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Evaluation of the Good Way Model

**A Treatment Approach for Young People
with Harmful Sexual Behaviour**

Victoria Weedon

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**Massey University
Auckland
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ABSTRACT

Adolescents with harmful sexual behaviour (HSB) have been identified as perpetrating a significant amount of child sexual abuse, and while treatment programmes have become more available, evaluation studies of these have lagged far behind. The primary aim of the research reported in this thesis was to evaluate the effectiveness of the Good Way model (GWM) intervention developed by Ayland and West (2006) for adolescent boys undergoing treatment for HSB. The GWM is advanced as a strengths-based cognitive behavioural approach which meets recommended key programme priorities for the treatment of youth with HSB. This study examined the effectiveness of the GWM within two community-based treatment programmes in New Zealand: WellStop, which is based in Wellington; and STOP, which is based in Christchurch. The participants were 12 male youths aged between 11 and 17 years and their families. Five participants were intellectually disabled. The study was carried out over a three-year period and by the end of the study, nine participants had completed treatment, two remained in treatment, and one had dropped out due to the impact of unstable placements. The average treatment length was 7.5 months. Treatment effectiveness was examined within a multiple-baseline design framework. In this study the magnitude of experimental change was largely established via visual analysis, the percentage of data points exceeding the median (PEM), and Cohen's *d*. The results imply a functional relationship between GWM treatment and the reduction of HSB and an increase in positively occurring behaviours related to strengths and resiliency. Positive results were obtained from measures focusing on outcome and therapeutic alliance. There was also evidence for change in individual participants across measures of internalising-type problems. Overall, the findings indicate that the introduction of the GWM intervention targeted the problem behaviour appropriately and that it was well received by participants.

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TABLE OF CONTENTS

ABSTRACT.....	iii
ACKNOWLEDGEMENTS.....	v
TABLE OF CONTENTS.....	vii
LIST OF FIGURES.....	ix
LIST OF TABLES.....	x
Chapter 1 Introduction.....	1
1.1 Statement of the Problem.....	1
1.2 Community-based Treatment in New Zealand.....	2
1.3 Background to the Study.....	3
1.4 Structure of the Thesis.....	3
Chapter 2 Child Sexual Abuse.....	5
2.1 Defining Harmful Sexual Behaviour.....	5
2.2 Prevalence.....	6
2.3 Underreporting.....	6
2.4 CSA Impacts.....	7
2.5 Summary.....	8
Chapter 3 Adolescents with Harmful Sexual Behaviour.....	9
3.1 Prevalence.....	9
3.2 Offence Characteristics.....	12
3.3 Individual Characteristics.....	13
3.4 Contextual Factors.....	15
3.5 Coexisting Problem Behaviours.....	16
3.6 Risk and Protective Factors.....	19
3.7 Typologies.....	20
3.8 Summary.....	21
Chapter 4 Causes of Harmful Sexual Behaviour by Adolescents.....	23
4.1 Pathway Theories of HSB.....	23
4.2 Theoretical Underpinnings of the GWM	25
4.3 Rehabilitation Theories.....	25
4.4 Integrated Theory of Sexual Offending.....	26
4.5 The Role of the Cognitive Perspective.....	29
4.6 The Role of Social Learning.....	29
4.7 The Role of Family Systems.....	31
4.8 The Role of Developmental Factors.....	31
4.9 Summary.....	33
Chapter 5 Treatment.....	34
5.1 Measuring Treatment Effectiveness.....	34
5.2 Early Treatment Approaches.....	36
5.3 Cognitive Behavioural Approaches.....	37
5.4 Systemically based Approaches.....	39
5.5 Neuropsychological Approaches.....	40
5.6 Integrated Approaches.....	40
5.7 Adaptations to Treatment Programmes for ID Youth.....	42
5.8 New Zealand Treatment Outcomes.....	45

5.9	Summary.....	49
Chapter 6 The Good Way Model.....		51
6.1	The Development of the Good Way Model.....	51
6.2	Intervention Premise.....	52
6.3	Language, Concepts and Support Material.....	53
6.4	Intervention Framework and Process.....	55
Chapter 7 The Current Study.....		60
7.1	Aims.....	60
7.2	Research Questions.....	60
7.3	Rationale for the Current Research.....	60
7.4	Evaluating Interventions in Real-world Settings.....	62
7.5	Evaluating the Effectiveness of Treatment for Youth.....	63
7.6	Manualised Treatment.....	64
7.7	Summary.....	65
Chapter 8 Methods.....		67
8.1	Participants Characteristics.....	67
8.2	Measures.....	69
8.3	Procedure.....	77
8.4	Ethical Considerations.....	84
8.5	Research Design.....	86
8.6	Data Analysis Strategy.....	88
8.7	Summary.....	91
Chapter 9 Results.....		92
9.1	Sexual Behaviours.....	92
9.2	Change to Concurrent Behaviours.....	99
9.3	Trauma Symptomology.....	109
9.4	Strengths and Resiliency.....	112
9.5	Outcome and Therapeutic Relationship.....	115
9.6	Summary of Results.....	119
Chapter 10 Discussion.....		120
10.1	Summary of Major Findings.....	120
10.2	Research Questions.....	121
10.3	Interpretation of Findings.....	124
10.4	Implications of Findings.....	127
10.5	Strengths and Limitations.....	130
10.6	Future Research.....	133
10.7	Conclusion.....	135
REFERENCES.....		136
APPENDICES.....		175
Appendix 1 Integrity Checklist.....		176
Appendix 2 Child Sexual Behaviour Inventory Results.....		177
Appendix 3 ACSBI – Self Report Results.....		178
Appendix 4 ACSBI – Caregiver Results.....		179
Appendix 5 Parent/Caregiver CBCL Results.....		180
Appendix 6 YSR Child Behaviour Measure Results.....		181
Appendix 7 Resiliency Scales for Children and Adolescents Results.....		182
Appendix 8 4-D Results.....		183

LIST OF FIGURES

Figure 4.1	The integrated theory of sexual offending	28
Figure 6.1	Possible areas which are the focus of therapeutic conversations.....	54
Figure 6.2	Example of a visual template.....	55
Figure 6.3	Treatment components of the GWM	56
Figure 6.4	The enriched version of the basic Good Way model.....	58
Figure 8.1	Study participants.....	67
Figure 9.1	Results of the ERASOR total score (static and dynamic factors) on modified Brinley plots across four conditions.....	93
Figure 9.2	Results of the ERASOR dynamic factors on modified Brinley plots across four conditions	93
Figure 9.3	Modified Brinley plots showing group data for the CSBI initial assessment score (x-axis) and phases of the intervention (y-axis).. ..	96
Figure 9.4	Modified Brinley plots showing group data for the ACSBI – Self-Report across initial assessment scores (x-axis) and phases of the intervention (y-axis)	97
Figure 9.5	Modified Brinley plots showing group data for the ACSBI – Parent Report across initial assessment scores (x-axis) and phases of the intervention (y-axis).....	98
Figure 9.6	Modified Brinley plots showing group data for the CBCL across initial assessment scores (x-axis) and phases of the intervention (y-axis).....	99
Figure 9.7	Modified Brinley plots showing group data for the YSR across initial assessment scores (x-axis) and phases of the intervention (y-axis). 102	
Figure 9.8	Changes in positive and negative behaviours across baseline (B) and treatment (T) phases for each participant.....	104
Figure 9.9	Modified Brinley plots showing group data for the RSCA initial assessment scores (x-axis) and phases of the intervention (y-axis)...	112
Figure 9.10	Individual participant results for ORS and SRS (P1, P2, P4, P5 and P7).....	117
Figure 9.11	Individual participant results for ORS and SRS (P8, P10 and P11).....	118
Figure 9.12	Individual participant results for ORS and SRS (P3, P6 and P9).....	118

LIST OF TABLES

Table 8.1	Participant characteristics, history and circumstances at assessment.	68
Table 8.2	Participant assessment and treatment information.....	81
Table 8.3	Frequency of measures throughout baseline, treatment and follow-up phases.....	84
Table 9.1	ERASOR results across data collection points.....	94
Table 9.2	Changes in level of reported positive behaviours (average for each participant) across baseline and treatment phases.....	107
Table 9.3	Changes in levels of reported negative behaviours (average for each participant) across baseline and treatment phases.....	107
Table 9.4	PEM scores for each participant.....	108
Table 9.5	TSCC scores across data collection points.....	103
Table 9.6	CASPARS results across data collection points.....	113
Table 9.7	Changes in level of reported ORS (average for each participant) during the treatment phases.....	116
Table 9.8	Changes in level of reported SRS (average for each participant) during the treatment phases	116

Chapter 1: Introduction

1.1 Statement of the Problem

Child sexual abuse (CSA) is a worldwide phenomenon and there is growing recognition of the far-reaching implications for survivors, their families, and communities. Studies on the many potential impacts of CSA have demonstrated significant short- and long-term psychological and physical effects (Draper, Pfaff, Snowden, Lautenschlager, Wilson, & Almedida, 2007; Fleming, Mullen, Sibthorpe, & Bammer, 1999; Mullen, Martin, Anderson, Romans, & Herbison, 1993; Spila, Makara, Kozak, & Urbanska, 2008) which have led to CSA being viewed as a public health issue (Barth, Bermetz, Heim, Trelle & Tonia, 2013; McMahon & Puett, 1999). Within New Zealand (NZ), CSA is considered to be a multifaceted social problem undermining the health and wellbeing of the population (Community Sexual Violence Sector in the Auckland Region, 2011; Fergusson, McLeod, & Horwood, 2013), with a personal and economic cost estimated at \$2.6 billion per year (Infometrics Ltd, 2010; Jülich, 2004).

Over the last 30 years researchers investigating CSA have widened their scope to further understand the perpetrators of CSA and have identified that adolescents carry out a significant portion of sexually abusive behaviour (Varker, Devilly, Ward, & Beech, 2008; Lambie & Seymour, 2006). Some of these young people continue to offend into adulthood (Abel, Mittelman, & Becker, 1985; Groth, Longo, & Mc Fadin, 1982; Marshall, Barbaree, & Eccles, 1991; Masson & Erooga, 1999). To prevent further victimisation, specialised offence-specific treatment programmes for youth with harmful sexual behaviour (HSB) have been developed. While treatment programmes have become more available, evaluation studies of these programmes exhibiting scientific rigor have lagged far behind (Letourneau & Borduin, 2008; Prescott & Longo, 2006), and few outcome studies have been published (Chaffin, 2008). A key objective of this thesis is to help fill the gap in evaluation research by evaluating the effectiveness of the Good Way model (GWM; Ayland & West, 2006), a treatment for youth with HSB which has been developed in New Zealand.

1.2. Community-based Treatment in New Zealand

Over the last 30 years four organisations in NZ have provided community-based treatment for young people with HSB. WellStop provides treatment in Wellington and the lower North Island; STOP provides a similarly organised service in Christchurch and across the South Island; and SAFE, which is based in Auckland, extends its services from Northland to Hamilton. Te Poutama Arahi Rangatahi (TPAR) is a residential programme in Christchurch which can accommodate a maximum of 12 young people and is reserved for those youth who cannot be treated safely in the community.

These treatment providers have a history of delivering innovative best practice programmes (Lambie, McCarthy, Dixon, & Mortonson, 2001) including the GWM, which is routinely used and is considered to be at the forefront of contemporary therapeutic approaches for working with a range of young people who have HSB (West & Ayland, 2010).

The effectiveness of these community-based treatment programmes was captured in a major evaluation study called “Getting It Right”, which focused on both outcome and process (Lambie, Geary, Fortune, Brown, & Willingale, 2007). Although this study mirrored many findings of international studies and was able to provide empirical evidence that treatment was able to reduce sexual reoffending behaviour (a 2% recidivism rate was found for those who completed treatment), a detailed understanding of the treatment models is yet to be developed. This is problematic in terms of replicating what was found to work in the programmes and generalising findings.

The results of the evaluation study identified the GWM as one of the reasons for positive change. In their recommendations for future research, Lambie et al. (2007) note that understanding the mechanics of the factors involved in successful treatment of youth with HSB would assist in modifying existing treatment programmes. One of the recommendations of the review was that “the Good Way Model be further developed and evaluated so it can be used more extensively, with different client groups and across other programmes” (p. 24).

1.3 Background to the Study

In order to address this issue highlighted by Lambie et al. (2007), Lesley Ayland¹ successfully secured funding in 2009 from the NZ Department of Internal Affairs Lottery Community Research Fund to evaluate the effectiveness of the GWM with males aged 11–17 years, with and without an intellectual disability (ID), who have presented with HSB. The commencement of this research was delayed, however, as a result of the 2010/2011 Christchurch earthquakes.

In 2010, I was approached by Ayland to undertake this project as part of my doctorate in Clinical Psychology at Massey University. My interest in this topic stems from working extensively in the field of sexual violence over a 15-year period. For several years I worked at HELP (Auckland Sexual Abuse Help Foundation) with survivors of sexual abuse, and I also worked for five years at SAFE Network providing treatment for youth with HSB, during which time I conducted research on the treatment needs of adolescent girls with HSB. Although the present research is a community-funded evaluation research project being conducted as a doctoral project, it is intended to inform and support the growth of community-based treatment programmes within the NZ context that are both clinically effective and cost-effective.

The current research seeks to evaluate the GWM treatment package and has the potential to make a unique contribution to effective treatment for youth with HSB. This was achieved by applying a single-case multiple-baseline research design (Barlow & Herson, 1984) to an existing treatment programme which uses the GWM, and involves both intellectually disabled (ID) and non-intellectually disabled youth. Study findings are based upon the results of psychometrics and provide an understanding of the effectiveness of the GWM as an intervention; they will also assist in its future development.

1.4 Structure of the Thesis

This thesis documents the evaluation of the GWM (Ayland & West, 2006) and consists of 10 chapters. This first chapter provides a brief orientation to the current study.

¹ Lesley Ayland (registered clinical psychologist) and Bill West (social worker) created the GWM. Ayland is currently the CEO of WellStop Inc., one of the community-based treatment providers involved in this study.

Chapter 2 then defines HSB and critically examines research on CSA, including prevalence and impacts. Chapter 3 critically evaluates the existing research and literature on youth with HSB, offence patterns, and typologies. Chapter 4 examines the relevant psychological theories, which have been used to account for the development of treatment approaches and models of offender rehabilitation. This is followed by a focus on cognitive behavioural theory (CBT) and the role of theories which underpins the GWM. Chapter 5 critically examines treatment effectiveness and outcome studies, and Chapter 6 outlines the general principles and processes of the GWM. Chapter 7 describes the current study in terms of its aims and research questions, rationale, and the methodology adopted to answer the research questions. Chapter 8 outlines the methodology adopted for this research and includes an explanation of how the study was implemented through the use of a non-concurrent multiple-baseline research design. The results of the study are presented in Chapter 9 and Chapter 10 offers a discussion of the findings in relation to the research questions, including the clinical significance of the treatment outcomes, the study's limitations, and considerations for future research.

Chapter 2: Child Sexual Abuse

This chapter begins by defining harmful sexual behaviour (HSB) and then examines the existing research and literature on child sexual abuse (CSA) in order to create a platform for further discussion in later chapters of the literature on youth with HSB.

2.1 Defining Harmful Sexual Behaviour

The terms “child sexual abuse”, “sexual offending”, “sexually abusive behaviour”, and “harmful sexual behaviour” tend to be used interchangeably in the literature. In NZ treatment programmes that target sexually abusive behaviours, “harmful sexual behaviour” is commonly used to describe the sexually abusive behaviour of adolescents in the public realm. This term has been selected specifically for youth to reduce the stigma associated with the term “sex offender” and “sexual offending”, which are legal terms. Terminology that emphasises behaviour rather than the criminality of the behaviour is preferable, and “sex offender” is thought to perpetuate social stigma of youth and collapse them into the realm of adult offenders.

HSB refers to patterns of sexual behaviours towards others that are abusive. While adolescents partake in a range of experimental sexual behaviours (Lightfoot & Evans, 2000), HSB is defined as deviations from normal and developmentally acceptable sexual behaviour. These sexual behaviours may or may not be reported; can cause both psychological and physical harm to others; and, depending on the age of the perpetrator, are often punishable by law (Ryan, 2010).

HSB is commonly characterised by a lack of informed consent and/or lack of equality and/or use of coercion or force (SAFE Network, 1998, pp. 2–7). Those who provide treatment to youth with HSB differentiate such behaviours from developmentally normative sexual behaviour, and these are commonly understood as “hands on” (involving physical contact such as unwanted kissing, touching genitals, digital penetration and rape), or “hands off” (no physical contact but involves exposure to a sex act, voyeurism and child pornography; Ryan, 2010).

2.2 Prevalence

It has been estimated that one in three-to-four girls (25%–33%) and one in six-to-eight boys (12.5%–17%) in NZ have experienced sexual abuse by the age of 16 (Anderson, Martin, Mullen, Romans, & Herbison, 1993; Clark et al., 2013; Fanslow, Robinson, Crengle, & Perese, 2007; Fergusson, Horwood, & Woodward, 2000; Fleming et al., 2007), figures which are similar to overseas rates. The highest prevalence rate is for Māori females who are twice as likely to experience CSA than Pākehā females (Fanslow & Robinson, 2004). Concerningly, it has been found that approximately 70% of the reported incidences involve genital contact (Mullen, Martin, Anderson, Roman, & Herbison, 1993).

In one longitudinal study ($n = 1,000$), CSA was considered as not an uncommon experience for children in NZ (Fergusson, Lynskey, & Horwood, 1996). This high frequency of CSA is also reflected in government statistics. During the 12 months to June 2012, Child, Youth and Family investigated thousands of care and protection notifications and were able to substantiate 1,396 cases of sexual abuse (Ministry of Social Development, 2012).

2.3 Underreporting

Even with the availability of these staggering statistics, a lack of reliable data and the underreporting of CSA continue to impact on our ability to accurately gauge incidence in NZ (Community Sexual Violence Sector in the Auckland Region, 2011; Lambie & Seymour, 2006). The problem of underreporting is most evident in adult sex crime statistics, which show that approximately only 9% of sex crimes are reported, 3% of which reach court, and only 1% of which lead to a conviction (Families Commission, 2009; Mayhew & Reilly, 2007).

It is not only the legal process and standards of evidence for conviction that reduce the visibility of CSA in NZ. Additional problems with reporting include the victim's ability to disclose CSA, the relationship they have with the offender, the perceived consequences of disclosure on family members (Fergusson et al., 2000; Priebe & Svedin, 2008), fear (Kogan, 2004) and embarrassment (Kellogg & Huston, 1995). This is reflected in a NZ study by McGregor (2003) of women who had experienced CSA ($n = 191$). Results showed that only 3.8% disclosed at the time, and

the remainder took 16 years on average before they told anyone about the abuse. This strongly suggests that the available sources of research data are limited; that they may provide a skewed picture of sexual abuse; and that they are not representative of the scale of the problem (American Psychiatric Association [APA], 2012).

2.4 CSA Impacts

The relationship between CSA and subsequent psychological effects has been widely documented (e.g., Barnes, Noll, Putman, & Trickett, 2009; MacMillan et al., 2001). CSA has been conceptualised as a risk factor for mental health (e.g., post-traumatic stress order and depression) and medical problems across the lifespan, and for future adverse experiences such as sexual and physical victimisation (Barnes et al., 2009; Bushnell, Wells, & Oakley-Browne, 1992; Cutajar et al., 2010; Fergusson, Horwood & Lynskey, 1997; Igarasshi et al., 2010; Fergusson & Lynskey, 1997; Maniglio, 2009; Romans, Gendal, Martin, & Mullen, 2001; Weinstein, Staffelbach, & Biaggio, 2000). CSA has the capacity to interfere in the development of healthy adolescent relationships and significantly affect the development of emotional regulation and general coping skills for those who have been abused (Cloitre et al., 2009; Cook et al., 2005).

Studies conducted to understand the impact of CSA suggest that the effects on individuals' functioning vary, and the negative sequelae that result from CSA are often complex, multifaceted and significant (Briere & Elliot, 2003). Although some survivors are extraordinarily resilient and overcome such effects (Noll, 2008), for others the impact can be immediate, and for still others, sleeper effects can occur. It is not uncommon for the effects of CSA to be delayed, presenting at varying developmental stages and lifespan experiences (Putman, 2003).

In one longitudinal study (Fergusson, Boden, & Horwood, 2008) of a representative NZ birth cohort ($n = 1,265$), CSA was associated with increased risks of later mental health issues (e.g., anxiety, depression, substance dependence, and suicide attempts at ages 16–25). CSA has been linked to the dysregulation of biological stress systems and adverse effects on neurocognitive development (e.g., verbal deficiencies, poor school performance, and intellectual impairment)(Cohen, Mannarino & Deblinger, 2006; De Bellis, Spratt, & Hooper, 2011). CSA has also been

identified as a precursor to criminal behaviours in adolescence and adulthood (McGrath, Nilsen, & Kerly, 2011).

It is important to note that studies on CSA are not without their methodological limitations. These include differences in the way CSA is defined, age demarcations for victims, and measurement, data collection and sampling techniques (Goldman & Padayachi, 2000). Males are underrepresented in samples (Watkins & Bentovim, 1992); there is a lack of analysis of the time period evaluated and mediating variables (Paolucci, Genius, & Violata, 2001), and the use of substantiated cases coupled with what is known about underreporting is problematic (Briere & Elliot, 2003; Pereda, Guilera, Forms, & Gómez-Benito, 2009; Townsend & Rheungold 2013). Notwithstanding these limitations, the studies consistently demonstrate common themes that strengthen the argument that CSA is a significant problem that can result in negative impacts.

2.5 Summary

The terms used to describe CSA are located in a number of definitional quandaries shaped by models of understanding, socially accepted behaviour, research standpoints, and legal frameworks. Nevertheless, the relationship between CSA and subsequent psychological effects has been widely documented in research and has been identified as a significant problem requiring specialist attention. The frequency of CSA perpetrated by young people is very concerning and warrants a focus on the prevention of further sexual abuse. The next chapter reviews the literature on adolescents with harmful sexual behaviours.

Chapter 3: Adolescents with Harmful Sexual Behaviour

In order to understand the approach to treatment taken by the Good Way model (GWM; Ayland & West, 2006) it is important to review the literature on adolescents with harmful sexual behaviour (HSB). This chapter begins by examining the known extent of child sexual abuse (CSA) perpetrated by adolescents, and then outlines the more prominent features of their background characteristics. What becomes apparent is that regardless of geographical location, the findings of descriptive studies provide broadly consistent evidence that youth with HSB are a heterogeneous population from varying socioeconomic, ethnic, and religious backgrounds (Righthand & Welch, 2005; Ryan, 1997).

This has led researchers seeking to understand what distinguishes youth with HSB from other adolescents to examine the relevance of diversity among the former in order to develop specific treatment targets. Important distinctions have been recognised for youth with an intellectual disability (ID)² and more recently the development of typologies has assisted in understanding subgroups and their individual nuances, motivations and offence patterns.

It is important to consider that much of the research reviewed in this thesis is based on international samples. While these samples share many similarities with New Zealand (NZ)-based research, they do not reflect the same sociocultural context and treatment services. For example, studies conducted in countries such as the United States often involve high rates of incarcerated youth or youth in residential treatment programmes. This is not reflective of NZ treatment programmes which are predominantly community-based. Where possible, NZ research that reflects the local treatment context will be emphasised.

3.1 Prevalence

Although researchers estimate that most perpetrators of CSA are men, adolescent boys commit a disproportionate share of CSA (Erooga & Masson, 2006). Both

² In this thesis an ID is defined as a complex and multifaceted disorder that includes various limitations in intellectual functioning and adaptive behaviour (Schalock et al., 2010).

international and NZ-based statistics indicate that adolescent boys perpetrate at least 15%–35% of reported sexual abuse (Anderson et al., 1993; Centre for Sex Offender Management, 1999; Davis & Leitenberg, 1987; Erooga & Masson, 2006; Finkelhor, Ormond, & Chaffin, 2009; Ford & Linney, 1995; Statistics NZ, 2012). Over a 10-year period (2000–2010), the NZ Police recorded 3,420 sexual abuse apprehensions by boys aged between 10 and 16 years. These high rates of HSB are a cause of great concern and warrant a focus on reducing the amount of CSA perpetrated by youth.

The seriousness of the problem is also reflected in research on survivors of CSA. NZ researchers Mullen, Anderson, Roman-Clarkson and Martin (1991) concluded that “teenage offenders were a large and often quite violent group, who carried out one quarter of the offences” (p. 2). In another NZ study, Anderson et al. (1993) focused on the prevalence and nature of sexual abuse within a female community sample ($n = 497$). One-third of participants disclosed that they had experienced sexual abuse prior to the age of 16 and almost half of the offenders were under the age of 25 years. In a more recent NZ study, Lambie, Seymour, Lee and Adams (2002) focused on adolescent boys with HSB. Of those boys who had themselves been sexually abused nearly half (42%) reported that the offenders were adolescents. These results reinforced Lambie’s (1998) study on male survivors of sexual abuse in which 35% of participants reported adolescents had abused them.

Although these findings indicate that young males are a high-risk group for CSA, the accuracy of statistics on CSA perpetrated by young people remains hampered by underreporting and the available sources of offence data, and are unlikely to represent the scale of the problem (Righthand & Welch, 2001). Both NZ criminal justice statistics and those drawn from community-based treatment programmes show that there is an overrepresentation of Māori youth within this group (Lim, Lambie, & Cooper, 2012). While adolescent girls also engage in sexually abusive behaviour, it is estimated that boys commit approximately 90% of youth offences against children (Statistics NZ, 2012). The large gender disparity shown in both victim and offender studies (e.g., Hackett, Masson, Balfe & Phillips, 2013; Ryan, Miyoshi, Metzner, Krugman & Fryer, 1996; Weedon, 2011; Williams, Tuthill, & Lio, 2008) and the overrepresentation of Māori are important factors for treatment programmes to take into account (e.g., cultural and gender-based responsivity).

Current international estimates also indicate that, relative to the general population where the prevalence rate for ID in both NZ and overseas varies between 1% and 3% (Bray, 2003; Harris, 2006), a sizeable portion of young people with HSB have an ID (Hackett et al., 2013). This is not unlike the proportion of ID youth found in the general youth offender population (Gray, Fitzgerald, Taylor, MacCulloch, & Snowden, 2007). Fortune (2007) collected information on NZ young people with HSB who were referred to three community-based treatment programmes over a 9½-year period ($n = 702$). She found that 133 (19%) were deemed to have below average intelligence, with no fewer than 67 (9.5%) having an ID ($IQ < 70$ based on a standardised measure such as the Wechsler Intelligence Scale for Children – Third Edition (WISC-III) (Wechsler, 1991).

The difficulty estimating the prevalence and exact numbers of HSB committed by ID youth is due to a number of factors including the intellectual capacity of offenders not being generally available in crime statistics; the lack of assessment and reporting of intellectual functioning itself (Wilcox, 2004); coexisting problems; and a lack of consistency in terms of definitional criteria to describe youth with low intellectual functioning (Blasingame, 2005; Griffin & Vettor, 2012; Miccio-Fonseca & Rasmussen, 2013; O’Callaghan, 2002). Furthermore, relative to non-ID youth, ID youth are thought to be more likely to be apprehended due to their limited skills in planning and deceiving (Wilcox, 2004).

Regardless of these limitations, young people with cognitive and adaptive functioning issues are clearly overrepresented in research on youth with HSB. ID youth have specific difficulties including being slower at learning, finding it hard to understand causal relationships, and having problems understanding behaviour and consequences, resulting in difficulties with decision making (Haaven & Coleman, 2000). They may have lower self-esteem and pretend to understand or exaggerate their accomplishments in order to avoid being labelled “dumb”. They may also be sensitive to criticism and resistant to change (Lambrick & Glaser, 2004). Treatment approaches for ID youth are more likely to demonstrate effectiveness if they are responsive to their level of cognitive functioning.

3.2 Offence Characteristics

Empirical research indicates that while there is variation in the HSB of youth, certain offence characteristics are more prevalent than others (Ryan, Leversee, & Lane, 2010). Research on offence trajectories shows that only a small group of youth with HSB begin their sexual offences in childhood; most begin with the onset of puberty in the pre-adolescent/early adolescent age group (Fortune, 2007; Nisbet et al., 2005; Riser et al., 2013). It is estimated that the majority of youth desist from sexual offending following adolescence (Cadwell, 2010; Lussier, Van Den Berg, Bijleveld, and Hendriks, 2012; Nisbet et al., 2004; Zimring, Piquero, & Jennings, 2007). These distinctions are supported by retrospective research with adult sex offenders which indicates that approximately half began their HSB before they became adults (Abel, Mittelman, & Becker, 1985; Groth, Longo, & Mc Fadin, 1982; Marshall, Barbaree, & Eccles, 1991). These findings have led to adolescents being classified as either “adolescent limited” offenders or “high-rate slow desisters”, who continue offending into adulthood (Lussier, Van Den Berg, Bijleveld & Hendricks, 2012).

Patterns and motivations for offending are also thought to vary. For example, studies on victim selection suggest that the majority of victims are likely to be females aged between 5 and 9 years old and known to their perpetrators (e.g., Flanagan & Hayman-White, 1999; Fortune, 2007; Righthand & Welch, 2005; Vandiver & Teske, 2006). Evidence for deviant sexual arousal has been found in only a small portion of young people (Seto, Lalumiere, & Blanchard, 2000 [25%]; Worling, 2004 [36%]), and those who offend against teenagers can be differentiated from those that offend against children. In the Fortune (2007) study mentioned above, the number of offences varied from one to multiple, with two-thirds having two or more victims. Many offences were carried out with the use of non-threatening grooming and threats.

Understanding variations in offence patterns assists in measuring risk and tailoring treatment to meet clients’ needs. Both ID and non-ID youth have been found to enact both “hands on” (e.g., rape) and “hands off” (e.g., exposure) HSB, though for ID youth the behaviours themselves are thought to be at times minimised, misconstrued or overreacted to (Ryan et al., 2010), and qualitatively different (e.g., motivations, contextual factors, opportunistic and developmental processes) (Day,

1994; Fyson, 2009; Gilby et al., 1989; Lane, 1997; Mc Kenzie & Matthews, 2009; O'Callaghan, 1998; Silovsky & Bonner, 2003; Timms & Goreczny, 2002). These distinctions are related to motivation and the term "coarse sexual improprieties" has been used to describe sexual behaviour of ID youth that reflects an unsophisticated awareness of psychosexual conditions, environments, or social situations (e.g., nuisance behaviours such as rubbing genitals in public, looking up skirts; Miccio-Fonseca, 2010).

Overall, the offence characteristics highlight the similarities and differences of sexual offending patterns and motivations of non-ID and ID male youth with HSB. The variations and clinical distinctions between youth with HSB emphasise the need for treatment flexibility and should inform the length, intensity and delivery of treatment.

3.3 Individual Characteristics

While early descriptive studies using relatively large samples were able to identify a number of similar psychosocial, contextual and developmental background characteristics (e.g., Ryan, Miyoshi, Metzner, Krugman & Fryer 1996), there remains a general consensus that the degree of individual difference suggests there is *no typical example of a youth with HSB* (Geary, 2007; Righthand & Welch, 2005). In an attempt to provide more effective interventions, more recent studies (e.g., Hackett et al., 2013) have continued to find similarities, however they have shifted their focus and emphasised the diversity among youth with HSB that is influenced by developmental factors, individual experiences and the nature and motivation of their offences.

While understanding the similarities and differences for youth with HSB continues to be an important focus for researchers, the repeated identification of particular static and dynamic risk factors that are believed to be associated with sexual recidivism is considered to hold relevance for treatment targets. Although what is known about the characteristics of youth with HSB is predominantly based on biased samples (Righthand & Welch, 2001) from international studies, many of these factors act as a background for understanding the manifestation of concurrent clinical issues and others are thought to be directly related to the etiology of HSB. It has become evident that youth with HSB have treatment needs that are related to, and overlap with, their early life, families/caregivers, learning, and social competencies, and the

resiliency and protective factors that mitigate HSB (Hackett et al., 2013; Veneziano & Veneziano, 2002).

3.3.1 Maltreatment Histories

Although a small group of youth with HSB have no record of maltreatment (e.g., sexual, physical, emotional victimisation, and/or physical and emotional neglect) in their histories, single or multiple traumatic childhood experiences of some sort are a consistent finding in many international studies (see e.g., Burton et al., 2002; Dent & Jowitt, 2003; Hackett et al., 2013; Kenny et al., 2001; Rasmussen, 2013; Taylor, 2003). In NZ studies on youth with HSB (Fortune, 2007; Lightfoot & Evans, 2000) ID youth tend to have more experience of abuse and are more likely to come from adverse family backgrounds (Craig & Hutchinson, 2005).

While these above studies tend to conduct comprehensive rather than specific analyses, which hinders a complex understanding of the subtleties of experience between and among each sample group (variations of gender socialisation and sexual development pathways and variations between experiences trauma and their impacts, for example, are not revealed), their findings nevertheless highlight the many possible coexisting problems for youth with HSB that are often linked to maltreatment experiences. These types of early life stressors can impact on brain development, the expression of behaviour, and increase the risk for later psychopathology (Mueller et al., 2010; Richie et al., 2009).

Clinically significant comorbid problems bring an added dimension of complexity to offence-specific treatment. A young person who presents with complex trauma is also likely to present with a range of developmentally, systemically, and contextually located problems and a range of internalising and/or externalising trauma-related behaviours that will impact on the clinical picture, wider issues related to risk, and the subsequent treatment pathway (Creedon, 2009; Rasmussen, Lev-Wiesel & Eisikovits, 2013). For example, problems associated with post-traumatic stress disorder (PTSD) include self-regulation, aggression, attention, dissociation, and interpersonal relationship difficulties. Avoidance strategies to deal with the chronic and intense distress caused by trauma can include substance abuse and tension-reducing activities, which increase inhibition (Briere, Hodges, & Godbout, 2010). The

GWM holds the capacity to incorporate trauma-relevant elements into treatment when required.

3.3.2 Learning-related Problems

The ability to learn and be educated is considered to have a direct protective or buffering protective effect (Lösel & Farrington, 2012). ID and/or cognitive impairments (e.g., learning disabilities, developmental delay, language problems) and problems in executive functioning (attention problems, impulsivity and self-regulation) feature in research on youth with HSB and are speculated to be much higher than in the general population (e.g., Burton, Demuynck, & Yoder, 2014; Ferrara & McDonald, 1996; O'Brien & Bera, 1986; Richardson, Graham, Bhate & Kelly, 1995; Taylor, 2003; Vizard, Hickey, French, & McCrory, 2007; Vizard, Monck, & Mich, 1995). A recent study by Hackett et al. (2013; $n = 700$) found that the rate of learning disabilities (otherwise defined as a cognitive impairment or ID) was estimated to be 38%. Such deficits have varying degrees of impact on learning, and lead to educational difficulties (Almond, Canter, & Salfati, 2006; Dolan, Holloway, Bailey, & Kroll, 1996; Epps, 1991; Hawkes, Jenkins, & Vizard, 1997). NZ studies mirror these findings and have found that impaired academic performance and problems such as truancy and disruptive behaviours also feature (Dillon, 2010; Fortune, 2007; Lightfoot & Evans, 2000; Purcell, 2010; Riser et al., 2013).

According to Burton et al. (2014), traditional forms of treatment (e.g., cognitive restructuring) may be impacted on by client learning abilities and their ability to understand the intentions of the therapeutic alliance. The GWM recognises that interventions for young people with learning-related problems need to vary depending on the nature of their cognitive deficit, and can be adapted to meet the learning needs of each individual young person.

3.4 Contextual Factors

While some male youth with HSB come from well-functioning and supportive families, both NZ and international studies have consistently identified that many have chaotic family backgrounds characterised by emotionally deprived and abusive family upbringings; criminal histories, family instability, substance abuse and dysfunction; removal from home (displacement); exposure to family violence; and disorganisation

(e.g., Bagley & Shewchuk-Dann, 1991; Becker & Hunter, 1997; Dillon, 2010; Fortune, 2007; Miner, Siejert, & Ackland, 1997; Morenz & Becker, 1995; Openshaw, Ascione, & Ericksen, 1996; Purcell, 2010; Riser et al., 2013; Vizard et al., 2007). Family dysfunction is a particular concern for young people as it can lead to a lack of warmth and care and disrupt the development of a healthy attachment process (Ryan et al., 2011). While a limitation of many of these studies is that their samples are drawn from young people already involved with child protection services, they nevertheless highlight the complexity and influence of contextual factors on young people with HSB. For example, exposure to violence and abuse can also increase the risk of psychopathology (Margolin & Vickerman, 2007) and influences developmental pathways (Pratt, 2013).

This is highlighted in a NZ study by Lightfoot and Evans (2000) that found high levels of family dysfunction in children and adolescents with HSB ($n = 20$; aged 8–16 years) compared to a matched group of boys and girls without HSB. In this study, youth with HSB were more likely to come from homes where they were exposed to a caregiver with a sexual offending history; where there had been multiple disruptions to attachment; or where a stable caregiving relationship was lacking. They were likely to internalise distress and although support was available, they would often withdraw during high states of emotional arousal. The combination of severely disrupted attachment combined with exposure to inappropriate sexualised behaviour increased the risk of HSB for young people. Interviews with participants identified that a negative emotional experience tended to precede offences.

Many of these young people had been separated from their families during childhood and as a result of their HSB may well have been separated from caregivers again for treatment purposes. The involvement of caregivers in the treatment process is considered essential (Flanagan & Hayman-White, 2003) and the GWM views the family and/or relevant community of support of each young person as an important part of both the assessment and treatment process.

3.5 Coexisting Problem Behaviours

3.5.1 Comorbid Internalising and Externalising Problems

Clinically significant comorbid problem behaviours which are attributed to psychiatric disorders (Grimshaw, 2008) bring an added dimension of complexity to offence-

specific treatment (see Burton et al., 2014; Lambie & McCarthy, 2004; McMackin, Leisen, Cusack, LaFratta, & Litwin, 2002; Rich, 2003). Consistent with the findings of international studies that indicate a large majority of youth with HSB meet the criteria for psychiatric disorders (e.g., Nisbet, Wilson, & Smallbone, 2004), a number of NZ studies have identified that many youth with HSB also struggle with clinically significant comorbid externalising (e.g., conduct disorder, attention deficit hyperactivity disorder [ADHD], PTSD) and internalising problems (e.g., depression and anxiety) (Dillon, 2010; Purcell, 2010). Fortune (2007) found that 65% of the study sample ($n = 457$) had a history of one or more mental health issues. The more commonly presenting coexisting problems associated with the population (e.g., conduct disorder, ADHD, PTSD, anxiety, depression, and substance abuse) complicate treatment and present an increased risk for many adverse outcomes, and later psychopathology and antisocial adult behaviour.

Studies that record the prevalence of substance abuse in samples of youth with HSB have provided results ranging from 3% to 72% (Fortune, 2007; Lightfoot & Barbaree, 1993), and substance abuse by such youth has been linked to relaxed disinhibition and the impact this may have on understanding action and consequence (Tinklenberg, Murphy, Murphy, & Pfefferbaum (1981), and has been linked to a higher number of victims (Becker and Stein, 1991). The lack of in-depth analysis (e.g., that identifies the type of substances, frequency of use, whether substances were used during the offending, or whether the use is historic) makes it difficult to infer conclusions about the link between substance abuse and HSB, and a direct association has yet to be established (Righthand & Welch, 2005). What can be stated at this point is that a group of youth with HSB have a historic or current problem with alcohol and/or drug use which may act as a risk factor for future offending (Kelly et al., 2004).

3.5.2 Non-sexual Offending

Studies indicate that a portion of adolescents with HSB present to treatment agencies with non-sexual offences in their repertoire of problem behaviours which have either pre-dated their index offence or coincided with it (Hackett et al., 2013), and that those who complete treatment are a greater risk of reoffending non-sexually than sexually (e.g., Lambie, 2007; Nisbet et al., 2004). This has led to a considerable number of

studies (e.g., Vandiver, 2006; Way & Urbaniak, 2008) focusing on the possible overlap of youth with HSB with general youth offenders rather than adult sex offenders from criminal populations, who can be distinguished by developmentally located differences (Butler & Seto, 2002; Pullman & Seto, 2012; Seto, 2010; Weinrott, 1996), and the implications this has for treatment pathways (Netland & Miner, 2012). This has generated much debate on generality/specialisation issues, with researchers trying to identify unique offending pathways and risk factors specific to sexual offending (e.g., Brown & Burton, 2010).

Pullman and Seto (2012) stress a distinction between specialist and generalist adolescent sex offenders because the dynamics of their future risk and their individual treatment needs and targets are likely to vary. This is developed by Pullman, Leroux, Motayne and Seto (2014), who re-frame this categorisation as a sex-plus (generalist perspective) and sex-only (specialist perspective) distinction and use it to validate the differences in etiological pathways for assessment and treatment purposes. Adolescents who fall into the sex-plus category are thought to be much like adolescents who have committed non-sexual offences and therefore share similar etiological pathways and treatment needs. However, a distinction between these groups is often made to argue for offence-specific treatment because framing HSB through research on antisocial behaviour alone for treatment interventions is too basic (Seto & Lalumiere, 2010). The frequently reported high rates of non-sexual recidivism suggest the need to understand the links between the two groups (Nisbet et al., 2010) and the applicability of evidence-based interventions for a more general range of problem behaviours (Nisbet, Rombouts, & Smallbone, 2005).

Recent meta-analyses have found that disruptive behaviour disorders such as conduct disorder have been effectively treated with CBT interventions (McCart, Priester, Davies, & Azean, 2006) and multisystemic therapy approaches (Curtis, Ronan, & Borduin 2004). There is now substantial evidence for the effectiveness and utilisation of CBT approaches for adolescents with depression (David-Ferdon & Kaslow, 2008; Michael & Crowley, 2002; Waslick, Schoenholz, & Pizarro, 2003; Weersing & Brent, 2006), anxiety (James, Cowdrey, & James, 2012), PTSD (Dorsey, Briggs, & Woods, 2011; Kowalik, Weller, Venter, & Drachman, 2011), self-regulation problems

(Didden et al., 2012) or complex trauma (e.g., Briere & Scott, 2012, Chiesa & Serretti, 2011; Hofmann, Sawyer, Witt, & Oh, 2010; Piet & Hougaard, 2011).

3.6 Risk and Protective Factors

There has been a heavy focus on identifying risk factors associated with recidivism and the commonly occurring factors related to “negative outcomes”, which are more likely to make youth sexually offend. Broadly speaking, these vary and include deviant sexual interest, social isolation, failure to complete treatment, dysfunctional family systems, maltreatment histories, delinquent peer relationships and behaviours, the nature and constellation of sexual offence characteristics, mental health issues and deviant sexual arousal problems with self-regulation (such as impulsivity and impulse control), and antisocial orientation (Hunter, Figuerdo, Malamuth, & Becker, 2003; Longo & Prescott, 2006; Riser et al., 2013; Worling & Langstrom, 2006). Social competence problems and the repeated identification of deficits in social skills is reflected in descriptive studies (e.g., Awad & Saunders, 1991; Becker, 1990; Blaske, Bourdin, Henggeler, & Mann, 1989; Fortune, 2007; Hunter et al., 2003; Miner & Crimmins, 1995; Seto & Lalumiere, 2010) and in NZ studies on personality-based typologies (Dillon, 2010; Purcell, 2010).

With regard to risk factors, there has been much less focus on protective factors and resilience – the strengths and positive characteristics that may contribute towards recidivism and positive outcomes (Efta-Breitbach & Freeman, 2004). Resilience is defined as the process of adapting well in the face of adversity or trauma; that is, achieving a positive outcome in the face of an expected negative outcome (Yehuda, Flory, Southwick & Charney, 2006). Positive outcomes experienced by at-risk youth have been linked to resiliency (Efta-Breitbach & Freeman, 2004). While the GWM recognises the role of static and dynamic risk factors as well as protective factors in guiding treatment, the concept of “psychological resilience” and the factors that contribute to resilience are an important focus of the model. These are thought to operate on three levels: the community, the family, and the individual. High self-esteem, stemming from positive relationships with parents and peers and positive school experiences, has been identified as one such factor (Asgeirsdottir, Gudjonsson, Sigurdsson, & Sigfusdottir, 2010). Although treatments are primarily focused on

reducing risk, the relationship between developmental factors (attachment), a lack of coping skills (internalising distress), and the contributors to the development of HSB in young people has received greater attention recently (see e.g., Miner, Robinson, Knight, Swinburne-Romine, & Netland, 2010). This suggests that interventions that emphasise building and engaging in positive attachments may potentially reduce the propensity to engage in HSB (Righthand & Welch, 2005).

3.7 Typologies

Due to the heterogeneity of youth with HSB and the limited success of interventions, the development of typologies has been considered a useful way to identify variations of risks of reoffending and individual treatment pathways and targets (Lambie & Seymour, 2006). Typologies are important because they support the notion that “one size does not fit all”; that there are numerous coexisting issues requiring attention; and that the information is able to guide the treatment process for each client (Rasmussen, 2005).

With this in mind, Dillon (2010) examined a sample of NZ youth with HSB ($n = 195$) to begin developing a typology that could embrace the diversity and commonality of such youth in order to enhance and inform assessment and treatment pathways. Through a hierarchical cluster analysis, the study identified seven key themes in clusters of clinical characteristics among the sample: trauma and neglect, sexual abuse and family mental health, mood dysregulation, sexual deviancy and delinquency, personality and social deficits, developmental difficulties, and family aggression and abuse. From this identification four distinct profiles were identified: (1) depressed relationship seeking, (2) trauma reactive, (3) hostile versatile, and (4) controlling entitled. This study used a larger sample size than typical of earlier typology research, making it more representative of the population; furthermore, its typology was derived from clinical knowledge about youth with HSB rather than creating groups based upon a specific problem and set inclusion and exclusion criteria, which is common practice within other research on typologies.

In another NZ study, Oxnam and Vess (2008) utilised the Millon Adolescent Clinical Inventory (MACI) (Millon, 2006) to generate typologies from adolescents with

HSB ($n = 82$) being treated within one community-based treatment programme. They identified four types by cluster analysis: a withdrawn, socially inadequate type ($n = 25$); an antisocial and externalising type ($n = 11$); a conforming type ($n = 20$); and passive-aggressive type ($n = 26$). The findings of this study provide evidence for potentially different etiological pathways and treatment needs (e.g., there were significant differences between groups for those who reported child physical abuse) and the heterogeneity of adolescents with HSB in terms of personality characteristics and psychopathology.

In a third NZ study, a review of the literature on typologies for youth with HSB, Lambie and Seymour (2006) surmised that there are three broad typologies. The first type consists of youth from stable and functional families who do not have clinically significant comorbid problems; the second type is likely to derive from multiproblem families and present with comorbid antisocial behaviours; and the third is made up of young people who are socially withdrawn and introverted.

Together these studies provide evidence of the specificity of similarities and difference among youth with HSB (Rasmussen, 2005), and provide both clinically and empirically derived typologies to understand the interrelationship of offence trajectories and problem characteristics. Regardless of which typology is used, typologies themselves clearly support the move away from offence-only to integrative-practice models. The GWM is an adaptable integrated approach to treatment that considers research on the diversity of treatment needs in the delivery of interventions.

3.8 Summary

Studies have consistently shown that although youth present with some commonality (e.g., family attributes and social skill deficits), they are not a distinct group with a single shared feature or characteristic. Rather they reflect a heterogeneous group from diverse psychosocial backgrounds (Fortune, 2007; Knight & Prentky, 1993; National Society for the Prevention of Cruelty to Children [NSPCC], 2002; Weinrott, 1996) and therefore have specific treatment needs (Letourneau & Bourdin, 2008; Veneziano & Veneziano, 2002). Many present with a range of coexisting problems, and for some this includes low intellectual functioning. The variations in both offending trajectories

(both sexual and non-sexual) combined with variations in developmental trajectories generate a complicated clinical picture, though there are identifiable typologies.

Research examining the historic and contextual factors which accompany youth with HSB has established that “one size fits all” approaches do not meet treatment needs (e.g., Hackett et al., 2013; Lambie, 2007). According to Worling (2013a), treatment approaches need to be systemic and developmentally matched, sensitive to variations in adolescent cognitive, social, and emotional development, and have an empirical basis and not risk iatrogenic harm. Each young person’s unique strengths and risks require consideration in treatment planning (Worling & Langton, 2012).

The holistic, semi-structured approach of the GWM can be adapted to the needs of each client to consider more than a set of variables and allows for the complexity of youth with HSB. The GWM, the evaluation of which is a focus of this study, integrates evidence-based trauma treatment components to address the systemic complexity inherent in working with youth with HSB. The next chapter examines the causes of HSB by adolescents.

Chapter 4: Causes of Harmful Sexual Behaviour by Adolescents

The research literature on youth with harmful sexual behaviour (HSB) suggests that the development trajectories and maintenance of HSB are complex, but an understanding of the theories that attempt to explain the phenomenon assists in identifying relevant treatment targets (Pullman et al., 2014). The difficulty with selecting a single theory is that human beings are multifaceted and integrated organisms (Ward, Polaschek, & Beech, 2006), and HSB perpetrated by youth is a multidimensional problem without a clearly defined causal pathway (Ryan, 2010). Complicating this picture further is that youth with HSB can present with very similar developmental pathways that have led to very different outcomes (Rich, 2003). While there is no empirically validated explanatory theory or single shared characteristic (Almond et al., 2006) to explain the development of HSB in adolescents, it has been recognised that conceptualisations need to be comprehensive in approach and include individual, family, and cultural variables (Becker, 1990).

This chapter critically examines the prominent psychological theories used to understand the etiology of HSB. These theories often overlap and interrelate, and together assist in understanding the causes of HSB. They include offence-specific explanations that are conceptualised as either multifactorial or single-factor theories. They incorporate earlier behavioural and cognitive theories (e.g., social learning) and are becoming increasingly developmental in perspective by taking into account normal developmental pathways, the influence of family, and recent research on brain development and the neuropsychological impacts of trauma on behaviour (Creedon, 2013). By being sensitive to the complexity of the phenomenon under study, these theories have informed current perspectives on treatment, including the Good Way model (GWM; Ayland & West, 2006).

4.1 Pathway Theories of HSB

Several adult and/or adolescent offence-specific theories of HSB have attempted to explain the development and maintenance of HSB perpetrated by boys. These include Finkelhor's (1984) four preconditions model, which focuses on sexual abuse dynamics and proposes that there are four conditions/barriers which must be met before a

person can sexually abuse; Marshall and Barbaree's (1990) integrated theory, which focuses on the impact of adverse early experiences on development; Hall and Hirschman's (1992) quadripartite model, which focuses on four factors which may explain HSB: personality problems, affective dysregulation, faulty cognitions, and atypical sexual responses; and offence-specific explanations such as Lane's (1997) sexual abuse cycle for adolescents, which proposes that being abused can lead to abusing others.

According to Seto and Lalumière (2010), most theories that try to explain the development of HSB in youth recognise the role of atypical sexual interests, and they suggest disinhibition, either as a state or trait, increases risk. The theories can be usefully categorised into those that focus on the role of a single variable in the lead-up to the sexual abuse of others and those that focus on the roles of multiple variables (Seto, 2008). Although most of the aforementioned theories originate from work with adults, their distinguishing trait is their developmental perspective (O'Reilly & Carr, 2004), which tries to account for the influence of formative experiences and processes which increase the risk of HSB. The empirical limitations of these theories relate to their criteria of unifying power, internal consistency, ability to predict future behaviour, heuristic value, and/or parsimony (Seto & Lalumière, 2010). From a clinical perspective, the variations between motivational factors and emotional states and cognitions are not consistently accounted for.

A recent meta-analysis conducted by Seto and Lalumiere (2010) tested special and general explanations of sexual offending by adolescent boys in 59 independent studies which compared sexual offending youth ($n = 3,855$) with non-sexual offending youth ($n = 13,393$) on theoretically derived variables. Although such studies are limited by the small number of studies in this area, the validity of self-report (due to the sensitive nature of CSA), and the impact of collapsing complex issues to increase effect size – which can lose sight of individual nuances – the results of this study do not support the idea that HSB by adolescent boys can be explained by a simple manifestation of general antisocial tendencies and the meta-analysis has provided valuable findings for the development of special explanations (e.g., offence-specific). The findings suggest significant roles for sexual abuse history, exposure to sexual

violence, other abuse or neglect, social isolation, early exposure to sex or pornography, atypical sexual interests, anxiety, and low self-esteem received support.

Within the developing field of treatment for young people with HSB there has been increasing recognition of the need to move away from a “one-size-fits-all” approach (Chaffin, 2008; Hackett et al., 2013; Morrison & Henniker, 2006). To understand the dimensions of empirically validated etiological factors and their relevance for treatment, the GWM draws upon a combination of offence-specific and psychological theories, with elements of risk management theories.

4.2 Theoretical Underpinnings of the GWM

The GWM originates from a cognitive theoretical orientation (Beck, 1997) and the fundamental principle that cognitive factors play a significant role in the development and maintenance of behaviour, and has a dual focus on *risk management* (e.g., Andrews, Bonta, & Hoge, 1990) and *psychological wellbeing* (Collie, Ward, Ayland, & West, 2007). The GWM adopts a multidimensional and multifactorial theoretical stance to anchor the treatment approach. It has evolved from critiques of both current and earlier general and psychological theories, each of which has made important contributions to its development.

4.3 Rehabilitation Theories

The GWM is consistent with the core principles of the risk-needs-responsivity (RNR) model (Andrews et al., 1990), which has been used to guide both adult and youth interventions. The RNR model has a strong evidence base and involves three overarching principles and has been used to assist in the assessment and treatment of offenders, and in the interpretation of research literature (Andrews, Bonta, & Wormith, 2006).

The *risk principle* focuses on which group is most in need of treatment and the factors (characteristics and circumstances) which are associated with an increased chance of future criminal activity. The low base rates for sexual recidivism indicate that most youth do not reoffend sexually after treatment (Caldwell, 2007) but the variation in levels of risk requires the careful consideration of individual factors relevant for

treatment (Viljoen, Mordell & Beneteau, 2012). The *need principle* focuses on what is being treated. For example, criminogenic needs (i.e. deficits) are dynamic risk factors or changeable attributes factors that lead either directly or indirectly to crime. Targeting change in these factors is thought to reduce chances of future criminal activity. The *responsivity principle* looks at how treatment is implemented. For example, individual characteristics which may be a direct or indirect cause of criminal behaviours must be accommodated to ensure effective treatment (e.g., treatment readiness/motivation, cultural background, language, cognitive ability; Andrews et al., 2006).

Early critiques of the RNR model note its heavy focus on criminogenic needs, with a lesser focus on the individual, contextual and/or ecological factors which may influence change. More recently, however, it has also been described as a model which holds the capacity to promotes a strength-based, pro-social approach to rehabilitation (Andrews, Bonta, & Wormith, 2011). Creedon (2013) states that when youth with HSB are viewed within the context of normal development, the RNR principles are able to guide treatment protocols. Youth with HSB are a diverse population with multiple pathways to offending that separate them from adult sex offenders and distinguish them from one another (O'Reilly & Dowling, 2008). Consistent with Andrews et al.'s (1990) principles, the GWM adopts a flexible approach which is able to capture the variability of relevant etiological factors.

4.4 Integrated Theory of Sexual Offending

The Integrated Theory of Sexual Offending (ITSO; Ward & Beech, 2006) is a conceptual framework which integrates various aspects of earlier models using the process of theory knitting (Kalmar & Sternberg, 1982) to create a comprehensive etiological framework. It has been successfully utilised to anchor an adult theory of rehabilitation called the Good Lives Model-Comprehensive (GLM-C; Willis, Yates, Gannon, & Ward, 2012). Although the GWM was developed independently from the GLM-C, both models reflect principles and processes that have a positive focus and emphasise strengths.

As a theoretical framework with a developmental perspective, the ITSO is able to combine and consider relevant theory and research on salient distal (e.g., early life experiences) and proximal factors (e.g., cognitive and behavioural factors within the offence chain and index offence), and risks for possible future offending for youth with HSB. This includes empirically supported theoretically derived variables (e.g., atypical sexual interests, sexual abuse history) and key psychological theories (e.g., the role of social learning and family systems).

The ITSO achieves this by moving beyond the simplistic notion of a single theory or approach to integrating a number of static and dynamic psychosocial, developmental and contextual factors to account for the individual experiences that may explain pathways to HSB and the function of the behaviour. For example, it enables the neuropsychological perspective to be considered in the development of problems rather than merely the analysis of surface discrepancy (e.g., emotional processes).

Although it is limited by its lack of specificity and empirical evidence (Seto, 2010), the ITSO is able to account for developmental and empirically factors. As shown in Figure 4.1, the ITSO proposes that clinical problems are a result of the dynamic interplay between biological factors (influenced by genetic inheritance and brain development), ecological niche factors (social cultural and personal), and neuropsychological factors (more specifically the interaction of the motivational/emotional, perception/memory, and action selection and control systems) that interact to produce clinical problems (e.g., emotional problems, social difficulties) in the development and expression of HSB (Ward et al., 2012).

According to one large UK study (Vizard et al., 2007; $n = 280$) focusing on the background psychosocial and behavioural characteristics of youth with HSB, the interplay of developmental context and five key areas of vulnerability (e.g., dysfunctional family environment, aggressive socialisation, inappropriate socialisation, neuropsychological deficits, and mental health problems) within the sample is likely to represent an etiological basis for the onset of HSB. According to the authors, a “life course” developmental perspective is needed to understand the influence and interactions of these factors for each individual and the multiple trajectories for both

sexual and non-sexual offences, pro-social criminal attitudes, and personality difficulties within this population for assessment and treatment purposes.

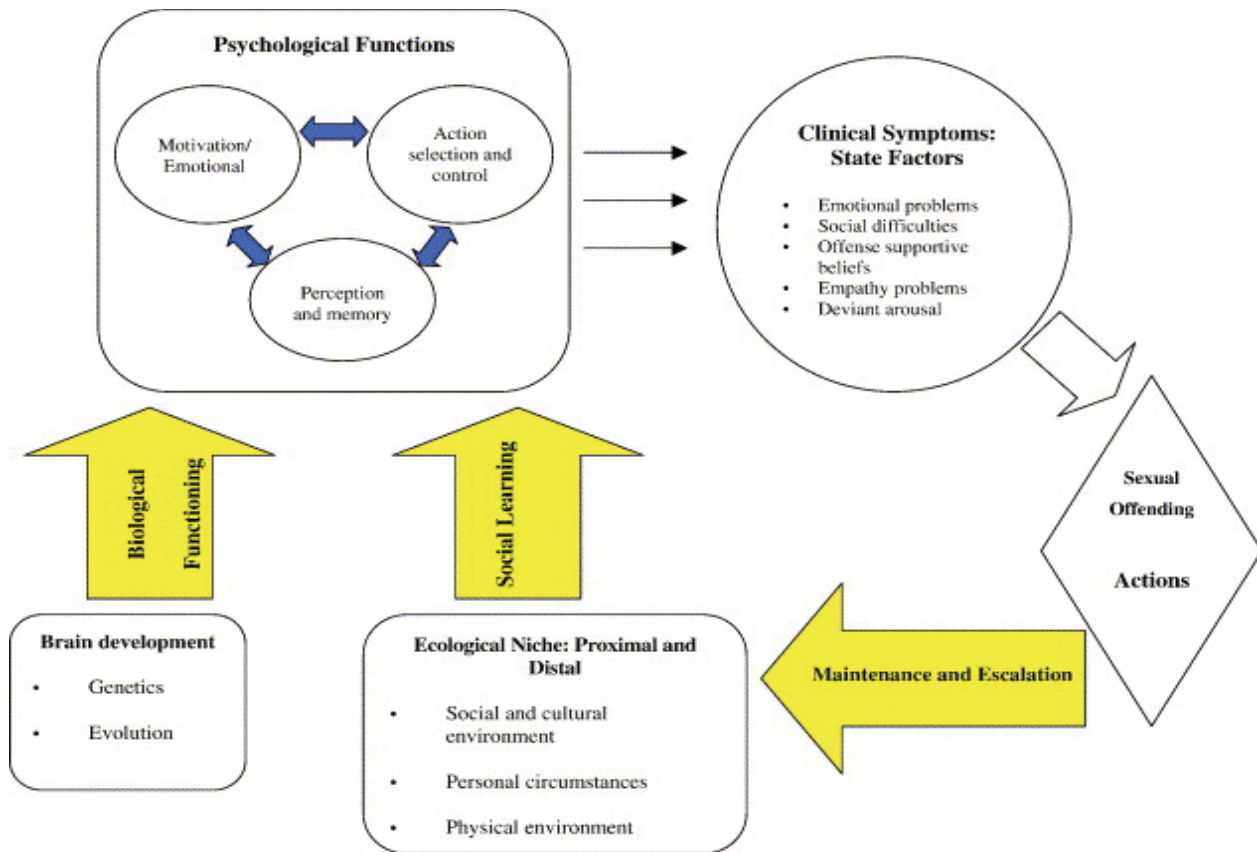


Figure 4.1 The integrated theory of sexual offending (ITSO; Ward & Beech, 2006, p. 51)

The developmental lens and dynamic nature of the ITSO makes it adaptable to youth with HSB and applicable to the GWM because it has the versatility to acknowledge that adolescence is likely to be shaped by differential developmentally and contextually located factors (e.g., adolescence as a milestone, family, peer and community contexts, and wider factors linked to reducing recidivism)(Collie et al., 2007); the complexity of typological presentations (Dillon, 2010; Purcell, 2010); the large literature base on abuse histories, social and moral development, attachment problems, neuropsychological deficits, and behavioural problems (e.g., Creedon, 2010; Vizard et al., 2007); evidence for specific explanations (e.g., Seto & Lalumiere, 2010); and the factors that shape or motivate the differences in HSB such as sexual deviancy, conduct disorder, poor social skills and/or a lack of social connections (Rich, 2012,

cited in Latham & Kinscherff, 2012). Furthermore, due to the varying experiences, developmental levels, and biological, physical and social variables found in young people generally (Briere & Langtree, 2008), normative developmental milestones and behaviours can be considered.

4.5 The Role of the Cognitive Perspective

Considering the role of cognitive and affective development is essential for the appropriate treatment of young people with HSB. The significance of thought processes in HSB patterns is highlighted throughout the literature (e.g., Apsche, Evile, & Murphy, 2004; Becker, 1990; Eastman, 2004) and is reflected in the prominence of cognitive behavioural approaches in treatment effectiveness research (e.g., Walker, McGovern, Poey, & Otis, 2004). From a cognitive behavioural perspective, behaviour is maintained by dysfunctional cognitive processes (e.g., maladaptive cognitions; Beck, 1997) and individuals with HSB are likely to have a personal vulnerability (i.e. a biological predisposition along with environmental events and/or stressors) which is thought to be exacerbated by dysfunctional cognitive processes stemming from the early development of cognitive schemas during formative years. The GWM recognises that these types of cognitive processes are essential to understanding the factors which cause and maintain HSB (e.g., offence-supportive beliefs).

4.6 The Role of Social Learning

Social learning theories suggest that individuals learn behaviours within their social context and environment; that is, a young person's behaviour is shaped by what they have learnt (i.e. by modelling and observational learning). The rate of child abuse for male youth with HSB is much higher than found in the general population (Fortune, 2007; Hackett et al., 2013) and has led to studies attempting to identify CSA as an antecedent to HSB.

Garland and Dougher's (1990) formulation of the "abused to abuser" relationship has been used to link the role of sexual victimisation in subsequent offending. Their "sexual abuse cycle" hypothesis seeks to explain HSB using the prevalence rates of CSA in the background of offenders. HSB, they propose, can be the

result of learning through exposure to inappropriate sexual behaviour. The subsequent re-enactment of the behaviour, followed by cognitive, emotional physiological reinforcements, may lead to maintaining the behaviour (Burton, 2003). The sexual abuse cycle concept has not been empirically validated, however a recent meta-analysis has confirmed various elements of it and found a significant but small relationship between history of sexual abuse and sexual reoffending (e.g., Mallie, Viljoen, Mordell, Spice, & Roesch, 2011; Seto & Lalumiere, 2010).

One of the limitations of this theory however is that many youth with HSB have never been sexually abused (Ryan, 1989). Exploring the relationship between CSA and HSB and which specific risk factors may be relevant, other researchers have found that offenders often have complex developmental and behavioural problems and have experienced more chronic histories of sexual victimisation (Burton, 2013; Burton, Miller, & Shill, 2002). While these studies look only at incarcerated youth, the findings suggest that CSA may create distinctions in antecedents, treatment responsivity, and HSB patterns.

This perspective is supported in a NZ study by Lambie et al. (2002) which collected retrospective information from adults who had offended as children and those that had not. They found that youth with HSB had complex experiences, and that sexual abuse alone is not a sufficient explanation. It has been suggested that exposure to trauma generally, not sexual abuse per se, is the etiologically significant factor in the emergence of sexually abusive behaviours in children and young people (Gray, Pithers, Busconi, & Houchens, 1999).

A number of studies have shown that a substantial portion of youth with HSB have experienced either one or multiple traumas (e.g., Hackett et al., 2013). The link between neuropsychological responses and behaviour is significant. Experiences of complex trauma (such as those evidenced in research on youth with HSB), can affect cognitive, physical, emotional, social and/or independent functioning (van der Kolk, 2006). The neurobiology of trauma is thought to have a direct link to mental health issues and problem behaviour in youth with HSB due to their high rates of maltreatment (Creedon, 2009).

According to Creedon (2010), while social learning theory is not sufficient to draw the link between trauma experiences and HSB, it has made an important

contribution to understanding the etiology of HSB for some youth. Consideration needs to be given to a deeper psychological interplay that is located in trauma and neuropsychological development (e.g., overwhelming emotional states). Social learning theory has identified the possible role of maltreatment histories and contributed towards trauma-informed treatment emphases which consider the effects of psychological trauma, particularly on neuropsychological development, and the relevance this has for effective intervention. This has led to the GWM incorporating elements to respond to the needs of young people who present with trauma.

4.7 The Role of Family Systems

Family systems approaches to conceptualising problem behaviours suggest that individuals are part of an interacting system and are therefore influenced by the interactions, patterns, hierarchies, and culture and communication styles of that system (Lewis, Beavers, Gossett, & Phillips, 1976). From this perspective the role of families and their influence on the development and maintenance of adolescent sexual behaviours, including of HSB, has been linked to dysfunctional family systems (Bennett, 2003; Vizard et al., 2007). Although there is a lack of empirical support for the view that family relationship problems are a direct casual factor for HSB (Seto & Lalumiere, 2010), the family systems perspective recognises the developmental stage that adolescents are in, the impact of HSB on the family (Hackett et al., 2013), and the need for family/support systems to be involved in treatment.

4.8 The Role of Developmental Factors

Developmental theories adopt a lifespan approach to understand obstacles to a positive developmental trajectory. For a portion of youth, disrupted and incomplete developmental growth is thought to result in HSB (Rich, 2003). These theories draw attention to the nuances of child and adolescent development; attachment experiences and their contribution to self-regulation; and the influence of family and social context on their neurodevelopmental behaviour (Creedon, 2013). For example, traumatic experiences (individual and contextual) interrupt the neurodevelopmental trajectory and the relationships which facilitate healthy development, growth and skill

development (Briere & Lanktree, 2013; Briere & Scott, 2012; van der Kolk, 2006). This leads to compromised functioning and behaviour such as problems with emotion regulation (Perry, 2009; Schore & Schore, 2008; Siegal & Harzel, 2003; van der Kolk, 2006).

From an attachment-informed perspective, the impact of poor attachment on developmental pathways and the possible link to HSB has been the subject of recent studies examining the link between an insecure attachment style and HSB (Awad & Saunders, 1991; Becker, 1990; Blaske et al., 1989; Davis & Leitenberg, 1987; Hunter et al., 2003; Knight & Prentky, 1993; Miner & Crimmins, 1995; Seto & Lalumiere, 2010). Youth with HSB have been characterised as socially isolated and lacking the confidence to engage in social interaction. Social competence problems such as inadequate social skills, difficulty maintaining close relationships, social isolation, and poor peer relationships have all been identified as problems for a portion of youth with HSB. An indirect association between anxious attachment and the sexual abuse of children has been identified, supporting the view that some youth engage in HSB to meet intimacy needs and their desire for closeness (Miner et al., 2010; Miner, Swinburne-Romaine, Robinson, Berg, & Knight, 2014).

Although studies have alluded to a link between the parent and child relationship and the development of HSB (e.g., Smallbone & Dads, 2000), and attachment theory (AT) provides a platform for valuable conceptualisations of early life experiences and physiological, psychological and cognitive adaptations to childhood maltreatment, a number of difficulties exist with this theory. There is much contention about the implied idealised childhood experience, and the suggestion that experiences that deviate from this lead to unquestioned difficulties in relationships. Use of this lens alone has been cautioned because although it is useful, no direct link has been found between poor attachment and the development of HSB (Rich, 2010).

Rich (2006) takes up this argument and posits a more reserved application of AT, suggesting that a sound understanding of the tenets of AT is missing in the search for possible causal explanations. Furthermore, even though attachment problems may be a contributing factor for a number of lifespan issues, it does not provide an adequate explanation for youth HSB. Many young people with poor attachment never

go on to develop HSB and attachment deficits are more likely to be one element of a complex pathway.

4.9 Summary

It has been well documented that adolescents with HSB are a heterogeneous group who have varying degrees of identified stable, static and dynamic risk factors present at the time of offending (Ryan, 2010), suggesting that for adolescents there are multiple pathways to sexually abusing others and that single-factor theories alone do not account for the complexity of causes. HSB perpetrated by youth is multifaceted (Rich, 2009) and offenders' characteristics are diverse (Veneziano & Veneziano, 2002).

The review of the theoretical underpinnings of the GWM carried out in this chapter indicates that caveats are required for when a specific theory is relevant, and that the use of single-factor theories to understand the causal pathway is insufficient; a multifactorial approach is clearly needed. The GWM was initially informed by cognitive behavioural, rehabilitation theories, and general psychological perspectives (e.g., social learning theory). More recently, the clinical approach has been expanded to include the use of developmentally focused theories such as the ITSO to account for the impact of, for example, adverse experiences and their relationship to current functioning (Longo & Prescott, 2013; Perry, 2010) and attachment relationships (Creedon, 2009). The next chapter discusses treatment approaches for adolescents with HSB.

Chapter 5: Treatment

While the number and availability of offence-specific treatment programmes have increased over the last three decades, evaluation studies based on empirical research and scientific rigor have lagged behind (Letourneau & Borduin, 2008). At present there is only a small number of outcome studies that provide empirical findings on the effectiveness of available treatments for youth with harmful sexual behaviour (HSB) within clinical settings (Rasmussen, 2013).

Building on the theoretical foundation for treatment presented in Chapter 4, this chapter focuses on treatment approaches and begins by discussing the difficulties involved in measuring treatment effectiveness. It then provides a brief historical overview of early treatment pathways and critically examines the current treatment perspectives and available treatment outcome literature. The Good Way model (GWM; Ayland & West, 2006) is introduced as an approach based upon a cognitive behavioural therapy (CBT) framework that has continued to be informed by research, clinical experience and changing perspectives and belief systems about what works best in treatment.

5.1 Measuring Treatment Effectiveness

While the measurement of treatment effectiveness has been captured with self-report measures (e.g., Kaplan, Becker, & Tenke, 1991), and much less frequently by changes to arousal when exposed to sexual stimuli, the most popular method by far for measuring effectiveness is recidivism rates (Camp & Thyer, 1993; Davis & Letenberg, 1987). With only a small number of outcome studies available to inform the development of treatment programmes, however, it is crucial to understand the limitations of recidivism as a measurement of change (Eastman, 2004).

Studies (e.g., Worling & Curwen, 2000; Worling, Litteljohn, & Bookham, 2010) indicate that sexual offending recidivism rates are variable for young people who have completed an offence-specific treatment programme, however they typically sit at approximately 10% or under (Nisbet et al., 2005). This is reflected in a critical review of 17 international studies and one based in New Zealand (NZ; $N = 3,189$ offenders),

which analysed recidivism rates (Fortune & Lambie, 2006). The authors found that although rates of non-sexual offending were substantial (on average 53%), sexual reoffending base rates were much lower (12%), suggesting that only a small portion of youth with HSB continue to sexually offend and that over half go on to offend non-sexually.

Criticism of the use of recidivism as a measure focuses on the reliability and the accuracy of rates due to the impact of underreporting, variable sources of data (e.g., police, family and self-report), and the difference in length of time between follow-up in studies (which can range from 1 to 10 years; Walker et al., 2004). Complicating this picture further is that treatment programmes provide a variety of treatment pathways to varying groups of youth with HSB. The focus on recidivism rates has also overshadowed understanding of the components within treatments which create change and fidelity to them (Eastman, 2004). Researchers also tend to ignore the implications of differential treatment delivery across research sites and change to treatment provision over the last three decades, both of which create replication difficulties.

In the abovementioned review by Fortune and Lambie (2006), the authors found that relevant studies are limited in number and are still in their early stages. Therefore, although they are able to provide an indication of treatment effectiveness, limitations relating to their design and location of participants (e.g., incarcerated youth) have implications for interpretation and generalisability. The authors also highlight that only a small portion of the available outcome studies use comparison groups or involve random assignment to different treatment conditions.

Many outcome studies' findings relate to populations in the United Kingdom, the United States and Canada that are dominated by Caucasians. Indeed, ethnic diversity is a very important issue to consider when working with NZ youth who have HSB. The 2013 Census (Statistics NZ, 2013) identified 213 ethnic groups in the country, with the largest being NZ European and Māori, closely followed by Chinese, Samoan and Indian. This represents a unique mix of social, cultural and ethnic diversity, and treatment-relevant psychosocial factors.

Despite these limitations, however, using recidivism as a measure can tell us whether a treatment is effective and provides support for the view that working with

the systems around the young person reduces the risk of sexual recidivism (Borduin, Schaeffer, & Heiblum 2009; Schaeffer & Borduin 2005) and may help with longer-term desistance.

5.2 Early Treatment Approaches

There has been a concentrated effort since the early 1980s towards the prevention of sexual abuse perpetrated by young people by way of specialised offence-specific treatment programmes. The absence of clinical knowledge on youth with HSB, combined with the availability of a larger body of knowledge on adult sex offenders, led to CBT-based programmes designed for adult males being modified and applied to youth (Righthand & Welch, 2005; Ryan & Lane, 2010), and further adapted for youth with an intellectual disability (ID) and/or developmental disabilities (Wilcox, 2004). Treatment components were focused on targeting risks and criminogenic needs (Andrews et al., 1990; Andrews & Bonta, 2006; Fisher, Morgan, Print, & Leeson, 2013). Specific treatment milestones included identifying the sexual abuse cycle (Ryan, Lane, Davis, & Isaacs, 1987), modifying cognitive distortions, reducing deviant arousal, developing victim empathy, anger management (Wood, Grossman, & Fichtner 2000), developing coping strategies to reduce reoffending, and making full disclosure (Rasmussen, 2013). The primary aim of early approaches was to reduce sexual recidivism. While reducing risk is an important aspect of treatment, it is insufficient alone for treatment effectiveness (Ward & Marshall, 2007).

Relapse prevention models (Gray & Pithers, 1993; Pithers, Gibat, Marlatt, & Marques, 1983), which originated in the substance abuse field, were used to help young people become aware of the factors which might lead them to sexually abuse and to escape risk situations (D’Orazio, 2013; Hunter & Longo, 2004). One of the difficulties with relapse prevention models is the risk of a too greater focus on deficits and weakness and an overemphasis on a single causal pathway to HSB (Longo & Prescott, 2010).

The practice of using the accumulated body of knowledge from adult sex offenders (both empirical research and theory) to understand, assess and treat youth with HSB has been called the “trickle down effect” (Prescott & Longo, 2010). Major

criticisms of this approach have included its lack of acknowledgement of the offence-specific and developmental differences (the protective factors and those that mediate risk) between adults and youth (O'Reilly & Dowling, 2008; Prescott & Longo, 2010; Ward & Siegert, 2002) and the risk of keeping young people in treatment much longer than needed (Pratt, 2013). Furthermore, the impaired cognitive capacities, low IQs and learning disabilities which feature in youth populations were often not considered.

The argument that the risks and treatment needs of adolescents with HSB are different to their adult male counterparts (Lambie & Seymour, 2006; Rich, 2003) is supported by the findings of Hackett, Masson and Phillips (2006) who surveyed practitioners in the United Kingdom ($n = 78$) about their current perspectives on good practice when treating youth who have sexually abused. A reoccurring theme in their findings was that young people were viewed as distinctly different from adult sex offenders and that both HSB and developmental considerations should be integrated into treatment.

5.3 Cognitive Behavioural Approaches

Treatment programmes have increasingly recognised that the rehabilitation of youth with HSB differs to that of adult sex offenders, and requires the consideration of a developmental perspective which takes into account youth-specific risk factors related to HSB (Creedon, 2013; Letourneau & Bourdin, 2008; Righthand & Welch, 2001). In 1988, a task force was commissioned in the United States to identify relevant treatment goals for adolescents with HSB which assisted in facilitating the integration of developmentally appropriate cognitive behavioural approaches to treatment (National Adolescent Perpetrator Network, 1988). In a recent study, McGrath, Cumming, Burchard, Zeoli and Ellerby (2010) collected information on current practices of practitioners and trends in treatment programmes in the United States ($n = 1,379$). Two-thirds of the sample continued to endorse the use of CBT with an emphasis on relapse prevention as their primary treatment model and the length of treatment length was often longer than a year. Systemically focused approaches – such as multisystemic therapy (MST) and strengths-based and trauma-based approaches were also commonly used. While CBT and relapse prevention strategies continue to be the most frequently used treatment modalities, a major advancement

from early approaches is that developmental needs are now much more of a focus and adolescents are no longer viewed as little adults (Bengis, Prescott, & Tabachnick, 2012).

Evidence supporting the effectiveness of CBT can be found in a study by Walker et al. (2004) who conducted a meta-analysis and review of 10 studies which focused on treatment for youth with HSB ($n = 644$). The findings indicate that treatments were generally effective overall, though treatment packages that were CBT-based yielded the largest effect size followed by MST which utilised CBT elements. Evidence for treatment effectiveness using CBT can also be found in another meta-analysis which used data from nine studies on treatment for youth with HSB ($n = 2,986$) to conduct a statistical review (Reitzel & Carbonnel, 2006). The review looked at recidivism rates and indicated a statistically significant effect size for CBT and MST therapies. Fanniff and Becker (2006) also conducted a review of research on specialised treatment interventions for youth with HSB. This included CBT, psychosocial educational treatment and MST. They found some empirical support for the effectiveness of CBT, however it could only be considered “promising” given the methodological issues within the studies.

Although all three reviews based upon recidivism rates, available meta-analyses and follow-ups of randomised-controlled trials (RCTs) on treatment for youth with HSB generally support short-term, sexually abusive behaviour-focused CBT interventions, particularly as part of MST, which also include substantive input from caregivers (Borduin 2009; Carpentier, Silovsky & Chaffin, 2006; Letourneau & Borduin, 2008; Walker et al., 2004).

Exceptions to the key focus on recidivism rates as a primary source of treatment effectiveness can be found firstly in a study by Eastman (2004), who used a crossover longitudinal research design to examine the attainment of treatment goals within an offence-specific programme. Eastman found significant changes in self-esteem, sexual knowledge and levels of cognitive distortion. A second study, by Worling (2008), evaluated a treatment programme which utilised CBT elements using reports from clients, caregivers and clinicians involved in treatment. Overall young people and caregivers were satisfied with the service they received and the programme provided positive outcomes.

5.4 Systemic Approaches

Young people with HSB present with a range of developmental, contextual and interpersonal needs, indicating that the treatment needs of youth with HSB – regardless of their cognitive ability – require a systemic lens which does not focus on sexual risk and recidivism alone. Young people are part of a multidimensional family system (Jones, 2003) and during the period of adolescence they experience critical life-related tasks which involve behavioural self-organisation, relationship-seeking external to the family, identity formation, and greater independence (Luciana, 2009; Miccio-Fonseca, 2009).

Emerging research and practice which focuses on strengths and resiliency factors have prompted reassessment of the efficacy of risk-reduction-focused approaches (Collie et al., 2007). Treatment approaches have become more systemically located and have begun to include strengths-based approaches such as positive psychology (Seligman, 2002) and contemporary theoretical approaches to working with youth such as narrative therapy (White & Epston, 1990) and the Circle of Courage (Brendtro, Mitchell, & McCall, 2009). Although these approaches vary and are yet to be empirically validated for youth with HSB, their emphasis is on individual and family functioning, and clients' competencies and strengths, resources, capacities and resiliency, rather than solely on deficits. In a review of 23 treatment studies for youth with HSB, Nisbet et al. (2005) found that regardless of treatment setting, programmes which apply more holistic interventions on more than just the individual level are more likely to demonstrate treatment effects.

As noted above, MST has been shown to be effective in two RCTs examining the treatment outcomes for youth with HSB (Borduin, Henggeler, Blaske, & Stein, 1990; Borduin & Schaeffer, 2001), and within an outcome study (Letourneau, Schoenwald, & Sheidow, 2004). The samples in these studies were made up of young people who resided in youth facilities for coexisting conduct-type problems, suggesting that MST was a successful intervention for a subgroup of youth with HSB, and that interventions which involve families are beneficial.

5.5 Neuropsychological Approaches

Current perspectives on treatment also consider the neuropsychological perspective to conceptualise, understand and treat youth with HSB (Ryan, 2010). This perspective is widely considered key to improving practice in the treatment of young people who have neuropsychological deficits, learning disabilities, language deficits, executive functioning difficulties, head injuries, and poor communication skills (Fago, 2003; Miccio-Fonseca, 2012; Seto, 2012; Veneziano & Veneziano, 2002). The traditional tenets of CBT are primarily verbal and rely on processing verbal information and therefore such treatment may be less accessible for these young people (Creedon, 2009).

More recently, interventions have integrated non-verbal evidence-based strategies to target common problems found in youth with HSB (e.g., learning self-regulation skills) and to improve the overall health and function of the brain (Longo & Prescott, 2013). This may involve treatment from a multimodal base (e.g., verbal, visual, movement, kinaesthetic, musical), and it may be the case that self-regulation (lower brain) should be targeted prior to higher-functioning language activities (talk therapy).

Current treatment perspectives also consider the neurodevelopmental impacts of trauma on the attachment process and behaviour (Ryan et al., 2010; Perry, 2009; Prescott, 2013). Burton (2000) states that many youth with HSB are significantly traumatised and suggests that this “validates the movement in the field toward resolution of that trauma as an important and relevant factor in treating child and adolescent sexual offenders” (p. 45).

5.6 Integrated Approaches

No longer in its infancy, research and clinical practice focusing on the treatment of youth with HSB has demonstrated significant shifts over time with treatment programmes moving beyond focusing on the index offence towards a more integrated and holistic approach focusing on protective factors and the overall wellbeing of each young person (Trout, Ryan, La Vigne, & Epstein, 2003). For example, Creedon (2013) recommends acquiring and developing pro-social experiences and skills for meeting broader developmental goals and living healthy lives.

According to Longo (2004), early approaches such as relapse prevention are more likely to be viable when included within an integrated approach. He advocates the integration of CBT, systemic approaches and developmental frameworks relevant to the overall treatment of the young person. Longo goes on to define integrated (holistic) approaches as a blend of traditional and non-traditional interventions for working with the whole person and the systemic context in which they live (family, school), not just the referred targeted issue. Furthermore, treatment effectiveness can be improved if it is tailored to the developmental needs of the young person (Holmbeck, Devine, & Bruno, 2010). This level of flexibility is consistent with the RNR approach (Creedon, 2013) and involves treatment plans based on learning styles, ability to self-regulate, neuroscience-based understandings of trauma and attachment, strengths, social competency skills, healthy sexual development, and involving families before the structure of the intervention is considered (Bengis et al., 2012; Creedon, 2013; Ryan et al., 2010). As youth-specific research has continued to develop it has become apparent that although youth have a common treatment goal of desisting from further offending, the clinical picture will vary depending on the needs of each young person (Worling, 2010).

The wide-ranging array of comorbid issues for youth with HSB identified in the research has contributed towards the adoption of varied elements in interventions to meet treatment targets and best meet the needs of the young person and their family. Lambie and Seymour (2006) have highlighted this issue by identifying that the repetitive indication of conduct disorder and oppositional defiant disorder populations requires a reordering of treatment to include a range of approaches which have efficacy in reducing the risk of antisocial behaviour developing further. For those youth with comorbid psychopathology a number of evidence-based practices exist and have led to the integration of treatment elements into existing treatment programmes. For example, Creedon (2010) describes the phase-orientated trauma treatment approach for youth with HSB which incorporates evidenced-based treatments such as biofeedback, CBT, dialectical behaviour therapy, and drama therapy.

In practice, the GWM uses a strengths-based CBT framework as its primary lens to understand clients and integrates concepts from other models (e.g., motivational interviewing, biofeedback, relapse prevention and narrative therapy; Ayland & West,

2012). An important distinguishing feature of the GWM is that although it has a strengths-based emphasis, it has drawn and built upon relevant previous and current understandings on youth with HSB. The model incorporates both specialised knowledge about sexual abuse and generalised knowledge of adolescent development. As a therapeutic framework the GWM targets HSB, is adaptable, and holds the capacity to deal with a number of developmental problems and coexisting problem behaviours. Drawing from the RNR model, the GWM is particularly responsive to an individual's developmental status, learning style and language deficits, executive functioning skills and cognitive abilities, culture, and trauma histories.

5.7 Adaptation of Treatment Programmes for ID Youth

While the literature on treatment approaches for youth with HSB continues to grow, its applicability to youth with ID is yet to be fully understood (McKenzie & Mathews, 2009). Treatment for ID youth with HSB has developed at a slower pace compared to the mainstream programmes, and few interventions have been validated empirically (Craig & Hutchinson, 2005; Lindsay, 2002). Rather than being similar to adults, ID youth are much more likely to be similar to other youth with various problem behaviours (Butler & Seto, 2002; Weinrott, 1996). A key difficulty is that abstract models of therapy that are modified for this client group were not developed from concepts most relevant to ID youth.

For the most part, treatment programmes for young people with ID have generally been modified from a combination of adult and youth mainstream programmes. This is often done by simplifying the concepts, using concrete illustrations, pictures and symbols to present information, and including other tools and interventions from the disability field (Lambrick & Glaser, 2004; Lindsay, Bellshaw, Cullross, Staines, & Michie, 1992; Wilcox, 2004). Relapse prevention and the method of skills teaching has been a popular approach to treatment (Blasingame, 2005; Lindsay, Symonds, & Sweet, 1979; Michie, Lindsay, Todman, & Smith, 1997). In a review of the literature on the treatment of ID offenders, Wilcox (2004) suggests that treatment approaches be modified to take into account the poor insight and abstract-reasoning abilities of ID clients.

The systemic and structured approach of applied behaviour analysis (ABA) is often employed to assist in shifting behaviour for ID youth because it is based on principles of learning (Neidert, Dozier, Iwata, & Hafen, 2010). ABA has been shown to produce improvements in problem behaviour for youth with ID because it is responsive to their learning disabilities and the likelihood of them being more dependent on their families. These same learning principles have been taken up in the GWM.

Although youth with ID navigate many of the same developmental milestones as non-ID youth, living with an ID will diversely impact on experiences with family, peers and wider social cultural responses from others (Blasingame, 2005). Compared to the general population, adolescents with ID have much higher rates of mental health issues and problem behaviours which are functionally impairing and can hinder social development (Einfeld, Ellis, & Emerson, 2011; Hassiotis & Turk, 2011). Recently therapists dealing with such clients have increasingly recognised their developmental differences, salient psychosocial factors, and coexisting cognitive, psychological and/or medical problems (Oeseburg, Jansen, Dijkstra, Groothoff, & Reijneveld, 2010). In this way their impulse control problems, deficits in adaptive behaviour, communicative and social skills deficits, genetic abnormalities, slower learning styles, and reduced ability to process information are being considered (Bremer, 2005; Hackett, 2006).

There are population-specific factors for youth with ID that are meaningful for intervention pathways (Blasingame, 2005; Neidert et al., 2010). For ID youth there is also likely to be a greater difference between chronological age and developmental age, which requires consideration in the delivery of interventions, and factors which influence sexual decisional making, such as opportunity and understanding (Blasingame, 2005). Studies focusing on ID youth with general delinquency recommend that treatment include skills training and should focus on problems with cognitive information processing and regulation of aggressive behaviours (Asscher, van der Put, & Stams, 2012). Lund (1992) suggests that with the right guidance, experiences and information many people with ID are capable of developing a normal and healthy sexuality and of experiencing loving, caring and intimate relationships.

One of the more recognised treatment approaches for working with ID adults with HSB is the Old Me/New Me model (Haaven, Little, & Petre-Miller, 1990). This

model was developed as a way of providing clients with a framework for challenging negative self-talk and behaviours and for identifying positive goals and behaviours. It was modified by Lambrick and Glaser (2004) into a pictorial model with an additional component to symbolise the achievement of long-term goals in the future.

Recent years have seen approaches to working with young people with ID and HSB that are more receptive to their developmental differences, individual needs and learning styles (Bremer, 2005; Hackett, 2006; Ryan, 1999) and recognise that for young people their family and/or communities of care play a significant role in contributing to the change process (O'Callaghan, 2004b). For example, the Greater Manchester Adolescent Programme (GMAP) in the United Kingdom is a treatment programme which recognises the need for a developmentally sensitive intervention consisting of individual, group and family work. The foundation to this programme is a detailed and holistic assessment which includes factors salient for ID youth (O'Callaghan, 2002). Following the identification of relevant treatment targets, interventions use expressive mediums, visual cues, simple language, and support from carers to encourage the uptake of learning. Individual work is conducted in an adjunct way to address the personal goals of each client. Repetition, reinforcement, and multisensory techniques are utilised to maximise retention. Treatment is based on a combination of individual and group work (which includes a number of set "topic blocks"). There is a heavy focus on the "road map" metaphor, where young people travel on a journey from their "old life" to their "new life" via a "muddle roundabout". The muddle roundabout is used to discuss times where they experience periods of confusion (O'Callaghan, 2004).

Youth with ID not only require different approaches, they also require consideration in terms of the lifelong marginalisation and vulnerability they experience. Lambie and Seymour (2006) suggest that youth with special intellectual needs be considered a "special population" with population-specific factors which should be catered for adequately within programmes for non-ID youth, due to the pervasive nature of their problems. The term "special needs" is widely used within NZ sexual abuse treatment provider services to describe young people who, as a result of their cognitive processes and/or functioning, are not suited to the mainstream treatment programmes. The commonality inherent in the special needs cluster is that the young person has difficulty learning using higher-order functioning and their brain

does not function in a way which is conducive to treatment as presented in mainstream approaches.

Although ID youth have traditionally been separated from non-ID youth within NZ treatment programmes, this has been within the context of multimodal treatment approaches in which group work is carried out. This is because ID youth typically have deficits in adaptive behaviour and slower rates of learning that become meaningful for treatment (Neidert et al., 2010). For example, the NZ SAFE Special Needs programme runs for approximately 18 months and caters for those clients with specific cognitive or learning difficulties (Fortune & Lambie, 2004).

5.8 New Zealand Treatment Outcomes

The majority of treatment services for youth with HSB in NZ are community-based (Fortune, 2013). Since the SAFE Network (Flanagan, 2003), the first community-based treatment programme in NZ for youth with HSB, was established in Auckland in 1988, two additional community-based organisations have been established. WellStop provides treatment in Wellington and the lower North Island, and STOP provides the same service in Christchurch and across the South Island. SAFE is based in Auckland and extends its services from Northland to Hamilton. These organisations operate together as a sector and work closely with a number of government and non-government agencies to provide specialised treatment to mandated and non-mandated youth with HSB. The majority of their youth referrals come from Child, Youth and Family (CYF), the Youth Courts, community agencies, schools and families (Flanagan, 2003). These organisations provide a range of sex abuse-specific programmes for children, adolescents and adults to cater for their different needs. These include early interventions programmes for children, special needs programmes for clients with an ID and/or developmental difficulties, girls' programmes, culturally appropriate programmes for Pacific Island clients, and Māori programmes which reflect Tikanga Māori (Fortune, 2013; Lambie et al., 2007).

Compared to treatment programmes in North America, NZ programmes offer a much more dynamic and fluid approach (Lambie, 2007). While early practices in NZ community-based treatment agencies mirrored those offered internationally, their interventions have since evolved to include a variety of youth-appropriate models

delivered within a multimodal programme (e.g., individual, family, group, and wilderness-based therapies; Geary, Lambie, & Seymour, 2011). Therapeutic interventions vary between NZ community-based treatment programmes but have traditionally included cognitive behavioural approaches with relapse prevention and cycles of offending (Dillon, 2010; Fortune, 2013). There exists some variation in service delivery between programmes in NZ. Over the last five years, STOP and WellStop have moved towards a more individualised approach to treatment which utilises a combination of strengths-based approaches and evidence-based components for aspects of the work, while SAFE in Auckland continues to use multimodal treatment and group-based wilderness camps. One of the difficulties with researching the effectiveness of multimodal treatment approaches is understanding the specific factors which create changes.

It is important to consider that the majority of NZ research on youth with HSB has been conducted using data from WellStop, STOP and SAFE, with only a small number of studies using samples sourced from elsewhere (e.g., Lightfoot & Evans, 2000). The largest NZ study was titled “Getting It Right” (Lambie, Geary, Fortune, Willingale, & Brown, 2007) and was commissioned in 2003 by CYF to provide robust empirical data to guide the development of treatment services in the country. The primary objective of this project was to evaluate the effectiveness of community-based treatment programmes for adolescents who sexually offend and determine whether treatment resulted in a reduction in sexual reoffending, improved psychological health and positive outcomes, and was cost-effective. Several of its findings hold direct relevance for this study.

The outcome evaluation of Getting It Right (Fortune, 2007) involved a file review and follow-up. This study showed that the configuration of interventions within the community-based treatment was effective on HSB and that although there was some change in rates, non-sexual offending remained problematic. It was found that many youth, including those who successfully completed treatment, those who dropped out of treatment, and those who did not receive treatment, continued to engage in non-sexual offending. As found in international studies (e.g., Miner et al., 1997; Rasmussen, 1999), although treatment programmes in NZ have been able to successfully reduce sexual recidivism, interventions showed minimal impact on non-

sexual offending. There was a 2% sexual recidivism rate for those who completed treatment, and a small reduction in non-sexual offending, which remained high at 38%. Those youth who dropped out of treatment represented a group who were at the highest risk of sexual and non-sexual recidivism. Those at most risk of non-sexual offending in this group were those with a history of non-sexual offending prior to their entry into the programmes. Almost half the special needs youth in this sample reoffended non-sexually. Results from pre- and post-treatment measures showed there was some indication that treatment was effective on behavioural and psychological problems, though the specificity of this was not accounted for.

The process evaluation for *Getting It Right* (Geary, 2007) interviewed a number of young people and their families who had been through treatment to establish their perceptions and experiences about what aspects of the treatment programmes had contributed to the successful outcomes and low recidivism rates found in the outcome study. Many of the factors which contributed towards positive change in behaviours for young people were systemically located (community, family, school, peers). Furthermore, characteristics which assisted the therapeutic process (e.g., treatment engagement and exploration of difficult issues) included involving family, strong therapeutic relationships, and multimodal and holistic interventions (e.g., culturally and developmentally responsive; Geary et al., 2011). The influence of the therapist and therapeutic relationship on successful treatment has only more recently identified (Marshall, 2005; Marshall & Burton, 2010; Ross, Polaschek, & Ward, 2008).

One of the overall recommendations from *Getting It Right* was that a “one-size fits all” approach does not work, and each client requires a tailored treatment intervention to meet their needs. Although NZ programmes are providing a holistic framework, the further integration of family and systemic work, the provision of interventions for coexisting problems (e.g., victimisation), and the introduction of treatment elements which focus on positive sexuality and healthy relationships may enhance programme effectiveness. Furthermore, the consideration of non-sexual offending rates and the place of appropriate interventions for this is warranted.

At the time of the *Getting It Right* study, the GWM was reported as the dominant therapeutic approach readily utilised at one of the three sites for the treatment of youth with ID in NZ. The model was also in the process of being adapted for use across

a more diverse range of clients. The evaluation also found that in programmes where the GWM was used, the model had high recall with the young people, was well received by parents and caregivers, and was considered a reason for positive change. Furthermore, the young people were able to describe in detail components of the GWM to the researchers. This indicated that they had understood and assimilated the model.

In his recommendations for future research, Lambie (2007) signalled that understanding the mechanics of the factors involved in successful treatment of youth with HSB would assist in modifying existing treatment programmes. One of the recommendations of the review was that “the Good Way Model be further developed so it can be used more extensively, with different client groups and across other programmes. Evaluation of this model is also required” (Geary, Lambie, & Seymour, 2006, p. 5).

This view was supported by a second study (Lancefield, 2006), also funded by CYF, which conducted a three-year review of WellStop's programmes against best practice standards and looked in depth at assessment processes and treatment delivery. Lancefield stated:

A key feature of Wellstop's Youth Programme is the Good Way model developed by staff of the team. The model has a sound theoretical base and generates a range of clinical conceptualisations that have clinical integrity and practical application. Practice observed demonstrates the utility of the model in addressing the treatment needs of youth with sexually abusive behaviours. The GWM provides a framework and range of therapeutic strategies that enhances the quality of clinical practice of the program. The writer is aware that staff have presented the model at international conferences with positive response and that it has received a considerable degree of interest from treating professionals. (pp. 5–6)

5.9 Summary

Establishing evidence for the effectiveness of HSB treatment approaches is no easy feat. The implementation of treatments has occurred at a much faster rate than research on the effectiveness on these treatments. Although outcome studies have indicated that treatment is effective for youth with HSB, there is as yet no empirically based treatment approach that can attend to the heterogeneity of youth with HSB. What can be said is that research has evolved from single studies to combined meta-analyses, giving a better indication of what is working and what areas require further consideration.

At the time of writing, there is little evidence to indicate that any one treatment type is more effective than any other, though CBT approaches with a systemic focus show more promise. All appear to have some benefit in terms of recidivism outcome and/or improvement of quality of life and the provision of less restrictive environments. The weighted use of recidivism to measure treatment effectiveness, whether it is a follow-up study or a comparison study, stops short of understanding how treatment is effective, and therefore stops us understanding, fine-tuning and replicating what is being delivered within a real-world setting.

Current best practice recognises the need for a holistic, developmentally sensitive, integrated, rehabilitative approach within youth interventions (Lambie et al., 2007; Prescott & Longo, 2010). There is an extensive range of factors which interact and are likely to contribute to HSB, and rather than focusing on the index offence alone, a broader focus on the development of all things sexual needs to be considered in treatment (Hackett et al., 2013). Not surprisingly, treatment targets, objectives and strategies vary among programmes, though most prominent approaches generally reflect the idea that effective treatment depends on the selected intervention's ability to decrease the "influence of static factors and shift current dynamic factors that increase risk for recidivism" (Nisbet et al., 2005). More recently there has been a significant shift from early approaches, which focused on using relapse prevention, towards treatments which consider developmentally sensitive, evidence-based models and interventions (Rasmussen, 2013). Furthermore, literature from outside sexual offending is also being considered.

The GWM has been proposed as a strengths-based cognitive behavioural approach which meets recommended key programme priorities for the treatment of youth with HSB by addressing both developmental and criminogenic needs within the rehabilitation process. The model is yet to be evaluated and its effectiveness is the focus on this study. The next chapter outlines the key tenets of the GWM.

Chapter 6: The Good Way Model

The primary goal of treatment is for adolescents with harmful sexual behaviour (HSB) to take responsibility for their behaviour and develop skills to prevent any further sexual abuse (Centre for Sex Offender Management, 2006). Treatment models based on a cognitive behavioural perspective are one of the most frequently utilised psychological interventions to treatment in criminal justice (Little, 2005) and are considered to be an appropriate treatment approach for youth with HSB. The Good Way model (GWM; Ayland & West, 2006; West, 2007) is a strengths-based cognitive behavioural approach for the treatment of HSB in adolescents that originated in New Zealand.

Although early process evaluations have indicated that the GWM has a positive effect on youth with HSB (West & Ayland, 2010), it is yet to be the primary focus of a research project. This chapter provides an overview of the development of the GWM and describes the intervention framework and key components of treatment. At this stage in the model's development we are looking to see if it works effectively as an intervention rather than researching the mechanics of the model.

6.1 The Development of the GWM

The GWM arose from work undertaken at a community-based treatment programme in Wellington, New Zealand, called WellStop during the late 1990s and the need for a simple tool to negotiate complex issues with “special needs” clients who think very simply and present with a wide range of problems, including HSB. These clients were from a range of cultural backgrounds and often presented with complex developmental and systemic issues. Many had an intellectual disability (ID) and/or learning difficulties and were regarded as having a high risk of reoffending (Ayland & West, 2006, 2012). The model's development was driven by a practical concern to communicate more effectively with these clients by paying close attention to their thinking styles and self-narratives (their descriptions of their experiences), and modifying therapists' language and best practice treatment concepts to create a better fit with client needs (Ayland & West, 2012). In this sense, the GWM was developed

pragmatically to provide an improved way of communicating with those who are considered to think in a more concrete manner.

Although in its original form the GWM was grounded in the language and concepts commonly used by young people with special needs, it has since been manualised and adapted successfully for higher-functioning adolescents in both community and residential settings (Ayland & West, 2010). The GWM is now being used routinely within WellStop and STOP community-based sex offender treatment programmes and in Te Poutama Arahi Rangatahi (TPAR) residential treatment programme for HSB in New Zealand; as well as Australian programmes (Ayland & West, 2006). The model has gained wide international recognition and is considered to be at the forefront of contemporary therapeutic approaches for working with young people who have HSB (West & Ayland, 2010).

6.2 Intervention Premise

Recognising that HSB is a multidimensional problem (Ryan, 2010), and that youth with HSB are a diverse group and therefore one size does *not* fit all, the GWM provides an integrative approach to the treatment of youth with HSB. While not dismissing the priorities of risk management, there is a major emphasis on identifying the strengths, resiliences, resources and good qualities of youth with HSB, their families and communities to help clients to live a better life.

Essentially, the GWM proposes that everyone has a “Good Side” and a “Bad Side”, and that taking more notice of one side will lead us to act either the “Good Way” or the “Bad Way” to meet our needs. This in turn will lead to positive or negative outcomes. Therefore we need to build on our Good Side strengths and learn Good Way skills in order to develop a “Good Life” that is both free of abusive or harmful behaviour towards others and meaningful and positive for the client.

The GWM also encourages youth with HSB to take responsibility for their abuse of others, and encompasses risk-need-responsivity (RNR; Andrews et al., 1990) principles and relapse prevention, with the ultimate goal of the young person having a Good Life (Ayland & West, 2006). Although the GWM has twin foci of reducing risk and enhancing lives, it does not aim to fix every problem the young person is experiencing. Therapeutic strategies focus on criminogenic needs to prevent recidivism and on

factors that are thought to be linked to and influence the young person's behaviours (e.g., the processes and/or cognitions that precipitate and maintain HSB).

Based on the individual needs of each young person, treatment packages vary in length and dose, and the GWM has the capacity to be flexible (e.g., the incorporation of behavioural interventions for clients with ID and more cognitive interventions for more able clients). It integrates a variety of techniques to best meet the different pathways to HSB and the diversity of clients' needs (e.g., the capacity to understand and attend to the role of complex trauma- and attachment-related problems, and other forms of adversity). This is an important aspect of the therapeutic process of the GWM which assists the young person to build internal capacity (skills, knowledge and competence) and external capacity (social support and opportunities; Collie et al., 2007).

Since young people, and especially those with an ID, have limited agency within their environments, most of the decisions concerning the management of their safety and welfare must remain the responsibility of parents, caregivers, teachers, social workers, and other adults in their lives. Therefore the key elements of rehabilitation are systemically located and are extended to include these adults in order to achieve the best outcome for a particular young person, especially the ability to create a supportive consistent stable environment and access to opportunities that will help develop their strengths and capacities.

6.3 Language, Concepts and Support Material

The GWM treatment programme offers a dynamic and creative vehicle for achieving therapeutic tasks (Ayland & West, 2006) and the language and concepts of the model provide a coherent narrative to discuss cognitions, behaviour and experiences (see Figure 6.1). At the basic level the GWM uses concrete language alongside a simple dualistic framework as one way to assist clients to communicate with others about their world. This framework is two-way and therefore also provides an effective pathway for young people to understand what professionals, carers and families are trying to communicate to them. For example, insecure/vulnerable clients may require a primary focus on connection and empathy, and more secure/engaged clients may respond better to guidance and teaching.



Figure 6.1 Possible areas which are the focus of therapeutic conversations

A variety of verbal, kinaesthetic and visual materials (see Figure 6.2) are used to match learning styles, engage clients, and meet treatment targets. There are a number of visual templates to assist with therapeutic conversations which also help young people learn and retain information. This was originally based on the premise that youth with low intellectual functioning and/or those who have varying cognitive capacities may respond more positively to a variety of mediums rather than merely written or verbally oriented CBT exercises. Further adaptations can be made based on age, gender and culture. Ideally the pace of therapy is determined by the ability of the client to understand the materials, and the themes and metaphors used in therapy are based on those meaningful to the client.

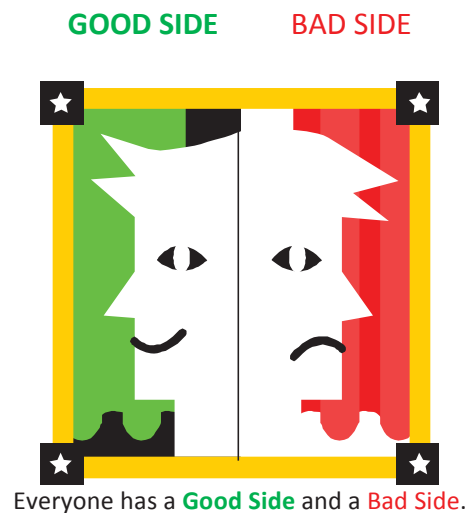


Figure 6.2 Example of a visual template

6.4 Intervention Framework and Process

The GWM intervention framework is made up of a comprehensive assessment phase and five broad treatment components (see Figure 6.3) which are adapted to meet the needs of the client.

6.4.1 Assessment Phase

In order to plan programme priorities for each young person the first stage of the GWM involves carrying out a comprehensive developmentally sensitive assessment. Holmbeck et al. (2010) argue that developmental issues shape treatment outcomes in interventions for young people. From their perspective, a developmentally sensitive intervention is based on an assessment that considers developmental and chronological ages and the meaning of deviations from what is considered to be a normal course of development across multiple areas.

The assessment also informs a safety plan and decisions about a young person's living arrangements called a "Good Way Care Plan". Working with young people requires the inclusion of their immediate care environments. Many young people referred to programmes for HSB are living either temporarily or permanently away from their immediate families. This can be the result of the introduction of safety plans, the victim residing in the home, or pre-existing care and protection issues. Some young people may not be involved in the school system.

Information is collected using clinical interviews and measures which gather information on relevant individual and family factors, characteristics and experiences; static and dynamic factors; emotional and behavioural functioning; and the identification of both risk and protective factors. Collecting information on factors which are thought to act as moderators of treatment outcome such as cognitive developmental levels and abilities and cognitive developmental process such as emotion regulation, abstract reasoning, perspective taking, and consequential thinking, and staggered development from trauma is considered relevant by the GWM as they can shape treatment delivery. A major focus during this phase of treatment is the setting of goals which are agreed upon with the family and young person. Treatment is moulded in a way that best suits the client and Good Way Care Plans are devised.

6.4.2 Treatment Phase

Clients address each of the five components during the course of their treatment programme, however the length of time spent covering these components and the emphasis of therapy is dictated by individual treatment needs.

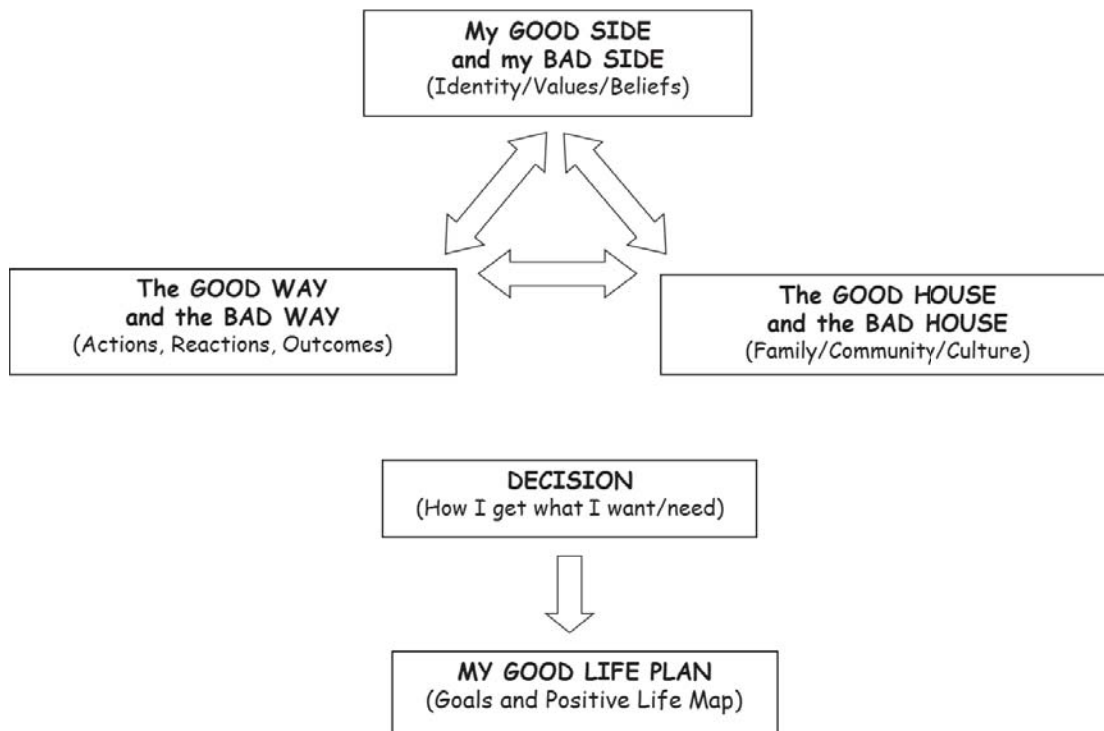


Figure 6.3 Treatment components of the GWM

Figure 6.3 shows the basic version of the GWM which is considered to be the bare bones of treatment. This version is most suited to clients with more concrete thinking styles (i.e. low IQ). To allow more detailed exploration and abstract conversations an enriched version (see Figure 6.4) of the model has also been developed. This is more suitable for higher-functioning youth. Typical treatment targets for young people include:

- Obtaining an understanding of the problem and creating a future vision of the life the young person and their family or significant others want to live (*The Decision*).
- Gaining an understanding of their Good Side and Bad Side to develop in turn an understanding of the consequences of their behaviour, to problem solve, set goals and learn how to have their needs met in a positive way (*Good Way/Bad Way*).
- Identifying what needs to happen to promote positive change and to identify strengths and resources that can be drawn upon to reduce problematic behaviour and work towards a Good Life (*Good Life Plan*).
- Dealing with loss and trauma, and the impact of their behaviour on others (*Good House/Bad House*).

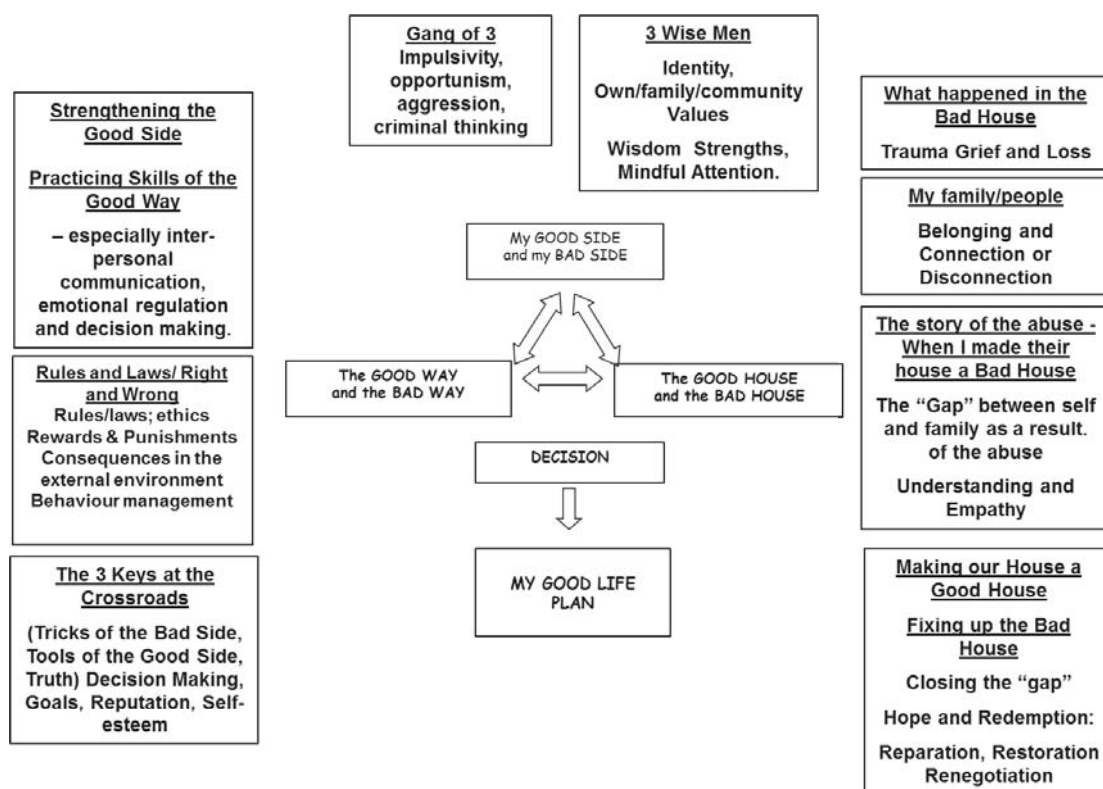


Figure 6.4 The enriched version of the basic GWM

To assist with the therapeutic change process the GWM integrates a number of therapeutic processes and practice elements from other interventions. This is most evident in the consistent primary externalisation of the Good Side/Bad Side. Narrative therapy and externalising conversations (White & Epston, 1990) are used to provide separation between the person and their positive (i.e. Good Side) and negative (i.e. Bad Side) characteristics, thoughts and values. This technique allows for use of terms such as “good” and “bad” without clients feeling judged as “bad people”. The use of the terms “good” and “bad” clearly communicates to young people about what is right or wrong in relation to harmful and/or unlawful behaviour.

Other techniques borrowed from narrative therapy include looking for unique outcomes or exceptions to the problem, utilising therapeutic letters (or stories), and relative influence techniques (mapping the influence of the problem on the person and person on the problem). Therapeutic techniques from other modified forms of CBT such as acceptance and commitment therapy (Hayes, 2004), dialectical behaviour therapy (Linehan, 1993); motivational interviewing (Miller & Rollnick, 2002); Socratic questioning (Mann, 2000); and techniques from solution-focused therapy (De Shazer,

1985) such as the miracle question, scaling and exception questions are also employed. Trauma interventions include “acute distress reduction (bio-feedback, mindfulness exercises and relaxation) and titrated exposure (therapeutic window and intensity control)” (Briere & Lanktree, 2013). Collectively these elements assist clinicians to build a safe foundation for the offence-specific components of the GWM and enable young people who have sexually abused others to move towards building their good qualities or Good Side and meeting their needs and desires the Good Way. A more detailed description of the GWM can be found in Ayland and West (2006), Collie et al. (2007) and West (2007).

While the GWM has responded to and integrated emerging research and clinical practice trends for youth with HSB, and has been well received and considered a reason for positive change (e.g; Lambie, 2007; Lancefield, 2006), at present it lacks empirical data to support its effectiveness. The next chapter describes the current study, which was designed to examine the effectiveness of the GWM for the treatment of youth with HSB.

Chapter 7: The Current Study

This chapter describes the current study in terms of its aims and research questions, rationale, and the methodology adopted to answer the research questions (see below). It outlines the process of evaluating interventions in real-world settings in general before detailing how the effectiveness of treatments for youth is evaluated. Finally, the importance of using a treatment manual for the purposes of implementing and replicating treatment with integrity is discussed.

7.1 Aims

This research project has been designed to be the first evaluation of the Good Way model (GWM) within its natural environment, the community-based treatment context. The primary aim of this study is to evaluate the effectiveness of the GWM as a clinical intervention for young people with harmful sexual behaviour (HSB). The secondary aim is to evaluate the effectiveness of the GWM in reducing non-sexual offending behaviour and comorbid clinically significant internalising and externalising difficulties when treating youth who have sexually harmed others.

7.2 Research Questions

The following research questions were developed:

1. Is the GWM effective for the treatment of HSB for ID and non-ID youth?
2. Is the GWM an effective treatment of comorbid externalising and internalising behaviours?
3. Is the GWM effective in reducing non-sexual offending?
4. Does the GWM work effectively regardless of changes in the treating clinician?

7.3 Rationale for the Current Research

Chapters 1 and 2 established that like elsewhere in the world child sexual abuse (CSA) is a significant problem in New Zealand, with far-reaching implications for survivors, their families, and communities. Researchers focused on understanding CSA have identified that adolescent boys are responsible for a significant portion of HSB. This has led to a body of knowledge that describes the etiology, prevention and treatment

of youth HSB. Professional responses have included the development of offence-specific treatment programmes, an example of which is the GWM.

Chapters 4 and 5 provided a historical overview of treatment pathways and the underlying theoretical frameworks used to conceptualise the relevant causes and correlates. This included a review of the literature which has moved away from approaches derived from work with adult sex offenders towards developmentally sensitive approaches. It was demonstrated that the treatment of youth who have sexually harmed others needs to focus on more than sexual risk and recidivism alone, and that there are key elements of treatment which need to be considered. It was proposed in Chapter 6 that the GWM is a contemporary strengths-based approach to treatment which meets recommended key programme priorities for the treatment of youth with HSB.

Chapter 3 meanwhile demonstrated that contemporary treatment approaches have incorporated recent research on youth with HSB, taking into account individual and family background characteristics, and the high rates of non-sexual offending behaviour and comorbid clinically significant internalising and externalising difficulties. These approaches aim to reduce risk as well as facilitate positive development by considering youth and family risk and protective factors, individual treatment needs and learning styles, and the integration of evidence-based elements. More recently, typology research and the identification of patterns within offending have also informed treatment needs and revealed the moderators that are likely to influence treatment outcome.

It is important for treatment programmes to be based on sound theoretical principles, research and empirical evaluation (Nisbet et al., 2005; Rasmussen, 2013), however the development of treatment programmes has occurred at a much greater pace than research on their effectiveness. Outcome studies of youth with HSB have heavily focused on recidivism rates and have established that a treatment “works” or that “treatment is better than no treatment”, for example, but the nature and specificity of treatments is an area that requires more detailed attention. Kazdin (2000) suggests that the specificity of treatment effects requires examination, alongside the factors/moderators that shape effectiveness itself. Understanding and

evaluating the models that contribute towards change is a logical step forward because this can support replication of “what’s working”.

7.4 Evaluating Interventions in Real-world Settings

To enable firmer conclusions about effectiveness results and to understand the models which contribute towards change in treatment, Fanniff and Becker (2006) stress that there needs to be improvement in the way methodological issues are tackled. According to Kazdin (2013), the use of scientific approaches in evaluation research allows for methodological transparency, rigour, and the ability to pursue replication of findings. The use of such approaches in evaluation research requires an understanding of the pathways to establishing evidenced-based psychological practice and of what is possible when research is conducted within real-world settings.

Evidenced-based psychological practice is defined as the integration of research and clinical expertise and includes the use of treatments which have the best research evidence (APA, 2006). While the use of randomised controlled trials (RCTs) is considered to be the gold standard of evidence for the efficacy of treatments, there are alternative study designs which have the capacity to provide strong evidence of effectiveness (Mudford, McNeill, Schneideman Walton, & Phillips, 2012). One of the major problems of efficacy research is that the conditions of the research itself require a major departure from the conditions and settings in which practice occurs, creating generalisability issues. Efficacy research is usually conducted within laboratory settings and focuses on internal validity (Huppert, Fabbro, & Barlow, 2006; Kazdin, 2006). In contrast, effectiveness research is able to demonstrate the extent to which an intervention produces a favourable outcome under “treatment as usual conditions” and can embrace and bridge the diversity of clients and clinician techniques inherent in real-world settings and clinical care (Kazdin, 2006).

Experimental research approaches such as single-case design are suited to exploratory research and can be applied within an existing treatment environment to gauge the effectiveness of treatment. A multiple-baseline design (Barlow & Hersen, 1984) is a type of single-case design for studying behaviour and has the capacity to demonstrate that a change in behaviour has occurred; that the change itself is the result of an intervention; and that the change is significant. It also enables fine-grained

analysis of effectiveness in particular circumstances (Dugard, File, & Todman, 2012). This design can be used on small numbers of participants to track client progress and is a viable alternative to RCTs (Goodheart, 2006; Hawkins, Sanson-Fisher, Shakeshaft, D'Este, & Green, 2007). Furthermore, it allows the researcher to begin identifying how and why something might work and how it can be improved, before moving on to efficacy research.

To meet its objectives this study employs a multiple-baseline design as a means of establishing the effectiveness of the GWM due to its appropriateness to the context of the study. The application of this design is discussed in more detail in Chapter 8.

7.5 Evaluating the Effectiveness of Treatments for Youth

Research on effectiveness examines what treatment, under which set of circumstances, and by whom, is most effective for this individual with that specific problem (Kazdin, 2014). Conducting research on interventions for young people is particularly complicated due to their developmental stage and varying degrees of dependency on families, which can act as mediators and moderators of treatment outcome. For young people with HSB the entry point into therapy itself is often mandated and their families are required to be involved in the treatment process. To evaluate the effectiveness of interventions in real-life settings there is a need for a pragmatic and rigorous research design which considers these factors.

Kazdin (2000) suggests that evaluating if an intervention is responsible for change requires more than a central focus on treatment effects, and proposes non-sequential foundational steps/areas for research that are aimed collectively at developing effective treatment. Effective treatments are based upon theory and research, and are targeted and based upon an understanding of the problem (including predisposing, precipitating, and maintaining factors) and potential moderators of that problem which shape the dimensions of treatment itself. A full picture of treatment effectiveness captures both the pro-social changes and the changes to symptoms/negative behaviours. In terms of treatment for children and youth, clinically significant systemic factors are also attended to, for example developing a safety plan, and the need for families to change, to facilitate change in the young person.

Kazdin (2000) goes on to present a blueprint for developing effective treatments that seeks to guide evaluation research on child and adolescent treatments. The model he presents evaluates different aspects of treatment and seeks to increase the likelihood of developing effective interventions by moving beyond studying treatment effects in isolation within the process. This framework includes multiple facets that collectively assist in understanding effectiveness. The three core areas are assessment, research design, and data evaluation. These components assist in gaining an understanding of “how treatments work, how they interface with clinical dysfunctions and to whom they can be effectively applied” (p. 155). In terms of a superior test of treatment outcome, the specification of the prescribed treatment within a manual is considered crucial.

7.6 Manualised Treatment

Over several years the principles and processes of the GWM treatment procedure have been operationalised into a treatment manual for the purposes of implementing and replicating treatment with integrity in relation to the training of staff. Clinicians treating youth with HSB often work in multidisciplinary teams and come from varied training backgrounds (e.g., social work, psychology, counselling). The benefits of a treatment manual within multidisciplinary settings include defining the underlying theory informing how the treatment achieves change (mechanisms and processes), how to focus treatment, and how to identify treatment targets. This includes understanding how the problem developed and how to change it from a GWM perspective. The manual has assisted in defining parameters to service provision.

Treatment integrity is related to degree of treatment outcome and Kazdin (2000) states that the use of treatment manuals assists in deciding which treatment should be administered; in adhering to treatment processes as they are prescribed; and in maintaining treatment integrity. The use of treatment manuals within research allows the specification of the treatment within the design, assists with the moderators of treatment, and allows the research to go beyond stating that “the treatment works and is effective” to understanding the guidelines for “how to do treatment and identifying the ingredients required for change”.

A carefully constructed treatment manual will outline the underpinning theoretical principles and processes of the approach and explain how they link to the selection of key treatment elements. Treatment manuals can be variable in their degree of specificity, detail and rigidity, and in the operationalisation of treatment and documentation of essential treatment components and themes. The use and development of treatment manuals assists in treatments being implemented as they were intended and manuals can be used to facilitate training (Wilson, 1998). The employment of a treatment manual which is flexible enough to meet an individual's treatment needs assists clinicians to use appropriate techniques and allows for dissemination of effective interventions.

Although criticism of manualised approaches is not uncommon, Kazdin (2000) argues that they can be used flexibly and as a roadmap to a destination, specifying the main "roads" to take. They also provide a consistent approach which is less likely to be affected by staff turnover and the variability of training and experience. To maximise the use of treatment manuals and to ensure they are operationalised correctly, expert supervision should be provided (Huppert et al., 2006).

7.7 Summary

This chapter has outlined the rationale for the study, and the factors which have led to the selection of the methodology used in this research. This study evaluates the GWM as it is delivered in a real-world setting for young people with HSB who receive treatment using the GWM. The use of manualised treatment in research allows for uniformity during treatment delivery.

Being the first study of its kind on the GWM, the role of this research is to take the first step towards establishing if the model works; that is, the effectiveness of the GWM in the context of the clinical setting. It is envisaged that this study's findings will provide a platform for future researchers to further examine the internal mechanics of the GWM and the complex questions of how and why it works, and to identify the components that facilitate change and the effects of variations in dose, strength and duration.

The approach of this study therefore differs from previous HSB effectiveness studies which have focused more on recidivism as a measure of effectiveness and have

not adequately addressed replication issues and changes to practice and practitioners over time. The next chapter describes the methodology adopted for the current research.

Chapter 8: Methods

This chapter presents the methods used in this study to evaluate the effectiveness of the Good Way model (GWM). It describes how the study was implemented by outlining the participants, the measures employed, the procedures followed, and the management of ethical considerations. The rationale for adopting a non-current multiple-baseline research design is given and the data analysis strategy described.

8.1 Participant Characteristics

The participants in this study were 12 young males aged 11–17 years who had been referred for the assessment and treatment of harmful sexual behaviours (HSB) at either STOP or WellStop. Recruitment occurred between June 2012 and June 2014. In total 15 boys agreed to participate in the study (see Figure 8.1). Three participants dropped out prior to commencing treatment due to unstable placements, and the final sample was therefore 12 ($n = 12$). Six participants were from STOP and nine were from WellStop.

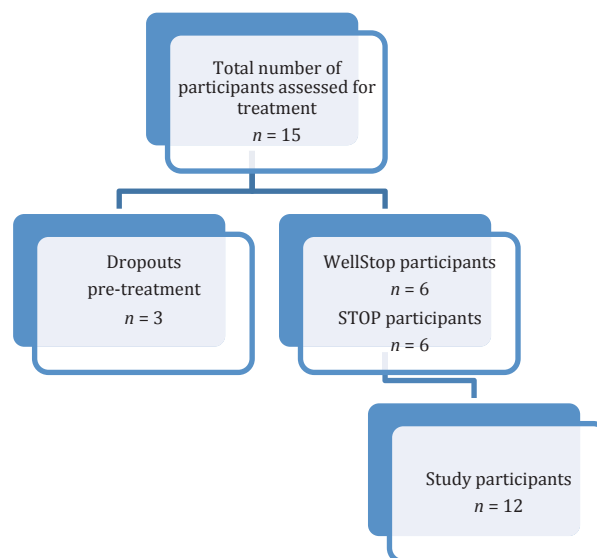


Figure 8.1 Study participants

Of those who participated ($n = 12$), three did not have an intellectual disability (ID) (P1, P4 and P11), five did have an ID (P2, P7, P8, P9 and P12), and four were “special

needs”³ (P3, P5, P6 and P10). Eleven of the participants were mandated to treatment as a result of a Child Youth and Family (CYF) Care and Protection Family Group Conference, while one was referred at the request of mental health services and their parents. All comorbidities had been formally diagnosed by professionals. The participant information collected at assessment is summarised in Table 8.1.

Table 8.1 Participant characteristics, history and circumstances at assessment

Participant information	Comorbidities and/or relevant historical factors	Living situation	Referrer
P1 15 yrs Non-ID NZ European	Attention deficit hyperactivity disorder (ADHD)	Lives with mother	CYF
P2 11 yrs ID NZ European	Cerebral palsy	Lives with mother	CYF
P3 14 yrs Special needs NZ European/ Māori	ADHD, Pervasive developmental disorder with Asperger’s traits, non-sexual offending Learning disability – dyspraxia, Social skill deficits	Lives with extended family	CYF Youth Justice
P4 12 yrs Non-ID Māori	ADHD, Depression and anxiety Exposure to domestic violence (DV), Intergenerational abuse Substance abuse	Lives in foster care	CYF
P5 12 yrs Special needs NZ European/ Māori	ADHD, Low average range cognitive abilities, Learning disability – dyslexia/dyspraxia	Lives with mother	CYF
P6 17 yrs Special needs NZ European	ADHD, Long history of police involvement, Substance abuse Exposure to DV, Anxiety, Learning disability – dyspraxia/dyslexia Attachment problems, Hypersensitivity to sound, FSIQ 79	Lives with parents	YJ CYF
P7 12 yrs ID NZ European	Hypoxic brain injury, Epilepsy, Medical problems, Speech impairments, Interpersonal relationship difficulties, Emotion regulation problems, Violence Difficulty learning consequences, Learning disability, Developmental delay	Lives with parents	MHS Family
P8 14 yrs ID NZ European/ Māori	Stealing, fire lighting, exposure to DV Oppositional defiant disorder, School problems, Conduct disorder, Learning disability, Language delay, Global	Lives with grandmother	CYF, Hospital, ID services

³ “Special needs” participants were defined as non-ID participants with low intellectual functioning and/or developmental difficulties and/or evidence of learning limitations.

Maori	developmental disability, ADHD Cognitive problems (memory and learning)		
P9 15 yrs ID Māori	FSIQ 68–74, Learning difficulties Aggression, Somatic complaints Sexual abuse (intra/extra) Medical problems, Anxiety, Child sexual abuse (CSA) – incest, Trauma, Emotional regulation difficulties Aggression/destruction of property	Lives with aunt	CYF MHS Therapist ID Services
P10 13 yrs Special needs NZ European	Foetal alcohol syndrome, Reactive attachment, Conduct disorder Unspecified anxiety disorder, Multiple placements, Exposure to DV, long history with CYF	Lives in residential placement	CYF
P11 14 yrs Non-ID NZ European	CSA	Lives with mother	CYF
P12 16 yrs ID NZ European	Currently a care recipient on a secure order under the Intellectual Disability Compulsory Care and Rehabilitation (IDCCR) Act. As part of this order he has been placed in a Youth ID Forensic Inpatient Service.		CYF
P13, P14 and P15	These participants did not start treatment – they dropped out due to unstable placements during the assessment period		

Note. CYF = Child, Youth and Family; FSIQ = Full Scale Intelligence Quotient; MHS = Mental Health Services; P = participant; YJ = Youth Justice.

8.2 Measures

Research on interventions requires utilising reliable and valid ongoing measures that are able to show effectiveness (Kazdin, 2004). In practice this requires collecting data on outcome and process variables, and dispositional attributes which map the gross effect of therapy across phases.

As part of the normal assessment protocol at both WellStop and STOP, therapists and the young people and their families are asked to complete a routine set of psychometric measures in order to provide a baseline against which to measure change in participants. With the exception of three introduced measures – the Outcome Rating Scale (ORS), Session Rating Scale (SRS) and Parent Daily Report (PDR) – the measures administered within this research were based upon the normal assessment and treatment practices used in each programme. This was intentional and aimed at replicating assessment and treatment process under usual conditions.

8.2.1 Routine Measures for the Young Person and Their Family

8.2.1.1 Externalising and Internalising Problems

Child Behaviour Checklist (CBCL)/6–18 years – Parent Form (Achenbach, 1991). The CBCL is a parent-report questionnaire presented in a standardised format and is completed by the parent (or other immediate caregiver). It is one of three components in the Achenbach system of empirically based assessment. The first section of this questionnaire focuses on social competencies and collects information about the child's activities, social relations and school performance. The second section contains 113 items which are designed to collect information about a child's behavioural problems and emotional functioning, now or within the past 6 months. Statements are made about a child's behaviour, and responses are recorded on a 3-point Likert scale from 0 (not true), 1 (somewhat or sometimes true), to 2 (very true or often true). This measure is based upon six DSM-oriented scales that reflect a number on internalising and externalising problems: (1) Anxiety Problems, (2) Affective Problems, (3) Oppositional Defiant Problems, (4) Conduct Problems, (5) Attention Deficit/Hyperactivity Problems, and (6) Somatic Problems. Scores are provided for nine behaviour syndromes, for the broader category of internalising and externalising problems, and as a total score. The scores are then classified as indicating normal, borderline, or clinical behaviour. This measure takes 15 minutes to complete. Reliability and validity are excellent, and extensive normative data exists (Achenbach & Rescorla, 2001).

Youth Self-Report (YSR)/11–18 years (Achenbach, 1991, Achenbach & Rescorla, 2001). The YSR is also a component of the Achenbach system of empirically based assessment. The YSR is completed by 11–18 year olds to describe their own functioning. The first section focuses on social competencies and collects information about the young person's activities, social relations and school performance. The second section contains 112 items which are designed to collect information from the young person about their behavioural problems and emotional functioning, now or within the past 6 months. Statements are made about a behaviour and responses are recorded on a 3-point Likert scale from 0 (not true), 1 (somewhat or sometimes true), to 2 (very true or often true). This measure is based upon six DSM-oriented scales that

reflect a number on internalising and externalising problems: (1) Anxiety Problems, (2) Affective Problems, (3) Oppositional Defiant Problems, (4) Conduct Problems, (5) Attention Deficit/Hyperactivity Problems, and (6) Somatic Problems. Scores are provided for nine behaviour syndromes, for the broader category of internalising and externalising problems, and as a total score. Scores are then classified as indicating normal, borderline, or clinical behaviour. This measure takes 15 minutes to complete. The reliability and validity are excellent, and extensive normative data exists (Achenbach & Rescorla, 2001).

8.2.1.2 Sexual Behaviours (Two Options – Age-based)

Child Sexual Behaviour Inventory (CSBI)/2–12 years (Friedrich, 1997). The CSBI is designed to assess and evaluate children aged 2–12 years who have been or may have been sexually abused. This measure uses parent report (i.e. mother or primary female caregiver) to collect information about sexual behaviour. There are 38 items which make up nine major content domains: (1) Boundary Problems, (2) Sexual Knowledge, (3) Sexual Interest, (4) Self-Stimulation, (5) Exhibitionism, (6) Voyeuristic Behaviour, (7) Sexual Intrusiveness, (8) Sexual Anxiety, and (9) Gender Role Behaviour. There are also three clinical scales which facilitate the interpretation of test results. These are the CSBI Total Scale, the Developmentally Related Sexual Behaviour Scale, and the Sexual Abuse Specific Items Scale. Friedrich reports that this measure has been used validly with children who have an ID. In these cases the developmental age is used when referring to norms. This measure takes 10 minutes to complete. The author reports a Cronbach's alpha coefficient of 0.72 and test-retest reliability of 0.85.

Adolescent Clinical Sexual Behaviour Inventory (ACSBI)/12–18 years – Parent and Youth Form (Friedrich, Lysne, Sim, & Shamos, 2004). The ACSBI is based on the CSBI. It contains 45 items and is used as a screening measure. The ACSBI was created to comprehensively assess a range of sexual behaviours and attitudes in high-risk adolescents, and subsequently utilise targeted interventions. Using both parent-report and youth-report information is elicited about the young person's sexual risk taking, non-conforming sexual behaviours, sexual interest, and sexual avoidance/discomfort behaviours over the past 12 months. There are two versions of this measure. This first

is a parent-report (ACSBI-P), and the second is an adolescent self-report version (ACSBI-S); both refer to the same items. The first section consists of 45 items and is scored using a 3-point Likert scale ranging from 1 (not true), 2 (somewhat true) to 3 (very true). The items are divided into five principal domains: (1) Sexual Knowledge/Interest (13 items), (2) Divergent Sexual Interests (9 items), (3) Sexual Risk/Misuse (8 items), (4) Fear (7 items), and (5) Concerns about Appearance (4 items). The second section consists of five questions which collect information on prior sexual partners, child abuse experiences and childhood sexual experiences. The reliability estimate based on Cronbach's alpha for ACSBI-P is .84, and for ACSBI-S it is .86. The individual items on the ASCBI require consideration during interpretation of elevations as a portion are static (e.g., "Has had a sexually transmitted disease"), and others require consideration in relation to the case at hand (e.g., "Describes self as gay, lesbian, or bisexual").

8.2.1.3 Trauma

Trauma Symptom Checklist Children (TSCC)/8–16 years (Briere, 1996). This 54-item measure is designed to elicit information on post-traumatic stress and related psychological symptomology in children who have experienced traumatic events such as childhood physical and sexual abuse or witnessing domestic violence. There are two validity scales (Underresponse and Hyperresponse), six clinical scales (Anxiety, Depression, Anger, Post-Traumatic Stress, Disassociation, and Sexual Concerns), and eight critical items. Sexual Concerns and Disassociation have subscales. A 4-point Likert scale is used to record the frequency of items. These range from 0 (never) to 3 (almost all the time). This measure takes 15–20 minutes to complete. The TSCC demonstrates high reliability and predictive validity. The Cronbach's alpha coefficients for the clinical scales range between .77 and .89. The Sexual Concerns subscales are slightly lower and range between the high 60s and low 70s.

8.2.1.4 Resiliency, Risks and Strengths

Resiliency Scale for Children and Adolescents (RSCA; Prince-Embury, 2006, 2007). The RSCA is for young people aged between 9 and 18 years and consists of three stand-alone self-report scales which can be used together or alone to provide a profile of

strengths within three aspects of personal resiliency. The first two scales – Sense of Mastery (20 items) and Sense of Relatedness (24 items) – are linked to protective personal characteristics. The third scale – Emotional Reactivity (20 items) – is linked to risk when confronted with adversity. Response items use a 5-point Likert-type scale ranging from 0 (never), 1 (rarely), 2 (sometimes), 3 (often) to 4 (almost always). The Cronbach's alpha coefficients for the scales range from .93 to .95, and the test-retest coefficient ranges from good to excellent (.70–.92).

8.2.2 Routine Assessment and Treatment Measures Completed by the Clinician

8.3.2.1 Resiliency, Risks and Strengths (Two Options – Age-based)

Clinical Assessment Package for Risks and Strengths (CASPARS) 5–13 years (Gilgun, 1994, 2004). The CASPARS consists of five clinical rating scales which focus on the children and the relationships in their family. The scales are (1) Relationships among Family Members (21 items), (2) Sexuality (22 items), (3) Family's and Child's Embeddedness in Community (13 items), (4) Emotional Expressiveness (16 items), and Peer Relationships (17 items). These scales are designed to assist in the assessment and treatment process of children who have experienced adversities. This instrument requires the clinician to combine their clinical judgement and information gathered about the child from clinical interviews and school information and other written records. The questions are designed to draw the clinician's attention to risks and strengths. Each item is placed on a continuum with "Strength" at one end and "Risk" at the other. The first step is to decide if the item is a strength or a risk "compared to a child who is functioning at an optimum level". A Likert-type scale is then used to identify if the strength or risk has a high (3), medium (2), or low rating (1). A score of 0 is used for "not known/not observed/absent". The final scores and rating are considered in relation to one another. Identified risks and assets are used to guide treatment, and to classify young people into one of four types. Gilgun reports that the Cronbach's alpha coefficients of the CASPARS show high reliability and are as follows: Emotional Expressiveness .94; Family Relationships .97; Embeddedness .96; Peer Relationships .90; and Sexuality .90. Furthermore, indicators of validity are highly satisfactory.

Four Dimensions for Youth Development (4-D) 12–19 years (Gilgun, 2002). The 4-D consists of four clinical rating scales: Belonging (7 items), Mastery (10 items), Autonomy (7 items), and Generosity (4 items). A fifth scale, “Role of Others”, also exists. These scales are designed to assist in the assessment and treatment process of young people who have experienced adversities. This instrument requires the clinician to combine their clinical judgement and information gathered about the young person from the young person themselves and their families and communities. The questions are designed to draw the clinician’s attention to risks and strengths located in young people, families, peer groups and communities. Each item is placed on a continuum with “Strength” at one end and “Risk” at the other. A Likert-type scale is used to identify if the strength is high (4), medium (3), or low (1). A score of 1 is used for an inconsistent young person who “sometimes shows a strength and sometimes shows a risk”. The Likert-type scale for risks range from low (2), medium (3) to high (4). The final scores and rating are considered in relation to one another. Identified risks and assets are used to guide treatment, and to classify young people into one of four types. Gilgun reports Cronbach’s alpha coefficients of .9, showing high reliability, and indicators of validity that are highly satisfactory.

8.2.1.2 Risk of Sexual Recidivism

Estimate of Risk of Adolescent Sexual Offence Recidivism (ERASOR; Worling & Curwen, 2001). There are currently no empirically validated actuarial instruments that can be used to accurately estimate the risk of sexual reoffending by adolescent males. Researchers and clinical experts who work with adolescent males who have HSB have identified a number of risk factors for sexual offending. ERASOR is an instrument that summarises these findings. It is an empirically guided checklist designed to assist clinicians to estimate the risk of sexual recidivism for young people aged 12–18 years using both static and dynamic factors. Many of the risk factors identified in the ERASOR are considered applicable for youth with below-average levels of cognitive functioning and adolescents who have committed non-contact HSB. All participants were asked to complete the ERASOR regardless of age or cognitive ability, as this measure provides relevant clinical information for this study. This tool can assist in matching client needs, managing variations in treatment length, managing risk, and

setting treatment targets. The clinician is required to have an understanding of the clinical population and then identify the presence of 25 items using the categories present, partially/possibly present, not present and unknown. The items are broken down into five categories (Sexual Interests, Attitudes and Behaviours; Historical Sexual Assaults; Psychosocial Functioning; Family/Environmental Functioning; and Treatment). A further category is available for “Other”. The clinician is then required to estimate an overall risk rating of low, moderate or high using clinical judgement. Information is collected from multiple sources including clinical interview, clinical assessment, and previous reports. Furthermore, information needs to be directly sourced from the young person, their caregivers, and official records in relation to offences. Numerous studies using the ERASOR have found high inter-rater agreement for clinical judgement, ranging from .68 to .87 (e.g., Morton, 2003; Nelson, 2010, 2011; Worling, 2004; Worling, Bookalam, & Litteljohn, 2012). The measure’s Cronbach’s alpha coefficient is .75 (Worling, 2004). The ERASOR has been found to be significantly predictive of sexual recidivism (Chu, Ng, Fong, & Teoh, 2012).

8.2.3 Additional Continuous Measures for the Treatment Phase

The following continuous measures were employed during the treatment phase.

Parent Daily Report Checklist (PDR; Chamberlain & Reid, 1991). The PDR is a 51-item parent/caregiver observation report designed to measure a range of positively and negatively occurring behaviours, including a number of relational and externalising difficulties. This measure was originally designed for use in child welfare settings, though has been adapted for a number of studies, particularly those interested in conduct-related problems. Parents/caregivers are contacted by telephone and asked whether or not a particular behaviour has occurred within the previous 24-hour period. The use of a 24-hour period reduces biases collected by retrospective reports. Each collection takes 10 minutes. This measure only records “presence” or “no presence”. It does not collect information about frequency and intensity. The estimates of reliability and validity for this measure are limited, though evidence suggests sound psychometric properties and a stable factor structure (Chamberlain & Reid, 1987; Keil, 2007). Validity and reliability of parent-reports is thought to increase

with the reduction of systematic and random sources of measurement error. Reportedly, adequate inter-rater reliability had been found (Chamberlain & Reid, 1991; Weinrott, Bauske, & Patterson, 1979).

Outcome Rating Scale (ORS; Miller & Duncan, 2000). The ORS is used as a global measure of psychological distress and is completed by the client. The measure has been designed for everyday clinical use and to assess overall, individual, relational, and social functioning through a set of four questions that take approximately 1 minute to complete. This four-item visual analogue scale tracks changes in clients following psychological interventions by asking clients to “look back over the last week, including today” before commenting on four key areas: Individual (personal wellbeing), Interpersonal (family close relationships), Social (work, school, friendships), and Overall (general sense of wellbeing). Each area is presented with a 10 cm line which underneath and the client is asked to make a mark on the line. Reliability of the ORS as assessed by Cronbach’s alpha was found to be .93 (Miller, Duncan, Brown, Sparks, & Claud, 2003).

Child Outcome Rating Scale (CORS; Duncan, Sparks, Miller, Bohanske & Claud, 2006). The CORS is an adapted version of the ORS and has been developed to meet the needs of children aged 6–12 years. This version taps into the same four areas, however it contains smiley or frown faces at the ends of each 10 cm line and uses child-friendly language, for example: Me (How am I doing?), Family (How are things in my family?), School (How am I doing in school?) and Everything (How is everything?). One study on the reliability and validity of the CORS found moderate validity and solid reliability, with a Cronbach’s alpha coefficient of .84 (Duncan, Sparks, Miller, Bohanske & Claud, 2006).

Session Rating Scale (SRS; Miller & Duncan, 2000). The SRS is used as a global measure of alliance and is completed by the client. This four-item visual analogue scale is used to identify alliance problems within the therapeutic relationship. The four key areas are (1) Relationships, (2) Goals and Topics, (3) Approach or Method, and (4) Overall. The measure is designed for everyday clinical use, and to assess the

therapeutic relationship, goals and topics, approach and method, and the overall intervention through a set of four questions that take approximately 1 minute to complete. Miller et al. (2003) report a Cronbach's alpha coefficient of .96 and test-retest reliability of .50.

Child Session Rating Scale (CSRS)/6–12 years (Duncan, Sparks, Miller, Bohanske & Claud, 2006). The CSRS is an adapted version of the SRS and has been developed to meet the needs of children aged 6–12 years. This version contains smiley or frown faces at the ends of each 10 cm line and uses child-friendly language, for example: (1) Listening (2) How important, (3) What we did, and (4) Overall. Furthermore, each face is placed next to words which define each side of the 10 cm line. For example, on the Listening line, “did not always listen to me” is opposed to “listened to me”.

8.3 Procedure

8.3.1 Research Setting

This study was run through two community-based organisations specialising in the treatment of youth with HSB. WellStop is based in Wellington and provides community-based treatment in the lower North Island (Lower Hutt, Gisborne, Napier and Palmerston North); STOP provides the same service in Christchurch and provides outreach services across the South Island (Dunedin, Westport, Invercargill and Nelson). These agencies already regularly use the GWM within their standard programmes for children and adolescents, and also within treatment programmes for young people with mild to moderate ID.

8.3.2 Treatment Manual

8.3.2.1 Peer Review

During the course of the GWM development, Lesley Ayland and Bill West wrote a treatment manual (West & Ayland, 2012) to facilitate uniformity and to guide the clinicians they trained to use the GWM. For the purposes of this research project and a prospective peer review, the researcher heavily edited the original manual, incorporating aspects of additional resources and current literature relevant to youth with HSB. The intention was to support the development of the GWM and facilitate

uniformity within the research process. The edited manual was broken into three parts. Part 1 explains the theoretical underpinnings informing the GWM, Part 2 provides an explanation of the model in practice and practical examples with a section containing frequently asked questions, and Part 3 provides visual templates to assist in the delivery of the intervention.

The peer review of the *Good Way Model-Revised Manual* (GWM-RM; West & Ayland, 2013) was completed by two internationally based experts on HSB. The first peer reviewer was Dr Jim Worling (PhD, C.Psych.) who is a clinical and forensic psychologist, researcher and consultant who specialises in work with youth who sexually offend. Worling has been widely published, particularly in relation to the development of an empirically guided checklist to estimate the short-term risk of sexual reoffending for youth aged 11–18 years (see ERASOR above; Worling & Curwen, 2001). The second peer reviewer was Jim Haaven. Jim Haaven is social worker, trainer and consultant in private practice. For 30 years he has specialised in the assessment and treatment of persons with developmental disabilities who have sexually abused. His publications include the co-authored *Treating Intellectually Disabled Sex Offenders: A Model Residential Program* (1990).

8.3.2.2 Consultation

Once the peer review was completed, a consultation process was then undertaken by the researcher with Associate Professor Ian Lambie (University of Auckland) to discuss the feedback. Associate Professor Ian Lambie is the most widely published expert in New Zealand on adolescents with HSB. Ayland used the recommendations from Lambie and the feedback from Worling and Haaven to further update the edited manual. The final stage of the review process was to give the updated manual to two clinicians who have used GWM previously for feedback. The intention of this step was to incorporate research and theory expertise alongside practice/practical considerations by those who would be using it.

8.3.2.3 Revised Manual

The GWM-RM was made available in electronic and hard copy form to clinicians and

supervisors involved in this study. To supplement the revised manual a “Book of Readings” which contained five articles and book chapters on the GWM and two articles about the impact of early trauma on brain development was given to the clinicians to act as a primer for using the GWM in practice.

8.3.3 Therapist Recruitment and Training

Therapists in this study were recruited from existing staff at WellStop and STOP. As part of this research project a 2-day training provided by Ayland and West was offered to all staff at WellStop and STOP. This workshop was designed to ensure that each therapist involved in the study was sufficiently trained and skilled to carry out the treatment as it was prescribed. During this training the researcher was available to explain the research process to staff, provide information about the project, and issue consent forms for clinicians to complete. During the course of the research a second advanced 1-day workshop was held in both Wellington and Christchurch for clinicians and supervisors involved in the study.

There were eight therapists, made up of formally trained family therapists and psychologists, who provided treatment to participants during the research period (see Table 8.2). Five of the therapists treated only one client and three treated two or more clients across the course of treatment. This was a result of staffing changes and one participant (P9) transferring between sites during the course of treatment.

8.3.4 Supervision and Support

A four-day training course was provided for senior clinicians from the WellStop and STOP offices who were already familiar with the GWM, who had attended the basic GWM training, and had been designated to take the role of supervisor in each office. These supervisors were themselves supported by either Ayland or West. For the duration of the research project regular clinical supervision (individual, peer and by appointment) was available to each therapist involved in the research.

To further streamline the study process the researcher was in regular contact with clinicians by phone and email. This framework supported the clinicians in the delivery of the treatment while meeting the requirements of the study and assisting with consistency across sites/clinicians.

8.3.5 Recruitment of Participants

From the outset of this research project it was expected that at least half of the participants would have either a mild ID (IQ 55–69) or an IQ within the borderline range (IQ 70–79) and/or evidence of learning limitations, although the final sample of course would be dictated by those who agreed to participate.

During the assessment phase clients and the parents/caregivers legally responsible for their care were asked if they were willing to participate in the study. The therapists provided information about the project and if clients and their parents/caregivers agreed to participate they were provided the consent/assent forms to complete. They were told that they had the right to withdraw from the study at any stage without it affecting their treatment.

8.3.6 Treatment Delivery

An overview of the assessment and treatment framework is presented in Table 8.2. The baseline phases ranged from 1 to 5 months. File reviews identified that safety planning was a consistent pre-treatment intervention during the baseline phase across both treatment settings. As part of the service provision within each agency, the parameters of safety planning are negotiated and interwoven into the assessment contract on the first session.

Following the completion of an assessment in the baseline phase, treatment plans were individualised depending on the risk level, needs and assets of the participant and their family. The treatment phases were naturally staggered as part of the referral process and ranged from 4 to 20 months, and the length of treatment and treatment configurations varied between participants and was based upon their treatment needs. The core treatment intervention was delivered within individual work with the young people, and this was supported by interventions by family and caregivers to assist participants to generalise the treatment.

At the end of the study, nine participants had completed treatment, two remained in treatment, and one (P10) had dropped out due to the impact of unstable placements. One of the nine participants (P5) who completed treatment for HSB using the GWM sexually re-offended within the follow-up period and following police involvement was returned to treatment by CYF.

Treatment delivery in real-world settings is naturally shaped by factors such as school holidays and school term structures, and annual and sick leave. During the course of the study one therapist (T3) became unwell and was unable to facilitate the collection of a full set of data with the participants they worked with. An additional consideration for this study was the 2011 Christchurch earthquake which led to STOP therapists having to relocate services and file information twice during the course of this study.

Table 8.2 Participant assessment and treatment information

Participant	Therapist(s)/Location	Length of baseline (months)	Length of treatment (months)	Treatment configurations/Status of treatment/Known sexual recidivism
P1	T1/ Christchurch	2	5	Individual and family work – Children’s Programme/Treatment completed/ No known re-offending
P2	T2/ Christchurch	1	5	Individual and family work – Children’s Programme/ Treatment completed; returned for booster sessions as concerning symptoms remained elevated/ No known re-offending
P3	T3/ Christchurch	3	14	Individual and family work – Adolescent Programme/ Treatment completed/ No known re-offending
P4	T3/ Christchurch	5	10	Individual and family work – Adolescent Programme/ Treatment completed/ No known re-offending
P5	T4/ Christchurch	4	5	Individual and family work –Children’s Programme/ Treatment completed/ Further harmful sexual behaviours 2.5 months post treatment, withdrew from study and returned to treatment.
P6	T1/ Christchurch	3	20 (to date)	Individual, family and group work – Adolescent Programme/ Treatment ongoing/ No known re-offending
P7	T5/ Wellington	3	5	Individual and family work –Children’s Programme/ Treatment completed/ No known re-offending
P8	T5/Wellington	2	11	Individual and family work – Adolescent Programme/ Treatment completed/ No known re-offending
P9	T6/T5	2	10	Individual and family work –

	Wellington			Adolescent Programme Treatment completed/ No known re-offending
P10	T7 Wellington	3	5	Individual work – Adolescent Programme/ Dropped out of treatment due to five unstable placements/ No known re-offending
P11	T7 Wellington	2	4	Individual and family work – Adolescent Programme/ Treatment completed/ No known reoffending
P12	T8 Wellington	4	8 (to date)	Individual and family work – Adolescent Programme/ Treatment ongoing/ No known re-offending

Note. ID = intellectually disabled; P = participant; T = therapist.

8.3.7 Treatment Fidelity

In order to ensure fidelity to the model under evaluation it was necessary to review the treatment process and documents related to the delivery of treatment. In consultation with Ayland and West, the researcher created a detailed “Fidelity Checklist” (included in Appendix 1) and checklist guide. The Fidelity Checklist includes descriptions of key treatment elements and milestones, and was designed to ensure that treatment was delivered as intended. The checklist and guide were distributed to the supervisors and clinicians for feedback prior to final implementation in the research.

It was a requirement for this study that all individual sessions were video-recorded. To monitor fidelity to the GWM a portion of each therapist’s videos (30%) were randomly selected for independent viewing by a two senior practitioners and rated using the Fidelity Checklist. For seven of the clinicians involved in the study adherence to the GWM treatment process, framework, content and material was rated 100% for delivery. Adherence to the GWM treatment process, framework, content and material was rated 50% for the remaining therapist (T3) involved in the study. Case notes and any written or pictorial work completed by all of the participants during treatment were also reviewed. This material was rated 100% for fidelity.

8.3.8 Administration and Scoring of Measures

As demonstrated in Table 8.2, the routine set of measures was administered at the pre-treatment, within treatment, end of treatment, and post-treatment phases; the continuous measures focused on the treatment phase only. Each measure was administered as instructed within the corresponding manual.

The pre-treatment phase ranged from 1 to 4 months. The first administration of routine measures were completed during the early stages of the assessment period in the pre-treatment phase and therefore each participant and their parents/caregivers was asked to redo the routine set of measures within a 24-hour period prior to their first treatment session. This taking of a second baseline measure was introduced to ensure that any change was the result of treatment itself rather than events occurring after the assessment and prior to treatment commencing. The routine measures were re-administered 6 monthly, at the end of treatment, and 6 months after treatment was completed. Mid-treatment measures were not completed if treatment was <6 months in duration.

To establish a baseline for the PDR, the primary caregiver was contacted 3 days consecutively within the period immediately prior to treatment commencing, and then once every 3–6 weeks during treatment. The targeted recall timeframe was 4 weeks, though school holidays etc. led to fluctuations.

Table 8.3 Frequency of measures throughout baseline, treatment and follow-up phases

	Pre-treatment phase		Treatment phase				Post-treatment phase
Measures	B1	B2	6 monthly	Every individual session	Once 3–6 weekly	End of TX	Follow-up
YSR	X	X	X			X	X
CSBI <i>or</i> ACSBI/ASC BI-P	X	X	X			X	X
RSCA	X	X	X			X	X
TSCC	X	X	X			X	X
CASPARS <i>or</i> 4-D	X	X	X			X	X
ERASOR	X	X	X			X	X
PDR		XXX			X	X	
ORS				X			
SRS				X			

Note. B = baseline; TX = treatment.

Where measures have variations based on age cut-offs, clinicians were asked to use their usual clinical judgement as to which measure would be best suited to their client. This practice recognises that chronological ages and developmental ages may vary for some clients

With the exception of the PDR, the measures were administered and scored at each site by therapists involved in the research. Fifty per cent of the measures were checked by the researcher and these showed 100% accuracy when compared to clinician scores. Although it was planned that a full set of measures would be collected for each young person in the study, this was not possible in all cases. In the absence of some data it is recommended that the findings for those cases (which are identified within the results chapter) are interpreted with caution.

8.4 Ethical Considerations

This study was carried out in accordance to the New Zealand Code of Ethics for Psychologists. Ethical approval was granted for this research project by the Massey University Human Ethics Committee in May 2012 (Reference Number 12/023). All information provided by participants and their families was treated as confidential. The key ethical issues which were considered in this study included the recruitment of

young people, some of whom had an intellectual disability; the management of privacy and confidentiality; dealing with disclosures; taping sessions; and cultural responsibility.

Participants and their families involved in the research were provided developmentally appropriate and detailed information sheets which explained the process of the research. They were asked to complete consent/assent forms which covered confidentiality, videotaping, and senior clinicians looking at notes, clinical work, and reports to ensure quality control and integrity to the GWM, along with the release of results of psychometric measures to the researcher. They were told that they had the right to withdraw from the study at any stage without it affecting their treatment.

Ethical issues could have arisen from recruiting young participants, especially where they may also have an ID. However, this issue was resolved through the participants in this study being clients already attending treatment who would be receiving the normal treatment they would receive if this study were not being undertaken. Treatment plans were developed within these agencies based on the needs of the client and their family and participants and they were not asked to do anything additional in the treatment process as part of the research, apart from agreeing to have the sessions taped, completing continuous measures, and having routine measures re-administered 6 months after treatment ended.

A further potential ethical issue was that the GWM was being evaluated using the results of psychometric measures. Having participants answer questions about personal matters could be seen as intrusive, however this was resolved by using standard measures that are used routinely as part of WellStop's and STOP's usual assessment processes. Concerns could also be raised about asking people with an ID to complete psychometric measures, but young people with an ID were not expected to complete any of the routine measures themselves; third-party information from parents or therapists was used.

Confidentiality was maintained for all participants, with the exception of safety issues. If disclosures are made during WellStop or STOP treatment, both agencies have clear protocols about reporting that information and both are party to an agreement with CYF under which any incident of sexual abuse that involves a child under the age

of 16 is reported. The obligations to report are also clearly spelt out to clients and families prior to assessment and this information was included in the Participant Information Sheets.

To ensure confidentiality when sessions were videotaped the camera was primarily focused on the therapist and not the client and digital recordings were encrypted and stored in folders on secure servers that were only accessible to the site supervisors and senior practitioners reviewing material. Once the randomly selected tapes were viewed all recordings were destroyed.

While Māori were not the primary focus of this study, Māori clients were participants in this research. Consultation was actively sought throughout the research process to ensure it was conducted in a culturally sensitive manner. Both WellStop and STOP made available their consultancy channels for working with Māori available to the researcher. These include Kaumatua and Māori Kaimahi. In addition, the researcher was able to seek external cultural consultation for this project at the interface of clinical and cultural practice.

8.5 Research Design

To investigate the effectiveness of the GWM as a clinical intervention for youth with HSB, the current research applied a non-current multiple-baseline design across participants with follow-up (Barlow, Nock, & Herson, 2009, 1984; Hayes, 1981; Watson & Workman, 1981). This is a type of single-case design which can be used to study treatment effects across multiple participants (Kazdin, 2013).

The rationale for selecting a multiple-baseline design was that it provides the individualisation and flexibility of a single-case design and also allows for a level of experimental control to demonstrate that changes in the targeted behaviours are a result of the treatment (Kazdin, 2003). In a multiple-baseline design, the primary focus of inquiry is the selected behaviour, although the design also lends itself to monitoring concurrent behaviours that are not the focus of treatment. Tracking these changes may lead to findings that add value to the key behaviour (Barlow et al., 2006). The design also allows for evaluation across a small number of participants who act as their own controls (Hawkins et al., 2007). In this study the clinical intervention (the GWM) was applied across the different participants in a staggered way, with a short time

delay to control for extraneous variables (Barlow, Hayes, & Nelson, 1984). The time delay occurred naturally as part of the referral and assessment process.

8.5.1 Baseline, Treatment and Post-Treatment Phases

A key component of the multiple-baseline design is the evaluation of change (repeated observations of performance) across different phases (Kazdin, 2003). In a multiple-baseline-across-participants design each participant experiences at minimum two phases of experimentation. The first phase is the baseline and the second phase is the initial treatment phase. There may be additional phases following the treatment phase such as a follow-up phase. The selected outcome measures are administered during each phase. This type of continuous assessment provides systematic data across the baseline, treatment and follow-up phases to track effectiveness.

The baseline phase acts as a control phase by collecting descriptive information (the level of functioning and pattern of stability and performance) on the target behaviour to allow predictions of future behaviour prior to the treatment being applied (Barlow et al., 2009). Observations then continue into the treatment and post-treatment phases to gauge if changes in the dependent measures occur at the time the intervention was implemented.

Methodological rigour is indicated when change occurs after the treatment is introduced and if the changes continue to occur over time beyond routine fluctuations; when the influence of extraneous variables is controlled (internal validity); and when the findings are replicable (external validity), which demonstrates that the functionality of the intervention is able to produce a change in the same target behaviours across a variety of participants (Horner & Baer, 1978). Single-case research design is not hypothetico-deductive and therefore does not require a sample and the specification of hypothesis at the population level (Blampied, 2013). The inference mechanism is direct replication of a reliable independent variable.

8.5.2 Replication of Results

Replication of results can establish the reliability of findings and assist in generalising (external validity) them to those who differ from the original participants. Barlow et al. (2009) provide guidelines for direct replication which include topographically similar

target behaviours across participants, matching across as many client variables as possible, uniform treatment across participants, one successful experiment with a minimum of three replications, and consistency across therapists and settings. Introducing the treatment concurrently within similar environmental conditions at different points in time demonstrates the strength of the intervention (Kazdin, 2003).

The effectiveness of the GWM clinical intervention was determined by:

1. Changes in behaviour and psychological functioning indicated on psychometric measures taken during the baseline phase, the treatment phase, and again during the post-intervention phase 6 months after treatment ended.
2. Changes in behaviour and psychological functioning captured by a subset of brief continuous measures; that is, those for which there are multiple measures per phase (e.g., PDR, ORS and SRS), administered to the young person and caregiver during the treatment phase.

8.6 Data Analysis Strategy

The primary data analysis strategy in this study was the visual inspection of time series graphs (Kazdin, 2003, 1982) and modified Brinley plots (Jacobson & Truax, 1991; Rucklidge & Blampied, 2011). The results of patterns over the intervention phases (pre-treatment, treatment and follow-up) were examined to determine if evidence of a relationship between the GWM intervention and a change in behaviour existed, and if so the strength of that relationship. During the core analysis of results the participants were viewed individually and as a group.

8.6.1 Time Series Analysis

The analysis of findings from the continuous measures was conducted using the non-statistical method of visually inspecting time series format graphical displays of the multiple-baseline data. Plotting and analysing the data on graphs enabled the reliability and consistency of the intervention effects to be gauged, and possible causal relationships to be inferred. The baseline phase graphs allow the stability of the baseline to be established. Comparison of the trend, level, and variability of each measured dependent variable in the treatment phase relative to its performance in baseline permits the detection of any change (ideally, in a therapeutic direction) in the

treatment phase. The inference that the treatment caused the change is permitted only when the change is observed to be replicated across cases, when and only when the treatment is introduced. Having baseline lengths of different duration protects the inference of a treatment effect from confounds such as non-specific effects of participation in the study and in the assessment procedures (Blampied, 2013).

Improvement was assessed according to the visual inspection criteria recommended for assessing change in multiple-baseline designs described by Kazdin (1982, 2003). This included evaluating the replication of effects across subjects and changes in the following characteristics across phases: the mean, the levels, the trend, and variations in the latency of change. External factors documented within treatment that may have influenced change were also accounted for within this process.

8.6.2 Modified Brinley Plot Analysis

Data from the standard measures administered across phases were visually presented in modified Brinley plots (see Figure 8.2). These are a form of scatter plot where the data from each participant's scores are plotted together as coordinate pairs (e.g., initial assessment score and treatment score). Where the baseline and treatment scores are identical or very similar the resulting data point will lie on or close to the diagonal line of no change (or line of no effect). This result is interpreted as "no systematic differences between conditions". In contrast, when data points for all or many participants deviate (either above or below the line), systematic differences have occurred (positive and/or negative). Arrows are placed on graphs to indicate the intended direction of change. Much of the data from the standard psychometric instruments used within WellStop and STOP (e.g., the ERASOR and CBCL) yielded one score per phase. Where more than one treatment score was available for an individual in any phase, a mean score for the phase was used.

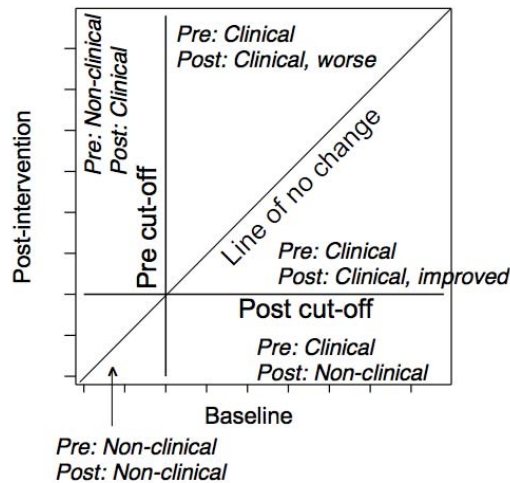


Figure 8.2 Modified Brinley plot interpretation (Rucklidge & Blampied, 2011)

8.6.3 Statistical Evaluation

Statistical evaluation was employed to complement the findings of the visual inspection. The intention of this type of evaluation is to ensure the small but reliable effects that may not be captured in the visual analysis are collected. This study focused on changes in behaviours that are harmful to others; therefore, any change to these types of behaviours warrants analysis to establish if the effect is a result of the treatment (Kazdin, 1982).

To further investigate the degree of change and strength of the treatment effect identified within the modified Brinley plot analysis, estimates of effect size, such as Cohen's *d*, and the percentage of data points exceeding the median (PEM) of the baseline phase (Ma, 2006) were utilised. The reliable change index (RCI; Jacobson & Truax, 1991) was considered for use but the observed results did not warrant this level of analysis because so little systematic change was observed.

8.6.4 Clinically Significant Change

Clinically significant change was also gauged from the results of the administered measures pre- and post-treatment. This enabled a social comparison (Kazdin, 1984) with peers to assess if the participants' behaviours fell within the normative levels of their peers as indicated by each measure post-treatment. In the early stages of

research on the effectiveness of the GWM, understanding the nuances of the change process aided in the further development of this clinical intervention and identify areas for future research.

8.7 Summary

A clear and structured method was developed to evaluate the effectiveness of the GWM. Twelve participants were recruited, assessed and treated with the GWM within two community-based treatment programmes for HSB. The procedures were sequential and involved a peer review of the treatment manual and the recruitment and training of therapists. The treatment process occurred within a real-world setting, outcomes were assessed with standard treatment settings measures, and three measures introduced for the purposes of the research. To maximise internal validity, extraneous variables were controlled by a staggered intervention, which was a naturally occurring event timed to coincide with the referral process, allowing the young people to act as their own case control.

Treatment effectiveness was examined within a multiple-baseline design framework (Kazdin, 2004) and the data analysis strategy involved the visual inspection of time series graphs, modified Brinley plots, and statistical evaluation. The strategies for determining whether changes had occurred during this study were the visual analysis of experimental data and determining the replication of results. This included looking at the magnitude of change between assessment, treatment and follow-up phases, and the rate of change for behaviours. The criteria for change included differences in the mean, level, slope, and latency, as well as evidence of systematic data patterns. To further examine the strength of change, Cohen's *d* and PEM were calculated on selected results. To further examine individual changes that may not have been captured within the experimental criteria, a fine-grained analysis of the therapeutic changes for each participant was conducted.

Chapter 9: Results

This chapter reports the results of the research and is divided into five main sections: Sexual Behaviours; Change to Concurrent Behaviours; Trauma Symptomology; Strengths and Resiliency; and Outcome and Therapeutic Relationship. A portion of the results are also presented in tables. Tables providing the individual score responses used in the modified Brinley plot and time-series analyses can be found in the appendices (see Appendices 2-8).

9.1 Sexual Behaviours

Three measures used in this study collected information on changes to sexual behaviours. The primary measure of change to harmful sexual behaviours (HSB) utilised was the Estimate of Risk of Adolescent Sexual Offense Recidivism (ERASOR); secondary measures included the Child Sexual Behavior Inventory (CSBI; Parent Report) and the Adolescent Clinical Sexual Behaviour Inventory (ACSB; Self- and Parent Reports).

9.1.1 ERASOR Results

The ERASOR focuses on 25 risk factors predictive of recidivism, which are itemised on a checklist and divided into four categories: Sexual interests, attitude, behaviours; Historical sexual assaults; Psychosocial functioning; and Family/Environmental functioning. For this study each item response was coded as: Present = 2; Possibly partially present = 1; Not present/Unknown = 0 (see Table 9.1).

Figures 9.1 and 9.2 display the ERASOR results across the four intervention conditions for 10 of the 12 participants. This enables a comparison of the assessment score with the subsequent phases of the intervention (pre-treatment, treatment and follow-up). Figure 9.1 presents a *total score* which includes both static and dynamic factors. The category of 'Historical sexual assaults' consists of static factors. These are very unlikely to change between phases as the items are based upon historic information on offences. Figure 9.2 presents the total item score across phases for remaining categories which are made up of dynamic factors only. Both figures, though

to a greater degree Figure 9.2, demonstrate a systematic pattern of change in a positive direction.

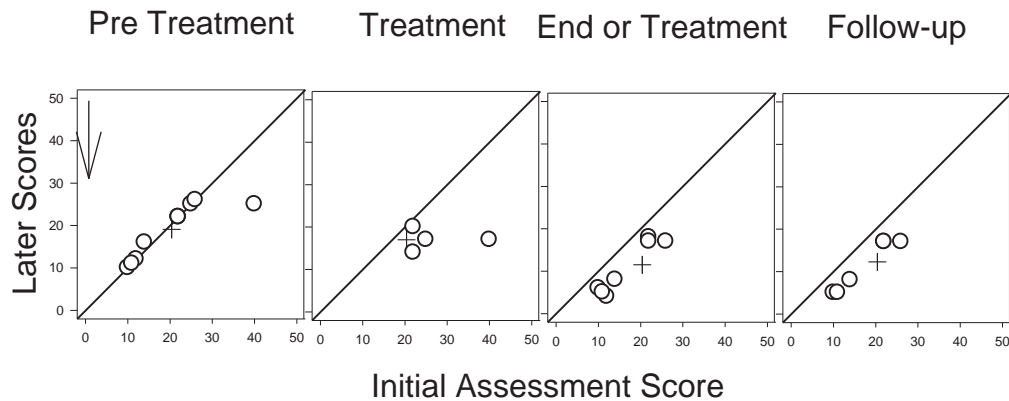


Figure 9.1 Results of the ERASOR total score (static and dynamic factors) on modified Brinley plots across four conditions

Note. x-axis = initial assessment scores; y-axis = phases of the intervention; + = mean; arrows are placed on graphs to indicate the intended direction of change.

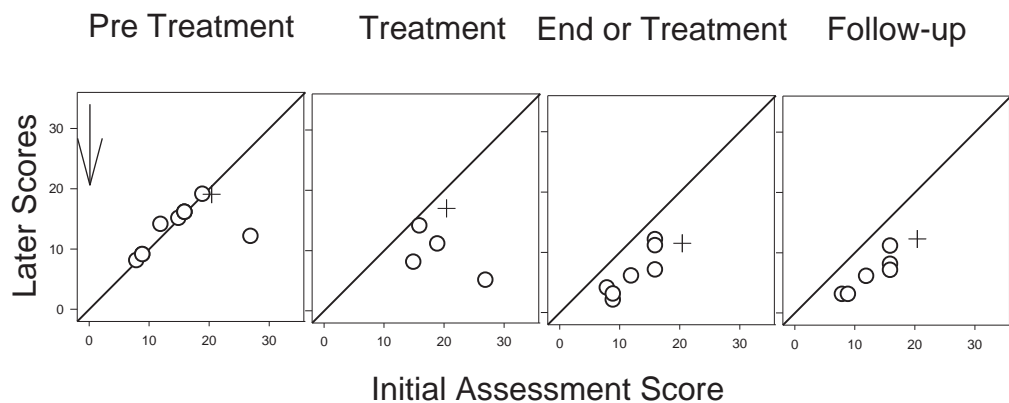


Figure 9.2 Results of the ERASOR dynamic factors on modified Brinley plots across four conditions

Note. x-axis = initial assessment scores; y-axis = phases of the intervention; + = mean; arrows are placed on graphs to indicate the intended direction of change.

The effect size (ES) was calculated using Cohen's d , which represents the size of the difference between means and ranges from small ($d = .2$) to medium ($d = .5$) and large ($d = .8$; Cohen, 1988). The ES for those that completed treatment during the course of the research (P1, P3, P5, P7, P8, P9 and P11) was medium ($ES = .6$), and this effect was maintained during the follow-up period.

As shown in Figure 9.1 and Table 9.1, the baseline phase for each participant on the ERASOR was stable and characterised by no change from initial assessment to the end of baseline with the exception of P12, whose dynamic factors reduced during the baseline phase. Regardless of their stage in treatment, once the Good Way model (GWM) intervention was introduced all participants showed a small reduction in their total score. The results imply a functional relationship between the GWM intervention and behaviour change. For participants who completed treatment, their estimated level of risk was maintained during the follow-up period, suggesting that the GWM treatment approach appropriately targets and reduces risk of further engagement in HSB.

Table 9.1 ERASOR results across data collection points

P	Results	Ax	Pre-Tx	Tx1	Tx2	Tx3	End of Tx	Follow-up
1	SI	2	2	-	-		1	1
	HSA	2	2	-	-		2	2
	PF	4	4	-	-		2	3
	FE	4	4	-	-		3	2
	Total	12	12	-	-		8	8
3	SI	1	1	-	-		0	*
	HSA	3	3	-	-		2	*
	PF	5	5	-	-		2	*
	FT	3	3	-	-		0	*
	Total	12	12				4	*
5	SI	4	4	-	-		3	3
	HSA	6	6	-	-		6	9
	PF	6	6	-	-		5	4
	FAM EN	6	6	-	-		4	1
	Total	22	22	-	-		18	17
6	SI	4	4	2	4	4	-	-
	HSA	10	10	9	9	9	-	-
	PF	4	4	4	3	3	-	-
	FAM EN	7	7	3	3	0	-	-
	Total	25	25	18	19	16	<i>In treatment</i>	
7	SI	0	0	-	-		0	0
	HSA	2	2	-	-		2	2
	PF	4	4	-	-		4	3
	FAM EN	4	4	-	-		0	0
	Total	10	10	-	-		6	5
8	SI	2	2	0	-		0	0
	HSA	6	6	6	-		6	6
	PF	6	6	6	-		7	7
	FAM EN	8	8	8	-		4	4

	Total	22	22	20	-	17	17
9	SI	2	2	*	-	1	1
	HSA	10	10	*	-	10	10
	PF	4	4	*	-	3	3
	FAM EN	10	10	*	-	3	3
	Total	26	26	-	-	17	17
10	SI	0	0	0	-	-	-
	HSA	3	3	3	-	-	-
	PF	11	11	5	-	-	-
	FAM EN	8	8	6	-	-	-
	Total	22	22	14	<i>Dropped out</i>		
11	SI	0	0	-	-	0	0
	HSA	2	2	-	-	2	2
	PF	3	3	-	-	1	1
	FAM EN	6	6	-	-	2	2
	Total	11	11	-	-	5	5
12	SI	7	3	0	0	-	-
	HSA	13	13	12	12	-	-
	PF	10	3	2	2	-	-
	FAM EN	10	6	3	3	-	-
	Total	40	25	17	17	<i>In treatment</i>	

Note. P = participant; Ax = assessment; Tx = treatment; ASI = sexual interests, attitude, behaviours; HSA = historical sexual assaults; PF = psychosocial functioning; FAM EN = family/environmental functioning.

9.1.2 CSBI Results

Figure 9.3 graphically displays the results of the four participants who completed the CSBI across the four intervention conditions. This enables a comparison of the assessment score with the subsequent phases of the intervention (pre-treatment, treatment and follow-up). A T score of 65 or above represents the cut-off for the clinical range (Friedrich, 1997).

While a stable baseline can be observed across each of the three conditions (see Appendix 2), systematic differences between subsequent conditions as a measurement of treatment effect are not observed on the Brinley plots. More specifically, of those participants with clinically significant elevations in pre-treatment scores, little change was demonstrated. Upon a closer inspection of individual results (included in Appendix 2), subtle changes within clinical ranges are demonstrated, and a reduction from the clinical to subclinical range for P10 during the treatment phase occurred.

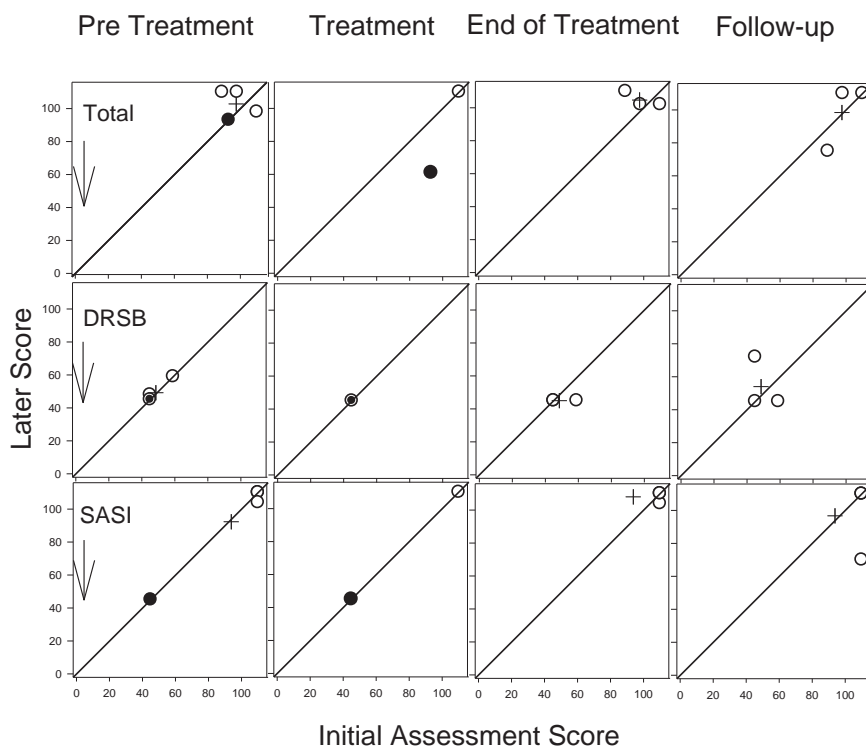


Figure 9.3 Modified Brinley plots showing group data for the CSBI initial assessment score (x-axis) and phases of the intervention (y-axis)

Note. DRSB = developmental-related sexual behaviour; SASI = sexual abuse specific items; white dots = ID youth; black dots = special needs youth; Arrows are placed on graphs to indicate the intended direction of change.

9.1.3 ACSBI – Self-Report Results

Figure 9.4 graphically displays the results of the seven participants who were administered the ACSBI across the four intervention conditions. There are no apparent systematic effects revealed by the visual analysis, however individual results (included in Appendix 3) demonstrate a stable baseline phase and a small change in direction between scales for some participants.

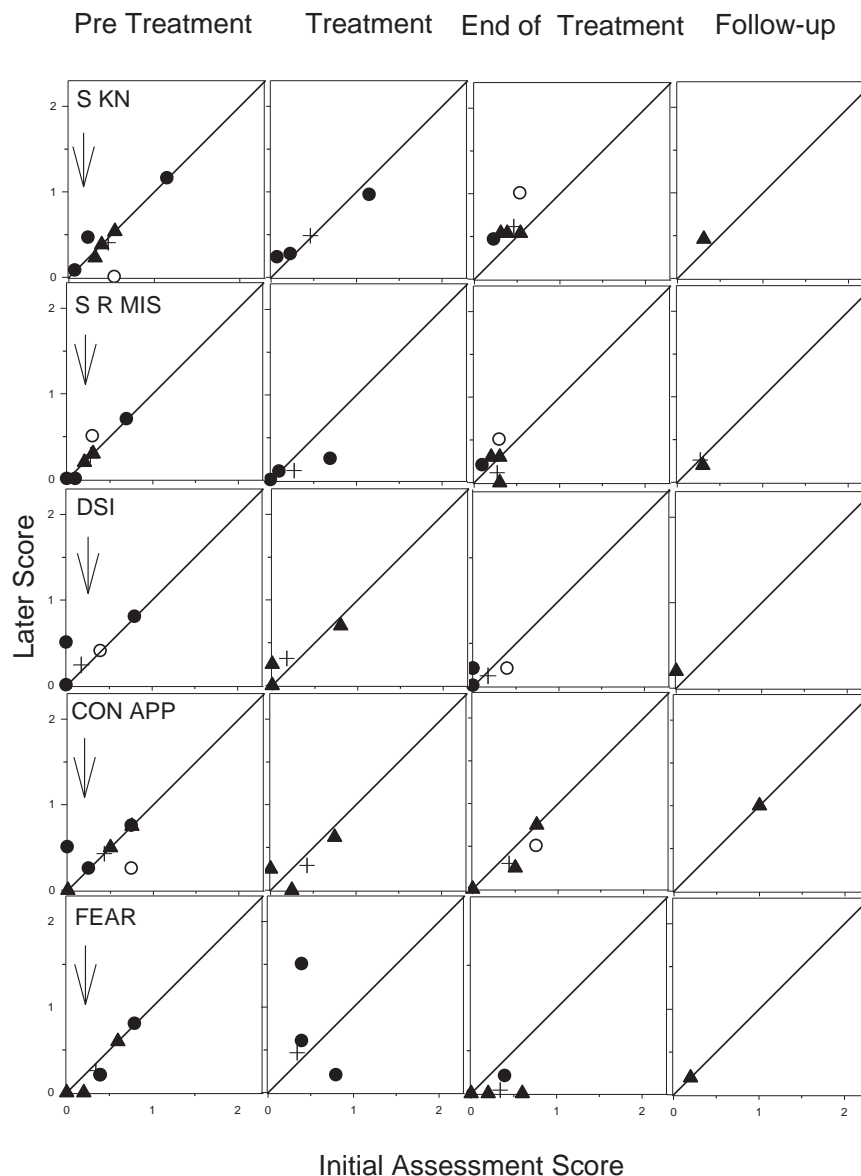


Figure 9.4 Modified Brinley plots showing group data for the ACSBI – Self-Report across initial assessment scores (x-axis) and phases of the intervention (y-axis)

Note. S KN = sexual knowledge/interest; S R MIS = sexual risk/misuse; DSI = divergent sexual interests; CON APP = concerns about appearance; white dots = ID youth; black dots = special needs youth; triangles = non-ID youth; arrows are placed on graphs to indicate the intended direction of change.

9.1.4 ACSBI – Parent Report Results

Figure 9.5 graphically displays the results of the caregivers who were administered the ACSBI – Parent Report across the four conditions. There are no apparent systematic effects evident, however individual results (included in Appendix 6) demonstrate fluctuations in direction across scales.

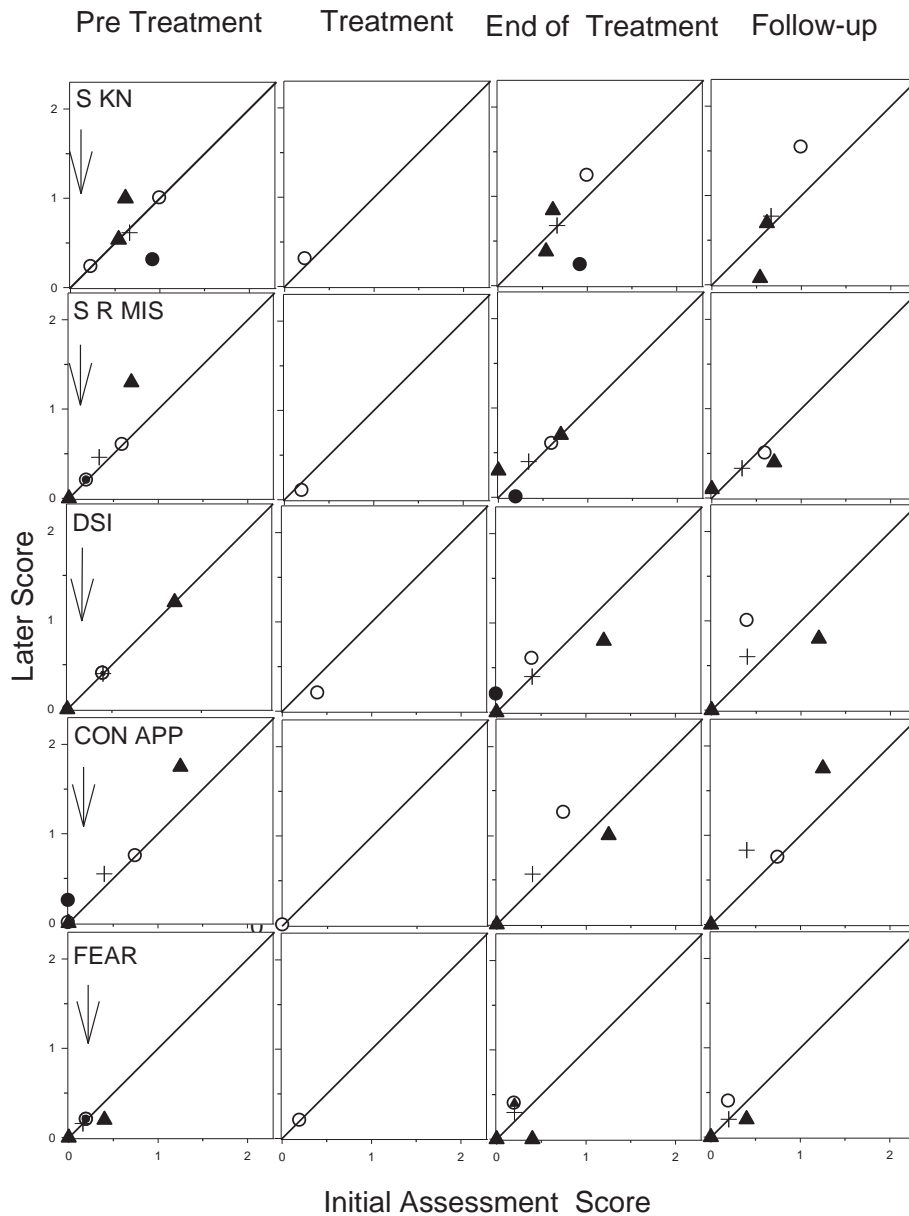


Figure 9.5 Modified Brinley plots showing group data for the ACSBI – Parent Report across initial assessment scores (x-axis) and phases of the intervention (y-axis)
Note. S KN = sexual knowledge/interest; S R MIS = sexual risk/misuse; DSI = divergent sexual interests; CON APP = concerns about appearance; white dots = ID youth; black dots = special needs youth; triangles = non-ID youth; arrows are placed on graphs to indicate the intended direction of change.

9.2 Changes to Concurrent Behaviours

Changes to comorbid clinical problem behaviours were monitored using the Child Behavior Checklist (CBCL) and the Youth Self-Report (YSR). A third measure, the Parent Daily Report (PDR), which is a continuous measure used to capture changes in positive and negative behaviours across the treatment phase, was also applied.

9.2.1 CBCL Results

Figure 9.6 graphically displays the results of the caregivers who were administered the CBCL across the four conditions. This enables a comparison of the assessment score with the subsequent phases of the intervention (pre-treatment, treatment and follow-up). Visual analysis reveals no apparent systematic effects.

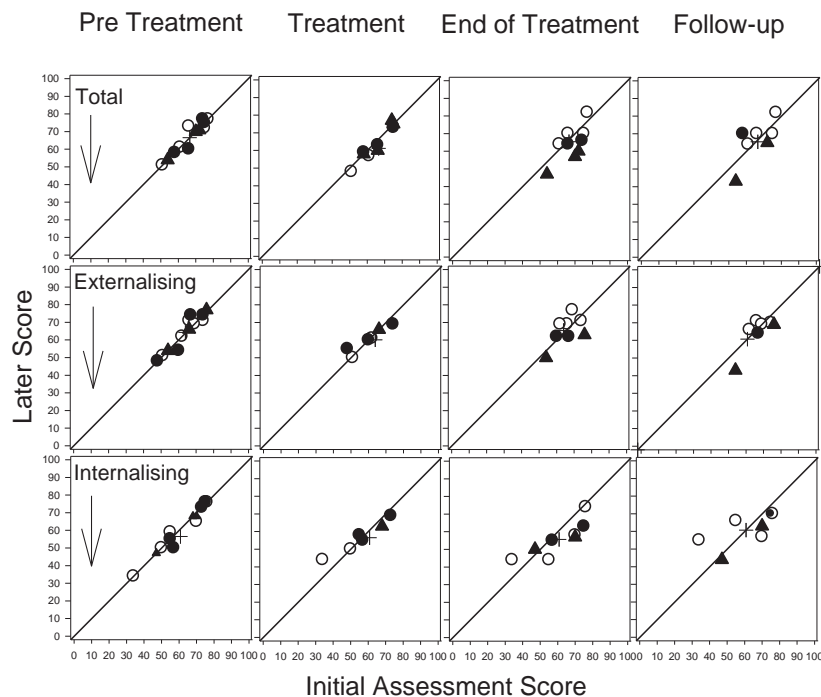


Figure 9.6 Modified Brinley plots showing group data for the CBCL across initial assessment scores (x-axis) and phases of the intervention (y-axis)

Note. White dots = ID youth; black dots = special needs youth; triangles = non-ID youth; arrows are placed on graphs to indicate the intended direction of change.

The individual T score results on the internalising, externalising and total problems for each participant reflect stability in the baseline phase, and were more variable – with both positive and negative fluctuations – in scores across intervention phases. To facilitate in-depth interpretation of the CBCL, the syndrome scales that make up the

internalising, externalising and total problem scores are included in Appendix 5. Syndrome scales are sets of problems that are found to co-occur. In addition to the internalising, externalising problem interpretation, item response scores of participants are also scored within DSM-oriented scales. For all syndrome scales, cut-off scores are less conservative than total scores. Scores of 65 or less are considered non-clinical, 66 through 70 are considered borderline, and 71 or greater are considered clinical (Achenbach & Edelbrock, 1991).

A detailed analysis of the complete set of results for each participant demonstrated that while changes between initial scores and later scores for externalising behaviours were subtle, inconsistent or non-existent, internalising-type problems demonstrated a positive pattern of change in the Anxious/Depressed and Withdrawn syndrome scales. This was supported by changes to a portion of participants' DSM Affective and Anxiety scales. These types of subtle changes are considered relevant within a treatment setting and inform treatment delivery.

The initial assessment scores showed elevations for internalising problems in 10 of the 12 caregivers. While three of the caregivers scores did not demonstrate remarkable change as a result of treatment, for seven of the caregivers there was a positive change to problem behaviours once the intervention was introduced.

More specifically, P1's initial score was in the clinical range for the Anxious/Depressed ($T = 72$), Withdrawal ($T = 78$) syndromes, and for DSM Affective scale ($T = 72$). These scores had dropped into the non-clinical range by end of treatment, and change was maintained during the follow-up period.

P2's initial score for the Anxious/Depressed syndrome was in the subclinical range ($T = 66$), in the clinical range ($T = 70$) for the Withdrawal syndrome, and in the clinical range ($T = 73$) for the DSM Affective scale. These scores dropped into the non-clinical range by end of treatment, and changes were maintained during the follow-up period.

P3 initially scored in the subclinical range on the DSM Affective scale ($T = 66$) but upon completion of treatment his score had fallen into the non-clinical range, and the change was maintained during follow-up. Similarly, P4 initially scored in the subclinical ranges ($T = 66$) on the Anxiety/Depression and Withdrawal syndrome

scales. Upon completion of treatment these scores had fallen into the non-clinical range.

P5 initially scored in the clinical range for the Anxiety/Depression syndrome (T = 74) and had fallen into the non-clinical range by the end of treatment. On the Withdrawal syndrome his initial score was in the clinical range (T = 79) but had dropped to subclinical range (T = 66) by the end of treatment.

P9's initial score on the Anxiety/Depression and the Withdrawal syndromes was in the clinical range (both T = 78) but both had fallen into the subclinical range by follow-up (T = 66 and T = 68 respectively). His Withdrawal scale showed fluctuations – he scored in the non-clinical range at the end of treatment.

P10's initial score on the Withdrawal syndrome scale was in the clinical range (T = 86) but fell to subclinical range (T = 68) once treatment was introduced.

9.2.2 YSR Results

Figure 9.7 graphically displays the results of the nine participants who were administered the YSR across the four intervention conditions. No strong systematic effects can be observed, though a small but statistically non-significant downwards trend in internalising problems is apparent.

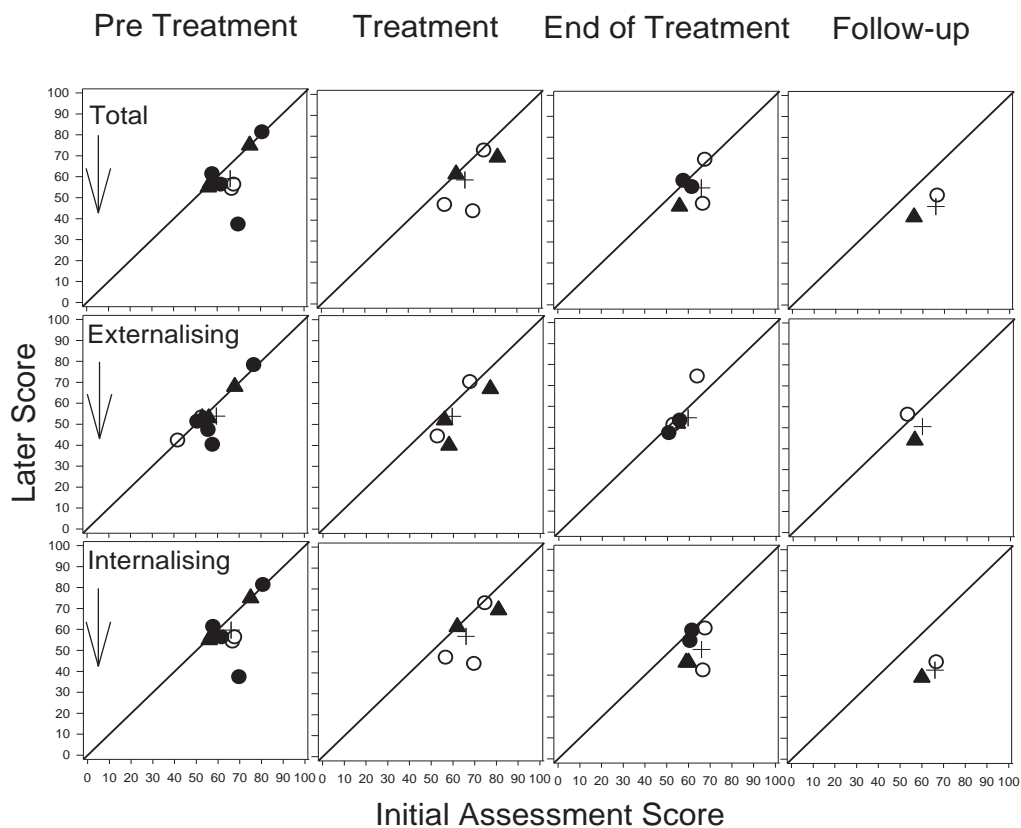


Figure 9.7 Modified Brinley plots showing group data for the YSR across initial assessment scores (x-axis) and phases of the intervention (y-axis)

Note. White dots = ID youth; black dots = special needs youth; triangles = non-ID youth; arrows are placed on graphs to indicate the intended direction of change.

To facilitate in-depth interpretation of the YSR, the syndrome and DSM-oriented scales are included in Appendix 6. While two participants demonstrated little to no change, five of the seven participants with elevations on the YSR initial subscale scores showed positive change.

P2's initial score on Somatisation syndrome scale fell from the clinical range ($T = 70$) to the non-clinical range, with the change maintained during the follow-up period. On the DSM-oriented scales, his subclinical scores on the Affective ($T = 67$), Anxiety ($T = 69$), Somatisation ($T = 65$) scales had fallen into the non-clinical range by the end of treatment. Changes were maintained in the follow-up period.

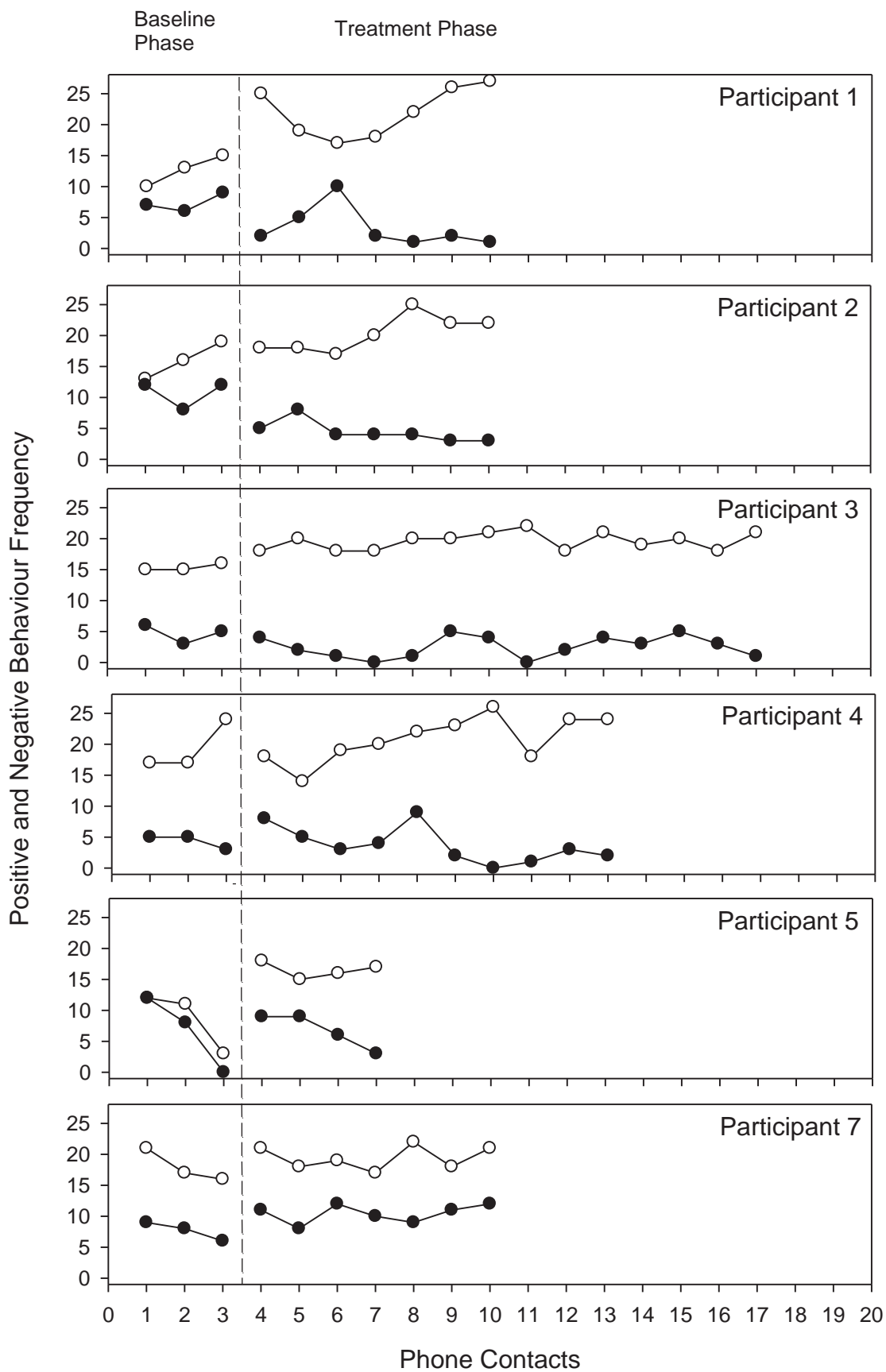
P3's initial score on the Affective scale was in the subclinical range ($T = 65$) but had fallen into the non-clinical range by the completion of treatment, with change maintained over the follow-up period.

P4's initial score on the Somatisation syndrome scale was elevated in the clinical range (T = 78), and fell to the non-clinical once treatment was introduced. P5's initial score on the Somatisation syndrome scale was in the clinical range (T = 70) but had fallen into the non-clinical range by the end of treatment. His initial score on the Affective scale was in the subclinical range (T = 65), as was his score on the Somatisation syndrome scale (T = 74) in the clinical range but both had fallen into the non-clinical range by the end of treatment.

P9's initial score on the Anxiety/Depressed syndrome scale was in the subclinical range (T = 65) and his Affective score in the clinical range (T = 70), but both had fallen into the non-clinical range by the end of treatment. P10 did not complete treatment, however he did show change once treatment was introduced. On the Anxiety/Depression and Withdrawal syndrome scales he fell from subclinical ranges (T = 65, T = 68 and T = 69 respectively) to non-clinical ranges. On the Affective scale his initial score was in the clinical range (T = 70), and this fell to the non-clinical range.

9.2.3 PDR Results

The PDR acts as a continuous measure to capture changes to non-sexual behaviours. This measure's focus is on the frequency of positive and negative behaviours as reported by the primary caregiver during the treatment phase. Figure 9.8 graphically represents the response levels for nine of the participants over the baseline and treatment phases in time series format.



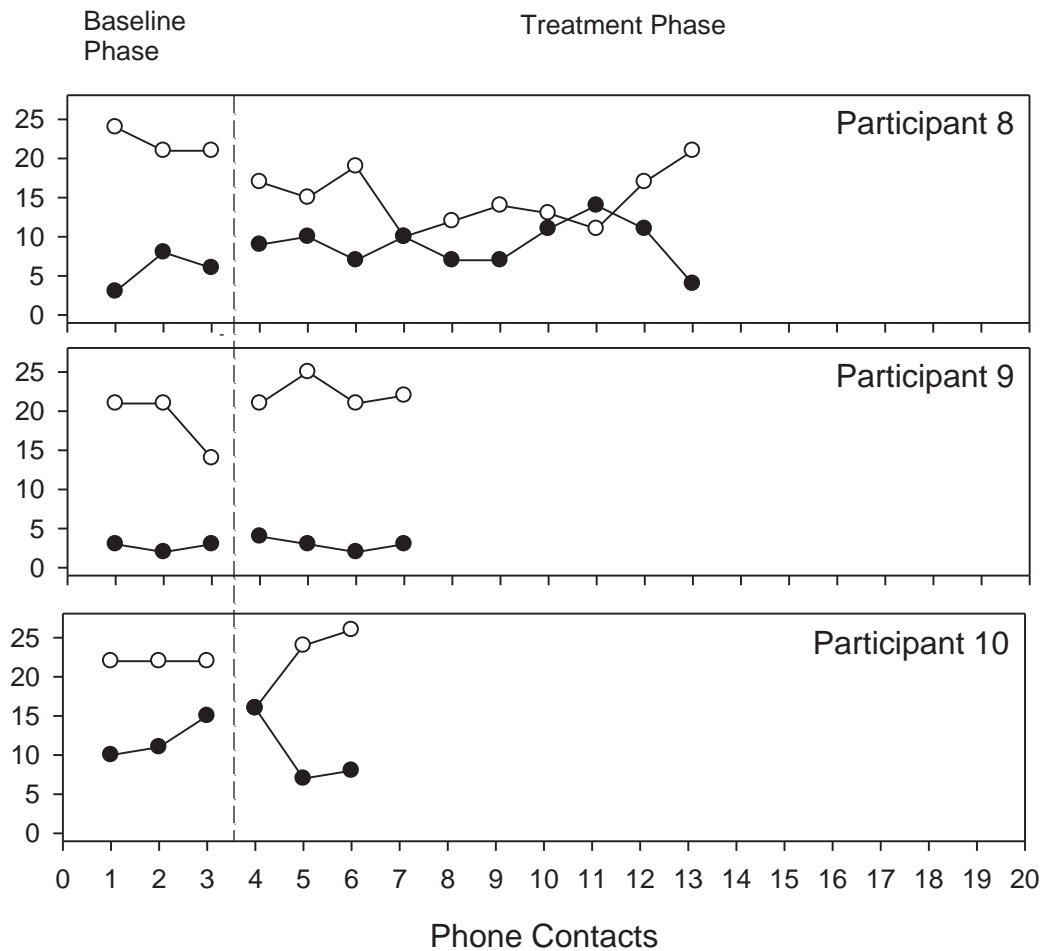


Figure 9.8 Changes in positive and negative behaviours across baseline (B) and treatment (T) phases for each participant

Note. White dots = positive behaviours; black dots = negative behaviours.

9.2.4 Baseline Phase

It is recommended that the baseline data be evaluated for stability at a minimum of three baseline points which are characterised by little variability and an absence of a slope (Kazdin, 1982). The variability found in the baseline scores was within an acceptable level (50%) for a single-case methodology in applied clinical research (Barlow & Herson, 1984).

The variability in the PDR positive behaviours baseline scores for the nine participants did not exceed 32% in any case (baseline ranges = 10–15, 13–19, 15–16, 17–24, 3–12, 16–21, 21–24, 14–21, and 22 respectively on a 28-item scale; variability = 18%, 21%, 4%, 25%, 32%, 18%, 11%, 25% and 0% for P1, P2, P3, P4, P5, P7, P8, P9 and P10 respectively).

The variability in the PDR negative behaviours baseline scores for the eight participants did not exceed 21% in any case (baseline ranges = 6–9, 8–12, 3–6, 3–5, 6–9, 3–8, 2–3, and 10–15 respectively on a 23-item scale; variability = 13%, 17%, 13%, 21%, 13%, 21%, 4% and 18% for P1, P2, P3, P4, P5, P7, P8, P9 and P10 respectively), with the exception of P5 (baseline range 0–12; variability = 52%). These results suggest a relatively level trend and therefore a stable baseline across participants (with the exception of P5), and that without intervention the participants in all probability would experience the same level of behaviours in the future.

9.2.5 Treatment Phase

Based on visual inspection of the PDR scores during the treatment phases for the group, changes occurred across participants. A change in level for both positive and negative behaviours occurred upon implementation of the treatment for all participants, with a more prominent change occurring in both behaviours for P1, P4, P5 and P7.

Although variable in quantity, the trend in data across the course of treatment indicates that overall positive behaviours systemically increased and negative behaviours systematically decreased, with the exception of P8. The direction of positive change for both sets of behaviours only occurred at the latter end of treatment. P7 showed a very slow pattern of change across time.

The PDR scores during the treatment phase for positive behaviours demonstrated a slow increase across the measurement points in six of the seven participants (P1, P2, P3, P4, P5, P7). In contrast, P6 demonstrated a decrease in positive behaviours over the course of treatment. For P7 and P8 the change upon implementation of treatment was more subtle and much less apparent. For P6, upon implementation of treatment the change was variable over the course of treatment.

The PDR scores during the treatment phases for the negative behaviours show less variation between participants. Two participants demonstrated a small positive change in negative behaviours by the end of treatment (P5, P6); four participants showed a gradual decrease in negative behaviours (P1, P2, P3, P4); and one participant, P7, demonstrated no change in negative behaviours.

With the exception of P2, ID participants (P5, P6, P7) showed less change than non-ID participants. Participant 10 did not complete treatment, however initial impressions suggested that a change had occurred.

Table 9.2 displays the overall group mean for positive behaviours. This shows an increase between baseline (mean = 16.85; *SD* = 4.29) and treatment phases (mean = 19.76; *SD* = 2.09). As can be seen in Table 9.3, the overall group mean for negative behaviours showed a decrease between baseline (mean = 6.77; *SD* = 3.11) and treatment phases (mean = 5.76; *SD* = 2.8).

Table 9.2 Changes in level of reported positive behaviours (average for each participant) across baseline and treatment phases

Participant	Baseline phase (<i>M</i>)	Treatment phase (<i>M</i>)
P1	12.67	22
P2	16	20.87
P3	15.33	19
P4	18.33	20.8
P5	8.67	16.5
P7	18	19.42
P8	22	16.54
P9	18.67	20.71
P10	22	22
Combined mean scores	16.85 (<i>SD</i> = 4.29)	19.76 (<i>SD</i> = 2.09)

Table 9.3 Changes in levels of reported negative behaviours (average for each participant) across baseline and treatment phases

Participant	Baseline phase (<i>M</i>)	Treatment phase (<i>M</i>)
P1	7.33	3.28
P2 (ID)	10.66	5
P3 (SN)	4.67	2.5
P4	3.4	4.33
P5 (SN)	6.67	7.25
P7(ID)	7.67	10.43
P8(ID)	5.66	8.23
P9(ID)	2.67	2.86
P10 (SN)	12	8
Combined mean scores	6.77 (<i>SD</i> = 3.11)	5.76 (<i>SD</i> = 2.8)

The overall means for ID, non-ID and special needs youth on positive behaviours and negative behaviours showed an increase between baseline and treatment phases for all three groups. The overall group mean for negative behaviours showed a decrease between baseline and treatment phases for the non-ID and special needs groups, and no change for the ID group. The ES was calculated with Cohen's *d*; for positive behaviours ES was medium (0.4), and for negative behaviours the ES was small (0.2).

9.2.6 Percentage of Data Exceeding the Median (PEM) Results

To add to the visual analysis, the PEM method (Ma, 2006) was used to calculate ESs (see Table 9.4). The effect of treatment is gauged by determining the percentage of data points which exceed the median point in the baseline data (below the line for negative behaviours, above the line for positive behaviours). PEM scores range from 0 to 1. A PEM of .90 and higher indicates highly effective; >.70 to <.90 represents a moderate effect; <.70 indicates a mild effect; and <.50 is considered ineffective.

Table 9.4 PEM scores for each participant

Participant	PEM positive behaviours	PEM negative behaviours
1	1.00	.86
2(ID)	1.00	1.00
3	1.00	.86
4	.90	.70
5	1.00	.50
7(ID)	.86	0
8(ID)	0	.10
9(ID)	.25	.25
10	.67	.33

9.3 Trauma Symptomology

Trauma-type symptoms were assessed by the Trauma Symptom Checklist for Children (TSCC).

9.3.1 TSCC Results

The T score results on post-traumatic stress and related psychological symptomology from the TSCC self-report measure are presented in Table 9.5. The results reflect the two validity scales (Underresponse and Hyperresponse) and six clinical scales (Anxiety, Depression, Anger, Post-Traumatic Stress, Disassociation, and Sexual Concerns). The TSCC was administered to a total of nine participants. The data on this measure were considered too incomplete to provide meaningful results. However, the available qualitative data results suggest valid response scores.

P1's and P11's subscale scores never entered the subclinical or clinical ranges. Of those participants whose assessment scores were in the clinical range, a general reduction in symptoms was apparent. P2's scores on the Anxiety, Depression, Post-Traumatic Stress, Disassociation, and Sexual Concerns subscales demonstrated a reduction in symptoms. These fell from the subclinical and clinical ranges of his assessment score to the non-clinical range at follow-up. P3 and P9 scored in the subclinical range for Post-Traumatic Stress and had both fallen into the non-clinical range by the end of treatment. On his Disassociation subscales there was a small reduction, and he was no longer in the clinical range by the end of treatment. During the assessment phase P4 scored in the clinical range on Disassociation. This had fallen into the non-clinical range by the end of treatment. P10's score on Sexual Concerns fell from clinical to subclinical range during treatment. P6 was the only participant to maintain an elevation in the clinical range through the assessment and treatment phases.

Table 9.5 TSCC scores across data collection points

Symptom category (T score)	P	Assessment	Pre-treatment	Treatment	End of Treatment	Follow-up
TSCC-UND/HYP	1	46/49	58/47	-	50/47	66/47
	2	56/62	66/62	-	*	51/47
	3	42/67	42/67	51/47	46/47	*
	4	41/78	41/78	*	66/47	*
	5	61/62	61/62	-	54/47	39/67
	6	42/47	42/47	39/47	-	-
	9	54/47	54/47	50/39	50/39	50/39
	10	39/47	39/47	54/47	-	-
	11	54/47	54/47	74/47	-	-
TSCC-ANX	1	51	41	-	41	41
	2	63+	66++	-	-	39
	3	59	59	46	46	*
	4	58	58	*	35	*
	5	50	50	-	44	64+
	6	72++	72++	67++	-	-
	9	56	56	44	44	44
	10	72++	72++	54	-	-
	11	44	44	41	-	*
TSCC-DEP	1	59	51	-	51	51
	2	70++	45	-	-	45
	3	59	59	46	51	*
	4	58	58	*	40	*
	5	53	53	-	43	56
	6	56	56	61+	-	-
	9	49	49	46	41	41
	10	54	54	44	-	-
	11	44	44	39	-	*
TSCC-ANG	1	50	36	-	45	38
	2	50	39	-	-	37
	3	54	54	48	40	*
	4	52	52	*	39	*
	5	43	43	-	41	46
	6	43	43	51	-	-
	9	38	38	38	50	50
	10	53	53	38	-	-
	11	41	41	36	-	*
TSCC-PTS	1	49	41	-	47	39
	2	75++	45	-	-	41
	3	64+	64+	64+	50	*
	4	58	58	*	39	*
	5	39	39	-	39	53
	6	74++	74++	74++	-	-
	9	64+	64+	49	53	53
	10	68++	68++	43	-	-
	11	41	41	37	-	*

Table 9.5 cont.

Symptom category (T score)	P	Assessment	Pre-treatment	Treat-ment	End of Treatment	Follow-up
TSCC-DIS	1	54/56/49	37/40/38	-	47/50/43	45/44/49
	2	78++/73++/76++	45/48/46	-	-	41/45/38
	3	78++/89++/49++	78++/89++/49	66++/70++/43	70++/61/54	*
	4	66++/79++/67++	66++/79++/67++	*	43/48/43	*
	5	37/39/38	37/39/38	-	45/42/48	50/45/49
	6	66++/67++/60++	68++/67++/65++	64+/92++/60+	-	-
	9	54/61+/38	54/61+/38	45/47/38	56/56/49	56/56/49
	10	66+/70+/54	41/42/45	37/39/38	-	-
	11	52/53/49	52/53/49	39/42/39	-	*
TSCC-SC	1	38/38/45	38/38/45	-	60/58/56	38/38/45
	2	67++/54/81++	42/43/44	-	-	42/43/44
	3	54/52/56	54/52/56	60+/55/77	44/45/48	*
	4	56/50/60+	56/50/60+	*	45/47/44	*
	5	45/47/44	45/47/44	-	50/54/44	60+/61+/66++
	6	81++/81++/77++	81++/81++/77++	97++/84++/111++	-	-
	9	66++/58/99++	66++/58/99++	38/38/45	60+/61+/45	60+/61+/45
	10	41/42/45	41/42/45	38/38/45	-	-
	11	54/55/45	54/55/45	38/38/45	-	*

Note. ++ indicates that T score is clinically significant ($T \geq 65$; SC $T \geq 70$); + indicates that T score is within the subclinical range ($T = 60-64$); * indicates missing data; P = Participant; TSCC = Trauma Symptom Checklist for Children; UND/TYP = Underresponsive/Hyperresponsive; ANX = Anxiety; DEP = Depression; ANG = Anger; PTS = Post-Traumatic Stress; DIS = Disassociation; SC = Sexual Concerns.

9.4 Strengths and Resiliency

9.4.1 Resiliency Scales for Children and Adolescents (RSCA) – Self-Report

The RSCA enables the identification and measurement of changes to the core characteristics of personal resiliency. Figure 9.9 graphically displays the results of the RSCA across the four conditions, which enables a comparison of the assessment score with the subsequent phases of the intervention (pre-treatment, treatment and follow-up). There are no apparent systematic effects within the visual analysis. Individual results were variable and are included in Appendix 7.

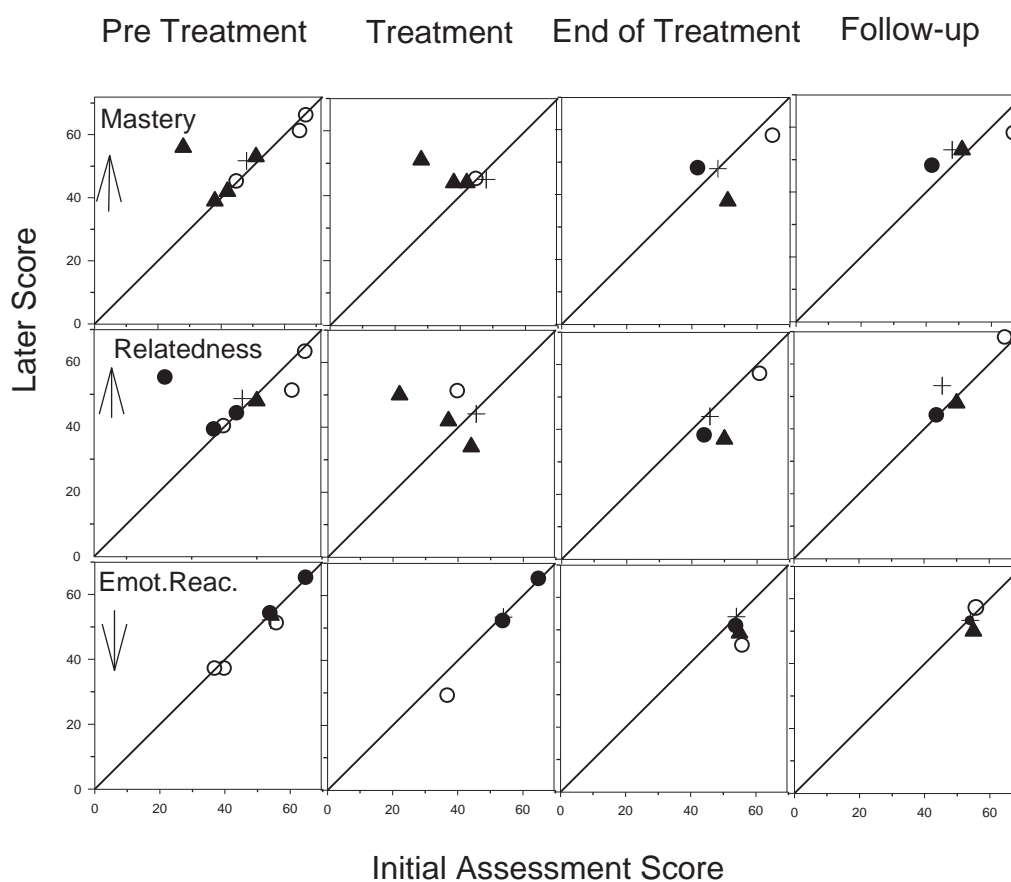


Figure 9.9 Modified Brinley plots showing group data for the RSCA initial assessment scores (x-axis) and phases of the intervention (y-axis)

Note. White dots = ID youth; black dots = special needs youth; triangles = non-ID youth; arrows are placed on graphs to indicate the intended direction of change.

9.4.2 Clinical Assessment Package for Risks and Strengths (CASPARS) – Clinician Estimate

Table 9.6 displays the results of the CASPARS. There was evidence of positive change for each of the four participants (P2, P5, P7, P8) who were administered this measure. The CASPARS has no cut-off scores, and the results of subscales are considered in relation to one another. All four participants demonstrated a stable baseline phase characterised by an acceptable level of variability (Kazdin, 1982). The direction of change between the assessment treatment phases was indicative of positive change across all four participants. With the exception of P5, for those participants with follow-up data (P7 and P8) the level of change was maintained or showed further improvement within the follow-up period. The results indicate that following a stable baseline period the participants demonstrated an improvement in functioning, inferring a functional relationship between behaviour change and treatment with the GWM.

Table 9.6 CASPARS results across data collection points

Scales %	P	Asset/ Risk						Change*
			Ax	Pre Tx	Tx phase	End of Tx	6 mth follow-up	
Emotional expressiveness	2	P2 Asset	4.17	4.17		25		+20.83
		P2 Risk	54.17	54.17		10.41		-43.76
	5	P5 Asset	39.5	39.5	-	45.83	29.17	+6.33
		P5 Risk	0	0	-	0	6.25	0
	7	P7 Asset	18.6	2.08	-	47.92	54.17	+29.32
		P7 Risk	47.92	6.25	-	0	0	-47.92
	8	P8 Asset	14.58	4.17	12.5	29.17	31.25	+14.59
		P8 Risk	41.67	39.58	27.08	4.17	10.42	-37.50
Family embeddedness	2	P2 Asset	7.69	7.69		46.15		+38.46
		P2 Risk	35.9	35.9		4.55		-31.35
	5	P5 Asset	53.84	53.84	-	61.54	53.84	+7.7
		P5 Risk	10.26	10.26	-	8.33	10.26	-1.93
	7	P7 Asset	66.67	66.67	-	69.23	84.61	+2.56
		P7 Risk	5.13	0	-	0	0	-5.13
	8	P8 Asset	20.51	20.51	20.51	43.59	33.33	+23.08
		P8 Risk	23.08	23.08	17.95	7.69	12.82	-15.39
Current family relationships	2	P2 Asset	22.22	22.22		49.2		+26.98
		P2 Risk	15.87	15.87		6.35		-9.52
	5	P5 Asset	60.32	60.32	-	84.13	55.55	+23.81
		P5 Risk	6.35	6.35	-	0	9.52	-6.35
	7	P7 Asset	63.49	63.49	-	71.43	73.01	+7.94
		P7 Risk	3.17	3.17	-	0	0	-3.17
	8	P8 Asset	26.98	26.98	22.22	34.92	60.31	+7.94
		P8 Risk	38.09	38.09	26.98	19.04	3.17	-19.05

Sexuality	2	P2 Asset	18.18	18.18		54.55		+36.37
		P2 Risk	33.33	33.33		6.06		-27.27
	5	P5 Asset	68.18	68.18	-	68.18	66.67	0
		P5 Risk	7.57	7.57	-	7.57	13.64	0
	7	P7 Asset	54.90	47.06	-	66.67	80.39	+12.09
		P7 Risk	13.72	30.92	-	0	0	-13.72
	8	P8 Asset	18.18	18.18	25.76	28.79	39.39	+10.61
		P8 Risk	16.67	13.64	3.03	3.03	4.54	-13.64
Peer relationships	2	P2 Asset	3.92	3.92		12		+8.08
		P2 Risk	47.06	47.06		8		-39.08
	5	P5 Asset	19.6	19.6	-	43.14	17.65	+23.54
		P5 Risk	35.29	35.29	-	5.88	15.68	-29.41
	7	P7 Asset	5.88	35.29	-	43.14	37.25	+37.26
		P7 Risk	45.10	7.84	-	3.92	3.92	-41.08
	8	P8 Asset	13.72	0	13.72	25.49	39.21	+11.77
		P8 Risk	43.14	50.98	19.67	3.92	7.84	-39.22

Note. * = degree of change between assessment and end of treatment scores; P = participant.

9.4.3 Four Dimensions of Youth Development (4-D) – Clinician Estimate

The 4-D acts as a clinical guide to assist the therapist to focus on strengths and risks, and to inform treatment. There are no cut-off scores or defined ranges; rather a profile of strengths and risks for each individual. The data were considered too inconsistent to provide patterns that were meaningful for Brinley plot analysis. This was largely due to missing data points and only a small number of the total group being administered the measure which is age based. A full table of results can be found in Appendix 8. P1 and P11 had both assessment and completion data available, with both sets of scores indicating an increase in strengths in their profile from baseline to the end of treatment phase. This positive trend was also reflected between the baseline and treatment phases of P3, P10 and P12, with P6's scores remaining mixed. P10 and P12 demonstrated a decrease in risks between the assessment and treatment phase. P3's and P6's scores remained mixed. P6 was the only participant in this study to be living independently and therefore the developmental transitional milestone of leaving home during stressful circumstances and boundaries imposed by safety planning are a factor for consideration when interpreting his results. From a therapeutic perspective, the available results indicate that following a stable baseline period a majority of participants demonstrated an improvement in functioning after receiving treatment with the GWM.

9.5 Outcome and Therapeutic Relationship

9.5.1 Outcome Rating Scale (ORS) and Session Rating Scale (SRS)

The GWM aims to provide a developmentally appropriate tailored treatment approach for each young person. Each young person's perception of the outcome of treatment and the quality of the therapeutic relationship were captured in real time during the treatment phase with the ORS and SRS. These tools assist the therapist to navigate and tailor the treatment approach accordingly. Figures 9.10–9.12 graphically illustrate the results of the ORS and SRS in time-series format and Tables 9.7 and 9.8 list the respective mean scores. As can be seen, there was some variability in change across participants, though the general trend was positive.

The ORS captures changes in a young person's progress when undergoing treatment using the GWM. The cut-off score for children is 32, and for young people (13+) it is 28. Based upon visual inspection of the ORS results, six of the nine participants who completed treatment, and the one still in treatment, obtained an overall mean score within the cut-off range. P3 was well below, and P4 demonstrated an elevation over the second half of treatment. While early scores for P6 sat on or below the cut-off, the mean score of the latter half of his treatment demonstrated a positive elevation (36.06, $SD = 4.85$). P7 did not reach the cut-off score, though there was a slight elevation over the course of treatment. Systemic factors are relevant when interpreting these results. All of the participants with unstable ORS results (P3, P6, P9, P10) experienced disruptions in their situations which were out of their control. For example, P3 had three placement changes and two school changes during his treatment; P10 had five placement changes and five educational/vocational changes during this treatment; and P9 also had placement and school changes.

The SRS captures data on a young person's perception of the therapeutic alliance when undergoing treatment using the GWM. The cut-off score for this measure is 36. Based on the visual inspection of the SRS, seven of the nine participants who completed treatment, and the two still in treatment at the time of writing, obtained average scores within the cut-off range. P3 and P7 consistently fell outside the cut-off, while P4 demonstrated an elevation towards the latter end of treatment. The individual session results of P11 fell on or around the cut-off.

The single participant who dropped out of treatment fell in the cut-off range for both measures, and the two clients with the lowest-scoring results were treated with the least fidelity to the model. No parent data were collected.

Table 9.7 Changes in level of reported ORS (average for each participant) during the treatment phases.

Participant	Sessions recorded	M	SD
P1	4	33.17	2.64
P2*	9	32.6	11.56
P3	21	23.96	7.85
P4	7	25.22	4.72
P5	7	34.48	3.36
P6	40	29.61	8.9
P7*	7	24.51	4.61
P8*	7	38.87	1.46
P9*	23	34.99	7.61
P10	15	28.95	9.84
P11	8	32.83	2.29
P12*	19	39.4	1.19
Mean	14	31.55	5.5

Note. * = ID youth.

Table 9.8 Changes in level of reported SRS (average for each participant) during the treatment phases

Participant	Sessions recorded	M	SD
P1	4	36	2.05
P2*	11	38.75	2.15
P3	28	28.73	5.07
P4	8	25.72	6.48
P5	7	37.11	1.57
P6	39	37.77	3.05
P7*	7	31.14	5.26
P8*	7	39.37	0.43
P9*	21	40	0
P10	15	39.72	0.66
P11	6	34.96	1.52
P12*	19	39.93	0.3
Mean	14	36.00	4.79

Note. * = ID youth.

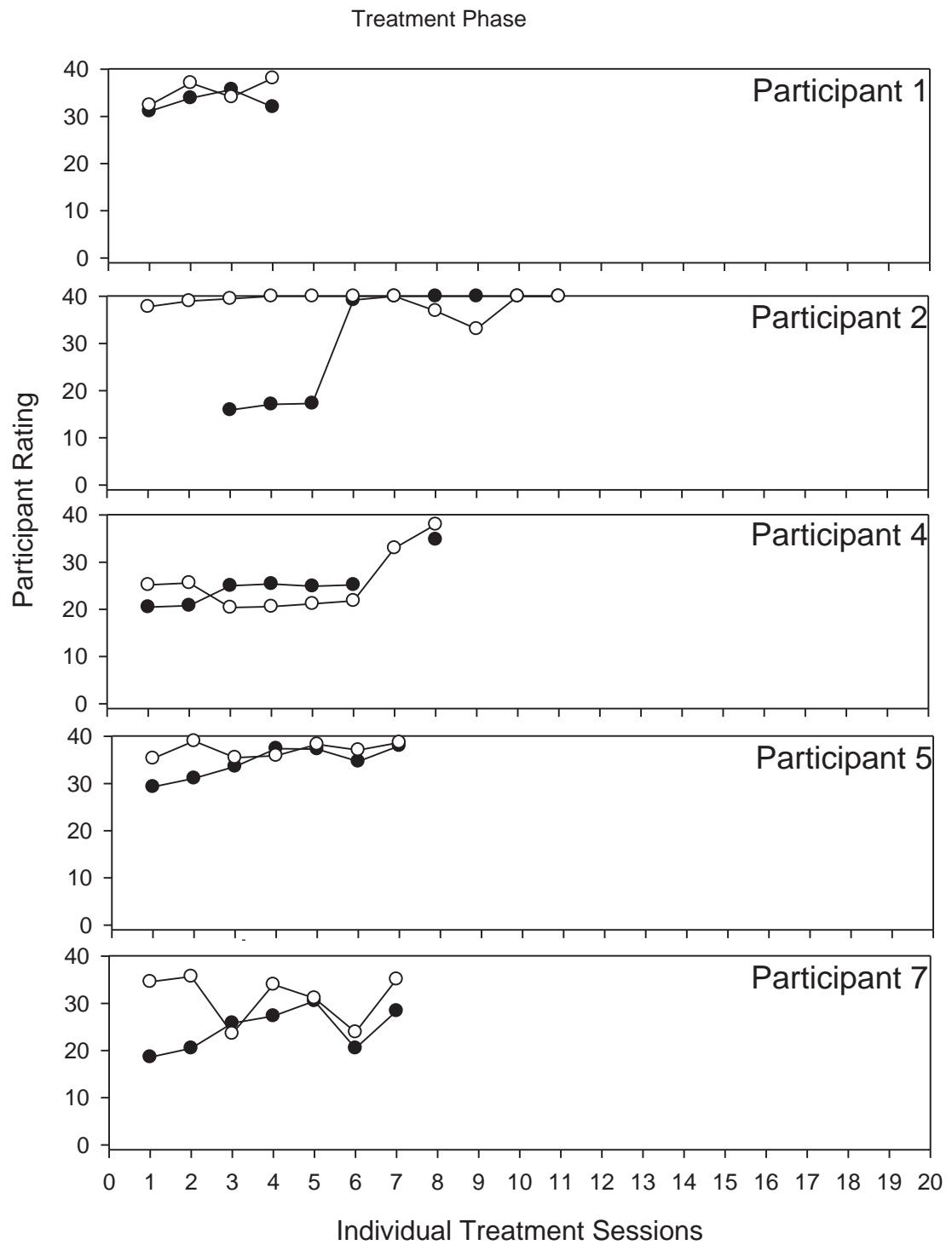


Figure 9.10 Individual participant results for ORS and SRS (P1, P2, P4, P5 and P7)

Note. White dots = SRS; black dots = ORS.

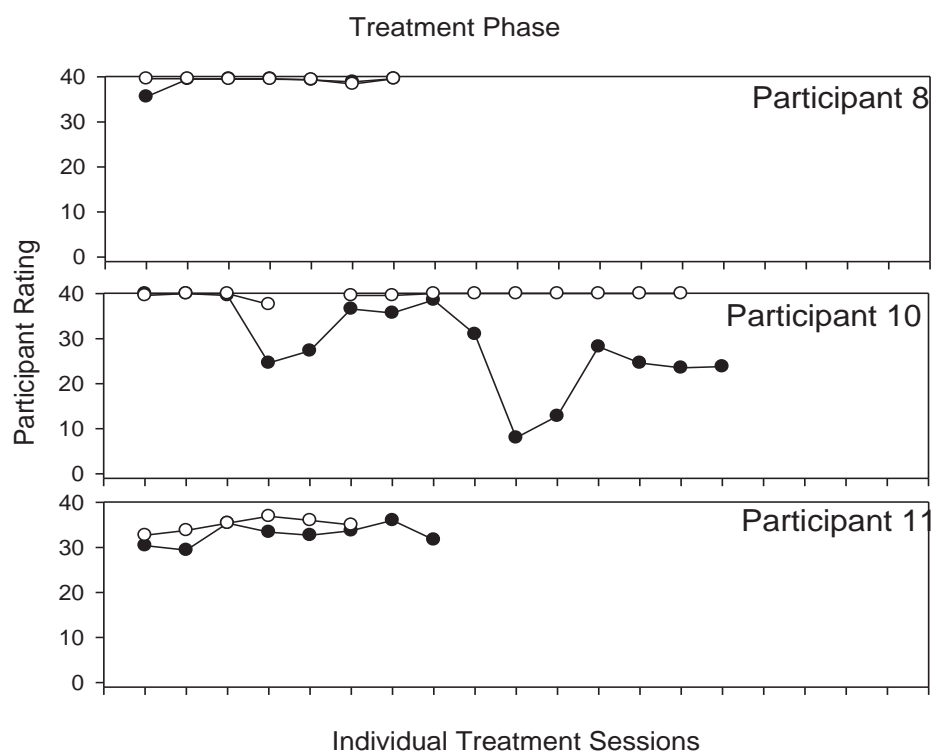


Figure 9.11 Individual participant results for ORS and SRS (P8, P10 and P11)
Note. White dots = SRS; black dots = ORS.

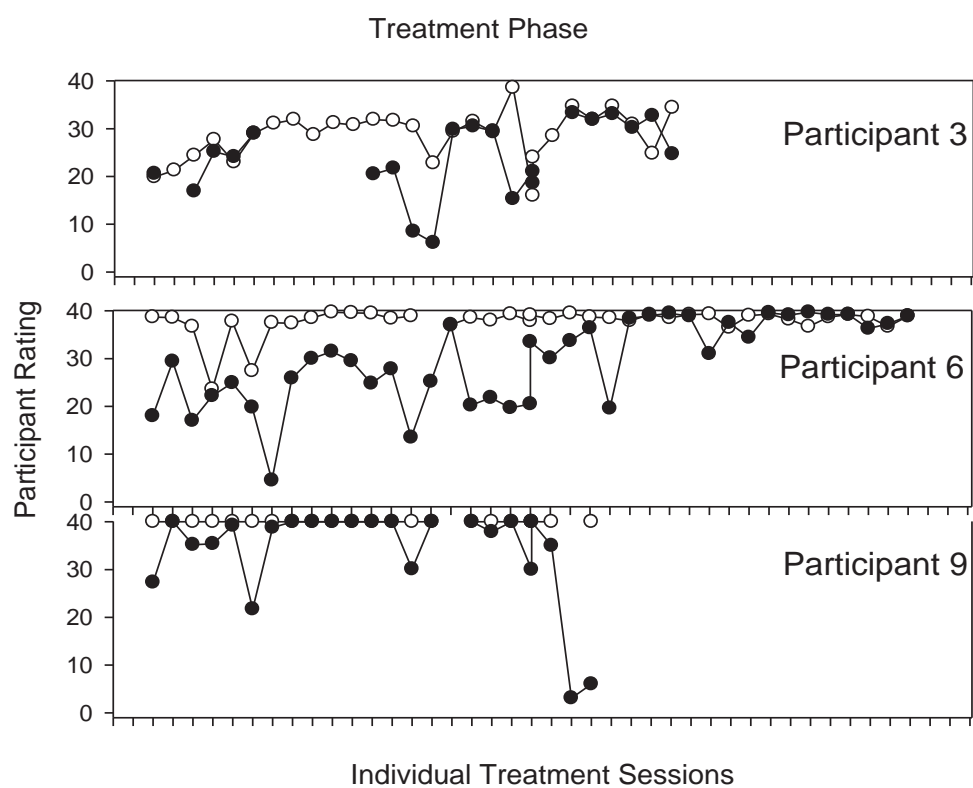


Figure 9.12 Individual participant results for ORS and SRS (P3, P6 and P9)
Note. White dots = Session Rating Scale; Black dots = Outcome Rating Scale

9.6 Summary of Results

This study was designed to evaluate individualised treatments devised within a general framework of the GWM model. The participants consisted of 12 male youth who ranged in age from 12 to 17 years, five of whom had an ID. During the period of the study nine participants completed treatment, two remain in treatment at the time of writing, and one dropped out as a result of unstable placements. One participant re-engaged in HSB and was returned to treatment.

Treatment effectiveness was examined within a single-case multiple baseline design framework. The results of measures, which capture factors directly relevant to the target behaviour – sexual recidivism – imply a functional relationship between the GWM treatment and the reduction of HSB.

Although clinically significant co-occurring problem behaviours have been identified in this research and were therefore the obvious target for changes, patterns of change were variable and effects were not deemed significant using a modified Brinley plot analysis. However, a small but statistically non-significant downwards trend for internalising-type problems was apparent when the individual results of participant responses were examined.

The results also indicate that the GWM assists in therapeutic alliance and positive outcomes. Although variable in degree, the majority of participants demonstrated an improvement in factors relating to positive changes in behaviour and resiliency. These results also imply a functional relationship between behaviour change and treatment with the GWM.

Chapter 10: Discussion

This research represents the first attempt to evaluate the Good Way model (GWM) developed by Ayland and West (2006) and is the first important step towards understanding its level of effectiveness in the treatment of youth with harmful sexual behaviour (HSB). This chapter is presented in seven sections. The first section summarises the findings of the study and the clinical significance of the treatment outcomes with reference to the research objectives. The second section answers the research questions while the third and fourth sections present interpretation of the findings and their theoretical and practical implications, respectively. The fifth section outlines the study's strengths and limitations and the sixth makes suggestions for future research. The final section presents the conclusions of the study.

10.1 Summary of Major Findings

The primary aim of this study was to evaluate the effectiveness of the GWM intervention for adolescent boys undergoing treatment for HSB. Methodological rigor (Hawkins et al., 2007) was demonstrated by the finding of a change in behaviour that corresponded with experimental manipulation. The results indicate that the GWM led to (a) a decrease in HSB and risk factors related to sexual recidivism, (b) an increase in pro-social behaviours related to strengths and resiliency, and (c) positive results for measures focusing on outcome and therapeutic alliance. There was also some evidence for change in individual participants across measures of comorbid problem behaviours during the course of treatment, although these results were variable and did not meet the experimental criteria for effectiveness.

Prior to the commencement of treatment and data collection, a peer-reviewed and subsequently revised GWM treatment manual was operationalised, and training and supervision specific to the GWM was provided to therapists involved in the study. The 12 participants, all male youth aged between 11.5 and 17.3 years, received treatment following a comprehensive assessment phase. Individualised treatment plans, responsive to the individual needs of each participant, were developed. Accordingly, treatment components, dosage and length varied between participants.

High treatment fidelity was established for seven therapists (100%), with the remaining therapist demonstrating moderate fidelity (50%).

Clinical significance as represented by patterns of change and the replication of findings across measures was variable. The results for the measures that captured factors directly relevant to the target behaviour – dynamic risk factors for sexual recidivism – suggest a functional relationship between the GWM treatment and the reduction of HSB (see Figure 9.2). The results also indicate that the GWM is helpful for assisting in positively changing behaviour in youth with HSB (see Figure 9.8). Positive results for both therapeutic alliance and outcome were also found (see Figures 9.10 and 9.11), although outcome measures reflected systemically related stressors (see Figure 9.12). Although clinically significant co-occurring problem behaviours have been identified in the research (e.g., Dillon, 2010; Fortune, 2007; Purcell, 2010) and were therefore the obvious target for changes, patterns of change for participants were variable and were not deemed as clinically significant within the modified Brinley plot analysis (see Figures 9.6 and 9.7). A positive pattern of change for internalising problems was apparent when the idiosyncrasies of participant responses were examined.

Overall, the results of the current study provided evidence that the introduction of the GWM intervention targeted the problem behaviour appropriately and that it was well received by participants. Evidence for change across co-existing problems was not statistically significant, however they were clinically meaningful. The stability of baseline phases demonstrated that the changes were more likely to be a result of treatment than extraneous events. While internal validity is strengthened by the replication of results across participants, the size of the effects suggests there are areas for further development. A consideration of the context of this research and a review of the results in relation to the research questions will facilitate a more in-depth analysis of the findings.

10.2 Research Questions

1. Is the GWM effective for the treatment of HSB for ID and non-ID youth?

In terms of changes to the target behaviour (HSB), this study found that both ID and non-ID youth benefited from treatment with the GWM. This outcome was measured

by looking at changes to dynamic risk factors related to engagement in HSB. Regardless of intellectual capacity, the results of the ERASOR indicated a systematic pattern of change in a positive direction. A medium effect size ($d = .6$) was found for those who completed treatment (P1, P3, P5, P7, P8, P9 and P11). The estimated level of risk for completers was maintained during the follow-up period, and this provided corroborative evidence for improvement.

One special needs participant (P5) sexually reoffended during the follow-up period and was returned to treatment. It is difficult to gauge if this was a measure of the model's ineffectiveness or related to treatment configuration and dosage. Reportedly P5's re-engagement with HSB was related to complex executive functioning difficulties. The magnitude of these problems became more apparent with further assessment. Although he appeared to demonstrate retention of the model during treatment, his significant difficulty with impulsivity and inhibition led to further offences. Upon return to treatment the GWM intervention became more systemically focused and a neuropsychological assessment was sought. Overall, these results imply a functional relationship between the GWM intervention and behaviour change suggesting that the GWM treatment approach effectively targets and reduces risk of further engagement in HSB.

The results of both the ORS and SRS were promising (see Figures 9.10–9.12 and Tables 9.7 and 9.8). Although these measures are not directly linked to sexual recidivism, they are linked to successful psychotherapeutic outcomes. Interestingly the participants with unstable ORS results (see Figures 9.10–9.12 – P3, P6, P9, P10) had a much greater frequency of systemic disruptions while in treatment. This being the case, their SRS results remained much more stable, suggesting that although they struggled with environmental factors, their perception of the therapeutic alliance was positive.

2. Is the GWM an effective treatment of comorbid externalising and internalising behaviours?

The results relating to changes in externalising and internalising behaviours were not deemed clinically significant as required by experimental criteria, though a closer examination of caregiver and individual participant response patterns demonstrated a

positive pattern of change for individuals with internalising problems (e.g., P1, P2, P3, P4, P5, P9 and P10). Changes to externalising behaviours were much less apparent. Some participants whom scored in the clinical range on the CBCL's externalising problems showed a change in a positive direction within the clinical range (e.g., P1, P2 and P5). For participants with pre-existing antisocial-type externalising behaviours (P3, P8, P9 and P10) there was little observed change between initial scores and later scores as captured by the CBCL and PDR. However, for these participants a positive direction of change was captured on measures of strength, resiliency and/or positive behaviours (see Table 9.6 and Figure 9.8).

The different indications of change seen in the clinically defined problems in the CBCL and YSR, and the behaviours captured in the PDR are another area for consideration. There were inconsistent effects observed in that some behaviours changed and some did not, and the strength of the effect was variable. What can be said is that there were similar themes across participants, and that a clinically significant change to positive and negative behaviours occurred during the course of treatment (see Table 9.5 – P1, P2, P3, P4, P5 and P7) and the effect sizes provided corroborative evidence for improvement (see Table 9.4). Furthermore, the weak treatment effects for pervasive and long-standing problems indicated by the CBCL and YSR (see Figures 9.7 and 9.8) are yet to be understood, though may be related to the short treatment periods in this research.

3. Is the GWM effective in reducing the occurrence of non-sexual offending?

While non-sexual offending occurred for one participant (P3), it was not a prevalent enough problem within this set of participants to make it an area of examination under the study design. The positive results for measures focusing on outcome and therapeutic alliance suggest that treatment engagement was enhanced. For those young people with unstable ORS results (see Figures 9.10–9.12 – P3, P6, P9, P10) there was a much greater frequency of systemic disruptions while in treatment – but still managed to create a change for the young person.

4. Does the GWM work effectively regardless of changes in the treating clinician?

A total of eight clinicians were involved in this study. Some therapists saw more than two participants (T1, T3, T5 and T7), and two therapists (T5 and T6) were involved with the same client (P9) following a shift in treatment sites. Although the lowest-scoring results were demonstrated in treatment provided by the therapist with the least fidelity to the model T3, both participants seen by T3 demonstrated a positive direction of changes across primary measures. The results imply that regardless of changes across therapists, treatment was successfully implemented. This is particularly evident in the results of the SRS and ORS which indicate therapy was meaningful. Although not formally assessed, feedback from the clinicians regarding the training, use of the manual, and implementation of the GWM was positive.

Nevertheless, greater replication of the findings for each therapist would have strengthened the results (e.g., therapists treating at least three participants). According to Blampied (2013), systematic replications with diverse samples hold significance for the generalisability of the findings along dimensions of difference.

10.3 Interpretation of Findings

10.3.1 Evaluating Behaviour Change

The preliminary data gathered for this research on the implementation of the GWM supports its effectiveness for the treatment of HSB. While the findings demonstrate a range of scores across participants, the repeated demonstration of change to the target behaviour reduces the likelihood that the change was a result of extraneous events, and suggests therefore that the changes linked to the intervention are real, reliable and valid (Kazdin, 2013). Furthermore, the maintenance of change in follow-up indicates that participants were able to generalise skills learned in treatment.

As demonstrated by the results of this evaluation, it is not unusual when examining the effect size of new interventions to find relatively weak effect sizes. According to Kazdin (1982), even small findings provide information that assists in developing models in the field, leading to research that may eventually produce large enough effect sizes for visual inspection. This being the first study of its kind on the GWM using a multiple-baseline design, it is not surprising that variable findings across measures occurred. Complicating the picture further is that a single target behaviour

was identified (HSB); the interpretation of change to other behaviours was based on three measures selected for the research, and then as a by-product of a wide assessment process utilising established treatment measures where the presence of clinically relevant comorbid factors was variable between participants (e.g., trauma, non-sexual offending).

According to Wolery and Harris (1982), there can be changes in an individual's performance within real-world settings which are clinically important. A more detailed analysis of each participant's scores identified subtle changes that did not meet experimental criteria for change but within a treatment setting held therapeutic relevance nevertheless (e.g., a positive direction of change to internalising symptoms (P1, P2, P3, P4, P5, P9 and P10) and trauma symptomology (P2, P3, P4, P9 and P10) across the course of treatment.

Kendall and Grove (1988) state that clinically significant change can be gauged by examining changes for individuals within measures (self-report, clinical cut-offs) and by feedback from clinicians and family (behavioural observations). From this standpoint, when considering the level of change to behaviour as a result of the implementation of the GWM, both experimental and therapeutic criteria require consideration.

10.3.2 Response Patterns

The response patterns and reflected effect sizes across participants indicated a positive trend in the reduction of risk factors for HSB, an increase in positive behaviours, and evidence of a strong therapeutic relationship, which are indicative of positive outcomes. While results meeting experimental criteria demonstrated internal validity through replication on some measures (ERASOR, PDR), the changes based on therapeutic criteria are important to consider because if change is observed (regardless of strength), something is happening. The impact of treatment on internalising behaviours appeared greater than on externalising behaviours (see Figure 9.6), and factors associated with strengths and resiliency showed a variable but positively increasing trend (see e.g., Table 9.7 – P2, P5, P7 and P8). Although the degree of change was somewhat variable between participants on secondary measures, these early results show what can be considered as *promising directions of change*.

It is possible that the characteristics of the participants in this study contributed to the level of responsivity reflected in the findings. All participants were able to be treated safely in the community, suggesting they were medium-to-low risk. Their reported offence histories suggest the group consisted mostly of “specialists” rather than “generalists” (Pullman & Seto, 2012), and were therefore more suited to the recommended CBT approaches (e.g., Worling & Curwen, 2000).

While the level of flexibility inherent in the GWM (e.g., selection of treatment components and length of treatment) is likely to be a factor in the changes observed, it is also possible that individual differences played a role in treatment responsivity. This was reflected in ORS results (e.g., for P3, P6, P9 and P10), and with the single participant who sexually reoffended (P5). As found in previous outcome research on youth with HSB, there are those young people who are least receptive to positive outcomes (e.g., Lambie, 2007). The types of problems these people may have compromise their ability to engage, uptake treatment and/or generalise skills and may require special consideration during treatment (Fortune, 2013).

In the treatment of youth generally, high dropout rates are an issue (Kazdin, 2004), and this has solidified the argument for collaborative clinical practice in which acquiring feedback from the young person’s perspective about progress and therapeutic alliance assists in positive outcomes (Duncan et al., 2006). The majority of young people in this study were mandated into treatment, therefore the therapeutic relationship and responsivity to the individual needs of each young person were considered vital when discussing difficult material. The meaning a young person makes of their treatment experience is also likely to factor in attrition rates and the generalisability of treatment material during the post-treatment phase. While the mechanism of understanding what transforms reluctant clients into willing clients in the treatment of HSB is yet to be discovered (Prescott, 2011), evidence that a strong therapeutic relationship is related to outcome is well established (Norcross, 2010; Orlinsky et al., 2004). This is a view supported by a previous evaluation of treatment services for HSB. According to Geary et al. (2011), acquiring direct feedback from young people and their families about their treatment assists in the improvement of service delivery and being responsive to the individual needs of the young person and their family.

10.3.3 Manualised Treatment

Examining treatment fidelity is a core methodological consideration in outcome studies and has been understood as the adherence–outcome association (McHugh, Murray & Barlow, 2009). According to Blasé and Fixen (2013), high fidelity coupled with successful outcomes provides evidence that the selected components have contributed towards change.

Although the therapists’ training backgrounds varied in this study, previous studies on the relationship between therapists and treatment outcome have found that treatment outcome is related to adherence rather than therapist variables (e.g., Huppert et al., 2001). For seven of the eight therapists in this study fidelity to the model was strong, and treatment was delivered the way in which it was operationalised in training. The remaining clinician (T3) demonstrated moderate fidelity as measured by the Fidelity Checklist (See Appendix 1) in that the model was integrated into therapy 50% of the time. In studies of manualised programmes high fidelity rates have been found for multisystemic therapy (MST), and have been used as evidence of its successful dissemination (Henggeler et al., 1998; Schoenwald, et al., 2009).

Applying flexibility while holding on to the principles and process of an intervention allows for appropriate adaptation (Roth & Pilling, 2007). The revised GWM treatment manual provided clinicians with an adaptable intervention framework that was designed to be used within the service settings across a variety of clients with HSB (e.g., ID and non-ID). As found in other successful manualised programmes (e.g., Craske & Barlow, 2007), the utilisation of the flexible components and support materials (e.g., visual templates) seen in this study is likely to have assisted with effectiveness.

10.4 Implications of Findings

CSA perpetrated by youth is a significant problem requiring specialist attention (see Chapters 1 and 2). A key priority in offence-specific treatment programmes is a reduction in sexual recidivism and associated risk factors. The GWM was proposed as a strengths-based developmentally appropriate approach to treatment which meets recommended key programme priorities for the treatment of boys aged between 11

and 17 years with HSB. It adopts a flexible and integrated approach where treatment is delivered by a variety of methods and involves family and caregivers (Geary, 2007).

Consistent with rehabilitation principles (Andrews et al., 2006) and the implications of recent research on recommended treatment targets (e.g., Pullman & Seto, 2012), the GWM was able to provide an individualised intervention for each participant. Unlike a “one size fits all approach”, positive change was promoted by appropriately adapting treatment to cater for distinct risk and etiological factors (e.g., Dillon, 2010; Fortune, 2006) of each participant.

Previous research indicates that of those young people with HSB who are treated, most do not continue to offend sexually (Nisbet et al., 2004). Similar to previous studies on treatment approaches for youth with HSB (e.g., Worling & Curwen, 2000), finds support for interventions based upon a cognitive behavioural perspective, and the view that understanding the role of cognitive and affective development is essential for the appropriate treatment of young people (Steinberg, 2005). The systemic focus and involvement of families in the application of the GWM align it with treatments that are able to target multiple domains such as empirically sound MST approaches (Borduin et al., 2009). While comparisons with treatment approaches for ID youth are much more limited, available studies on what works with challenging behaviours for people with an ID support the use of behavioural approaches (Heyvaert, Maes, Van den Noortgate, Kuppens, & Onghena, 2012).

Alongside the reduction in risk factors, the increase in pro-social behaviours related to strengths and resiliency suggest the GWM was able to reflect elements of successful psychotherapeutic outcomes (e.g., interventions which enhance engagement, are flexible, and are delivered in a holistic manner while providing a more positive psychological approach; Bumby, 2006).

For treatment programmes based in New Zealand (NZ), one of the most important implications of this study is the preliminary data it has collected on the effectiveness of the GWM within community-based clinical settings with youth. The most indicative of these data are the results of the ERASOR, which recognises the relationship between youth-specific risk factors related to sexually abusive behaviours and the importance of this relationship to treatment outcome (Righthand & Welch, 2001). In this study, the average length of treatment was 7.5 months ($SD = 3.60$), a

considerably shorter and more cost-effective treatment period than that in the study by Fortune (2007), where the average length of time young people spent in treatment was 17.0 months.

The implications of these findings are important because previous NZ research evaluating treatment has more broadly focused on process and outcomes. These studies have included recidivism rates as a measure of effectiveness and captured consumer perspectives (Lambie et al., 2007). Although these studies have been able to identify key approaches to treatment (including the GWM) and show that a treatment works, the specificity of the treatment models being utilised was not examined.

This study pays more detailed attention to treatment provision with the GWM, and the use of the treatment manual assisted with fidelity and the replication of a strengths-based approach during the study. Understanding the mechanics of treatment delivery within real-world settings facilitates the development of a replicable model which retains a high level of treatment integrity when transposed into similar environments (Letourneau & Borduin, 2008). Due to the unique nature of this research, there are few studies to which these results can be compared. Previous research focusing on outcomes in NZ-based treatment programmes has also identified the GWM as a reason for positive change (Fortune, 2007; Lancefield, 2006). Positive preliminary results in research on MST for youth with HSB (Borduin et al., 1990; Borduin & Schaeffer, 2001) suggest that systemic interventions (i.e. those working with the young person's family and caregivers) that work beyond the index offence with youth with HSB are promising. The results of this research provide evidence that the GWM (also a systemic intervention) assists in the treatment of youth with HSB.

The reduction in risk seen in this study was achieved within a developmentally sensitive approach informed by research on considered known correlates and causes of HSB in youth (Letourneau & Borduin, 2008) that contrasts with earlier approaches that utilise CBT and relapse prevention. This is in line with contemporary perspectives and research on treatment effectiveness which consider wider factors than those related to the individual, extending into family and contextual factors, risk and protective factors, and evidence-based elements to reduce risk as well as facilitate positive development.

This research also looked at the factors that have been identified as promoting a positive treatment response for youth with HSB. In accordance with the findings of Geary et al. (2011), who looked at effectiveness from a consumer perspective, treatment effectiveness with the GWM was underpinned by establishing stability within the early stages of treatment; providing a flexible and integrated approach which was responsive to the needs of the young person; family involvement; and the quality of the client–therapist relationship.

Predictors of treatment outcome and positive treatment response indicate that actively engaging clients is a critical factor for successful treatment outcomes. The findings of this study are in line with the principles of successful interventions which recommend incorporating feedback about treatment progress and relationship (Lambert, 2010). Furthermore, the clients who are most likely to complete programmes and to have reduced risk of sexual reoffending are those who can establish meaningful and relevant treatment goals (Prescott & Miller, 2014).

In accordance with previous literature (e.g., Fortune, 2007; Knight & Prentky, 1993), the participants in this study were diverse, and were representative of the typologies proposed by Lambie and Seymour (2006). From this perspective they were those from “relatively stable and functional families and do not have significant comorbid disorders and/or other non-sexual offending behaviours; those with high levels of conduct disorder and antisocial behaviour who are likely to come from dysfunctional and multiproblem families; and those who are socially withdrawn and introverted” (p. 179). According to Blampied (2013), systematic replications with diverse sets of participants hold significance as they allow for the generalisability of the findings along dimensions of difference.

10.5 Strengths and Limitations

This study represents an important first attempt to establish the effectiveness of the GWM and define the parameters as to “what is being done” and “what is making a difference”, however it is not without its limitations. These are predominantly methodological constraints related to the interface of the study design and undertaking the research in a real-world setting.

This research occurred within a real-life setting within two NZ-based community treatment programmes. Although this was the natural environment in which the model had been developed, conducting research to evaluate the effectiveness of the GWM within real-life settings was no easy task. Challenges were mostly evident in the recruitment of participants. The existing referral and assessment process inherent within each agency impacted on the final number and make-up of participants. More specifically, the pace of referrals into each service influenced the number of possible participants. A decision was made early in the study to adopt an “open door” recruitment approach to maximise numbers, and the wide range in cognitive abilities within the final group, coupled with a small number of participants, became meaningful for external validity inferences (e.g., the number of direct replications across participants with similar cognitive profiles). An additional challenge in conducting research with young people from complex backgrounds, included the difference between chronological and developmental ages.

Relative to the more protected approach found in efficacy research, studies conducted in real-life settings with youth open up the process of therapy to considerably more extraneous variables, as well as more mediators and moderators of treatment outcome (Kazdin, 2000). During this study extraneous factors such staff changes, staff sickness, unstable placements, and secondary consequences of the 2010/2011 Christchurch earthquakes all had an impact. Additional stressors for participants included involvement with statutory agencies, mandatory reporting processes inherent within treatment programmes, and comorbid and systemically related issues (e.g., multiple placements and school changes, and family stress).

It is also important to consider the psychosocial stressors that exist within the adolescent period. Participants’ exposure to such stressors became meaningful for treatment delivery and was reflected in scores (e.g., for the ORS). Although each of the aforementioned issues provided challenges to the research process, exposure to real-life conditions is considered advantageous because these are the conditions in which the model is applied. According to Kazdin (2013), conducting research in the real-life settings in which treatment delivery occurs allows for the more natural replication of findings. Furthermore, factors which inhibit change can begin to be identified and considered in the development of the model and in future research (Kazdin, 2000).

Working within an existing treatment environment provided the capacity to carry out a detailed analysis of effectiveness in particular circumstances (Dugard et al., 2012). One of the advantages of this approach is its provision of a feedback loop which was able to enhance the treatment delivery process during the course of the research. This was particularly demonstrated with the use of the ORS and SRS by clinicians in real time.

Analysing the end state of the research provided valuable data in relation to the challenges of working in community-based treatment programmes and how to create an environment in which change was possible. This is important for understanding treatment attrition rates – why people drop out and what happens to them. In this study, four participants dropped out (P10, P13, P14 and P15) over the course of assessment and treatment. For these young people it was difficult to stay in treatment due to unstable placements and/or problems which took precedence over HSB (e.g., safety issues related to care and protection or mental health problems), rather than any difficulties with the GWM itself. According to Geary et al. (2011), establishing stability prior to the commencement of therapy assists with factors related to attrition.

An additional area of consideration is that the research design fell within an existing assessment structure that was designed to change the direction of behaviour (e.g., with safety planning). It is possible that the mere act of entering a service for HSB, coupled with a highly structured baseline phase, assisted in a change which was consolidated within treatment.

While the results of this study provided evidence of effectiveness, this occurred within context which can be shaped by wider factors (e.g., organisational infrastructures, funding, and involvement with statutory agencies). Furthermore, young people receiving treatment within community-based treatment settings are deemed safe enough to be treated within the community, and therefore the external validity and the generalisability of the experimental effects to different settings with different clients (e.g., with incarcerated or more complex and “risky” youth) is limited.

In this study, the measurement of change was mostly conducted using the standard treatment measures within each agency. This brought forward issues in terms of research outcomes. Firstly, over the course of the research alternative measures have been introduced into the treatment agencies. The Strengths and

Difficulties Questionnaire (SDQ; Goodman, 1997) replaced the CBCL, and the Desistence for Adolescents who Sexually Harm (DASH-13) was introduced (Worling, 2013b). These new measures were not included in this research and may have provided valuable outcome data.

Secondly, there was the requirement for each participant to complete a full set of measures twice, which is more than is usually required. Coordinating high-stress families who can be disenfranchised is difficult, and this resulted in incomplete data sets, particularly for the follow-up measures. Furthermore, reporting on measures during stressful and distressing experiences has been found to lead carers to overestimate problems (e.g., Edelbrock, Costello, Dulcan, Conover, & Kala, 1986; Engle, Rodrigue, & Gefken, 1994).

Thirdly, a decision was made to exclude the findings of complementary measures which were considered too difficult to consistently administer during the course of the study. The parent report for the ORS was excluded as family involvement and availability was variable, as was the teacher report form which often accompanies the CBCL, due to school changes and unstable living environments. These may have provided valuable data and a broader view of change and enabled firmer conclusions about the effectiveness of the results. Kelley et al. (2010) found that the quality of the therapeutic alliance with the caregiver impacts treatment outcome for the young person.

Although it was demonstrated that the changes in behaviour occurred only when the GWM treatment package was applied, a more detailed understanding of the core elements and variations of treatment that define complex interventions (i.e. the active ingredients; Embry, 2004) was not able to be achieved in this study. These types of details impact on internal and external validity, and therefore also on replication and dissemination of treatment (Perepletchikova, Treat, & Kazdin, 2007).

10.6 Future Research

It is envisaged that the results of this study will contribute to the further development of the GWM and the establishment of an evidence-based manual to guide service delivery. This being the first research of its kind on the GWM, there are many areas to consider for future research.

The GWM is in wide use within NZ-based community treatment programmes. Although evidence of effectiveness for participants in this study was found, in order to extend what is known about the GWM and to support its future development and external validity, the results need to be replicated by other researchers. Only with additional research will we fully understand the specificity of effects.

Future research could also aim at understanding the GWM's mechanisms for change (the active ingredients), including those which assist in changing internalising and externalising problems, and those which can be adapted to maximum responsivity (e.g., according to risk, culture, ethnicity, gender, age and cognitive ability). This will assist with the development of the GWM and manual and the appropriate adaptation of treatment components.

This study has shown that the intervention was beneficial to participants under usual conditions, though the dose–effect relationship – the amount/length of the intervention and its link to the responsivity of participants to treatment (Howard et al., 1996) – and inferences about the amount of therapy (treatment length and frequency) are areas that would benefit from future investigation.

The GWM's versatility for different groups in treatment settings could be explored using a typology framework which is likely to add depth to the use of the model, maximise treatment responsivity, and guide treatment planning and relevant modifications as to the direction, dose and length of treatment within a manualised treatment approach. Empirical evidence will also assist in defining the boundaries and limitations for what is possible.

Although it was outside the scope of this research, interviewing clinicians would yield valuable feedback in terms of the model itself and the place of manualised treatment. It may also provide information concerning the influence of regular monitoring of behaviour and close contact from professionals outside of the treatment protocol with families/caregivers on treatment. Finally, future studies could collect recidivism data from statutory agencies and consumer feedback from the participants about their experience of treatment.

10.7 Conclusion

This study has provided initial evidence of the effectiveness of the GWM, a manualised treatment approach for HSB. While the findings are variable, overall they indicate a positive trend of change. They also show that the GWM can be effectively utilised in the treatment of HSB and is helpful in the reduction of further HSB.

The GWM meets the requirements of a developmentally sensitive intervention that considers empirical research about what works best and evidence-based practice models and interventions (Rasmussen, 2013). Despite the complexity and unpredictability contained within real-life settings, this research has demonstrated, with limitations, that the GWM is helpful for those undergo the treatment. Respectfully working with practitioners on the front line to understand the work they are traversing no doubt will assist in the development of cutting-edge service provision. The findings of this research suggest that practitioners and researchers should be encouraged to continue examining the wider effectiveness of the GWM.

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Appendices

Appendix 1: Integrity Checklist

Client Code:		Integrity Check #:	1	2	3	4	5	6
Therapist Initials:		Session Date:	/	/	/	/	/	/
Strength Focused Assessment								
Component One: The Base (Care Plan, Safety Planning, The Gap)								
Component Two: Good Side/Bad Side								
Component Three: Good Way/Bad Way								
Component Four: Good house/Bad House								
Component Five: The Decision								
Component Six: My Good Life Plan								
Item	Process Component. (Tick these items whenever they happen in the course of therapy)							
#1	The therapist distinguishes between the problem itself and the client's responsibility for continuing to choose to participate in the life of the problem.							
#2	The therapist is engaging the client to develop a coherent narrative through which clients and therapists can effectively describe and discuss behaviour and experiences.							
#3	By use of elements of the model e.g. "The Gap", the therapist shows they are able to motivate the client with simple and coherent life goals.							
#4	The therapist uses the language of the model in a way that engages the client.							
#5	Throughout each step of the process the clients' statements are being recorded, amplified and guided towards the summary of understanding.							
#6	Conceptual Item: Each person has a Good Side and a Bad Side							
#7	Therapy is approached as a joint, creative exploration							
#8	Use of Colour Coding							
#9	Use of Programme Assignments (B/W to G/W)							
#10	The therapist modifies the model (basic and enriched) appropriately							
Item	Practice Components (Tick these items whenever they happen in the course of therapy)							
#11	Good Side/Bad Side							
#12	Good Way/Bad Way							
#13	Consequences (Rewards and Punishments)							
#14	Making the Decision							
#15	Good Way Safety Plan							
#16	Strengthening the Good Side and Practising Going the Good Way							
#17	The Gang of Three and the Three Wise Men							
#18	The Three Keys at the Crossroads							
#19	The Good House and The Bad House							
#20	What happened to me in the Bad House							
#21	What it was like for other people when I made My/Their House a Bad House							
#22	Fixing things Up							
#23	Making My House a Good House							
#24	My Good Life Plan							
Item	Practice Component for Summary of Understanding							
#25	Clients have their own folder of written and pictorial work that is added to regularly. Random Checks by Supervisor (x3)	1. Present/not Present	2. Present/not Present	3. Present/not Present				

Fidelity

- ☐ 1. A strength-based assessment has been completed
- ☐ 2. At least one process component is present per viewed session
- ☐ 3. Reviewer 1 and Reviewer 2 show agreement (inter-rater reliability)
- ☐ 4. Identified phase is evidenced by at least one key process item and one key practice item (component 2-6 only)
- ☐ 5. Current (over the last 1-4 sessions) written and/or pictorial work is present in the client file for all three random checks

Appendix 2: Child Sexual Behaviour Inventory Results

Category	Participant	Assessment points				
		Ax	Pre-treatment	Treatment phase	End of treatment	6 month follow-up
CSBI	P2	45	48	-	45	45
DRSB	P7	59	59	-	45	45
	P8	45	45	45	45	72
	P10	45	45	45	Dropped out	
CSBI	P2	>110	>110	-	104	>110
SASI	P7	>110	>110	-	>110	70
	P8	>110	>104	110	110	>110
	P10	45	45	45	/	/
CSBI	P2	98	>110	-	102	>110
TOTAL	P7	89	>110	-	>110	75
	P8	>110	98	110	102	>110
	P10	93	93	61	Dropped out	

Note: Ax = Assessment; DRSB = Developmentally related sexual behaviour; SASI = sexual abuse specific items.

Appendix 3: ACSBI – Self-Report Results

Category	Participant	Assessment points					
		Ax	Pre- Tx	Tx1 phase	Tx2 phase	End of Tx	6 month follow-up
ACSBI S KN	P1	0.308	0.231	-	-	0.538	0.461
	P3	0.231	0.461	0.154	0.385	0.461	*
	P4 *	.385	.385	*	*	0.538	*
	P6	1.154	1.154	0.692	1.231	In treatment	
	P9	0.538	0	*	-	1	*
	P10	0.077	0.077	0.231	-	Dropped out	
	P11	0.538	0.538	-	-	0.538	*
ACSBI S R MIS	P1	0.3	0.3	-	-	0.3	0.2
	P3	0.1	0	0	0.2	0.2	*
	P4	.3	.3	*	*	0	
	P6	0.7	0.7	0.2	0.3	In treatment	
	P9	.3	.5	*	-	.5	*
	P10	0	0	0	-	Dropped out	
	P11	0.2	0.2	-	-	0.3	*
ACSBI DSI	P1	0	0	-	-	0.2	0.2
	P3	0	0.5	0.25	0.25	0	**
	P4	0	0	*	*	.2	*
	P6	0.8	0.8	0.4	1	In treatment	
	P9	.4	.4	*	-	.2	*
	P10	0	0	0	-	Dropped out	
	P11	0	0	-	-	0	*
ACSBI CON APP	P1	0.75	0.75	-	-	0.75	1
	P3	0	0.5	0.25	0.25	0	*
	P4	.5	.5	*	*	.25	*
	P6	0.75	0.75	0.5	0.75	In treatment	
	P9	.75	.25	*	-	.5	*
	P10	0.25	0.25	0	-	Dropped out	
	P11	0	0	-	-	0	*
ACSBI Fear	P1	0.2	0	-	-	0	0.2
	P3	0.4	0.2	0.6	2.4	0.2	*
	P4	.6	.6	*	*	0	*
	P6	0.4	0.2	0.4	0.8	In treatment	
	P9	0	0	*	-	0	*
	P10	0.8	0.8	0.2	-	Dropped out	
	P11	0	0	-	-	0	*

Note: Ax = Assessment; Tx = Treatment; S KN = Sexual knowledge/interest; S R MIS = Sexual risk/misuse; DSI = Divergent sexual interests; CON APP = Concerns about appearance; *= missing data point.

Appendix 4: ACSBI – Caregiver Results

<i>Assessment points</i>						
<i>Category</i>	<i>Partici- pant</i>	<i>Ax</i>	<i>Pre- treatment</i>	<i>Treatment phase</i>	<i>End of Treatment</i>	<i>6 month follow-up</i>
ACSBI	P1	0.615	1	-	0.846	0.692
S KN	P3	0.923	0.308	*	0.231	*
	P9	1	1	-	1.231	1.538
	P11	0.538	0.538	-	0.384	0.076
	P12	0.231	0.231	0.307	In Treatment	
ACSBI	P1	0.7	1.3	-	0.7	0.4
S R MIS	P3	0.2	0.2	*	0	*
	P9	0.6	0.6	-	0.6	.5
	P11	0	0	-	0.3	0.1
	P12	0.2	0.2	0.1	In Treatment	
ACSBI	P1	1.2	1.2	-	0.8	0.8
DSI	P3	0	0	*	0.2	*
	P9	0.4	0.4	-	0.6	1
	P11	0	0	-	0	0
	P12	0.4	0.4	0.2	In Treatment	
ACSBI	P1	1.25	1.75	-	1	1.75
Con Ap	P3	0	0.25	*	0	*
	P9	0.75	0.75	-	1.25	.75
	P11	0	0	-	0	0
	P12	0	0	0	In Treatment	
ACSBI	P1	0.4	0.2	-	0	0.2
Fear	P3	0.2	0.2	*	0.4	*
	P9	0.2	0.2	-	0.4	0.4
	P11	0	0	-	0	0
	P12	0.2	0.2	0.2	In Treatment	

Note: Ax = Assessment; S Kn = Sexual Knowledge/interest; S R MIS = Sexual risk/misuse; DSI = Divergent Sexual Interests; CON APP = Concerns about appearance; *= missing data point.

Appendix 5: Parent/Caregiver Scores on the CBCL

<i>Scales (T scores)</i>	<i>P</i>	<i>Assessment</i>	<i>Pre- treatment</i>	<i>Treatment</i>	<i>End of treatment</i>	<i>Follow- up</i>
Internal	1	70-C	68-C	-	57	63-B
	2	M70-C;	M65-C	-	M58	M57
	3	SF 65-C	SF 54	SF 61-B	SF 59	*
		M57	Mo 50	M55	Mo 55	
		Un 44	Un 52	Un 57	Un 44	
	4	M 68-C	M68-C	M63-B	*	*
		SF 65-C	SF 65-C	SF 47		
	5	75-C	76-C	-	63-B	70-C
	6	55	55	58		
	7	F61-B	F58	-	F54	F66-C
		M 55	M59		M44	
	8	34	34	44	44	55
External	9	76-C	76-C	*	74-C	70-C
	10	73-C	73-C	69-C		
	11	M47/G66-C	M47/G66-C	-	M50/G54	M44
	12	50	50	50		
	1	76-C	77-C	-	63-B	69-C
	2	M74-C	M71-C	-	M71-C	M70-C
	3	SF 55;	SF 53	SF 56	SF 57	
		M 60-B;	M 54;	M60-B	Mo 62-B	
		Un 57	Un 57	Un 51/61	Un 54	
	4	D66-C	D66-C	D56	*	*
		M66-C	M66-C	M66-C		
	5	67-C	74-C	-	62-B	64-C
	6	48	48	55	-	-
	7	F70-C/M66-C	F70-C/M71-C	-	F69-C	F71-C
					M69-C	
	8	62-B	62-B	61-B	69-C	66-C
	9	69-C	69-C	*	77-C	69-C
	10	74-C	74-C	69-C		
	11	M54/G66-C	M54/G66-C	-	M50/G55	M48
	12	51	51	50		
Total	1	72-C	71-C	-	60-B	65-C
	2	M75-C	M72	-	M70-C	M70-C
	3	SF 59	SF 58	63-B	SF 63-B	
		M66-C	M 60-B	M 66-C	M64-C	
		Un 60-B	Un 59	Un58/64	Un 57	
				SF		
	4	D69	D69	D21	*	*
		M70-C	M70-C	M67-C		
	5	74-C	77-C	-	66-C	70-C
	6	58	58	59		
	7	F72-C/M66-C	F72-C/M73-C	-	F71-C/M	F73-C
					70-C	
	8	61-B	61-B	57	64-C	64-C
	9	77-C	77-C	n/c	82-C	73-C
	10	75-C	75-C	73-C		
	11	M54/G66-C	M54/G66-C	-	M47/G55	M43
	12	51	51	48		

Notes: A T score falling <60 is considered to be in the normal range; T scores ≥60–≤63 are in the subclinical range (B); and a T score >63 is in the clinical range (C).

P = Participant; M = Mother; Un = Uncle; SF = Stepfather; G = Grandfather.

Appendix 6: YSR on Child Behaviour Measure Results

<i>Behaviour scales (T scores)</i>	<i>Assessment points Participant</i>	<i>Assessment points</i>					
		<i>Ax</i>	<i>Pre-Tx</i>	<i>Tx1</i>	<i>Tx2</i>	<i>End of Tx</i>	<i>6 month follow-up</i>
YSR Internal	1	60-B	56	-	-	46	39
	2	67-C	59	-	-	42	46
	3	61-B	56	63-B	51	56	*
	4	73-C	73-C	68-C	*	*	*
	5	62-B	63-B	-	-	61-B	67-C
	6	76-C	76-C	60-B	76-C	-	-
	9	68-C	51	*	*	62	-
	10	68-C	44	48	Dropped out		
	11	59	59	46	-	46	*
YSR External	1	56	53	-	-	51	44
	2	53	42	-	-	51	56
	3	56	47	51	52	53	
	4	68	68	70	*	*	*
	5	51	51	-	-	47	58
	6	77-C	78-C	62-B	69-C	-	-
	9	64-C	53	n/c	n/c	74-C	-
	10	58	40	40	Dropped out		
	11	53	53	44	-	44	*
YSR Total Score	1	56	55	-	-	47	42
	2	67-C	54	-	-	48	52
	3	62-B	56	62-B	56	56	
	4	75 -C	75-C	73	*	*	*
	5	58	61-B	-	-	59	67-C
	6	81-C	81-C	62-B	79-C	-	-
	9	68-C	56	n/c	n/c	69	-
	10	69-C	39	44	Dropped out		
	11	57	57	-	-	47	*

Notes: A T score falling ≤ 60 is considered to be in the normal range; T scores ≥ 60 - ≤ 63 are in the subclinical range (B); and a T score > 63 is in the clinical range (C).

Ax = Assessment; Tx = Treatment; *= missing data.

Appendix 7: Resiliency Scales for Children and Adolescents (RSCA)

Results

<i>Behaviour scales (T scores)</i>	<i>Assessment points</i>						
	<i>Participant</i>	<i>Ax</i>	<i>Pre-Tx</i>	<i>6 months</i>	<i>12 months</i>	<i>End Tx</i>	<i>6 month follow-up</i>
Sense of Mastery Scale	P1	51	53	-	-	38	53
	P2	67	66	-	-	**	58
	P3	42	42	47	41	48	48
	P6	38	39	49	38	In treatment	
	P9	65	61	*	-	58	
	P10	28	56	51	Dropped out		
	P11	45	45	45	-	-	-
Sense of Relatedness Scale	P1	50	48	-	-	37	48
	P2	65	63	-	-	**	68
	P3	44	44	37	30	38	44
	P6	37	39	40	44	In treatment	
	P9	61	51	*		57	
	P10	22	55	50	Dropped out		
	P11	40	40	51			
Emotional Reactivity Scale	P1	55	53	-	-	49	50
	P2	56	51	-	-	45	57
	P3	54	54	53	51	51	53
	P6	71	68	62	73		
	P9	40	37	*		71	
	P10	65	65	65			
	P11	37	37	29			
Resource (Strengths) Scale	P1	52	52	-	-	39	52
	P2	68	67	-	-	**	65
	P3	43	43	42	37	44	47
	P6	40	40	46	42	In treatment	
	P9	65	58	*		60	
	P10	23	58	52	Dropped out		
	P11	43	43	49			
Vulnerability Subscale	P1	51	50	-	-	55	48
	P2	42	40	-	-	**	44
	P3	56	56	56	57	53	52
	P6	66	64	58	66	In treatment	
	P9	36	38	*		55	
	P10	75	53	57	Dropped out		
	P11	45	43	37			

Note: A T-score falling ≥ 60 is considered in the high range; T-scores 56-59 above average range ; 46-55 average; 41-55 below average; and ≤ 40 Low. A T-score on the Resource and Vulnerability Index score falling ≥ 60 is considered in the high range; T-scores 55-59 above average range ; 45-54 average; 41-44 below average and ≤ 40 Low.

Appendix 8: 4-D Results

Strengths subscales	P	Assessment points						
		Ax	Pre T	T1 phase	T2 phase	T3 phase	End of Treatment	Follow-up
4-D Belonging	P1	2.571	1.428	-	-	-	2.714	2
	P3	0.287	0.287	0.714	*	*	*	*
	P6	2.571	2	2.143	2.286	1.857	In treatment	
	P9	1.857	1.857	*	-	-	*	2
	P10	0.428	0.428	0.857	-	-	Dropped out	
	P11	1.428	1.428	-	-	-	2.143	2.143
	P12	1.143	2	3.571	3.571	-	In treatment	
4-D Mastery	P1	2.2	1	-	-	-	2.3	2
	P3	1.4	1.4	1.571	*	*	*	*
	P6	1.3	1.5	2.3	2.5	2.3	In treatment	
	P9	1.1	1.1	*	-	-	*	2.1
	P10	0.4	0.4	1	-	-	Dropped out	
	P11	1.8	1.8	-	-	-	2.5	2.5
	P12	1.3	2.1	3.4	3.4	-	In treatment	
4-D Autonomy	P1	2	2	-	-	-	3.145	1.286
	P3	1.286	1.286	0.571	*	*	*	*
	P6	1.286	2.286	3.143	2.857	2.714	In treatment	
	P9	1.714	1.714	*	-	-	*	0.571
	P10	0.25	0.25	0	-	-	Dropped out	
	P11	1.857	1.857	-	-	-	2.714	2.714
	P12	0.428	1.286	2.714	2.714	-	In treatment	
4-D Generosity	P1	1	1.25	-	-	-	1.74	1
	P3	0	0	0.75	*	*	*	*
	P6	2.5	2.25	1.5	2.75	2.25	In treatment	
	P9	1.25	1.25	*	-	-	*	1.5
	P10	0.25	0.25	0	-	-	Dropped out	
	P11	0.25	0.25	-	-	-	2	2
	P12	0.25	1.25	2.25	2.25	-	In treatment	
4-D Roles of others	P1	1.25	1	-	-	-	2.25	1
	P3	1	1	1	*	*	*	*
	P6	3	3	3.5	3.5	2.75	In treatment	
	P9	3	3	*	-	-	*	1.25
	P10	1	1	1.75	-	-	Dropped out	
	P11	2	2	-	-	-	3.5	3.5
	P12	2	2.5	3.75	3.75	-	In treatment	

Note: P = Participant; Ax = assessment phase; T = treatment phase

<i>Risks</i>	<i>P</i>	<i>Assessment points</i>						
<i>Subscales</i>		<i>Ax</i>	<i>Pre T</i>	<i>T1</i>	<i>T2</i>	<i>T3</i>	<i>End of Treatment</i>	<i>Follow-up</i>
4-D	P1	0.428	0.857	-	-	-	0.143	0.428
	P3	2.571	2.571	1.571	*	*	*	*
Belonging	P6	0.571	0.428	0.428	0.428	0.857	In treatment	
	P9	0.857	0.857	*	-	-	*	0.285
	P10	2.428	2.428	1.571	-	-	Dropped out	
	P11	0.714	0.714	-	-	-	0.286	0.286
	P12	0.857	0.428	0.143	0.143	-	In treatment	
4-D	P1	0.2	1	-	-	-	0.2	0.3
Mastery	P3	0.8	0.8	1	*	*	*	*
	P6	1.5	0.9	0.3	0.1	0.2	In treatment	
	P9	1.1	1.1	*	-	-	*	0.3
	P10	2.4	2.4	1.3	-	-	Dropped out	
	P11	0.8	0.8	-	-	-	0.1	0.1
	P12	1.5	0.4	0	0	-	In treatment	
4-D	P1	0.428	0.149	-	-	-	0	0.714
Autonomy	P3	0.714	0.714	1.714	*	*	*	*
	P6	1.143	0.286	0	0	0	In treatment	
	P9	2.4	2.4	*	-	-	*	1.428
	P10	1.143	1.143	2.149	-	-	Dropped out	
	P11	0.143	0.143	-	-	-	0.143	0.143
	P12	1.428	0.714	0	0	-	In treatment	
4-D	P1	1	0.75	-	-	-	0.5	1
	P3	2.75	2.75	1.5	*	*	*	*
Generosity	P6	0.5	0.25	1	2.5	0.5	In treatment	
	P9	1.75	1.75	*	-	-	*	0.75
	P10	3	3	2.5	-	-	Dropped out	
	P11	1.25	1.25	-	-	-	2	2
	P12	2	0.75	0.5	0.5	-	In treatment	
4-D	P1	0	1	-	-	-	0.25	1
Roles of others	P3	1	1	1	*	*	*	*
	P6	0	0	0	0	0	In treatment	
	P9	0	0	*	-	-	*	0.75
	P10	1	1	0.5	-	-	Dropped out	
	P11	0	0	-	-	-	0	0
	P12	0	0	0	0	-	In treatment	

Note: P = Participant; Ax = assessment phase; T = treatment phase