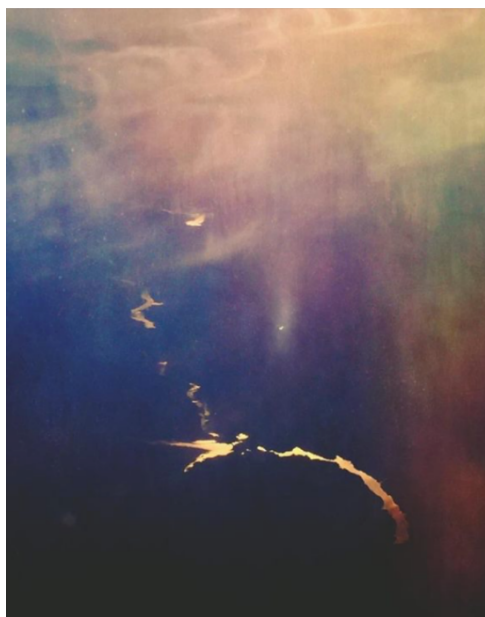


Portfolio volume 1: Major Research Project

The Experiences of Parents of Children and Young People who  
have Engaged in Harmful Sexual Behaviour: An Interpretative  
Phenomenological Analysis



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June 2017

Submitted to the University in partial fulfilment of the requirements of the  
degree of Doctor of Clinical Psychology

## Acknowledgements

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Firstly, I would like to give thanks to the parents who I have called Anna, Elaine, Laura, James, Angela and Sue. It is through for their great generosity and openness in sharing parts of their lives with me that this research has been possible. Also, thanks is given to the foster carer who helped create the interview schedule. For me, it was a wonderful and lively experience of collaboration in research which will shape my practice into the future.

Pieter, thank you for inspiring and pushing my thinking forward and for kept me on track with your support and kind words. Our meetings helped me through. To Mel, it was wonderful to have you as my supervisor once again. Your knowledgeable guidance was so appreciated and I could not have asked for a better support. To Stephen, thank you for being so open to and invested in the project and for helping to shape it. Thanks also to the HSB service therapists and admin team, who were a great help.

To the family and friends who have been kind and patient. A special thanks to my Mum, Dad and Alice for being there for me always, reminding me to be kind to myself, cheering me up and cheering me along. It has been so appreciated. To my three house buddies your smiles/ wagging tail made this much easier. To the 'best ones', thank you for being just the best. To cohort 14, it was a pleasure to be on this journey with you all. You made the bumps less bumpy! Finally, to Akos, my adventure partner. To have had you alongside me through this has been just amazing. We are so lucky!

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# Definitions and Abbreviations

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- CAMHS..... Child and Adolescent Mental Health Services
- CYP.....Children and Young People
- HSB.....Harmful Sexual Behaviour
- IPA.....Interpretative Phenomenological Analysis
- PPF's.....Parents and Parental Figures

## Chapter 1: Abstract

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**Background and Aims:** The importance of the involvement of parents in treatment approaches for Children and Young People (CYP) who have engaged in Harmful Sexual Behaviour (HSB) has been consistently highlighted within the literature. Given that HSB arises in a family context, parents are considered key agents for change where CYP remain in their care. Professionals may work with them as a means of improving the CYP's therapeutic outcomes. Despite this, little is known about their personal lived experiences and representations of meaning, which remain largely unexplored. The current study aimed to address this gap and gain a rich understanding of the experiences of parents, from their own perspective.

**Methodology:** Semi-structured interviews were used with six biological parents who were recruited via purposive sampling from a specialist service working with CYP who have engaged in HSB and their families. During interviews, four broad areas of interest were explored: the personal psychological impact of their child engaging in HSB; the impact on the parent-child relationship; wider familial and community responses; and parental coping. Interviews were audio-recorded and their verbatim transcripts analysed using Interpretative Phenomenological Analysis (IPA).

**Findings and Conclusions:** The analysis produced four main themes; '*A devastated and overwhelmed life*'; '*Threatened and trying to feel safer*'; '*A challenged relationship with son*'; and '*Space for hope in the face of hopelessness?*'. It was highlighted that parents' experiences and meaning-making appeared intimately woven with a complex web of powerful relational and socially constructed factors. The research outcomes provide valuable insights for professionals working with young people who have engaged in HSB and their families. In learning more about what it is like to be the parent of a CYP who has engaged in HSB, it is hoped that professionals will have a richer framework from which to provide support to both the parent and to their child. Implications for clinical practice, the strengths and limitations of the methodology and directions for future research are discussed.

## Chapter 2: Introduction

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That was probably the darkest week of my life without a doubt. All the anger and the rage, the confusion, the revulsion. I couldn't look at her.

'Claire', BBC *Newsnight* and *File on 4* report, 2010.

### 2.1 Overview

This chapter will set the scene for this research project by providing a brief overview of the construction of Harmful Sexual Behaviour (HSB) in Children and Young People<sup>1</sup> (CYP), introducing terminologies in the area. My personal interest in the topic will be described, as well as my epistemological position. A comprehensive review of the literature will follow in the next chapter, followed by the rationale for and aims of the research.

### 2.2 The Problem of Harmful Sexual Behaviour in Young People

Many sexual behaviours displayed by CYP can be understood as forming part of healthy development. However, some CYP engage in behaviours which compromise the safety and well-being of themselves and/or others and are a cause for concern for those around them. Although it is common to think of the sexual abuse of CYP as being committed by adults, it is estimated that approximately one-third of all such abuse in the United Kingdom (UK) is committed by other CYP (Hackett, 2014). Some studies estimate even higher rates. In one UK based random population sample, two thirds of CYP who had indicated that they had been victim to contact sexual abuse stated that this had been committed by a person under the age of 18 (Radford et al., 2011)<sup>2</sup>. It is important to note that all such statistics might be crude in nature, and likely under-estimate instances of HSB. Many instances of HSB either never come to light or are not reported to agencies such as police, health or education (Langstrom, 2001; Smith, Bradbury-Jones, Lazenbatt & Taylor, 2013).

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<sup>1</sup> The term children and young people (CYP) is used throughout to refer to all persons under the age of 18, as opposed to referring to children and adolescents respectively.

<sup>2</sup> In the UK, crime statistics form a main source of information from which incidence of HSB is estimated. In 2013-2014 an NSPCC freedom of information request made to UK police forces found that 4,200 CYP were reported to have engaged in the sexual harming of another person

## 2.3 Preferred Terminologies

There is little consensus in the terminology used to describe CYP who engage in sexual behaviours which cause harm within the research literature<sup>3</sup>. I have chosen to use the terminology 'harmful sexual behaviour' (HSB), as this places emphasis on the deleterious impact of the behaviour and highlights that CYP are more than the behaviours which they have engaged in (Ryan, 2010). It is generally agreed by researchers and clinicians alike that CYP should not be termed 'sex offenders' or 'sexual abuse perpetrators' (Cavanagh-Johnson & Doonan, 2005; Vosmer, Hackett, & Callanan, 2009). These terms, which have been previously commonly used, may be harmful in that they imply that the behaviour is part of a CYP's identity and labels them in an enduring manner<sup>4</sup>. I feel that researchers and clinicians hold a responsibility in considering the words they use due to the transformative power of language in shaping identities.

## 2.4 Defining 'Typical' and 'Harmful' Behaviours

Contemporary attempts to distinguish 'typical' and 'harmful' sexual behaviours in CYP have been made by several authors (Friedrich, 2007; Johnson, 1999). This distinction is arguably of relevance to both parents and professionals who encounter children's sexual behaviours (such as in health, education and social care) and attempt to make sense of whether they should take steps to intervene. Conversely, some may question the value and validity of terms such as 'typical' and 'harmful', which are shaped by social and cultural context and political influences, and are therefore fluid and changeable.

Ideas of both 'typical' and 'harmful' sexual behaviours are defined in differing ways within various contexts, with no one agreed classification. 'Typical' sexual behaviours are commonly suggested to meet socially defined developmentally-appropriate expectations. Gil (1993) states that:

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<sup>3</sup> There are several other commonly used terms to describe such behaviours including 'sexually concerning', 'sexually problematic' and 'sexually abusive'.

<sup>4</sup> The powerful nature and impact of language in this field is particularly notable. There is great variability in use of vocabularies, holding important implications with regards to what is evoked in the reader.

“The dynamics of age appropriate sexual behaviour includes, spontaneity, joy, laughter, embarrassment and sporadic levels of inhibition and disinhibition. It is also about mutuality, consent, and curiosity, with no intent to cause hurt. The children involved engage in the behaviour freely and can disengage when they choose” (p.21-40).

It is commonly suggested that ‘typical’ sexual interactions usually occur between CYP who know each other and are of about the same age, size and intellectual ability (Kikuchi, 1995). One widely utilised description of HSB from Calder (2002) states that the term pertains to:

“Young people (below the age of 18 years) who engage in any form of sexual activity with another individual, that they have powers over by virtue of age, emotional maturity, gender, physical strength, intellect and where the victim in this relationship has suffered a sexual exploitation and betrayal of trust” (p. 2)<sup>5</sup>.

HSB is an umbrella term used to describe a range of sexual behaviours which are beyond those commonly encountered within a child’s developmental stage. Such behaviours include (but are not limited to) the use of sexually explicit words, downloading or sending indecent images, exposing genitals, inappropriate touching of genitals and penetrative sex (Hackett, 2011; Rich, 2011). HSB refers to both behaviours without an identifiable victim but where the wellbeing and development of the child exhibiting the behaviour is at risk (commonly referred to as ‘problematic’) and those where another child is at risk of harm (commonly referred to as ‘harmful’; Hackett, 2011). Where another child is involved in the behaviour, the interaction may involve differences in power and elements of coercion, dominance, threat or force (Gil, 1993). Emotions such as anger, fear, shame, disgust or guilt may be evoked in the child engaging in the HSB, the victim or both (Gil, 1993).

## 2.5 Researcher's Positioning <sup>6</sup>

As a researcher engaging in this exploration, I see that my own understandings and inclinations have been profoundly and unavoidably involved in the process. I believe it to be

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<sup>5</sup> Although there are more contemporary definitions, this speaks to the implicit issue of ‘power’ and how this can be operationalised.

<sup>6</sup> First-person language forms are used to highlight the personal processes and perspectives which have influenced this research.

of importance to share something of myself and my experiences, so that the reader can, to some degree, put the words written here into perspective.

My interest in working with children and their families initially developed professionally through working in child and adolescent mental health services (CAMHS). This was followed by working in a specialist service with families where a child's sexual behaviour was a concern for their family or the system around them. I spent time with families trying to deal with an intensely troubling issue who were hoping for help and trying to reconstruct their lives and worked alongside inspiring colleagues who were working hard to help families to heal. I felt very connected to the service and to the families it served. Many years later, I still reflect on our work as a team and the many people I met during that time. This continued interest and connection has undoubtedly returned me to the team, this time as a researcher.

As a clinician and researcher, my interest lies in the stories that people tell about their lives and the meanings they make of their experiences. Early on in my career I was particularly moved by writings which spoke about the often individualised and restrictive ways that human distress is often thought about, understood and responded to. More recently, I have enjoyed exploring narrative approaches, which privilege lived experience (White & Epston, 1989). Hearing stories of how people make sense of themselves in the world speaks to the part of me which finds the decontextualisation of complex human issues and expressions of distress to be limiting. A desire to engage in this phenomenological research comes in part from a wish to explore and share multiple possibilities and complexities of experience and meaning, in an area where there is little understanding of lived experiences.

## **2.6 Epistemological Approach**

'Epistemology' reflects how people make sense of the world around them. In research, it makes reference to the relationship between the researcher and knowledge (Denzin & Lincoln, 2000). A researcher's epistemology is driven by their beliefs about the nature of reality, known as 'ontological' beliefs, as these prescribe what can be knowable to them.

Prior to training as a Clinical Psychologist, the ideas shaping my understandings were predominantly 'positivist' and 'realist'. Over time, hearing ideas in relation to the theory of knowledge and engaging in discussions has helped me to make sense of my stance and I have developed greater confidence in delineating my own current positioning. With regards to ontology, I believe that there is no measurable 'real world' outside of differing and independent



personal perceptions of 'reality', or that there is any 'true' way of looking at or understanding something. It is my sense that realities are constructed organised and maintained in interaction with others. Such ideas are closely aligned with the work of Gergen (1994) and with systemic ideas of circularity (Haslebo, 2000). My epistemological approach would be best described as sitting within a social constructionist framework.

## Chapter 3: literature Review

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### 3.1 Overview

This chapter, which provides a summary of the research literature relating to the lived experiences of parents of CYP who engage in HSB, made use of a two-part strategy. Initially, a generic search was conducted, which highlighted the literature base within which this research study is situated. Following this, a specific systematic search of the existing qualitative literature was undertaken. As this was the case, this chapter is set out in two broad sections. The first section helps to orientate the reader to literature regarding the cultural and historical context, developmental risk factors, and the possible consequences of HSB. In addition, it introduces literature about parents and their involvement in interventions. The chapter will then progress to a systematic review of the existing qualitative literature regarding the lived experiences of parents.

### 3.2 Cultural and Historical Context <sup>7</sup>

There was great interest in the sexuality of children in nineteenth century England. During this time, ideas were shared which proposed that as children develop, there are not only changes to their bodies and behaviours but also to their knowledges, beliefs and drives (Freud, 1905). Children were found to commonly have sexual physiological responses from early infancy and to show sexual expression through language, touching and sexual play from an early age, this allowing them to learn about both themselves and others (DeLamater & Friedrich, 2002; Santrock, 2008). Despite these ideas, by and large the concept that children hold sexual identities has remained diligently suppressed in Western society. Burr (2003) comments on narratives of sexuality stating that “the discourses on offer in our present society offer a limited menu for the manufacture of sexual identity. However, two well-established discourses in particular call upon us to identify ourselves with respect to them: “normal” and “perverted” sexuality” (p. 107). Egan and Hawkes (2009) take such ideas further, stating: “children's

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<sup>7</sup> There has been some reluctance to consider that sexuality across the lifespan is historically based, with Western dominant ideologies promoting ideas of sexuality as ‘innate’ and ‘instinctual’ (Snitow, Stansell & Thompson, 1984). Ideas around childhood sexuality are situated within wider cultural and historical discursive contexts and their exploration is therefore of relevance here.

sexuality has been constructed as the result of a dangerous and socially unacceptable outside stimulus” (p.389). This highlights the assumption that all children who engage in sexual behaviour have been subject to premature sexualisation (e.g., through abuse or media portrayals), with sexuality being “something imposed upon children, rather than the property of children” (Burman, 2008, p.117).

Dominant stories are rooted in a long history of disparaging and depersonalising descriptions of sexual ‘offenders’<sup>8</sup>. Those who commit sexual offences against children labelled as ‘evil’, (Edwards & Hensley, 2001; Simon, 1988), ‘monsters’ (Heiman, 2001) and ‘dirty beasts’ (Jackson, 2000). This comes alongside recent campaigns calling for harsher sentencing and the recent governmental prioritisation of child sexual abuse (HM Government, 2015). Although such rhetoric is not specifically about CYP who engage in HSB, a one-size-fits all perspective can exist, with this differentiation appearing trivial, particularly in relation to adolescents (Prescott & Longo, 2005; Salerno et al., 2010). Despite the relative prevalence of HSB by CYP, the term ‘child sexual abuse’ limits ideas to those of adult offenders, which is accompanied by a cultural context of moral outrage. Indeed, despite important differences between CYP and adults who engage in HSB, ideas exist that CYP who engage in HSB are “mini sex offenders”, destined to offend sexually in their adult lives (Chaffin & Bonner, 1998; Hunter & Lexiert, 1998), seemingly heightened by the media portrayal of children who harm other children.

It is easy to see how within this cultural and historical context children who do display usual sexual behaviours let alone harmful sexual behaviours may be defined as ‘damaged’ or ‘deviant’ (Flanagan, 2010). As such, it is perhaps unsurprising that there has been widespread silencing and infringing of the experiences of CYP who have engaged in HSB and their families. As highlighted by a Barnardos report (2016), “Abuse by adults is taboo, but abuse by children is doubly taboo” (p. 2).

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<sup>8</sup> In 1988 the National Society for the Protection of Children (NSPCC) described the sexual abuse of children as the ‘vilest crime’ (Jackson, 2000). There has been little movement in public perception since these times.

### 3.3 Developmental Risk Factors

Research in the field of HSB has most commonly occupied itself with the use of quantitative methods to identify common characteristics of children who engage in HSB<sup>9</sup> (Friedman, Langan, Little, & Neave, 2004; Grambsch, Broughton & Kuiper Beilke, 1991). The findings of such studies have indicated that CYP who harm sexually are diverse in their characteristics (Hackett, 2014). A complex and diverse mix of developmental, social, familial and economic factors are thought to contribute to an increased risk of engagement in HSB.<sup>10</sup>

Most CYP who engage in HSB are male, although there are also a substantial and increasing number of females who harm in this way (Kahn and Chambers, 1991; Kahn & Lafond, 1988; Silovsky & Niec, 2002)<sup>11</sup>. Although most CYP first engage in HSB during puberty, for some first engagement occurs at a very young age (Cantwell, 1988; Freidrich & Luecke, 1988). Figures suggest a 'peak' in incidence in males occurs at around 14-15 years (Hackett, Masson, Balfe & Phillips, 2013; Nisbet, Rombouts & Smallbone, 2005).

Retrospective studies suggest that the vast majority of CYP who engage in HSB have experienced abuse or trauma in some form, with multiple forms of trauma common (Hackett, Masson, Balfe & Phillips, 2013; Silovsky & Niec, 2002; Vizard, 2006). A particularly strong association has been found between violence within the family (e.g. DV) and the risk of engagement in HSB (Awad & Saunders, 1991; Hatch & Northam, 2005; Righthand & Welch, 2004). Indeed, the literature highlights that physical violence is more common in the histories of CYP who engage in HSB than sexual victimisation, although it is unclear on why this may be. Studies suggest that for CYP who exhibit HSB, a range of difficulties in addition to the HSB are commonly indicated. These include attachment difficulties, low self-esteem, limited sexual knowledge, delayed social skills and additional learning needs (Awad, Saunders & Levene 1984; Hackett, 2001). CYP may be diagnosed with a range of concurrent psychiatric disorders, the most typical of which include 'Conduct Disorder' (Fehrenback et al., 1986; Shields 1995), 'Attention Deficit Hyperactivity Disorder' (Shields 1995) and 'Post-Traumatic Stress Disorder' (McMackin et al., 2002). There is also an overrepresentation of CYP with Learning Disabilities

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<sup>9</sup> Such research has looked at norms and indicators of 'deviance'. Literature regarding developmental risk factors can be of use in developing understandings of how HSB may be shaped, however notably says little with regards to families experiences once the HSB becomes known about.

<sup>10</sup> Although it is not possible to describe the evidence in relation to characteristics of CYP who engage in HSB in a comprehensive way within this chapter, several notable findings are described.

<sup>11</sup> One hypothesis for the overrepresentation of males has been argued to lie in social and cultural norms regarding gender and power, and the condoning of problematic sexual attitudes displayed by young men (Epps & Fisher, 2004),

Hackett, Masson, Balfe & Phillips, 2013), arguably due to their greater social isolation, greater difficulty in processing trauma experiences and higher chances of being caught (Epps, 1991; Timms & Goreczyn, 2002).

This heterogeneity is not only true with regards to the indicated contributing factors, but also the possible drivers for such behaviours. Sexual stimulation and gratification at times appear relevant, more commonly so for adolescents than for children (Chaffin, Letourneau & Silovsky, 2002). Harmful behaviours may also be associated with anxiety, self-calming, curiosity, attention seeking or imitation (Silovsky & Bonner, 2003), hence the importance of understanding the meaning behind behaviours.

### **3.4 Consequences of Harmful Sexual Behaviour**

The profound psychological, emotional, social and physical impacts of sexual abuse are well recognised, with often painful and long-lasting consequences for victims (Finkelhor, 1984). Commonly reported responses to sexual abuse include anxiety, low mood, abuse of substances, eating difficulties and difficulties in trusting others (Rudd & Herzberger, 1999; Shaw, 2000). Factors which may increase the psychological impact of abuse include the interpersonal dynamics, the use of force or coercion, how often the abuse occurred and its physical invasiveness (Brown, 2004).

Significant consequences also exist for the person who harms. They may experience some of the same emotional responses as their victims, for example anger, shame, disgust, guilt or anxiety (Gil, 1993). In addition, legal and social repercussions may also be relevant. Over the age of ten (the age of criminal responsibility), CYP who engage in HSB can be imprisoned as a 'young offender' for up to five years under the Sexual Offences Act (UK Parliament, 2003). Such legal implications can shrink a young person's world and future opportunities. In addition, although many CYP remain within their families (Moultrie & Beckett, 2010), a significant minority may be moved to substitute care as a safeguarding precaution<sup>12</sup> or may be already in substitute care when they engage in the HSB. Where the HSB occurs between siblings, CYP are more likely to become 'looked after' outside of their immediate family (Erooga & Mason, 2006; Hyde, Bentovim & Monck, 1995).

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<sup>12</sup> These CYP may be accommodated voluntarily or subject to a Care Order.

### 3.5 Familial Contexts

Several quantitative studies have focused on the characteristics and family contexts of CYP who engage in HSB<sup>13</sup> It has been reported that the family contexts of CYP who engage in HSB may deleteriously impact on them in both direct and more subtle ways. For example, there may be a higher prevalence of physical, sexual or emotional abuse within the family than the general population<sup>14</sup> (Kaplan, Beker & Martinez, 1990; New, Stevenson & Skuse, 1999; Worling, 1995), more familial instability and more economic disadvantage (Gray et al., 1999). In a study by Thornton et al. (2008), three quarters of CYP who had engaged in intra-familial HSB reported little or no contact with at least one parent, a finding replicated in other studies (Fehrenbach et al., 1986; Kahn & Chambers, 1991). CYP also reported poor satisfaction with the family environment and high levels of conflict. Research focusing on family communication style has found that within families where a CYP has engaged in HSB, there may be more aggressive statements and interruptions (Borduin et al., 1990) and poorer quality of communication (Bischof, Stith & Wilson, 1992; Stith & Bischof, 1996; Thornton et al., 2008). Due to the research methodologies of these studies, it remains unclear whether highlighted differences in communication commonly precede HSB or occur as a result. However, one study CYP reported poor familial communication prior to their engagement in HSB (Franey et al., 2005) and the early attachment relationship has been implicated.

Although literature describes associations between certain parental factors and a child's engagement in HSB, association is not synonymous with causation (Bowers, 2002). As stated by Duane and Morrison (2004), "it is possible only to say that these factors may be linked to the development of sexually abusive behaviour in some young people" (p. 119). In addition, Chaffin et al. (2002) describe how "family backgrounds are diverse" (p.14) and Bowers (2002) highlights that negative parenting practices are not always relevant. Although evidence for any simple and direct causal relationships is limited, it is interesting to consider the way that these findings may be disseminated and interpreted. A context of deficit-heavy narratives and a focus on parental factors may lead to limiting generalisations, with parents' capacity to act as important supportive agents in their child's lives perhaps consequentially obscured<sup>15</sup>.

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<sup>13</sup> A notable gap in the literature exists with regards to fathers. This can be perhaps explained in part by societal emphasis on the mother-child pair.

<sup>14</sup> Cross-sectional research has highlighted that a substantial proportion of mother's report experiences of domestic violence, physical abuse and sexual abuse. In one study of 37 mothers, 75% reported domestic violence. In the same study 65% of mothers reported physical abuse and 65% reported childhood sexual abuse (New, Stevenson & Skuse, 1999).

### 3.6 Family Involvement in Interventions

When a child engages in HSB, their parents may play a substantial role in interventions offered by professionals, as the people responsible for their child (NICE, 2016). The day-to-day implications of treatment impact on the whole family. Parents may be asked by professionals to provide historical information, remain vigilant to signs of further HSB and encourage the child and participate in the therapeutic intervention (Hackett, 2001; Kolko et al., 2004; Lawson, 2003; Zankman & Bonomo, 2004). They may also be involved in 'safety planning'<sup>16</sup> (e.g., providing 'line of sight' or 24-hr supervision; NICE, 2016) which may be experienced as very practically demanding; (Jones, 2015).

The importance of family-based interventions has been consistently highlighted within the literature (Carpentier, Silovsky & Chaffin, 2006; McGarvey & McKeown, 1999) and 'Think Family' approaches are commonly promoted. There is growing evidence that Multi-Systemic Therapy (MST) is an effective approach to intervening in the context of HSB, as it places emphasis on the individual who has harmed being embedded (and therefore treated) within their relational context. MST involves the family in addressing risk factors for further HSB and providing support for change<sup>17</sup>. With regards to efficacy, two randomized controlled trials and one controlled study have found MST to reduce reengagement in HSB compared to individual therapy (Borduin et al., 1990; NICE 2016), although it is argued that MST has not yet been conclusively established to be advantageous compared to other modes of treatment (Karnick & Steiner, 2007; NICE, 2016).

That family work can promote treatment efficacy by strengthening family relationships (Kolko et al., 2004), building on strengths, resources and competencies (Hackett, 2004), addressing boundary issues (Kolko et al., 2004), supporting CYP's successful completion of interventions (Hackett & Mason, 2006) and aiding in the short-term and long-term management of risk (Hackett, 2004; Zankman & Bonomo, 2004) has been highlighted. With the promotion of family-based interventions in the UK in mind, it may be surprising that a national review of HSB provision found there to be a noticeable absence of such work (Smith et al., 2013), with many services highly reliant on individualised interventions with CYP.

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<sup>16</sup> "Safety planning" involves risk management recommendations such as increased levels of parental supervision, in the hope of improving the safety of the child and others

<sup>17</sup> As highlighted by Curtis, Ronan and Borduin (2004), there is a focus on empowering parents to 'facilitate pragmatic changes in the youth's and the family's natural environments' (p. 411).

## 3.7 Systematic Qualitative Literature Review

### 3.7.1 Search Strategy Methodology

For the purposes of the present systematic review, a systematic search of the available peer-reviewed literature was performed, using formal procedures for searching. A number of methodological steps were undertaken. Firstly, a focused research question was identified for the review (Beecroft, Rees & Booth, 2006). It was initially decided that the systematic literature review question should be: ***‘What are the experiences of parents of CYP who have engaged in HSB?’***, with the review summarising available peer-reviewed qualitative research literature relating to this question. However, this search subsequently resulted in the identification of only one appropriate study. As such, the terms of the search were redefined and extended, to include studies related to the experiences of a wider population: both biological parents and parental figures (PPF’s; e.g., kinship carers, foster carers and adoptive parents). The search therefore aimed to find literature speaking to the following question: ***‘What are the experiences of parents and parental figures of CYP who have engaged in HSB?’***. The methodology for this systematic review can be found in Appendix A. The nine relevant articles which were identified will now be summarised and their findings synthesised. Four main themes generated from the synthesis of included research studies will be reported on as well as their highlighted implications and a quality appraisal of the identified studies will follow.

### 3.7.2 Descriptive overview of studies

Nine studies meeting the inclusion and exclusion criteria were identified as eligible for inclusion in the literature review. A summary of the major features of each study is outlined in Table 1 below. The studies listed involved a number of participant groups, primary areas of focus, methods of data collection and analytic strategies, as detailed.



Table 1: Summary of articles from systematic review

Authors & Title	Main Area of Exploration <sup>18</sup>	Study Participants	Method (1) Sampling strategy, (2) Method of data collection, (3) Analysis	Key Findings and Conclusions	Main Strengths and Limitations
1) Hackett, Phillips, Balfe & Masson (2014).  Family responses to young people who have sexually abused: anger, ambivalence and acceptance	Explored professionals' interpretations of how PPF's experienced finding out about the HSB and how family functioning was affected in the short and longer term.	PPF's of 117 CYP attending specialist HSB assessment and intervention service in the UK (sample size not specified). Demographic characteristics of PPF's not described.	(1) Stratified purposive sampling to identify representative subsample (2) Observation (Review of CYP's historical case file data) (3) Thematic analysis	PPF's could present with negative (shunning/ shaming) or unconcerned (ambivalent) initial responses to the abuse or show initial supportive responses. HSB could place families under considerable stress. <u>Conclusions:</u> Wide range of responses to HSB. Important for professionals to engage with PPF's to help them to support CYP to desist from HSB	(+) Review of large number of cases (+) Self-report bias mitigated (+) Analytic strategy fitting for research (-) Uses case file data rather than interview data (professional rather than personal perspective of experiences-not objective or bias free) (-) PPF's experiences may have either been not known to professionals or not reported by professionals in file (-) Unclear who coded the data.
2) Hackett, Masson, Balfe & Phillips (2015).  Community reactions to young people who have sexually abused and their families: a shotgun blast, not a rifle shot	Explored professionals' interpretations of how people within the local community responded to finding out that a CYP had engaged in HSB and impact of community responses on positioning of family in their community and family functioning.	PPF's of 117 CYP attending specialist HSB assessment and intervention services in the UK (sample size not specified). Demographic characteristics of PPF's not described.	(1) Stratified purposive sampling to identify representative subsample (2) Observation (Review of CYP's historical case file data) (3) Thematic analysis	PPF's could experience 'courtesy stigma' or discrimination due to their child engaging in HSB and this information 'getting out'. Negative consequences included families being threatened as well as actual acts of violence or crimes against the family. Some families moved house due to community reactions and some PPF's lost their jobs. <u>Conclusions:</u> Issue of negative community responses is significant. Professionals should do more to proactively address issues at community level.	(+) Describes cultural and political context of study (+) Review of large number of cases (+) Self-report bias mitigated (+) Unique in focus on impact of community reactions: contribution to knowledge (+) Analytic strategy fitting for research (-) Uses case file data rather than interview data (professional rather than personal perspective of experiences-not objective or bias free) (-) PPF's experiences may have either been not known to professionals or not reported by professionals in file

<sup>18</sup> Some studies peripherally addressed our specific concern with the experiences of parents in the body of the text, yet had an alternate yet related main area of focus. These were deemed appropriate for inclusion in the review, as per inclusion criteria 6.

<p>3) Hackett &amp; Masson (2006).</p> <p>Young people who have sexually abused: what do they (and their parents) want from professionals?</p>	<p>PPF's experiences of professional involvement due to their child engaging in HSB</p>	<p>n=9 PPF's accessing specialist community based HSB assessment and intervention services in the UK and Republic of Ireland. n=8 females and n=1 males. Further demographic characteristics not described.</p>	<p>(1) Purposive sampling (2) Structured questionnaire data (3) Analytic strategy not specified- descriptive presentation of qualitative data</p>	<p>PPF's found it difficult to come to terms with the HSB and its consequences. They experienced feeling that they were not respected by professionals. They felt a pressure placed on them by professionals to accept that the HSB had happened. Parents valued being able to share their feelings about the HSB with professionals. <u>Conclusions:</u> Importance of seeking feedback of parents highlighted.</p>	<p>(+) Questionnaire data- PPF's may be more open with their responses (+) Ethical issues related to collection of data carefully considered (-) Questionnaire data may not capture elements of experience, limited richness (-) Self-selection bias due to PPF's deciding whether to answer questionnaire (-) No clear analytic strategy employed or described, simply descriptive presentation of questionnaire data.</p>
<p>4) Thornton, Stevens, Grant, Indermaur, Chamarette &amp; Halse (2008).</p> <p>Intrafamilial adolescent sex offenders: Family functioning and treatment.</p>	<p>The experience for PPF's of their child engaging in intrafamilial HSB and impact of being involved in treatment on family functioning</p>	<p>n=38, PPF's attending a community based HSB treatment programme in Australia. Demographic characteristics not described.</p>	<p>(1) Purposive sampling (2) Semi structured interviews pre-intervention (n=38) and post-intervention (n=8) (3) Interpretive Phenomenological Analysis</p>	<p>Range of emotional experiences in response to the HSB (e.g., anger, guilt and shame). Relationship with CYP strained. Divided loyalties due to intrafamilial nature of HSB. PPF's avoided talking about HSB with child. Felt in need of support and conflicted about how to deal with the situation. Unresolved issues relating to own sexual victimisation triggered. Wished to trust child again. <u>Conclusions:</u> Important to address issues within the family to enable CYP to make progress in treatment.</p>	<p>(+) Interviewed PPF's twice to enhance a temporal understanding of their experiences (+) Study highlights implications with regards to treatment and policy (+) Themes well anchored in direct quotes (-) Participants who volunteered to take part may have had significantly different experiences to those who did not (-) Those interviewed post-intervention may have had different experiences to those who dropped out. (-) Criticisms regarding subjective interpretation and generalisability (-) Large sample size for IPA- questionable whether full appreciation of each account possible (-) Interviewer influence on generated data not discussed</p>
<p>5) Jones (2015).</p> <p>Parents of adolescents who have sexually offended: providing support and coping with the experience.</p>	<p>Study 1: Parents experiences of supporting their child after the HSB. Study 2: Parents experiences of coping.</p>	<p>n=8 PPF's (Study 1: n=4 interviewed individually Study 2: n=4 different participants in focus group) of adolescents attending hospital based HSB treatment programme in the USA. n= 7 females and n=1 male. Age</p>	<p>(1) Purposive sampling (2) Semi-structured interviews and focus groups. (3) Content analysis and constant comparison</p>	<p>Study 1: PPF's highlighted attempts to love and support child whilst helping them accept responsibility for and consequences of HSB. Emotional toll experienced (e.g., anger, frustration, feeling overwhelmed/ defeated). PPF's held hopes and wished for their child's future. Study 2: PPF's tried to find ways to cope with the initial disclosure, feelings of responsibility and feeling</p>	<p>(+) Thorough background and rationale for study provided (+) Manifest as well as underlying meanings of participant's communications considered (+) More complex and multi-layered view through use of both interviews and focus group (-) Criticisms regarding subjective interpretation and generalisability (-) Small sample size (-) Interview guide may have been limiting</p>

		range 39-65 years old. White African and African American PPF's.		alone and overwhelmed. Felt that they benefitted from support group. <u>Conclusions:</u> Treatment programmes need to address PPF's issues, e.g., by responding to their experiences of trauma and feelings of self-blame	(-) All PPF's had children who were successfully completing treatment (recruitment strategy introduced bias)
6) Pierce (2011).  The lived experience of parents of adolescents who have sexually offended: I am a survivor.	The lived experiences of parents of adolescents who had sexually offended.	n=4 PPF's attending hospital based HSB treatment programme in the USA. All females. Age range 39-55 years old. White African and African American PPF's.	(1) Purposive sampling (2) Ethnographic (observations, prolonged engagement with the culture and interviews to collect data). Interviews guided by the Trauma Outcome Process (TOP) model. (3) Content analysis and constant comparison	PPF's described experiences of coping with their initial reaction, changes to their relationship with their child, feeling responsible for the HSB and feeling isolated in their experience and overwhelmed. They described the benefits of being in a support group, "dealing with it," and surviving it. <u>Conclusions:</u> PPF's could benefit from individual therapy to help them to process feelings, to identify sources of support, explore factors impacting on relationship with child and to facilitate self-awareness.	(+) Use of ethnographic approach justified (considered as 'unknown culture' and connection through group membership) (+) Researcher's prolonged engagement with PPF's prior to recruitment through attending groups (+/-) Parents experiences mapped onto TOP (a theoretical underpinning). Although may add to sense making may also distract from PPF's experiences as they stand. (-) Children of all PPF's had successfully completing treatment: recruitment strategy introduced bias. (-) Small sample size, researchers state saturation indicated however assertion not qualified
7) Duane, Carr, Cherry, McGrath & O'Shea (2002).  Experiences of parents attending a programme for families of adolescent child sexual abuse perpetrators in Ireland.	Parental psychological adjustment over course of a parents' group programme.	n=5 birth parents of CYP attending Community based HSB treatment programme in Ireland. n=3 females and n=2 males. Demographic characteristics not described.	(1) Purposive sampling (2) Semi-structured individual interviews conducted pre and post intervention (3) Thematic content analysis	Parents described painful feelings related to disclosure (e.g., shock, confusion, shame, self-blame, anger, sadness). Distance and mistrust in relationship with son negative experiences within community, support and solidarity from other parents, shame in sharing experiences with others, positive effects of group psychotherapy on son. <u>Conclusions:</u> Parents can experience particular patterns of emotional response following HSB. Parent support programme should be further evaluated.	(+) Simple conceptual model of adjustment process generated (+) Only study to sample birth parents only (+) Good Inter-rater reliability of thematic category codes established (+) Rich analytic narrative (+) Useful perspective on parent/parental figures experiences over time (-) Thematic analysis as a methodology arguably lacks rigour and commitment to considering underlying meanings of speech (-) Specific focus on experiences in relation to their accessing of a specialist intervention service (-) Limited discussion of implications of findings

<p>8) Hubert, Flynn, Nicholls &amp; Hollins (2007). I don't want to be the mother of a paedophile': the perspectives of mothers whose adolescent sons with learning disabilities sexually offend.<sup>19</sup></p>	<p>Female PPF's feelings and attitudes in relation to their sons, their changing role as a parent and impact on relationships.</p>	<p>n=5 PPF's attending Community based HSB treatment programme in the UK. All female, further demographic characteristics not described.</p>	<p>(1) Purposive sampling (2) Semi-structured individual interviews (3) Thematic analysis</p>	<p>PPF's struggle to make sense of their son's HSB and what it meant about them. PPF's described disbelief at HSB and conflicting feelings, a lack of support in managing sons' care, wanting to help and support son and worrying about son. Some described group psychotherapy as helpful to both them and their son whilst one was concerned about its impact. <u>Conclusions:</u> Families do not receive sufficient professional help. Support often in context of risk and allegations rather than day to day input.</p>	<p>(+) Description of study context (e.g., personal, service level, political) (+) Analysis contextualised in existing literature (-) Study strengths and limitations not considered by author (-) Thematic analysis as a methodology arguably lacks rigour and commitment to considering underlying meanings of speech (-) Main themes not always internally coherent (-) Strategy for thematic analysis poorly outlined (-) Findings specific to PPF's of CYP with a LD</p>
<p>9) Mason, Hackett, Philips &amp; Balfe (2014). Fostering and adoption of children with harmful sexual behaviours: carers' reflections on their experiences</p>	<p>Fostering/ adoptive carers reflections on their experiences of caring for a CYP with HSB, the impact on them and their family and what they think helped or hindered the success of the placement.</p>	<p>n=9 fostering/ adoptive carers who had cared for CYP with HSB in 1990's for over 18 months. n=5 females and n=4 males. Further demographic characteristics not described.</p>	<p>(1) Stratified purposive sampling to identify representative subsample (2) Semi-structured individual interviews (3) Thematic analysis</p>	<p>Foster parents described appreciation of training and sources of support. Highlighted stressors and challenges on caring for CYP who has engaged in HSB, satisfaction of child's progress, being committed despite the struggles, the importance of male role models, worrying about CYP's risk and vulnerability, advocating for the CYP and the strain of managing contact with birth parents. <u>Conclusions:</u> Training and support to foster parents of importance. Professionals should recognise and respect carers as important members of team around the CYP.</p>	<p>(+) Only study where parental figures looked back on retrospective experiences, thus offering novel perspective (+) Thorough literature review with focus on children with HSB in substitute care (-) Thematic analysis as a methodology arguably lacks rigour and commitment to considering underlying meanings of speech (-) All the foster placements had been relatively successful; recruitment strategy may have introduced bias. (-) Findings specific to foster parents</p>

<sup>19</sup> This study recruited four birth mothers and one foster carer.

### 3.7.3 Research participants

To gain access to this group of PPF's, studies either used purposive sampling or stratified purposive sampling. Such methods are appropriate as PPF's were deliberately sampled as expert in the phenomena researched. All PPF's were or had been accessing a treatment service for the child's HSB and were approached through the services with which they had engaged.

Sample sizes varied greatly, with the lowest being four and the highest 38 participants. Studies which obtained information about parent experiences from client files did not clearly report sample sizes. Comprehensive information regarding the demographic characteristics of samples was overall limited<sup>20</sup>. Of the six studies reporting on gender, an underrepresentation of males was found: 32 out a total of 40 participants were female. Only one study reported on the experiences of biological parents alone (Duane et al., 2002). All other studies included foster carers, kinship carers and other parental figures in their samples. In none of these studies was the data from biological parents separable from that of non-biological parental figures.

### 3.7.4 Method of data collection

Thornton et al. (2008) and Duane et al. (2002) interviewed PPF's twice (at intake into a treatment programme and 12 months on), to enhance a temporal understanding of their experiences. Pierce (2011) made use of an ethnographic approach, which consisted of observing a PPF group and using interviews as a means of data collection. Jones (2015) also made use of a focus group, to triangulate and enrich collected data. Hackett and Masson (2006) used questionnaires in the hope of reducing the risk of parents providing socially appropriate answers about this sensitive area, and both Hackett, Phillips, Balfe and Masson (2014) and Hackett, Masson, Balfe and Phillips (2015) conducted case file reviews. These reviews comprised of PPF's experiences as depicted by professionals within case files, and therefore it is important to note that these two studies did not report first-person accounts.

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<sup>20</sup> Several gave no or little detail. It is likely that this was due to the word limits of the research articles and/or concerns regarding the possible identification of PPF's.

### 3.7.5 Synthesis of study findings <sup>21</sup>

The methodology for this synthesis took from Textual Narrative Synthesis, with study findings reported upon in a descriptive discussion (Evans, 2002). The primary focus of the synthesis was not to 'go beyond' the findings of the primary studies by offering fresh interpretations of the data, therefore it could be broadly classified as descriptive. Four main themes were generated and will now be reported on, followed by their key implications:

#### **i. Personal psychological impact of child engaging in HSB**

Six studies highlighted that the emotional wellbeing of PPF's can be dramatically impacted by the initial disclosure of the child's HSB. PPF's could feel profoundly emotionally affected and reported differing combinations of strong feelings of anger, guilt and shame (Pierce; 2011; Hackett, Phillips, Balfe and Masson, 2014); Hubert, Flynn, Nicholls & Hollins, 2007; Thornton et al., 2008). It was highlighted that it was common for PPF's to feel traumatised by the news of their child's HSB (Duane et al., 2002) and to experience numbness in relation to their feelings (Jones, 2015).

Four studies highlighted PPF's confusion about how the HSB had come to happen, with PPF's struggling to make sense of 'why' and engaging in searching and questioning both within themselves and with professionals (Duane et al., 2002; Hackett & Masson, 2006; Pierce, 2011; Thornton et al., 2008). Five studies reported that, particularly where parents had in part acknowledged their child's HSB, they commonly experienced feelings of sadness, with one parent stating "I was very down over it ..." (Duane et al., 2002). Helplessness often accompanied this sadness, with parents feeling unable to change the situation (Duane et al., 2002; Jones, 2015; Thornton et al., 2008). In this helpless state, some PPF's wished their lives would end (Hubert, Flynn, Nicholls & Hollins, 2007; Pierce, 2011) as illustrated by one mothers who described how she took medication "to stop killing myself...I just want to die" (Hubert, Flynn, Nicholls & Hollins, 2007).

Three studies reported on PPF's feelings of guilt and responsibility for the HSB, and their sense that they had not lived up to expectations as a PPF (Duane et al., 2002; Jones, 2015).

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<sup>21</sup> Where the study by Duane et al., (2002) is referenced, the synthesis will refer to participants as parents. In addition, where the relationship of the participant to the child has been specified in the results of a study, this will be reported.

Pierce (2011) reported that PPF's felt that they had failed their child. For example, one PPF's felt that she should have predicted and stopped the offence due to her own abuse history and a further PPF stated "If we would have just intervened earlier...his life was in my hands". Duane et al. (2002) reported that two parents appeared to experience a sequence of shame, self-blame and guilt. The authors quoted one mother who stated "What did I raise, that he done this, you know? It was shame."

Four studies highlighted that PPF's initially struggled with coming to accept that their child had engaged in HSB, especially when the child was denying that it had happened. In the study by Hubert, Flynn, Nicholls and Hollins (2007) one mother stated "I've now got to look at the prospects that these allegations are true. Until now, I've blanked them out", and in Pierce's (2011) study a PPF stated "When I first found out about it, I didn't believe it". Duane et al. (2002) highlighted that denial and minimisation of the HSB by parents can act as a defense mechanism, offering protection from the pain of fully processing their child's actions.

Five studies highlighted the practical demands of parenting a child who has engaged in HSB, in particular in relation to the challenges of putting into place intervention recommendations such as 24/7 supervision, ensuring the safety of other children, and introducing curfews (Hackett, Phillips, Balfe & Masson, 2014; Hackett & Masson, 2006; Hubert, Flynn, Nicholls & Hollins, 2007; Jones, 2015; Mason, Hackett, Philips & Balfe, 2014; Thornton et al., 2008). PPF's struggled to have time for activities of daily living or time with their spouse or friends (Hubert, Flynn, Nicholls & Hollins, 2007; Jones, 2015). Practical demands were reported to lead to feelings of stress, frustration, anger and helplessness (Hackett & Masson, 2006).

Two studies reported that for some PPF's, their child engaging in HSB led to the retriggering of memories of their own sexual abuse and victimisation (Hackett & Mason, 2006). In the study by Hackett, Balfe, Masson, & Phillips (2014) professionals stated that several mothers began to perceive that their child was like a deviant ex-partner or abuser following the disclosure of HSB.

## **ii. Impact on relationship with child.**

Hackett, Balfe, Masson and Phillips (2014) reported that 'many' PPF's show ambivalent, negative or unempathic responses to their child following the disclosure of the HSB, and that some PPF's asked social services for the child to be removed from their care. There were reports of intense anger and disdain from some PPF's towards their child (Duane et al., 2002; Hackett, Balfe, Masson & Phillips, 2014; Jones, 2015), with a PPF in the study by Pierce

(2011) reporting severely punishing and 'spanking' their child. In Jones (2015) study, one PPF stating "I almost hated him to the point that I wanted nothing to do with him". Thornton et al. (2008) also spoke of the strain on the parent-child relationship. Contrastingly, there were also protective and supportive responses from PPF's towards their child within four of the studies reviewed (Hackett, Balfe, Masson & Phillips, 2014; Hubert, Flynn, Nicholls & Hollins, 2007; Jones, 2015; Mason, Hackett, Philips & Balfe, 2014). Jones (2015), identified that several PPF's were emotionally available for their child following the HSB, providing them with love, empathy, support and security. Foster carers and adoptive parents in the study by Mason, Hackett, Philips and Balfe (2014) described advocating for their child and promoting their best interests, and demonstrated their ongoing commitment to them.

Four studies reported on the labeling of the child by the PPF, with reports of PPF's referring to their child as a 'predator' (Thornton et al., 2008) a 'monster' (Jones, 2015) and a 'paedophile' (Hubert, Flynn, Nicholls & Hollins, 2007). Hackett, Phillips, Balfe and Masson (2014) reported that PPF's had reported viewing their child as a 'sex offender', 'evil person' and 'rapist'. A PPF in both the studies by Duane et al. (2002) and Jones (2015) wondered whether their child was a 'psychopath'. Both of these studies also highlighted that a number of PPF's did not label their child and appeared to find a way to separate the child and their abusive behaviour. Indeed, Hubert, Flynn, Nicholls and Hollins (2007) found that some parents were highly concerned about their child being labeled as a 'sex offender'.

In the studies by Duane et al. (2002) and Thornton et al. (2008), parents described struggling to discuss the HSB with their child, avoiding conversations about the problem. Parents were encouraged to talk with their child about sex as part of their child's treatment, which could be experienced as particularly challenging (Jones, 2015). This finding was nuanced in that some PPF's actively encouraged their child to engage in open communication about the HSB and the treatment (Jones, 2015).

### **iii. Impact on relationship with wider family, peer and community systems.**

Four studies described PPF's sense of having no one to turn to following the HSB. PPF's stated that they felt that no one would understand (Hackett & Masson, 2006), that they may be judged (Hackett & Masson, 2006; Pierce, 2011), that they couldn't trust others (Pierce, 2011), and that they had to manage the experience alone (Jones, 2015; Thornton et al., 2008). In Jones' study (2015), PPF's described a lack of support from families, and Duane et al. (2002) highlighted that where the HSB was intra-familial, PPF's often did not feel able to talk to their relations about what had happened. Some PPF's stated that they wished they had



more support from professionals and described having to manage legal, educational and treatment issues resulting from the HSB without adequate assistance (Pierce, 2011).

The review highlighted that PPF's could experience persecutory and isolating responses from their communities, as reported in four studies. Foster carers and adoptive parents in the study by Mason, Hackett, Philips and Balfe (2014) described living in constant fear of complaints from neighbours and schools about their child. In the study by Duane et al. (2002), parents described verbal abuse, threats, stigma and isolation. Hackett, Masson, Balfe & Phillips (2015) found evidence of damage to property, threats and violence. Hackett & Masson (2006) also reported on threats from neighbours and violence, the loss of friendships and some PPF's even moving house following their child's engagement in HSB.

#### **iv. Coping with present circumstances**

Four studies reported on PPF's experiences of talking to other PPF's whose children had engaged in HSB, through their engagement in group interventions. In the study by Thornton et al. (2008), PPF's described the relief of learning that they were not the only family to deal with HSB, and in the study by Hackett & Masson (2006), a PPF stated "Parents need to talk with parents because unless you've been through it, you can't understand". All PPF's interviewed in the study by Thornton et al. (2008) stated that they benefitted from talking with other PPF's and discussing skills, however one PPF shared that they initially felt judged when they shared their experiences. According to Duane et al. (2002), parental discussions within a group setting engendered a sense of solidarity and support, with PPF's holding worries about how they would cope when the group came to an end.

All PPF'S in the study by Jones (2015) reported that talking to professionals could be helpful. PPF's in the Thornton et al. (2008) study found professional assistance with parenting skills to be particularly beneficial. Two studies highlighted that for PPF's, talking with a professional helped them to make sense of what had happened (Hackett & Masson, 2006; Thornton et al., 2008), with one PPF stating this helped them to gain 'peace of mind'. Mason, Hackett, Philips and Balfe, 2014 reported that some foster carers and adoptive parents found that professional meetings led to them feeling like everyone was working towards the same goals. However, this theme was nuanced in that some PPF's reported that professional input could feel personally intrusive, confusing and stressful (Duane et al., 2002; Jones, 2015), that safety plans were over-restrictive and detrimental to the child (Mason, Hackett, Philips & Balfe, 2014), that interactions with professionals could feel disrespectful (Hackett & Masson, 2006;

Mason, Hackett, Philips & Balfe, 2014) and that the length of professional involvement could feel abusive (Hackett & Masson, 2006).

All four PPF'S interviewed by Jones (2015) shared that their religion served as a means of coping with the HSB, which may be reflective of the community within which the study was undertaken. One PPF stated that they "Pray. Just pray. All I can do" and for another, prayer time was used to talk through worries. For a further PPF, her relationship with God appeared soothing and "strengthening" and she reflected that "he isn't allowing anything to happen that he's not prepared to take care of". Foster carers and adoptive parents in the study by Mason, Hackett, Philips and Balfe (2014) also spoke of church contacts as a source of support.

Three studies highlighted that for PPF's holding hope for their child was a way of coping with the HSB (Jones, 2015; Mason, Hackett, Philips and Balfe, 2014; Pierce (2011). Jones, 2015, reported a PPF's hope that their child would be able to manage and gain control of "negative parts" and become a "functional adult and good person". PPF's described a sense of relief as they drew towards the end of treatment, felt that they had "survived" this and were moving into another chapter of their lives Pierce (2011). Parents' stage in interventions and as such the support they had received appeared to impact on their sense of hopefulness.

## **v. Study implications**

Important implications for professionals, services and policy-makers in considering the provision offered to PPF's were highlighted by the reviewed studies. These included engaging PPF's in interventions (Hackett, Phillips, Balfe & Masson, 2014; Hackett & Mason, 2006), empowering them to help their child desist from HSB (Thornton et al., 2008), providing an opportunity for PPF's to vent, and make sense of their feelings (Hackett & Mason, 2006; Hackett & Mason, 2006; Thornton et al., 2008), helping to reduce self-blame (Jones, 2015) and helping PPF's to feel that they are not alone (Pierce, 2011). It was noted that professionals should be proactive and supportive (Hackett & Mason, 2006; Hubert, Flynn, Nicholls & Hollins, 2007; Thornton et al., 2008), be considerate of the parental toll due to interventions (Thornton et al., 2008), provide information and advice (Hubert, Flynn, Nicholls & Hollins, 2007; Mason, Hackett, Philips & Balfe, 2014), take PPF's views, knowledges and skills seriously (Mason, Hackett, Philips & Balfe, 2014) and consider and address community responses to families (Hackett, Masson, Balfe & Phillips, 2015). Two studies highlighted that a trauma framework can helpfully inform work with PPF's (Pierce, 2011; Thornton et al., 2008). Finally, it was highlighted that there was a need for more comprehensive national service provision, training and research in the area (Hubert, Flynn, Nicholls & Hollins, 2007). From my perspective,

undertaking the review and having a broader view of the literature highlighted the importance of individualising input to the needs of each PPF, given the great variability in parental circumstances, experiences and coping. With this in mind, well considered and systemically informed psychological formulations were indicated, these arguably being central to the effectiveness of interventions for HSB.

### **3.8.6 Literature appraisal: design and quality**

Whilst useful to evaluate the strength and quality of qualitative research studies in an area of interest, it can be argued that there is no simple and fixed 'right' approach to conducting qualitative enquiry. I wanted to carry out an appraisal of the studies outlined within this systematic review in a way that adopted a pluralist ethos. I therefore selected to use principles developed by Yardley (2000). Flexibility of interpretation is highlighted in the applicability of these criteria, with the ways in which studies are deemed to meet its principles varying according to their epistemological grounding and research methodology. The principles are therefore suitable for diverse qualitative methodologies. Yardley's proposed characteristics for evaluation include: (i) Sensitivity to context; (ii) commitment and rigor; (iii) transparency and coherence; and (iv) impact and importance of the research. Each of these areas are outlined in detail in Appendix B and touched upon in Table 1.

### **3.7.7 Literature overview**

This systematic review was undertaken as a means of informing the present study. The studies within the review generated important information about the experiences of PPF's of CYP who have engaged in HSB. However, the main finding from the review was in relation to the paucity of research in this area, with the low number of studies generated from the systematic search<sup>22</sup>. Overall the review highlighted that currently, there are only nine available studies which explore the personal lived experiences of PPF's of CYP who engage in HSB. As such, there isn't a good understanding of their experiences and meaning-making. Several possible hypotheses which may in part account for this were considered:

1. Stigma and shame and pain may close down the permissibility of talking about what it's like to experience your child harming in this way, with sense-making instead occurring

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<sup>22</sup> The lack of research in this area was also reflected in personal telephone communications with Simon Hackett (author of several of the reviewed studies) on 12<sup>th</sup> November 2015 and email communications with Ron Frey (who co-authored book chapter on parents of both CYP and adults who have engaged in HSB) on 28<sup>th</sup> October 2016.

within a private context.

2. Space may not be carved out for the voices of these parents in research, with views from their position as experts on the topic undervalued.
3. Wider contextual and political forces (e.g., moral agenda around child abuse) may limit interest in or empathy for these parents. Perhaps issues of discrimination, marginalization and powerlessness also shines through at the level of research.
4. A focus on reducing recidivism within a dominant positivist framework may constrain the focus of research in the area.
5. Professionals may paternalistically worry about the possible intrusion of research with parents who they perceive as vulnerable or traumatised, which may limit researcher engagement.
6. A risk averse research culture (e.g., scrutinising ethical procedures) may limit or constrain researchers.

Overall, the available literature was found to be of variable quality, according to criteria set out by Yardley (2000; Appendix B). In most studies, there was a focus on particular aspects of PPF's experiences, with for example the study making use of a particular conceptual framework to guide interview questions (e.g., the Trauma Outcome Process model in the study by Pierce, 2011), or being driven by a specific research question (e.g., the intervention evaluation undertaken by Duane et al., 2002). In some studies, PPF's with particular characteristics were recruited (e.g., child has LD, Hubert, Flynn, Nicholls & Hollins, 2007; parental figure is a foster carer, Mason, Hackett, Philips & Balfe, 2014), or the analysed data described the experiences of parents through the words of professionals (Hackett, Masson, Balfe & Phillips, 2015; Hackett, Phillips, Balfe & Masson, 2014). All studies usefully added to the overall body of research, however these factors impacted on the overall usefulness of study findings in important ways.

Limited attention was given to the experiences of birth parents alone. Eight of the nine studies also sampled parental figures (e.g., foster carers, kinship carers and step-parents). In this context, the particular and potentially differing experiences of birth parents may be lost<sup>23</sup>. This is likely to pose practical implications when considering best practice when working with CYP who remain in the care of their family of origin.

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<sup>23</sup> Although a proportion of CYP who harm in sexual ways may be in cared for by foster carers and kinship carers, a significant number of birth parents also experience finding out that their own child has engaged in HSB.

As research in this area has not been previously summarised this review forms an important contribution to the literature, generating knowledge for practice and serving as a useful reference function.

### 3.8 Rationale: The Contribution of the Present Study

When a CYP engages in HSB this occurs within the context of family, community and society. Its influences and impacts therefore stretch further than the CYP involved. There has been an emphasis within the research literature on establishing the characteristics of parents of CYP who engage in HSB, family factors contributing to HSB and the role of parents in treatment (Kolko et al., 2005; Zankman & Bonomo, 2004). Such research has largely relied on quantitative methodologies, with deficit-based conceptualisations prominent. This narrow focus is arguably limiting, in that it has the potential to result in an incomplete single story about parents and assumed meanings (e.g., of deficit, dysfunction and causality), neglecting the complex and interwoven aspects of parents' experience. In addition, such research does not speak to the personal lived experiences of parents or their own personal representations of meaning, which remain under-heard and under-valued (Evans, 2007; Hackett, Masson, Balfe & Phillips, 2015). This is particularly the case in relation to the lived experiences of birth parents, where there is a clear paucity of research. In learning more about what it is like to be the parent of a CYP who has engaged in HSB, it is hoped that professionals will have a richer framework from which to provide appropriate support to both the parent and their child.

### 3.9 Research aims

The experiences of birth parents of CYP who engage in HSB remains a largely unexplored and particularly poorly understood area. This study hopes to address this gap by exploring the experiences and meaning-making of birth parents specifically, allowing for a deep and rich understanding of the lived experiences of these parents, from their own perspective.

The primary aim of this research was to answer the research question<sup>24</sup>:

*“What are the experiences of birth parents of children and young people who have engaged in Harmful Sexual Behaviour?”*

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<sup>24</sup> That the research question was broad was reflective of the limited understanding of the many influences on birth parents' experiences, as highlighted by the literature review.

## Chapter 4: Methodology

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### 4.1 Overview

The study explored the experiences of parents of CYP who have engaged in HSB. It adopted an explorative cross-sectional qualitative design and recruited six participants via purposive sampling. Semi-structured interviews were carried out and transcripts were subsequently analysed using Interpretative Phenomenological Analysis (IPA; Smith, Flowers & Larkin, 2009). In this chapter I will outline this chosen methodology in greater depth and highlight the rationale for the use of this approach. The process of recruitment, ethical considerations, data collection and data analysis will be reported. Following this, an evaluation of the quality and validity of the research will be reported. The chapter will conclude with an exploration of self-reflexivity.

### 4.2 Choosing a Qualitative Approach

Research into the parents of CYP who have engaged in HSB has generally been a neglected area, with studies predominantly making use of quantitative methodologies (e.g., risk factors associated with CYP's recidivism) and qualitative investigations of parent experiences are sparse. As the experiences of parents have been under-researched, assumptions have been made. As such, this research aimed to explore and report on rich, complex and in-depth accounts of the experiences of parents. A methodology which allowed for close contact with parents' personal perspectives, made use of a broad research question, and led to the generation as opposed to the testing of hypotheses was preferred (Silverstein, Aurbach & Levant, 2006), therefore a qualitative methodology was deemed to be best suited.

### 4.3 Choosing Interpretative Phenomenological Analysis

A range of qualitative methodologies were considered, including Grounded Theory, Narrative Analysis and Discourse Analysis (see Appendix C). Due to the experiential nature of the research question and the researchers interest in parents' sense-making, it was eventually decided that IPA was best suited<sup>25</sup> (Smith & Osborn, 2008). As a phenomenological approach,

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<sup>25</sup> A summary of the consideration of these alternative methods I detailed in Appendix 2)

IPA concerns itself with the study of what experiences are like for people and the way in which they give meaning to these experiences (Smith, Flowers & Larkin, 2009). Phenomenology considers the importance of personal interpretations in meaning-making alongside social influences. IPA is heavily ideographic, aiming to “capture the quality and texture of individual experience” (Willig, 2001, p. 53). The main aim of IPA is not to make generalisations with regards to a population, but to instead focus on studying in-depth accounts from a small number of people (Smith & Osborn, 2008). Generalisations are not avoided, however they are located in the particular. That this methodology does not portray experiences in homogenised terms corresponds well with the intentions of the current project, which aims to capture diversities between parents.

Through IPA’s inductive aspects, the researcher’s role is not simply to describe but to interpret, therefore consideration is given to aspects of participants’ accounts which are not immediately conscious to them in their tellings (Smith, Flowers & Larkin, 2009). If participant’s utterances are taken on face value, much of what may be of interest may remain unexplored. There may be complex processes which contribute to meaning-making which are hidden from the view of the participant, yet which through the interpretive process are perceived by the researcher to play a role in sense-making. It has been stated that phenomenological approaches can be limited in their ability to consider unconscious processes contributing to meaning-making (Moran, 2000). However, it is here argued an interpretive lens can be used to ‘go underneath’ participants’ statements and to throw light on unconscious psychological processes informing their meaning-making. This involves more hermeneutic reading of the transcript, with additional conceptual inferences made and deeper level of abstraction, which may go beyond participants own explanations of their experience (Eatough & Smith, 2008). As an example, through the analysis, it is possible to call upon theories (e.g. psychodynamic concepts to highlight defensive processes or through use of an attachment lens), as part of interpretative process used in IPA.

Due to the hermeneutic assumptions underpinning IPA and its contextual perspective, use of an IPA methodology was felt to fit with the constructivist philosophies on which the study was based (Smith & Eatough, 2006) and with the degree of objectivity which was felt to be possible when exploring participants’ ‘insider perspective’. IPA acknowledges that through the interpretive analytic process the researcher is not conducting an exploration of a person’s sense-making completely or directly, or providing an accurate description of their experiences. Instead, their own meaning-making plays a mediating role, as they try to make sense of the

participants own sense-making<sup>26</sup> (Smith & Osborn, 2003). As in IPA any summaries made about a phenomena are contingent upon the researcher acting as co-constructer, in using this methodology it is of central importance to take active steps to come as close to a person's lived experience as is possible. Engagement in self-reflexivity (exploration of own perspectives and presumptions) is seen to be critical. The importance of a process known as 'bracketing' is stressed, where the researcher makes efforts to limit the influence of their own 'filters' on their understandings of participant experiences (Chan, Fung & Chien, 2013; Smith, Flowers & Larkin, 2009).

#### 4.4 Process of Recruitment

The study aimed to identify and recruit people who could offer a meaningful perspective on the experience of being the parent of a CYP who has engaged in HSB. Participants were identified and recruited through one UK based site, a specialist assessment and intervention service working with CYP who have engaged in HSB and their families (referred to as 'the HSB Service' from this point). The HSB service is a multi-agency partnership provision, hosted by an NHS Trust. 'Care coordinators' from the service (the professional most involved in the family's care) were asked to identify suitable parents to participate in the study. This request was initially made during a face to face meeting and subsequently through follow-up emails.

'Care coordinators' were asked to introduce the study to parents who fulfilled participation criteria (Section 4.5) during the parent's usual assessment or intervention sessions, verbally providing them with broad details about the research study. If the parent decided that they may be interested in taking part then they were given an information sheet which provided additional details about the study (Appendix D). In addition, they were asked to consent to their contact details being shared with the researcher.

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<sup>26</sup> This making sense of participants' sense-making is known as the 'double hermeneutic'. In reading the findings of an IPA study, the reader is also constructing meaning through unique interpretations of the accounts presented, yet a further layer is added to the hermeneutic process (Smith et al., 2009).



## 4.5 Participation Criteria

Due in part to the IPA methodology, it was of importance that the parents approached to participate were a “closely defined group for whom the research question will be significant” (Smith, 2008, p. 56). As such, purposive sampling was used, with parents holding pre-specified characteristics determined to be eligible for the study:

### 4.5.1 Inclusion criteria:

1. Must identify as biological parent of a child who has exhibited HSB
2. Must be the parent of a child currently attending HSB Service
3. Must be aged 18 or over
4. Must be able to understand the information about the study and to give informed consent to participate

### 4.5.2 Exclusion criteria:

1. Must not be the adoptive parent, foster carer or kinship carer of the child who has exhibited HSB
2. There must not be a current formal safeguarding investigation involving the parent underway
3. The parent must not lack capacity and as such be unable to consent to take part

## 4.6 Challenges of Recruitment

There were several challenges during the recruitment process. Firstly, as part of a busy team ‘care coordinators’ faced a number of pressures which understandably limited the mental space available to them for consideration of parental suitability. Meeting with them and sending reminder emails was therefore useful in facilitating recruitment. It was also found to be beneficial to have the team’s Clinical Psychologist and Service Manager invested in the research, as respected and influential members of the team.

In total, eight parents expressed interest in the study and six were interviewed. With regards to the other two parents not interviewed, one parent became concerned about being audio

recorded feeling that this may induce paranoid thoughts (for which she had previously received therapeutic support). I did not feel that it was ethically acceptable to encourage use of the recording equipment and it was decided that it was not methodologically appropriate to write notes throughout the interview.<sup>27</sup> One further parent was identified and agreed to meet for the formal consenting process at her home, however during the visit safeguarding concerns were raised, after which the parent no longer wished to participate.

With regards to the six parents who were recruited, two (who were married) were known to me through a previous role within a different service, although I had not worked with them therapeutically. My relationship with these parents and the impact of elements of personal knowing and contact (e.g., on trust and openness) was thought through with my research supervisor. It was felt that they should be given the opportunity to consider participation for themselves. Upon discussion, they were positive about speaking to me and were keen to take part.

Contrary to my expectations, all other parents who were approached stated that they wished to take part and seemed motivated to meet with me. Parents highlighted their wish to share information which had been privately held (“I’m grateful for the opportunity to talk”), a desire to share important information that may inform clinical practice (“if it helps other parents”) and a wish to be helpful to me and perhaps also the HSB Service (“if it helps you”).

## 4.7 The Sample

A total of six parents participated in the study, with a sample of between four and ten recommended for a doctoral-level study using IPA (Smith, Jarman & Osbourne, 1999). It has been highlighted that in using this ideographic approach it is “important not to see higher numbers as being indicative of ‘better’ work” (Smith, Flowers & Larkin, 2009, p.52). Table 2 overleaf gives details of these participants. The information provided is limited, so as not to compromise the anonymity of parents. The ages of the CYP’s who had engaged in HSB are listed below for the same reason: 9 (n=2), 11 (n=1), 13 (n=1), 15 (n=1), 16 (n=1).

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<sup>27</sup> Not only did it seem that this would take away from my ability to be psychologically present, it also seemed that I would be making decisions about which information to include or leave out from the notes in the moment during the interview, without time to consciously consider my reasons for doing so. This would add another layer to the complexity of analysis and potentially lead to my views and assumptions having a greater impact on the data.

Table 2: Participant characteristics

Name <sup>28</sup>	Ethnicity	Marital status	Approx. time accessed HSB Service	Name of child who has engaged in HSB	Gender of child	Nature of HSB	Relationship with child/ren harmed
Anna	White British	Married to birth father	12 months	Theo	Male	Contact (Penetrative act without consent)	Intra-familial
Elaine	White British	Separated from birth father (single)	18 months	Jake	Male	Non- contact (sending indecent images and sexually explicit language)	Extra-familial and intra-familial
Laura	White British	Married to birth father (James)	18 months	Karl	Male	Contact (attempted penetrative act without consent) and non-contact behaviours	Extra-familial and intra-familial
James	White British	Married to birth father (Laura)	18 months	Karl	Male	Contact (attempted penetrative act without consent) and non-contact behaviours	Extra-familial and intra-familial
Angela	White British	Separated from birth father (in new relationship)	12 months	Adam	Male	Non- contact (Exposure)	Extra-familial
Sue	White British	Married to birth father	12 months	Kieron	Male	Contact (inappropriate sexual touching of CYP's without consent)	Extra-familial

Anna was the only parent where the HSB was solely intra-familial, and notably her son committed the most physically invasive sexual act. For the other parents, the HSB was either solely or predominantly extra-familial. For example, with regards to James and Laura, although the attempted penetrative behaviour was with a child outside of the family, concerns about their son's use of sexual behaviour and language with children within the family were also reported by the parents.

## 4.8 Ethical Considerations

Ethical approval for the study was granted by the University of Hertfordshire Ethics Committee in August 2016 (Appendix E). In addition, a favourable opinion was given by West Midlands-Solihull REC in October 2016 (Appendix F) and Health Research Authority approval November 2016 (Appendix G). Further local approval was also required (Appendix H).

<sup>28</sup> Names of all parents and their children have been changed to prevent their identification.

### **4.8.1 Informed consent**

Participants were provided with initial information about the study via their 'care coordinator', both verbally and through use of the information sheet. If they consented to me contacting them then I telephoned to explain the study further and answer any questions. This was also to "maximise the opportunity for trust and rapport to be established" (Flowers, 2008, p.26). If the parent was still interested in participating then they were invited to meet with me for a more formal consenting process. This took place prior to interviews at the HSB Service or at the participants own home, at a time convenient for them. During this meeting, I discussed the study further with the parent, the information sheet was revisited and the parent was encouraged to ask questions. If they decided that they still wished to take part following this then they were asked to consent to participate by signing the consent form (Appendix I).

### **4.8.2 Confidentiality**

It was anticipated that parents of CYP who have engaged in HSB may be particularly concerned about the possibility of confidentiality being breached (Hackett, 2001). The information sheet explained confidentiality and participants understanding of confidentiality and its limits was checked prior to them giving their consent. My research supervisors and I followed ethical and legal practice relating to confidentiality, data handling and record keeping<sup>29</sup>.

One issue with regards to confidentiality related to the inclusion of married parents (Forbat & Henderson, 2003). This did however raised questions regarding confidentiality, as through engaging in the interview process parts of their accounts would be publically available (and therefore available to one another). After receiving this additional information, both parents still wished to participate and it was therefore deemed that they had given their informed consent. I interviewed this couple individually rather than as a diad, to facilitate open reflection.

### **4.8.3 Safeguarding issues**

It was agreed that if safeguarding issues emerged during the research process (e.g. there was a concern about the participant's safety or the safety of others), I would discuss this with a

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<sup>29</sup> Information from interviews was anonymised and stored securely. Interview recordings and interview transcript were stored in password protected files on a password protected computer, so that only the researchers had access to them. Information that could be used to identify the participant, their family or anyone else was removed or changed to ensure anonymity and a pseudonym was utilised for identification.

member of the HSB Service team as part of my duty of care. In such an instance the HSB Service would follow their usual safeguarding procedures (e.g., contact with Social Care and/or GP). This meant that in this instance, what the participant said would not be kept completely private. It was agreed that I would do my best to discuss this with the participant first. Participants were informed of these procedures prior to consenting. Some parents did hold concerns about this aspect of taking part, and further discussions about this formed a significant aspect of the consenting process.

#### **4.8.4 Potential participant distress**

It was thought possible that elements of the research interview may be experienced as distressing for parents. As such, it was highlighted that they would be able to take a break or stop the interview at any time. They were reminded of this during interviews at times of particular distress. At the end of the interview, participants were given debrief information (Appendix J), which told them about some possible sources of emotional support. They were advised that they could speak with a professional from the HSB Service following the interview, to talk about any issues raised. They were also provided with the researchers contact details, and were able to make contact to discuss questions or concerns.

#### **4.8.5 Researcher safety**

It was agreed that for some potential participants it was possible to conduct the consent and interview processes within their homes, if deemed appropriate following the HSB Services usual risk assessment process. When conducting home visits, I abided by the Trust's Health & Safety and Lone Working Policies, alongside the HSB Services local procedures<sup>30</sup>. Two recruited participants were interviewed at home and another potential participant was visited yet the identified risk issues prevented recruitment.

### **4.9 Interview Design**

Individual interviews with parents were used as a means of data collection. The interviews were semi-structured in that each interview was guided by the topics which the parent raised as pertinent to them, however also touched on four main predetermined areas of interest

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<sup>30</sup> This involved ensuring that the HSB Service administrative team on the day had a record of the address visited and the time which the visit is expected to conclude. I also made a phone call before and after the research visit.

based on the review of the extant literature:

1. The personal psychological impact of their child engaging in HSB
2. The impact of the child engaging in HSB on the parent-child relationship
3. The wider familial and social impact
4. How parents coped

An interview schedule was devised which comprised of open ended questions related to these four areas, alongside prompts to give interviewees the opportunity to elaborate<sup>31</sup>. The interview schedule was developed with guidelines by Smith et al. (2009) in mind (e.g., considering sensitivity when sequencing questions and using general questions alongside more explicit and specific prompts). It was reviewed by my supervisors, who advised that the number of questions be reduced. Service user consultation with a male foster carer accessing the HSB Service was then used to refine the interview schedule<sup>32</sup> (Appendix K), with subsequent alterations made resulting in a more clear, coherent and empathic interview schedule, which reflected several issues pertinent to parents not previously considered. The foster carer reported that contributing was a positive experience and from my perspective it was a valuable and inspiring collaboration which changed my relationship to service-user consultation. Appendix L shows the adaptation made to the interview schedule through the foster carer's comments. The final draft of the interview schedule listing interview topics and questions can be found in Appendix M. The scheduled was loosely followed in that I did not ask all included questions but did touch on each of the four areas with each participant.

#### 4.10 Interview Process

If a parent consented to take part, then a one-to-one interview was conducted at the HSB Service or in their own home directly following the consent process. Interviews lasted between 55 and 90 minutes and were audio recorded using a dictaphone. During the interview, parents were initially asked some basic questions about how they came to attend the service, how long they had attended for and what intervention (if any) they had received. They were also asked basic information about their child, including their name, age and gender. They were

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<sup>31</sup> I tried to join parents own language and offered tentative summaries to allow them the possibility of correcting misinterpretations.

<sup>32</sup> This involved a one and a half hour meeting wherein he gave his general views on the research and the schedule. Several questions were asked to further inform changes.

then asked to discuss their experiences as the parent of a child who has engaged in HSB. After the interview, the participant had the opportunity to ask further questions and were given debriefing information (Appendix J). They were given a £10 supermarket voucher to compensate for their time and as a token of appreciation for their taking part.

## 4.11 Data Analyses

Interviews were audio recorded and transcribed verbatim by the researcher. IPA was then used to analyse transcripts. There is no one prescribed IPA methodology, however the analysis involves progressing through several stages to identify themes (Smith & Osborn, 2008).

### 4.11.1 Individual Case Analysis

During **stage 1** interviews were transcribed and each transcript read through several times. I made initial notes in the right-hand page margin according to several descriptive and interpretative aspects. Linguistic (significant quotes/ patterns/ significance of words/ expressions), conceptual (theoretical and personal understandings) and reflexive comments were made. This was a dynamic and recursive process, in that I moved back and forth between the transcript text and my inductive and deductive interpretations and comments. **Stage 2** involved making further interpretive inferences with regards to participants' experiences and sense-making, with patterns drawn from the analysis of the data capturing a "broader level of meaning" used to generate subthemes (Langdrige, 2007, p.111). These subthemes were written in the left hand page margin, and were checked and re-checked against the text. During **stage 3**, I went on to list the generated subthemes in a separate document. I then tried to identify connections between subthemes (e.g., associations, similarities, differences) which brought them together. These subthemes were clustered and combined to create superordinate themes. As I did so, I continued to look back to the transcript text, to check for consistency with verbatim quotes. During the **forth stage** of the analysis, superordinate themes and their subthemes were organised to form tables. I used a separate document to list verbatim extracts from the original transcript, checking that I had remained close to the data and making changes where there was not a good fit. This staged process was repeated for all transcripts. In this way, the experience of each participant was focused

on in detail prior to consideration of those of the wider groups experiences (Smith, Flowers & Larkin, 2009).

### **4.11.2 Cross case analyses**

Once a table of superordinate concepts and related clustered subthemes had been generated for each participant, a process of clustering was begun. This was achieved through once again looking for the patterns of connection (e.g., convergences and divergences), this time between participants. To conclude the process, a final table of superordinate themes and subthemes was created, with the experiences of individual parents balanced with those which appeared more generalized. An audit trail evidencing the steps of this analysis can be found in Appendices O-Q.

## **4.12 Establishing the Quality of the Research**

To critically appraise strength and methodological rigour through the research process, the four principles for evaluating the quality of qualitative studies proposed by Yardley (2000) were once again used. These accessible criteria have been deemed suitable for use in evaluating research employing an IPA methodology (Smith et al., 2009).

### **4.12.1 Sensitivity to context**

**i. Relevant literature.** As evidenced by Chapter 2 of this research, a systematic review of relevant theoretical and empirical literature was used to locate a gap in understanding, which led to the formulation of the research question. In Chapters 4 and 5 (findings and discussion), themes will be clearly and meaningfully grounded in the existing research literature and theoretical underpinnings.

**ii. Participants' perspectives and sociocultural setting.** This research made use of service-user consultation in devising the interview schedule, to increase sensitivity to participants' perspectives and contexts. IPA holds that socio-cultural, political and historical influences play a central role in personal sense-making (Smith & Eatough, 2006; Smith, Flowers & Larkin, 2009). Semi-structured interviews allowed for these alongside the influences of demographic and personal characteristics on participants' perspectives to be shared



through parents' descriptions<sup>33</sup>. I highlighted pertinent aspects of the cultural and historical context within which the research is situated within Section 3.2. Interpretations were grounded in verbatim extracts from transcripts, to highlight consistency with participant perspectives.

**iii. Ethics.** Ethically responsible ways of collecting research data were considered throughout, and ethical permissions were given to conduct the research (Section 4.8). I thought hard about the anonymisation of data, removing aspects of the text and the name of the recruitment site due to the possible identification of participants. The ethics of recruiting participants who were known to me and a married couple was considered. That I made use of service-user consultation also speaks to ethics, as such input remains uncommon in this area.

## 4.12.2 Commitment and rigour

**i. In depth topic engagement.** Understandings gained from my past professional experiences of working in a HSB Service were built on and developed through the process of in depth engagement in this topic area through reading book chapters and articles. I tried to ensure further sensitivity to the research area studied through service-user consultation, speaking with lead researchers in the field and discussions with the Service Manager and Clinical Psychologist within the HSB service.

**ii. Methodological competence and skill.** Methodological rigour was upheld through becoming well acquainted with the methodology (reading books and papers and attending research methods lectures including one presented by Jonathan Smith). I also attended the London IPA group on two occasions, benefitting from the ideas generated by the group. Following my own initial analysis, my academic supervisor who is an expert in IPA looked over and commented on one whole analysed transcript, adding additional perspectives on the data. He assisted me in increasing the rigour of my analysis, taking it to a more interpretative and refined level. He also looked over the overall clustering of themes and final list of themes. Following this another IPA researcher independently analysed a section of another transcript<sup>34</sup>. Finally, I took my analysis to the regional IPA group to present a subsection of my analysis, with the group helping me to troubleshoot some methodological queries and

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<sup>33</sup> For example, gender, culture, religion, age, ability, social status, sexuality, spirituality and relationship status (Burnham, Alvis Palma & Whitehouse., 2008; Burnham, 2011)

<sup>34</sup> This was used as a way of refining my analysis and identify further perspectives on the data as opposed to a reaching of consensus of analysis.

highlighting ideas with regards to theme clustering.<sup>35</sup>

**iii. Data collection.** I aimed to sample people who could provide their account of the specific experience under analysis. It was initially hoped that I may be able to recruit through an online community, however it became clear that no such forum existed<sup>36</sup>. As such, to approach parents through the HSB Service was logical despite the limitations such an approach brought (e.g., sense of connection between the research and the professional body, only recruiting parents where the HSB was known to services).

### 4.12.3 Transparency and coherence

**i. Transparent methods.** Clear details regarding the analytic process have been provided within this Chapter and an analytic audit trail has been shared to show the way that interpretations were supported by the data (Appendices N-R). I have also highlighted aspects of my influence on interpreting and constructing the accounts of parents' experiences (Section 4.13). Some details about the parents' characteristics are not shared, as a purposeful attempt to protect their confidentiality.

**ii. Fit between theory and methodology.** The rationale for use of an IPA methodology has been clearly described, alongside the steps taken to ensure that analytic processes were grounded in the philosophy of IPA and its hermeneutic guiding principles (e.g., self-reflexivity, developing the analysis to a sufficiently interpretative level).

**iii. Reflexivity.** Both the constructivist philosophies underpinning this research and the chosen IPA methodology place importance on consideration of the context of the research, and the influence of the researcher on the interpretative process. As such, I have given information about my personal and professional context, considered the possible impact of my own assumptions on generated data and highlighted means of achieving reflexivity (Sections 2.5 and 4.13).

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<sup>35</sup> I chose not to use member checking to check "trustworthiness" of the data following some thought, due to the interpretative nature of the methodology used.

<sup>36</sup> No subculture of support seemed to exist for these marginalized parents and could find no online forums through which I was able to identify parents of CYP who had engaged in HSB. The reason to recruit from a service was pragmatic rather than theoretical.

#### **4.12.4 Impact and importance**

The overall interest and usefulness of this research will be considered further within the Discussion Chapter, which highlights the importance of the insights gained from this research with these parents whose voices are largely underrepresented. Following the interviews, participants were asked whether they would like to receive a summary of the findings of the research in due course (presented in format of broad themes alongside key quotes). A visual representation of study findings was created and can be found in Section 6.2.6 of this thesis. In September 2017 the research was presented both at the international National Organisation for the Treatment of Abusers (NOTA) conference and to the manager of the HSB Service from which parents were recruited. It is hoped that the findings of this thesis will be disseminated wider within the recruitment site (to other professionals and to parents themselves) and through several publications in peer-reviewed journals.

#### **4.13 Reflexive Considerations**

##### **4.13.1 Self as researcher**

In keeping with the studies postmodern philosophical assumptions, as a researcher I feel that my personal characteristics, social context, biases, preconceptions, preferred theoretical frameworks and prior engagement with the topic area influence both the collection and interpretation of the research data (Kvale, 1996; Willig, 2001). I will here highlight aspects of my reflexive research practice<sup>37</sup>. It is my hope that this transparency will provide a richer contextual understanding of the research, illuminating the dynamic interplay between myself and parents and allowing you to interpret the findings reached in a more informed way.

I am a White French (brought up in the UK), middle class 30-year-old hetero-identifying female. My parents are working class raised and hold mixed working and middle class values, educations and lifestyles. I am neither a parent nor have I or to my knowledge any members of my family engaged in what would be considered HSB. In this way, I consider myself to be positioned in these important domains as an 'outsider researcher' (Corbin Dwyer & Buckle, 2009). That said, being part of a family where there have been adversities, secrets and

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<sup>37</sup> Reflexive thinking within research was quite novel to me, however in many ways paralleled the processes of self-monitoring and attention to aspects of transference and counter-transference which were familiar to me from my therapeutic practice.

marginalised voices, and where distress has resulted in contact with services informs my sense-making.

At the start of the research process, I was aware of aspects of my assumption in relation to the experiences of the parents I would be interviewing (e.g., around trauma and shame), mainly informed by my work with parents of CYP with HSB and theoretical understandings about the impact of adverse experiences on the emotional wellbeing of families. I arrived with a sense of compassion.

In almost all interviews, parents and I shared the same skin colour and gender. As such, I reflected that there was a risk that I may minimize differences and make normative assumptions about parents, despite these factors being associated with great variety in the culture, power and privilege in the UK. All parents highlighted additional stressors on their family's lives (e.g., trauma, physical illness, discord and financial struggles). I am part of a family where there have been adversities in some of these areas, with some of our experiences connected in this way.

With such thoughts about sameness and difference came considerations of how I may be perceived by parents. I felt that parents may be aware of my childlessness (although not disclosed to them) and may anticipate an impact of this on my ability to understand their positions as parents. Due to my professional identity, it was likely clear that I am educated to a university level, with empowerment and privilege attributable to this area of difference. I also wondered whether my professional identity aligned me in parents' minds with the professional systems which had inevitably held a role in their journeys following the HSB.

#### **4.13.2 Psychological processes as researcher**

Aspects of this research led to strong emotions, which were more powerful than anticipated and I encountered my own feelings of sadness, hopelessness and frustration. Interview conversations could also be deeply touching in other ways, for example when parents spoke with pride about how they had managed this difficult situation, with interview questions allowing valued aspects of identity to be shared which brought me close to tears on one occasion. These strong responses clearly had the propensity to impact on my positioning during interviewing and analysis.

Bearing witness to parents' stories and distress both within the interviews and when analysing

them had more of an impact on my own sense of inner wellbeing than I had imagined. At times during the process I felt incredibly unsettled, vulnerable and unsafe. Outside of the interview setting, disturbing and vivid dreams (of risky clinical situations) and threatening and intrusive thoughts (e.g., of the possibility of someone attacking me or of crashing my car) invited themselves into my life. Through personal therapy and discussions with my research supervisors I came to understand that these experiences were part of processing what I had heard. The sense of threat which I was feeling was in part reflective of the emotional states of parents whose lives I was immersed in, this perspective adding to my 'ecology of ideas' around parent's experiences (Bateson, 1972).

### **4.13.3 Making sense of self in relation to the data**

I felt that aspects of 'self' influenced what was knowable to me during the interviews (what was shared, what I heard and how I interpreted). It struck me that multiple connected relational and interpretative layers impacted on research findings. For example:

1. Parents perceptions and positioning of me may have influenced what they told me and what therefore became 'knowable' to me through the research process.
2. I may have been drawn to show interest in particular aspects of parents' experiences in more or less overt ways (wording of question, tone of voice and body language), my own views and beliefs becoming known to parents in this way.
3. Particular words, ideas and feelings may have resonated with me due to my current interests in particular psychological theories and models (e.g., systemic, psychodynamic), with certain constructs more readily accessible to my sense-making.
4. My assumptions and meaning-making shaped the research findings particularly when moving from concrete to abstract and implied meanings through the interpretive process.

Engagement in reflexivity before, during and after interviews, in line with best practice in IPA, served to keep the participants own experiences at the center of the analysis. Prior to interviews I considered elements of 'emotional preparing' (Fredman, 2007), wishing to hold a respectfully open and curious stance with regards to parents' experiences (Cecchin, 1987). As highlighted by Ezzy (2010):

"good interviewing is facilitated by a reflexive awareness of, and engagement with, the emotional, embodied, and performed dimensions of the interview" (p. 163).

Throughout the research process I made use of bracketing and reflexivity<sup>38</sup> to increase my conscious awareness of thoughts, feelings and beliefs in relation to the participants and the data (Shaw, 2010). I made attempts to 'observe' these and to consider from which personal and professional contexts I was drawing from. Notably, reflection within supervisory conversations actively shaped the final generated themes. For example, though such a conversation I became aware of my own desire for the results to end 'nicely' and 'tidily' with the last superordinate theme initially generated to capture parental hope and resourcefulness. I went back to the data and adjusted this to reflect the complexity of several parents feeling trapped and hopeless in enduring ways. My desire to highlight this from the data perhaps spoke to my own difficulty in sitting with the parents' hopelessness and an expectation from Western culture about how stories should end.

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<sup>38</sup> I made audio recordings of my own thoughts and feelings after the interviews, filled in personal reflection sheets (Appendix R) and made additional written notes between and following interviews. I also thought about the research within my own psychodynamic psychotherapy and within research supervision.

# Chapter 5: Findings

## 5.1 Overview

This chapter presents the findings of a phenomenological investigation of six parents' experiences, developed through the analytic process described earlier. From the systematic analysis and interpretation of interview data, four superordinate themes were derived<sup>39</sup>. These superordinate themes and their associated subordinate themes will be presented and explored in this chapter, alongside supporting and illustrative verbatim participant quotes<sup>40</sup>. The superordinate and subordinate themes are presented discretely for their summation, however interrelate and overlap to some extent.

### 4.2 Superordinate themes and related subordinate themes

Superordinate Themes	Subordinate Themes
1) A devastated and overwhelmed life	<i>"The whole world came down"</i> : Distressed and struggling
	<i>"It was basically left to me"</i> : Coping alone
	<i>"We're spinning so many plates"</i> : 'Help' as an added burden
2) Threatened and trying to feel safer	<i>"I refused to think about it"</i> : Escaping the awful feelings
	<i>"You keep it behind closed doors"</i> : Hiding in shame
	<i>"I backed away"</i> : Rejected and in retreat

<sup>39</sup> It is acknowledged that findings are socially-constructed and incomplete (Smith & Osborn, 2008) and there is a degree to which others may look at parents' descriptions differently. However, as the analysis was systematic, sensitive and rigorous therefore it is likely that common consensus would be found.

<sup>40</sup> To increase the readability of accounts, the extracts used to illustrate themes have been edited. Where a short segment of material less relevant to what is being reported has been omitted, this is represented with a dotted line in brackets (...). Pseudonyms are used throughout to protect participant anonymity, with additional identifiable information also altered or removed.

3) A Challenged relationship with son	"Where is this coming from?": Searching for meaning by questioning why
	"I just couldn't bear to be around him": Wanting distance
4) Space for hope in the face of hopelessness?	"Something hanging over me all the time": Trapped and helpless
	"It was just nice to think that you're not on your own": Valuing support
	"You just brush yourself down": Inner strength through adversity

## 5.2 A Devastated and Overwhelmed Life

This superordinate theme was the most prominent and took up a lot of the interview space, with all parent's descriptions drawing attention to its importance as part of their experience. It was derived to capture the rich and powerful descriptions of the various ways that finding out about the HSB was a critical life event, with a profoundly traumatising, overwhelming and burdening impact on their lives.



### 5.2.1 "The whole world came down": Distressed and struggling

Across participant accounts, the initial psychological implications of finding out about the sexual harm were referenced, with a spectrum of powerful emotions experienced. The shock of finding out about the HSB was mentioned by all parents interviewed. Parents gave profound



and vivid portrayals of their sudden and overwhelming realisation of what had happened. There was a sense that when it occurred their lives as they knew them fell apart around them, as reflected in the following quotes from Anna:

*Anna: I do remember walking out... and I just collapsed on the ground because I didn't know what to do, I felt everything just come away.*

*Anna: She told me that someone had been touching her so immediately I thought myself you know, who is it? You know tell me I want to know. She said "it was Theo" and just ever... the whole world came down...*

The emotions experienced by parents were variable and complex. Alongside shock, parents described a range of other powerful initial emotions including worry, embarrassment, sadness and anger.

*James: I wouldn't go so far as to say it's rage, but it is... it's a mixture of anger, and disgust, and despair.*

For parents, thinking could become dominated and troubled by the HSB. That the behaviour was sexual in nature appeared to add complexity to their distress, and parents seemed drawn to yet repulsed by thinking about an association between their child, sex and abuse. It felt that they had descended into a dark landscape and were encountering something very "messy". James described how he found it "bloody disturbing" that his son's sexual behaviour seemed purposeful and premeditated in a way which was at odds with 'normal notions of childhood' and representations of innocence.

*James: ...it wasn't just a young kid experimenting and you know maybe playing doctors and nurses, and curiosity, why have you got that and I've got this type of thing. Because it was more sort of contrived (...) he chose the child because she couldn't speak, that really disturbs me. Really, really troubles me.*

Anna was also troubled and disgusted by her son's behaviour, here describing her discovery of hardcore pornography on his laptop prior to the HSB disclosure. Her response in relation to

my enquiry about her experience appeared to reflect the magnitude of her distress; still now it appeared too disturbing to be thought about.

*Anna: It wasn't just your standard porn it was really horrible... yeah quite hard-core stuff... a lot...you know.*

*I: What was it like for you to come across that?*

*Anna: I just felt sick.*

Anna's son's engagement in intra-familial HSB retriggered memories and feelings in relation to her own childhood sexual abuse. She clearly described identification with her daughter as victims of abuse.

*Anna: ... in the end her abuse...I go to bed it turns into my abuse and I can't go to sleep where I feel like we've got this awful connection in a horrible way.*

Her words highlight that in intra-familial abuse parental perceptions of the child who is harmed is also changed. Anna went on to describe feeling caught between her children, with divided loyalties seeming to heighten her distress.

All parents reported that they became consumed with a search to find a reason for their child's behaviour, such thoughts appearing circular, relentless and psychologically draining. Parents could locate responsibility in their parenting therefore feeling that they had failed to meet the 'good parent' ideal. Although trains of thought such as "where have I gone wrong?" resulted in painful guilty feelings, such self-blame seemed to function as an attempt to find sense in a complex, uncertain and confusing situation.

*Elaine: I felt like a letdown as a parent. I felt like...is there something that I could have done to stop him?*

*Laura:...in the quiet times I think god...do you know what...how...this is my...my fault really. The guilt is horrible, it really is.*

Parents described how the degree of psychological impact was great, and they struggled to function on a day-to-day basis. The words “hard” and “tough” were used many times. Parents spoke of additional problems within their family (e.g., conflict, mental illness, physical illness), which added to their sense of being emotionally overwhelmed. Elaine, described how “everything is a struggle”, particularly due to the added stressors of parenting alone in a cramped house.

*Sue: ...everything was coming in on the top of me, and I found it really difficult to cope.*

For Anna, hearing voices was a sign that she was overwhelmed.

*Anna: The cracks started to show because I was hearing voices, and usually that's like a start of it... one of my triggers if I'm stressed. I ignored it, um but then actually I started listening to them again... and talking to them.*

For Laura, who was married to James however described being otherwise socially isolated, distress was experienced as an episode of significant low mood, anxiety and sleeplessness.

*Laura: I got really down, really depressed, everything was a problem um...everything was just really hard. I felt stressed all of the time.*

Angela, Sue and James described how they found themselves unable to easily separate from thoughts related to the HSB and struggled to sleep, emphasising how “things play over in your head” and “you can't turn off and you just...mull things over”. When invited to specifically consider the kinds of thoughts which prevented sleep, parents highlighted fears for the future and worry about circumstances over which they felt they had little control.

*Sue: I didn't...couldn't sleep at night because you know I was thinking about everything that was going on and um...and then I sort of got worked up, and the more that I got worked up the more that I couldn't sleep.*

From parents' descriptions, it was an added burden that they were unable to relinquish caregiving roles whilst processing their feelings:

*Anna: I was wound up or I would be feeling things and I couldn't talk about it, because Theo was there.*

Experiences of being completely overwhelmed and consumed had the propensity to limit the parents' availability to the child as well as their protective capacities, as highlighted by an extract from Anna:

*Anna: She asked where the children were and I said "I'm not sure" and they were across the road and I'd left them on their own, where it just...it just all came down.*

### **5.2.2 "It was basically left to me": Coping alone**

This superordinate theme captures parents' isolation and sense of aloneness with their experience, with all parents reporting feeling that others around them would not or could not support them. There was a clear sense of separateness from others; parents felt they were left to manage both the practical and the emotional aspects of the experience alone. Parents felt that their needs were not met at this crucial time, and with this came an accompanying sense of deep loss.

*Anna: I was trying to juggle everything... juggle too much. Trying to be a mum to Ella, mum to Theo, mum to Liam, a supportive wife... and my mum... I felt like I was popping everyone else up and no one was propping me up for a long while.*

*Sue: ...I was trying to involve my husband in everything...I think that he didn't want to admit that there was a problem and he wanted nothing to do with it, so he was just like "well it's up to you, get on with it" sort of thing. So it was basically left to me and I found it difficult to cope.*

For Anna, holding onto the burden of the situation appeared to be a conscious position, with her pushing her husband away as a means of protecting him in her mind. She later reflected elsewhere that her usual predisposition was to assume this role, at times to her detriment.

*Anna: I don't think he could manage to cope with it, so I sort of made sure I took control of making sure that what things happened was with me...and I sent my husband back to work.*

Sue highlighted that taking on the bulk of responsibility was a gendered position, here speaking in relation to her perception of her husband's attitudes:

*Sue: it was sort of "well you're going with him, I've got to work and I'd rather work than deal with the situation", so again I think it's sort of a Mum thing.*

The impact of gender was also central to James's sense-making. His participation in the interview stimulated new thoughts about his aloneness, bringing into discursive consciousness little previously reflected upon considerations of his emotional isolation, which held strong resonance for him. James was longing for male reciprocity stating "I ain't got any mates that I can share that with", whilst equally appearing to desire the support of a nurturing maternal figure. His tears when thinking about the way that those around him simply expected him to get on with things seemed to reflect the loss of not being held in another's mind.

*James: I do feel selfishly about it when this happens but occasionally I think, nobody's texted me to know how I am. So that has a big impact so... yeah so that's just hit me quite hard actually (crying). Um...(...) no one has texted me to say "how are you dealing with it?". And I guess I take on sort of that...that male role of being the matriarch in the home and being the support and the backbone and the shoulder to cry on, but...(pause). it's sort of like hit me that I don't necessarily have the support.*

Challenges and tensions in parents' relationships with their spousal partner following the HSB were described. These were generally centred around parents' perceptions that their partner did not sufficiently understand them, empathise with them, or help them in light of the current situation. Relational difficulties were manifested in several tangible ways, with descriptions of deteriorations in communication, increasing feelings of distance, and a reduction in sexual intimacy. The emotional separateness could be so great that some parents appeared to be living in almost different worlds to their partner.

*Sue: ...we didn't talk to each other for a couple of weeks, and it did become really sort of strained at one stage. I mean, you know some it can bring couples closer, whereas me and my husband it sort of pushed us apart a little bit. And even now, I mean we're still not sort of 100%.*

Anna, who had been sexually abused as a child, explained that her son engaging in HSB transformed representations of intimacy in her mind, with acts of affection becoming once again connected with a dirtied and sordid representation of sexual violence. Her sexual relationship with her husband “took a massive hit” and she explained that she did not want him “holding my hand or cuddling me in front of the kids”. The couple eventually separated temporarily. Her experience is illustrated with a quote that highlights fused aspects of the way she describes people, experiences and memories, these seeping into one another without boundaries or separation.

*Anna: I didn't want him touching me because it just proved how much sex and violence can cause. I don't know... It doesn't feel right any more, not at the moment. I'm hoping that when I've had my own therapy that might help... sort of... but I just, it always seems to me like it's always...thoughts just turns into negative you know, especially after what Theo has done to Ella it's hard to think about really.*

### **5.2.3 “We’re spinning so many plates”: ‘Help’ as an added burden**

This sub-theme was dominated by descriptions of ‘helping systems’ as bringing added strain to parents’ lives. Aspects of the input from police, social care and therapeutic provisions input could leave parents feeling overwhelmed and powerless, with parents experiencing conflictual feelings in relation to the receipt of the ‘support’ given. Most of the families had been concurrently involved with multiple agencies, and the coordination of their care was experienced as problematic.

For Yvonne and Laura, early interactions with police and social services following the HSB were experienced as particularly distressing. There was a lack of trust in professional responses, with representations of social care in particular as critical and persecutory. These

parents felt they would be in “trouble” and seen as “bad parents”. Laura became terrified that her son would be removed from her and James’ care.

*Yvonne: ... the social worker wanted to take him on his own and I said no, because I didn't trust anybody, I don't trust social workers and things like that.*

*Laura: I thought they'd take him away, um into care or something like that. It was my very first experience of anything (...) so I was thinking wow, I've gone from nothing to this and everyone's gonna just come at us.*

Parents experienced an influx of professional input, with Laura describing how “*the help just snowballed*” and “*when something like that happens they just sort of chuck all of the services at you*”. Appointments and meetings were described as frequent and time consuming, with a significant impact on parents’ day-to-day lives.

*Anna: ...when you got social workers, reviews, and all of those sorts of things...it just feels like every other week it's something else and it's really hard you know. You've got no time to yourself.*

For Laura and James, the level of professional input was experienced as too great, Laura’s words highlighting her perceived vulnerability to the possibility of becoming completely overwhelmed by it.

*Laura: ...what James said was, we're spinning so many plates at the moment, if you come in with your service and you want meetings um, he said actually it's gonna blow. You can't actually keep spinning that many plates. So we're now finding ourselves refusing services.*

Anna, James and Laura spoke of not feeling that their own needs were held in mind by services when planning their provision. As such, there was an underlying narrative of not being cared for and thought of as a person whose wellbeing holds value. Alongside feeling neglected in the considerations of services, equally they felt they were given significant safeguarding

responsibilities and faced with high expectations. Some parents clearly felt frustrated and angry about this, returning to the topic several times during the interview.

*Laura: ...they're helpful but they help the kids. But actually, it's just more pressure on me to get them there or you know, help them afterwards (...), who is this actually helping? Cos it ain't helping me very much. And there's appointments for everything, meetings for everything, and then...nobody actually thinks, hang on a minute I actually have to...I have a life.*

Alongside practical demands, therapeutic sessions were sometimes experienced as “draining” and could consume parents’ thoughts and minds long after they had left the session.

*Laura: Yeah...it's always there...even though it's only really one hour at (HSB Service), sometimes it can be quite intrusive in your life. And... it takes you a few days, especially for me, to just sort of shake it off a bit, to sort of try and snap out of it.*

Anna, spoke of the personally challenging and “heavy’ nature of the focus on issues related to sexual abuse, and of the way that time after sessions could feel taken from her.

*Anna: Because you just sort of want to leave it there, I've done the session, I need to get on and do other things the rest of my day. I can't afford to be still trying to leave myself in this place of feeling a little bit...I don't know...I think because you know the reason why you're here, you kind of come out feeling...it feels heavy (...). Cos it's all based around sexual abuse you know.*

For Anna, there was a sense of a requirement to reexamine memories and ‘bear all’ in an exposing way. There was no sense of agency in being able to choose which information she shared, and in this way Anna appeared powerless to professionals’ demands.

*Anna: I've been very open with her you know, you have to be. You have to give everything up when you come in here, it feels like you have to be an open book, that you have to speak about your life experiences. They want to know everything that's happened from Theo being born to Theo being now. So you got to really dish...dig it all out.*



Laura and Angela described an additional burden of interventions was the impact on their sons' mood. Laura described how following therapy sessions "he'd be awful" and that "school would refuse to have him". She also spoke of feeling guilty about implementing safeguarding recommendations in the home which she felt affected her son's sense of self through their implicit message that "you're a sexual deviant". Angela similarly spoke of her son's distress in relation to safeguarding measures. Her own associated and difficult to tolerate emotions although unspoken were apparent.

*Angela: ...he's got to go to the toilet separately from others (...) And I think that they're watching him a bit more in swimming time. And he does get a bit teary, because um...that he's a freak. That's what he thinks you know. And he hasn't done it for a while, but he has done self-harming.*

That safeguarding procedures could be both practically and emotionally burdensome for parents was clear. Both the focus on maintaining safety by "constantly having to be vigilant" and the worrying threat of any lapses to safeguarding seemed to be "constantly there", maintaining both the restriction on their lives and the pervasiveness of their distress.

*Laura: So it's always in the back of my mind, but now it's a way of life that we have to keep them safe (...) So it is always there. And that's been drummed into me, into us, that we have to keep them safe, we have to keep them safe. And I don't want to lose the kids.*

*James: We need to make sure we know where Karl is, they're not allowed to be in the same bedrooms...he's not allowed um where the children are naked (...). He has to shower and change in the bathroom, and get dressed in the bathroom. Um, so yeah. It's just all too bloody much at times. Absolutely too much. So yeah so we're always on that. Always always always on that um (crying). It feels like a lot (crying). Christ.*

These descriptions starkly highlight the almost chant-like internal voice of parents in relation to safeguarding. This appeared to represent internalised paternalistic messages from services, highlighting a sense of parental loss of power and control. Parents went on to describe feeling judged by professionals, with Laura saying she felt "scrutinised for what I've

done wrong” and distrustful which led her to “pull back” from services and become “not very responsive” and cooperative. Elaine described how professional involvement made her feel incompetent in her role as a parent, with this conceptualized as a shameful and stigmatizing symbol of her poor parenting.

*Elaine : It's like a tie, like something I've... you know I feel like I'm not doing a very good job you know as a parent. Just that I'm not, you know not a strong enough person and you know I just...sort of quite a soft parent and I just don't know how to deal with it all.*

### 5.3 Threatened and Trying to Feel Safer

This superordinate theme captures the methods consciously or unconsciously taken up by parents as means of warding off feelings of anxiety, guilt and shame in the face of a threatening world. Such inter- and intrapersonal ways of relating seemed to offer some protection and relief (albeit temporarily) from emotional pain and function as a way of the parent feeling more in control in the face of highly challenging circumstances.



#### 5.3.1 “I refused to think about it”: Escaping the awful feelings

Across interviews it was clear that parents engaged in conscious or unconscious attempts to inhibit distress, with meandering processes of contact with and distance from emotional pain. Emotional suppression appeared relevant as both an intra and inter-personal strategy, with feelings not only a personal experience but also a relational communication to others.

Particularly in the immediate aftermath of finding out about the HSB, there was a strong theme of disconnection and detachment from the reality of the situation, with limits to the way that the traumatic event was initially integrated into parent's awareness.

*Elaine: It sounds stupid but, I just thought it wasn't happening to me.*

*Anna: I can't really remember the next few hours (...) a bit of a blur really sort of thing...I just couldn't believe it happened.*

*Angela: It's just like as if it was in a bad film (nervous laughter). It's not really happening to you.*

Parents found different ways of coping in the immediate aftermath of finding out about the HSB, however their actions essentially appeared to function as means of blocking out thoughts of the HSB.

*Laura: I remember walking around here and just doing stuff and making the tea and doing this and just...just doing it because that's what I had to do, and I sort of blocked it for quite a while until the kids were in bed. (...) I just refused to think about it.*

*Anna: ...I went home and I turned the radio up really loud because everything was just going round my head and I had I think it was three shots of brandy where I felt... just...just everything was just coming in.*

Elaine carried on "going to work and stuff and just doing everyday things" in an attempt to limit contact with the reality of what was happening, as did Angela:

*Angela: I've just carried on I suppose, I don't...things have been difficult with everything, so I just carried on as normal I suppose and.. tried to blank it out I suppose you know.*

For Anna, something strikingly different appeared to serve a similar function, with her experience of voice hearing offering temporary relief of sorts from the reality of the situation:

*Anna: ...when I'm having them nothing else matters around me.*

Anna, Angela and James spoke of attempts to “bottle up” their feelings or “shove my feelings about things to one side”. James described how he made attempts to control his thoughts and feelings by “compartmentalizing” them as a means of finding relief, although commented that this method was not always successful because his feelings could be close to the surface and easily triggered, seemingly in a way which made him feel out of control:

*James: I have trained and become very good at compartmentalising things and putting them into their little files. That's how I manage it and that's how I deal with it. It's not forgotten, it's not lost. It's still there but it's not in my head at the time, it's filled away. But certain things will trigger that (...) Um... so when those sorts of things happen it all sort of like comes out in a pot if you like. And I just have to remind myself that I'm the responsible adult.*

Alongside internal ways of managing emotions, parents also described how physically finding a space away from reminders of the problem could be beneficial, offering some respite “just to relax yourself” and “just to calm my mind down”. Activities which offered appreciated psychological distance from the current situation included taking on additional hours at work (Sue, James), tidying alone (Angela) and taking a quiet bath (Anna). Angela explained how moving to a new house, although stressful, served as a welcome distraction from thoughts relating to the HSB:

*Angela: That took me mind off things for a bit, cos you're busy concentrating on something else for a change which was nice. When your brain wants to think on it, it's nice that something takes you away from that.*

For Sue, lone walks in nature offered temporary escape from the emotional intensity present at home. She enjoyed this space as not only a place for peaceful awareness of her surrounding, but equally as a context for engaging in thinking and making sense of what had happened.

*Sue: ...just time to get away from the house and just ignore everything and everybody, and it was nice to sort of just sit in the park and listen to the wind rustling through the trees and watch the kids play. It was just like...oh bliss. (laughing). Absolute bliss.*

*Sue: ... that little bit of peace and quiet where I was able to sort of think and sort of work through it what we've gone through, what I've done.*

Throughout interviews there were occasions when I became aware that parents were describing they and their son's present circumstances in ways which seemed to serve as internal and external walls of protection in the context of shame. Some of these may be described as 'minimising' statements or 'cognitive distortions'. It was unclear whether these ways of seeing things were emerging only now in the exposing interview setting or represented usual sequences of approach and avoidance as part of parental sense-making.

*James: ...we've yet to see any evidence that he has sexual tendencies.*

*Sue: ...was it sort of down to that he wanted a friend but didn't know how to sort of approached her and sort of ask to be friends?<sup>41</sup>*

*Angela: ...you know if it's happened to other people then you know it's not your fault. (...) You've got other children and they're not...they wasn't like this when they was young.*

### **5.3.2 “You keep it behind closed doors”: Hiding in shame**

This sub-theme highlights the deep shame evoked by the HSB, and captures parents' concerns about revealing information about their child's engagement in HSB to those around them, due to a belief that they may be fundamentally rejected. Parents appeared to pull away from their social worlds or even remove themselves almost entirely, resulting in isolation and disconnection.

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<sup>41</sup> These ways of describing were quite contrasting to the depictions parents had given at other times, for example Sue describing how her son had isolated another child and touched their genitals without consent.

The sense of wanting to disappear and be away from others in the context of shame was highlighted within parents' descriptions. Each of the parents felt it important to limit who knew about the HSB, choosing to keep the experience either completely to themselves or disclose to only a few select individuals. The idea that others may come to know about what had happened seemed very threatening, and parents anticipated judgement and rejection. As a result, they rationalised that "the less amount of people that know the better" and that they'd "just best keep it private".

*Angela: I really felt that the earth could swallow me up. Just the humiliation of it and it's just like... You just keep it within closed doors sort of thing*

For parents, expectations that they would be judged and related to with disdain and rejection appeared intimately interwoven with societal discourses and "the stigma with sexual behaviour". This was often the driving force for choosing not to speak about the experience when faced with the dilemma of disclosing or concealing the HSB. Angela particularly highlighted the media as a propagator of stigma alongside a perceived lack of distinction in public perception between children and adults who engage in HSB:

*I: And what do you think has um...what made it that way that you haven't told people?*

*Angela: I just think that cos um...embarrassed and ashamed. So that's...just keep it to myself really.*

*I: And what sense do you make of that that you feel embarrassed and ashamed? What about it makes you feel that?*

*Angela: I don't know. Well I think it's just like the media innit. It's a bit like oh god he's a paedophile you know. Just that type of thing that you think that people would think. They might think that your son's a psycho or whatever you know.*

The overwhelming and ultimately shameful nature of sexual harm was a prominent theme across interviews. Parents' descriptions of the seemingly burdensome alternative stories used

to explain why they were attending appointments and the problems they would prefer rather than HSB strikingly shining a light on this:

*Anna: Everyone thought they was just...because Theo had anger issues that was the reason tha.... we just said he just sort of basically hurt Ella.*

*Angela: The stigma with sexual...because self-harm I think they won't think any less of Adam, because of the stigma with sexual behaviour I think that it's better to say that he's coming for a different reason really. I think it's just the media you know...that there's something wrong with your child. You know, there's something majorly mentally wrong.*

*Laura: I would feel much more comfortable saying to somebody at the end of the day yeah he's got ASD and unfortunately his fixation is fire (...). I wish that he'd have an obsession with fire or something...*

Following the HSB, parents felt relationally unsafe and at risk. They described their fear of others' responses should they catch a glimpse of the problem, reflective of the experienced of anticipated persecution. This led to families 'closing ranks', resulting in depleted social circle.

*Elaine: ...if I had people round, if I had anybody round I would be worried about what he'd be like with them.*

*James: ...if you've got someone that comes into your home...and....um...what they might see or what they might hear...it makes you guarded around who comes into your house.*

Parents were concerned about what could happen if others came to know about the HSB, commonly fearing that their private information may be revealed further without their consent as "gossiping" got "out of control". There was a strong sense that others finding out about the HSB would result in a loss of status. Angela spoke of predicting she would be "looked down on" and that "they would think less of me and Adam", highlighting important shifts in her own personal sense of identity. She was also fearful that her and her family may be viewed as 'abnormal' or too much to manage, here describing her reasoning for keeping the HSB secret from her boyfriend:

*Angela: I just think he might think "jeez, what have I got here" you know. I don't know just has he come into a weird family, I don't know. You know, just not the norm really.*

Parents explained that their decisions around disclosure were driven in part by a strong sense of responsibility to protect their child and the broader family from hostility and rejection. It seemed very difficult for parents to know how others would react to finding out about the HSB due to the novel nature of the situation. There seemed to be a lack of a clear point of reference other than the nature of societal responses to problems of this kind, with parents aware of the tendency for sexual harm to polarise people and opinions.

*Angela: I think it's best to keep it private and protect Adam really (...) they could tell their kids "keep away from Adam. I don't think that in school that they would want to know him. You don't want people really like I said just gossiping and saying your sons some sort of dirty young boy.*

*Sue: ...if they knew they'd probably sort of say "well we don't want him around" um that's just the sort...I'm probably being completely overboard but it's just a feeling I've got.*

The idea that disclosure of the HSB would lead to rejection was also highlighted by Laura, who felt certain that other parents may fear for the safety of their children if they knew. As such, with one close friend she chose to keep the information to preserve the relationship.

*Laura: This other friend I've got, I know she'd just be scared like for her kids and just go woa woa woa, no no no and I'd lose her as a friend. So if I don't tell her that then I get to keep her as a friend*

Laura spoke of how she imagined that if she herself was on the other side of being told about a child's HSB she would also back away from the friendship. She alludes that she has withdrawn from other friendships in anticipation of how she predicts other mothers would feel about the possible risk to their child if they knew about the HSB, commenting on her state of isolation.



*Laura: ... if I wasn't in this position and I was the other side I would just think, actually if it's that friendship and I put my children at risk, actually I wouldn't have that friendship. I would just be like it's not worth it. That's what I base that on really. Which is why I've got no friends.*

Laura described how the shame experienced as a result of her son engaging in difficult to manage behaviours at school alongside the HSB led her to draw away from the world around her, resulting in an insular and confined life.

*Laura: I just stayed in, and I didn't even go to the shops. I used to just stay in (...) I probably didn't go out for 18 months something like that. (...) I was ashamed really and just...I used to hide that was it. Literally I'd be in here, I'd have the blinds shut and wouldn't really do much I'd just be like that all day long.*

She reflected that this isolation had detrimentally impacted on her wellbeing, leading to “depression”. This state appeared to mark a sense of loss of a valued self who was acceptable to others and a sense of there being no route to repair.

### **5.3.3 “I backed away”: Rejected and in retreat**

Although all parents held expectations that they may be rejected in the context of others coming to know about the HSB, for some there were actual experiences of pushed away. Elaine for example described her mother’s response to finding out about the HSB, and the impact it had on her sense of connection with her family. In addition, Laura described rejections from her own father as well as the father of her son, indicating that the situation was too much for them to deal with. In these examples, it struck me that perceived rejection of the child perhaps also felt like a rejection of themselves, with their children as an extension of their being.

*Elaine: ... she didn't really want him around. It affected me in that way because I felt like I couldn't um...you know (pause) ...have him around all my family.*

*Laura: My dad stopped seeing us after Karl had his problems, because he couldn't deal with it.*

Anna shared an experience of information about the HSB being shared between friends without her permission. She described how the person who had been told about the HSB stated “what I don’t get is how you can stand by your son” and told her that her son was no longer welcome in her house. This sense of being “judged” impacted on her in a profound and painful way, and she subsequently made an attempt to end her life.

*Anna: I just tried to jump, alright I... someone grabbed me and you know I was just screaming and screaming and screaming (...) I'd trusted people and they just done this to me. And I nearly ended it because of them.*

For Anna, the experience of confiding and having the promise of confidentiality broken seemed to leave her feeling stripped of all protection and unsafe. She described how “I don’t talk about that anymore with anyone”, “I wouldn’t tell anyone else again ever” and “it’s made me a bit more wary of people”, highlighting that such an experience could serve to prevent future parental help-seeking. Anna subsequently distanced herself from friends who knew about the HSB and made new “friends at a distance” with whom she did not have to engage in emotionally open and therefore vulnerable conversations with:

*Anna: I just backed away and made sort of...not new fr...you know...I made friends but it's more friends I can just go out with and have a good time with, not talking about your personal life.*

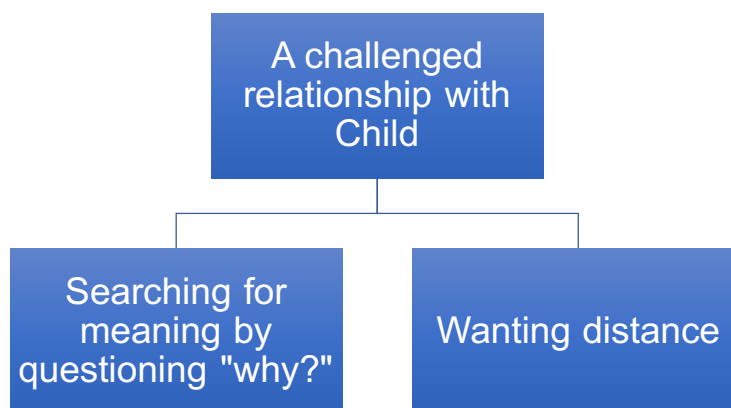
For James, the rejection experienced in his relationship with a male friend was more subtle. He felt that the friend began to cast judgment over the situation and over his son, which led to greater distance within their relationship.

*James: ...the perception is that you've got somebody like Karl who's got the propensity to do the things that he does or has done, it comes down to that sort of like well it's not fair (...) Why can't decent people win it, you know? (...) So, I think he might have a sort of like thought in his head like that you know. It's come across as being like that sometimes.*

Laura felt rejected by other mothers at her child’s school, which she perceived was due to her son’s behavioural difficulties and neurodevelopmental difficulties. She described how “the other mums don't make friends with you, do you see. Because they're like your kids got special needs”. Because she already felt quite different from other mums and perceived that they could be “really bitchy”, this increased her reluctance to speak about the HSB and she became “quite secretive”.

## 5.4 A Challenged Relationship with Child

All the interviewed parents described a significant impact of the HSB on their relationship with their child, this superordinate theme capturing the nature of this impact. Their perceptions of their child seeming to form part of their sense-making with regards to the cause of the HSB, and parents highlighted shifts in the way that they viewed child and their sense of closeness with them.



### 5.4.1 “Where is this coming from?”: Searching for meaning by questioning why

Through parental sense-making processes following the HSB, a range of explanations had been generated about the cause of the behaviours. Such explanations varied widely and were at times conflicting, reflecting the complex nature of the parent’s struggle to understand the family’s current circumstances. One common explanation was that the HSB problem could be attributed to a fundamental quality held by the child. Several psychiatric labels were mentioned

across the interview, with such labels seeming to play a pivotal role in parental understandings about causality and what the behaviour 'means':

*Angela: He doesn't seem to know what's right and what's wrong. I still think that, that's something I don't know really like mild case of autism or ADD, it's something that... even he described it one time, he said I just can't stop, I can't think my brain's too busy.*

James, who described his son's behaviour as "almost sadistic in nature" spoke of how he used the concept of paedophilia when making sense of the behaviours, again pointing to a fixed cause, this time an enduring sexual perversion.

*James: You know we both understand how Karl is to an extent. You know what he is, because it becomes a what in my mind you know. Unfortunately or fortunately people are labelled based on their behaviours and what they do. Um...you know, words like sexual deviant come to mind, paedophile comes to mind, um...all those things come to your head.*

For Elaine, the nurture of her son's HSB difficulty was intrinsically linked with his male gender.

*Elaine: ...boys will be boys and you never know what they'll get up to.*

Although for several parents, there was very little meaningful consideration of systemic or familial hypotheses in relation to the cause of the HSB, this was not always the case. Angela and Elaine positioned the relationships between family members and resulting psychological distress for their child as central to the HSB. For both mothers, their son's experience of parental separation held an important role. Hypotheses of this nature appeared to result in more empathic responses to the child, however to allow for this the blame moved to someone else.

*Angela: ...he needs someone to tell him that he's important, that he's loved, is he you know still really bitter about the break-up cause you know at the end of the day he wants his dad around.*

A second strong pattern across interviews relevant to this subtheme lay in the striking and sudden changes in parents' perceptions of their sons. Some parents felt that their son could unpredictably shift between two kinds of starkly different presentation. For others it felt almost impossible to integrate the 'innocent' son they knew who was "my little teddy bear" and "my little boy" with the son who had engaged in the HSB. This splitting of 'good and bad' could be so fundamental that they constructed their son as having two completely separate personalities.

*Angela: ...bit like a split personality really, one minute you know he can be shy and cry and next minute he could be shouting and screaming.*

*Anna: Every time I looked at him... I...I just felt sick. I felt like I was looking at a monster and then in the next hand he starts talking and then I'm looking at my son.*

Such splitting could be experienced as almost seductive to parents, who could feel drawn in and controlled by their child. When the parent appeared to assume that their son was purposeful in their behaviour, this led to greater resentment and even fear. The relationship could appear so fragile that the child ended up holding a powerful position in the family.

*Anna: He was rude, he was just not very nice to be around but at the same time when he'd drop these attitudes he could manipulate you...to adore him um he would be so loving and you never knew what you got.*

*Laura: The relationship with Karl, I'm always very careful, very wary of him. James will go mad because he says that I spoil him, I put him on a pedestal. I do, I just try to keep him happy.*

For Anna her own psychological trauma clearly impacted on her perception on her son, with the intergenerational impact of abuse marked over the course of the interview. In particular, there was confusion between her perception of her son and her perceptions of his father who had perpetrated acts of sexual violence on her. For Anna, they were inextricably linked with no boundary or distinction, and it was as if her son's mind and body has been invaded by his father's perversity.

*Anna: It's frightening the way that I look at Theo. You know it's horrible but you start to think...I can remember his dad's sexuality and his own curiosity with things and I can remember how hard-core it could be and how painful it could be and I start to think is it... it's weird, like that person has gone into Theo, like he's turning into his dad right before my eyes and I can't stop him, they're very similar and it is hard to look at him sometimes.*

The sense of terror experienced in Anna when her son was transformed into his father in her mind was clear, this bringing up questions to my own mind about the ways in which he, in being positioned as an abuser, may be drawn to take up and enact such a position. Anna's maternal availability could seem particularly limited by intergenerational issues of power and abuse.

#### **5.4.2 “I just couldn't bear to be around him”: Wanting distance**

In the context of difficult and overwhelming feelings and attributions in relation to their child and what they had done (e.g., anger, disgust, fear) as well as themselves as parents (not good enough, to blame), all parents at some point experienced a desire to emotionally and physically move away from their child. James spoke of how it was the disgust and resentment he felt towards his son which contributed to his desire to withdraw:

*James: At times he absolutely disgusts me. And I find it exceptionally difficult to deal with those emotions.*

Sue described how she “just couldn't bear to be around him”. Her account highlights her experience of her child's dependency as almost unbearable.

*Sue: I just felt as if I just wanted to sort of push him away. I couldn't bear him giving me hugs and kisses and I was sort of like he's not my son, but I've got to deal with this.*

In a description similar to that of Sue's, Anna also spoke of her sense of responsibility to her son as his mother. She described the utter confusion she felt in relation to her conflicting feelings towards him.

*Anna: I couldn't understand all of these feelings that I was having of hating him, loving him... And then also trying, I don't know, to be there for both of them, when I didn't really want to be there for him but...I felt I had to because I was his mum.*

Later in the interview, Anna spoke of finding relief following her son's removal from the family home. The painful nature of disclosing that the HSB had impacted the love she felt for her son is apparent in her fragmented speech:

*Anna: I think I've taken a step back now. We maybe watch a film together but I'm only seeing him for a couple of hours. And I think our relationship is better this way, healthier for both of us because I don't think...you know... I don't think I... you know... I don't know if I love him the way that I did before, I think it's changed.*

Anna spoke of how she perceived her son was managing well following the HSB, highlighting resentment towards him for this. Her account highlights how part of her desired for him to suffer for his actions, perhaps as a punishment for not only the pain which she felt had been inflicted on the victim of his HSB but also on her vicariously as not only his mother but also as a victim of sexual abuse.

Anna: ...he's thriving and he's happy and so far everything seems to be going well you know...it makes me angry...partly.

In relaying a recent conversation with his wife Laura, James's described how circumstances were propelling the family towards separation. It seemed that his son was at risk of becoming a Pariah, cast out of the home:

*James: There's a lot of things that have been brought into this house because of Karl's behaviour. And I guess from my perspective there's a significant amount of resentment from that. I do say to her that, you know, we need to think about whether he can continue to stay in this house for the welfare and the benefit of the other children and ourselves.*

Some of parents Laura's descriptions provided insight into the way she had in the past experienced her son as an embodied representation of the harmful sexual act, with his presence alone triggering painful memories. As such, physical distance from her son appeared to function to limit the emotional pain of remembering traumatic details about the HSB. Her description highlights a journey over time in relation to this experience.

*Laura: I don't look at Karl and think about it all the time now. I did for years.*

Longing for distance from their child or holding hateful feelings towards them as the person whom society dictates they should protect at all costs seemed to lead to painful feelings; the symbolic cord between parent and child could bring great conflict. In time, some but not all parents appeared to move forwards in regaining an interest in their child's internal world, showing concern and compassion towards them and desiring to reconnect with them.

*Sue: Something made me think well up until now I've been pushing him away and maybe you know, maybe now he does want to have a cuddle he needs his mum around. You know we've got to do something. I kept trying.*

## **5.5 Space for Hope in the Face of Hopelessness?**

This superordinate theme was derived to capture parents' descriptions of feeling both trapped in a perpetually continuing crisis as a result of the HSB, unable to move on with their lives and conversely their sense that there was possibility and hope going forwards. There was variety in the hopefulness parents could hold on to, as they moved through both their lives following the HSB and the process of recounting aspects of this journey through the interview itself.





### 5.5.1 “Something hanging over me all the time”: Trapped and helpless

This subtheme aimed to capture participants’ enduring preoccupations in relation to the HSB and their sense of being stuck within, confined by and powerless to the situation at hand<sup>42</sup>. For some parents, the continuation of the emotional and practical consequences of the HSB seemed never-ending. It was as though they were unable to move on with their lives, instead powerlessly and hopelessly living life in the shadow of the HSB, able to focus on little else.

Anna spoke of the dominating nature of her thoughts in relation to the HSB, her account highlighting her view that this intensity of preoccupation was not ‘normal’ and in some way outside other peoples’ range of experiences. She went on to describe a prevailing emotional numbness, with a lack of enjoyment in aspects of experience.

*Anna: it just overtakes everything...every thought that you have. It’s always there, its constant... it’s not normal you know. Even when I’m around my kids and were playing a game, I don’t quite feel as natural anymore...I feel like there’s something hanging over me all the time*

For Laura too, there seemed to be no escape from the situation.

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<sup>42</sup> The subtheme ‘Feeling Trapped’ was also intimately woven with the superordinate theme ‘Distressed and struggling’, however its connection with parents’ connection with hopefulness appeared particularly significant.

*Laura: This never moves on, this has been going on for years hasn't it. And it's not moved on and it won't move on. Actually, the only way it's moved on is it's got worse, so this will go on for years for me. There's no break. There's no respite from it.*

For Laura and James physical distance away from their son (when James was at work and during their son's respite care) was not synonymous with relief. James described that whilst he could gain physical distance he did not find it possible to distance his mind from the goings-on at home, with Laura equally unable to find separation.

*James: It's not sort of like total exclusive time away from home. Um you know we do talk, and if there are difficulties she'll share them with me, so whilst I'm not here in body I'll be here in mind.*

*Laura: You think that that's lovely respite but all I do is instead of dealing with it here I deal with it on the phone, and that's it.*

James also felt that it was the close contact with his son's engagement in HSB which resulted in a lack of subsiding of his strong emotional responses to it.

*James: ... things like Jamie Bulger, Baby P, you see media, you hear these things but your shock is short-lived, because you're not close to it. When you're close to it...it stays with you a lot longer (...) at the time you might be disgusted, shocked, horrified um...but then I think those reactions are short-lived because it's not in your life. But when it's happening in your house and it's constantly in your face it stays with you.*

He also described how his son's continued engagement in "disturbing" cycles of sexual enactment in the home and elsewhere following the initial (and most serious) instance of HSB resulted in him feeling unable to move on:

*James: A lot of Karl's sexual presentations over the years since then um are really quite disturbing. Um and that I think to me that doesn't help to um, to*

*put those sorts of thoughts at rest and move on. Because it's a constant reminder of what he did.*

Parents minds were also preoccupied by “worrying” thoughts about the possibility of their child harming again in future, such as “where is this leading”, “what is he capable of” and “is it going to get worse”, alongside an enduring and powerful sense of threat.

*Laura: I'm expecting trouble all the time. Always we're on high alert, always.... it affects every bit of life.*

*Elaine: You can't be normal it feels like it's quite worrying and scary that everyday he's um, your worrying about whether you know it's gonna happen again.*

*James: What if in years to come we get a knock at the door and it's the police come to arrest Karl because he's raped somebody? Because that is potentially possibly in our minds where this might lead.*

Safeguarding procedures were felt by James to exacerbate this, keeping the problem in the foreground of his thinking and maintaining the sense of pervasive threat.

*James: It's just constant reminders that maybe will spark up an "oh my god, here we go again", or "what on earth has he done now", or " why on earth's that happening?", and the fact that we've got all this safeguarding around the home, and when um...it's just constantly there.*

### **5.5.2 “It was just nice to think you’re not on your own”: Valuing support**

This subtheme aims to capture parents’ experiences of both professional involvement and personal relationships as providing pathways for support, these resources enabling containment and a sense of the possibility of a better future.

With regards to professional input, for most parents it was felt that therapy held at the HSB service had resulted in important changes and improved outcomes for their child:

*Sue: He seems to have completely changed. But it's only since he's been doing these courses at (HSB Service) that he's been able to...whether it's having somebody outside of the family to talk to, and he's able to sort of open up more I don't know, but whatever it is it's worked.*

*Angela: ...(it) does help him coming here you know like um...the rules and steps he's got to do if he feels frustrated or...he's learnt a lot of ways to cope with it.*

Parents felt that something which had changed their child's trajectory was the advice and practical input which both they had received in relation to parenting. Elaine, Angela and Sue in particular reflected that their confidence as parents had increased and they now felt more able to set boundaries at home:

*Angela: It's very good information. Obviously it helps you to like when you praise your child don't concentrate on the negatives too often you know. You must praise them and when you praise them actually say what he's done. So like labelled praise yeah.*

*Sue: She suggested sort of compromises or ways to deal with it and how to sort of approach that particular subject um... Yeah so it has been good to have somebody sort of come up with other ideas and sort of suggestions.*

Parents also described the benefits of the emotional support received from the HSB service. Speaking of their therapists, parents described how:

*Anna: She seems lovely to talk to and she's been really supportive and an easy listener and at the same time gives quite good views about how to think differently about things and gives you a lot of things to think about.*

*Sue: She was really good and she sort of you know if...she said if it got too much you know I could ring her and we could have a chat and she'd sort of*

*find ways of sort of dealing with the situation and sort of having somebody to talk to, she said "it might help".*

For Anna, family therapy sessions provided a context for an important shift in the quality and openness of communication between her and her husband. She also described how these sessions facilitated greater honesty in communication with her son, supported by the perceived sense that things could be discussed safely in this space.

*Anna: ...he's talking more so it means that I talk more...cos he was in the family therapy, we talk about it, discuss it, so when we're at home we can discuss it. And then we feel...ughh...yeah actually we do feel better now and we're talking about it, where before that didn't really happen.*

*Anna: ...when we have family therapy sessions you get to speak out. I wouldn't want to do that with him if I was on my own. I think having professionals around does help with that. Where you can say how you feel but they're there and it's safe...*

Whilst it was acknowledged that professional help was needed, importantly for these isolated parents the HSB Service could provide a context for meeting other parents who had been through similar circumstances. Peers were seen as a resource; people who had been through it and had developed expertise in coping with it. Parents didn't hold the same worries about being judged that they did in other relationships in their lives.

*Sue: I think it's easier to sort of talk to other parents than it is professionals. Because I mean the professionals can only go so far.*

*Angela: They knew why we was here. The children obviously done the same. So we was all in the same boat really and it was like no stigma really was there. Because they can't look down on you so you know you're not looked upon any different. So it was nice to chat to the mums. And it was uh (pause)...yeah cos I think that that was...especially cos I kept it private, so like with these mums it was OK to talk.*

Angela strongly highlighted the importance of not feeling “like the odd one out” and there was a connection with an experience of normality in how contact with peers made her feel. After feeling that she was in a parallel reality to others, finding people with a similar experience seemed to be of importance, their support and empathy providing something of an antidote to her shame.

*Angela: I suppose it's just you know that someone's been in the same position as you so you just...it was just nice to think that you're not the only one, you're not on your own.*

Sue also saw the importance of contact with supportive peers, although her perspective was a hypothetical one as she had not had contact with other parents as part of her son's intervention. She yearned for such a connection, feeling that other parents would understand better than anyone.

*Sue: I think that it would have been good. You know that you're not on your own, there are other families that have been through these sort of situations and we can sort of talk to them and find out how did they deal with it. Cos it was sort of like not knowing who to talk to, it's sort of like...I think if we'd had that sort of support group of some sort then you know you'd probably find it easier to cope with the actual situation that you're going through.*

Alongside professional help, some parents who chose to take the risk of telling friends or family about the HSB subsequently received much appreciated help, reassurance, encouragement and support. For these parents who were stood on unstable emotional grounds, such relationships could provide safety, containment and empowerment, bolstering them at a time when they needed it most.

*Sue: She said, “from here...at the moment you're down there (gesturing with hand), but now we can only go up”, she said “it can only improve now, we've just got to work at it one day at a time”. And she's been there ever since. She's been absolutely brilliant.*

*Anne: ...with my mom, actually she's been pretty amazing. She was there for me, she listened to me, we'd openly talk about it and she was a really good rock to have.*

Sue's mother also appeared to hold a containing function through her qualities of emotional receptivity and tolerance:

*Sue: I used to sort of go and say "look I've had a bad day, can we talk?", and I'd go over there and we'd have coffee and I'd sort of literally shout and scream and yell and she'd sit there and like "Got it out of your system?" "Feel better now?", you know and she didn't sort of like go "how dare you talk to me like that", she was just there. And then she'd give me a hug and sort of say "we'll deal with it, we'll get there".*

Despite the potentially fragmenting impact of HSB on relationships, this challenge could also provide a contact for increased closeness and unity. In describing their families, Laura explained that "we all like pulled in" and Anna described how "we've got a lot stronger". The loyalties held within some families were striking, such relationships appearing to lighten the burden of the HSB on the parent's life. Some parents also spoke of the way that, despite the vulnerability involved in disclosing the HSB to friends, doing so could also bring closeness:

*Anna: So we [sister] were very close and she sort of was really supportive... very supportive with practical stuff. So, is sort of has affected but then it's probably brought us closer in one way rather than apart.*

*Sue: The friendship there hasn't really changed, if anything we've got stronger if you like.*

For James and Laura, their relationship with one another was described as beneficial and valued. They felt that the maintenance of their marriage despite this extreme test to their family was due to their deep care for and respect of one another. They spoke of being thankful that they had each other to talk to draw strength from, and there was a clear relational quality to the decision made by them about how to manage the HSB.

*Laura: If I'm worried I call him up and I say listen to what's just happened (...) this is what's going on, and we'd discuss it and we'd come up with a plan together so it's not all on my head.*

*James: I guess the good thing is that Laura and I do discuss it, you know openly.*

### **5.5.3 “You just brush yourself down”: Inner strength through adversity**

For some parents, there was a movement from a more passive stance, to one within which they were positioned and positioned themselves as active agents in their lives. As such there was a sense that they held resources and capabilities which could assist them in coping with the situation moving forward. Within a narrative of determined commitment to make things better for their child, parents took steps to deal with the problem including finding avenues of support, engaging in treatments, working on their parenting, safeguarding their child and trying to improve their relationship with their child. In proactively making attempts to ameliorate the situation, parents appeared to develop a greater sense of control, self-efficacy and confidence.

*Sue: I've had to deal with me and Kieron on my own. Um...you know I've had to sort of deal with all of the meetings, going to the police station, um dealing with the social workers, all of the paperwork. And it's just been down to me, um and I sort of feel that if I can cope with that then I can cope with anything and I'm sort of a much better person. So yeah I'm definitely a stronger different person.*

Many of these parents had, through negotiating the challenges brought forth by the HSB with courage and tenacity, developed a sense of pride and achievement.

*Angela: ...it feels a bit like an achievement you know, we've done it we've stepped up to it.*

*Laura: I suppose where I am now is that I'm quite proud because I've worked hard. And I did it myself.*



The HSB had not simply been a one off difficult experience in isolation for these parents. There was a backdrop of other adversities which had required them to call on their capacities of resilience and endurance, bringing to mind the image of strong trees that weather storms.

*Angela: I've always been quite determined and it's like uh with my other sons I have been a single parent before so...been quite strong and stern and then um, and now it's happened again I just think to myself I've done it once I can do it again. You know you just brush yourself down and pick yourself up kind of thing.*

*I: And do you think that kind of mindset has been helpful in this situation?*

*Angela: mmm hmmm yeah. Just like um, and now they're just distant memories so...this will be too you know.*

As Elaine, Angela and Sue approached the end of their treatment they reflected on the process of change that had taken place in both their sons and themselves. For these mothers there was the sense of there being space for hope for the future, as they aspired that their lives could come to be painted in a brighter colour.

*Angela: Life does go on dun'it, time goes past you know quite fast so...I mean especially with Adam, he starts a new school in September so...and he's going to a good school as well.*

*Sue: ...you know there's light at the end of tunnel, you've just got to deal with it first. You've got the problem this end and the lights that end.*

## 5.6 Summary

Overall, findings spoke to the overwhelming nature of this experience and the gravity of its impact on parents' lives and relationships. They described finding ways of negotiating distressing thoughts, feelings and memories connected to the experience, as a way of getting by day-to-day. It was common for parents to withdraw from their relationships with others, feeling deep shame about what had happened and what it meant about them and their family. They could also experience complex and confusing feelings in relation to their child. Connections with and the reactions of family, friends and professionals could bring further

distress at this difficult time, through parents' perceptions of rejection and the subsequent pain experienced. However, it was also the case that relationships could act as a lifeline, providing much needed support and containment and impacting on the parents' sense of self. Many parents remained stuck in an emotionally intense place, although for others it was possible to feel some hope for the future, particularly when they felt the support of others and when they trusted in their own capacities to manage and get through this difficult time. These findings will be discussed in greater detail in the following chapter.

## Chapter 6: Discussion

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### 6.1 Overview

The findings from interviews with six parents generated through the process of IPA resulted in four superordinate themes. This chapter will discuss these findings, highlighting a number of possible ways of understanding parental experiences and situating them within the context of existing theory and literature. This research represents an important contribution to knowledge in this little researched area and as such holds implications for clinical practice, which will be highlighted. Methodological strengths and limitations and important areas upon which future research may focus are discussed.

### 6.2 Summary of Findings

#### 6.2.1 Consumed and overwhelmed by what is happening

The theme '*Consumed and overwhelmed by what is happening*' speaks to parents' experience of the HSB and its consequences having an unexpected and traumatic impact on their lives, leaving them feeling very unsafe. Parents experienced significant distress and symptoms of a trauma response, mirroring the wider literature on both PPF's (e.g., Duane et al., 2002; Pithers, Grey, Busconi & Houchens, 1998) and family members of individuals who have caused harm to others (Condry, 2007). Parents' descriptions of their varying emotions following the HSB were in line with research which highlights non-linear emotional responses in the context of difficult and distressing life events (Creek et al., 1987), however worry, embarrassment, anger, despair and disgust were commonly highlighted. The HSB and its consequences seemed, at least temporarily, to rip apart the fabric of parents' lives and send them into a state of inner turmoil.

Seemingly as a means of restoring order and meaning, parents became motivated to form a coherent account of what had happened and why. That circumstances were often murky with no easily definable singular cause seemed to present a barrier to meaning-making, resulting in even less of a sense of predictability and control and perpetual all-consuming searching. Similarly, Hackett & Masson's (2006) highlighted that PPF's could find a lack of certainty upsetting, a finding mirrored within the wider literature on loss (Rando, 1993). Some parents blamed themselves and questioned their own worth, consistent with the wider literature

focusing on PPF's (Jones, 2015; Pierce, 2011). Meaning-making of this kind appeared to exacerbate their distress.

The HSB problem saturated parents' minds and, at least initially, they struggled to manage day-to-day life. Holding a parental role whilst being involved in treatment and experiencing their own emotional responses in relation to the HSB was a heavy burden. Their parenting skills along with the provision of support and safety for their child were at times compromised, a finding rarely mentioned within the literature on PPF's<sup>43</sup>. For many parents this was not the only strain on their lives, with multiple familial stressors including isolation, ill health, discord, separation and loss, abuse and social disadvantage. One mother highlighted how her son engaging in intra-familial HSB retriggered memories and feelings in relation to her own sexual abuse, in line with findings from further studies (Hackett & Mason, 2006; Hackett, Balfe, Masson, & Phillips, 2014). Whether these pre-existing problems and life events made parents more vulnerable to the impact of the HSB was not possible to determine. However, it doesn't seem a great leap to suggest that wider familial experiences resulted in parental distress over and beyond that imposed by the HSB. This highlights that parents' psychological responses to the HSB should be placed within a much wider web of psycho-social factors which interact to make the impact of this event ever the more complex.

For parents, having their child engage in HSB was reportedly a lonely trauma, as they perceived that others were not there to support them at this difficult time, mirroring research into the experiences of PPF's (Jones, 2015; Thornton et al., 2008). As highlighted by Pithers (1998):

*"It is easy to imagine the psychological weight that parents must carry...particularly when they believe that there is no one with whom they can talk about their private anguish" (p. 139).*

A particularly striking and novel finding related to the deleterious impact of the HSB on parents' emotional connectivity with their spouse. Parents commonly did not feel held in mind by their child's other parent. Within this study, the father interviewed spoke of feeling he was simply

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<sup>43</sup> In the wider literature, it has been conceptualised that a reciprocal, bi-directional relationship is formed between parental and child distress (Brofenbrenner 1979; Lombardo & Motta, 2008). A child's behaviours can result in significant emotional disruption for parents and can increase parental distress (Gross, Shaw & Moilanen, 2008; Neece, Green & Baker, 2012). In addition, high levels of parental distress may directly influence a child's developmental context by compromising the parent's responses to their child's behaviours and reducing their ability to interact with their child in supportive and containing ways (Anthony et al., 2005; Neece, Green & Baker, 2012; Webster-Stratton, 1990).

expected to emotionally cope and mothers reported that they were expected to take greater responsibility in responding to the family crisis. This finding mirrors literature on the experiences of parents of CYP who have MH difficulties (Walters, Tasker & Bichard, 2001) and sits alongside feminist theory which identifies socially and politically driven gender disparities as a contributor to difficulties in family functioning (Bem, 1993; Hare-Mustin, 1978). That parents struggled to benefit from social resources (e.g., family, friends neighbours) and engender a context of support and care within which emotions could be safely expressed is an important finding. Such support is widely considered protective in challenging times (Southwick, Vythilingam & Charney, 2005), functioning to reduce parental stress and improve self-esteem (Koeske & Koeske, 1990).

Following the HSB, several agencies and their respective professionals became involved in parents' lives and for some this was felt to increase distress and compound the original trauma. Initial professional contact was usually with Social Workers, from whom parents could anticipate criticism and persecution, highlighting the impact of pre-established internal representations of professional helping systems (Reder & Fredman, 1996). The coordination of concurrent involvement from multiple agencies could feel overwhelming and emotionally draining, particularly alongside work and childcare commitments. All parents reported that risk management procedures were practically and/or emotionally demanding, this adding to the sense of burden, a finding mirrored within the wider PPF literature (Hackett, Phillips, Balfe & Masson, 2014; Jones, 2015; Thornton et al., 2008). The present study seemed to particularly illuminate the severity, intensity and toll of risk management on parents. For some parents, their ability to fully access or partake in interventions appeared limited by their distress, as also highlighted by Corcoran and Pillai (2008).

Some parents' spoke of feeling that professionals did not keep their needs in mind and took a paternal role, leaving them left in the dark and excluded from decision-making. With a sense that their role within the family was compromised in this way, they experienced a significant loss of control and confidence. As highlighted by Dallos & Boswell (1993), it is possible that professional responses can act as "intrusions into the family's life" with the consequence of "preventing the family from maintaining their ability to make their own decisions" (p.92). It may be hypothesised that perceptions of personal control and self-efficacy are most likely to result in parents taking responsibility for helping to overcome the HSB. Two parents highlighted that they became "less helpful" to services, seemingly in the face of feeling controlled and as a

means of “gaining enough power to protect their vulnerable selves<sup>44</sup>” (Holloway, 1989, p. 60). This finding is of concern, as to not engage may result in deleterious consequences for the parent and their child (Duane & Morrison, 2004).

## 6.2.2 The need for self-preservation

The theme *'The need for self-preservation'* speaks to attempts made by parents to manage the force of their emotional experience and avoid negative social reaction, as a means of enhancing emotional and interpersonal safety. Parents appeared to protect themselves from difficult feelings (e.g., anxiety, guilt and shame) at least in the shorter term through mechanisms such as detachment and minimisation<sup>45</sup>, consistent with common responses to trauma observed within the wider literature (Liotti, 2004; Van der Kolk & Fisler, 1995; Van der Kolk, McFarlane & Weisaeth, 1996). The use of 'avoidance based strategies' by parents was consistent with findings by New, Stevenson and Skuse (1999)<sup>46</sup>. It is suggested that people more commonly use avoidance as a means of coping when a stressor is particularly severe or they feel they lack control (Lazarus, 1983), in line with the context described by these parents. Such strategies have been associated with the perpetuation of psychological distress (Littleton et al., 2007).

It has also been hypothesised that avoidance early in the process of coping can be adaptive (Suls & Fletcher, 1985), and more recent and non-linear models of coping highlight that both emotional 'approach' and 'avoidance' strategies can be adaptive and restorative following trauma (Boerner & Heckhausen, 2003; Hayes et al., 2006). Such flexible oscillation with periods of temporary respite may therefore also be conceptualised as understandable, useful and necessary<sup>47</sup>. Despite this, Hackett, Phillips, Balfe and Masson (2014) reflect that such parental responses are commonly interpreted by professionals as barriers to success in HSB interventions and indicators of parenting difficulties, perhaps partly due to their association with greater psychological absence in the parent-child relationship (New, Stevenson and

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<sup>44</sup> It is also possible that parents' views of services as 'all bad' may also be understood through the psychodynamic concept of splitting (Hinshelwood, 1991).

<sup>45</sup> Parents highlighted that the coping mechanisms they used were established prior to the HSB and represented commonly utilised ways of managing in hard times (e.g., compartmentalizing, trying to manage alone).

<sup>46</sup> Study compared use of avoidance based strategies in mothers of CYP who had engaged in HSB and mothers of boys with non-sexual behavioural difficulties.

<sup>47</sup> Some 'avoidance' based strategies highlighted by parents are commonly considered 'adaptive' (e.g., having a bath, going on a walk) as they can take the mind away from worries and renew a sense of control.

Skuse, 1999). In addition, where parental minimising statements are considered to be a form of avoidance, it may be of concern to professionals that the CYP may be exposed to narratives which do not reflect the seriousness nature of the HSB.

Prior research highlights that PPF's can experience severe persecution (e.g., Duane et al., 2002; Hackett & Masson, 2006). Obviously punitive responses were not evidenced within this study. However, parents did experience profoundly distressing rejections and less than supportive responses. This research also highlighted parental experiences of subtler negative social responses (e.g., parents not talking to them in school; indications that others' feelings towards them had changed), which could equally be experienced as deeply hurtful. As such, parents' relational experiences following the HSB seemed to result in further trauma, in line with systemic processes highlighted by Vetere (2017).

Strong perceptions were held by parents that they and their family now held a 'deviant' or 'spoilt' social identity (Goffman, 1963; Becker, 1963). The theoretical concept of stigma appears relevant, with Goffman's (1963) definition highlighting this as "an attribute that is deeply discrediting" and transforms its bearer "from a whole and usual person to a tainted, discounted one" (p. 3). Several social discourses underpinned parents' perceptions about their devalued identity, with the media clearly described as one source of their perceptions. Parents appeared to think that these negative social connotations now applied directly and personally to them<sup>48</sup>.

Parents commonly reported pulling away from relationships and interactions with others, as a means of protecting themselves and their child from the possibility of rejection or scrutiny, in line with research with PPF's (Jones, 2015; Thornton et al., 2008). That some parents described pulling away from others in anticipation that they would be rejected, before this rejection had occurred, speaks to the way in which realities are shaped by how we feel others understand and receive our experiences. That others may come to know of the HSB greatly preoccupied parents. Secrecy was used as a means of preserving identity and avoiding scrutiny, in line with common responses to the receipt of particular mental health diagnoses (Link et al., 2004).

The wider literature highlights that becoming defined and confined by identification with a stigmatised label or status can result in deleterious outcomes (Link et al., 1997; Rosenfield,

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<sup>48</sup> As highlighted by Von Franz (1986), "where we touch the unknown, there we project an archetypal image" (p. 5), perhaps particularly so bearing in mind the harsh socio-cultural context outlined in Section 3.2.

1997; Wright, Gonfrein & Owens, 2000). For these parents, their social withdrawal impacted on their self-esteem, mood, social connectivity and quality of life. One parent also felt there had been a subsequent impact on her young son's wellbeing, an important finding when viewed alongside evidence that social isolation is a risk factor for further HSB in CYP (Prentky & Righthand, 2003).

### **6.2.3 A challenged and changed relationship with son**

The theme '*A challenged and changed relationship with son*' speaks to parents' perceptions of their child following the HSB and their sense of connection with them. Some parents described that the parent-child relationship could be distant and conflictual prior to the HSB, (highlighting possible attachment difficulties<sup>49</sup>, Ainsworth et al., 1978), with the HSB adding a further layer of complexity to the relational milieu. Attachment needs have been commonly highlighted (Durham, 2006; Marsa et al., 2004).

Many parents described a wish to find distance from their child following the HSB, moving between seemingly ambivalent and more supportive feelings and responses<sup>50</sup>. This was particularly the case where the HSB was intra-familial, with the parent divided in their loyalties, mirroring findings from Cherry (2009). It appeared that children could become almost an embodied reminder of the "disturbing" sexually behaviour. In addition, as parents viewed their child as almost an extension of themselves, particularly strong parental feelings emerged. They could feel implicitly and shamefully involved in the abuse (Grey & Pithers, 1993). For some parents, alongside distance with their son, there were also times of closeness and support. This highlights several powerful psychological processes within the parent-child relationship both prior to and following the HSB, which may be difficult for both the parent and the child to make sense of and manage.

Parents held several hypotheses in relation to the cause of the HSB, however commonly attributed its origins to a fundamental quality held by their son. A number of psychiatric labels were mentioned across interviews. These appeared to play a pivotal role in parental sense-

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<sup>49</sup> Attachment refers to the relationship between a child and its primary caregiver/s. Attachment theory proposes that the a secure attachment (a close emotional and physical bond) is important in defending against the deleterious impacts of adversity in the child's life and social and emotional development.

<sup>50</sup> Descriptions of supportive closeness were generally observed. For one parent closeness appeared intense, for example there were descriptions of the child knowing the parent's mood and needs intuitively and periods of intense physical affection (cuddles and kisses), which appeared to overwhelm their child.



making, with assumptions and beliefs connected to such labels seeming to be a way parents could make meaning of the HSB. There may be a range of explanations for the common use of labels by parents, including the increasingly common practice of the medicalisation of children's distress and the possibility that this process offers parents some relief from looking to their parenting or their child's developmental experiences for answers<sup>51</sup>.

Parents described striking and sudden changes in their perceptions of their child, with descriptions of irreconcilably divided personalities, whereby 'good' and 'bad' aspects could not be simultaneously in mind, conceptualised psychanalytically as splitting (Hinshelwood, 1991). Parents could also use fixed and singular attributional constructions to describe their child (e.g., paedophile), an observation highlighted within the wider literature (Heiman, 2001). As CYP's sense of who they are and who they can be is arguably shaped within attachment relationships (Bowlby, 1973) and children can be highly influenced by the parent's belief systems and orientations, being perceived as 'bad' or 'deviant' may be internalised (Tronick, 2003<sup>52</sup>). Discourses around gender appeared important, with males conceived as almost innately predisposed to sexual preoccupations. CYP could be perceived as calculating or controlling, and for one parent, there was confusion between her perception of her son and her abuser, who became almost merged in her mind. This appeared to impact on the emotional transactions between parent and child, highlighting the role of trans-generational trauma, with parents appearing to at times act out of their own relational systems (Figley & Figley, 2009). As highlighted by Borcsa and Stratton (2016):

*'The child is positioned and takes positions (e.g. abuser of parent) in that parent appears frightened of the child as their own trauma responses are triggered by interactions with the child.'* (p. 137)

For parents, the above mentioned perceptions of their child, which were variably transient or more fixed, appeared to make it difficult for them to act out of a position of empathy. Many parents struggled to be close to their child, hold empathic feelings towards them or support them following the HSB. This was a complex finding because for some these qualities within the parent-child relationship appeared somewhat pre-existing. As strong attachment

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<sup>51</sup> There was some overlap with the theme of '*the need for self preservation*' as for parents both finding distance from their child and seeing the problem as stemming from within their child could relieve them of difficult to manage emotional experiences.

<sup>52</sup> Tronock (2003) speaks of children taking up "dyadic states of consciousness" with their parent.

relationships are consistently found to be protective in times of anxiety and distress (Ainsworth, Blehar, Walters & Wall, 1978; Fonagy et al., 1991) can serve to strengthen children's ability to cope with adversity (Canetti et al., 1997; Hughes, 2009) and help them with to mentalise and self-reflect (Fonagy et al., 1991) such findings held important intervention implications.

Overall, findings highlighted a complex and multi-layered relational dynamic between parent and child, with parent's own distress, relational history and positioning of the child impacting on their provision of care and support following the HSB. Elements of these findings could be made sense of using key concepts from attachment theory, trauma theory and intergenerational systemic theory.

#### **6.2.4 Space for hope in the face of hopelessness?**

The theme '*Space for hope in the face of hopelessness*' speaks to parents transient or more perpetual experience of feeling trapped, as well as the shifts for some parents to a greater sense of hope moving forwards. Parents could feel confined and limited in their lives by the HSB and its consequences<sup>53</sup>. For some parents, it did not feel that this situation could be resolved and the sense that the family was at threat prevailed, mirroring findings from research with PPF's (Hubert et al., 2007; Pierce, 2011). This feeling appeared less perpetual for those who were nearing the end of the HSB intervention and/or whose child had engaged in HSB of a comparatively less serious nature, who seemed to move to occupy more of a restoration orientation.

Most parents highlighted a benefit of therapeutic sessions in enhancing their practical parenting skills. These parents noticed that they felt more confident in their parenting and their child was more emotionally settled, mirroring the experiences of some PPF's (Hackett & Masson, 2006; Thornton et al., 2008). The benefits of sharing and the emotional support provided by their therapist/s was also described. It has been found that the process of confiding and account-making can be beneficial in the assimilation of events, reducing the generalisation of the sense of a lack of control and perceived threat to other parts of a person's

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<sup>53</sup> Parents spoke of how feeling unable to escape thoughts about possible future harm, their child becoming a reminder of the HSB, their child's continuing to engage in HSB and risk management procedures perpetuated the dominance of the HSB their minds and lives over time.

life (Harvey, Turnquist & Aostinelli, 1988). Parents generally felt that both the practical and more emotional aspects of therapy were beneficial to both them and their child.

Some parents who chose to speak with friends or family about the HSB found themselves in receipt of appreciated practical and emotional support, this playing an important role in increasing their sense of security, containment and empowerment. For some there was an unexpected benefit of their family pulling together to manage the challenge, this serving to strengthening relationships. The benefits of inner representations of containing others (Darar, 1996) and family resilience in coping are widely acknowledged (Walsh, 2006), as is the positive influence of wider family in HSB treatment (Bunston, 2000).

Through accessing the HSB service, some parents were offered group interventions which brought them together with other parents whose child had also engaged in HSB. Where this was the case, parents reported feeling the benefits of finding that they were not alone and speaking without feeling judged. The wider literature advocates for the use of support groups alongside individual therapy sessions in the provision of effective parental support (Bennett & Marshall, 2005) and this finding is in line with the beneficial impacts of peer-contact highlighted by PPF's (Duane et al., 2002). It was a notable finding that a parent who had not been offered a group intervention of this kind strongly wished for contact with other parents.

A sense of the possibility of a brighter future also came from parents' sense that they had the inner capacity and skills to manage and survive this situation<sup>54</sup>. Some parents expressed clear intentions to ameliorate the situation for their child and reduce the risk of future harm. They took positive action to this effect, for example providing comfort and safety and being receptive and responsive to interventions put in place. This replicates observations from McGarvey & McKeown (1999) that some parents are very motivated to be involved in their child's treatment and wish to help them to desist from sexual harm. These parents expressed that they were proud of what they had achieved in tackling the HSB and contributing to a process of change, feeling that the process had led to personal growth<sup>55</sup>. This is a finding rarely mentioned within the wider literature, however the general benefits of finding positive benefit in experience of

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<sup>54</sup> This also appeared relationally based and contingent upon the support of others and internalized messages of competency.

<sup>54</sup> It was striking that parents sense of hope for the future, growth and development led me to an energetic optimism for their lives going forward, contrasting to the stuckness I could otherwise feel during interviews. This perhaps highlights the dynamic emotional interplay occurring between parents and the professionals working with them

coping to longer term adjustment and wellbeing have been highlighted (Davis, Nolen-Hoeksema & Larson, 1998).

Overall, this theme highlighted the transient and sometimes illusive nature of hope for parents, seemingly impacted by their wider circumstances and stage in therapy. That parents could feel more contained and positive in light of therapeutic input and social support highlights relational and collective aspects of the process of transition towards restoration in the aftermath of the HSB, with aspects of trauma and attachment theory meeting at this juncture. A positive relationship between social support and coping supports this finding (Siedlecki et al., 2014).

### **6.2.5 Theoretical lenses through which parents' experiences were viewed**

In this discussion, I have drawn on particular lenses through which findings may be viewed. Prior research in relation to PPF's experiences described in the systematic review (Chapter 1) called upon models of trauma (Pierce, 2011), grief (Duane et al., 2002) and behavioural change (Duane et al., 2002), as theoretical underpinning to their studies and to making sense of their findings. Parent experiences were therefore largely represented on an individual level. In doing so the contextualization of parental experience and meaning-making as intimately woven with a complex web of powerful relational and socially constructed factors was under acknowledged<sup>56</sup> (Hewitt, 1984; Ryle & Kerr, 2002; Vetere, 2017, p.13). Although findings from this study have been in part decontextualized through their reporting, (in a way which is not completely satisfactory yet perhaps inevitable), it feels important to highlight the importance of the broader perspective, as is represented diagrammatically in Appendix S<sup>57</sup>.

Parents' experiences and meaning-making were dynamically influenced by societal discourses, with their subjective experience constructed through social interaction. Although it has not been possible to highlight all culturally shared beliefs and values which appeared

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<sup>56</sup> It was in partly the interpretive level of the analysis which allowed me to draw out the importance of such layers as parents did not always consciously 'know' or communicate in direct words their influence. In the analysis I made attempts to not just "listen to the words but try to 'hear' what lies behind them; what they obscure as well as what they reveal; the unsaid as well as the said" (Gadd & Jefferson, 2007, p. 454).

<sup>57</sup> In line with a systemic constructionist perspective it is acknowledged that parents described one facet of their view of their experiences in one context (with me, in the interview setting, recruited through the HSB service). This may have influenced what was made 'knowable' to me (Fredman, 2008).

influential, these commonly centered around the morality of childhood sexuality/ sexual harm, responsibility to society, ideas around 'normality', parental and gendered roles and responsibilities, medicalisation of distress, and the responsibility of the individual/familial (as opposed to wider society) for 'clinical problems'. Issues of intersectionality were apparent, particularly in relation to gender. This conceptualisation of parental experiences holds consequences with regards to the clinical implications of findings, as in looking further than the individual we come to different "prescriptions for action" (Sayce 1998, p.332).

#### **6.2.6 Visual Representation of Findings for Dissemination**

To ensure that research findings were suitable for dissemination to a wide audience, including both professionals and parents themselves, it was felt that visual representations of the findings would be of benefit. Despite the creation of a visual model being unusual for IPA, visual means of communicating findings can have the benefit of minimising complexity to ensure accessibility and allow for a clearer overall view.

One main figure depicting the way in which the themes are interconnected was created, alongside four further figures highlighting each of the superordinate themes alongside a number of quotes from parents. These can be found in figures 1-5 below.

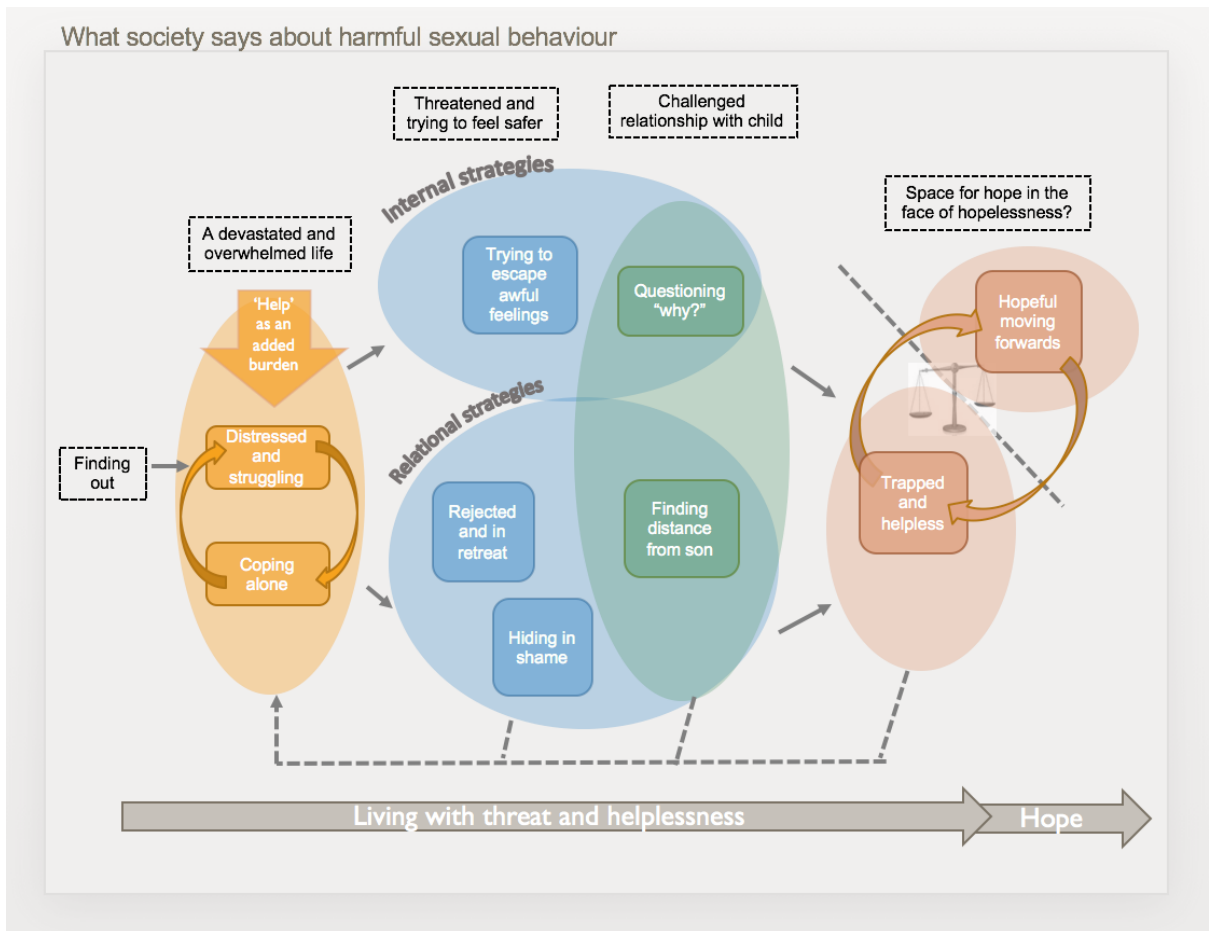


Figure 1: Overall Visual Model of Study Findings

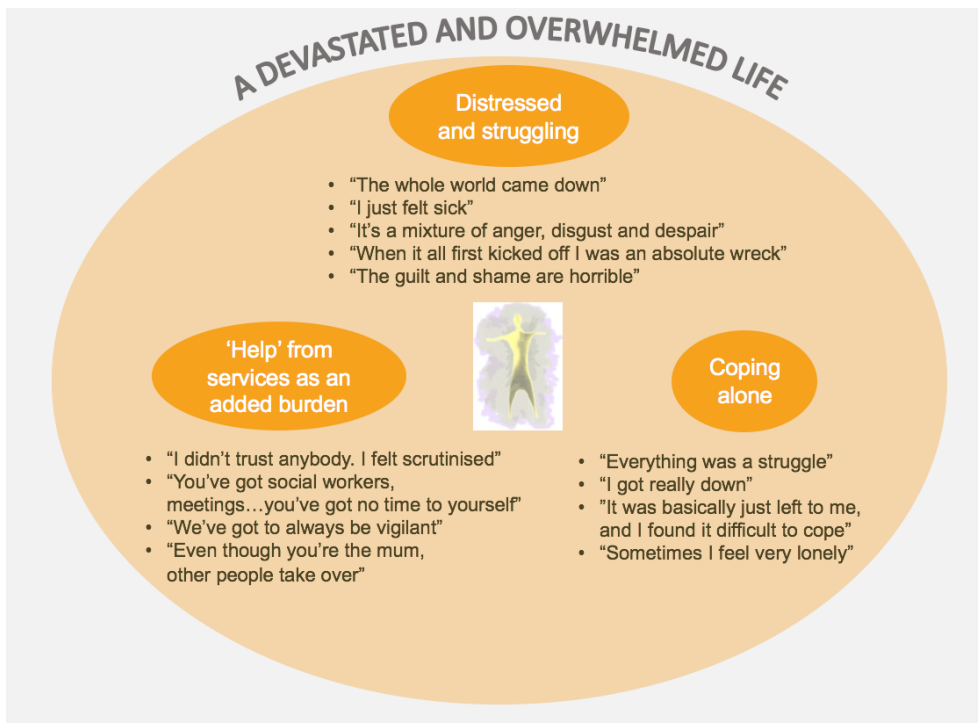


Figure 2. Main theme 1- A devastated and Overwhelmed Life



Figure 3. Main theme 2- Threatened and Trying to Feel Safer

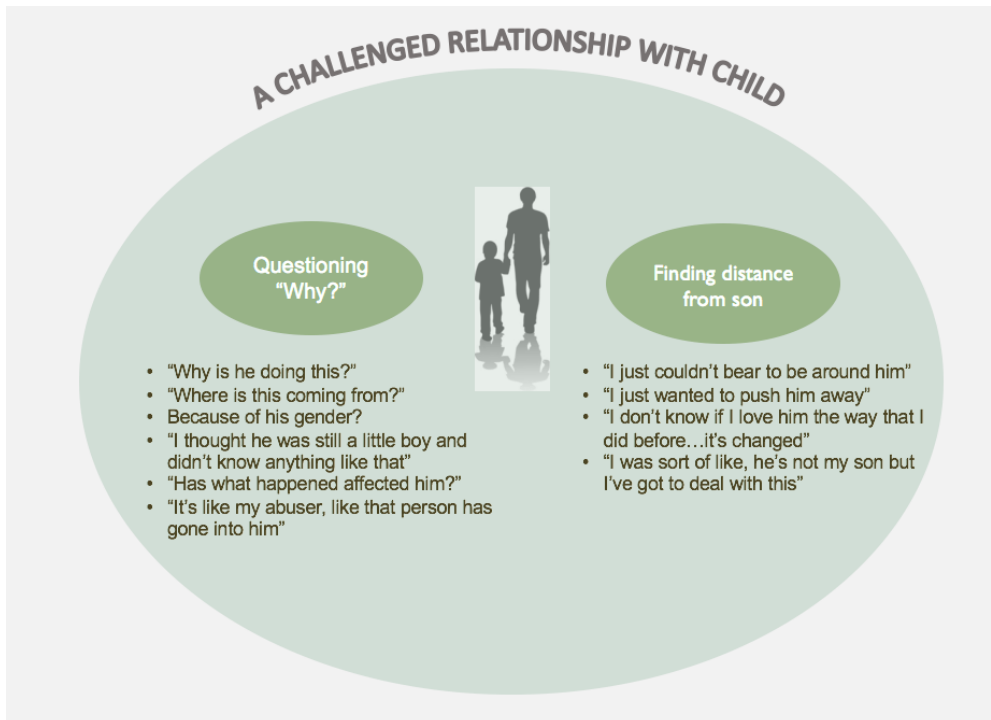


Figure 4. Main theme 3- A Challenged Relationship with Child

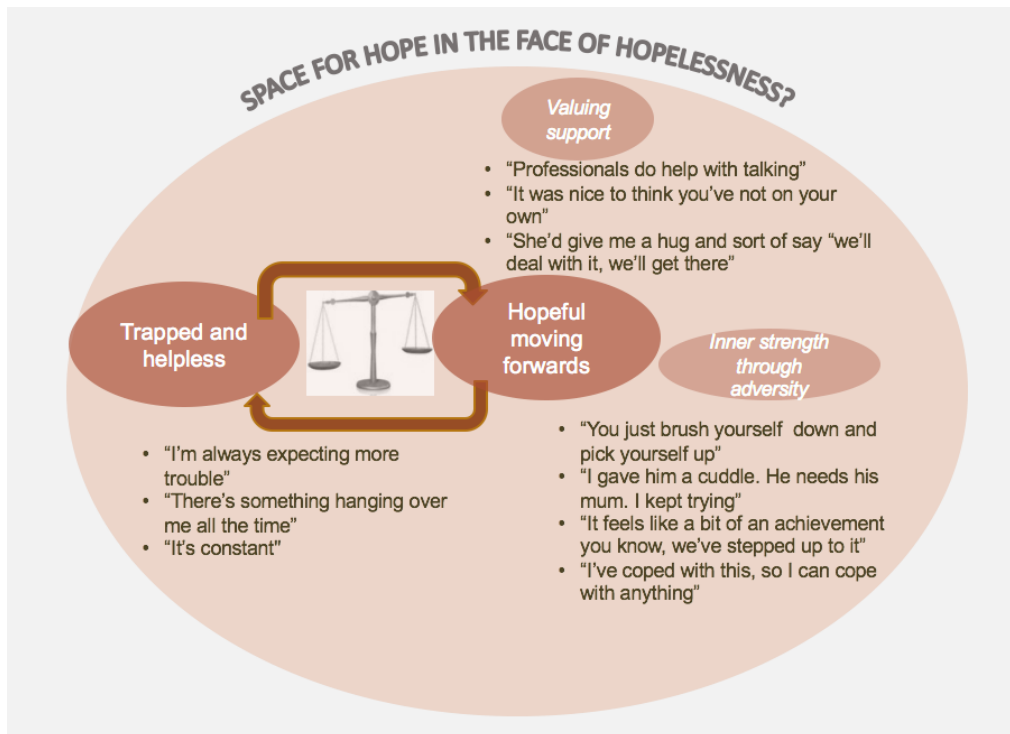


Figure 5. Main theme 4- Space for Hope in the face of Hopelessness?

Short quotes from parents were included in Figures 2-5 to represent each of the subordinate themes, as the parents interviewed had indicated that they want to hear about the experiences of other parents in their own words. By including quotes, parents own voices were centered. The clinical implications of these visual models are discussed in section 6.3.

### 6.3 Clinical Relevance and Implications

Given that HSB arises in a familial context, parents are considered key agents for change when intervening with CYP who engage in HSB (Carpentier, Silovsky & Chaffin, 2006; McGarvey & McKeown, 1999), as supported by outcome research (Letourneau et al., 2009). Parents can influence the success of HSB interventions by supporting their child to engage in interventions, increasing their motivation and monitoring for early signs of risk of reengagement in HSB (Durham, 2006; Wiehe, 1997). Arguably, parents' role in treatment is central and vital to reducing risk of reengagement in sexual harm and promoting positive outcomes for their child. As such professionals may work closely with parents as a means of improving the CYP's therapeutic outcomes. Despite this, systemic practice is not consistently established in this area and nationally there is an absence of family work in HSB provisions for CYP who have engaged in HSB (Smith et al., 2013).



This research highlighted that the experience of being the parent of a CYP who has engaged in HSB can be extremely challenging and that these parents present with therapeutic needs. Given the nature of these needs alongside the wider literature, it is suggested that parent and family based interventions are integral to the support of families, and should be provided as standard. Some aspects of parents' needs could also be met through alternate therapeutic provision, such as adult mental health (AMH) services, therefore the need for effective links between specialist HSB services and AMH provision is highlighted. As child services are commonly criticised for keeping the child in mind at the expense of the parent, and adult services criticised for recognizing the needs of the adult at the expense of the child, closer liaison and clear demarcation of roles seems vital.

Some parents shared their experience of feeling disempowered, out of control and not held in mind in relation to multi-agency involvement. Although interventions must work to protect the child (Coulshed & Orme, 2006), it may be that further developing and negotiating collaborative practices which empower and respect the experiences and views of parents (even in light of systemic anxiety and a safeguarding orientation) is integral to both parents' wellbeing and their support of their child. It is highlighted that the voices of parents should be prioritised by working alongside them, involving them in meaningful ways in interventions and as researchers, trainers and consultants (as successfully demonstrated by Milner, 2006)<sup>58</sup>. Parents had a lot to say about their experiences of being supported by multiple targeted services, as part of interagency input. The involvement of multiple systems could feel overwhelming and fragmented for parents who already felt overwhelmed by the impact of the HSB. This research suggested that there may be lessons to be learnt with regards to the impact of the intensity of therapeutic input (including safeguarding procedures) on parents own wellbeing, on their relationships with significant others and on their ability to support their child. It was highlighted that effective and open communication with parents and between agencies could assist in mitigating some problems experienced. With this in mind, and because placing responsibility solely on the shoulders of professionals may not be an adequate representation of a complex relational process which occurs within a wider context, therapeutic conversations with a focus on aspects of 'relational reflexivity' (Burnham, 2005) may be helpful in shifting stuck positions for both professionals and parents.

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<sup>58</sup> Johnson et al., (2000) also highlight that peer support networks can also positively impact professionals' perceptions of and interactions with parents, engendering greater empathy, an additional possible benefit.

A main finding related to the highly specific kind of discrimination faced by parents; this is not an area where there appears to be a public mood of empathy, and families could experience disapproval. This study found that societal context and discourses played an important part in the stigma and shame they felt, highlighting the need for therapies which pay attention to this level of influence. An important implication of findings lay in the power and influence of both actual and feared stigmatisation on parents. There is a need for shifts at a wider level (e.g., through the influence of considered media coverage). There is also scope for clinicians providing support in the context of stigma and shame (Hayward & Bright, 1997). In the field of mental health, user groups have highlighted that professionals can assist in lifting the veil of shame by helping people to decide who to disclose to (Faulkner & Sayce, 1997), support them in responding to rejections from others (Lindow, 1994) and providing peer group spaces where they feel solidarity with others who face similar experiences (Lindow, 1994). Findings from this group of parents also indicated the importance of including impact of stigma and shame in family assessments and psychological formulations.

A primary clinical implication from this research is indicated to be the provision of peer-support groups and networks for parents, due to their striking levels of isolation and the deleterious impact of this they described. Parents highlighted that connecting to other parents' experiences and ways of coping was of importance to them. Parents generally found peer spaces to feel safe, validating and normalizing. It was highlighted that written information about other parents' experiences (e.g., through a leaflet) would have been a beneficial addition to their care<sup>59</sup>. Individual therapy was also generally positively viewed, with parents valuing input with regards to their parental skills which could help them to feel more confident and competent. A therapeutic focus in family based interventions on the re-negotiation of family relationships (e.g., parent-child and couple relationships) was also indicated to be beneficial, this building family resilience and assisting families to be a continued source of support for one another and their child. These findings also support the benefits of considering patterns of inter-generational experiences on meaning-making. Overall, attachment based work was indicated, at multiple levels of the system.

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<sup>59</sup> A leaflet or a weblink as a widely available means of providing broad information about possible experiences as the parent of a child who has engaged in HSB was suggested. This seems important as not all parents are offered a group intervention, there are gaps in specialist service provisions for CYP who have engaged in HSB and their families nationally and there are parents who learn about their child's HSB yet do not seek professional assistance. Parental consultation into the creation of such a resource would be invaluable. I will take steps to collaborate with parents in the creation of such resources.

A further implication of findings for professionals lies in balancing the conceptualisation of 'avoidant' strategies as resourceful means of coping with attention to their possible detrimental impact on parent wellbeing and the parent's positive presence in their child's life. Professionals may benefit from paying attention to and making sense of the emotional reactions of parents and their use of different coping mechanisms through the process, helping to guide parents through this.

Parents highlighted that when their child engaged in HSB, they felt very alone in this experience. Some parents went online, in an attempt to find a forum to gain information and to connect with other parents. Unfortunately, online resources relating to the experiences of other parents are extremely limited. One parent in particular, Yvonne, felt strongly that the study findings should be shared with other parents, and could provide a valuable resource:

*"I mean if we can sort of put sort of some sort of leaflet together and sort of you know hand it out to parents when these sort of things happen, then at least the parents know...sort of what...what might happen and how to deal with it"*

The authors agreed that the study findings could provide a useful resource for parents. For example, the visual representations of study findings highlighted in Figures 1-5 (Section 6.2.6) could be shared with parents in a handout, which also highlights sources of support such as the [stopitnow.org.uk](http://stopitnow.org.uk) website and associated telephone helpline for parents who are concerned about their child's sexual behaviour. This could be shared with parents attending services for assessment intervention in the context of HSB as part of individual, family or peer support sessions. It is hoped that the handout may help to orientate discussions to aspects of experience which may (or may not) be relevant to them. Providing a resource such as this may hold a function of increasing parents' sense that it is permissible to discuss particular aspects of their experiences, as they are not alone in these.

The authors are in communication with the creators of the [stopitnow.org.uk](http://stopitnow.org.uk) website to consider disseminating findings online, perhaps through their website. In addition, the authors aim to disseminate findings to parents and professionals working within and accessing the HSB Service which acted as the recruitment site, as well as other services working with CYP who have engaged in HSB and their families. For example, they are due to present their findings to the National Clinical Assessment Treatment Service (NCATS), which works with CYP with high risk HSB nationally and will provide the service with the handout for parents.

Parents' experiences both prior to and in light of the HSB appeared to impact the way they viewed and understood themselves and the world around them. They tried to manage this difficult life circumstance as best they could. Aspects of parents' experience (in relation to the HSB or otherwise) appeared to have disconnected them from the skills, strengths, resources and resilience's which could assist them moving forwards. It was indicated that therapeutic work with a focus on meaning reconstruction with regards to key issues of 'self' and 'self in relationships' (e.g., through narrative means) may be beneficial<sup>60</sup>

## 6.4 Methodological Reflections

### 6.4.1 Strengths

Although much has been written about the importance of including families in interventions for HSB, the evidence underlying such practice has largely not been meaningfully informed by parents' insider perspective<sup>61</sup>. Through six rich accounts, this IPA study successfully provided a close exploration of parents' experience, in a way which way methodologically sound and in line with its underlying epistemological assumptions. A key strength of the study was that through in-depth rich accounts, understandings of parental meaning-making were gained. This depth was facilitated through a meaningful level of my engagement with the data, interpretation and reflexivity, as is illustrative of high quality IPA research. As such, it adds to the sparse knowledge base and provides an original contribution to the field which may inform professional practices.

As an inductive approach, IPA allowed for descriptions of unexpected aspects of parental experience, through which new understandings were developed. Although a collective framework of four superordinate themes was generated, the study was successful in interpreting not only convergences but also divergences amongst parents' experiences and meaning-making. Retrospectively, this was particularly important due to the complexity and differences within and between interviews found through their analysis, making it possible to remain close to parents' sense-making. In addition, through IPA's interpretative methodology,

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<sup>60</sup> Discursive therapeutic input may beneficially assist parents in the articulation and renegotiation of meaning-making.

<sup>61</sup> Perhaps this highlights the prioritisation of expert-generated scientific theories and techniques over and above lived experiences, a focus on the child or a heavy safeguarding agenda. Whatever the underlying reason, there is a risk of assumed perceptions about what is most helpful with regards to professional provisions of family support, which may result in well intentioned yet misinformed input.

analytic attention could be given to said and unsaid facets of the complex and interwoven aspects of parents' experiences.

### **6.4.2 Limitations**

The finds of this research come from interviews with a small and homogenous sample of parents of CYP who have engaged in HSB. The intention of the study was not primarily to make generalisations about the experiences of all parents of CYP who have engaged in HSB, due to its idiographic nature. Although statements have been made about the parents interviewed, one must be careful about the broadening of claims. It should be kept in mind that these were a selective group of parents contacted through a HSB service who were currently involved in assessment or intervention due to their son's HSB and were willing to tell their story<sup>62</sup>. That said, findings do inform sense-making with regards to the experiences of one particular group of parents of CYP who have engaged in HSB and should inform practitioners' knowledges when considering possible important areas in working with and meeting parent's needs.

Although homogeneity in the sample was sought in relation to several areas, parents were at different stages of assessment or intervention, which is likely to have impacted on their responses. In addition, the recruitment strategy led to only one male being recruited, which arguably reduced the homogeneity of the sample. I did however find that inclusion of a father added great richness to the data.

A final thought about results from the development of my own ideas in relation to positioning and co-creation in research over the course of this investigation. As a new experience for me, I found that consulting with a foster carer in research design was so energetic and connecting. Following the research, I reflected that I would have liked to have extended the involvement of parents in the interview process in a more actively collaborative way. Reflecting following

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<sup>62</sup> Results are not inclusive or representative of all parents of a CYP who has engaged in HSB. It is likely that there are many parents who find out about their child's engagement in HSB yet do not seek professional help (Print & Morrison, 2000). These parents were accessing a specialist provision, for which there is variable availability nationally, and some parents of CYP who engage in HSB may be provided with interventions in more generic settings. In addition, parents who have completed interventions may vary in their experiences and meaning-making. It is notable that no parents of female children were recruited, therefore this research unfortunately does not assist in better understanding the complexities and differences in the experiences of parents of girls or young women who engage in HSB.

this research, I feel that the power held in the process, may have been limiting (mirroring perhaps the balance of power between parents and professional systems). Although a shift in methodology, in combining enquiry and action within the process, the ideas, resource and energy parents held may have been naturally carried forwards. A great example comes from Cox (1996), wherein a group of women explored their experiences of obesity, thinking about their experience in society and interaction with services. Parents made thoughtful suggestions about how services could be developed which would have been harnessed into positive participant led action through this methodology. NHS policy evidences the importance of such contributions (Department of Health, 2013; INVOLVE, 2012).

## 6.5 Suggestions for Further Research

This research was temporally limited to interviewing parents at one specific point in time in their journey following their child's engagement in HSB. Longitudinal research, with the representativeness of samples more highly specified, may be useful with a larger group of parents, to capture their experiences and sense-making over time. In addition, further research which considers key aspects of intersectionality in relation to parental experiences is indicated. Parents had a lot more to say about their experiences than was possible within the interview time, and as such possible experiences and meaning-making may be underrepresented in the research findings. Future research may benefit from integrating multiple interviews with each parent into their methodology, to gain "thicker" data.

Additional research contributions into the psycho-social impact for parents of stigma, (particularly on interactions with others including their child) as a way of informing therapeutic interventions was also indicated. Drawing on theoretical underpinnings from Link et al., (1997) which conceptualises not only the impact of actively being discredited but also the impact of feeling one is discreditable, may be useful, as a seemingly important facet of parental experience.

## 6.6 Conclusions

This research aimed to shed some light on the experiences of parents who are rarely seen in both public discourse and the research literature, those who have a child who has engaged in HSB. Despite the importance of the parent role, little is known about what it is like for them to have their child engage in HSB, and how they make sense of their experiences. Six parents were interviewed and an in-depth qualitative IPA analysis highlighted four superordinate themes capturing parents' accounts. Parents described the emotionally unsettling impact of

the HSB and its consequences on their lives, their attempts to find increased safety in a threatening and uncertain time, changes to their perceptions of and desire to be close to their son and their sense of themselves as stuck in a difficult and hopeless situation or able to move forward in their lives. These themes were discussed in relation to a number of theories and their positioning in relation to a wider socio-cultural and relational context was highlighted. Findings supported several clinical recommendations including the coordinated and considerate professional involvement, paying attention to the personal meaning-making of parents and influence of the wider societal context, and facilitating the provision of spaces for peer-support. If the aim of services working with CYP who engage in HSB is to promote positive outcomes for the CYP and reduce their risk of future harmful behaviour, meaningful parent involvement in therapeutic processes is essential.

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# Appendices

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## Appendix A: Systematic Review Methodology

A broad approach to finding potentially relevant studies was undertaken, with an electronic search of five key databases: PubMed; PsychNet; Scopus; Web of Science and Social Policy and Practice. Google Scholar was also used to identify any articles which had not been generated during the electronic database searches. A subsequent review of the reference lists of all relevant full text articles was undertaken, to source further articles<sup>63</sup>.

Table 3 below shows the list of search terms used in the systematic literature search. These were selected following preliminary engagement with the research literature and subsequent input from the Clinical Psychologist working at the study recruitment site. No date limits were set, as an exhaustive summary of all literature on the topic area was desired. Boolean operators were used to combine search terms and truncation was undertaken where deemed appropriate (e.g., abus\* = abuse, abusing, abusive).

Table 3: List of Search Terms Used in the Systematic Literature Search<sup>64</sup>

Terms related to Sexual Harm		Terms Related to Participant Group:		Terms Related to Child:
"sexual* harm*" or "harmful sexual*" or "sexually concerning" or "concerning sexual" or "sex* offend*" or "inappropriate sexual" or "sexual* act* out" or "act out sexual*" or "sex offender" or "sexual* abus*"	AND	"mother" or "father" or "mum" or "dad" or "parent*" or "carer" or "caregiver*" or "famil*" or "foster*" or "kinship" or "adopt*"	AND	"child*" or "young people" or "young person*" or "adolescen*" or "youth" or "teen*" or "juvenile*" or "son*" or "daughter*" or "boy*" or "girl*" or "young male*" or "young female*"

Following the initial search, the titles of articles were screened to ascertain whether they likely referred to the experiences of PPF's in the context of a CYP who has engaged in HS. Through

<sup>63</sup> The literature search was carried out between September 2016 and February 2017.

<sup>64</sup> Search terms related to study design within the systematic review (e.g., Qualitative, Interpretive Phenomenological Analysis, Grounded Theory, Thematic Analysis, Content Analysis, Interviews, focus groups) were originally used, however these were subsequently removed due to their over-restriction of the results.

reviewing the abstract and subsequently the full text of the article it was ascertained whether they met a number of inclusion and exclusion criteria as listed in Table 4 below:

Table 4: Table outlining inclusion and exclusion criteria

Inclusion Criteria	Exclusion Criteria
<b>1) Language:</b> English Language	Non-English Language
<b>2) Methodology:</b> Qualitative methods <sup>65</sup> used for data collection <u>or</u> where mixed methods is used it is possible to extract qualitative data <sup>66</sup>	Non-Qualitative methods of data collection.
<b>3) Population:</b> Studies focusing on PPF's of children aged <18 who have engaged in HSB	Studies focusing on PPF's of individuals who were adults when they engaged in HSB
<b>4) Population:</b> Reports on the experiences of biological parents or parental figures* (e.g., kinship carers, foster carers, adoptive parents) of CYP who have engaged in HSB.	Experiences of biological parents or parental figures cannot be separated from those of others (e.g., young people/professionals/parents of adults who have engaged in HSB)
<b>5) Study Type:</b> Involves primary data collection, directly examining the experiences of PPF's	Secondary analysis (e.g., review of literature, opinion piece, describes a model)
<b>6) Condition of interest:</b> Highlights the <u>lived experiences</u> of PPF's	Focus is not on the lived experiences of PPF's (e.g., describes the population)
<b>7) Publication:</b> Reported in peer-reviewed journal	Study is not reported in peer-reviewed journal

A description of the process of identifying relevant studies during the systematic literature search, involving a staged process, can be found in Figure 6 overleaf. A title screen was initially conducted to ascertain whether inclusion and exclusion criteria were met, followed by the screening of article abstracts and finally the full text of the article.

<sup>65</sup> Research was considered qualitative if the analysis and reported findings was consistent with descriptive, thematic, phenomenological, narrative, grounded theory, ethnographic or other interpretive approaches.

<sup>66</sup> The review focussed on qualitative data as it aimed to outline existing enquiries which appreciate the unique experiences of each individual. It did not include quantitative data which attempt to make such experiences measurable.

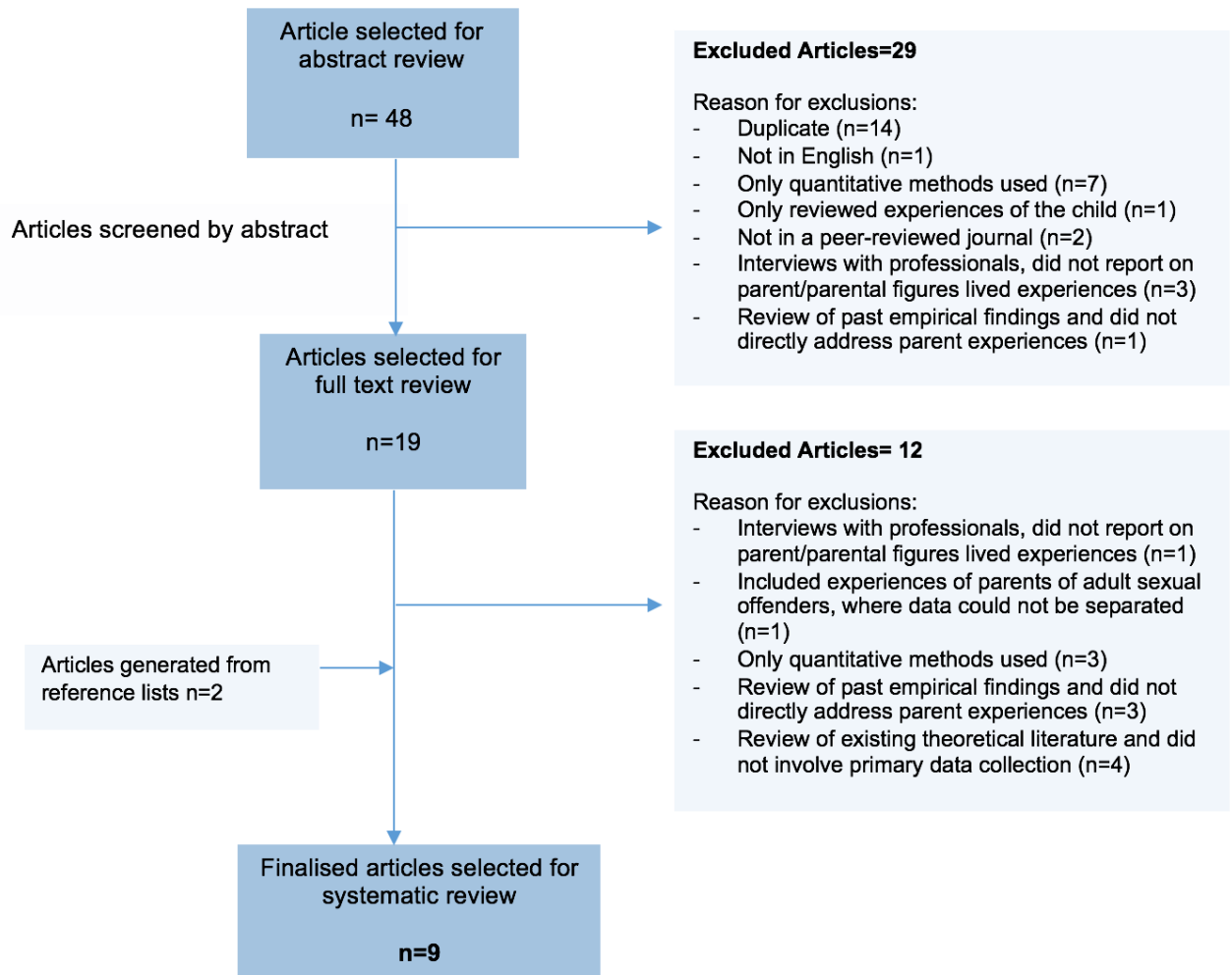


Figure 6. Flow diagram of literature search process

## Appendix B: Evaluation of Strength and Quality of Qualitative Research included in Systematic Review

N.B. Principles derived by Yardley (2000).

### Sensitivity to Context

**i. Relevant literature.** The studies summarised relevant literature to ground their research, with attention given to a wide variety of specific areas for example: factors associated with HSB in CYP (Thornton et al., 2008), family functioning in HSB (Thornton et al., 2008), PPF's adjustment following HSB (Duane et al., 2002; Hackett, Phillips, Balfe & Masson, 2014), the inclusion of family in interventions (Hackett, Phillips, Balfe & Masson, 2014; Jones, 2015), service user views about professional responses to HSB (Hackett & Mason, 2006), community responses to HSB (Hackett, Masson, Balfe & Phillips, 2015), issues specific to CYP with intellectual difficulties (Hubert, Flynn, Nicholls & Hollins, 2007) and the conceptual framework of a trauma model to understanding PPF's experiences (Pierce, 2011). In only a few studies were the generated themes clearly and meaningfully grounded in the existing research literature (Hackett, Masson, Balfe & Phillips, 2015; Thornton et al., 2008; Jones, 2015) or theoretical underpinnings (Pierce, 2011).

**ii. Participants' perspectives and sociocultural setting.** With regards to sensitivity to the participants perspectives and context, Pierce (2011) provided thorough and sensitive consideration to the social and cultural setting within PPF's are situated and to issues arising in access to this group as an out-group researcher as did Hackett and Mason (2006). All of the studies attempted to demonstrate that their reports of PPF's experiences were close to their actual experiences, by grounding their interpretation within PPF's actual words within the text.

**iii. Ethics.** Hackett and Mason (2006) discussed the issue of ethics in detail, particularly with regards to ethically responsible ways of approaching participants and collecting research data. Several studies did not mention ethical issues in any meaningful way (e.g., Hackett, Balfe, Masson & Phillips, 2014, Jones, 2015) and two studies did not reference the ethical permissions given to conduct their research (Duane et al., 2002; Hackett, Balfe, Masson & Phillips, 2014). The anonymisation of participant data was discussed by Hackett and Mason (2006) and Hubert, Flynn, Nicholls and Hollins (2007) although was not mentioned in other studies. Although perhaps due to word count limitations, this raises questions about the identification of research participants, particularly as the recruitment site

was often named. That Pierce's (2011) analytic procedures incorporated the participants' own perspectives has an ethical component, due to the impact on the balance of power between researcher and "subject", in an area where service users input in research is uncommon (Yardley, 2000).

## **Commitment and Rigour**

**i. In depth topic engagement.** Engagement in understanding the topic in a prolonged and in-depth way was clearly thorough within some of the studies (e.g., Jones, 2015; Pierce, 2011). It was difficult to consider the sensitivity of the research interviews to the area being studied, as little detail was given. Where interviews were conducted, it was not made clear in any of the studies whether the researcher was attentive to participant's non-verbal communications, which may be argued to be of importance when considering the barriers to PPF's openly describing their personal experiences with the researcher. Although Pierce (2011) used memo's to support their analysis, this was not made clear within their journal article. In the study by Pierce (2011) was it acknowledged that study findings were co-constructed by participant and researcher, with participants themselves conducted the preliminary analysis of data.

**ii. Methodological competence and skill.** In studies by Thornton et al. (2008) and Pierce (2011) the choice of approach and rationale for this was summarised and it was briefly mentioned by Jones (2015) although decisions regarding choice of formal analytic procedure or grounding in the philosophy of the approach was not explicitly commented upon in other studies included in the review. Jones (2015) made use of Content Analysis as her analytic strategy. She sufficiently described the analysis and appeared rigorous in their analysis, with attention given to data saturation. In the study by Hackett, Balfe, Masson, & Phillips (2014), thematic analysis of case file data was undertaken. PPF's experiences as depicted by the professionals writing in their case files was taken at face value. Contextualisation of the data as forming part of a professional record (e.g., in relation to linguistic meaning and function) was limited. In the study Hackett, Masson, Balfe and Phillips (2015) which held a similar methodology, the influence of the role of the professional, their relationship with families and their views were much more thoroughly commented upon. In both studies and that by Hackett and Masson (2006) the analysis was not developed to an interpretative level in a meaningful way, in line with the constraints of Thematic Analysis. Considering the researchers' practical and pragmatic approach this appeared suitable. Notably, Thematic Analysis is arguably the least rigorous of qualitative methodologies due to the absence of clear guidance around its application (Antaki, Billig, Edwards, & Potter, 2002).



Several authors increased their methodological rigor by consulting with an expert in the analytic strategy (Jones, 2015), using multiple researchers when analysing the data to establish inter-rater reliability (e.g., Jones, 2015; Duane et al., 2002) or by partially shared their analysis with research participants for the purpose of seeking their feedback (Jones, 2015). In the IPA study by Thornton et al. (2008), it appeared that analysis of the data was mainly superficial and development to a more interpretative level was not apparent, which is inconsistent with IPA's hermeneutic guiding principle (Smith, Flowers & Larkin, 2009).

**iii. Data collection.** All of the studies cited used purposive sampling or stratified purposive sampling, with this method being congruent with the nature and purpose of the research. As PPF's are a difficult to reach group within the community, to approach PPF's through their access to services is logical despite its limitations. The research studies aimed to gather a sample which could give their account of the specific experience under analysis (Smith, Flowers & Larkin, 2009), as opposed to making use of a representative sample. Some authors highlighted that their samples may be biased, for example due to self-selection or PPF's nearing completion of an intervention (Hackett & Masson, 2006; Mason, Hackett, Phillips & Balfe, 2014; Thornton et al., 2008). As findings may not be representative of the experiences of other PPF's of CYP who have engaged in HSB this impacts on generalisability. In some studies service user consultation shaped the interview schedule or questionnaire questions (Hackett & Masson, 2006), these were piloted with professionals working clinically with HSB (Hackett & Masson, 2006; Jones, 2015), or in the case of the study by Pierce (2011) the interview schedule was shaped by the study participants themselves. The studies which used Content Analysis and Constant Comparison as their analytic study stated that they reached saturation (a concept which is debatably 'valid' in any case), although as Pierce (2011) sampled four PPF's it is questionable whether all potential issues about the experience and impact of being involved in treatment were explored.

## **Transparency and Coherence**

**i. Transparent methods.** The majority of studies were clear and informative regarding their methodologies, with detailed information about the steps undertaken which resulted in the generated findings. For example, Hackett and Masson (2006) listed question level items in their questionnaire and Jones (2015) were transparent regarding the questions asked of PPF's in the interview and Pierce (2011) was detailed in the description of their ethnographic approach. There were some notable absences from studies which impacted on transparency, including missing or limited information about the sample size (Hackett, Phillips, Balfe & Masson, 2014; Hackett, Masson, Balfe & Phillips, 2015), sample characteristics (e.g., Thornton et al., 2008; Duane et al., 2002) and the analytic strategy (Hubert, Flynn, Nicholls &

Hollins, 2007; Thornton et al., 2008).

**ii. Fit between theory and methodology.** In none of the studies was the researcher's epistemological stance stated. It could be deduced that the majority of studies employed a phenomenological approach, as determined by their aims and methodology which attempted to explore PPF's personal perspectives, experiences and understandings. At times elements of the methodology were not sufficiently outlined, for example, as the researchers influence on interpreting and constructing the accounts of PPT's experiences was not detailed within the IPA study by Thornton et al. (2008), it is unclear whether the analysis was consistent with the underlying principles of the method.

**iii. Reflexivity.** In no study was the influence of the researcher in shaping the findings meaningfully acknowledged and no authors made meaningful reference to issues of reflexivity. For example, Hackett and Mason (2006) gave comprehensive information about the researchers personal and professional context, although did not comment on how this may have influenced their analysis. In addition, Hubert, Flynn, Nicholls and Hollins (2007) appeared to be an 'in house' review (rather than being conducted by external researchers), with this lack of impartiality not reflected upon. No studies transparently described the possible impact of their own assumptions, preunderstandings and prior engagement with the research literature on generated data. This was particularly lacking in the IPA study by Thornton et al. (2008), as the importance of reflexivity is recognised within this approach (Smith & Osborn, 2008).

## Appendix C: Consideration of Alternative Qualitative Approaches

IPA was chosen as the studies analytic strategy due to its suitability to the research question. I will here outline several other considered approaches:

### **Grounded Theory**

Grounded Theory (Glaser & Strauss, 1967; Strauss & Corbin, 1998) focusses on creating a theoretical account of a phenomena (Smith, Flowers & Larkin, 2009). It was an attractive choice, due to the focus on the voices of participants structuring data interpretation, however it aims to provide a broad applicability of findings, achieved through its sampling strategy and analysis (Smith & Osbourne, 2008). There is arguably less of a focus on similarities and differences in participant idiosyncratic accounts as IPA.

### **Narrative Analysis**

Narrative Analysis (Riessman, 2008) focusses on the way in which people interpret the world through making and using stories, and attempts to highlight the narrative means used by participants in the laying out and sense-making of particular experiences. It's use fitted well with the constructionist philosophy of this research, as it does not interest itself in the truth of such stories and also challenges modernist views of truth. The focus of this analysis lies more in the way that participants structure narratives and their genre and content (Crossley, 2000) rather focusing on their individual experiences.

### **Discourse Analysis**

Discourse Analysis (Potter & Wetherall, 1987; Willig, 2003) focuses on the way that participants use language. It involves investigation of speech and interaction in relation to an experience, with this perceived to be socially constructed and context specific (Smith, Flowers & Larkin, 2009). Use of IPA was felt to align itself better with the aims of the research due to its focus on meaning-making over the use of language used to describe the experience (Smith, Jarman & Osborn, 1999).

## Appendix D: Participant Information Sheet



### Participant Information Sheet

**Research Title:** Children who have Engaged in Harmful Sexual Behaviour;  
Exploring the Experiences of their Parents

#### Introduction

You are being invited to take part in a research study being conducted by Elisabeth Archer, Trainee Clinical Psychologist. Before you decide whether or not to take part, please take time to read the following information about why the research is being carried out and what it will involve:

#### What is the study about?

The aim of the study is to explore the experiences of parents, where sexual behaviour has been a problem for their child. In the UK, thousands of children and adolescents a year experience problems with their sexual behaviour. Many of those children have parents who have found out about these difficulties. Despite this, we don't know much about what life is like for these parents or how they make sense of what has happened. Not many researchers have asked parents about this. Although each parent's experiences are different, it is hoped that the information that we find out from this study will help us to gain a better understanding of what some parent's can experience, when their child has had problems with their sexual behaviour.

#### Why have I been invited to take part?

You have been invited to take part because you are the parent of a child or young person accessing the [REDACTED] service, which works with children and adolescents who have or have had problems with sexual behaviour. This study is hoping to interview eight parents where sexual behaviour has been a problem for their child.

#### Do I have to take part?

It is up to you whether you decide to take part in the study or not, as participation is voluntary. You are free to withdraw from the study at any time without giving a reason. If you decide that you do not wish to take part, this will not affect the care that you and your family receive at [REDACTED].

#### What will be involved?

A member of the [REDACTED] team will have given you this information sheet. If you decide that you may wish to take part in the study then, with your permission, they will contact me (Elisabeth Archer) to let me know that this is the case. With your agreement, they will provide

me with your contact details. We will then arrange to meet at the [REDACTED] service a time which is convenient for you. I may also be able to meet with you at your own home if this is preferred, but I can't guarantee that this will be possible. When we meet, I will do my best to make sure that you understand the information sheet and will answer any questions which you have. If you decide that you would like to take part, you will be asked to sign a consent form. You will then be invited to participate in an interview with the researcher, which will be no more than an hour and a half long and will be audio recorded. During this time, you will be asked some questions about how and when you came to access [REDACTED]. You will then be asked to discuss your experiences as a parent of a child who has had problems with their sexual behaviour. The interview will cover a number of topics related to your experiences and will be guided by the things that you talk about. After the interview you will have an opportunity to ask questions.

#### Will my taking part in this study be confidential?

We will follow ethical and legal practice and the information which you provide us with will be handled in strict confidence. If you decide to take part, all of the information from the interview will be anonymised and stored securely. The interview recording and the transcript will be stored in a password protected file on a password protected computer, so that only the researchers will have access to them. The transcript will be anonymous. This means that any information which could be used to identify you, your family or anyone else will be removed or changed so that the interview can't be traced back to you. If during the course of the research we have serious concerns about your safety or the safety of others, we would discuss this with a member of the [REDACTED] as part of our duty of care. [REDACTED] would follow their usual safeguarding procedures. This may involve contacting Social Care and/or your GP. This means that in this instance what you say would not be kept completely private. Should this occur, I would do my best to discuss this with you first.

#### What will happen to the study results?

We may use small bits of what you have said (which will be anonymised) when we report on the study in a Doctoral thesis. It may be that a shortened version of the overall findings of the project are published in a research paper or presented at conferences, so that other people can benefit from hearing about what we found out. This may also include brief sections of what you said in the interview. Again, this would not include any information that could identify you or anyone else.

You will be asked whether you would like to receive a summary of the research findings at the end of the study (in around September 2017). This would include general information about what we found out about the experiences of parents, from the people who contributed to the research. Again, no quotes or identifiable information would be included. It is completely up to you whether you would like to receive this information.

#### What are the potential benefits of taking part in the study?

The information we get about the experiences of parents may have implications for services working with young people who have had sexual behaviour problems, as well as healthcare policy. What is said by the parents who take part may be considered by professionals when thinking about good practice and helpful responses to other parents in a similar situation. With

regards to the more direct possible benefits in taking part, some researchers and clinicians suggest that talking about experiences openly can be therapeutic or helpful. You will be offered a £10 gift voucher as thanks for your time and as an acknowledgement of the important contribution which you have made to this research.

Are there any potential disadvantages to taking part in the study?

It is important to let you know that talking about your experiences may lead to some emotional discomfort or distress. You will be able to take a break or stop the interview at anytime should you wish. Following the interview, you will be given a debrief sheet, which explains more about the study and tells you about some possible sources of support. You will also be able to talk to a member of the [REDACTED] team should you wish, to talk about any issues which were raised during the study.

Who has reviewed this study?

All NHS research is looked at by an independent group of people, called a Research and Ethics Committee, in order to protect your safety, rights, wellbeing and dignity. This study has been reviewed by the West Midlands - Solihull Research Ethics Committee (IRAS Protocol number 214162) and the University of Hertfordshire (Protocol number LMS/PGR/NHS/02412) and given approval.

What should I do if I have questions or concerns about the study?

If you have any questions or concerns, please feel free to contact the researcher. Alternatively, you can contact the Research Supervisor, Pieter Nel. Contact details are provided overleaf:

**Name of Principle Researcher:**

Elisabeth Archer  
Trainee Clinical Psychologist  
Supervisor University of Hertfordshire  
Email address: [REDACTED]  
Telephone number: [REDACTED]

**Research Supervisor:**

Dr Pieter Nel  
Clinical Psychologist, Research  
University of Hertfordshire  
Email address: [REDACTED]

Postal address: DClinPsy Course, Health Research Building, University of Hertfordshire, AL10 9AB

If you would like any further free and independent advice about taking part in research, you can contact the [REDACTED] Patient Advice and Liaison Service (PALS) by telephone on [REDACTED] or by email on [REDACTED]. You can also contact PALS if you wish to complain formally about any aspect of the research.

**Thank you for taking the time to read this information**

## Appendix E: UH Ethical Approval Letter



Dr P Nel & Miss E Archer  
Department of Psychology & Sports Sciences  
School of Life and Medical Sciences

University of Hertfordshire  
Higher Education Corporation  
Hatfield, Hertfordshire  
AL10 9AB

Telephone +44 (0) 1707 284000  
Fax +44 (0) 1707 284115  
Website www.herts.ac.uk

17 August 2016

Dear Dr Nel and Miss Archer,

**Re: UNIVERSITY OF HERTFORDSHIRE SPONSORSHIP IN PRINCIPLE for the following:**  
**RESEARCH STUDY TITLE:** Children who Engage in Harmful Sexual Behaviour: Exploring the Experiences of their Parents  
**NAME OF CHIEF INVESTIGATOR (Supervisor):** Dr Pieter Nel  
**NAME OF INVESTIGATOR (Student):** Miss E Archer  
**UNIVERSITY OF HERTFORDSHIRE ETHICS PROTOCOL NUMBER:** LMS/PGR/NHS/02412

This letter is to confirm your research study detailed above has been reviewed and accepted, and I agree to give University of Hertfordshire sponsorship in principle.

Before you commence your research you must be in full compliance with all NHS Governance requirements. You must also secure full University of Hertfordshire sponsorship, for which you will need to have supplied the following documentation:

- Final version of the submitted IRAS form (pdf)
- Approval from the relevant HRA (NHS) Research Ethics Committee (REC) as well as confirmation of favourable opinion of any amendments
- Evidence of relevant NHS Permissions (eg Research Passport) and NHS Trust Management Permissions (previously known as R&D Approval) as they are received
- The final versions of the protocol, patient information leaflet and informed consent form
- One page summary CV for the Chief Investigator (CI) as submitted to IRAS
- Any other regulatory permissions required for your research, eg from the National Information Governance Board (NIGB), under the Human Tissue Act or the Ionising Radiation (Medical Exposure) Regulations
- If applicable, copies of any contracts/agreements with external organisations (eg funders, collaborators, co-sponsors) involved in your research study.

As a condition of receiving full sponsorship, it is the responsibility of the Chief Investigator to inform the Sponsor of any changes to the duration or funding of the project, changes of investigators, changes to the protocol and any future amendments, or deviations from the protocol, which may require re-evaluation of the sponsorship arrangements. It is also the responsibility of the Chief Investigator to inform the funder, the HRA (NHS) Research Ethics Committee (REC) and the relevant University of Hertfordshire Ethics Committee with Delegated Authority (ECDA) and any other relevant authority of any of these changes.

I look forward to receiving the above documents before you commence your research. Please email these to [research-sponsorship@herts.ac.uk](mailto:research-sponsorship@herts.ac.uk) so the University can confirm sponsorship. In the meantime, we wish you well in pursuing this interesting research study.

Yours sincerely

Professor J M Senior  
Pro Vice-Chancellor (Research and Enterprise)

*Encl: Insurance certificate*

## Appendix F: West Midlands- Solihull REC Approval



**Health Research Authority**

**West Midlands - Solihull Research Ethics Committee**

The Old Chapel  
Royal Standard Place  
Nottingham  
NG1 6FS

**Please note: This is the favourable opinion of the REC only and does not allow you to start your study at NHS sites in England until you receive HRA Approval**

19 October 2016

Dr Pieter Nel  
Director of the Doctorate in Clinical Psychology  
University of Hertfordshire  
University of Hertfordshire  
Hatfield  
Hertfordshire  
AL10 9AB

Dear Dr Nel

<b>Study title:</b>	<b>Children and Young People who have Engaged in Harmful Sexual Behaviour; Exploring the Experiences of their Parents</b>
<b>REC reference:</b>	<b>16/WM/0405</b>
<b>Protocol number:</b>	<b>LMS/PGR/NHS/02412</b>
<b>IRAS project ID:</b>	<b>214162</b>

Thank you for your letter, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to make a request to postpone publication, please contact the REC Manager, Miss Vic Strutt, [NRESCcommittee.WestMidlands-Solihull@nhs.net](mailto:NRESCcommittee.WestMidlands-Solihull@nhs.net).



## **Confirmation of ethical opinion**

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

## **Conditions of the favourable opinion**

Management permission must be obtained from each host organisation prior to the start of the study at the site concerned.

*Management permission should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).*

*Guidance on applying for NHS permission for research is available in the Integrated Research Application System, [www.hra.nhs.uk](http://www.hra.nhs.uk) or at <http://www.rdforum.nhs.uk>.*

*Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.*

*For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.*

*Sponsors are not required to notify the Committee of management permissions from host organisations*

## **Registration of Clinical Trials**

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database within 6 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication trees).

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to contest the need for registration they should contact Catherine Blewett ([catherineblewett@nhs.net](mailto:catherineblewett@nhs.net)), the HRA does not, however, expect exceptions to be made. Guidance on where to register is provided within IRAS.

**It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).**

## Ethical review of research sites

### NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

## Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
Covering letter on headed paper [Cover letter for REC]	1	04 October 2016
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Evidence of Sponsors Professional Indemnity]	1	08 August 2016
Interview schedules or topic guides for participants [Draft Interview Schedule]	1	04 June 2016
IRAS Application Form [IRAS_Form_02092016]		02 September 2016
IRAS Application Form XML file [IRAS_Form_02092016]		02 September 2016
IRAS Checklist XML [Checklist_11102016]		11 October 2016
Letter from sponsor [In Principle Sponsorship Approval]	1	04 June 2016
Other [Confirmation of AWP Litigation Authority Liabilities to Third Parties Scheme]	1	01 April 2016
Other [Debrief Information for Participants]	1.0	04 June 2016
Participant consent form [Participant Consent Form]	1	04 June 2016
Participant information sheet (PIS) [Information Sheet for Participants]	2	03 October 2016
Research protocol or project proposal [Research Protocol]	2	03 October 2016
Summary CV for Chief Investigator (CI) [Curriculum Vitae for Chief Investigator/ Research Supervisor (Pieter Nel)]	1	04 June 2016
Summary CV for student [Curriculum Vitae for Student (Elisabeth Archer)]	1	04 June 2016
Summary CV for supervisor (student research) [Curriculum Vitae for Local Collaborator/ Research Supervisor Dr Melanie Turpin]	1	04 June 2016

## Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

## After ethical review

### Reporting requirements

The attached document "*After ethical review – guidance for researchers*" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments

- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

### **User Feedback**

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website:

<http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/>

### **HRA Training**

We are pleased to welcome researchers and R&D staff at our training days – see details at

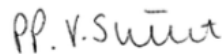
<http://www.hra.nhs.uk/hra-training/>

**16/WM/0405**

**Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project.

Yours sincerely



**Dr Rex J Polson**  
**Chair**

Email: NRESCommittee.WestMidlands-Solihull@nhs.net

Enclosures: "After ethical review – guidance for

Copy to: *Professor John Senior*

*Elisabeth Archer*

## Appendix G: Letter of HRA Approval



Health Research Authority

Dr Pieter Nel  
Director of the Doctorate in Clinical Psychology  
University of Hertfordshire  
Hatfield  
Hertfordshire  
AL10 9AB

Email: [hra.approval@nhs.net](mailto:hra.approval@nhs.net)

1 November 2016

Dear Dr Nel

### Letter of HRA Approval

**Study title:** Children and Young People who have Engaged in Harmful Sexual Behaviour; Exploring the Experiences of their Parents  
**IRAS project ID:** 214162  
**Protocol number:** LMS/PGR/NHS/02412  
**REC reference:** 16/WM/0405  
**Sponsor:** University of Hertfordshire

I am pleased to confirm that **HRA Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications noted in this letter.

#### Participation of NHS Organisations in England

The sponsor should now provide a copy of this letter to all participating NHS organisations in England.

*Appendix B* provides important information for sponsors and participating NHS organisations in England for arranging and confirming capacity and capability. **Please read *Appendix B* carefully**, in particular the following sections:

- *Participating NHS organisations in England* – this clarifies the types of participating organisations in the study and whether or not all organisations will be undertaking the same activities
- *Confirmation of capacity and capability* - this confirms whether or not each type of participating NHS organisation in England is expected to give formal confirmation of capacity and capability. Where formal confirmation is not expected, the section also provides details on the time limit given to participating organisations to opt out of the study, or request additional time, before their participation is assumed.
- *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* - this provides detail on the form of agreement to be used in the study to confirm capacity and capability, where applicable.

Further information on funding, HR processes, and compliance with HRA criteria and standards is also provided.



It is critical that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details and further information about working with the research management function for each organisation can be accessed from [www.hra.nhs.uk/hra-approval](http://www.hra.nhs.uk/hra-approval).

### Appendices

The HRA Approval letter contains the following appendices:

- A – List of documents reviewed during HRA assessment
- B – Summary of HRA assessment

### After HRA Approval

The document “*After Ethical Review – guidance for sponsors and investigators*”, issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

In addition to the guidance in the above, please note the following:

- HRA Approval applies for the duration of your REC favourable opinion, unless otherwise notified in writing by the HRA.
- Substantial amendments should be submitted directly to the Research Ethics Committee, as detailed in the *After Ethical Review* document. Non-substantial amendments should be submitted for review by the HRA using the form provided on the [HRA website](http://www.hra.nhs.uk), and emailed to [hra.amendments@nhs.net](mailto:hra.amendments@nhs.net).
- The HRA will categorise amendments (substantial and non-substantial) and issue confirmation of continued HRA Approval. Further details can be found on the [HRA website](http://www.hra.nhs.uk).

### Scope

HRA Approval provides an approval for research involving patients or staff in NHS organisations in England.

If your study involves NHS organisations in other countries in the UK, please contact the relevant national coordinating functions for support and advice. Further information can be found at <http://www.hra.nhs.uk/resources/applying-for-reviews/nhs-hsc-rd-review/>.

If there are participating non-NHS organisations, local agreement should be obtained in accordance with the procedures of the local participating non-NHS organisation.

### User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please email the HRA at [hra.approval@nhs.net](mailto:hra.approval@nhs.net). Additionally, one of our staff would be happy to call and discuss your experience of HRA Approval.

### HRA Training


We are pleased to welcome researchers and research management staff at our training days – see details at <http://www.hra.nhs.uk/hra-training/>

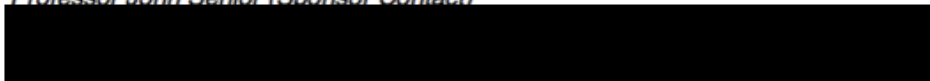
Your IRAS project ID is **214162**. Please quote this on all correspondence.

Yours sincerely

Dr Claire Cole  
Senior Assessor

Email: [hra.approval@nhs.net](mailto:hra.approval@nhs.net)

Copy to:   
*Professor John Senior (Sponsor Contact)*

  
*Miss Elisabeth Archer (Student)*

## Appendix A - List of Documents

The final document set assessed and approved by HRA Approval is listed below.

<i>Document</i>	<i>Version</i>	<i>Date</i>
Covering letter on headed paper [Cover letter for REC]	1	04 October 2016
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Evidence of Sponsors Professional Indemnity]	1	08 August 2016
Interview schedules or topic guides for participants [Draft Interview Schedule]	1	04 June 2016
IRAS Application Form [IRAS_Form_02092016]		02 September 2016
Letter from sponsor [In Principle Sponsorship Approval]	1	04 June 2016
Other [Schedule of Events]	1	31 October 2016
Other [Statement of Activities]	2	01 November 2016
Other [Confirmation of AWP Litigation Authority Liabilities to Third Parties Scheme]	1	01 April 2016
Other [Debrief Information for Participants]	1.0	04 June 2016
Participant consent form [Participant Consent Form]	1	04 June 2016
Participant information sheet (PIS) [Information Sheet for Participants]	2	03 October 2016
Research protocol or project proposal [Research Protocol]	2	03 October 2016
Summary CV for Chief Investigator (CI) [Curriculum Vitae for Chief Investigator/ Research Supervisor (Pieter Nel)]	1	04 June 2016
Summary CV for student [Curriculum Vitae for Student (Elisabeth Archer)]	1	04 June 2016
Summary CV for supervisor (student research) [Curriculum Vitae for Local Collaborator/ Research Supervisor ██████████]	1	04 June 2016

## Appendix B - Summary of HRA Assessment

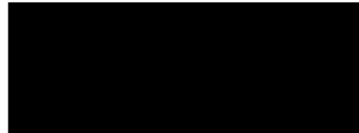
This appendix provides assurance to you, the sponsor and the NHS in England that the study, as reviewed for HRA Approval, is compliant with relevant standards. It also provides information and clarification, where appropriate, to participating NHS organisations in England to assist in assessing and arranging capacity and capability.

**For information on how the sponsor should be working with participating NHS organisations in England, please refer to the, *participating NHS organisations, capacity and capability and Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria) sections in this appendix.***

The following person is the sponsor contact for the purpose of addressing participating organisation questions relating to the study:

Name: Professor John Senior

Email: [j.m.senior@herts.ac.uk](mailto:j.m.senior@herts.ac.uk)



### HRA assessment criteria

Section	HRA Assessment Criteria	Compliant with Standards	Comments
1.1	IRAS application completed correctly	Yes	No comments
2.1	Participant information/consent documents and consent process	Yes	No comments
3.1	Protocol assessment	Yes	No comments
4.1	Allocation of responsibilities and rights are agreed and documented	Yes	A Statement of Activities will act as the agreement between the sponsor and the participating NHS organisation.  All the activities in the Schedule of Events have been attributed as 'no activity'.
4.2	Insurance/indemnity arrangements assessed	Yes	Where applicable, independent contractors (e.g. General Practitioners) should ensure that the professional



Section	HRA Assessment Criteria	Compliant with Standards	Comments
			indemnity provided by their medical defence organisation covers the activities expected of them for this research study
4.3	Financial arrangements assessed	Yes	No funding will be provided to sites.
5.1	Compliance with the Data Protection Act and data security issues assessed	Yes	Student will transcribe the audio-files. Files will be uploaded remotely to the University server.
5.2	CTIMPS – Arrangements for compliance with the Clinical Trials Regulations assessed	Not Applicable	No comments
5.3	Compliance with any applicable laws or regulations	Yes	No comments
6.1	NHS Research Ethics Committee favourable opinion received for applicable studies	Yes	No comments
6.2	CTIMPS – Clinical Trials Authorisation (CTA) letter received	Not Applicable	No comments
6.3	Devices – MHRA notice of no objection received	Not Applicable	No comments
6.4	Other regulatory approvals and authorisations received	Not Applicable	No comments

### Participating NHS Organisations in England

*This provides detail on the types of participating NHS organisations in the study and a statement as to whether the activities at all organisations are the same or different.*

One site type for this study. All research activities as detailed in the study documents will take place at site.

The Chief Investigator or sponsor should share relevant study documents with participating NHS organisations in England in order to put arrangements in place to deliver the study. The documents should be sent to both the local study team, where applicable, and the office providing the research management function at the participating organisation. For NIHR CRN Portfolio studies, the Local

LCRN contact should also be copied into this correspondence. For further guidance on working with participating NHS organisations please see the HRA website.

If chief investigators, sponsors or principal investigators are asked to complete site level forms for participating NHS organisations in England which are not provided in IRAS or on the HRA website, the chief investigator, sponsor or principal investigator should notify the HRA immediately at [hra.approval@nhs.net](mailto:hra.approval@nhs.net). The HRA will work with these organisations to achieve a consistent approach to information provision.

## Confirmation of Capacity and Capability

*This describes whether formal confirmation of capacity and capability is expected from participating NHS organisations in England.*

Participating NHS organisations in England **will be expected to formally confirm their capacity and capability to host this research.**

- Following issue of this letter, participating NHS organisations in England may now confirm to the sponsor their capacity and capability to host this research, when ready to do so. How capacity and capability will be confirmed is detailed in the *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* section of this appendix.
- The [Assessing, Arranging, and Confirming](#) document on the HRA website provides further information for the sponsor and NHS organisations on assessing, arranging and confirming capacity and capability.

## Principal Investigator Suitability

*This confirms whether the sponsor position on whether a PI, LC or neither should be in place is correct for each type of participating NHS organisation in England and the minimum expectations for education, training and experience that PIs should meet (where applicable).*

A Local Collaborator should be in place at site to facilitate access for the external research team.

GCP training is not a generic training expectation, in line with the [HRA statement on training expectations](#).

## HR Good Practice Resource Pack Expectations

*This confirms the HR Good Practice Resource Pack expectations for the study and the pre-engagement checks that should and should not be undertaken*

Members of the external research team who do not have a contractual relationship with the participating NHS organisation should obtain a Letter of Access. Occupational Health Clearance and DBS Clearance should be confirmed.

## Other Information to Aid Study Set-up

*This details any other information that may be helpful to sponsors and participating NHS organisations in England to aid study set-up.*

## Appendix H: Local Letter of Access



4 November 2016 – reissued 7 November 2016 to reflect correct end date.

Dear Elisabeth,

**Letter of access for: Children and Young People who have Engaged in Harmful Sexual Behaviour; Exploring the Experiences of their Parents**

This letter should be presented to each participating site before you commence your research at [redacted]

In accepting this letter, the organisation confirms your right of access to conduct research through their organisation for the purpose and on the terms and conditions set out below. This right of access commences on 4 November 2016 and ends on 1 June 2017 unless terminated earlier in accordance with the clauses below.

The information supplied about your role in research at [redacted] NHS Trust has been reviewed and you do not require an honorary research contract with this NHS organisation. We are satisfied that such pre-engagement checks as we consider necessary have been carried out.

You have a right of access to conduct such research as confirmed in writing in the letter of permission for research from the organisation. Please note that you cannot start the research until the Principal Investigator for the research project has received a letter from us giving the organisation permission to conduct the project.

You are considered to be a legal visitor to [redacted] NHS Trust premises. You are not entitled to any form of [redacted] NHS Trust in any other relationship between you and [redacted] NHS Trust in particular that of an employee.

While undertaking research through [redacted] NHS Trust you will remain accountable to your place of study, University of Huddersfield, but you are required to follow the reasonable instructions of your nominated [redacted] in each site or those given on her behalf in relation to the terms of this right of access.

Acting Chair

Trust Headquarters

Chief Executive



*'We are a teaching, learning and research trust; we aim to inform you about relevant opportunities, unless you tell us otherwise.'*



Where any third party claim is made, whether or not legal proceedings are issued, arising out of or in connection with your right of access, you are required to co-operate fully with any investigation by [REDACTED] NHS Trust in connection with any such claim and to give all such assistance as may reasonably be required regarding the conduct of any legal proceedings.

You must act in accordance with Research & Development Department policies and procedures, which are available to you upon request, and the Research Governance Framework.

You are required to co-operate with [REDACTED] NHS Trust in discharging its duties under the Health and Safety at Work etc Act 1974 and other health and safety legislation and to take reasonable care for the health and safety of yourself and others while on Avon [REDACTED] NHS Trust premises. Although you are not a contract holder, you must observe the same standards of care and propriety in dealing with patients, staff, visitors, equipment and premises as is expected of a contract holder and you must act appropriately, responsibly and professionally at all times.

If you have a physical or mental health condition or disability which may affect your research role and which [REDACTED] if you have not already done so, you must notify your [REDACTED] NHS Trust prior to commencing your research role at each site.

You are required to ensure that all information regarding patients or staff remains secure and *strictly confidential* at all times. You [REDACTED] with the requirements of the NHS Confidentiality Code of [REDACTED] Furthermore you should be aware that under the Act, unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

The organisation will not indemnify you against any liability incurred as a result of any breach of confidentiality or breach of the Data Protection Act 1998. Any breach of the Data Protection Act 1998 may result in legal action against you and/or your substantive place of study.

You should ensure that, where you are issued with an identity or security card, a bleep number, email or library account, keys or protective clothing, these are returned upon termination of this arrangement. Please also ensure that while on the premises you wear your ID badge at all times, or are able to prove your identity if challenged. Please note that the organisation accept no responsibility for damage to or loss of personal property.

This letter may be revoked and your right to attend the organisation terminated at any time either by giving seven days' written notice to you or immediately without any notice if you are in breach of any of the terms or conditions described in this letter or if you commit any act that we reasonably consider to amount to serious misconduct or to be disruptive and/or prejudicial to the interests and/or business of the organisation or if you are convicted of any criminal offence. You must not undertake regulated activity if you are barred from such work. If you are barred from working with adults or children this letter of access is immediately terminated. Your place of study will immediately withdraw you from undertaking this or any other regulated activity and you MUST stop undertaking any regulated activity immediately.

Your place of study is responsible for your conduct during this research project and may in the circumstances described above instigate disciplinary action against you.

If your circumstances change in relation to your health, criminal record, professional registration or suitability to work with adults or children, or any other aspect that may impact on your suitability to conduct research, or your role in research changes, you must inform your place of study through its normal procedures. You must also inform the nominated manager in [REDACTED] NHS Trust.

## Appendix I: Participant Consent Form



### Participant Consent Form

**Research Title:** Children who have Engaged in Harmful Sexual Behaviour; Exploring the Experiences of their Parents

**Name of Principle Researcher:** Elisabeth Archer, Trainee Clinical Psychologist

I agree with the following statements (please tick the box if you agree) **Please tick the box**

1. I confirm that I have read and understood the information sheet provided. I have had opportunity to consider the information, ask questions and have these answered satisfactorily.
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason and without my care being affected.
3. I consent to the interview being audio recorded. I understand that the recording transcript will be stored securely.
4. I understand that the information I provide will be anonymised, to ensure that my identity is protected.
5. I understand that what I say will be kept confidential, unless the researcher is concerned about my safety or the safety of others. In this instance, the researcher would do their best to speak with me before passing on the information.
6. I understand that information gathered in the study may be published. I understand that parts of what I have said in the interview may be included and that steps will be taken to ensure that my identity is protected.

If you agree to take part in the above research study, please sign below:

\_\_\_\_\_  
Name of participant                      Signature                      Date

\_\_\_\_\_  
Name of person taking consent                      Signature                      Date

## Appendix J: Debrief Information for Participants



### Debrief Information for Participants

**Research Title:** Children who have Engaged in Harmful Sexual Behaviour; Exploring the Experiences of their Parents

**Name of Principle Researcher:** Elisabeth Archer, Trainee Clinical Psychologist

This study aimed to explore the experiences of a number of parents who have a child who has shown difficulties with their sexual behaviour. This included:

- The impact of your child having shown difficulties with their sexual behaviour on you personally (e.g., the thoughts and emotions this brought up for you)
- The impact of your child having shown difficulties with their sexual behaviour on your relationship with your child
- The way that your child having shown difficulties with their sexual behaviour affected your relationship with other people (e.g., your wider family and local community)
- The meanings you made of your experiences

There is hardly any information in the academic literature or from media sources into this area. The little research there is has mainly involved researchers looking at notes made by professionals in clients' case files or has used brief questionnaires. This research has indicated that there may be a personal psychological impact for parents, of having had a child engage in concerning sexual behaviour. It has also indicated that this situation may change the parent's relationship with not only their child but also their relationships with family, friends and others within their community.

It is hoped that this exploratory research will help us to gain greater insight into some of the experiences of parents from their perspective. Findings may provide a foundation on which to build psychological theory with regards to parent's experience. Importantly, findings may also help us in thinking about how best to support not only children but also their families through a potentially difficult time.

## **Sources of Support**

The process of talking about your experiences during the interview may have been upsetting for you, which would be understandable. Having experienced being a parent whose child has difficulties with sexual behaviour may be a very worrying and difficult to process experience for parents and talking about this may have brought up some difficult or distressing feelings. You might find it helpful to make use of a number of sources of support:

1. Speaking with someone who you trust, such as your own friends and family.
2. Talking with a professional at [REDACTED]
3. Some health care professionals (e.g., psychologists or counsellors) support people who have had difficult experiences and help them to explore their feelings related to these experiences. If you are feeling worried or sad, you may wish to speak to your GP who might refer you to local support services to access talking therapy with a counsellor or psychologist.
4. There are several national organisations who's support you may wish to access. The Samaritans is a voluntary organisation which offers a 24 hour a day helpline for anyone who wants to talk. Although they are not trained specifically in issues related to being a parent of a child with this difficulty, they listen and offer support to all people in emotional distress. You can contact the Samaritans helpline on telephone number 08457 909090 or you can access their website for further information: [www.samaritans.org.uk](http://www.samaritans.org.uk)
5. If you are concerned about your emotional wellbeing, you may wish to speak about this with your GP.

**Thank you for your generosity in helping to make this important research possible**

## Appendix K: Service User Consultation Questions

### Questions to ask to service user screening my interview schedule:

- Did the questions make sense to you?
- Which questions made less sense?
- Was there any language that you didn't understand? If yes: What words/ language would make more sense?
- Were there any times when you didn't quite know what I meant? If yes: What might have been a better/ clearer way of saying it?
- Were there any questions which felt too intrusive or too unsafe to answer? If yes: How do you think that the question could be changed?
- Was there anything you wanted to be included however wasn't?
- If you were to give me any other advice about what I should change before interviewing the first parent, what would you say?

### More general consulting about my project

- Do you think research relevant?
- Do you think research is important?
- What do you think the impact might be?



# Appendix L: Service User Consultation on Interview Schedule

## Draft Interview Schedule

**Research Title:** Children who have Engaged in Harmful Sexual Behaviour; Exploring the Experiences of their Parents

**Name of Principle Researcher:** Elisabeth Archer, Trainee Clinical Psychologist

**Introduction:** The aim of this research is to develop a greater understanding of the experiences of parents who have had a child who has shown problems with their sexual behaviours. The interview will likely last about an hour and I'll be recording it with a Dictaphone. During the interview, I'll be asking some questions about your experiences and what meaning you give to your experiences. There aren't any correct or incorrect answers.

**Main topics of content and draft study questions:**

<p><b>General opening questions:</b></p> <p>Warm up conversation: Journey time, familiarity with service etc.</p> <p>1) Could you tell me briefly about how you came to attend 'Be Safe'? What happened?</p> <p><i>Prompts: How long have you been attending the service? Reason? Current stage of assessment and treatment process?</i></p>
<p><b>Personal psychological impact (part 1- impact on self and identity)</b></p> <p>2) Can you tell about what (child's name/ your child) showing problems with his/her sexual behaviour has been like for you?</p> <p>Simple. Can go anywhere. Nice easy q.</p> <p><i>Prompts: How it has affected you? Consequences for you?</i></p> <p>3) What was it like when you first found out about what had happened with (name)?</p> <p><i>Prompt: What were initial thoughts/ feelings when found out about the sexual behaviour/s?</i></p> <p>4) <b>Have your feelings changed in the time since you found out?</b></p> <p><i>Prompt: What happened with these feelings? What happened when you moved beyond these initial feelings? What is it like now?</i></p> <p>6) <b>As (name's) parent, how has his/her sexual behaviour affected you in everyday life? Thinking about the impact on you as a parent, how has (child's name/ your child) having had problems with (his/her) sexual behaviour affected your everyday life?</b></p>

<p><i>Prompt: If so, how? Are things different for you now? What is it like for you?</i></p> <p>6) <b>Thinking about you as a person, how have these events affected the way you see yourself? Has (child's name) having had problems with (his/her) sexual behaviours changed the way you see yourself?</b></p> <p><i>Prompt: If so, how? Has the way you think or feel about yourself changed? Do you see yourself differently now, to before the problematic sexual behaviours? Changed the way that you view yourself as a parent?</i></p>
<p><b>Relationship with their child:</b></p> <p>7) What were your initial thoughts and feelings about (child's name/ your child) when you found out about what had happened?</p> <p><i>Prompts: What were initial reactions? How did you view him/her</i></p> <p>8) <b>How have your feelings about (name) changed over time? Did you move beyond these initial thoughts and feelings about (child's name/ your child)?</b></p> <p><i>Prompt: If so, what happened? How did your thoughts and feelings change over time?</i></p> <p>9) <b>How has your relationship with (child's name) been affected? Can you tell me about how the problems with the sexual behaviour have affected your relationship with (child's name)?</b></p> <p><i>Prompt: Affected what you do together? How close you are? Thoughts or feelings about child?</i></p>
<p><b>Wider familial/Social Impact:</b></p> <p>10) If you're in a relationship currently, has (your child/child's name) sexual behaviour had any effect on it?</p> <p><i>-your relationship with your husband/wife/partner?</i></p> <p><i>Prompt: Members of your family, friends, work colleagues, community, school, neighbours, religious community, social life, Areas can go to</i></p> <p>11) Did (your child/child's name) having problems with his/her sexual behaviour affect your relationships with other people?</p>

<p><i>Prompt: Members of your family, friends, work colleagues, community, school, neighbours, religious community, social life, Areas can go to</i></p> <p>12) <b>Do you think that (child's name) having had problems with his/her sexual behaviours changed the way that other people see you?</b></p> <p><i>Prompt: members of your family, friends, work colleagues, community, school, neighbours, religious community</i></p>
<p><b>Personal psychological impact (part 2- coping)</b></p> <p>13) <b>Has any professional support that has been offered helped you to cope?</b></p> <p><i>Prompt: Community? Professional? Practical emotional support? If not, what would have helped?</i></p> <p>14) <b>What else has helped you to cope with what has happened, both individually and as a family?</b></p> <p><i>Prompt: On a day-to-day basis, how do you deal with what has happened? Do you have particular strategies for helping you? Strengths? Ways of coping? Practical/ emotional support? Talking vs not talking?</i></p>
<p><b>General ending conversation:</b></p> <p>Ending- Cool down conversation (e.g. getting home, plans for the day etc). Option to sit with a coffee/tea for a few minutes little chat to bring them back to the world before you move on</p>

## Appendix M: Interview Schedule

### Interview Schedule

**Research Title:** Children who have Engaged in Harmful Sexual Behaviour; Exploring the Experiences of their Parents

**Name of Principle Researcher:** Elisabeth Archer, Trainee Clinical Psychologist

**Introduction:** The aim of this research is to get a better understanding of the experiences of parents who have had a child who has shown problems with their sexual behaviour. The interview will last up to an hour and a half and I'll be audio recording it with a Dictaphone (show device). I'll be asking some questions about your experiences and your perspectives. There aren't any right or wrong answers.

**Main topics of content and draft study questions:**

#### General opening questions:

Warm up conversation: Ease of journey, familiarity with service etc.

- 1) Could you tell me briefly about how you came to attend [REDACTED]? What happened?

*Prompts: How long have you been attending the service? Reason? Current stage of assessment and treatment process? Age and name of child*

#### Personal psychological impact- Impact on self and identity

- 2) Can you tell about what (child's name) showing problems with his/her sexual behaviour has been like for you?

*Prompts: How it has affected you? Consequences for you?*

- 3) What was it like when you first found out about what had happened with (child's name's) sexual behaviour?

*Prompt: What were initial thoughts/ feelings when found out about the sexual behaviour/s?*

- 4) Have your feelings changed in the time since you found out?

*Prompt: What happened with these initial feelings? What happened when you moved beyond these initial feelings? What is it like now?*

- 5) Thinking about the impact on you, how has this affected you in your everyday life?

*Prompt: Are things different for you now? What is it like for you?*

- 6) Thinking about you as a **person**, how have these events affected the way you see yourself?**

*Prompt: Has (child's name) having had problems with (his/her) sexual behaviours changed the way you see yourself? Has the way you think or feel about yourself changed? Do you see yourself differently now, to before the problematic sexual behaviours? Changed the way that you view yourself as a parent?*

### **Relationship with Child**

- 7) What were your initial thoughts and feelings about (child's name) when you first found out about what had happened?**

*Prompts: What were initial reactions? How did you view him/her*

- 8) How have your feelings about (child's name) changed over time?**

*Prompt:-Did you move beyond these initial thoughts and feelings about (child's name/ your child)? If so, what happened? How did your thoughts and feelings change over time?*

- 9) Can you tell me about how your relationship with (child's name) has been affected?**

*Prompt: did the sexual behaviour affect what you do together? How close you are? Thoughts or feelings about child? How able are to talk about what happened?*

### **Familial/ wider Social Impact**

- 10) If you're in a relationship currently, has (child's name's) sexual behaviour had any effect on it?**

*Prompt: Emotional closeness v's distance, intimacy, talking about the difficulty*

- 11) Has (child's name's) sexual behaviour had any effect on your relationships with any other people?**

Prompt: *Members of your family, friends, work colleagues, community, school, neighbours, religious community, social life, areas can go to*

**12) Do you think that (child's name) having had problems with his/her sexual behaviours changed the way that other people see you?**

*Prompt: members of your family, friends, work colleagues, community, school, neighbours, religious community*

### **Coping with the Impact**

**13) What has helped you to cope with what has happened, both individually and as a family?**

*Prompt: On a day-to-day basis, how do you deal with what has happened? Do you have particular strategies for helping you? Strengths? Ways of coping? Talking vs not talking?*

**14) Has any other practical or emotional support been useful?**

*Prompt: Community? Professional? If not, what would have helped?*

### **General ending conversation:**

Ending- Cool down conversation (e.g. getting home, plans for the day etc.). Option to sit with a coffee/tea for a few minutes' before they go home.

### **General Prompts:**

- How did you experience that?
- What sense did you make of that?
- How do you make sense of that?
- What did that mean for you?
- How did you come to understand that?
- And what did you think about that?
- What do you make of that?
- What do you think happened there?

## Appendix N: Superordinate Themes and Subthemes

### Anna

Superordinate Themes (=4)	Subthemes
1) A distressed and consumed self	Feeling overwhelmed and suffering
	Being consumed by the HSB and its consequences
	Struggling to find a space for 'me'
	Re-living own abuse
2) Coping with the problem alone	Backing away from relationships
	Shame of being seen
	Managing it alone
	Feeling let down by Professional systems
3) A challenged and changed relationship with son	Son as an abuser
	Disliking son
	Son must pay penance
	Both loving son and hating son: conflicting feelings
	It's too painful: Distancing self from son
4) Making sense of it and negotiating life moving forward	Searching and questioning: am I responsible for this?
	A meandering process of denial and acceptance
	Findings ways to get through it
	A commitment to dealing with this in the right way

### Elaine

Superordinate Themes (=6)	Subthemes
1) The upset of it	The shock of finding out
	An upsetting discovery
	Embarrassment and shame of it
	Unwanted contact with thoughts about child's sexuality
	Family upset by it
2) Mind consumed by making sense of it and legitimising	Stuck in thoughts of 'why?'
	Ideas about why: vulnerable and in need of love and attention
	Ideas about why: born this way
	Others also hold blame
	It wasn't that bad
	Considering thresholds of appropriateness
3) It's too hard for me as a mother	Considering own fault in it and feelings of guilt
	Life with and without the problem as a struggle
	Alone with it
	Self as an incompetent parent
4) Relationship with son	Pushing away feelings to get by
	Feeling empathy for son
	Emotional distance and disconnection
	Suspicion and mistrust
5) Relationship to professionals and treatment	Disrespected and overpowered
	Positive feelings about receiving help
	Ambivalent feelings about professional assistance
	Professional involvement as a symbol of incompetence
6) Worries for the future	Making use of the input: committed action to reduce future harm
	Worries for his future
	Fear of future harm
	Self as impotent: Powerless to prevent future harm

## Laura

Superordinate Themes (=5)	Subthemes
1) Overwhelmed: stuck in it and powerless	Pressure/ Strain of the situation on life
	Distress as a result of the behaviours
	No Escape
	Living life centred on risk
	Fearful about what the future holds
2) Alone with the problem	Holding all the responsibility
	Threat of being seen and being judgement
	Being rejected and pulling away: A shrinking social world
	Aggressive inter-relational ways of evading own mental pain
3) Emotional turmoil of relationship with children	Empathy for son
	Guilt and shame as a mother
	Guilt and fear: catalysts for process of toxic reparative action
	Powerless to stop him
	Son as inherently different
4) Trying to cope with the situation	Benefits of togetherness
	Calling on own strength as a mother
	Trying to push away the distress
	Trying to find a way to accept son's: It's not their fault
5) A fractured and compromised relationship to help	Not held in mind/ adequately supported
	Feeling threatened and at threat
	Pulling away
	It's too much: 'Help' as unhelpfully overwhelming
	Powerlessness: put in an impossible position and feelings

## James

Superordinate Themes (=6)	Subthemes
1) The harmful sexual act and what it evokes	Disturbing immersion in the murky landscape of abuse
	The difference of being in the position of dad
	Guilt: Conscience, morality and responsibility
2) Feelings towards son	Son is bad/threatening/ disgusting
	What is son capable of?
	Son is the source of the problem
	Conflicting feelings: Wanting to protect and reject
3) Overwhelmed and struggling to cope	Burden of professional support and safeguarding
	The strain of it: It's too much to deal with
	Yearning for a different life
4) Alone with it	Going into hiding
	Honest talking as dangerous
	Emotional distance from wife
	Responsibility to look after at the expense of being looked after
5) Held captive and can't escape	Trapped by it: an invaded and overwhelmed mind
	Unsuccessful attempts to escape it (Feelings don't go away)
6) Coping	It's easier together: benefits of being two
	Talking Helps
	Getting away

## Angela

Superordinate Themes (=6)	Subthemes
1) So close and so distant: relationship to son	Distance from son and powerless to influence
	Painful connections with son's unhappiness
	Empathy: own emotions contingent on his
	Offerings of care and support to son
2) Relationship with real and imagined sharing	Keeping it private as embarrassed and ashamed
	A harsh and blaming world: Expectations of judgement/ rejection
	Silent as loyalty and protection of son
	Experiences of sharing as contrary to expectation
3) Processing the HSB: Trying to find sense and meaning	Son as a naïve child
	Something wrong with son?
	Inadequacy as a parent
4) Getting away from the turmoil within	Initial feelings about the HSB
	Preoccupying lingering thoughts
	Not wanting to think about the behaviours
	Getting away from the feelings
5) Experiences of treatment	Challenges of treatment
	Usefulness of treatment in terms of sons behaviours
	Sessions providing containment and scaffold parenting skills
	Treatment as relational endeavor: Journey of treatment together
	Solidary with other mums: togetherness through it
6) Moving through difficult experiences and managing	The easing of the pain over time
	A strong person who weathers storms
	The tides are turning

## Sue

Superordinate Themes (=5)	Subthemes
1) Overwhelmed, powerless and struggling to understand	Emotionally troubling experience: feelings too much to contain
	Making sense of it
	Insensitive and disempowering professional input
2) Isolation: No space for talking and processing	Aloneness in it
	Relationship with husband: a vast space between
	Telling as a vulnerable and dangerous act: shame and loneliness
3) Relationship to the problem: "Can't escape it, must go through it":	Initial desire to escape it
	Initial rejection of son
	Unable to escape it
	Taking steps to get through it
4) Something good has come of this	HSB service support: altered parenting and a changed son
	Telling and increased closeness
	A progressed relationship with son
	Discovery of inner strength: Experience enriching to self
5) A desire for something more	Seeking peer contact
	More thoughtful professional input

## Appendix O: Superordinate Themes Across Participants

### Interview 1: Anna

- 1) A distressed and consumed self
- 2) Coping with the problem alone
- 3) A challenged and changed relationship with son
- 4) Making sense of it and negotiating life moving forward

### Interview 2: Elaine

- 1) The upset of it
- 2) Mind consumed by making sense of it and legitimising
- 3) It's too hard for me as a mother
- 4) Self as a mother: disempowered and disconnected
- 5) Help to help me to manage this (but not too much): a complex relationship
- 6) Worries for the future

### Interview 3: Laura

- 1) Overwhelmed: stuck in it and powerless
- 2) Alone with the problem
- 3) Emotional turmoil of relationship with children
- 4) Trying to cope with the situation
- 5) A fractured and compromised relationship to help

### Interview 4: James

- 1) "Exposed to some messy stuff": The harmful sexual act and what it evokes
- 2) Son as a threat to the family
- 3) "It's all too bloody much": Overwhelmed and struggling to cope
- 4) Cut off and unheard
- 5) Held captive and can't escape
- 6) Benefits of connection and distance

### Interview 5: Angela

- 1) So close and so distant: relationship to son
- 2) Relationship with real and imagined sharing
- 3) Processing the HSB: Trying to find sense and meaning
- 4) Getting away from the turmoil within
- 6) Experiences of treatment
- 5) Moving through difficult experiences and managing

### Interview 6: Yvonne

- 1) Overwhelmed, powerless and struggling to understand
- 2) Isolation: No space for talking and processing
- 3) Relationship to the problem: "Can't escape it, must go through it"
- 4) Something good has come of this
- 5) A desire for something more



## Appendix P: Table Showing Themes across Participants

<u>Superordinate Theme</u>	<u>Subordinate Theme</u>	<u>Anna</u>	<u>Elaine</u>	<u>Laura</u>	<u>James</u>	<u>Angela</u>	<u>Sue</u>
Consumed and overwhelmed by what is happening	Distressed and struggling	X	X	X	X	X	X
	Left to cope alone	X	X	X	X	X	X
	'Help' as an added burden	X	X	X	X	X	X
The need for self-preservation in the face of threat	Control of affect	X	X	X	X	X	X
	Avoiding being seen	X	X	X	X	X	X
	Rejected and in retreat	X	X	X	X		X
A challenged and changed relationship with son	Striving for meaning through perceptions of son	X	X	X	X	X	X
	Ambivalence and distancing	X	X	X	X	X	X
Finding hope in the face of hopelessness	Feeling trapped	X	X	X	X	X	X
	Finding value in experiences of support	X	X	X	X	X	X
	Inner strength through adversity	X	X	X		X	X

## Appendix Q: Table showing Themes and Illustrative Quotes

<u>Superordinate Theme</u>	<u>Subordinate Theme</u>	<u>Illustrative quotes</u>
Consumed and overwhelmed by what is happening	Distressed and struggling	<p><b>Anna-</b> "I'm a bit shaky you know the rest of the day because in my mind I can't move it"</p> <p><b>Elaine-</b> "...it's quite upsetting to have a child that would do things like that"</p> <p><b>Laura-</b> "I cry a lot on my own"</p> <p><b>James-</b> "I will go to bed and think "what a day, what a day", you know?"</p> <p><b>Angela-</b> "I think I realised how serious it was obviously more than Adam"</p> <p><b>Sue-</b> I felt as if I was having to sort of balance half a dozen things at once, so it was like really difficult. Really really difficult</p>
	Left to cope alone	<p><b>Anna-</b> "you find that you wish you didn't have to do all of this for yourself"</p> <p><b>Elaine-</b> "this does upset me because I've asked his dad to have him but he won't"</p> <p><b>Laura-</b> "sometimes I feel very lonely in it because it's my problem"</p> <p><b>James-</b> "I don't know of anybody that I can really express myself with, share my feelings with that I don't want to share with Laura"</p> <p><b>Angela-</b> "I do tell his dad a few things but uh, some of the things that I experience with him his dad don't understand."</p> <p><b>Sue-</b> "he just sort of like just left me to deal with it all, go to the police station and...I mean he did come to the school when we had the meeting with the school, but then again he was sort of like "no he wouldn't do something like this"."</p>
	'Help' as an added burden	<p><b>Anna-</b> "P: You get to these big meeting and then everyone's there just trying to catch up on things. And you sort of think, well why am I here if you lot just need to find out what you've all been doing between yourselves"</p> <p><b>Elaine-</b> "...it's how long it's gonna carry on, how long I need the social services involved it's like, one of the questions is how long have I got (HSB service) involved in his situation?"</p> <p><b>Laura-</b> ".you know when something like that happens they just sort of chuck all of the services at you don't they"</p> <p><b>James-</b> "work, it's you know and then there's the appointment, there's the going to the (HSB service) and separating that out and trying to get time off work..."</p> <p><b>Angela-</b> "it would be nice for it to end, because uh like I said it's been since September that we've been coming here. So it's a long stint you know to give up once a week"</p> <p><b>Sue-</b> "somebody got the ball rolling somewhere and it just sort of snowballed and sort of took off and...I'm sort of like you know sort of left behind trying to catch up sort of things"</p>

<p>The need for self-preservation in the face of threat</p>	<p>Control of affect</p>	<p><b>Anna-</b> “I don’t know I had this vision in my head like oh OK we can be a happy family again”</p> <p><b>Elaine-</b> “he probably thought that it was OK at the time, so when it happened again he got confused cos he might have thought that girls they didn't mind”</p> <p><b>Laura-</b> “I just refused to think about it, so I didn't get upset, I didn't get angry, I didn't...there was no emotion if you like, I was just like processing it I suppose</p> <p><b>James-</b> “we do talk about things a lot. Um...there are times when I don't want to and I'll shut Laura down.”</p> <p><b>Angela-</b> “you've got other children and they're not...they wasn't like this when they was young, so you just think that you know it's not the way you've brought them up and how you've learnt them”</p> <p><b>Sue-</b> “I was able to switch off, 10 minutes-half an hour and just be able to sort of breathe and sort of try and relax a little bit”</p>
	<p>Avoiding being seen</p>	<p><b>Anna-</b> “she asked how things were and I said “things are good” and then moved on to another subject... because I didn’t really...I didn’t really want to talk about my life, my personal life.”</p> <p><b>Elaine-</b> “he wouldn't do it outside of the house which was, you know that's a good thing that you would keep it all...he wouldn't go out and be rude”</p> <p><b>Laura-</b> “I used to literally I'd be in and out and gone. And I'd try not to make eye contact with the teachers, I honestly I'd run away”</p> <p><b>James-</b> “I think you've just got to be guarded around you know who comes into the home, what sort of conversations you have, things that happened you know”</p> <p><b>Angela-</b> “obviously it's by choice to keep it private and that I don't want to talk about it to anybody... You just feel ashamed. And it's not, it's not the kind of thing that you can tell people you know”</p> <p><b>Sue-</b> “We've kept to the absolute basics, umm and we have told them that we don't want the rest of the family knowing, it's been difficult as it...as it is”</p>
	<p>Rejected and in retreat</p>	<p><b>Anna-</b> “well I just want to let you know that Andy my husband says that Theo is no longer welcome in this house” and I said “he never came in your house anyway”, and that’s when I realised how judgemental people were”</p> <p><b>Elaine-</b> “she was disappointed, she didn't really want a grandchild like that with his sexual issues”</p> <p><b>Laura-</b> “His dad used to see him maybe on the Saturday, but as soon as we reported that initially I think he saw him one Saturday and then he stop seeing him”</p> <p><b>Sue-</b> “I'd say you know "hiya how's your day?" and then he wouldn't say anything, he'd just ignore me. But he'd talk to Kieron, and he'd would speak to Kieron. But me, he would just completely ignore”</p>

<p>A challenged and changed relationship with son</p>	<p>Striving for meaning through perceptions of son</p>	<p><b>Anna-</b> “t feels like you’re looking man and not a boy... and it can be quite...it can be quite daunting and quite scary... You know. It has been hard to do that, to look at him sometimes”  <b>Elaine-</b> “I didn't think I'd have a child like that, I didn't even think that in his head was able to even like do things like that, I thought he was still like a little boy and um, you know he didn't even know about anything like that, but he obviously did”  <b>Laura-</b> “he says "I don't look at them like that", he says "I wouldn't look at them like that", but I can't trust that can I.  <b>James-</b> “he's absolutely brilliant at being able to press people's buttons, find their triggers, utilise them and then he steps back. And he's quite open that he enjoys doing it, he enjoys seeing the reaction that he gets when he does these things”  <b>Angela-</b> “like I said you know he just wasn't registering it is head for some reason. Because he does have problems now we don't know what he's got but he is seeing a doctor about um, if he's got ADD or something similar.  <b>Sue-</b> “yeah he's sort of just one of those little lads that you just want to sort of cuddle all the time”</p>
	<p>Ambivalence and distancing</p>	<p><b>Anna-</b> “Christmas actual day was lovely just us just sat down together at home and it was having dinner home together, and it was easy and enjoyable and I didn't miss Theo as much then. Not as much as I thought I was going miss him”  <b>Elaine-</b> “he didn't really talk to me a lot”  <b>Laura-</b> “if he is going to abuse you and wants to abuse you I mean like verbally abuse you, when I say abuse you I mean verbally abuse you, it's always sexual. Always.”  <b>James-</b> “he's been told that if he harms other children, if we suspect then we would have to find somewhere else (for him) to live”.  <b>Angela-</b> “I felt really disappointed in him you know”  <b>Sue-</b> “I mean Kieron did try a few times tried to give me a cuddle and I was like "don't touch me, leave me alone". I just couldn't bear to be around him”</p>
<p>Finding hope in the face of hopelessness</p>	<p>Feeling trapped</p>	<p><b>Anna-</b> “I sort of think, you know I've just walked out of (HSB Service) and I think you know, I shouldn't really be...but it's there on your mind and you're going over it”  <b>Elaine-</b> “I know that at the end of the day I've got to come back to my kids and it's all you know, I've got to be a parent”  <b>Laura-</b> “You think that that's lovely respite but all I do is instead of dealing with in here I deal with it on the phone, and that's it.  <b>James-</b> “it is a constant thing in our lives. So it is, you could almost say that it's all the time, you know there isn't many days go by when we don't have a reminder or a reason to um not discuss it necessarily in detail, but it's just constant reminders”  <b>Angela-</b> “Yeah just lots of sleepless nights. Just thinking...you know just things going on in your brain and you can't turn off and you just...sort of mull things over and you're sort of thinking, you know what the hell is going on here.”</p>

		<p><b>Sue-</b> “I found it really difficult to sort of really find that sort of space to sort of have me time and just get away from it all, it never worked that way.”</p>
	<p>Finding value in experiences of support</p>	<p><b>Anna-</b> “I: What are the things that help? I know you said the therapy for yourself...”  Anna: I think it’s just talking together, making sure that everyone is on the right path that were not thinking different things or...you know, we all agreed on things you know, it was...this was what was gonna happen and stuff. I think it’s just talking really, to each <u>other</u>...”</p> <p><b>Elaine-</b> “they just used to support me by saying you know “obviously it's just something that has just happened and there is not a lot you can do about it”</p> <p><b>Laura-</b> “James, just me and him together and that's it. Um, there is no other way.</p> <p><b>James-</b> “...the good thing is we talk about these things, we don't swallow them up that's a good thing. So whilst it might be a subject that may be a little bit awkward or uncomfortable, maybe raise some tensions, at least it's out there. And that's one of the ways that we deal with it we do talk, we do share things, maybe not everything I don't know, but I think pretty much everything we do”</p> <p><b>Angela-</b> “... all the mums, I've seen a few mums come and gone. So it was nice to chat to the other mums.”</p> <p><b>Sue-</b> “my mum's always been good with me, I mean she sort of knows how to sort of handle me sometimes cos I do get...I have a short temper um, so sometimes I do get sort of a little bit angry over things and she'll sort of like "stop it! You're getting angry, calm down". And she'll just sort of put my arms around me like this (simulating 'bear hug') around the shoulders and she'll just hug me tight.”</p>
	<p>Inner strength through adversity</p>	<p><b>Anna-</b> “I don’t wanna give up on him and I knew that from the start... I could of... but I didn’t want to”</p> <p><b>Elaine-</b> “I do think I'm doing a good job to have them involved, to try to sort them out. For him to be a better child I suppose”</p> <p><b>Laura-</b> “you know when you might question or you might think to yourself why me? Why have I been dealt this hand? See and I think it is just because I do cope with it. I think to myself if my friend had them, I think she'd be melted by now. And she says to me, "I can't believe, how on earth do you do it everyday?” Um...that's what I mean by that really is that I think I probably am made for it</p> <p><b>Angela-</b> “it feels a bit like an achievement you know, we've done it we've stepped up to it.”</p> <p><b>Sue-</b> “my own sort of...my own world that I sort of, not live in but on a sort of day to day basis sort of like well you know with working and then coming home and having to deal with Kieron's situation and it's sort of like OK I can do this. I'm much stronger now and I know how to cope with it. And I can deal with it, you know and I've got to get on with it and it's got to be dealing with. So... yeah much better.”</p>

## Appendix R: Interview Process Personal Reflections Sheet

Participant/ Date & Time:	4, 20/02/2017
Interview, where & when:	At parents' own home
Rapport and how the interviewee made me feel?	Kind and welcoming. Interview in the shed which was office. From saying he may not have much time, got sense that he was willing to really think and be emotionally present. Ignored a few incoming calls (business related). Very engaged. Thoughtful, reflective. Got sense of a man who really appreciated a space to talk. Seemed confident about wanting to help and not worried about sharing experience frankly. Sense of someone very used to professional involvement- but not used to talking in this way (upset was unexpected for him), unmet need of males? Noticed I wanted to make him feel understood, respected and appreciated through the research interaction. Left with compassion for him in his position, and for family as a whole in this struggle which they felt was ever present.
Salient themes	<ul style="list-style-type: none"> <li>- Initial professional involvement difficult to deal with</li> <li>- Being the supporter</li> <li>- The strain of day to day</li> <li>- escapism</li> <li>- Lacking supportive other</li> <li>- Impact on relationship</li> <li>- Strong feelings towards son</li> <li>- Impact of gender on how view the abusive experience</li> <li>- Filing it all away</li> </ul>
Links to theory	<p>-Emotional suppression</p> <p>-Male gender role strain</p> <p>- Disintegration of worldview, sense of world as tainted, role of trauma in changing view of world as safe and predictable</p>
Topics/Issues to explore in future Interviews?	Being a male in this situation- gender orientated enquiries to be added?
How did I feel the following day/night?	Middle-class family- biases around social situations of families challenged. Thinking about this the next day. Why my surprise? What has informed these feelings?- biases around class/ financial deprivation. Struck by his emotion-felt raw with previously unexplored thoughts, stayed with me.
Any other comments?	Elements of couple participation that I had not considered prior appeared important retrospectively. For example, parent feeling important for their own contribution- had a different feeling with partner involved too, aspects of ownership??

**Appendix S: Figure showing interaction between parental experiences and meaning-making and multiple contextual aspects.**

