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SCHOOL OF MANAGEMENT AND MARKETING

Factors that Motivate or Demotivate Young People with
Sexually Abusive Behaviours and Their Families to Seek
Help: A Social Marketing Perspective

Janice Bagot
(B.Communication)

This thesis is submitted as part of the requirements for the award of the degree of
Master of Marketing – Research
of the

UNIVERSITY OF WOLLONGONG

2008

THESIS CERTIFICATION

I, Janice Bagot, declare that this thesis, submitted in partial fulfilment of the requirements for the award of Master of Marketing – Research in the School of Management and Marketing, University of Wollongong, is wholly my own work unless otherwise referenced or acknowledged. The document has not been submitted for qualifications at any other academic institution.

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ABSTRACT

Child sexual abuse is a widespread social problem in Australia and across the world. Young people perpetuate a significant proportion of this abuse and many convicted adult paedophiles begin sexually abusive behaviours in their adolescence. One public health strategy to reduce juvenile sexual offending is to increase the numbers of young people receiving assessment and treatment services to address their behaviour. This requires parents to seek help and access services for their child.

In order to be able to 'market' help, this study has aimed to add to the slim body of knowledge about factors that motivate and demotivate young people with sexually abusive behaviours and their families to seek help and utilise treatment services.

The theory of planned behaviour and a social marketing framework were used to inform semi-structured interviews conducted with NSW experts in juvenile sexual offending. The study explores expert opinions about the attitudes, social acceptance, perceived ease or difficulty, benefits and costs that young people and their families experience towards seeking help, including the utilisation of treatment services. Results indicate that young people with sexually abusive behaviours towards children are unlikely to seek help before others detect their behaviour. Factors that contribute to a lack of intention to seek help include:

- (a) unfavourable attitudes towards seeking help prior to their behaviour being detected
- (b) social stigma associated with sexually abusing children and weak social norms around offenders seeking help for their behaviour
- (c) lower perceived behavioural control towards seeking help
- (d) high perceived costs and low benefits associated with disclosing their behaviour.

This study finds that the most common pathway for young people to receive treatment services in NSW is through the voluntary disclosure of the abuse by young victims and the notification of suspected child sexual assault to statutory child

protection agencies by mandatory reporters, and a subsequent investigation and referral. Once their behaviour is detected, young people often display more favourable attitudes towards attending treatment services and experience a range of benefits from attending quality treatment provision. This study finds that young people are generally reliant on their parent(s) to be able to access and attend treatment services.

A key finding of this study is that many parents are motivated to (and do) take action to address their child's sexually abusive behaviour. Concern about their role as parents and family wellbeing are identified as central drivers for parents who try to keep the crisis within the family or reach out to informal or formal sources of help. However, the study reveals a number of demotivating factors towards help-seeking, such as:

- (a) psychological distress and defences once parents become aware of their child's behaviour
- (b) a lack of knowledge about sexual abuse and where to get help
- (c) social stigma
- (d) unfavourable attitudes at involving external agencies in their family.

Parents can experience a range of benefits if they are able to access and complete effective therapeutic intervention for their child, particularly if this involves the family. Factors that help enable families to utilise treatment services include pressure, support and consequences from statutory authorities and structural factors, such as available, affordable and accessible treatment services.

However, a current lack of expertise and skill by service providers and a dearth of affordable and available services, as identified in this study, can leave families frustrated, dissatisfied and reluctant to seek further help.

This study highlights the need and opportunity to develop a range of social marketing-based interventions to increase the numbers of parents seeking and receiving help to address their child's behaviour. Before help is marketed to families in NSW, however, more high quality, affordable and accessible services are needed to meet both current and future demand. The study recommends that the benefits of treatment services and mandatory reporting be promoted to government

policymakers, politicians and funding providers, as well as to statutory child protection agencies working directly with young people and their families.

The study also recommends that social marketing strategies to increase the incidence of parents seeking formal help for their child address:

- (a) unfavourable attitudes towards seeking help from formal sources, such as statutory child protection services
- (b) low community acceptance and stigma associated with help-seeking for perpetrators of child sexual assault
- (c) the perception (and actuality) that it is hard for families to seek help and access treatment services in NSW.

This study finds that statutory services play a key role supporting and encouraging parents to seek help for their child. Increasing the favourable attitudes of caseworkers towards treatment and reducing organisational barriers may enable parents to persist with help-seeking. The study also recommends using targeted public campaigns to increase the social acceptability of help-seeking for sexually abusive behaviours. Social marketing-based strategies are also recommended to:

- (a) increase the disclosure of sexual abuse by victims
- (b) increase identification of abusive behaviours and where to get help for families of young people 'at risk' of sexual offending and families in general
- (c) align the product of 'treatment' with parental desires and motivations.

Further research, conducted directly with young people and families, is needed to more accurately gauge their attitudes, perceived benefits and costs and ease or difficulty in seeking help. This customer-focused research would inform any social marketing-based interventions to increase help-seeking behaviour.

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There are many people who have made it possible for me to bring together my interest in marketing with my desire to help reduce child sexual assault. This has been a great dream to have and a personal marathon to achieve. Luckily, I have had great people to help me ALL along the way.

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The experts that I interviewed for this study provide an amazing and invaluable service to young people and their families, which I hope this study has been able to highlight.

I dedicate this work to my precious nephews Rowan, Braden, Gabe and Justin and to all the young people who are growing up to be strong, no matter what.

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1. INTRODUCTION

This study is an exploration of the factors that motivate and demotivate young people with sexually abusive behaviours, and their families, to seek help and utilise treatment services, particularly within NSW, Australia. Such an exploration is an essential first step in the development of a social marketing-based intervention to address this issue.

Background

The sexual abuse of children is a serious and prevalent public health issue, both internationally and within Australia. The World Health Organisation (2002) estimates that around 20 per cent of women and five to 10 per cent of men worldwide have suffered child sexual abuse. In Australia, there were 55,921 substantiated reports of child abuse for the period 2005/06. Sexual abuse accounted for around 10 per cent of these claims (Australian Institute of Health and Welfare 2007). Rayment-McHugh and Nisbet (2003) suggest that siblings are commonly the victims of younger perpetrators of child sexual assault. Being sexually abused as a child often results in negative effects over both the short and long-term. Long-term effects include anxiety, depression, difficulty with intimacy, substance abuse disorders, eating disorders, suicide and post traumatic stress disorders (Mullen & Fleming 1998).

It is estimated that, in Australia, between nine and 16 per cent of all sexual abuse is committed by young people. In NSW, 16 per cent of victim reports of child sexual assault are attributed to young people under the age of 16 years (Australian Institute for Family Studies (AIFS) 2006). The New South Wales Department of Community Services (DoCS) reports that, during 2005/06, there were 4845 reports of 'child inappropriate sexual behaviour' (DoCS 2006). This equates to around 13 reports to NSW statutory child protection services each day. This is likely to be an underestimate as sexual assault is an under-reported crime. Some adolescents will also be excluded from crime statistics or criminal liability and conviction (Vizard, Monck & Misch 1995, Davis & Leighton 1987, AIFS 2006).

In its investigation into child sexual assault in Aboriginal communities, the NSW Attorney General's Department (2006 p. 40) uses the definition that child sexual assault occurs whenever an adult, adolescent or older child uses their power and authority over a child, or takes advantage of the child's trust and respect, to involve them in a sexual activity. It includes touching, fondling, and/or masturbation, having the child touch, fondle or masturbate the abuser, oral sex performed by the child, or on the child by the abuser, and anal or vaginal penetration of the child. It also includes prostitution and exposure to, or participation in, pornography. In Australia, child sexual assault is a criminal offence.

For the purposes of this study, a child is an individual under the age of 16 years, as per the *Children and Young People (Care and Protection) Act 1998* definition. In some states and territories, health, police, welfare and education professionals have a mandatory obligation to report suspicions of child abuse to their statutory bodies, such as the Police and Community Services. In NSW, there are mandatory reporters who are legally required to make a report to DoCS if they have any current concerns about the safety, welfare or wellbeing of a child, including the risk of sexual assault. Mandatory reporters in NSW include health, welfare and educational professionals and law enforcement services, as well as children's residential and disability services.

The literature commonly refers to young people under 18 years of age who sexually abuse children as 'juvenile sex offenders'. More recently, practitioners and researchers also refer to 'young people with sexually abusive behaviours'. Although this thesis will refer to juvenile sexual offending, it will predominantly use the term 'young people with sexually abusive behaviours'. This preference recognises that sexually abusive behaviours are not the sum total or necessarily a fixed aspect of the personalities of these young people.

While the large majority of adult and juvenile sexual offenders are male (AIFS 2006), adolescent girls also sexually offend, though at much lower rates of between one to five per cent of all juvenile sexual offending (Davis & Leitenberg 1987, Finklehor 1994, Vizard, Monck & Misch 1995). Studies of young females with

sexually abusive behaviours indicate that their sexually offending modus operandi against children is similar to that of young males (Hunter, Becker & Lexier 2006).

Despite many assumptions to the contrary, not all young people with sexually abusive behaviours against children go on to sexually offend in adulthood. Worling and Langstrom (2006, p. 219) have identified five possible outcomes with regard to young people repeating sexually abusive behaviours:

- (a) Adolescents who have committed sexual assaults, who are never detected by authorities or treatment providers, and who stop offending on their own
- (b) Adolescents who commit sexual assaults but are never detected and go on to offend sexually as adults
- (c) Adolescents who have offended sexually and who stop offending once they have been detected by authorities
- (d) Adolescents who have committed a sexual offence and will stop only after being both detected and treated
- (e) Adolescents who have offended sexually and continue to do so despite being detected and treated.

From a public health and humanitarian point of view it is ideal to stop all sexual offending as early as possible, and ideally before it starts at all. The added risk of not identifying and assessing young people who have displayed sexually abusive behaviours towards children is that some of these young people will continue to sexually offend against a number of children over their lifetime. Studies of adult sexual offenders have found that many began offending against children in their adolescence (Davis & Leitenberg 1987, Pithers & Gray 1998). An Australian study of charged and convicted adult sex offenders found that they had committed approximately 380 sexual offences and abused approximately 76 children. (Victorian Department of Human Services 1998).

One strategy to decrease the sexual assault of children is to increase the early detection and numbers of young people receiving effective assessment and treatment services. Although a number of young people may stop their sexual offending spontaneously or after having been caught, effectively treating young people with sexually abusive behaviours has been shown to reduce levels of repeat

offending. A literature review of the success of treatment services (Nisbet, Rombouts & Smallbone 2005) found that recidivism rates for young people who had successfully completed a treatment program were typically below 10 per cent. The authors found that, in studies that used comparison groups, differences in sexual recidivism of up to 13 per cent were observed between treated and untreated groups. In their review of the impacts of programs for adolescents who sexually offend, Nisbet, Rombouts and Smallbone (2005) concluded that the most effective treatment programs are those that are holistic, involve the family and address functioning across the individual, family, school and community systems.

An initial impetus for this study arose from a recommendation that there be a Quit-style awareness campaign to encourage child sexual offenders to come forward and seek treatment, including via telephone help services (Szego 2005). This recommendation prompted this researcher to wonder how organisations would market such treatment services to young people, and what would motivate or demotivate young people from seeking help for their sexually abusive behaviours. This line of questioning has been extended towards their families, as the majority of young people under the age of 18 years are usually under the immediate care and influence of their parents.

This study is primarily situated in the broad field of help-seeking behaviour. The researcher has selected a social marketing framework as an appropriate method to gain insight into what factors might motivate or demotivate young people with sexually abusive behaviours, and their families, to seek help. It is hoped that insights gained from this study can be used to inform experts (policy and decision makers, legislators, statutory and private treatment providers) about social marketing strategies that may help increase the frequency of help-seeking and the uptake of treatment services.

2. LITERATURE REVIEW

This section examines what is already known about what motivates and demotivates young people with sexually abusive behaviours, and their families, to seek help. The focus is mainly on the broader field of help-seeking, as the intention behind this study is to understand more about what might increase the incidence of help-seeking, rather than to gain more forensic knowledge into sexual offending.

The literature review is structured into five key areas:

- 2.1 Help-seeking theories, models and concepts
- 2.2 Young people with sexually abusive behaviours
- 2.3 Families of young people with sexually abusive behaviours
- 2.4 Relevant theoretical frameworks
- 2.5 Summary

2.1 Help-seeking theories, models and concepts

The investigation of factors that might facilitate or inhibit help-seeking behaviour started to become common in the late 1970s and early 1980s and followed an earlier focus on the variables that influenced individuals to give help. The study of help-seeking behaviour touches on a number of disciplines such as psychology, sociology, health and medicine and service utilisation. Criticisms have been made about a lack of unifying theory on help-seeking behaviour (De Paulo 1983, Rickwood et al. 2005). However, there are definitions, models, concepts and findings evident in the literature that are applicable to the investigation of the help-seeking behaviour of young people with sexually abusive behaviours and their families. The following two definitions introduce important aspects of help-seeking, which will be expanded in some detail further in the Literature Review. In their study of factors that affect help-seeking among young people for mental health problems, Rickwood et al. (2005, p. 8) conceptualised help-seeking as the process of actively seeking out and utilising social relationships, either formal or informal, to help with personal problems. De Paulo (1983, p. 3) defined help-seeking as: 1) an individual has a problem or need; 2) the problem is of a sort that might possibly be alleviated

or solved if the time, effort and resources of others were committed to it; and 3) the needy individual seeks the aid of another in a direct way. Rickwood's definition embeds help-seeking within existing or new relationships between an individual or family looking for help and a person or service from which assistance is being sought. DePaulo's definition also contributes a bigger picture complexity to help-seeking behaviour that recognises structural issues, such as the appropriateness and availability of services that can impact on the help-seeking behaviour of an individual or family.

There are three stages of the help-seeking process commonly outlined in help-seeking literature: 1) problem recognition; 2) decision to seek help; and 3) selection and utilisation of services (Gross & McMullen 1983, Rickman et al. 2005, Andersen 1995, Prochaska, DiClemente & Norcross 1992). Investigations of mental health service utilisation by parents for children with behavioural and emotional problems have supported the notion that parents firstly have to recognise that there is a problem; secondly, they have to consider the need for help; and thirdly, they have to overcome their own attitudinal or physical barriers to actually seek help (Pavuluri, Luk & McGee 1996, Owens et al. 2002). Overall, the stages of the help-seeking process are not considered necessarily linear and individuals may revert to previous stages, or cycle through stages many times (Gross & Mc Mullen 1983). Individuals are unlikely to seek help unless they first recognise that they have a problem (Andersen 1995, Prochaska, DiClemente & Norcross, Gross & Mc Mullen 1983). This prerequisite is also present in the Stages of Change Model (Prochaska, DiClemente & Norcross 1992) whereby an individual will move to an 'action' stage to overcome his/her problem when he/she is aware that a problem exists and is at the 'contemplation' stage of addressing it. Individuals who are unaware or resist recognising that they have a problem are said to be at the 'pre-contemplation' stage, where it is often more common for friends and family to be aware of the problem. Researchers have identified a number of factors and variables that they argue influence the behaviour of individuals throughout the process of seeking help for a problem. These variables are presented and discussed within the following models and studies, located within the help-seeking literature.

2.1.1 The Behavioural Model of Health Services Use

The first model chosen to examine the influences on help-seeking behaviour is the Behavioural Model of Health Services Use, which was developed to understand what factors facilitate or impede the use of health services by families and individuals. Anderson's (1968) initial model proposes that an individual's use of health care services can be predicted by: a) their predisposition to use services that included demographic, social structure and health belief factors; b) factors that enable or impede use, such as personal/family and community resources; and c) the perceived or evaluated need of a family for medical care. In a subsequent review of the Behavioural Model of Health Services Use, Andersen (1995) reflects that enabling variables and needs associated with a disease play a more influential role in the utilisation of services by individuals. Andersen (1995) argues that, for service use to take place, enabling structural community resources (such as available services and staff) are needed, and people require the personal enabling factors of knowledge and resources to be able to access these services. Assuming that a problem is amenable to treatment and that appropriate services exist and are known to help-seekers, Anderson also argues that perceived need by individuals or evaluations by professionals is a predictor of service utilisation. Customer satisfaction is also considered to influence further service utilisation.

The Behavioural Model of Health Services Use introduces key factors that have been identified in subsequent studies as influencing help-seeking behaviour. While the literature does not identify any typical profile of a help-seeker, variables such as gender and class have been found to influence help-seeking in general populations. Although not empirically supported by Anderson, a number of studies have identified that females are more likely to seek help than males (Commonwealth of Australia 2001, Rickwood et al. 2005, Booth et al. 2002, Kuhl, Jarkon-Horlick & Morrissey 1997). Seeking help is often considered to be at odds with notions of masculinity (Rochlen & Hoyer 2005). Rickwood et al. (2005) point out that boys seem to be socialised out of seeking help from any sources from early to mid-adolescence.

The personal and community resources argued by Anderson (1995) as being necessary to enable service utilisation have been shown by other studies to either facilitate or impede help-seeking behaviour. In their study of families needing mental

health services for their child, Pavuluri, Luk and McGee (1996) found that lower levels of income, parental separation and adversity resulted in parents being less likely to seek help for their child. A lack of knowledge that help is available and where to seek that help have been identified as a barrier for parents who are aware that there is a problem and that help was necessary for their child (Pavuluri, Luk & McGee 1996, Douma et al. 2006, Owens et al. 2002). Similarly, structural barriers, such as services being too costly, inconvenient or unavailable have also been perceived as barriers by parents to utilising mental health services for their children (Pavuluri, Luk & McGee 1996). The role of need has also been substantiated by other studies as a predictor of mental health service utilisation. An eight-year follow up study of the variables associated with the use of mental health services by 857 Finnish children found that one of the most potent predictors at age eight of later referral included total problem behaviours and antisocial problems in parental and teacher evaluations (Sourander et al. 2001). Other studies have found to the contrary: that the degree of child psychopathology can be unrelated to whether parents seek help for their child or not. Parents may recognise that their child needs help but perceive that they should be able to deal with the problem themselves (Pavuluri, Luk & McGee 1996, Douma et al. 2006). Customer satisfaction has also been supported as a factor that affects help-seeking. Previous positive experiences with services have been shown to facilitate further help-seeking for young people with mental health problems (Rickwood et al. 1995). Alternatively, disappointment with previous help has been identified as a barrier for parents seeking mental health services for their children (Pavuluri, Luk & McGee 1996, Douma et al. 2006).

2.1.2 The Health Belief Model

The second model relevant to help-seeking behaviour is the Health Belief Model – a psychosocial model developed in the 1950s. The Health Belief Model (Janz & Becker 1984) proposes that an individual's health-related behaviour is dependent upon two factors – first, the desire to avoid illness or, if ill, to get well; and second, the belief that a specific health action will prevent (or ameliorate) illness (i.e. the individual's estimate of the threat of illness, and of the likelihood of being able, through personal action, to reduce that threat). The Health Belief Model has four key dimensions: i) perceived susceptibility – an individual's subjective perception of

their risk of contracting a condition; ii) perceived severity – personal feelings about the seriousness of contracting a condition or of leaving it untreated, including an evaluation of the clinical and social consequences such as the effect on family life and social relationships; iii) perceived benefits – if an individual accepts their susceptibility and the seriousness of a condition, any course of action taken is likely to be dependent upon beliefs regarding the effectiveness of the various actions available in reducing that disease threat; and iv) perceived barriers – the potential negative aspects of a particular health action may act as impediments to undertaking the recommended behaviour. Within this dimension, a type of cost-benefit analysis is thought to occur whereby the individual weighs up the effectiveness of actions against negative perceptions; e.g. it may be expensive, dangerous, unpleasant, inconvenient or time consuming.

In their review of 46 Health Belief Model studies, Janz and Becker (1984) concluded that, across the studies, perceived barriers proved to be the most powerful of the dimensions. Studies of why parents did not seek mental health services for their child, despite recognising a need, have identified the following barriers: parents not taking their child's problems seriously; thinking it would go away; or, thinking they should be strong enough to handle it (Pavuluri et al. 1996, Douma et al. 2006, Owens et al. 2002). Barriers that parents experience can adversely influence attitudes towards their child's treatment. In his examination of the perceived barriers to treatment participation and acceptability for anti-social children and their families, Kazdin (2000) found that the greater the barriers that parents experience, the less likely that they are to consider the treatment methods to be acceptable.

The Health Belief Model identifies an important concept found in help-seeking literature – that individuals can experience a reluctance to seek help due to a number of vulnerabilities and costs associated with help-seeking. Once a problem has been recognised, the decision to seek help and the type of help utilised is considered to be heavily influenced by a weighing up of the benefits verses the costs of seeking help (Gross & McMullen 1983, Prochaska, DiClemente & Norcross 1992). It has been argued that variables which increase the costs of help-seeking inhibit an individual's willingness to seek help (Gross & McMullen 1983). There are a range of both financial and non-financial costs associated with seeking and receiving help; such as fees associated with the sources of help, time and effort

needed to seek and attend help, personal costs of seeking help and social costs such as embarrassment (Gross & McMullen 1983). Shame at disclosing personal concerns and issues of confidentiality are costs that some young people associate with seeking help (Booth et al. 2002). Although the costs of not seeking help can be associated with the continuation (or even worsening) of the problem, it is argued that individuals are much more likely to adopt a behaviour when they perceive that the benefits outweigh the costs (Andreasen 2006, Blair-Stevens 2005, Gross & McMullen 1983).

2.1.3 The social organisation strategy

The third model or framework used to examine factors that influence help-seeking behaviour is the social organisation strategy. Pescosolido (1992) criticises any reduction of help-seeking to a rational cost-benefit analysis. He argues that interaction is the prime driving force behind the process of individuals deciding whether something is wrong, whether anything can be done about it, what should be done and how to evaluate the results. Pescosolido argues that individuals live within existing social networks and help-seeking decisions are part of socially constructed patterns, including consulting with others. From a study of the help-seeking of medical care of 1,119 respondents, Pescosolido (1992) looks beyond demographic data to explore differences in help-seeking strategies and social networks. Individuals are found to often use co-workers and family members, in addition to physicians, for help with health problems. A preference for individuals to seek help from family and friends is well documented in the help-seeking literature. Young people often prefer to seek help through informal sources such as family, and, increasingly, as they get older, friends, rather than formal professional help (Sheffield Fiorenza & Sofronoff 2004, Boldero & Fallon 1995, Rickwood et al. 2005, Booth et al. 2002, Commonwealth of Australia 2001, Miraldo & Pettigrew 2002). A survey of 986 Australian children identified that 93 per cent would nominate their family as a source of help when they needed it (Australian Childhood Foundation 2006). A study measuring the barriers to help-seeking behaviours in 280 high school students found that their reliance on family, friends and self is the most significant barrier to help-seeking (Kuhl, Jarkon-Horlick & Morrissey 1997).

The quality of the relationships between young people and their families, friends and wider social networks has also been shown to enable or impede help-seeking for problems. The availability of sources of trusted relationships and the ability of young people to express their feelings to others has been shown to predict help-seeking (Rickwood et al. 2005, Sheffield, Fiorenza & Sofronoff 2004). Low social competency has been shown to inhibit help-seeking in young people (Rickwood et al. 2005). Elevated parental stress caused by additional problems with their child and parental characteristics, such as psychopathology and limited social support, have been shown to lower the ability of parents to perceive emotional and mental health problems with their children (Douma et al. 2006). Low family conflict has been shown to be more predictive of young people's willingness to seek psychological help (Kuhl, Jarkon-Horlick & Morrissey 1997). In contrast, a study of Australian young people who had witnessed family conflict and violence found that 36 per cent did not seek help at all regarding their parent's conflict and violence (Commonwealth of Australia 2001). Fear of stigmatisation and any consequences associated with others finding out about personal problems have been identified in the literature as major barriers to help-seeking, both for young people (Rickwood et al. 2005, Booth et al. 2002) and parents of children with mental health problems (Owens et al. 2002).

2.2 Young people with sexually abusive behaviours

Adults who sexually abuse children have been discussed in the literature since the 1940s. However, it is only since the 1970s that adolescent sexual offenders have been investigated as a distinct population. This has in part been motivated by the finding that many adult sexual offenders begin offending in adolescence (Davis & Leitenberg 1988). Practitioners have called for social research that adds to typologies, theories and the body of knowledge on young people with sexually abusive behaviours in their own right, rather than as 'mini-adults' (Nisbet, Rombouts & Smallbone 2005). From the late 1980s, there has been a flurry of new research, theories and typologies of young people with sexually abusive behaviour – predominantly from the USA and Canada, and, to a lesser extent, the UK and Australia.

Despite earlier tendencies to dismiss adolescent sexual offending as 'boys will be boys', studies of sexual development indicate that while experimentation and exploration are normal, coercive, non-consensual, unequal relationships are not (AIFS 2006). While the heterogeneous nature of young people with sexually abusive behaviours is often highlighted (Vizard, Monck & Misch 1995, Nisbet, Rombouts & Smallbone 2005, Duane et al. 2003, Kenny et al. 2000), certain characteristics and demographics have been observed in the literature. The first evidence of sexual offending can be identified in children from as young as four years of age (Burton, Nesmith & Badten 1997). Nisbet, Rombouts & Smallbone (2005) noted that sexual offending is markedly bi-modal, with a peak at age 14 and then a decline until another peak in the late 30s. In a study of the characteristics of 232 male juvenile sexual offenders attending treatment services in NSW, Nisbet and Seidler (2001) found that 68 per cent identified as Anglo-Australian, followed by 14 per cent as Aboriginal and 5 per cent as Lebanese. The majority of the sample (58 per cent) had not completed their Year 10 School Certificate. Eleven per cent of the sample were deemed to be developmentally delayed.

Young people that sexually offend against children have often experienced child abuse and neglect and grown up in environments with high levels of conflict, domestic and family violence (Bentovim 2002, Davis & Leitenberg 1987, Vizard Monck & Misch 1995, Veneziano & Veneziano 2002, Pithers et al. 1998, Kenny et al. 1999). An analysis of 70 pre-sentence reports by the NSW Department of Juvenile Justice Sex Offender program found that, of a sample of 46 young people, 24 per cent were known to have been physically abused, 22 per cent emotionally abused, 19 per cent sexually abused and 23 per cent neglected (Kenny et al. 2000). An association has been found between a child's personal history of child abuse and neglect and subsequent criminality. A study of 41,700 children born in Queensland in 1983 found that 10 per cent of the children came into the child protection system by the time they were 17 years old and that one of the predictive factors for juvenile offending included child maltreatment (Stewart, Denison & Waterson 2002). Many adult and juvenile sexual offenders have been found to have a past and concurrent history of criminal delinquency such as theft, arson, cruelty to animals and illegal substance abuse (Davis & Leitenburg 1987, Kenny et al. 1999). Nisbet and Seidler (2001) identified four subgroups of offender typology from a study of 232 male juvenile sexual offenders receiving treatment services in NSW:

Delinquents – where previous non-sexual offending is non-violent (11 per cent of the sample), Violent Offenders – likely to have several previous orders for violent offences (five per cent), Experimental Sex Offenders – typically received an order for a sexual offence consisting of only one charge (40 per cent), Primary Sex Offenders – adolescents who had more than one order or had been charged with more than one count for a sexual offence (43 per cent).

Overall, young people with sexually abusive behaviours can display a higher incidence of anti-social behaviour. Worling (2001) categorised the personality typologies of 112 juvenile sexual offenders and identifies four subgroups of personality types: antisocial/impulsive; unusual/ isolated; over-controlled/reserved and; confident and aggressive. Of these four categories, the anti-social personality type is the most common. A meta-analysis of 82 recidivism studies found that sexual deviancy and antisocial orientation are the two biggest predictors of future sexual offending of juvenile and adult sex offenders (Hanson & Morton-Bourgon 2005). Sexual deviancy is also directly related to recidivism in Australian juvenile sex offenders (Kenny, Keogh & Seidler 2001). An investigation of factors associated with the service utilisation of 86 adjudicated male adolescent sex offenders found that a high degree of juvenile justice and total services utilisation was correlated with recorded psychiatric problems, high scores on the psychopathology scale, affirmative indications of non-sexual abuse and high scores on the severe vulnerability scale (Laffern 2004).

A significant number of young people with sexually abusive behaviours have experienced impaired family relationships (Davis & Leitenburg 1987, Veneziano & Veneziano 2002, Vizard, Monck & Misch 1995). Emotional distance between parents and young people with sexually abusive behaviour has been a common theme in literature on sex offending, which identifies a poor or disrupted early attachment between primary caregivers and their perpetrating child (Smallbone 2006, Pithers et al. 1998). Juvenile sexual offenders have also been shown to be socially isolated from their peers, feeling inadequate and fearing rejection (Hunter et al. 2003, Blaske et al. 1989). Marshall and Barbaree's Integrated Model of Sexual Offending (1990) outlines that the pathway to sexual offending can begin with young people experiencing developmental vulnerabilities, such as childhood abuse, family violence and conflict, and punishing parenting styles that create an insecure

attachment with primary caregivers. The authors argue that young people with developmental vulnerabilities have a particularly hard time during puberty where they develop their sexual identity, partner preferences and physical, emotional and social intimacy with peers. Increased hormonal activity, inability to separate sex and aggression, a lack of self-regulation and social incompetence can result in young men learning to meet their intimate needs with sexually deviant behaviour.

One of the key motivations for young people to sexually abuse children is from unmet needs for intimacy and closeness (Hunter et al. 2003). In their study of juvenile sexual offenders in NSW, Kenny et al. (1999) found that, of 114 sexual offences where information was available, the motivation that juvenile sexual offenders most cited for their behaviour was poor conflict resolution (34 per cent), misogyny/sadism (15 per cent), alcohol (10 per cent), anger/revenge (10 per cent) and isolation (6 per cent). A study of a sample of adults who had sexually offended against children, or were at risk of doing so, (Stop it Now! 2005) found that the perceived benefits of a child sexually offending against other children include sexual satisfaction, a sexual high or mood enhancement, love and companionship. The perceived costs of offending include loss of family, loss of job/career and loss of everything.

In their theory on the cycle of sexual assault, Ryan et al. (1987) outline two key cognitive distortions which provide significant psychological barriers to young sexual offenders recognising that they have a problem. Although they may feel transitory guilt when they have sexually assaulted a child, juvenile sexual offenders quickly move into a phase where they rationalise that they are not going to get caught, followed by the cognitive distortion that they will not do it again. An additional major psychological barrier to help-seeking is that sexual offenders predominately deny, minimise and blame others if their sexually abusive behaviours are detected (Ryan et al. 1987).

2.2.1 Young people with sexually abusive behaviours and help-seeking

While there is a paucity of literature identifying whether young people seek help from friends and family regarding their sexually abusive behaviours, a very small

number do appear to seek formal help. Kids Helpline (a national free phone and web-based service for Australian young people from five to 18 years) reported that, of their 5,154 contacts during 2003/04, 48 contacts (i.e. one per cent of calls) were related to young people's sexual offending (Kids Helpline 2004). Of those young people, 15 per cent were seeking clarification about their offending and a further 23 per cent were experiencing intrusive thoughts about children. In 29 per cent of contacts, the young person purported previous contact with a child and the remaining contacts were from young people establishing or currently in an abusive relationship with a child. Incidences of child sexual assault by young people are much more likely to be identified as a problem by health, welfare and police who are mandated to report any suspicions of child sexual assault. DoCS (2006) reported that, during 2005/06, three out of four of all notifications of suspected child abuse and neglect in NSW, including inappropriate sexual behaviours by young people, were reported by mandatory reporters such as police, school and health professionals. There were no identifiable reports of young people ringing up concerned about their behaviour. In a study where 91 convicted adult child sexual offenders were asked why they failed to seek help (Elliot, Browne & Kilcoyne 1995), 46 per cent thought that no help was available, 17 per cent had found help ineffective, and 37 per cent didn't realise they needed help. Research (Stop It Now! 2005) with 29 adult males who had sexually offended against children, or considered it, found that the vast majority (21) sought treatment after being arrested or because legally required, eight were urged by loved ones to seek treatment and only seven sought help on their own initiative. Barriers and costs identified by adults seeking treatment for sexually offending against children (Stop It Now! 2005) included not wanting anybody to know, fear of legal consequences and court, fear they will be demonised and threatened with violence, cost of treatment, fear of losing their job and family, fear of unknown consequences, not knowing where to turn, and a strong desire to continue the behaviour.

The benefits for young people with sexually abusive behaviours to attend treatment have been typically related to decreased recidivism rates (Nisbet, Rombouts & Smallbone 2005). Perceived benefits of initially attending treatment for adult child sexual offenders (Stop It Now! 2005) included desire to take responsibility, desire for relief from the secrets and lies or an end to remorse and concern for victims. When asked about the perceived benefits after attending treatment, nearly all said that:

arrest, accountability and treatment were positive life-changing events; treatment had helped, they had found relief from secrets and lies, they had been able to change their thinking and understand the harm they had done, and they had learnt how to prevent harming another child.

2.3 Families of young people with sexually abusive behaviours

Earlier knowledge about the families of young people with sexually abusive behaviours has arisen out of research with juvenile sexual offenders and, more recently, with parents and caregivers directly. Young people with sexually abusive behaviours often come from two caregiver families but commonly live with one biological parent and a step-parent (Pithers et al. 1998, Burton, Nesmith & Badten 1997). Bischof, Stith and Whitney (1995) have found that caregivers come from a range of ethnic and religious backgrounds, educational levels and occupations. The parents of juvenile sexual offenders have been found to have a number of their own problems, including higher incidences of drug and alcohol abuse (Burton, Nesmith & Badten 1997, Duane & Carr 2003, NSW Juvenile Justice 1999), criminal arrests (Duane & Carr 2003, Pithers et al. 1998), childhood abuse and neglect, including sexual abuse (Bentovim 2002, Duane & Carr 2003) and higher levels of depression and anxiety (Duane & Carr 2003).

The perpetration of childhood sexual abuse can often be found within the broader family. A study of the families of 72 children with sexually abusive behaviours (Pithers et al. 1998) found that, excluding sexual abuse performed by the index child in the study, 62 per cent of the extended families contained at least one additional person who had performed a sexually abusive behaviour, with 94 per cent of the victims being relatives. Only 10 per cent of the perpetrators in the extended family had admitted responsibility for their acts. It is well documented that young people with sexually abusive behaviours often grow up with early exposure to pornography, sexual material and sexualised family behaviour (Barbaree & Langton 2006, NSW Juvenile Justice 1999). Families of juvenile sex offenders have been found to commonly exist on or below the poverty line (Pithers et al. 1998, Bischof, Stith & Whitney 1995, Burton, Nesmith & Badten 1997). Families have been found to have a limited range of internal resources to deal with family problems, including the

disclosure of child sexual abuse (Marshall & Barbaree 1990, Pithers et al. 1998). Pithers et al. (1998) found that caregivers of young people with sexually abusive behaviours can experience high levels of stress, withdrawal, self-doubt and social isolation. Most of the available personal resources of the family members were devoted to maintaining the basic integrity of the family with few resources for intellectual, moral or cultural growth of families. Juvenile delinquents (including sex offenders) have reported their families as having and encouraging lower levels of independence and self-sufficiency than other families (Bischof, Stith & Whitney 1995). Parents of young people with sexually abusive behaviours have been observed to have lower rates of positive communication with their child and report lower levels of parental satisfaction (Blaske et al. 1989, Duane et al. 2003, Pithers & Gray 1998, Friedrich & Leucke 1988). Pithers and Gray (1998) found that such parents view their children as disappointing and excessively demanding of their attention and time, and feel that interactions with their children are unrewarding. Parents were also observed to be emotionally distant and rejecting.

2.3.1 Help-seeking by families of young people with sexually abusive behaviours

DoCS (2006) reports that, in 2004/05, families made up 15 per cent of all non-mandatory child protection notifications to its child protection line. However, suspected sexual assault of children is not a frequently reported issue by families, including the reporting of either child victims or young perpetrators of child sexual assault. Some families do seek formal and informal help of their own volition for suspected or disclosed child sexual abuse. The Stop It Now! National Helpline, which encourages perpetrators to stop sexual assault, reports (2005) that friends and family members of adults and young people at risk of sexually abusing a child are their most frequent callers (approximately 68 per cent). In most cases, these callers know both the person who may be abusing and the child at risk of victimisation. Mothers of children who have been sexually abused, including by other family members, have been found to seek help from their social networks, friends and families in preference to contacting agencies (Hooper 1992, Plummer 2006). In Hooper's study (1992), this includes looking for validation that something is wrong from people who know both the child victim and the suspected abusive

family member. This help is often sought indirectly due to fears that family and friends may be disbelieving and seek to lay blame. When contact is made with more formal professional sources of help (such as doctors) the choice is dependent on: immediate need (e.g. their child is pregnant); the perception of the problem and past experiences of help-seeking for other problems; and previous experience with agencies.

There are a number of psychological, social and structural barriers for parents to seeking help outside the family following the disclosure of their child's behaviour. Duane and Carr (2003) identify that parents commonly experience disbelief, shame, guilt and anger when their child's sexually abusive behaviour is brought to their attention. Mothers of children who have been sexually abused have been found to experience similar emotions (Hooper 1992). Rich (2003) has found that many families deny, minimise and blame others for their child's behaviour. Some parents try to 'self-manage' the situation rather than involve authorities. Plummer (2006) found that, of 125 mothers of sexually abused children, most had found out through verbal reports from their abused child. Almost half of these mothers had a sense that something was quite not right prior to knowing about the abuse. The majority of mothers took actions such as talking to their child (66 per cent), watching things closely (47 per cent), trying to get more information (37 per cent) and confronting the suspect (35 per cent). Hooper (1992) found that costs to mothers seeking informal and formal help for their sexually abused child include shame and the feared loss of family privacy and control if others such as friends, families and agencies get involved. Working class mothers additionally fear losing their children if agencies become involved. Parents of young people with sexually abusive behaviours can experience feelings of inadequacy at professional intervention into their situations (Duane & Morrison 2004, Hooper 1992). Duane & Morrison (2004) identify stigma and public humiliation as barriers to parents coming forward about their child's sexually abusive behaviours. Lack of information and availability of help have been highlighted as barriers to seeking help for the sexual abuse of a child by a family member (Hooper 1992).

It has been posited that many parents of young people with sexually abusive behaviours are uninterested in the logistics of treatment and are resistant to seeking treatment for their child's behaviour (NSW Juvenile Justice 1999, Rich 2003). In

contrast, Pithers and Gray (1998) observed that, once engaged in treatment, many families positively respond to putting in measures to reduce the risk of their child further sexually abusing children, if their strengths as parents, rather than their shortcomings, are emphasised. In their investigation of engagement of families with child welfare services, Dawson and Berry (2002) found that families experience a higher level of customer satisfaction with caseworkers that are supportive and non-punitive and provide concrete services.

2.4 Relevant theoretical frameworks

There are a number of behavioural theories relevant to this study from the disciplines of sociology, criminology, psychology, psychiatry, social psychology and marketing. The Health Belief Model and the Behavioural Model of Health Services Use are useful tools with which to investigate variables on the help-seeking behaviour of young people and their families, such as perceived susceptibilities and needs and structural barriers or enablers. It is also useful to examine, via the social organisational strategy, the role that social interaction (that is, the influence of family, friends and the wider community) plays on help-seeking. The three stages of the help-seeking process: 1) problem recognition; 2) decision to seek help; and 3) selection and utilisation of services, provide a solid foundation for exploring the spectrum of help-seeking stages for this study.

Although there may be legal ramifications as a result of disclosing a young person's sexually abusive behaviours, seeking help and attending treatment services are still predominantly voluntary behaviours. Because this study seeks to identify factors that motivate or demotivate young people and their families to seek help, it is useful to select research frameworks that are suitable for developing insights into consumer behaviour. The researcher has selected Ajzen's (1991) theory of planned behaviour (TPB) and the Benefits, Costs, Others, Self Assurance (BCOS) factors from the discipline of social marketing (Andreasen 2006) as underlying frameworks to inform the research design of this study. While there is some obvious crossover between the two frameworks, together they provide a useful social marketing approach to exploring and developing insights into the key factors that influence the voluntary help-seeking behaviour of juvenile sex offenders and their families. Both

these frameworks recognise the influence that social referents have on individuals, which is pertinent to the socially taboo behaviours of sexually abusing children. Both frameworks also consider behaviour to be influenced by changes made to behavioural determinants, such as increased favourable attitudes, social norms and perceived behavioural control, and increased benefits and decreased costs associated with a behaviour. This approach offers a valuable opportunity for developing social marketing strategies that can increase help-seeking behaviour for sexually abusive behaviours.

The theory of planned behaviour is an extension of the theory of reasoned action (Ajzen & Fishbein 1980). A key premise of both theories is that an individual's intention to perform a (voluntary) behaviour is the best predictor of that behaviour (Ajzen 1991). A particular behavioural intention occurs as a result of an individual's attitude toward performing the behaviour, plus the effect that significant others have on the individual's performance of the behaviour (subjective norms). In the theory of planned behaviour (Ajzen 1985) there is an additional factor that influences behavioural intention, which is the perception of ease or difficulty in performing the behaviour (perceived behavioural control). The impetus for this addition is to allow prediction of behaviours that are not under complete volitional control. Ajzen (1991) proposes that the more favourable the attitude and subjective norm with respect to behaviour and the greater the perceived behavioural control, the stronger an individual's intention should be to perform the behaviour under consideration.

Ajzen (1991) argues that human behaviour is guided by three kinds of salient beliefs that determine a person's intentions and actions – behavioural, normative and control beliefs. Behavioural beliefs are about the likely consequences or other attitudes about the behaviour such as associated costs. People learn to favour behaviours that they believe have positive outcomes and form unfavourable attitudes towards behaviours with undesirable consequences.

Normative beliefs relate to the likelihood that important referent individuals or groups approve or disapprove of performing a given behaviour.

Control beliefs may be based on past experiences with the behaviour but will also be influenced by what an individual has heard from others and by factors that increase or decrease the perceived difficulty in performing the behaviour.

These beliefs are considered to be the antecedents of attitudes, subjective norms and perceived behavioural control that influence behavioural intention and behaviour.

Figure 2.1

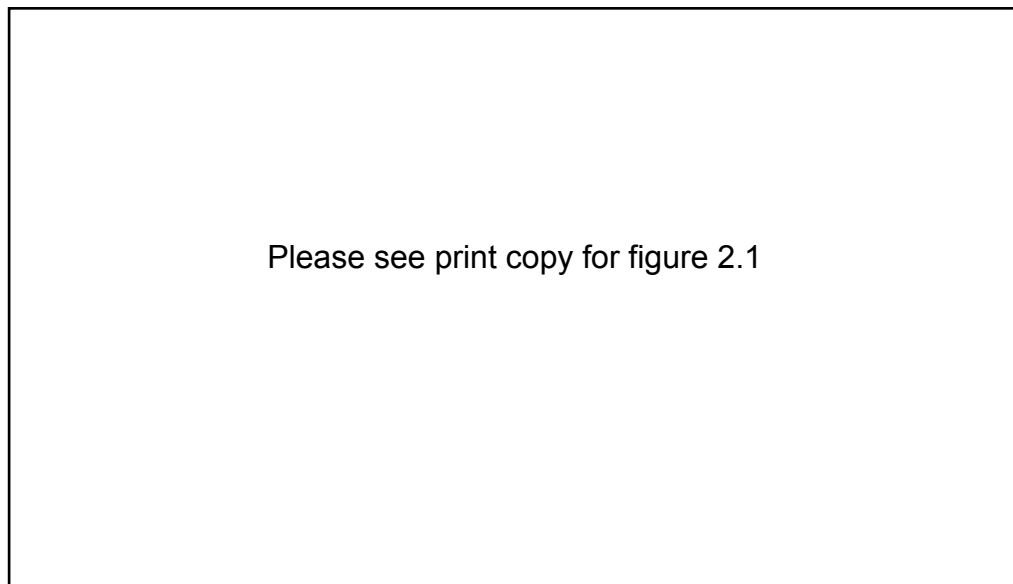


Figure 2.1 Theory of planned behaviour (Armitage & Connor 2001, p. 471, fig.1)

Intention to perform a behaviour is an indication of how hard people are willing to try or the effort they are planning to exert in order to perform the behaviour. As a general rule, the stronger the intention, the more likely it is to occur (Ajzen 1991). However, this can only occur if the behaviour in question is voluntary. The performance of most behaviours also depends on non-motivational factors such as money, skills and cooperation of others. Together these factors represent an individual's actual control over the behaviour. If a person has the opportunities, resources and intention to perform a behaviour, then he or she should be able to achieve it. There are three determinants of intention:

- (a) Attitudes towards the behaviour refer to the degree to which a person has a favourable or unfavourable appraisal of the behaviour in question.
- (b) Subjective norms relate to the perceived social pressure to perform or not perform the behaviour.
- (c) Perceived behavioural control is the psychological perception of the degree of perceived ease or difficulty of performing the behaviour. This is assumed to reflect past experience as well as anticipated impediments and obstacles. Perceived behavioural control is more easily predicted when an individual believes he or she possesses the necessary resources and opportunities, coupled with the anticipation of fewer obstacles and impediments to carrying out a behaviour. This is especially the case when there is a high correlation with actual control. (Ajzen 1991, Webb & Sheeran 2006). According to the theory of planned behaviour, perceived behavioural control, together with behavioural intention, can be used directly to predict behavioural achievement (Ajzen 1991).

Attitudes toward the behaviour, subjective norms with respect to the behaviour and perceived behavioural control have been found to predict behaviour intentions with a high degree of accuracy (Ajzen 1991, Armitage & Conner 2001).

Subjective norms have been found to be a weaker predictor of intentions (Ajzen 1991, Armitage & Conner 2001). Behavioural intentions, in combination with perceived behavioural control, can account for a considerable proportion of variance in behaviour (Ajzen 1991, Armitage & Conner 2001). A meta-analysis of 47 experimental tests of intention-behaviour relations by Webb and Sheeran (2006) concluded that a medium to large change in intention engenders only a small to medium change in behaviours and that intentions have less impact on behaviour when:

- (a) participants lack control over the behaviour
- (b) there is a potential for social reaction
- (c) circumstances of the performance are conducive to habit formation.

2.4.1 Benefits, Costs, Others & Self-assurance (BCOS) factors

Social marketing techniques can be used to influence the behaviour of decision makers who can enable target audiences to seek and access treatment services. Social marketing strategies and campaigns can also target at-risk young people or those displaying sexually abusive behaviours, their families, and the wider community in order to support their help-seeking and service utilisation behaviour. As well as promoting desirable behaviours, such as sun protection and condom use, social marketing campaigns have been developed to persuade individuals to stop or seek help for undesirable behaviours, such as smoking and sexual and domestic violence. In the USA it has also been used to market help to sexual offenders (i.e. Stop It Now!). The importance of weighing up the perceived costs and benefits, identified earlier in the literature review, is also a feature of the social marketing approach. Social marketing posits that when a target audience contemplates undertaking a behaviour, whether desirable or undesirable, an exchange occurs, whereby an individual gives up some costs in order to receive some benefits (Andreasen 2006, Blair-Stevens 2005). Social marketers are also urged to understand what the associated benefits and costs are for a target audience in relation to the competition or the undesirable behaviour (Blair-Stevens 2005). For the purposes of this study, the competitive behaviour is young people with sexually abusive behaviours and their families not seeking and utilising treatment services.

Andreasen (2006) has broken down the motivators and demotivators of behaviour into four BCOS factors including:

- (a) Benefits (motivators)
- (b) Costs (demotivators)
- (c) Others in an individual's environment (either motivators or demotivators)
- (d) Self-assurance; i.e. perceptions of opportunity and ability.

There are clear similarities between the meanings of the key determinants of behavioural intention, that Ajzen names 'subjective norms', and 'perceived behavioural control' and Andreasen in turn coins 'others' and 'self-assurance'. For the purpose of this study, the terms 'attitudes', 'social norms' (which is a commonly

recognised term within social science research), 'perceived behavioural control' and 'benefits' and 'costs' will be the main focus of investigation and reported findings.

2.5 Summary

Despite the significant incidence, internationally and within Australia, of young people with sexually abusive behaviours towards children, there is an identifiable gap in what is publicly known about the factors that motivate or demotivate these young people and their families to seek help. This study aims to add insights to the small amount of extant literature across a number of disciplines, including juvenile sexual offending, individual and family psychology, social marketing and help-seeking behaviour. Overall, the literature review has raised several questions that are worth further investigation to see whether or not they demotivate or motivate young people with sexually abusive behaviours and their families to seek help.

These questions include:

- (a) What are the attitudes, social norms, perceived behavioural control and perceived benefits and costs of young people with sexually abusive behaviours and their families with regard to help-seeking and service utilisation?
- (b) What role do enabling factors play in facilitating the help-seeking behaviour of young people with abusive behaviours and their families, including the impact of service quality and availability and the resources and ability of young people and their families to access treatment services?
- (c) How does problem recognition and need influence whether or not young people with sexually abusive behaviours and their families seek help?
- (d) Does gender as a variable have any impact on the help-seeking behaviour of juvenile sexual offenders and male and female caregivers?

The theory of planned behaviour and BCOS factors, along with other relevant behavioural influences identified in the Literature Review, have been utilised to develop interview questions and insights into what motivates or demotivates young

people and their families to seek help and utilise treatment services. Findings from this study will contribute to what is known about the help-seeking behaviour of young people with sexually abusive behaviours and their families and provide a precursor to the development of any social marketing orientated intervention.

3. METHODOLOGY

This section outlines the methodology used in this study to gain new insights, themes and hypotheses with regard to factors that may motivate or demotivate young people with sexually abusive behaviours, and their families, to seek help. This can inform and lead to appropriate social marketing intervention. Specifically, this section discusses the rationale for using a qualitative research approach, the steps in the qualitative research process, ethical considerations and the study's validity and reliability. The methodology has been structured into eight areas:

- 3.1 Research design
- 3.2 Identification of the research questions
- 3.3 Selection of relevant site(s) and subjects
- 3.4 Data collection
- 3.5 Interpretation of data
- 3.6 Ethical considerations
- 3.7 Validity and reliability
- 3.8 Summary

3.1 Research design

3.1.1 A qualitative research approach

A qualitative research strategy was chosen because of its suitability to the study of a social phenomenon such as help-seeking behaviour. An interpretive perspective enables the researcher to investigate the subjective meaning of the help-seeking behaviour (Bryman 2004). This includes identifying the personal motivations and barriers that might influence whether or not young people with sexually abusive behaviours and their families seek help and utilise treatment services. A quantitative approach to this study would not have been suitable because of its limitations in collecting such sensitive data and because there is also currently a lack of any

preconceived theory that could be tested by measuring numbers and the cause and effect relationship between any established variables.

A significant amount of the literature on young people with sexually abusive behaviours and their families has been presented within edited book chapters by practitioners in the field of juvenile sexual offending. Studies have typically featured smaller sample sizes and have generally lacked quantitative, experimental and longitudinal design methodologies. Some of the small amount of information that addresses help-seeking behaviour has been conducted with young and adult offenders. However, research on this aspect of the sensitive topic of sexual offending for young people and their families is scarce. Conducting social marketing research to gain insights into behaviour is ideally carried out with target audiences themselves (Blair-Stevens 2005). However, due to the sensitive nature and legal implications of sexual offending, and the ethical and logistical difficulty in directly accessing young people and their families, the researcher chose to interview experts in the field of juvenile sexual offending.

Because little research has been published about the help-seeking behaviour of young people with sexually abusive behaviours and their families, there is a need to explore the opinions of people with expertise in this area who are able to share their experiences and insights. Exploratory research is a useful approach to creating data in an area that lacks current knowledge and is not well documented, in order to identify and probe new issues (Sarantakos 2005, Bryman 2004). Findings from this study may generate categories of data that might be measured in future studies.

3.1.2 Theoretical approach

A number of key behavioural influences outlined in the Literature Review and relevant to social marketing have been used to inform the design of this study. The researcher investigates the attitudes, social norms and perceived behavioural control of young people and families towards seeking help for sexually abusive behaviours, with reference to the theory of planned behaviour and Andreasen's Benefits, Costs, Others and Self Assurance (BCOS). The researcher also explores the influence of cost-benefit analysis identified within the social marketing BCOS

factors and the Health Belief Model. Factors that impede or enable young people and their families to seek help (such as availability and quality of services, as identified in the Behavioural Model of Health Services Use) also inform the design of research questions.

The following well-established stages in the qualitative research process (Bryman 2004) underpin this study:

- (a) Identification of the research questions
- (b) Selection of relevant site(s) and subjects
- (c) Collection of relevant data
- (d) Interpretation of data
- (e) Conceptual and theoretical work
- (f) Writing up of findings and conclusion.

These stages are outlined in further detail in the following pages.

3.2 Identification of the research questions

As outlined by Bryman (2004), the selection of research questions followed a series of steps of progressively focusing in from a general research area to specific research questions. The researcher's interest is in the area of how to reduce the incidence of juvenile sexual offending through social marketing techniques. The selected aspect of the research area is increasing the incidence of young people receiving treatment for their sexually abusive behaviours. The research questions are focused around the help-seeking behaviour of sexually abusive young people and their families.

The overarching research question selected for this study is: what are the factors that motivate or demotivate young people with sexually abusive behaviours and their families to seek help and utilise treatment services?

3.3 Selection of relevant site(s) and subjects

The researcher selected experts in the field of treating juvenile sexual offenders as research participants for the study because of their recognised skills, knowledge and understanding of young people with sexually abusive behaviours and their families, including their help-seeking behaviours and utilisation of treatment services. These experts are also considered less likely to exhibit the social bias that young people and their parents might display when answering personal questions about their experiences of the sensitive and stigmatising topic of the perpetration of child sexual assault.

Ten experts in the field of treating juvenile sex offenders were interviewed regarding their perceptions of the help-seeking behaviour of young people with sexually abusive behaviours and their families. The experts were selected from a range of private practice and NSW State Government services, such as the Departments of Juvenile Justice and Community Services and NSW Health. The sample contained a mixture of four females and six males who have at least five years experience working in the field of juvenile sexual offending. These experts were predominately selected from a public list of accredited members of the NSW Commission of Children and Young People's NSW Child Sex Offender Counsellor Accreditation Scheme. The majority of these are accredited to work at a clinical level with young people directly and some are accredited to clinically supervise other professionals providing counselling services to young people with sexually abusive behaviours towards children. A number of the experts interviewed also work at services that provide counselling services to the families concurrently to their child's treatment.

The data collection phase of the study was terminated after ten experts were interviewed and there were no new concepts or categories being developed from the transcribed and coded material, whereby theoretical saturation had been achieved (Bryman 2004, p.403).

3.4 Data collection

The research techniques of in-depth interviews with semi-structured questions were appropriate for this study for a number of reasons. They provided the flexibility to explore the widest range of responses from interviewees and to probe responses to further understand underlying motivators and demotivators. This process also allowed the emphasis to be on how the interviewee frames and understands the issues and what is important in explaining and understanding events, patterns and forms of behaviour (Bryman 2004). Unstructured and in-depth interviews also provided interviewees with the opportunity to seek clarification of the researcher's question or line of questioning. This is particularly appropriate in relation to the cross-disciplinary nature of the study, whereby certain marketing concepts might not be familiar to practitioners specialising in juvenile sexual offending; for example, exploring the marketing notion of the competitive behaviour of not seeking help by asking what might be the possible benefits to not seeking help for sexual offending. One-to-one interviews rather than focus groups also allowed each expert the opportunity to comment on the barriers associated with service provision without the fear of identification or retribution.

The interviews ranged from forty five minutes to one hour thirty minutes. They were conducted either face to face in the expert's workplace or by phone between January and December 2006.

The interviews were treated as confidential with the anonymity of each expert being upheld in the writing up of the findings. This was to facilitate frank and socially unbiased responses within a politically sensitive area of human services delivery.

See Appendix 7 – Semi-structured interview questions for expert informants.

3.5 Interpretation of data

3.5.1 Data preparation

Interviews with expert respondents were audio-taped. Responses from each interview were treated as confidential and anonymous, with each expert being allocated a code, i.e. E1, E2, E3 etc. The audio-taped interviews were transcribed verbatim.

3.5.2 Coding

Coding enables the researcher to organise, classify and generate concepts from the data (Coffey 1996). The initial coding process applied to the interview transcripts was 'open coding' which seeks to 'open up' and expand the data, rather than reducing it (Strauss 1987, Coffey, 1996). This is a useful technique when not much is known about the topic investigated and when developing pre-determined codes would be inappropriate. In order to develop provisional concepts from the data, the researcher broke up interview transcripts line by line and attributed them with a level one in-vivo code or tag that described the processes or action taking place and reflected the language directly used by respondents. An example of open coding from one of the interviews follows:

Figure 3.1 Sample coding transcript

<i>Transcript</i>	<i>In-vivo code</i>	<i>Theoretical Memo</i>
Q. What do you think are the main reasons adolescents don't seek help for their sexual offending?		
A. Fear is a huge one and also shame. They know they've done something really grotty and they have a lot of shame about it and they also have a lot of genuine fear about it.	Don't seek help -fear -shame -feel grotty	Awareness they have done something wrong supports the sex offending literature. ? Feeling 'grotty' /shame about it is a potential cost associated with offending and a psychological

barrier to seeking help.
Explore 'fear' further i.e. what are they fearful of? Does 'genuine' relate to realistic consequences that are likely to incur if they seek help?

The researcher used theoretical memos to raise questions from the data about possible types and properties of categories that the responses indicated. This began the process of lifting the data to a second, more abstract level, through the establishment of categories. General categories were created which related to the questions themselves, such as the benefits of families seeking treatment or pathways to receiving treatment. Other categories were developed by comparing the level one codes with each other to identify what category individual incidents indicated and which incidents were similar and could be included under the same category. For example, the category 'psychological barriers to help-seeking for young people' included guilt, shame, lack of problem recognition, denial, minimisation and fear of consequences.

The researcher used axial coding on the identified categories to determine properties of the category, such as individual conditions and consequences of the phenomenon described. Each category was compared to others to ensure they were each mutually exclusive (Strauss 1987). These categories and related incidents were further elevated into more general 'concepts' and 'themes' in order to interpret the findings. Concept Cards (Martin & Turner 1986) were developed to place all the data relating to a code or category in the one place, so that all the categories could be displayed and explored in order to understand the themes, patterns, relationships and contrasts evident in the data. This also assisted the development of more general meanings about the help-seeking behaviour of juvenile sex offenders and their families. Whilst this study uses methods found within the Grounded Theory approach to data analysis (Glaser & Strauss 1967), it does not seek to develop formal theories from the concepts and themes which emerged from the data.

3.5.3 Findings and conclusion

Analysed data from the interviews with experts have been written up into findings and the social marketing and policy implications discussed in the following 'Findings and Analysis' section of this Thesis.

3.6 Ethical considerations

The researcher gained ethics approval from the Human Research Ethics Committee at the University of Wollongong (HE05/253 – see Appendix1). She directly approached experts by letter or phone call and provided each with an information package, including an information sheet about the study (see Appendix 2) and a consent form (see Appendix 3).

The researcher gained additional ethics approval from South Western Sydney Area Health Service (SWAHS) to interview a number of staff working with young people with sexually abusive behaviours and their families (HREC2006/9/4.7(2428) – (see Appendix 4). It was clearly stated in the SWAHS Participation Information Sheet (see Appendix 5) the Consent Form (see Appendix 6) and verbally before interviews commenced that participation in the study was voluntary and that participants could refuse to answer any questions or withdraw their involvement at any time without any negative consequences. Because the nature of the study referred to the illegal activity of sexual offences against children, it also stated in the participant information sheets that the focus of the study was on the help-seeking behaviour of young people and their families and not related to incidences of specific criminal sexual activity.

3.7 Validity and reliability

Mostyn (1985) notes that the reliability and validity of qualitative research can rarely be guaranteed due to the subjective nature of the research material and the one-off

nature of most projects. Empirical validation is not possible for this study. However, the following measures were taken to strengthen the validity and reliability of this study. Validity tells the researcher whether an instrument measures what it is supposed to measure and whether this measurement is accurate and precise (Sarantakos 2005, Bryman 2004).

3.7.1 Internal validity

Internal validity refers to the extent to which the research design impacts the design outcomes (Sarantakos, 2005). Interviews with experts in the field of juvenile sexual offending provided credible and valid data on the help-seeking behaviour of young people with sexually abusive behaviours and their families. All the respondents interviewed have a number of years of clinical expertise providing psychological treatment services to young people who have sexually abused children. Many of them have also worked directly with their clients' parents and families. This appropriate method of data collection helps to increase research validity (Silverman 2006). As previously mentioned, using experts rather than young people or families also reduced the risk of social bias, especially in a sensitive area of sex offending whereby the editors Renzetti and Lee (1993) have identified that respondents are likely to fear being identified, stigmatised or criminalised through their responses about deviant activities.

3.7.2 External validity

External validity refers to the extent to which research findings can be generalised (Bryman 2004). Findings from this research study support some important concepts identified in extant help-seeking and social marketing literature. One of the criteria for validity is that it tests the ability to produce findings that are in agreement with theoretical or conceptual values (Sarantakos 2005). As in previous studies, high costs versus low perceived benefits are associated with inhibiting behaviour; i.e. help-seeking in young people with sexually abusive behaviours. This study also supports the theory of planned behaviour premise that: a lower intention to seek help, particularly for young people with sexually abusive behaviours, arises from

unfavourable attitudes; there are low social norms associated with seeking help (including the social stigma associated with child sexual offenders): and there is a low perception of help being available and easy to obtain. Interviews with experts have supported a relationship between parents having a low perception of perceived behaviour control towards seeking treatment services and a decreased intention to seek further help. The findings of this study have an application for NSW in particular, as data was gathered from practitioners in a range of clinical settings across the state.

3.7.3 Reliability

A method is reliable if it produces the same results whenever it is repeated and is not sensitive to the researcher, the research conditions or the respondents (Sarantakos 2005). Efforts to achieve internal and external reliability were addressed in a number of ways.

3.7.4 Internal reliability

The researcher developed professional procedures that could be externally audited and used by other scholars to check internal validity. As previously mentioned, the interviews were audio-taped and transcribed verbatim. A methodical approach was made to the detailing of the data transcripts, coding and researcher's notes. The researcher was mindful about subjectivity during the analysing phases, especially since only one person conducted the coding. In keeping with the ethics approval from Sydney West Area Health Service, participants from these services were sent the draft findings, conclusion and recommendations and subsequent feedback and comments about the overall accuracy of the researcher's perceptions and interpretation of the data were included.

3.7.5 External reliability

In order to increase external reliability, the researcher set a clear boundary for the study – to investigate the help-seeking behaviour of young people and their families once the sexual assault of a child has taken place. She clearly documented the sampling technique, including the reasons why respondents with expertise in juvenile sexual offending were chosen to participate. Interviews with these experts provided a saturation of responses to the research questions posed in this study, whereby no new or contrasting data was being gathered after a number of interviews.

3.8 Summary

The researcher selected a qualitative methodology as the most suitable research design to explore the lack of extant knowledge about what motivates and demotivates young people with sexually abusive behaviours and their families to seek help. She conducted semi-structured interviews with recognised experts in the area of juvenile sex offending in order to gain new insights and develop concepts that are informed by many years of professional practice with juvenile sex offenders and often their families. These interviews were also less likely to be influenced by social bias that can be the result of respondents speaking personally about sensitive topics. The collected data was transcribed verbatim and coded to raise the data to increasingly abstract levels, in order to derive concepts and more generalised meanings about the help-seeking behaviour of juvenile sex offenders and their families. The researcher took measures to strengthen the validity and reliability of the study, such as transparently documenting the sampling and analytic methodology, keeping systematic notes, declaring personal biases and getting feedback from the respondents about the overall accuracy of the findings.

4. FINDINGS AND ANALYSIS

This study investigates what factors motivate or demotivate young people with sexually abusive behaviours and their families to seek help and utilise treatment services. The findings of this study cover the continuum of the three stages of the help-seeking process:

- (a) Problem recognition
- (b) Decision to seek help
- (c) Selection and utilisation of services.

Factors that have been associated with influencing behaviour from Ajzen's (1991) theory of planned behaviour framework and Andreason's (2006) Benefits, Costs, Others, and Self-assurance factors were used to seek expert opinions on:

- (a) the help-seeking behaviour of young people with sexually abusive behaviours and their families
- (b) the attitudes and motivations that young people and their families have towards seeking help and utilising treatment services
- (c) the social norms associated with seeking help for a young person's sexually abusive behaviours
- (d) the perceived behavioural control that young people and their families have towards seeking help and utilising treatment services
- (e) the benefits and costs young people and families associate with seeking help and utilising treatment services.

Factors that facilitate or impede service utilisation from the Behavioural Model of Health Service Use (Anderson 1968) were also used to explore factors that either enable or make it harder for young people and their families to seek help and utilise treatment services. Motivations and 'benefits' associated with the competitive behaviour of not seeking help were also explored with experts.

The gathered data was analysed and a series of significant themes emerged concerning the help-seeking of young people with sexually abusive behaviours and

their families. In this chapter, each of these themes is examined within two key sections.

- (a) Help-seeking of young people with sexually abusive behaviours (at 4.1)
- (b) Help-seeking of families with sexually abusive children (at 4.2)

4.1 Help-seeking of young people with sexually abusive behaviours

This section explores the theme of what motivates and demotivates young people with sexually abusive behaviours to seek help and utilise treatment services. Results from the data are organised and discussed in detail around the following sub-themes:

- 4.1.1 Help-seeking behaviours
- 4.1.2 Attitudes
- 4.1.3 Social norms
- 4.1.4 Perceived behavioural control
- 4.1.5 Benefits
- 4.1.6 Costs
- 4.1.7 Factors that enable young people to attend treatment services
- 4.1.8 Sexual offending motivations and costs
- 4.1.9 Discussion

4.1.1 Help-seeking behaviours

When experts were asked if young people seek help for their sexually abusive behaviours of their own volition, a key theme emerged:

- (a) Young people rarely seek help voluntarily before their behaviour is detected

All the experts interviewed for this study indicated that in their experience it is very rare for juvenile sexual offenders to seek help of their own volition.

I can't think of a single case where someone has put their hand up and said 'look, I have offended against my sister, cousin, whatever and I want help for it'. (E3)

Very rarely, they certainly don't present to me. (E2)

Not usually of their own volition. That's not my experience. (E4)

I haven't had experience with many or any adolescents really who seek help at that phase. (E1)

Of the 10 respondents (who all have significant experience working in this area), only two had worked with a couple of young people each who had sought help before their behaviour was detected by others. It appears that young people do not usually seek help voluntarily with concerns about their behaviour.

(b) Pathways for young people to receive treatment services

Of the extremely small number of young people who had sought help voluntarily, one young man approached a private therapist because he didn't like his behaviour. He travelled to meet the therapist regularly in another country town for two years despite family pressure not to seek help. Another young person contacted a private therapist because of his fear that another member of his family was 'onto his behaviour'. Another avenue where young people have received help before being caught is from attending sexual assault services as a victim and disclosing their own abusive behaviours and subsequently getting referred to treatment providers.

Some parents catch their child sexually abusing another child. However, in NSW, the majority of sexually abusive behaviour by young people comes to the attention of DoCS through the disclosure of abuse by their victims to professionals working across a number of health, welfare, police, medical, education and children's services who are legally required to report the abuse to statutory authorities.

The usual modus operandi is that they will get caught somehow or other (and) the Department of Community Services may get involved. Worse case scenario police will get involved and help-seeking will be forced upon them. (E3)

Once the suspected behaviour has been reported to DoCS (through its Helpline), staff determine whether the alleged abuse fits criminality criteria. If it does, then it will be referred to a Joint Investigative Response Team (JIRT), who will decide if young person is to be charged with a criminal offence. Otherwise the notification will be forwarded to a DoCS Community Service Centre for a case worker to follow up. In the much less common scenario – that young people are charged with an offence – they may be convicted and ordered by the Children's Court to receive an assessment. The results of this may influence the Magistrate to sentence the young person to attend a Juvenile Justice or community treatment program. Overall, it is more likely for the families to be investigated by DoCS caseworkers and either be subsequently referred to attend treatment programs voluntarily, or not referred at all. Experts perceive that if young people are attending treatment services it is usually because parents have organised it.

4.1.2 Attitudes

Young people who sexually abuse children can experience a number of unfavourable attitudes and psychological factors that inhibit them from seeking help prior to others discovering their behaviour. These factors include a fear of the consequences, guilt and shame associated with their behaviour, psychological defences such as denial, minimisation and blame and developmental constraints.

(a) Fear of consequences

Experts perceive that young people know that their sexually abusive behaviour towards children is wrong. Sexual offending is carried out in secret because they do not want to get caught. Many of these young people appear to know they have a problem and many want help, but often think that they won't do it again. They hope

that the behaviour will go away. They tend to keep their negative attitudes towards sexually offending to themselves, as E2 highlights.

Most of these kids are so good at convincing themselves there's no problem and creating a whole pattern of thought and behaviour around what they're doing that they are not setting their thinking (to) 'I should go to counselling'. (E2)

Experts consider that young people are inhibited from seeking help due to fear of the possible consequences of being caught, such as getting into trouble with their parents and the law and suffering possible sanctions placed on them, including gaol, being placed on a sex offender's register or having their usual activities, (i.e. school and sports) disrupted. They can be very concerned that they might have to leave the family, as E3 has found.

In most cases where sexual offending is identified, what will occur is there will be quite large-scale disruption to the family. Quite often the child is required to leave the family and these stories get around. So these kids have a lot of fear about what's going to happen if they get caught. (E3)

(b) Guilt and shame

Although young people might not admit it until they are engaged in treatment, the majority of experts feel that the guilt and shame young people experience about their abusive behaviour are key reasons why they do not seek help, as E3 and E1 highlight.

The twin issues of shame if they are caught and sanctions that might be applied to them tend to make them less likely to seek help in this particular area almost than in any other area I can think of. (E3)

Usually they would feel incredibly ashamed and guilty and bad about it [sexual offending] but they would be unlikely to express that until they were somewhere down the sort of path of getting some help. So they

would be usually denying and minimising it and saying they hadn't done it, it didn't happen, wasn't their fault, either it was the victim's fault, or the victim wanted it, (the) victim made it happen. (E1)

(c) Psychological defences

A number of experts speak about the cycle of offending and explain the first phase is a range of negative attitudes that juvenile sexual offenders feel about committing a sexual offence such as guilt, feeling bad, knowing they have a problem and saying 'I know I need to stop'. This is replaced by a phase where the young person feels like a victim themselves, denying or minimising their behaviour, blaming others and swearing that they will never do it again. This occurs until the urges they have to sexually abuse children build up again and they re-offend. Even when their behaviour is reported to others, experts unanimously agree that juvenile sexual offenders will continue to vehemently deny their behaviour, minimise it or blame the child victim unless skilled treatment providers can work therapeutically with them to address their offending behaviour.

A lot of children convince themselves it was consensual or the other child was participatory or even instigating. (E7)

(d) Developmental constraints

A number of experts indicate that there is a difference between the cognitive abilities of young people with sexually abusive behaviours and adult sexual offenders. This may explain why young people are much less likely to seek help over concerns about what they may be thinking about doing to children. Unlike adults, they don't have the developed cognitive ability to monitor their thoughts and be concerned about them, as E3 and E10 point out.

The notion that a young person would be monitoring their thoughts, it's a nice notion but it very rarely happens and so most young people are unaware that's how they're thinking. (E3)

They may be worried about themselves or what they have done but

cannot articulate it. (E10)

4.1.3 Social norms

Family and friends are perceived as being the most important social referents for young people, then teachers and the wider community. Young people are thought to receive some positive messages from families and teachers once their behaviour had been disclosed. Overall, experts advise that there continues to be a great deal of social stigma attached to sexual offending and that help-seeking is not considered to be a common behaviour for perpetrators.

(a) Parents and family members

Parents are considered especially important and influential to young people with sexually abusive behaviours, particularly the younger ones. Members from the wider family, such as siblings and grandparents, can also be important to young people. Grandparents are identified as often being the temporary caregivers (if a child is removed from his/her family due to abusive behaviours) and are often supportive of their grandchild receiving help in order to restore the family. It is the experience of many experts that mothers are more likely to believe that the abuse took place and that fathers convey less supportive attitudes for seeking help. However, experts highlight that parents can either support help-seeking or actively discourage it, as E4 illustrates.

The ones with parental support say 'you've made a mistake, done something wrong and need to fix it up.'....Some families will tell the kid not to tell anyone – they will lose their networks if removed. (E4)

One expert believes that, if there is existing sexual abuse in the family, a young person may watch to see how the disclosure of another perpetrator is dealt with.

(b) Peers

A few experts advise that peers are important to young people with sexually abusive behaviours. However, it is more commonly thought that peer-based relationships

are somewhat weaker for many juvenile sexual offenders, who are often more socially isolated or prefer the company of children. Peers are not considered to be as influential as other family members to adolescents with sexually abusive behaviours.

Adolescent sex offenders tend to be much more isolated kids, tend to be the loner and the kid who gets on well with little kids. (E1)

(c) Teachers and the wider community

Teachers are considered to be important, particularly to younger children and their families, and have the potential to support families to seek help for their abusive child. Some were found by experts to have given positive messages to families about their child 'getting better'. Sporting, social and school networks are seen as important to these young people. One expert feels that sporting and video characters within media can be of influence to the older individuals. A number of experts consider that young people appear to know that their behaviour crosses social taboos and that others in the broader community, including wider media, stigmatise sex offenders as 'monsters' and 'paedophiles' and 'once an abuser always an abuser'.

All this hysteria in the media about paedophiles, stuff like that, creates more of a problem than it solves. (E3)

Young people know that others see it as deviant and weird. (E1)

These negative messages can set up expectations in young people that this is how they will be treated if they talk about their behaviour, which can increase their reluctance to seek help.

4.1.4 Perceived behavioural control

Factors that contribute to young people thinking it is hard to seek help include a lack of awareness that they need help, what help is available and support to find help.

One notable exception to this is one young man who voluntarily contacted one of the experts after seeing a documentary featuring treatment for sex offenders, as E4 describes.

There were a couple of email addresses given out for help at the end of the program. He contacted the Australian and New Zealand Association for the Treatment of Sexual Abuse and looked for someone to talk to.
(E4)

However, the predominant perception of experts is that if young people are receiving help for their sexual offending it is usually because someone else is making them.

Young people's perception of how easy or hard it is to get help is also dependent on the responses of the people around them. A lack of understanding by parents, DoCS and other systems surrounding young people about sexual abuse dynamics and risk management can also make it harder for young people to be aware of the help that they need, as E2 highlights.

The major problem is often not the child, it's DoCS, parents and other systems involved with children where they don't understand the dynamics of sexual abuse, what's required in treatment and the management of risk. You end up in situations of sorts of chaos, conflict and competing beliefs and ideas about what these kids need. (E2)

4.1.5 Benefits of attending treatment

Experts advise that young people do not seem to perceive any benefits to seeking help prior to being caught. However, once their behaviour has been detected, young people often attend treatment voluntarily and can experience a range of benefits, including improved family relationships, improved self-esteem and reduced sexual offending.

(a) Improved family relationships

One of the key motivations and benefits for young people to attend treatment can be that they are reunited with their family, especially if they or their sibling victim have been removed. Experts consider that young people know if they want to be restored to their family they need to do something about their behaviour.

It is thought that young people know that their behaviour hurts their victims and the majority feel bad and can admit their feelings of guilt and shame further into the treatment process. The benefit to someone that the young person cares about, e.g. his or her sibling, can be perceived as a positive outcome of treatment.

I think it's a rare situation where there isn't any concern about the harm they've done. (E7)

For young people, the time spent with a parent taking them to treatment can be positive and affirming of their parents care for them. Experts have seen that treatment often results in improved communication and positive changes in a young person's relationships with his/her family, as E7 illustrates.

...They see a change in the relationships that they have with family members, they see a repairing of rifts that have been caused by their behaviour. (E7)

One of the aspects of improved family relationships is related to young people being able to make restitution of harm caused and experiencing less shame because they are doing something to address their behaviour. Through treatment they can also have the opportunity to address a range of psychological issues, such as unfair things that may have happened to them.

(b) Improved Self-Esteem

A perceived benefit for young people to attend treatment is the opportunity to move forward with their lives and to develop a positive self image rather than an identity as a bad person.

A young person who's learnt a lot about how their behaviour's hurt other people, they're really committed to doing something about it. And that can be about identity as well. (E9)

As treatment progresses, young people can often develop greater hopes and expectations for the future. In some programs they develop better school outcomes and relationships with peers. They are also able to get freedom back when they can demonstrate responsibility.

(c) Safety and reduced risk of further offending

Attending treatment can provide young people with improved safety planning so they are able to reach out for help if they are scared about repeating their sexually abusive behaviours. The safety of the young person themselves is considered to be a key benefit, as E8 points out.

The headline benefit is to be safe. These are young people, overwhelmingly coming from situations where they've been abused in one way or another, or several ways. We've got a hypothesis about the lack of safety and experience of abuse which is the connector between behaving in a sexually abusive way. (E 8)

4.1.6 Costs of seeking help

A number of experts think that, for many young people, the perceived consequences of their behaviour coming to light, such as having to talk about their behaviours, leaving the family, going to prison and a disruption to their current lives, far outweigh any perceived benefits to seeking help prior to being caught, as E3 states.

With kids who have not been caught, I actually do not know how you would engage them because I think the risks for them of divulging that information simply outweigh any obvious benefits from talking about it. What would be the benefit to a child of talking about something that's

going to be so shameful and carry such potentially horrendous outcomes that to broach it would just be awful for them? (E3)

4.1.7 Factors that enable young people to attend treatment services

Legal consequences, the support of others, stable schooling and accommodation and clinical engagement can motivate a young person to attend treatment services *once* their behaviour has been reported.

(a) Legal consequences

Many young people go to treatment voluntarily once their behaviour has been detected; however, being legally mandated to attend treatment and having legal consequences if they do not can motivate a resistant young person.

So unfortunately motivation is pretty much external motivation, being the court mandate. (E5)

(b) Support of others

Experts also consider that support from others around them, such as parents, has a motivating influence on young people completing treatment, as E4 demonstrates.

You get heaps of parents who say ‘You’re doing such a good job talking about it. I’m really proud of you’. They focus on the therapeutic intervention, not that ‘You did something really bad, that’s why you’re coming here’. Those parents can really help that child move right through and you can see an end in sight. (E4)

Maintaining stable accommodation and school attendance are also considered to enable young people to make progress in treatment.

(c) Clinical engagement

Experts indicate that the majority of juvenile sexual offenders who are referred to attend treatment services can be willing to attend regularly despite their reluctance to talk about their sexual offending.

Most kids come to counselling even when they don't want to be there.
(E2)

Young people with sexually abusive behaviours are thought to be more likely to attend treatment voluntarily if they are confident that counsellors know what they are doing, and can help young people find a way to talk about their behaviour. It is felt that these young people will not talk about their offending, or admit or take responsibility for their behaviours, unless they are engaged with the treatment process.

These kids don't want to talk about it. It's horrible, embarrassing and they are ashamed – but if you can acknowledge that and talk to them, find the language to talk to them, they do – 99 per cent of them will. (E2)

4.1.8 Motivations and costs associated with sexually abusing children

The experts advise there is no easy or singular answer as to why young people sexually offended. However, there are a range of contributing vulnerabilities, such as unsafe and sexualised family backgrounds, puberty, and having the opportunity to abuse children. A number of experts identify key psychological motivations as contributing to this behaviour, including young people wanting to feel better about themselves, retaliation and compensation. Costs that young people can experience as a result of sexually offending include feeling bad about their behaviour, realising the impact it has on others and a fear of getting caught and the associated consequences.

(a) Vulnerabilities

The majority of young people treated by the experts come from family backgrounds characterised by violence, sexual abuse and neglect. They have often been the victims of abuse and neglect themselves. Experts observe that young people who have experienced abuse often have poor self esteem, anger, acting-out behaviours, poor impulse control, poor social skills and disturbed psycho-sexual development. These are often characteristics of juvenile sexual offenders. Experts emphasise that these young people have chosen to abuse and not all young people from these backgrounds go onto sexually abuse. Environmental family factors are also considered to support sexually abusive behaviours, with juvenile sexual offenders often being exposed to pornography and sexualised family dynamics. Their parents are thought to often have their own abuse histories, depression and mental health issues.

They often come from families where there's been other kinds of physical or sexual abuse, or very sexualised kind of stuff. (E1)

Biological processes that occur in puberty, such as sexual development and arousal, are also thought to create more sexually motivated problem behaviour in vulnerable young people.

(b) Psychological motivations

Experts consider that young people who sexually abuse often have low self esteem. One of the motivations for sexual offending that emerges from this study is that being with children, and/or fantasising what they might do sexually with children, 'feels good'. It can be easier for these young people to relate to children than their own peers, as E7 identifies.

So they might be meeting a connection in a way that's low risk or low challenge. Or they've experienced rejection or failure with peers. (E7)

A number of experts highlight the following two key psychological motivations that young people have for sexually abusing children:

Retaliation – young people can try to get back at step-parents and others by sexually offending against their child or other children. Many are also angry with victims, such as step-siblings.

I've had a number of adolescent cases where the boy has tended to act out against step-children in the family, in part as a displacement activity against what they see as the fact the dad is now more interested in the family than they are in them. So you can get anger, particularly within incest or step-incest families. (E3)

Compensation – many juvenile sex offenders have been neglected and abused children and can have unmet needs for connection, affection and closeness with others. Some of them may have been sexual with siblings since they were small because it feels nice and they feel loved and connected.

With the compensatory stuff it's often about meeting unmet needs. It could be connection, affection, closeness. (E2)

(c) Costs of sexual offending

Because they know their behaviour is wrong, that it hurts others and they are going to get into trouble for it, young people may experience anxiety about getting caught, investigated and possibly having to leave the family. They may feel weak and out of control soon after offending. They may not want to be a sex offender and have to override their conscience about sexually abusing a child. Without getting treatment for their behaviour they can feel bad about what they've done while living with their brother or sister (in the case of sibling abuse), or when they get older (if they offended when young).

They feel strong and powerful in the moment. Afterwards they don't. They feel weak and out of control. It's a paradoxical thing in a way. (E1)

4.1.9 Discussion

Two key findings from this study are that young people appear to be reluctant to seek help before their behaviour is detected, but can be motivated to attend treatment once caught. A number of factors that motivate and demotivate young people to seek help have been identified both prior to and following their behaviours being detected. This study highlights a number of themes about the help-seeking behaviour of this population of young people.

- (a) Young people can have unfavourable attitudes to seeking help prior to being caught

Although there are rare instances where young people voluntarily approach service providers for help, it appears from this study that juvenile sexual offenders have very little intention to seek help for their sexual offending before being caught. This significant finding supports literature on juvenile sexual offending which identifies that young people carry out their behaviour in secret because they do not want to get caught (Ryan et al. 1987).

This study has identified a number of psychological, developmental and social factors that can demotivate young people to seek help before being caught. These include:

- (i) feelings of shame and guilt that young people do not want to expose
- (ii) a developmental cognitive inability to monitor their thoughts and behaviour
- (iii) fear of the possible and real social and legal consequences to disclosing their abusive behaviours.

These findings argue against treating young people as mini adults and expecting them to identify, let alone report, any precursive thoughts and sexually abusive behaviours. It has been identified that young people know their behaviour is wrong. Getting into trouble with their parents and the ensuing disruption to their family lives and activities (including possible removal from their families) are considered key costs for young people in disclosing their behaviour. Child sexual assault is also a crime and if charged and convicted can result in spending time in a juvenile

detention facility. Juvenile sexual offenders have been found to minimise the extent of their offending because of feared consequences of incarceration and stigma by other people if their motivations and behaviours are disclosed (Kenny et al. 1999). These costs of seeking help are similar to help-seeking barriers identified by adult sexual offenders (Stop it Now! 2005), which included fear of legal consequences, stigma and fear of losing family. The stigma that experts perceive as a demotivation for young people disclosing their sexually abusive behaviour supports studies that have identified stigma and fear of consequences as a major barrier to help-seeking (Rickwood et al. 2005, Booth et al. 2002). The costs associated with seeking help voluntarily, before others detect their behaviour, appear to far outweigh any immediate perceived benefits. This finding is supportive of literature which argues that variables that increase the costs of help-seeking inhibit an individual's willingness to seek help (Gross & Mc Mullen 1983).

- (b) There are weak social norms for young people to seek help for their behaviour

The finding that parents and family are the most important referents for young people with sexually abusive behaviours is consistent with other findings that a high percentage of young people in Australia prefer to seek help from their family (Australian Childhood Foundation 2005). The negative attitudes and stigma that families can show toward sexual offenders is of concern, especially in light of the weakened relationships with peers (Hunter, Becker and Lexier 2003, Blaske et al. 1989). However, this study has found that there is a positive role that others, such as teachers, can play – by giving encouraging messages about seeking and getting help to young victims, perpetrators and their parents when the abuse is brought to their attention.

- (c) Young people can have low perceived behavioural control towards seeking help

Although this study highlights an extremely small number of young people who had contacted service providers and attended treatment services of their own volition, it was against their parent's knowledge and required a lot of effort. Seeking help themselves appears much more of an exception, especially for younger people who

are especially reliant on their parents. Experts are in agreement that if young people attend treatment it is usually because someone else is making them.

(d) There are motivations and 'benefits' associated with sexually abusing a child

The experts make it clear that the majority of children who have been abused do not subsequently go on to sexually abuse. However, the disadvantaged backgrounds and vulnerabilities of young people with sexually abusive behaviours found in this study are well documented in juvenile sex offending literature (Bentovim 2002, Davis & Leitenberg 1987; Vizard, Monck & Misch 1995, Veneziano & Veneziano 2002, Nisbet, Rombouts & Smallbone 2005, Pithers et al. 1998).

Major psychological motivations young people can have for sexually abusing a child, identified in this study, were associated with intimacy, connectedness and being around young children because it feels good. These motivations and 'benefits' associated with sexually abusive behaviours pose significant competition against the perceived costs of help-seeking for young people. Young people might have moments of being concerned about their abusive behaviours; however, feeling bad immediately after the abuse appears to be short lived before psychological defences such as denial, minimisation and blame override negative feelings associated with sexually abusing a child. These responses support Ryan et al.'s (1997) 'cycle of sexual assault', which identifies a relationship between defences commonly found in young and adult sexual offenders and a reluctance to seek help or admit to sexual offences when caught.

(e) Once caught, young people can experience benefits to attending treatment

An encouraging finding of this study is that, once caught, many young people are willing to engage in treatment processes with skilled service providers in spite of psychological defences such as denial and minimisation. A key motivation and perceived benefit for young people who attend treatment seems to be especially linked to maintaining and improving their relationships with their family. Significant and valuable longer term benefits (for young people completing treatment) can be unexpected and relate to positive self-identity beyond being labelled a 'sex offender', and a sense of hope and optimism about their future. This adds a mental

health benefit for young people attending treatment programs beyond the public health benefit of decreased recidivism.

This study may provide an insight into why there are low percentages of young people who reach out for help for sexually abusive behaviours. It cautions that they might not be likely to call a helpline if one was promoted, particularly prior to their behaviour being detected. The findings highlight that parents and caregivers will need to take the lead in seeking help as their child is likely to deny and minimise their behaviour. Statutory workers need to support families to seek treatment services once their child's behaviour has been investigated and substantiated. This study also identifies the benefits that young people can receive from attending treatment by skilled counsellors. This not only helps reduce human suffering by preventing further abuse but is considered by experts to improve the overall quality of life for a young person who has been sexually abusive. As parents play a key role in whether treatment is sought for young people or not, social marketers need to understand what factors motivate or demotivate parents to seek help and utilise treatment services for their sexually abusive child.

4.2. Factors influencing the help seeking of families

This section explores the theme of what motivates and demotivates families to seek help from the time they are aware of their child's sexually abusive behaviours through to utilising treatment services. Results from the data are organised and discussed in detail around the following sub-themes:

- 4.2.1 Help-seeking behaviour of families
- 4.2.2 Attitudes
- 4.2.3 Social norms
- 4.2.4 Perceived behavioural control
- 4.2.5 Benefits
- 4.2.6 Costs
- 4.2.7 Factors that enable parents to seek and access treatment
- 4.2.8 Discussion

4.2.1 Help-seeking behaviour of families

As previously discussed, the most common pathway for a sexually abusive young person to receive treatment in NSW is through the disclosure of abuse by the victim, notification of suspected sexual abuse by mandatory reporters and a subsequent investigation and referral by statutory authorities. However, experts also identify that many families take steps to address their child's behaviour prior to any involvement with statutory authorities. This includes self-managing the situation, reaching out to others they trust or contacting treatment providers directly.

(a) Many families take action to stop their child from sexually offending

Where families might be aware of the abuse, experts advise that a number of parents do something to stop the behaviour, as respondent E9 states:

So there's a whole variety of things when you become aware of the behaviour that you could do and my belief is that families will do something and they will intervene in some way. They will try to change the behaviour. (E9)

Self-managing the situation

A number of experts identified that some families try to self-manage the abuse within the family, as E5 and E10 illustrate.

So there'd been some sort of sexual abuse within the family, by a teenage boy, and the family wanted to deal with it internally. (E5)

We had a presentation once where a mum was actually sleeping in the hallway outside her child's, her younger child – the girl's – bedroom door to make sure her son wouldn't go in the bedroom at night. So that hyper-vigilance, I can't even begin to imagine what that would be like. (E10)

Experts identify that measures that families might take to self-manage the situation usually subsequently fail and the young person's behaviour continues.

Reaching out to others they trust

Families also might seek help from others, such as trusted family and friends, family doctors, school counsellors or ministers of religion.

And they go to church as well, ministers of religion, and they'll search some trusted family circles. (E8)

Although parents can hesitate about letting others outside the family know about the situation, it can be relieving and positive when they do, as E7 points out.

Their experience usually is one of support from those who know them and care about them. (E7)

Contacting service providers directly

Both government and private treatment providers have experience of a small number of families contacting them directly soon after becoming aware of the abuse. They have heard about the services from friends or by word of mouth. Sometimes families want to do this anonymously to find out what will happen to them and their child if they do seek further help, as E7 identifies.

A few weeks ago I had a phone call from someone who wanted to remain anonymous and they were just asking for advice about a situation where someone they knew within their family, a teenager... it had recently come to light that he'd sexually assaulted some other children in the family. I don't know where they got my phone number but they were basically sounding me out about what would be best for the young person. (E7)

These families are encouraged by treatment providers to notify statutory authorities about their child's behaviour because of child protection requirements. NSW treatment services such as New Street are unable to provide treatment unless the

statutory child protection authorities have formally investigated the situation. However, most families that contact treatment services such as New Street have had an investigation by DoCS and a referral to attend treatment services.

4.2.2 Attitudes

Experts identify unfavourable and favourable attitudes that parents have towards taking action, seeking help and utilising treatment services to stop their child's behaviour. Unfavourable attitudes include negative psychological reactions to their child's behaviour and loss of control over their family. Favourable attitudes or motivations for seeking help include concern for their role as parents and the wellbeing of their child(ren).

(a) Negative psychological reactions to their child's behaviour

Experts are in agreement that the disclosure of a child's sexually abusive behaviours has a significant impact on families and can often throw them into a state of crisis. Parents commonly experience a reaction to trauma and stages of grief such as disbelief, anger, denial and bargaining. Parents can be particularly angry with their offending child or blame others. In cases of sibling abuse, parents can be particularly concerned about how to respond to both children. They're often devastated to learn about their child's behaviour and experience feelings of responsibility, shame and self-blame about their parenting skills, as the following quotes from E9 and E5 illustrate.

A lot of families that we work with would not have been aware that there had been abusive behaviour until it's disclosed, but when it was disclosed they can think of things and they feel a great sense of responsibility and blame for not putting those things together. (E9)

It's difficult to get parents to talk about their experiences with their kids who have sexually abused because there's a great deal of shame involved, and a lot of parents obviously feel that it reflects badly on them in terms of their parenting ability or whatever if their son has committed a sexual offence. (E5)

Experts believe the negative emotions parents often feel (such as embarrassment, shame, guilt, self-blame and fear of being judged by others) can inhibit help seeking.

Often self-blame is so huge that it silences people..... the shame silences people from seeking out help. (E10)

Experts identify a range of psychological defences some parents display when they learn about their child's behaviour that can demotivate them from seeking help. Many parents do not want to think that their child is capable of such behaviour and some will override their own suspicions to believe that it was a one-off occurrence. Some families try to ignore the abuse and pretend it didn't happen or buy into their child's denial, while some families display psychological defences that are similar to their abusive child, such as denial and minimisation of the abuse and blame towards the victim for their child's behaviour, as E1 points out.

...Sometimes (parents) will go into the same denial and minimisation. You don't want to believe your child is doing something as terrible as that, understandably, so they'll deny it. (E1)

One of the key benefits that parents are thought to receive as a result of not seeking help is the avoidance of negative emotions, particularly associated with their sense of parenting and their relationships with their child(ren), as E9 articulates.

So the benefit is possibly keeping your identity intact, as a parent – your beliefs about your family intact. (E9)

Fathers of young people with sexually abusive behaviours are identified by many of the experts as often being less willing than mothers to believe that their son is being sexually abusive to children. Some of the experts believe that fathers, in particular, want to protect the family integrity. Many experts found that fathers often do not want to know the details of the sexual abuse, as E4 highlights.

I've had fathers bring sons here and say 'I don't want to hear what he has to say', go for a walk and don't want to know. That's as far as they can come, to bring him. (E4)

A number of experts find that parents of young people with sexually abusive behaviours try to self-manage the sexual abuse, because they perceive that the situation might break up the family. They do not want others to know about their child's behaviour because of the possible consequences. These can include their child being charged and sent to juvenile justice or gaol, the perpetrator or victim being removed by statutory authorities and disruption to schooling and sporting activities. They may also fear the social stigma and labelling attached to child sexual abuse and offenders.

A number of experts feel that parents generally want to retain control of the family and don't welcome an intrusion from services regarding their child's behaviour, as E8 summarises:

I think there is a culture around Australian families and privacy and boundaries around families is quite a significant part of that, particularly intrusion from agencies or authority. There's also the issue of what else can be seen and found within the family because there could be fears about being judged or whatever. (E8)

(b) Loss of control over their family

Experts believe that many families know that they need to seek help and that they think that the right thing to do is to contact services. However, families can have a negative perception about getting 'welfare' agencies and police involved, as E7 describes.

Finding out that seeking therapeutic assistance also involves justice and child protection input – they see that as difficult. (E7)

When a notification of suspected child sexual abuse is made to statutory authorities in NSW, experts perceive that it unfolds a whole series of processes over which families feel they have no control. These include:

- (i) the NSW Department of Community Services becoming notified and involved
- (ii) an investigation and possible separation of their offending child in cases of intra-familial abuse (often considered best practice and supported by some of the treatment experts)
- (iii) possible charges being laid
- (iv) a subsequent conviction, and
- (v) placement of their child on a sex offender register.

In the instances of sibling abuse, families perceive that services are asking them to choose between their children. Fear of the exposure of other abuse and violence and social problems within families of young people with sexually abusive behaviours can also inhibit parents to seek help. Victims of domestic violence can fear for their personal and family safety from a violent partner if family violence comes to light. Family therapy resulting from treatment can confront parents with injustices they may have perpetrated against their own child(ren); for example, having pornography and sexually inappropriate practices in their home, and gender and domestic violence issues.

(c) Motivations to seek help for their child(ren)

Most of the experts have clinical experience of a number of families who have voluntarily sought help from private and government services. These families have directly and independently sought help when sexual abuse is disclosed by victims who are often in their immediate family, or as a result of a treatment referral by statutory authorities following an investigation. It is generally considered that many families are desperate and are 'crying out' for help, as E6 states.

You basically know it's wrong. They want help. (E6)

Key motivations for parents to seek help for their child are concern about their role as parents, the wellbeing of their children, family restoration and pressure from external agencies.

(i) Concern about their role as parents

The implications of their child's behaviour on their parenting and what they may have done wrong is identified as a strong initial motivation, along with the need that parents have to work through the process with service providers, as E10 highlights.

Often you have parents who come in and talk about 'what did I do wrong? What does this mean for me? What does this say about me as a mum' (E10)

A number of experts who work directly with parents advise that some of them display tremendous concern for, bonding with and willingness towards helping their child, in spite of any family disadvantage and dysfunction, as E7 and E8 highlight.

The kids are attached to their families and that attachment may be strained, may be problematic, may have dynamics that are unhelpful, but the reality is there is an attachment and that attachment is a real one and is an enormous part of addressing the behaviour. (E7)

Their concern for the child who did the abusing often gets under recognised or wrongly interpreted in our view as being protective, denying etcetera, and it just doesn't add up because you have parents who are going through the process of asking for help. (E8)

Reuniting their family is identified as a strong motivation for parents to seek treatment services, particularly if their child has been removed due to their sexually abusive behaviour (which is often the case in sibling abuse).

There may be an Apprehended Violence Order in place. And one of the big motivations is wanting to get your family back together. (E9).

(ii) The wellbeing of their children

In the instance of sibling abuse, experts identify that parents want to do something for both children – they want their abusive child to address his/her behaviour and to encourage and support their non-offending child to report any inappropriate

behaviour, so they can take action to prevent further abuse. Families can go to extraordinary lengths to get help for their children, as E6 attests.

I've known families to travel to Brisbane, outside our state, to try and find help. Even though there might be issues in the family, it could be DV, it could be sexual exploitation by parents, it could be a number of things. Dysfunctional, toxic type families. A lot of those times they know their daughter or even their son is being abused, (and) they want help. But they want help for both. (E6)

One of the negative outcomes that can occur when parents do not seek help for sibling abuse is that the victim receives negative messages about his/her parents validating the perpetrator. Parents can worry that they haven't got help for their child and what that could mean for their own role as a parent and their future, as E9 points out.

You'll be carrying a sense that one of your children has been hurt and they haven't got help for that. One of your children has been hurt and they're going to be hurt again. That possibly there's something you have got wrong in the way you're managing the behaviour of the kids in your family, and you've not addressed that. (E9)

The fear of their child further offending is often still on the minds of parents who become hyper-vigilant about his/her untreated behaviour.

4.2.3 Social norms

The most important people to parents of young people are considered to be other family members, friends, professionals and external organisations. Parents receive positive and negative messages about help-seeking, with social stigma perceived to inhibit parents reaching out to others.

(a) Family members

Experts believe that other family members (such as grandparents and victims that are family members) are the most important people to parents. Kinship ties are considered especially important for Aboriginal families. The dynamics around the disclosure of the abuse are different for each family; however, experts relate a range of experiences, from family members being disparaging about 'paedophiles', to pulling together to support each other, as the contrasting quotes from E10 and E7 illustrate.

Families sit and watch the TV together and you know when Joe Bloggs who has sexually abused is on the news and the father says 'he needs to be castrated'. (E10)

We see families that are very estranged working well together. (E7)

(b) Friends

Experts working with families perceive that sometimes it can be a big hurdle for families to get non-agency support and some families can be socially isolated. However, many parents of sexually abusive young people do have a number of friends. Although families often don't want to burden family and friends, it can be a big relief when they do tell friends and family. It can often be friends who help parents know who to contact for help.

So you have some families who have really supportive extended family networks or friendships and they get great support via those. (E10)

(c) Professionals and external organisations

Professionals and external organisations are also thought to be influential to families and their help-seeking. Some parents turn to help for their child's behaviour from ministers of religion and medical professionals (such as general practitioners and hospital doctors). A common message that experts feel these professionals give to families in response to the disclosure of abuse is the need to report the abuse to police. Once statutory services are involved with a family, experts feel that families

see DoCS caseworkers as having power in the situation. Key messages that experts perceive the families receive are often about the safety of the child victim, as E6 highlights.

DoCS workers state 'You must make sure your child's safe. If you don't, we will'. (E6)

Some knowledgeable case workers, dealing with sibling abuse where parents are torn about how to respond to both children, tell parents that both the victim and perpetrator need to be supported.

Schools are considered to play an important role with families, as appropriate staff need to be informed when a young person has been sexually abusive in order to develop a safety plan.

For most people with kids, your most direct line with the community is the school. (E9)

Although parents are usually reluctant to disclose the abuse to schools, experts feel that schools often have a good understanding of child sexual assault and that they give parents supportive messages about valuing the help their child receives towards 'getting better'.

(d) Social stigma

Experts identify stigma as a significant barrier for parents in disclosing their child's behaviour to others. Many of the families do not want others to know of their child's behaviour because of concern about how the victim and perpetrator are viewed. This fear of labelling and vilification can be a reality for families, as E10 illustrates.

I had one family (where) the boy sexually abused a friend of the family who happened to live in the same neighbourhood. The friendships between the families ended and then it became a community issue. So this family would go to the local shops and all of a sudden the grandfather of the child would be in the shops as well, and they would be yelling out 'your son is a sex offender' – that kind of thing. Which is

just not helpful and I think that's what families are afraid of. (E10)

Experts believe there is great deal of stigma associated with sexually abusing a child, particularly within the family. If abuse is intra-familial, families worry about how they look to other family members. Families often want to maintain the façade (of how other people see the family) within the community, and they believe that they can't maintain this if they seek help.

4.2.4 Perceived behavioural control

One of the key themes that emerged from the interviews is that parents can both perceive and actually find that it is hard to seek and find help for their child's behaviour. Factors that can contribute to this lower perceived behavioural control include: parental lack of knowledge about sexual abuse and treatment, poor quality of service delivery from statutory and treatment service providers and structural issues.

(a) Parental lack of knowledge about sexual abuse and treatment

A lack of understanding of the dynamics and seriousness of sexual abuse, treatment processes and risk management are identified as inhibiting some parents from seeking help for their child. Many families don't understand that they cannot self-manage the problem and that young people need to be reported, investigated and treated. They often don't know where to get help and are not sure what to do, as E7 points out.

I think there's a whole catchment that don't come to attention because there's a lack of awareness or understanding of what's available, what services or what needs can be met. (E7)

(b) Poor quality service provision

Some experts express a concern that there is an apparent lack of interest by police and/or DoCS to investigate disclosures of children being sexually abused by young people. Experts advise that DoCS workers do not always view these young people

as clients, despite a referral being made to them. Some experts state that there is a lack of problem recognition or prioritisation by DoCS if the issue is not related to child protection, and that there is more of a focus on the victim and younger children.

Because my young client (a young person with sexually abusive behaviours) was also a previous client of DoCS, DoCS (has) a duty ... to that young person but I couldn't get them interested and so I contacted a person who used to work in the area of sexual abuse and now works for DoCS and tried really hard but ultimately DoCS said to me 'his age means we are putting money into someone who is really not our client'. (E4)

(i) Lack of knowledge and expertise of service providers

Some existing treatment providers are thought to lack expertise in working effectively with young people with sexually abusive behaviours. They are unable to communicate a coherent treatment plan, or may advise a treatment plan that is 'blanket' and long-term, without making assessments and tailoring it to individual needs. Some experts criticise the Sex Offender Counsellor Accreditation Scheme as being too lax, with its current lack of pass or fail system and the practices of accredited people being too broad. It is thought by some experts that private practitioners can get lots of well-paid work in this area and it can be an open invitation for some who:

- may not be as ethical or qualified as others
- work in isolation
- don't integrate treatment with families
- offer a service that is attractive (i.e. short-term, less intensive and less involving), rather than addressing the nature of the problem with families.

The critical thing with families when they contemplate the service is that, from our perspective, the service we've got, we've tried to put into it, all of the bits that match the research for the best outcome for kids. Which means it's comprehensive, it means the parents get as much, in fact they get more counselling than the kids, and that it's multidimensional, so

were looking at school, at peer relationships and stuff. That takes a lot of resourcing and I don't believe it can be matched by private providers. They just couldn't afford to do it because of the time involved. (E8)

(ii) Lack of engagement or treatment advocacy and follow up

A number of experts advise that DoCS workers who do not advocate, educate or alert families about treatment make it harder for treatment providers to engage families.

Most of the families we work with are open to seeing us or the behaviour being addressed. The time where we see the least amount of motivation from families is when somebody else within the process of the behaviour being disclosed and investigated has a different view to the rest of the people for example, a case worker or a JIRT worker. (E9)

At the beginning, families often might have been promised things and that's not been followed through with, in particular with the child protection system. So that's definitely a demotivation for families. (E10)

Experts state that many DoCS workers lack the skills to understand the issues and motivations and ability to support families of young people with sexually abusive behaviours. A current lack of DoCS policy or a standardised training package on sibling abuse is identified as a problem as it is a common issue for statutory authorities and treatment providers. Inexperienced caseworkers and a lack of agency guidelines can result in negative impacts on families, as E9 illustrates.

Families can be really confused and even drawn towards easier solutions, so there needs to be consistency. If there is a lack of consistency, that can be a real barrier for the family. So all of the individuals working with the family need to have a really clear sense about what's important. (E9)

Many families are referred to help after the reported behaviour is investigated but there is very little follow up or emotional support to seek help. There can be an assumption by investigators that families will do what they need to do without

following up. A lack of support by statutory service providers can result in less external pressure for families to take their child to treatment.

Not all the families that get referred to me see me. (They) end up in inadequate or no treatment and there's no way of knowing that – DoCS don't follow it up, nobody follows it up, once investigation is closed that's it. They just assume families will just do what they need to do and a lot of them don't. (E2)

(iii) Inappropriate responses by service providers

Experts identified that statutory bodies have often removed an abusive child but not referred the child for assessment and treatment services, sometimes reinstating the same child without any treatment. Many younger children with sexually abusive behaviours have not been referred to treatment at all. Some children are referred for assessment but not followed through to attend treatment and subsequently re-offend.

I have case after case of kids referred to me for assessment and I do an assessment and go 'You knew about that case when the kid was 10 and he raped his sister. Why didn't he get into treatment then? And he's 13 and still doing it'. (E2)

It is acknowledged by a number of experts that it is a challenge for statutory bodies and treatment providers to get the balance of response to the disclosure of sexually abusive behaviours right.

I think it's difficult, from a systemic point of view, for the various agencies to get the mix right between an appropriate assessment of what the risks are and then choosing an appropriate level of supervision and then finally working towards family reunification. (E5)

However, the interviews identify a polarity of inappropriate responses from statutory and treatment service providers to the disclosure of the sexual abuse. These services often either minimise the behaviour and view it as part of sexuality, or view the behaviour as evil and deal with it punitively; for example, by giving the young

people a hard time, removing the child victim (sometimes into inappropriate care), or being heavy-handed and traumatising families.

There's a hysteria these days and we're in a very difficult position where Community Services, in particular in some areas, overreacts like crazy and breaks up families and punishes these kids awfully, including the victims, 'cause if the parents say 'I'm not letting you take my boy out', they say 'right, we'll take the victim out' and so what happens is that families become extremely reluctant to cooperate. So even if a family member does suspect, there's huge implications for the family member in doing anything about it as well. (E3)

(c) Structural issues

(i) Lack of inter-agency coordination

Experts identify an impasse that often occurs between Health, Juvenile Justice and DoCS about whose responsibility young people with sexually abusive behaviours are and who should fund treatment services. This impasse can often result in families not receiving any services, as E2 points out.

It becomes this ball thrown between New Street, Juvenile Justice and DoCS and usually what happens is nothing happens. (E2)

(ii) Lack of available services

Families want a good service, good cost, available service outside school hours. (E4)

Experts agree that the current lack of available services to treat young people with sexually abusive behaviours is the key barrier to families seeking help for their child. There are only two free NSW government services for young people who haven't been charged. These are run by NSW Health and include New Street Adolescent Service, which is based in Sydney, and Rural New Street, which has only just been established in Hunter/New England. Interviews with experts determined that the original New Street service in Sydney has to turn away three out of four referrals

made to them because of a lack of available places; meaning that they are only able to treat approximately 25 per cent of referrals to the service.

So we receive between sixty and eighty referrals a year for families and young people, and we ... have been able to offer assessment to twenty five percent of them. (E7)

There are a number of government and private therapists based in Sydney that are accredited to work with young people with sexually abusive behaviours. It is estimated by one expert that private therapists might see one out of those three turned away by community services. This means that two out of four families might intend to seek help for their child's behaviour but are unable to receive services. Overall, there is a lack of community based treatment throughout NSW and a number of experts identified that the demand for treatment programs currently outstrips the supply, as E6 points out.

There's no problem in seeking help ... the main problem is their ability to receive help. (E6)

Even when many families manage to work through personal and institutional constraints and report their child's sexual abuse of a sibling, the long-winded and intrusive process that parents often experience when dealing with child protection services can make them wish they hadn't embarked on seeking help.

(Families) see it as very hard. The first thing is feeling ... (isolated) by thinking the problem is unique to them. The other is finding that there are services available – quite often that takes them down a long pathway. Finding out that seeking therapeutic assistance also involves justice and child protection input they see as difficult. (E7)

Many of the interviews highlight a theme of families experiencing regret at getting statutory authorities involved because of the adverse and unsupportive process they have experienced; a sentiment with which some experts, such as E6, can empathise.

So you've got all these government departments now knowing your business and poking and prodding. That's how they feel. So what happens is they go 'Why did I do this in the first place?' and to be honest, if one of my children were abused I'd deal with it myself. I wouldn't ever get the police or DoCS involved. (E6)

Availability and the cost of services are considered to influence a family's perception of how easy or hard it is to seek help for their child, as E9 highlights.

Some would get referred and would get a service, so they wouldn't be aware that other families would find it really difficult to get a service. That they've wanted a service, that they've needed to re-refer and refer. That they've needed to push DoCS to help them re-refer. They've looked at private practitioners and looked at the cost and what's on offer. Some would perceive it as extremely hard and extremely frustrating and also just really unfair – that they've wanted behaviour to be addressed and dealt with but they're not being given a service available to them for six months, eight months. (E9)

4.2.5 Benefits to seeking help and utilising treatment

Experts identify short and longer-term benefits that families can gain when they engage with treatment services for their child's sexually abusive behaviours. These include parental support, prevention of further abuse and improved relationships with and positive outcomes for their child.

(a) Parental support

Experts working with families identify that one of the benefits of talking to someone is that parents feel less alone and discover that their problem is not uncommon. Persisting with the treatment process can often mean that parents experience a reduction in worry and stress and have a greater sense of certainty of their child developing normally and into independence without requiring continuous supervision. For families, counselling is seen as a process that can be entered into and finished. Treatment provides a sense of hope out of the early stages of chaos

and despair, whereby parents progress from not knowing how to get through it, to eventually seeing a way through. Treatment is able to match their concern about the impact of what's been done, with 'something can be done'. It can also help parents to reduce their self-blame, as E6 highlights.

Attending treatment can also stop parents feeling frustrated about the situation and blaming themselves. (E6)

(b) Prevention of further abuse

Parents often want to understand what happened and what they can do. Through treatment, parents can gain insight into how the family got to the point where the abuse happened and what sexually abusive behaviours are, and be part of creating a safe plan to prevent further abuse.

Wanting to know that this is a behaviour that's not going to be repeated or continued; (that) will be (a) motivation. (E9)

Families also want to see something done for the victim and other people around them who've been hurt. Attending treatment can be a tangible indicator for parents that their child has tried to make restitution to the victim, their family and the community. Parents are often surprised and proud when their child takes responsibility for what they did through the treatment process.

(c) Improved relationships with their child

Many experts stated that attending treatment can improve the communication processes between the young person and their family. Gaining back the trust that was lost between parents and their sexually abusive child is considered an important benefit of family-based treatment in particular.

I don't think we've ever seen a family where trust hasn't been an issue. In particular, after a child has sexually abused, how do you trust them again? What does it mean? To work on that issue through the counselling process and over time with the young person is often really a positive. (E10)

Another important benefit that experts identify is that parents often gain an increased satisfaction with their parenting skills. Further along the treatment process, parents can find that they have developed better relationships with their child than they had with their own parents. One of the unexpected benefits of their child undertaking treatment can be the quality time that parents get to spend with their child, both at services that work with parents and in the journeys to and from treatment. Experts providing treatment processes that address wider family issues find that this can benefit the whole family. Parents who address their behaviour towards their child(ren) and their own mental health issues, such as depression and anxiety, can find an increased sense of parenting fulfilment, as E8 points out.

(There is the) potential for having the sorts of relationships with their children that they'd like to have, when often they haven't had those sorts of relationships with their own parents and they've wanted to be different with their children. (E8)

(d) Positive outcomes for their child

Through the process of their child attending treatment, parents can perceive the following positive influences on their child:

- (i) The goals their child are addressing are good for them
- (ii) Their child develops ways to communicate with adults around them
- (iii) Their child makes positive and respectful choices
- (iv) The young person's identity is more than their offending behaviour
- (v) There is a different kind of future for their child and that he/she will be OK.

Parents can also see their child develop in other ways, such as improving their school performance and developing better relationships with peers.

The kids that go through the program ... all (have) marked improvements in their participation (and) outcomes at school. (E8)

4.2.6 Costs of seeking help and utilising treatment services

When their child's behaviour is detected and investigated, parents can experience emotional costs to their family and financial and time commitments associated with taking their child to treatment.

(a) Impact on the victim

Some experts highlight that there are emotional costs borne to victims as a result of disclosing the sexual abuse that families may not perceive. In the case of sibling abuse, the victim may feel to blame for consequences such as his/her sibling being removed from the home and having a criminal record and his/her parents fighting – which can have negative outcomes, as E6 highlights.

She sees that because she's opened her mouth, all these things have happened to her family that are just atrocious, that she sees herself responsible for. So then she accommodates, or she retracts the statement. She says 'I lied'. (E6)

(b) Financial costs

While juvenile sexual offender programs are free within NSW state government settings such as Juvenile Justice and Health, counselling sessions by private practitioners often cost over \$100 per hour. If families are able to get a Medicare rebate from attending a psychologist they will still have to pay some contribution to the cost. It also costs parents money to transport their child to treatment, which is often some distance from their home. Some parents regularly have to take time off work without pay to take their child to treatment or to attend family treatment. There can also be accommodation costs associated with a child being removed from his/her family.

The financial costs of treatment (by private practitioners in particular) and the lack of subsidised services are identified by experts as a demotivation to families seeking and attending treatment services. Some families cannot afford for their child to attend treatment at all if they cannot get into a free service, as E2 explains.

I think lots of families would seek treatment but they can't pay for it, so what do they do, they've got no choice – they do nothing. (E2)

The cost of private practitioners at \$100 or more per session is prohibitive to many families who cannot afford to be paying that much on a regular basis, especially on top of travel costs and/or time off work.

The lack of fully funded or subsidised treatment or expenses to cover travel costs can mean that some families do not receive treatment for their child. One private practitioner observed that parents that have to pay often drop out sooner than parents who are lucky enough to gain some financial support from services.

(c) Time and commitment

Although the treatment time for young people with sexually abusive behaviours varies, families with a child attending New Street service often need to make a commitment to attend approximately 18 months of weekly treatment in order to complete the program. This may involve parents taking time off work and taking their child out of school one day a week. Time off work can potentially jeopardise jobs. Parents are often required to travel long distances to bring their child to treatment services.

Most of our referrals come from Sydney and that's to do with people being able to get here. And this is a significant commitment for families. You're talking about 18 months, at least, of weekly counselling. (E9)

4.2.7 Factors that enable parents to seek and access treatment

Once their child's behaviour has been detected and referred to authorities, factors that motivate parents to seek and attend treatment include: external pressure from agencies and statutory service providers that engage and support families to seek help; treatment providers who include families; provision of financial support to families; and proactive responses to young people who re-offend.

(a) External pressure from agencies

Experts working in both government and private counselling settings have found that families will bring their child for help voluntarily even without any without legal consequences if they don't. Other parents may seek assessment and treatment for their child because of a court mandate or because DoCS has told them to, as E10 points out.

Although we are a voluntary service, it's often involuntary because they have DoCS standing behind them telling them they have to come. Some families know that they can just say no and nothing will ... sometimes something will happen but sometimes DoCS doesn't follow through on that. But the majority of families just do what DoCS tell them they have to do because they're the child protection agency. They're telling them, they might threaten them with gaol or children's court, they're telling them how serious this is. (They) get undertakings from them to come to services like ours. (E10)

(b) Service providers who engage and support families to seek help

Experts consider the initial investigation of a child sexual assault notification to be an important opportunity for statutory authorities to engage and support families.

Initial skills in engaging families are thought to consist of:

- (i) staff treating families with respect
- (ii) providing support for struggling or isolated families in crisis
- (iii) having a safe place families can talk about the impact of the offending on the family and the child's life.

Case workers who develop a connection with families are seen as enabling them to work through issues of shame. Addressing parental issues upfront is thought to help parents deal with traumatic consequences of their child's behaviour, as E8 points out.

....generally families can locate ways to work [on safety and separation of siblings], as long as their own issues are addressed in the first place. (E8)

Managers and caseworkers who are knowledgeable and are advocates for assessment and treatment can help families understand that child sexual assault needs to be reported, investigated and treated. Workers can also reinforce:

- (i) how serious the sexually abusive behaviour is
- (ii) who is responsible
- (iii) why separation between the victim and perpetrator is necessary
- (iv) that families need to present for help.

Some experts believe that DoCS engaging a family at the investigation stage is helpful to later facilitation of assessment and treatment processes, as E2 raises.

If they could engage these families at the end of the investigation and have a language to help them understand why this is important – why they get help – it would motivate these families much more to do that.
(E2)

Service providers who are non-judgemental and motivate parents by giving them a positive perception of their parenting are displaying the types of attitudes that enable parents to seek help more readily, according to the experts. They agree it is important for service providers to think about what is happening for the family and not get upset if parents don't do what they want them to. E7 also states that being treated with respect positively influences a family's relationships with statutory and treatment service providers.

In terms of them coming to a point where they're willing to provide information, a big part of that is in experiencing being respected and experiencing that their children are going to be treated and not vilified and not labelled – and ... understanding that the child protection agencies are part of the solution. (E7)

(c) Treatment providers who include families

Many of the expert treatment providers consider it best practice to be able to engage and work with the family of a sexually abusive child.

I know other kids who see other people and the family basically have nothing to do with treatment ... (The treatment providers) shut the door, see the kid and 'bye, see you next week' and I don't work like that. As far as I am concerned, parents are part of the process and kids know that and we update them regularly and let them know what they need to know to help them and to understand what happened. (E2)

Experts commonly believe that, while families may contribute to (or be the crux of) the problem, they are also crucial to enabling their children to remain in treatment and achieve positive outcomes.

The outcome research is showing very, very clearly that it's the quality and manner in which parents participate that gives the best outcome for kids. (E8)

(d) Provision of financial support

Providing partial or complete financial support is considered to be a significant enabling factor for families to attend treatment, and, in some settings, improves the quality of treatment they receive, as E2 expresses.

The treatment is intensive and complex for a lot of these kids and parents are not usually able to bring their kids every week. You don't get to do perhaps all the things you might do if it's a contracted case with DoCS where they are paying for treatment and there's provision for consultation with other professionals, provision for meetings, things in place which mean you can have a really effective case plan. With families that pay for themselves it's really different, because there's not the same level of case plan and support and encouragement and financial support for treatment. (E2)

New changes to Medicare payments now enable families to receive subsidised treatment from mental health social workers and psychologists if they have a referral from a doctor (mandated reporting of their child's sexually abusive behaviour would still apply).

(d) Proactive responses to young people who re-offend

A number of experts noted they had seen young people who had been previously brought to the attention of statutory bodies, but not referred or able to get treatment. When these young people have subsequently re-offended, statutory authorities have had to refer them for treatment.

They don't get treatment and something else happens and they (DOCS) go 'Can you see the kid now?' (E2)

4.2.8 Discussion

Findings from this study reinforce that parents play a critical role in enabling their sexually abusive child to receive assessment and treatment services. Understanding factors that encourage or inhibit their help-seeking behaviour is pivotal to developing any social marketing intervention and product offer designed to increase this behaviour. This study cannot report how frequently patterns of behaviour occur. However, it does provide insights into preferences, attitudes and underlying motivations, social pressures and perceptions of ease or difficulty that parents can experience towards seeking help and utilising services for their child's behaviour.

(a) Many families are motivated to stop their child's behaviour

Prior to contact with services

Experts have identified that parents often take action when they find out about their child's sexually abusive behaviours, including taking proactive steps to intercept further possible abuse between siblings. Plummer (2006) also found that mothers of child sexual assault victims took a number of actions, when they had suspicions that something was not quite right, to increase their child's safety. This motivation can also be about keeping their child's behaviour within the family and not reaching out to formal sources.

After contact with services

(b) Parents can experience favourable attitudes towards help-seeking

This study has highlighted a very encouraging finding that, despite many barriers and difficulties and reluctance to involve government services in their family, many parents (particularly mothers) are motivated to access treatment services for this problem. Key motivations for seeking treatment services include:

- (i) concerns about their family
- (ii) external pressure from statutory child protection services
- (iii) concern about their parenting skills
- (iv) the wellbeing of their child(ren)
- (v) family restoration.

This study finds that mothers are more likely to believe that their child is sexually abusive and consistently take their child to attend treatment services. Findings in the general help-seeking literature indicate that women are more likely to seek help and that help-seeking is more likely to be socialised out of boys (Rickwood et al. 1995) and considered to be at odds with masculinity (Rochlen & Hoyer 2005).

Previous studies have indicated that many parents are uninterested in the logistics of treatment and are resistant to seeking treatment for their child's behaviour (NSW Juvenile Justice 1999, Rich 2003). In contrast, this study finds that many parents of sexually abusive young people do pursue treatment services, often despite a lack of engagement or treatment advocacy by individual statutory and treatment service providers, or a lack of available services and financial support. A number of families are making an extraordinary effort to seek help, often travelling long distances over a lengthy period of time and even taking their child interstate for treatment. Many families are shown to also participate in family-based treatment, despite the possible discomfort at being required to address their own violent and abusive behaviours.

A key finding is that families who do take action to address their child's behaviour often do so out of concern about their parenting and the wellbeing of their child(ren). This provides a ray of hope and contrasts against the current bleak picture of impaired attachment and relationships between these parents and their children (Blaske et al. 1989, Duane et al. 2003, Pithers & Gray 1998, Friedrich & Leucke 1988). The findings that a number of parents are motivated to seek help due to an

underlying concern about their parenting, the wellbeing of their child(ren) and keeping their family together provide valuable insights to align the marketing of treatment services with.

(c) Many parents experience benefits from utilising treatment services

If parents are able to access treatment services, particularly those that involve families, there are significant short and long-term benefits that experts perceive families gain, including:

- (i) parental support
- (ii) prevention of further abuse
- (iii) improved relationships with their child.

The benefits that parents may perceive from utilising treatment services can help inform how the 'product' of treatment is marketed to parents contemplating seeking help for their child.

(d) Families can be reluctant to seek external help

This study has found that the most common way for a young person's sexually abusive behaviour towards a child to come to light is through a disclosure by the victim. Previous literature has shown that families of sexually abused children also commonly find out through a verbal disclosure from their abused child (Plummer 2006). However, DoCS statistics (2006) show that, in 2004/05, mandatory reporters in NSW contributed 75 per cent of the current notifications for young people with sexually abusive behaviours, and only 15 per cent of all notifications to its Helpline came from families. In NSW, families who voluntarily seek treatment services for their child appear to do so because of a referral from statutory authorities following an investigation of a mandatory notification. The role of 'evaluated need' through professional judgement of people's health status and their need for medical services identified by Anderson (1995) appears to be a significant factor influencing the help-seeking and the utilisation of treatment services for families of young people with sexually abusive children in NSW.

(e) Parents can experience unfavourable attitudes towards help-seeking

Parents can experience significant negative impacts once they become aware of their child's sexually abusive behaviours. This supports previous literature (Duane & Morrison 2004) which identifies that parents commonly experience shock, confusion and anger, and use denial and minimisation as a defence against acceptance of their child's behaviour. Other psychological factors that negatively influence help-seeking include:

- (i) possible minimisation and denial of the abuse by parents (especially fathers)
- (ii) a lack of knowledge about sexual abuse dynamics or where to seek help, which can lead to a lack of problem recognition and perceived need to seek help.

Parents can often experience guilt and self-blame in response to the disclosure of their child's behaviour (Duane & Morrison 2004). The negative impact that the disclosure of a child's sexually abusive behaviours has on the self esteem of parents is considered to inhibit help seeking. One of the benefits associated with *not* seeking help is that parents do not have to look at their parenting in relation to their child's behaviour.

This study identifies that many parents feel inhibited towards seeking formal assistance because of beliefs they hold about negative consequences associated with seeking help. Many parents (fathers in particular) want to keep their family intact and are reluctant to have any involvement from government agencies such as DoCS. The shame and avoidance associated with the discovery of other existing family issues, such as child abuse and domestic violence, supports Duane and Morrison's (2004) finding that parents of sexually abusive young people can be reluctant to expose other underlying violence and abuse. Mothers are also reluctant to expose violence committed by their partners towards them or their children (Hooper 1992). One of the short-term benefits perceived by the experts for families not seeking help is not having to talk about the abuse with others and not getting services involved in the family.

Gender has arisen in this study as a factor that can influence the help-seeking attitudes and behaviour of parents regarding their child's behaviour. Experts have

experienced fathers being involved in their child's treatment; however, fathers have also been identified by a number of experts as:

- (i) being less likely to believe that their child has committed the alleged sexually abusive behaviours
- (ii) wanting to maintain control over and privacy for the family and avoid external involvement
- (iii) being less willing in treatment settings to listen to details of their child's behaviour.

Further research with fathers would be useful to understand more about what would motivate them to seek help for their child or their family.

One of the key demotivators for families seeking formal services for their child's behaviour is pre-existing negative attitudes towards statutory services. This can be due to past personal experience or from the experience of others known to the parents. Resentment towards outside agencies is a common feature in child protection cases, especially when the report has not come from the family (Duane & Morrison 2004). A past experience of blame or disbelief by services has been found to inhibit further help-seeking of mothers of sexually abused children. Working-class women, in particular, are afraid of losing their children to care (Hooper 1992). Unfortunately, this study identifies that a number of families that have come into contact with NSW statutory authorities and some treatment providers have experienced inadequate service delivery. Many of the experts perceive that this contributes to a degree of dissatisfaction and a reluctance to seek further help.

- (f) There are mixed social norms towards seeking help

Stigma and fear of public humiliation are identified in the literature as barriers to help-seeking for parents with children who have perpetrated sexual abuse (Duane & Morrison 2004). Both extant literature and findings from this study have shown that this is not just an 'imagined' fear and that families of children with sexually abusive behaviours do experience real public humiliation and harassment by members of their communities. This study shows that NSW families also experience minimising and negative attitudes towards sexual offenders from important social referents, such as other family members. These negative perceptions appear to increase negative social norms towards help-seeking for families of young people with

sexually abusive behaviours. Mothers of children that have disclosed sexual abuse have been found to have increased doubts about the abuse when disbelieved by other family members (Plummer 2006).

However, it is evident from this study that a number of families of young people with sexually abusive behaviours do reach out to friends, trusted family members and doctors about their child's behaviour. Mothers of sexually abused children have also been found to talk to relatives, friends and family doctors about their concerns (Plummer 2006, Hooper 1992). These findings reinforce the influential role that family, friends and wider social networks play in the help-seeking behaviour of individuals and families, which is articulated in the social organisation strategy framework (Pescosolido 1992). There is a valuable opportunity for developing social marketing strategies to increase the social acceptability for young people with sexually abusive behaviours to receive help to stop their behaviour and improve public health outcomes.

(g) Some families can find seeking treatment services too hard

Andersen (1995) argues that, for service use to take place, enabling structural community resources, such as available services and staff, are needed. Individuals need to have the knowledge and the resources to be able to access these services. Experts identify that some families do not know where to seek help when they learn of their child's behaviour. However, a key finding of this study is that, despite many families in NSW being motivated and desperate for services to address their child's behaviour, the current responses from NSW statutory authorities and some service providers, coupled with costly, poorly regulated and unavailable treatment services, can make it extremely hard for families to seek and find quality treatment services in NSW. Experts indicate that a number of families do seek out treatment services despite any harsh treatment by statutory authorities and lack of financial support and available services. However, families can eventually drop out of seeking services because it is too hard and too reliant on them having to make the effort. Also, they are often unable to find or afford current treatment services. These constraints can result in parents experiencing a low level of actual and perceived behavioural control towards seeking treatment services for their child. Perceived behavioural control has been identified as a key indicator of an individual's intention to perform a behaviour (Ajzen 1991). Increasing the perceived and actual

behavioural control that parents have towards seeking help for their child is an important area to focus social marketing efforts.

These demotivating factors can result in significant disappointment and regret for families that have involved statutory services. This may have negative implications for further help-seeking behaviour for their child. Not pursuing, or being unable to find, adequate treatment services has concerning implications for families that bear the costs of not getting help. Experts identified these as leaving the problem unaddressed, impaired relationships, possible further offending and a reluctance to get authorities involved again. Unfortunately, Duane and Morrison (2004) have observed that the longer a family is left without services and support, the less likely it is to engage with it when it is eventually offered.

The lack of available treatment services and the cost of private services make it ethically difficult to promote treatment to families that they cannot access or pay for. NSW Treasury needs to fund regional treatment centres that are based on evidence and best practice models, which have been found in the literature to address functioning in a broad range of areas including the individual, family, school and community systems (Nisbet, Rombouts & Smallbone 2005). The public health risk of government agencies not developing a well coordinated and resourced response to these young people and their families is clear. Interviews undertaken for this study have highlighted situations where it wasn't until a child was found reoffending that action was finally taken. The findings of this study point to an urgent need for government and non-government services to plan and implement strategies to make it easier for families to seek and receive quality services to address their child's behaviour. This is the only way to ensure an increase in children and families receiving the services they need to reduce recidivism.

(h) Statutory services can support families to utilise treatment services

In NSW, statutory child protection services are the primary gateway for notification of suspected child sexual abuse and the conduit of subsequent investigations and possible referrals to treatment providers. Frontline staff are in a significant position of influence – they have the power to motivate or demotivate the help-seeking behaviour of the families of young people with sexually abusive behaviours. As discussed in detail later in this chapter, these findings also have implications for the

development of any social marketing intervention. They identify 'distribution' elements of the marketing mix that need to be considered in providing avenues that enable families to feel comfortable and confident in seeking help. If families in NSW continue to be far less likely to report their child's sexually abusive behaviours to the statutory authorities than mandatory reporters, this has implications for the NSW state government to continue, and possibly expand, mandatory reporting. This could include other professionals that families also turn to for help, including religious and spiritual leaders. National mandatory reporting policies could be useful because of the chronic under-reporting of child sexual abuse.

This study also highlights that families may be more likely to seek treatment services if they are receiving support and pressure from statutory child protection services. To enable families to seek help, child protection staff need to:

- (i) be knowledgeable and skilled about young people with sexually abusive behaviours
- (ii) become advocates of treatment
- (iii) encourage, follow up and support parents to seek services for their child
- (iv) focus on increasing the level of satisfaction that these families experience so that they do engage with treatment providers and are not reluctant to call DoCS with any future concerns over their child's behaviour.

Dawson and Berry (2002) found that families with multiple problems rated caseworkers most helpful when they were:

- (i) willing to help and be with the family
- (ii) supportive and non-punitive
- (iii) listening to clients
- (iv) encouraging them, and
- (v) providing concrete services.

Focusing on the strengths of parents of young people with sexually abusive behaviours, rather than their shortcomings, has been shown to reduce family risk in juvenile sexual offending (Pithers & Gray 1998). Receiving emotional support and positive encouragement of parenting skills is considered essential if parents are to

recover sufficient self-esteem and increase their levels of acceptance and competence to deal with their child's behaviour (Duane & Morrison 2004). Improved communication between parents and children has been found to be a benefit of treatment programs. It also helps to reduce the anger felt by parents towards their child (Duane & Morrison 2004). From this study it seems to be particularly so when parents are able to attend and complete treatment programs and have access to therapeutic interventions. Experts who provide services to parents at the same time as their child articulate more positive outcomes for parents than experts who work predominantly or only with the sexually abusive child. A notable flipside to these positive benefits (articulated by New Street practitioners) is that the young people whose families don't complete the New Street program experience worse outcomes than young people who complete the program or young people who don't do the program at all.

This study highlights that child and welfare professionals are key channels for promoting and supporting families to seek treatment services for their child's behaviour. Their level of influence on the behaviour of parents is likely to be far greater than any single brochure or website content could be expected to be. This enabling role has implications for resourcing, training and development of staff in order to promote the benefits of treatment and reduce the costs and barriers for families to seek and receive treatment. Child Protection Services, DoCS, Health and Juvenile Justice need clear mandates and policies related to their role of preventing and intervening with young people that sexually abuse children. An immediate challenge arising from this finding is that outsiders and statutory authorities are often looked at negatively and not approached for help by many families, despite their motivation to stop their child's behaviour. A social marketing-based intervention is needed to increase the favourable attitudes families have towards statutory authorities and social norms associated with seeking help. However, unless action is taken to increase the availability and affordability of treatment services, there will continue to be extremely limited and unsustainable options for parents to access, even if they have made the effort of seeking formal sources of help.

5. RECOMMENDATIONS AND LIMITATIONS

5.1 Social marketing implications and recommendations

Findings from this study have significant implications for developing possible social marketing interventions or campaigns, particularly with the goals of: a) increasing the quality, quantity and affordability of services for sexually abusive young people and their families; and b) increasing the numbers of young people and their families who are accessing these services. Tackling this complex and sensitive social issue and public health problem effectively requires social marketing strategies that address the broader social, political and economic environment context and the motivations and behaviours of individuals and families.

These two approaches within social marketing have been called 'upstream' and 'downstream' marketing respectively. Donovan and Henley (2003) explain the upstream approach as organisations putting in preventative measures (so that "people will not fall in the water"), which can often be more cost effective, and the downstream approach, which provides individuals with recommended behaviours (that can help them negotiate the river safely). Potential upstream and downstream social marketing strategies for increasing the numbers of young people receiving help are outlined below. It should be noted that this thesis recommends that the upstream recommendations are enacted as a priority in order to increase available treatment, so that downstream marketing activities can then motivate families to seek help and attend services.

5.1.1 Upstream marketing strategies

Structural changes made by government, non-government organisations and businesses can often assist target audiences to act as desired (Andreasen 2006, Donovan & Henley 2003). Policymakers, legislators, funding bodies and planners within federal and state human services can help increase the numbers of young people and their families seeking and receiving help. Findings from this study can

be utilised to 'market' help to these influential groups through the following suggested strategies.

- (a) Market the benefits of treatment services to government policymakers, politicians and funding providers

Two of the identified key barriers for NSW families to access treatment services for their sexually abusive child are a lack of affordability and availability of services, especially outside Sydney. The demand for treatment services by families exceeds the current availability, and this is without the development of campaigns to increase the numbers seeking treatment services. It is inadvisable to market services that do not exist and risk families getting more frustrated and becoming reluctant to seek any further help. Therefore it would be more effective to ensure that there are affordable and accessible services for families to attend before encouraging them to do so. As a matter of priority, it would be advisable to develop an upstream campaign aimed at achieving bipartisan political support to develop and fund further treatment services that are accessible and affordable. It needs to be emphasised to decision makers that the longer the current lack of services remains, the more families will be put off accessing the services when they do become available.

Advocating for a non-punitive approach to such a socially sensitive issue would necessitate that the upstream campaign highlights the public health benefits and cost savings achieved through providing effective evidence-based treatment, versus the human and financial costs resulting from the untreated sexual abuse of children. In this upstream marketing approach it would be useful to identify those individuals with decision making power and investigate what they perceive as the benefits, costs, enabling factors and barriers to increasing the availability and affordability of family based treatment services. Influential 'champions' or those contemplating increasing services could be mobilised to positively influence decision makers within Australian states and territories.

Mediums for delivering this upstream marketing approach could include presentation of evidence-based approaches to reducing juvenile sexual offending and whole of government integrated planning and policy development to increase assistance for young people and their families.

(b) Promote the usefulness of mandatory reporting

Mandatory reporting is currently the key mechanism in NSW for investigation and referral to treatment services of young people with sexually abusive behaviours. This government policy needs to be maintained at the very least, and ideally increased to cover any professionals working with families, such as religious workers. Social marketing strategies targeting all policymakers and health, welfare, childcare and educational services working with children and young people need to reinforce the importance and benefits of their role in helping reduce child sexual assault. The barriers and fears associated with mandatory reporting should also be investigated and reduced wherever possible.

(c) Build the capacity of service providers to market and support parents to seek treatment for their child

The Memorandum of Understanding between the NSW Directors-General of the Department of Health, DoCS, Juvenile Justice, the Department of Education and Training and the Commissioner of Police outlines that DoCS has a dual role – to provide care and support services that protect victims and to ensure that children or young people that exhibit sexually offending behaviour have access to Department of Health treatment services. In NSW, DoCS plays a central role as the gateway for notifications for child sexual assault and referrals for young people with sexually abusive behaviours. Caseworkers are a key channel for marketing the importance and benefits of treatment to parents. They are in a prime position to motivate and enable families to actually take their child to receive assessment and treatment services. It is extremely important that child protection staff are knowledgeable about harms and risks related to young people with sexually abusive behaviours and are strongly supportive of notification, investigation and appropriate assessment and treatment. Both mandatory reporters and statutory services need to be aware that many parents are concerned and motivated to address their child's sexually abusive behaviour. However, parents can also be inhibited by their concern about telling others and having services involved in their family, especially in regard to such a stigmatising problem.

Key messages could:

- (i) reinforce the key role that mandatory reporters and statutory authority workers play in protecting children from sexual abuse, including the reduction of sexually abusive behaviours in young people
- (ii) provide evidence-based support for the role that assessment and treatment of sexually abusive young people plays in reducing further incidences of child sexual abuse; i.e. reducing their future caseload
- (iii) raise awareness that parents are often reluctant to involve agencies in private family business and that the behaviour of child protection professionals towards families can inhibit or enable parents to seek assessment and treatment services for their child
- (iv) identify worker behaviours that motivate or demotivate families to seek help.

A crucial starting point to increase customer satisfaction would be for statutory authorities to support, rather than punish, families of sexually abusive young people. This includes recognising that parents often have very negative and devastating experiences related to finding out about their child's behaviour and associated feelings of shame and self-blame. Family strengths need to be focused upon and their contemplation and efforts to seek treatment services need to be encouraged, followed up and supported emotionally and financially where possible. These approaches can assist with reducing the psychological costs and barriers associated with getting services involved in their private family domain. It can also contribute to a longer term community perception that statutory authorities are there to assist, rather than hinder, families.

The barriers preventing statutory authority workers providing a quality service need to be investigated as a matter of urgency. These barriers, and any associated costs, must be reduced wherever possible, and workers must be provided with the training and resources deemed necessary. Case workers that are skilled and knowledgeable in engaging families of sexually abusive young people could be identified and utilised as organisational 'champions'. This could assist with promoting the staff and organisational benefits of providing appropriate and supportive, rather than punitive, responses to notifications of this behaviour. Policymakers within child protection services need to develop best practice

guidelines for providing services to families of young people with sexually abusive behaviours, including a clear and consistent policy on managing sibling abuse.

Mediums for increasing supportive attitudes and behaviours of mandatory reporters and child protection workers may include:

- (i) interagency management and policy planning sessions
 - (ii) professional seminars and training
 - (iii) professional journals
 - (iv) internal communications.
- (d) Increase community social norms associated with seeking help for sexually abusive behaviours towards children

It is important to reduce the ignorance and stigma present in families and the wider community towards individuals who sexually abuse children. Campaigns need to increase favourable attitudes and social norms towards victims, perpetrators and their families seeking help to address this behaviour. Providing information to families in general about normal sexual development, signs of sexually abusive behaviours and how to access help and support could also be a useful contribution to achieve this. 'Stop it Now! Australia' could be utilised as a central national contact point for concerned families and other individuals.

Print, TV, radio and electronic media sources are potentially effective channels for promoting the importance and benefits of getting help to stop sexually abusive behaviours. Developing documentaries and storylines for popular media which concretely demonstrate the help-seeking process and associated benefits to a range of audiences could be useful for normalising seeking help but not sexually abusive behaviours. These mediums could also facilitate an increased community understanding of the psychological and social complexities associated with juvenile sexual offending whereby many of their victims are immediate family members.

Key messages could:

- (i) raise awareness of juvenile sexual offending across all families
- (ii) acknowledge that many families will feel bad about their child's behaviour and their own parenting but reinforce that most parents want the best for their children and family

- (iii) recognise that parents often want to 'self manage' sensitive topics such as child sexual assault within in the family. Raise awareness that the situation needs to be assessed and treated by professionals to decrease further risk
- (iv) promote the effectiveness and community benefits of young people and families getting help to stop this behaviour
- (v) promote concrete ways that the community can support families to seek help for their child's behaviour and prevent child sexual abuse.

The role that media can play helping to increase the incidence of families seeking help could be promoted through industry events, such as a media conference at the Canberra Press Club, and by lobbying empathetic journalists. Government and non-government child protection agencies could formally recognise and reinforce media activities that increase the social norms and incidence of help-seeking.

5.1.2 Downstream marketing strategies

Downstream marketing focuses specifically on target audiences who are exhibiting, or might exhibit, problem social behaviour (Andreasen 2006). Potential social marketing strategies to increase the incidence of young people and their families are recommended as follows.

(a) Increase the help-seeking behaviour of child sexual assault victims

It is critical to encourage children to tell others they trust if they are the victims of sexual abuse, in order to have the behaviour stop and to gain therapeutic help. Disclosure by the victim of abuse is currently the primary mechanism by which the sexually abusive behaviour of young people comes to the attention of statutory authorities. Social marketing campaigns aimed at encouraging victims to tell someone they trust would also need to recognise the feelings associated with disclosing abuse by someone they know or who might be part of their immediate family. The benefits and costs for a victim to disclose abuse would need to be identified by victims themselves. Strategies to increase the benefits and decrease the costs should be addressed in upstream and downstream approaches.

Campaign messages could:

- (i) identify what sexually abusive behaviours are and why they need to stop
- (ii) reassure the victim that it is not his/her fault
- (iii) acknowledge the abuser is likely to be someone he/she knows and may care about
- (iv) urge victims to tell someone they trust so they can get help
- (v) raise awareness that the person who is perpetrating the abuse needs to get help to stop his/her behaviour.

Suitable channels for promoting help may include the relevant areas of the Personal Development, Health and Physical Education school curriculum, posters, magazines, television storylines within relevant media and peer-based education.

- (b) Market help to parents of young people at risk of sexually abusive behaviours

It would currently be a waste of resources to undertake a major downstream marketing approach of promoting help-seeking to young people with sexually abusive behaviours prior to their behaviour being detected. Findings in this study indicate that this target audience is predominantly in the pre-contemplative stage of seeking help. Young people who don't stop of their own volition, either independently or as a result of being caught, are likely to continue to sexually abuse children.

A more productive preventative strategy, as recommended by many of the experts, is to market and provide help for children and young people who have experienced hurt, abuse and neglect before they progress to sexually abusive behaviours. One of the key channels to market this help to families would again be child protection professionals who receive and investigate reports of child abuse and neglect, including family violence.

Families are also a primary target audience for the marketing of help-seeking for a child's sexually abusive behaviours. Families in general need to increase their awareness of what is normal child and adolescent sexual development and what are the warning signs of sexually abusive behaviours. The importance of seeking help

and not trying to self manage the situation, along with positive actions they can take, needs to be highlighted for parents. At-risk families, such as those already experiencing domestic violence, abuse and neglect, should be especially targeted. This is due to the high incidence of these factors in the backgrounds of young people with sexually abusive behaviours. Research with families of young people with sexually abusive behaviours would be needed to determine their perceived benefits, costs, barriers and the enabling factors associated with help-seeking. Communication strategies for segmented families would need to be developed and pre-tested, including the promotion of the benefits of treatment which have been aligned with their core motivations and desires.

Based on the findings of this study, the benefits to families of seeking treatment could be positioned to acknowledge their feelings of shame and guilt about their child's behaviour, efforts to self-manage the situation and reluctance to get external agencies involved in 'family business'. Treatment needs to appeal to their hopes and dreams about parenting and their concerns for the wellbeing of their children and family. Some of the positive outcomes that are not foreseen by families immediately, such as increased safety and improved relationships with their perpetrating child and family, as well as positive academic and social outcomes for their perpetrating child, could be marketed as benefits to taking the child to treatment. The campaign could also warn of the costs associated with not seeking formal help as a result of self-managing, denial or minimising the situation. These costs include impaired family relationships, not being able to trust their perpetrating child and the risk of further abusive behaviours. This study has identified some key channels for promoting these messages, including teachers, friends and other family members, ministers of religion and spiritual leaders, as well as health and welfare professionals, such as doctors and caseworkers.

Although further research would be needed to establish more accurate gauge of the relationship between gender and the help-seeking behaviour of parents, service providers could use this information to increase their awareness that fathers may need increased support to accept their child's behaviour and encouragement to reach out to external sources for help. Appealing to mothers to seek help and treatment services might be more fruitful for statutory service providers advocating treatment, as mothers may be more likely to be contemplating seeking help.

Key messages could:

- (i) increase understanding of what normal sexual development is and the signs of sexually abusive behaviours
- (ii) raise awareness that juvenile sexual abuse occurs across many families and can involve immediate family members
- (iii) empathise that it is hard for any parent to believe that his/her child is capable of sexual abuse and that many families might want to keep the situation to themselves or hope it will go away
- (iv) reassure parents that they can make the situation better for themselves and their family by seeking help for any child that they are worried about or know has been accused of sexually abusive behaviours
- (v) reinforce that these children need to be assessed by professionals and possibly receive treatment to stop their behaviours
- (vi) urge families to contact child protection services so that they can get the necessary referrals for assessment and treatment services
- (vii) reinforce that seeking help for their child's behaviour and awareness that treatment is associated with good parenting and can result in a range of short and long-term benefits to their child and their family
- (viii) raise awareness that not seeking help or trying to manage the situation in the family can result in a repeat of the sexual offending and result in more harm to the victim and their perpetrating child.

Suitable channels for promoting help could include:

- (i) popular print, TV and online media, e.g. storylines, magazine and newspaper articles and tips on healthy sexual development, talk show topics, social networking and information sites
- (ii) child and family and other professionals working in a range of areas, e.g. childcare, schools, sporting and social clubs, spiritual settings and parenting groups
- (iii) posters, brochures and collateral on healthy childhood sexual development being made available in a wide range of physical and online settings frequented by parents, such as doctor's surgeries, parenting websites and child and welfare services.

5.2 LIMITATIONS AND FURTHER RESEARCH

Because interviews were conducted with experts who provide treatment services primarily to young people, this study is limited to providing specific insights, particularly into families that are engaged with formal sources of help. As a first step in developing any social marketing-based intervention, interviews with statutory service providers may provide additional insights into why families may or may not pursue help.

Although many of the findings of this study are relevant to all Australian families of young people with sexually abusive behaviours, interviews were only conducted with experts in NSW. For example, their comments about mandatory reporting and service availability and quality refer to this state's services. Not all Australian states and territories have mandatory reporting, thus the pathways to treatment may vary. When investigating strategies to increase help-seeking of all Australian families affected by a child's sexually abusive behaviours, a researcher would need to consider these differences in order to tailor approaches that are regionally appropriate.

This study is particularly limited from a social marketing perspective because of a lack of investigation of the target groups themselves. Research needs to be conducted directly with a range of families to gain the necessary 'customer' insights government departments and services require in order to more fully and accurately understand the factors that both assist and impede families seeking and accessing treatment services. This would include investigating families in the general population as well as at-risk families (those already substantiated as experiencing abuse, neglect and domestic violence) about their understanding of normal and abnormal sexual development, attitudes, social norms and perceived behavioural control towards help-seeking and the perceived benefits, costs, barriers and enabling factors. This research also needs to include families whose child is a previous or current client of child protection services due to their sexually abusive behaviours.

Research into child sexual assault needs to be approached sensitively. While families attending treatment for their child might be easier to approach through their

service providers, families who have not yet had contact with formal help-seeking mechanisms might be more difficult to access. Issues of confidentiality, ethics and social bias would need to be thoughtfully considered and managed.

6. CONCLUSION

This study applies a social marketing approach to the challenge of reducing the incidence of child sexual assault by young people. Using the theory of planned behaviour and social marketing frameworks, this study explores the factors that experts in the field of juvenile sexual offending consider motivate or demotivate young people and their families to seek help and utilise treatment services. The social marketing implications and recommendations from these findings have been proposed to increase the numbers of young people and their families seeking and receiving help. This study has added insights into juvenile sexual offending, help-seeking behaviour and social marketing.

6.1 Young people with sexually abusive behaviours and help-seeking

This study finds that young people with sexually abusive behaviours towards children do not appear to seek help of their own volition prior to their behaviour being detected. Drawing on behavioural determinants from Ajzen's (1985) theory of planned behaviour and the benefits and costs factors from Andreasen's BCOS factors (2006), this study finds that experts in the field of juvenile sexual offending consider that young people with sexually abusive behaviours predominantly experience:

- (i) unfavourable attitudes towards seeking help
- (ii) negative messages about seeking help from those most important to them and the wider community
- (iii) a sense that seeking help would be too hard – that the costs are too great and that there are few benefits associated with seeking help before their behaviour is detected.

In addition to this, the study identifies that seeking help is in competition with a number of psychological motivations that some young people have towards sexually abusing children. Guilt and shame associated with sexually abusing a child and

cognitive distortions that they won't get caught or do it again also contribute to young people denying or minimising their behaviour. Developmentally, young people also have a lack of cognitive ability to monitor their thoughts and be concerned about them.

These findings support an underlying premise of the theory of planned behaviour, whereby the behaviour of young people to *not* seek help before they are caught can be explained by a lack of intention to do so. This lack of intention to seek help is made somewhat predictable from the themes that have emerged from this study of negative attitudes, low social norms and low perceived behavioural control towards seeking help for sexually abusive behaviours. The negative consequences and lack of perceived benefits to disclosing their behaviour has also reinforced the behavioural concept that, when perceived costs outweigh perceived benefits, behaviour (such as help-seeking) is less likely to occur.

However, on a more positive note, this study finds that, once a victim has disclosed their sexual abuse and it has been reported to authorities, young people can show more favourable attitudes and be motivated towards attending treatment services voluntarily. Although many are still reluctant to admit their behaviour, key motivations for engaging with service providers seem to revolve around a desire for a restoration of family relationships, especially if they have been removed. Apart from decreasing recidivism, attending effective treatment services can also help young people achieve positive outcomes, such as improved peer relationships, academic performance and quality of life, thus enabling young people to move forward with their lives and develop a more positive self image. The attitudes and skill of the treatment practitioner are found to also motivate (or demotivate) a young person to continue attending treatment.

This study does not recommend marketing help directly to sexually abusive young people before their behaviour has been detected, as this target audience largely appears to be in the pre-contemplative stage of help-seeking (Prochaska, Di Clemente & Norcross 1992). This study prioritises the downstream social marketing strategy of encouraging victims of child sexual assault to come forward and seek help. Also recommended, as a matter of urgency, is the lobbying of policymakers and legislators for the maintenance and expansion of the important role of

mandatory reporting of child sexual assault, particularly in light of the low number of parents currently notifying authorities about their child's behaviour.

This study has identified that child protection workers and treatment clinicians are a key channel for enabling and motivating young people to attend treatment programs. The findings of this study suggest that investments made in providing skilled, knowledgeable and supportive child protection workers and treatment providers might increase the favourable attitudes that young people have to voluntarily attending treatment services.

6.1.1 Help-seeking and families of young people with sexually abusive behaviours

This study has found that that, in NSW, the most common pathway for a child to receive help is via his/her parents voluntarily pursuing treatment services following an investigation and referral from child protection authorities. Gaining a deep understanding of the attitudes, motivations and perceptions of behavioural control of families with young people with sexually abusive behaviours is a cornerstone to developing any effective social marketing strategies to increase help-seeking behaviour. This study has added to the growing body of literature on families of young people with sexually abusive behaviours in a number of ways. It has supported extant literature indicating that parents are commonly shocked and despairing at their child's behaviour and feel guilt and shame, seeing it as a reflection on their parenting. It has found that some parents (particularly fathers) do not recognise there is a problem, that help is needed, or where that help would come from. An important theme that is less commonly found in the literature has emerged from this study, possibly because the experts interviewed often work with families that are motivated to seek help. This study has found that that many parents do take action to stop their child's behaviour when their child's behaviour is discovered or disclosed. Some parents try to self-manage the situation by taking actions within the family to prevent sibling abuse from occurring. Other parents try to reach out to friends, extended family members and professionals, such as doctors and treatment services, directly. Parents can experience a range of negative or encouraging messages about seeking help for their child's behaviour from those

most important to them, such as other family members and friends. However, this study has also reinforced earlier studies which have found social stigma to impede or demotivate parents from seeking help for their child's sexually abusive behaviour.

This study identifies that a number of parents of young people with sexually abusive behaviours can be wary of getting outsiders, especially statutory services, involved in what they consider to be private family business. This unfavourable attitude towards seeking help from formal sources can be associated with a prior negative perception of statutory services and a perceived loss of control over their family once these services become involved. This may provide some insight into the low numbers of families in NSW who report suspected sexual abuse by their child. While families might not be initially enthusiastic about getting statutory authorities involved, experts have found that many families of sexually abusive young people are motivated, and often desperate, to seek help. Parents appear to be motivated largely by concern about their parenting and the wellbeing of their child(ren). Another motivation is the inability to self-manage the problem and the desire for family reunification, particularly if their child has been removed, or has an AVO against them, which commonly occurs in sibling abuse cases. External pressure, support and consequences from agencies such as DoCS and the legal system appears to be another motivation for parents to seek help for their child's behaviour. This study found that 'enabling' factors such as the knowledge, skill, engagement and support provided by child protection and treatment staff, plus the provision of affordable and accessible treatment services, can also motivate families to seek help for their child.

If parents are able to receive affordable, effective treatment that also engages them, they can experience short and long-term benefits that often meet and exceed their expectations. Key short and long-term benefits include: receiving support and feeling like they are not alone; the knowledge that something can be done about the problem; seeing their child taking responsibility and earning back their trust; understanding how the problem happened and what they can do to help prevent further abuse; increased safety for their child(ren); increased communication between the parents and their child; and increased parenting satisfaction and hopes for the future. Unfortunately, the biggest current demotivating factors (in NSW at least) are institutional and structural barriers. These impeding factors relate to an

overall lack of quality, affordable and accessible investigative and treatment services for young people with sexually abusive behaviours and their families. Some families can experience a lack of problem recognition, engagement and support, or alternatively, punitive responses from statutory services when a notification is made about their child's behaviour. These structural barriers, accompanied by a low level of perceived behavioural control and satisfaction with the way statutory services have responded, can result in families feeling angry, frustrated and regretful at involving external agencies in their situation, and a subsequent reluctance to notify them of any future sexually abusive behaviours. Young people that do not have the practical and emotional support of their parents to engage in treatment services appear less likely to obtain the help they need. They are then often not followed up by the statutory authorities. This is clearly problematic when it is known that a number of young people will go on to repeatedly sexually abuse children throughout their life if their behaviours are left undetected, unassessed, untreated or unmonitored. This results in significant costs in human suffering and the need for expensive tertiary service responses across a range of human services and judicial areas.

Downstream social marketing planning and implementation strategies are somewhat premature if there are not enough good quality, affordable and accessible responses for the families who bravely put up their hands for help. The bottom line remains that, even if the numbers of families seeking help were to increase, there are not enough treatment services to even meet the current demand. As a matter of priority, upstream social marketing strategies must be developed to encourage state and federal treasuries to fund more treatment services and service providers operating under 'best practice' guidelines. Decision makers need to recognise and resource the critical role that statutory authorities play in engaging and supporting families to participate in their child's treatment. Increasing the positive attitudes of parents towards statutory bodies and treatment services may increase the intention, actual help-seeking and reporting of any further concerns about their child's behaviour.

It would be worth investing in downstream marketing strategies to encourage parents to identify and actively seek help for their child's behaviour, including the promotion of benefits associated with taking their child to treatment. Further

research needs to be undertaken directly with families to determine what they consider to be the benefits and enabling factors, or the costs and barriers, to seeking help for their child.

Findings from the study have contributed to the body of literature on help-seeking behaviour. It has supported the influential role that social networks and norms have been found to play on the help-seeking behaviour of individuals and families. A major demotivating factor for young people admitting their behaviour is their fear of negative consequences from their parents and having to leave their family. Family restoration is a primary motivation for attending treatment. Although there are isolated incidents of young people seeking help without the support of their family, it appears that parents play a key role in enabling their attendance at treatment. The social stigma attached to sexual offending, particularly within the family, has been identified as being a significant demotivating factor for young people and their families in seeking help outside the family. Like many other individuals across the general help-seeking literature and for sensitive issues such as sexual assault, parents have been found to show preferences for self-managing the problem or seeking help through informal sources. Social marketing strategies need to be developed to decrease social stigma and to improve the social acceptability of young people and adults receiving treatment.

This study also reinforces the influential role that institutional and structural factors, such as service availability, affordability and quality, can have on whether a problem gets addressed, despite an individual recognising they have a problem and taking active steps to seek help. The findings also support an association between families experiencing dissatisfaction with the responses from welfare services and their reluctance to use those services in the future. A lack of good quality, available and accessible treatment services in NSW appears to have a considerable negative influence on the help-seeking behaviour of families. Enabling factors, such as skilled statutory and treatment professionals and the availability and affordability of services, are considered to motivate parents to seek help for their child's behaviour.

This study calls for more in-depth and rigorous inquiry with the key individuals and groups that are in a position to be able to increase the incidence of help-seeking behaviour of young people and families. Future social marketing research could

help to establish a stronger evidence-based platform from which to design government and non-government strategies to increase the numbers of young people and families receiving effective treatment services for sexually abusive behaviours.

From this study, it is evident that it will take a concerted upstream and downstream social marketing effort to effect any sustainable increase in the help-seeking behaviour of young people with sexually abusive behaviours and their families. This could be seen as an overwhelming challenge for public health and social marketing professionals alike. On a positive note, this study highlights that there are significant opportunities available to increase the numbers of young people with sexually abusive behaviours and their families receiving help to reduce further abuse. This will help decrease the numbers of children across all our families who have suffered child sexual assault.

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APPENDICES

Appendix 1 – Ethics Approval from the University of Wollongong

SYDNEY WEST AREA HEALTH SERVICE (Westmead Campus)

HUMAN RESEARCH ETHICS COMMITTEE

Research Office, Clinical Sciences
Westmead Hospital Campus
Westmead NSW 2145

Telephone: 02 9845 8183
Facsimile: 02 9845 8352
Email: researchoffice@westgate.wh.usyd.edu.au

In reply please quote:

HS/pme HREC2006/9/4.7(2428)

Committee Secretariat:

Professor Stephen Leeder AO
Chairman
Professor of Public Health &
Community Medicine

Dr Howard Smith
Secretary
Medical Graduate -
Endocrinologist

Committee Members:

Mr Leonard Burney
Layman

Dr Michael Cole
Medical Graduate - Neonatal
Paediatrician

Mrs Patricia Fa
Clinical Trials Pharmacist

A/Prof Lorraine Ferguson AM
Nursing Research Unit

Mr John Fisher
Lawyer

Ms Janet Fox
Law Graduate

Ms Jillian Gwynne Lewis
Patient Representative

Dr Anthony Harris
Medical Graduate -
Psychiatrist

Dr Jim Hazel
Medical Graduate -
Endocrinologist

Ms Vicki Hewson
Social Worker

Ms Jan Kang
Diversity Health Institute

A/Prof Ian Kerridge
Haematologist and Bioethicist

Ms Rada Kusic
Clinical Trials Manager

Rev Sarah Plummer
Minister of Religion

Mr John Shaw
Layman

Dr Geoff Shead
Medical Graduate - Surgeon

Mrs Carol Walsh
Laywoman

Ms Shane Waterton
Laywoman

20 October, 2006

Ms Janice Bagot
108 Warren Road
MARRICKVILLE NSW 2204

Dear Ms Bagot

Research Proposal: Seeking Help - A study of the benefits and barriers for young people with sexually abusive behaviours and their families - Seeking Help Benefits and Barriers Study

Thank you for submitting the above project which was considered by the Sydney West Area Health Service Human Research Ethics Committee at its meeting held on 26 September 2006. The HREC is constituted and operates in accordance with the National Health and Medical Research Council's *National Statement on Ethical Conduct in Research Involving Humans* (June 1999) and the *CPMP/ICH Note for Guidance on Good Clinical Practice*.

*The Committee resolved to **approve** this research proposal. Participant Information and Consent Sheet Version 1 dated August 2006 has been reviewed and approved by the Committee.*

Please note the following conditions of approval:

- The approval of this research proposal applies to the ethical content of the study and individual arrangements should be negotiated with heads of departments in those situations where the use of their resources is involved (eg nursing etc).
- The HREC has the delegated authority to approve the commencement of this research on behalf of Sydney West Area Health Service.
- The Principal Investigator must immediately report anything which might warrant review of ethical approval of the project in the specified format, including any serious or unexpected adverse events and any unforeseen events that might affect continued ethical acceptability of the project.
- The Principal Investigator must report proposed changes to the research protocol, conduct of the research, or length of HREC approval to the HREC for review.
- The Principal Investigator must notify the HREC of the date of commencement of the study and recruitment of subjects.
- The Principal Investigator must inform the HREC, giving reasons, if the study is discontinued before the expected date of completion.

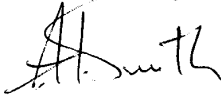
- The Principal Investigator must provide an annual report to the HREC and a final report at completion of the study, in the specified format. HREC approval is valid for 12 months from the date of final approval and continuation of the HREC approval beyond the initial 12 month approval period, is contingent upon submission of an annual report each year. A copy of the Annual / Final Research Report Form is attached and can be obtained electronically from the Research Office on request.
- It should be noted that compliance with the ethical guidelines is entirely the responsibility of the researcher.
- A copy of the HREC's Standard Operating Procedures is attached.

Please return the attached copy letter, signed and dated in acknowledgement, to the Research Office.

Should you have any queries about your study, please contact the HREC Executive Officer or the HREC Secretary through the Research Office on 9845 8183. The HREC membership details and standard forms are available by telephoning the Research Office or emailing researchoffice@westgate.wh.usyd.edu.au.

In all future correspondence concerning this study, please quote your approval number **HREC2006/9/4.7(2428)**.

Yours sincerely



Dr Howard Smith
Secretary
Sydney West Area Health Service
Human Research Ethics Committee

Appendix 2 – Participant Information Letter (for non SWAHS participants)

Research Project: Seeking Help – A study of the needs of adolescents who sexually offend.

Name of the researchers:

Janice Bagot, Masters of Marketing by Research
School of Management and Marketing, Faculty of Commerce
University of Wollongong, mob 0402 644 918, Janice.bagot@gmail.com

Supervisors: Dr Gary Noble, School of Management & Marketing, University of Wollongong. Ph: 02 422 15994, gnoble@uow.edu.au
A/Professor Professor Sara Dolnicar, School of Management & Marketing
sarad@uow.edu.au

Aims of research

This study explores the help-seeking behaviour of adolescents who sexually offend against children. It aims to identify attitudes of young people towards getting help for their sexual offending, the perceived social pressure for young people to get help for their sexual offending and the perceived ease and difficulty for young people to seek help for their sexual offending.

Procedures used:

Practitioners who have expertise in working with adolescents who sexually offend will be individually interviewed for approximately 1-1.5 hours about their insights and understanding of the motivations, needs and barriers for young people towards seeking help for their sexual offending behaviour.

There will not be any risk to participants. Information will be gathered about adolescent offenders in general and not in relation to specific incidences of criminal activity.

Interviews with experts will be recorded by audio tape or by written correspondence and treated as confidential and anonymous information. The interviews will be transcribed, de-identified and pooled together with other interviews. Only emerging themes and categories from total responses will be reported in the Masters thesis and possible journal or conference publications. Any quotes used to support these themes will not be attributed to any respondent by name or organisation but will be allocated a code or some other mechanism of attribution.

Information provided by participants is confidential and will be securely stored in a locked filing cabinet in my supervisor's office in the Faculty of Commerce, UOW for a minimum of five years. The only people with access to this data are the named researchers.

The findings from this exploratory research can inform organisations who wish to promote help-seeking behaviour in adolescent population(s) at risk of sexually offending. Copies of this completed thesis will be made available to experts interviewed for this research project.

Participation in the research project is voluntary. Participants will be asked to sign a consent form. However, participants are free to withdraw consent without refusal or having their refusal have any consequences or affecting participants in any way.

If participants experience any emotional distress from the interviews they will be referred to the Child Abuse Prevention Service (ph Toll free 1800 688 009) which provides 24 hour free telephone support to parents and families to reduce family stress.

Please feel free to contact the researcher with any questions you might have about participating in this research project. If a participant has any concerns or complaints regarding the way in which the research is or has been conducted, they should contact the Ethics Officer, of the UOW Human Research Ethics Committee on (02) 4221 4457.

Appendix 3 – Consent Form (for non SWAHS participants)

UNIVERSITY OF WOLLONGONG

CONSENT FORM

Seeking Help – A study of the needs of adolescents who sexually offend

Researcher - Janice Bagot

I have been given information about 'Seeking Help – A study of the needs of adolescents who sexually offend' and discussed the research project with Janice Bagot, who is conducting this research as part of a Masters of Marketing by Research supervised, by Dr Gary Noble and Associate Professor Sara Dolnicar in the School of Management and Marketing at the University of Wollongong.

I understand that, if I consent to participate in this project, I will be asked to:

- participate in an individual semi-structured interview with the researcher
- have my interview recorded by audio-tape or in a written format
- allow the information from my interview to be anonymously pooled together with other interviews and written up for the researcher's thesis and possible journal and conference publications.

I have been advised of the potential risks and burdens associated with this research, which include having my de-identified data published in her thesis, and possible journal and conference publications. I have had an opportunity to ask Janice Bagot or her supervisors any questions I may have about the research and my participation.

I understand that my participation in this research is voluntary, I am free to refuse to participate and I am free to withdraw from the research without any affect on my relationship with the University of Wollongong.

If I have any enquiries about the research, I can contact (Janice Bagot (mob 0402 644 918) or Dr Gary Noble (ph: 02 422 15994) or if I have any concerns or complaints regarding the way the research is or has been conducted, I can contact the Ethics Officer, Human Research Ethics Committee, Research Services Office, University of Wollongong on 4221 4457.

By signing below I am indicating my consent to participate in the research entitled 'Seeking Help – A study of the needs of adolescents who sexually offend', conducted by Janice Bagot, as it has been described to me in the information sheet and in discussion with Janice Bagot. I understand that the data collected from my participation will be used for her thesis and possible journal and conference publications, and I consent for it to be used in that manner.

Signed

Date

...../...../.....

Name (please print).....

Appendix 4 – Ethics Approval from Sydney West Area Health Service (SWAHS)



WESTMEAD SCIENTIFIC ADVISORY COMMITTEE

Research Office Room 2020 Clinical Sciences
Level 2 Westmead Hospital
Hawkesbury & Darcy Roads Westmead NSW 2145

Telephone 02 9845 8183
Facsimile 02 9845 8352
Email address: researchoffice@westgate.wh.usyd.edu.au

Our Ref: HZ/TG SAC2006/9/4.7(2428)
Date: 13 September 2006

Ms Janice Bagot
108 Warren Road
Marrickville NSW 2204

Dear Ms Bagot

Research Proposal: 'Seeking Help - A study of the benefits and barriers for young people with sexually abusive behaviours and their families - Seeking Help Benefits and Barriers Study'

Your research proposal was reviewed at the Westmead Scientific Advisory Committee meeting held on 11 September 2006. I am pleased to advise you that our committee has agreed to the scientific validity of the project and that your proposal can be forwarded to the Human Research Ethics Committee for further consideration of the ethical issues provided a response is received to the issues raised in the scientific review (below) by Monday, 18 September 2006:

1. ***The proposed study is not located in relation to existing research on the issue. The literature review refers to 'reports and journal articles that do present limited findings' but these are not cited. The investigator should provide a brief account of previous research in the field.***
2. ***The research participants are practitioners in the field and are likely to have considerable interest in this study's findings. Consideration should be given to sending them a copy of the draft analysis, conclusions and recommendations for comments to be incorporated in the final report.***

Note: This is an interview survey of expert practitioners. If the investigators respond to the above recommendations, I see no reason why the proposal should not be forwarded to the HREC.

The Committee wishes you all the best for your ongoing research at Westmead. Please quote reference number **SAC2006/9/4.7(2428)** in all future correspondence.

Yours sincerely

A handwritten signature in dark ink, appearing to be "Hans Zoellner".

A/Prof Hans Zoellner
Secretary
Westmead Scientific Advisory Committee

ABN 70667812600
PO Box 63 Penrith NSW 2751

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Holroyd • Parramatta • Hawkesbury • Penrith • Blue Mountains • Greater Lithgow

Appendix 5 – SWAHS Participant Information Sheet

SYDNEY WEST

Area Health Service

PARTICIPANT INFORMATION

Study Title: Seeking help – A study of the benefits and barriers for young people who sexually abuse and their families

Short Title: Benefits & barriers of help seeking

Chief Investigator: Janice Bagot
Masters of Marketing by Research student, University of Wollongong

What is the purpose of the study?

The aim of this exploratory study is to identify the benefits, barriers, costs, social pressures and perceived difficulty and ease associated with seeking and receiving help for young people with sexually abusive behaviours and their families. Established 'experts' in this field will be interviewed for their perceptions of these motivating or demotivating factors with regard to seeking help.

Identifying the benefits and barriers to help and treatment can assist Government, Non-Government organisations and private practitioners with future planning to promote the benefits of help and treatment and address barriers for young people with sexually abusive behaviours and their families.

Who will be invited to enter the study?

You have been invited to enter the study because you are an accredited member of the NSW Commission of Children and Young People's NSW Child Sex Offender Counsellor Accreditation Scheme and have recognised expertise in the area of working with young people with sexually abusive behaviours towards children.

What will happen on the study?

Practitioners who have expertise in working with adolescents who sexually offend will be individually interviewed for approximately one hour about their insights and understanding of the motivations, needs and barriers with regard to seeking and receiving help for young people with sexually abusive behaviours and their families.

Interviews with expert informants will be recorded by audio tape or by written correspondence and treated as confidential and anonymous information. The interviews will be transcribed, de-identified and pooled together with other interviews. Only emerging themes and categories from total responses will be reported in the Masters thesis and possible journal or conference publications.

Are there any risks?

There are no ethical dangers or risks associated with the planned research.

Participation in the research project is voluntary. Participants will be asked to sign a consent form. However, participants are free to withdraw consent without refusal or having their refusal have any consequences or affecting participants in any way.

The individual and cultural opinions, perceptions and beliefs of each expert will be respected and documented by the researcher and not challenged. Individuals and their places of employment will not be identifiable in any public documents.

The sensitive nature of the questions will be focused on the benefits and barriers to seeking and receiving help for young people with sexually abusive behaviours and their families and not specific criminal sexual activity.

The recorded interviews do not document the name or organisation of the expert informant but are attributed with a code. The interviews will be transcribed, de-identified and pooled together with other interviews. Only emerging themes and categories from total responses will be reported in the Masters thesis and possible journal or conference publications. Any quotes used to support these themes will not be attributed to any respondent by name or organisation but will be allocated a code or some other mechanism of attribution.

Copies of this completed thesis will be made available to experts interviewed for this research project.

Are there any benefits?

This study will add to the body of knowledge about the motivating and demotivating factors that influence the help seeking behaviours of young people with sexually abusive behaviours and their families.

Identifying the benefits and barriers to help and treatment can assist government and non-government organisations and private practitioners to more effectively promote the benefits of help and treatment and address barriers.

Confidentiality

All aspects of this study, including results, will be strictly confidential and only the researchers will have access to your personal information. Any publication of the results from this study will only use de-identified information.

What will happen at the conclusion of the study?

The interviews will be transcribed, de-identified and pooled together with other interviews. Only emerging themes and categories from total responses will be reported in the Masters thesis and possible journal or conference publications.

Copies of this completed thesis will be made available to experts interviewed for this research project.

Do you have a choice?

Your participation in this study is entirely voluntary. If you choose not to join the study, or you wish to withdraw from it at any time, your medical care will not be affected.

Complaints

If you have any concerns about the conduct of the study, or your rights as a study participant, you may contact
Westmead Hospital Patient Representative, Ms Jillian Gwynne Lewis,
Telephone No 9845 7014 or email jillian_lewis@wsahs.nsw.gov.au

Appendix 6 – SWAHS Consent Form

CONSENT TO PARTICIPATE IN RESEARCH

Study Title: Seeking help – A study of the benefits and barriers for young people who sexually abuse and their families

Name of Researcher: Janice Bagot

1. I understand that the researcher will conduct this study in a manner conforming with ethical and scientific principles set out by the National Health and Medical Research Council of Australia and the Good Clinical Research Practice Guidelines of the Therapeutic Goods Administration.
2. I acknowledge that I have read, or have had read to me the Participant Information Sheet relating to this study. I acknowledge that I understand the Participant Information Sheet. I acknowledge that the general purposes, methods, demands and possible risks and inconveniences which may occur to me during the study have been explained to me by Janice Bagot ("the researcher") and I, being over the age of 16 years, acknowledge that I understand the general purposes, methods, demands and possible risks and inconveniences which may occur during the study.
3. I acknowledge that I have been given time to consider the information and to seek other advice.
4. I acknowledge that refusal to take part in this study will not affect the usual treatment of my condition.
5. I acknowledge that I am volunteering to take part in this study and I may withdraw at any time.
6. I acknowledge that this research has been approved by the Sydney West Area Health Service Human Research Ethics Committee.
7. I acknowledge that I have received a copy of this form and the Participant Information Sheet, which I have signed.

Before signing, please read 'IMPORTANT NOTE' following.

Name of participant _____

Date of Birth _____

Address of participant _____

Signature of participant _____

Date: _____

Signature of researcher _____

Date: _____

Signature of witness _____

Date: _____

IMPORTANT NOTE

This consent should only be signed as follows:

1. *Where a participant is over the age of 16 years, then by the participant personally.*
2. *Where the participant is between the age of 14 and 16 years, it should be signed by the participant and by a parent or person responsible.*
3. *Where the participant is under the age of 14 years, then the parent or person responsible only should sign the consent form.*
4. *Where a participant is under a legal or intellectual disability, eg unconscious, then particular consent should be sought from the Human Research Ethics Committee as to whether the person should take part in the research.*

WITNESS:

I, _____ (name of witness)

of _____ hereby certify as follows:

1. I was present when _____ ("the participant") appeared to read or had read to him / her a document entitled Participant Information Sheet; or
I was told by _____ ("the participant") that he/she had read a document entitled Participant Information Sheet (*Delete as applicable)
2. I was present when Janice Bagot ("the researcher") explained the general purposes, methods, demands and the possible risks and inconveniences of participating in the study to the participant. I asked the participant whether he/she had understood the Participant Information Sheet and understood what he/she had been told and he/she told me that he/she did understand.
3. I observed the participant sign the consent to participate in research and he/she appeared to me to be signing the document freely and without duress.
4. The participant showed me a form of identification which satisfied me as to his/her identity.
5. I am not involved in any way as a researcher in this project.
6. (Delete this clause if not applicable) I was present when _____ ("the interpreter") read the Participant Information sheet to the participant in the _____ (here insert appropriate language) language. I certify that when the researcher explained the general purposes, methods, demands and possible risks and inconveniences of participating in the study that what was said by both the researcher and the participant was translated by the interpreter from the English language into the above language and vice versa. When I spoke to the participant what I said and what the participant said was translated by the interpreter from the English language into the above language and vice versa.

Name of witness

Address

Signature of witness _____

Date: _____

Relationship to participant _____

Appendix 7 – Semi Structured Interview Questions

General opening questions

1. What avenues of 'help' are there for young people who sexually offend against children and their families?

Probe: Can you give some examples?

2. From your experience, do you think young people who sexually offend against children seek help for their behaviour?

Probes: Why? - What motivates them to seek help?

Why not? - Why don't they seek help for their sexual offending?

Attitudes

3. What do young people and their parents think and feel about seeking help for their behaviour?

4. What do young people and their parents think are the benefits, if any, of seeking help?

5. What do young people and their families think are the benefits of receiving help and/or treatment services?

6. What do young people and their parents think are the disadvantages of seeking help?

7. What do you think is the key motivation that young people have for sexually abusing children?

Probe: What benefits do they think they get out of sexually abusing a child?

8. What do young people think are the disadvantages or costs of their sexually offending behaviour?

Social norms

9. Who do you think are the most influential people to adolescents who sexually offend and their parents?

10. What messages do you think adolescents and their parents get from these people in relation to seeking or not seeking help?

Probe: How do you think this influences their help seeking behaviour?

Perceived behavioural control

11. How easy or hard do young people and their families think it is for them to get help and utilise treatment services?

12. Enablers

What would make it easier for young people and their families to seek help and utilise treatment services?

General

13. Are there any recommendations that you have about how to increase the incidence of young people and their families seeking help and accessing treatment services?

14. Is there anything that you would like to add regarding the help seeking behaviour of young sexual offenders?