervention. As stated the choice to, and motivation for, engaging in sexually harmful behaviour may be different for different types of clients. The results of this study seem to suggest different pathways (motivating factors and intrinsic needs) to offending, and different offence trajectories across the four profiles. Further exploration of this theory may offer valuable insights into determinates of sexual harming for youth populations. What is clear from these results is that the early identification and interpretation of the inter-relationship of problem characteristics present for this population would be very beneficial for referrers. This knowledge would enable them to identify the intervention needs of certain YSH and advocate for specialist treatment more successfully.

The outline for a new assessment instrument discussed in this thesis was developed as an outcome of the exploration of the themes and profiles found in this study. As discussed in chapter three, current assessments with YSH are typically costly and time consuming. It is intended that should the assessment instrument outlined in this study be developed into a practical measure which could be utilised to enhance the assessment YSH, then those issues may be negated. Further, the results of this study indicate the outcomes of this type of assessment may increase the likelihood of understanding important treatment target factors as they relate to other factors. As discussed, the profiles of YSH determined in this study appear

to have differing treatment needs and a reduction of all types of offending is possible if interventions target the inter-related difficulties each profile of YSH presents with.

The concerns raised in this thesis regarding the assessment processes currently used in New Zealand are not about the quality of the data collected during assessments – it is about how that data is used. Because it seems that only cursory attention is given, by clinicians, to interpreting the interrelationship of the characteristics, life experiences and personality traits that are found to be present for clients. Without a valid method for enabling an interpretation of the large amounts of data collected, clinicians are less likely to develop appropriate treatment plans. Further, without an understanding of primary treatment target factors for specific profiles of YSH, specialist agencies are unable to advocate for appropriate funding and resources with which to successfully treat these youth.

In this researcher's clinical experience the results of lengthy psychometric testing or the results of an ERASOR are reported in the YSH initial assessment report, along with other data collected. However, the formulations offered in specialist assessment reports do not adequately integrate the discrete data obtained, with summaries consisting of equivocal statements. The recommendations, as a consequence, are often generalised requests for the youth to 'be referred for specialist treatment'. This type of report does not allow for funders or referrers to adequately assess the resource requirements of the YSH; and even if the required resources are clearly established, the specialist agencies in New Zealand are unable to advocate for this funding, because they do not have an assessment instrument which can highlight the inter-relationship of problems factors – validated with a New Zealand sample of YSH.

It may be money and time not well spent to continue to use psychometrics that either measure only specific constructs, or that do not highlight treatment target factors. Currently the array of collected assessment data does not appear to translate into individualised treatment plans. Typically YSH in New Zealand receive CBT based individual therapy, with some also receiving group therapy. The only alternate model currently being used is the Good Way which has not been clinically validated as efficacious for this population. Further, while efforts have been made to train clinicians to use the model, most clinicians, in this researcher's experience, tend to utilise the narrative, dichotomous principles of the model with YSH who have intellectual difficulties. However, in this study YSH with intellectual difficulties were present in three of the four profiles, and those difficulties were not the primary problems these youth experienced.

## Limitations

The data collected for this study were not originally gathered for the purposes of research. As such clinicians undertaking the original assessments may not have asked questions that would have highlighted all the characteristics used in this study. Further, the quality of clinician's recordings of problem characteristics may have differed between clinicians – so some files may have contained robust information which clearly alerted the coders that a problem characteristic was present, whereas some files may not. In addition, no female YSH data was collected, and future research with a female sample may generate different themes, with gender specific profiles the outcome. Further, the characteristics used in this study did not capture all the factors which would have improved understanding of the Controlling Entitled YSH.

## Directions for Future Research

The results of this study encourage further research and signal the method and characteristics used do have the potential to increase the efficacy of assessment and treatment for YSH. Future research with comparison populations, such as youth who offend generally or violently, those referred to community mental health services, and youth in a general population would enable an examination of the degree to which certain characteristics might be present in those populations. This has implications for understanding how YSH may differ from other youth and may also highlight which characteristics and life experiences are deleterious for all young people.

Using the current study's method and characteristics with other samples of YSH would allow an exploration of the similarity of emergent profiles and determine how YSH from different countries and cultures may differ from New Zealand YSH. The method employed in this study allows for relatively quick data collection and this means additional research would not be overly difficult or costly to undertake.

During the analysis of this study's data no attempt was made to decrease the number of characteristics used, apart from those present at rates of less than 10 percent. Further investigation of the stability of these results, in terms of themes and profile membership, without some of the characteristics is required. It may be that similar results can be achieved without some characteristics and this would be beneficial for the development of an assessment instrument. If less data is required to determine an accurate formulation for a client this means fewer resources and less time may be required to complete assessments. Caution would be required however, because the complexity of the inter-relationship of

characteristics and the interpretative expertise needed to accurately assess these youth should not be undermined.

Future development and research with this characteristic list so that it could be used as an assessment instrument is a goal for this researcher. Subsequent to this research clinical trials of its usefulness could be undertaken within specialist agencies. In addition, further research of treatment components which may be beneficial for different profiles of YSH may enable clinical trials.

## Conclusions

The results of this research, and specifically the breadth of characteristics and the method used to analysis the data, does enhance knowledge and understanding of YSH. The information available with which to develop this typology was more comprehensive than any other typology research has attempted thus far. The description of client profiles which emerged from within the typology appear clinically similar in presentation to YSH clients. These outcomes have the potential to reinvigorate discussion about the population – how they are identified, described, assessed and treated.

Youth sexual harming is clearly a major problem with legal, social and public health safety ramifications. Effective assessment and treatment methods are vitally important. In 2002 Veneziano and Veneziano reported there were no validated classifications of youth sexual harmers. In the ensuing eight years none have emerged. It is hoped the results of this study encourage researchers and clinicians that a valid typology is possible and that a more effective way of assessing and treating YSH can be achieved when within profile similarities are discerned.

# Appendices

1. Kappa agreements of 66 characteristics, within seven themes
2. Phi-4 correlation matrix for 67 characteristics
3. Characteristic Dendrogram
4. Client Dendrogram
5. Characteristic percentages for each profile

# Appendix 1 – Kappa Agreements for 66 Characteristics

| | |
|---|---|
| **Sexual Deviancy/Delinquency** | |
| Attachment difficulties | 1.00 |
| Inappropriate sex boundaries home | 1.00 |
| Consenting sexual experience | 0.87 |
| Deviant sexual interests | 0.75 |
| Sexual interest in children | 0.71 |
| Fire | 0.92 |
| Previous offence against person | 0.83 |
| Alcohol/drug problem | 0.84 |
| Behaviour problems school | 1.00 |
| Exposure to sexual material home | 0.86 |
| History school suspension | 0.84 |
| Conduct disorder | 0.83 |
| Behaviour problems home | 1.00 |
| Viewing adult pornography | 0.85 |
| Antisocial | 0.90 |
| Perpetrator of bullying | 0.89 |
| Previous offence against property | 0.81 |
| Not in school/training | 0.84 |
| **Neglect & Trauma** | |
| In care at assessment | 0.94 |
| History of removal from home | 0.94 |
| Absent mother | 0.88 |
| Victim of neglect | 0.95 |
| Death of parent/caregiver | 0.83 |
| PTSD | 1.00 |
| History of self-harm | 0.72 |
| Victim sexual abuse non-family | 1.00 |
| Prior sex offence undisclosed | 0.94 |
| Victim emotional abuse non-family | 0.91 |
| **Sexual Abuse/Family Mental Health** | |
| History sexual abuse in family | 0.83 |
| Maternal psychiatric problems | 1.00 |
| Speech/hearing problems | -0.03 |
| Paternal psychiatric problems | 1.00 |
| Victim sexual abuse family | 0.92 |
| **Mood Disregulation** | |
| Anxiety | 0.63 |
| Depression | 0.65 |

| | |
|---|---|
| **Personality & Social Deficits** | |
| Envious personality | 0.94 |
| Dramatic personality | 0.74 |
| Social isolation | 0.56 |
| Prior sex offence known to family/CYFs | 0.80 |
| Dishonest | 0.90 |
| Lacks appropriate remorse | 0.50 |
| Lacks social skills | 0.53 |
| Impulsive | 0.44 |
| Victim of bullying | 0.80 |
| Harbours feeling of injustice | 0.85 |
| Animal cruelty | 1.00 |
| Prior sex offence (generic therapy) | 0.93 |
| Egocentric | 0.80 |
| Controlling | 0.70 |
| **Developmental Difficulties** | |
| Reading difficulties | 1.00 |
| Mathematics difficulties | 0.88 |
| Writing (spelling) difficulties | 0.80 |
| Diagnosed learning disorder | 1.00 |
| Low self-esteem | 0.67 |
| Family isolation | 0.79 |
| Paraphiliac behaviour | 0.75 |
| ADHD | 1.00 |
| Oppositional defiant disorder | 0.48 |
| Chronic medical problems | 0.79 |
| TBI (mild/moderate) | n/a |
| **Family Aggression & Abuse** | |
| Parental criminal offending | 0.93 |
| Living with extended family | 1.00 |
| Victim physical abuse family | 0.90 |
| Victim emotional abuse family | 0.75 |
| Exposed to domestic violence | 0.71 |
| Family alcohol/drug problems | 0.95 |
| Absent father | 0.89 |

## Appendix 2 – Phi4-point Correlation Matrix

## Appendix 3 – Characteristic Dendrogram

## Appendix 4 – Client Dendrogram

## Appendix 5 – Characteristic Percentages for Each Profile

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