Physical Activity as an Intervention with Young People Exhibiting Harmful Sexual Behaviour: A Review

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Young people, Harmful sexual behaviour, Physical activity interventions, Adventure therapy, Wilderness therapy

ABSTRACT
A number of treatment approaches have been used with young people who exhibit harmful sexual behaviour (YPHSB). Other young offenders (OYO) have sometimes received an alternative form of treatment - physical activity (PA)-based intervention. Positive outcomes have been reported for these young people. Some authorities have argued that YPHSB and OYO are similar in terms of their psychosocial characteristics and therefore might benefit from PA-based interventions. There are a small number of evaluations of such interventions with YPHSB but they are limited to adventure therapy (AT) or wilderness therapy (WT). This paper will provide an outline of PA-based interventions used with OYO; assess any overlap in psychosocial characteristics between YPHSB and OYO; and evaluate the evidence as to the efficacy of PA-based interventions with YPHSB.

Background
There are suggestions that an appreciable proportion of child sexual abuse is perpetrated by other children and young people (CYP) (Cooper and Roe, 2012; NSPCC, 2013; Smith, Bradbury-Jones, Lazenbatt, and Taylor, 2013). Hackett (2014), for example, indicated that a third of sexual offences were committed by CYP, and Campbell, Booth, Hackett and Sutton (2018) estimated that 30–50% of all childhood sexual abuse was perpetrated by other young people. There are, though, no reliable figures as to the extent of this offending by CYP (NSPCC, 2018). Young people aged 10 years and over in England and Wales can be held criminally liable for any offences they commit, including sexual offences (HM Government, 2015). It is recognised, however, within the UN Convention on the Rights of the Child, that young offenders are still children, and as such their welfare and rehabilitation are paramount (NSPCC, 2008).

It is essential that any welfare and rehabilitative provision for young people who exhibit harmful sexual behaviour (YPHSB) includes effective treatment. The majority of interventions for YPHSB in the UK comprise cognitive behavioural therapy (CBT) or relapse prevention (Masson and Hackett, 2003). A limited number of additional treatments have been developed over the past decade (NSPCC, 2011) including art, drama and yoga therapies (Hall, 2010). A few dedicated residential treatment centres have also been established (Glebe House, 2012; G-map, 2014). These residential treatment programmes strive to provide a youth-oriented service rather than simply reproducing the provision that exists for adult sex offenders.

Physical activity (PA)-based interventions for other young offenders (OYO) have been funded and promoted by successive governments in the UK (Armour, Sandford and Duncombe, 2013; Kelly, 2011; Nichols and Crow, 2004). This official enthusiasm is founded on the belief that such
interventions target ‘some of the risk factors associated with the reasons for involvement in crime’ (National Association for the Care and Resettlement of Offenders-NACRO, 2008, p.2). PA-based interventions are believed to facilitate personal, social and moral development. The social relationships formed during these interventions are viewed as being particularly crucial in affecting behaviour change (Audit Commission, 2009; Hartmann and Depro, 2006; Long and Sanderson, 2001; NACRO, 2008; NSPCC, n.d).

The present authors explore, in this paper, whether there are similarities between YPHSB and OYO in terms of their psychosocial characteristics, whereby interventions that have been shown to be effective in improving the psychosocial adjustment of the latter might be effective with the former. The authors also consider whether participation in PA, as part of a wider treatment programme, might help improve the psychosocial adjustment of YPHSB and prevent their re-offending sexually. Only those interventions where PA was a central element of the treatment programme were considered. All of the interventions that the authors could identify were limited to adventure-and wilderness-based activities, which took place in Australia, New Zealand or the US (Gillis and Gass, 2010; Grüring, 2007; Kjol and Weber, 1990; Lambie et al, 2000; Simpson and Gillis, 1998; Somervell and Lambie, 2009; Tidmarsh and Kilby, 2003). The authors’ aim, in analysing the methods and outcomes of existing PA treatment programmes with YPHSB, is to contribute to discussions as to the possible efficacy of PA-based interventions with this group.

The use of PA-based treatment interventions with OYO

PA-based interventions have been successful in engaging young people ‘at risk’, and in preventing offending and reoffending (Coalter, 2007; Kelly, 2011; Nichols, 2007). These interventions include physical fitness programmes, and outdoor and adventure activities, such as the HSBC/Outward Bound and the Tall Ships projects (Lubans, Plotnikoff, & Lubans, 2012; Sandförd et al, 2008). PA-based interventions have also been linked with a range of positive outcomes in OYO: psychologically – improvements in empathy, self-esteem, confidence and sense of responsibility (Andrews and Andrews 2003; Sandförd et al., 2008; West and Crompton, 2001); behaviourally - greater pro-social behaviour and reduced offending (Armour & Sandford, 2006; Nichols, 2007); and socially – development of relationships with staff and peers, and an ability to work in teams (Audit Commission, 2009; NACRO, 2008; Nichols, 2007).

A number of theoretically- and empirically-based explanations have been put forward to account for the beneficial impact of PA interventions on the psychosocial adjustment of OYO. It has been argued, for example, that personal growth takes places within adventure education as a result of young people being faced with challenging situations (Nichols, 2007). Nichols believes that personal growth occurs through two critical aspects of such situations: ‘risk’, both physical (through participation in activities) and emotional (via assessing and managing difficult situations), and ‘competence’ (through overcoming increasingly challenging activities).

Other authorities have emphasised the sense of security that participation in PA interventions can generate. It has been contended that PA interventions, such as the Youth Inclusion Programme, provide a positive environment in which young people feel physically and emotionally safe (Sampson and Themelis, 2009). Young people within such an environment can build positive relationships with staff, and are able to discuss their offending in a non-threatening context – the belief being that this will reduce a young person’s exposure to risk factors and lower their chances of reoffending.

The importance of relationship building has been underlined in other studies. Meek and Lewis (2014) sought to use sporting activities to facilitate young men’s transition from prison to the community. They found that the intervention increased participants’ quality of life whilst in custody by enhancing their relationships within the institution and by improving their behaviour (the latter of which was brought about being better able to managing their frustration and anger). A similar sports-based intervention, in a youth offenders’ institution, was also found to be associated with improvements in behaviour and attitudes, with participants evidencing less aggression and greater opposition to offending (Williams, Collingwood, Cloes & Schmeer, 2015). Sports-based interventions have also been linked with self-transformation’ among young people involved in criminal or anti-social activities (Kelly,
These transformations were, according to Kelly, due to the development of mentoring and supportive relationships formed during the physical activity sessions. Participation in sport has also been credited with raising the self-esteem of youth offenders as well as ‘helping them acquire team working, communication, and life skills’ (Chamberlain, 2013, p.1281).

Improvements in psychosocial adjustment have, though, been ascribed to a range of physical activities. The ‘troubled’ young people who took part in the HSBC/Outward Bound project (involving residential outdoor/adventurous activity) were reported to have made positive developments on a range of attributes, including self-confidence, trust and empathy/social responsibility (Armour, Sandford & Duncombe, 2013).

Some authors have, though, been more cautious as to the efficacy of PA-based interventions with OYO. Sandford et al., (2008) accept that PA can have beneficial effects on a young person’s psychosocial adjustment but argue that it is the ‘social processes inherent within programmes, and the explicit focus on personal development, that are most significant in effecting behaviour change’ (p.422). Other writers point out that PA should be only one element within a holistic programme of interventions with OYO (Holroyd & Armour, 2003), which should include, for instance, educational and employment training opportunities (Andrews and Andrews, 2003). Yet other workers have pointed out that if these interventions are to be effective, they have, in addition, to address the causes of a young person’s offending (Sampson and Themelis, 2009).

Some scepticism and also criticisms have been expressed in relation to the effects of PA-based interventions with OYO. This includes a questioning as to whether PA interventions have a) reduced reoffending (Luthar, Sawyer and Brown, 2006), and b) benefited OYO’s wider development (Sandford et al., 2006). PA-based interventions have been criticised on account that they may, by bringing ‘at risk’ young people together, reinforce characteristics that are congruent with offending behaviour (Jacob and Lefgren, 2003). It has been further suggested that interventions involving any element of competition may lead to some young people experiencing a decrease in self-esteem, self-confidence and locus of control (Gardner et al. (2009). These effects may be greater for girls, especially those with low fitness or skill levels (Andrews and Andrews, 2003; NACRO, 2008).

Adventure and wilderness therapy

There is a substantial history to the use of adventure therapy (AT) and wilderness therapy (WT), and with a range of young people. Ernest Balch’s Camp Chocura, for example, was established in the late 1800s to address a ‘poor work ethic’ among boys from ‘privileged’ backgrounds (Gass, Gass & Russell, 2012). The UK and US Scouting movements were set up at the turn of the 20th Century, and the first ‘therapeutic’ initiatives, such as Camp Ramapo (1922), offered therapy to ‘emotionally challenged young people (Gass et al). AT and WT are now practised in a number of countries, with a variety of service users and goals, and they incorporate a range of activities (Association for Experiential Education, 2014; Australian Association for Bush Adventure Therapy, 2013; Fletcher & Hinkle, 2002; Outdoor Education Australia, 2013; Wilderness Education Association, 2015).

AT involves, at its heart, outdoor activities, such as rock climbing and high rope challenges, alongside experiential leaning and counselling (Gass et al., 2012). WT consists of the same multidimensional approach but is undertaken in a wilderness setting and usually for extended periods of time (Harper, Russell, Cooley & Cupples, 2007; Russell & Hendee, 2000). The outdoor activities incorporated in AT and WT are designed to be physically and psychologically demanding, and they include an element of risk (Richards, 2003). Individuals faced with the challenges of AT and WT are encouraged to develop a sense of mutual support, trust and accountability with staff and peers (Fletcher & Hinkle, 2002). Staff use these interactions and relationships to encourage individuals to reflect upon their feelings, thoughts and behaviour, take responsibility for them, and ultimately undergo psychosocial change (Gass et al., 2012).

AT/WT are associated with a number of positive outcomes, including improvements in self-concept, personal growth, self-actualization, personal efficacy, self-confidence and well-being (Ewert, 1989; Fletcher & Hinkle, 2002), internalised locus of control, interpersonal development and social skills (Hattie, Marsh, Neill & Richards, 1997). AT/WT have been used successfully with young
people from a wide range of service user groups, such as those with challenging behaviour, substance misuse issues and mental health difficulties. It is partly as a result of this efficacious and diverse application of AT and WT, that these interventions have been recommended for vulnerable and troubled young people in general, including YPHSB (Norton, 2010; Scott & Duerson, 2010).

**Characteristics of YPHSB and OYO**

It is important to establish whether YPHSB are similar to OYO, in terms of their psychosocial characteristics, as this would help determine whether PA-based interventions that appear to be effective with the latter might work with the former. The contention that YPHSB and OYO have similar psychosocial characteristics has been questioned (Calder, 2007; Hutton and Whyte, 2008). Sheerin (2004), for example, pointed out that there were high rates of psychiatric disorder among YPHSB but not among OYO. O’Halloran et al. (2002) found that YPHSB, in terms of their psychological profiles, more closely resembled their ‘normal control group’ (no behavioural, interpersonal or psychological problems) than the ‘clinical control group’ (behavioural difficulties but no sexual offending).

Considerable overlap in the psychosocial characteristics of these two groups has been reported including: low self-esteem, poor academic achievement and dysfunctional home lives (Hackett, 2007; NSPCC, 2008); internalising (depression and affective disorders) and externalising symptoms (behaviour problems) (Van Wijk et al., 2007); and high rates of psychiatric disorder (Garland et al., 2001; Teplin et al., 2002).

Other authors have put forward a more nuanced perspective, claiming that there are distinct subgroups within the YPHSB population, only some of whom are similar to OYO (Hackett, 2007; Worling, 2001). Pullman and Seto (2012), for example, state that although the majority of YPHSB are ‘generalist’ (i.e. similar to OYO in terms of their ‘risk and etiological factors’), some are ‘specialist’. Worling (2001) contends that one-half of all YPHSB fit into an ‘antisocial/impulsive’ typology, which indicates an overall tendency for rule breaking, akin to OYO.

Additionally, Hackett (2007) believes that overall YPHSB and OYO are more similar than dissimilar and therefore should receive the same interventions:

If young people with sexually abusive behaviours are not fundamentally different from other young people in trouble and with problems, this means, that we could, and indeed should, be able to take from what we know constitutes ‘good practice’ from work with other groups of children and young people and apply them to this population too (p.13).

There appears to be support for the view that interventions used with OYO can be used with YPHSB (Erooga & Masson, 2006). However, a number of authors, whilst accepting that these interventions may work for many YPHSB, assert that some will need other forms of treatment (Pullman and Seto, 2012; Quinsey, Skilling, Seto & Lalumiere, 2010).

There are some strengths in the above studies in general. They tended to: be based upon large samples; cover a range of ages; and utilised standardised measures. There are also, though, numerous weaknesses in this body of work. Most of the studies are: based upon males only; are restricted to adolescents; were carried out in the US; and drew their samples from quite different sources, such as incarcerated youth and young people in state care. It is not clear, therefore, as to how similar – or different – YPHSB and OYO are to one another in terms of their psychosocial characteristics.

**Evaluations of AT and WT-based treatment programmes**

There is limited research on the impact of AT and WT-based interventions with YPHSB (Grüring, 2007). Both Kjol and Weber (1990), and Tidmarsh and Kilby (2003), made claims as to the efficacy of AT in regards to the psychosocial adjustment of YPHSB, but both provide only anecdotal evidence to support their arguments. Kjol and Weber (1990) described the work of *Treetop Adventure* – a five-day camp, combining adventurous activities, such as high rope activities, with counselling. A fundamental aspect of the intervention was the use of exhilarating activities, which were said to
produce endorphin and adrenaline ‘rushes’. Kjol and Weber (1990) suggested that what was critical in the intervention was not engagement in the high risk activity itself but the interaction that this facilitated between YPHSB and staff. The young people were, through this interaction, able to develop an understanding of their emotions, first in relation to the activities and then in respect of their lives more generally. Kjol and Weber (1990) claimed that this enabled the young people to address their self-doubt and anger, develop greater trust in people, disclose undetected harmful sexual behaviours, and gain greater control over their lives.

AT has also been explored within the context of the Male Adolescent Programme for Positive Sexuality (MAPPS) (Tidmarsh and Kilby, 2003). The MAPPS intervention comprised three distinct stages: the basic group, the transition programme and the advanced group. The key elements of MAPPS included separating YPHSB from their usual environment; engaging them in adventure activities; and exposing them to a ‘pro-social culture’, in which they developed mutually positive and helpful relationships with other young people and staff. This latter element was felt to be especially important in helping the young people build trust, express their emotions and address their anxieties. Tidmarsh and Kilby (2003) contend that as the young people progressed through MAPPS, they were able to understand, take responsibility for, and avoid repetition of, their previous SHB. There are, though, major problems with the two above works. They were both based on small and unrepresentative samples, and the programmes comprised several aspects, which makes it difficult to determine which element was having what effect, if any. The evaluations also did not use any outcomes measures, so there is no reliable evidence to support the claims of the authors.

Evidence-based Studies

**Referral, acceptance and allocation**

A search of the literature identified five AT/WT programmes for YPHSB that have been subject to systematic evaluation (see Table 1). YPHSB ‘arrived’ in these programmes through a variety of routes. YPHSB in the Gillis and Gass (2010) study were identified through the records of the Juvenile Justice Department. Self-referrals were accepted in the programme evaluated by Lambie et al (2000) but these were limited in number. The referred and self-referred young people in the studies by Simpson and Gillis (1998), and Lambie et al (2000), were further divided to determine their readiness for the programmes and for the purposes of allocating participants to different streams within a programme.

**Additional therapeutic provision**

Arrangements for the provision of therapy, additional to the AT and WT, varied between the different interventions. Individual, group or family therapy was offered in all programmes with the exception of Gillis and Gass (2010). Multi-group family therapy was provided only in Lambie et al.’s (2000) programme, and a range of other therapies were delivered across all the programmes, including CBT, art therapy and psychodrama. Parent/carer participation was an integral part of the treatment process in all programmes, except Gillis and Gass (2010), and was used in the pre- or post-assessment of YPHSB or in therapeutic sessions.

**Programme duration**

There were differences in the length of time young people spent in AT or WT, and in the programme overall. Some participants spent only four to six days in the AT/WT environment (Somervell and Lambie, 2000), while others spent one week per month in AT/WT (Simpson and Gillis, 1998). Young people could spend up to 26 days in one wilderness-based programme (Grüring, 2007). The duration of the programmes overall ranged from 9 months to two years.

See Table 1 on next page.
Table 1
Characteristics of evaluated programmes utilising AT or WT with YPHSB

<table>
<thead>
<tr>
<th>Study</th>
<th>Therapy</th>
<th>Programme</th>
<th>Referral method</th>
<th>Type of experience (solo/group)</th>
<th>Community based or residential</th>
<th>Parental involvement</th>
<th>Programme length</th>
</tr>
</thead>
<tbody>
<tr>
<td>Simpson and Gillis (1998)</td>
<td>Family therapy techniques; Individual and group counselling; Art Therapy; Adventure Therapy: -One week camping per month</td>
<td>LEGACY Programme USA: 4 levels to the programme: Level 1 – The Foundation Level 2 – Treatment Level 3 – Academics Level 4 – Transition</td>
<td>Court Service Worker</td>
<td>Group</td>
<td>Residential</td>
<td>NO</td>
<td>10 months plus 8 month aftercare programme</td>
</tr>
<tr>
<td>Lambie et al (2000)</td>
<td>Group, Family and Individual Therapy; Multi-family Group Sessions; Psychodrama; Outdoor Wilderness Group Therapy: - 2 x 6 days and 1 x 4 days</td>
<td>SAFE Adolescent Programme New Zealand: Multi-faceted treatment approach with 6 levels, 3 streams: A Standard Programme (medium risk); Adolescents with special needs; A high risk group.</td>
<td>Referred via Child Protection Services and 3 self-referrals</td>
<td>Group</td>
<td>Community</td>
<td>YES</td>
<td>1-2 years (Average 18 months) plus 18 month follow up including individual, family and group therapy.</td>
</tr>
<tr>
<td>Grüring (2007)</td>
<td>Individual, group and family therapy; CBT; psychodrama; art, animal, horticultural therapies. Wilderness and adventure therapies: 1st setting – adjunctive adventure therapy and yearly camping trips 2nd setting – integrated adventure therapy and wilderness expeditions (9-26 days duration)</td>
<td>USA</td>
<td>Selection of participants at the 2 settings based on accessibility to the researcher</td>
<td>Group and Solo experiences. Solo included backpacking, skiing, mountaineering and rock climbing.</td>
<td>Residential – 2 settings</td>
<td>NO</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Somervell &amp; Lambie (2009)</td>
<td>Individual, group and family therapy; 2-5 camps of 4 – 6 days duration</td>
<td>SAFE Adolescent Programme: New Zealand</td>
<td>Referral via Department of Social Welfare and FGC (n=6), district court (n=1)</td>
<td>Group</td>
<td>Community</td>
<td>NO</td>
<td>12-24 months</td>
</tr>
<tr>
<td>Gillis and Gass (2010)</td>
<td>Behaviour Management through Adventure approach (BMtA)</td>
<td>LEGACY Adventure-based behaviour management programme: USA</td>
<td>Archival data provided by Department of Juvenile Justice. Committed via juvenile courts</td>
<td>Not applicable</td>
<td>Retrospective study of 3 different types of settings: 1 – LEGACY (Residential) 2 – Youth Development Centre (Residential) 3 – Other specialised programme (Hospital or residential)</td>
<td>NO</td>
<td>Youth followed for 3 years after leaving each programme. LEGACY programme 12 months Data considered at 1, 2 and 3 years</td>
</tr>
</tbody>
</table>
**Other programme features**

Participants had solo experiences of AT/WT in one of the interventions (Grüring, 2007). Three of the five programmes evaluated were community-based and two were residential (Gillis and Gass, 2010; Grüring, 2007). Post-treatment support was offered in only one programme (Simpson and Gillis, 1998). This support consisted of weekly contact, and monthly on-site and placement visits.

**Evaluation Format**

**Research design**

There were similarities but also notable differences in the methods used to evaluate the programmes. The evaluations incorporated either one discrete research design or elements of different research designs (see Table 2). These included matched group design (Gillis and Gass, 2010), embedded case study (Grüring, 2007) and programme evaluation (Simpson and Gillis, 1998). All but one of the five evaluations employed a longitudinal design, following up participants over varying periods of time post-treatment ranging from 8 months to 3 years.

**Sample size**

Sample sizes were typically quite small, ranging in four of the studies from 5-24 young people. Only one study used an appreciably sized sample (n=285) (Gillis and Gass, 2010). The YPHSB in the five programmes ranged in age from 13-19 years, except in one study where they were aged 8-18 years (Gillis and Gass, 2010). All of the young people were male. The extent and quality of other socio-demographic data collected on the samples were variable and control groups were not used in any of the studies.

**Methods**

A range of methods were used in the evaluations. Standardised questionnaires were completed by young people in two studies. Participants in the Lambie et al., (2000) evaluation completed the *Rosenberg Self-Esteem Scale* (Rosenberg, 1965); and the *Sexual Response Questionnaire* (SRQ), developed by the New Zealand Family Planning Association, to assess young people’s sex education levels and sexual attitudes (Lambie et al, 2000). Young people in the Simpson and Gillis (1998) study completed the *Minnesota Multi-Phasic Personality Inventory – Adolescents* (MMPI-A) (Butcher et al, 1992), and the *Tennessee Self-concept Scale* (Fitts, 1965).

Interviews were carried out in four of the evaluations but at different stages of the programme. Simpson and Gillis (1998), and Lambie et al (2000), employed pre-treatment interviews. These interviews were used not only for research purposes but also to determine the most appropriate form of treatment for the young people based upon any risk they might pose to themselves or other young people on the programme.

Interviews with participants were also used during the intervention phase, to examine progress during treatment, and post-treatment interviews were employed to assess a range of outcomes, including participants’ self-esteem, relationships and recidivism (Lambie et al., 2000; Somervell and Lambie, 2009). Grüring (2007) conducted single and group interviews with the young people. Interviews were also undertaken with therapists (Somervell and Lambie, 2009), and in another study interviews with YPHSB were undertaken at different stages of the programme (4, 8 and 12 months) (Lambie et al, 2000).

See Table 2 on next page.
Table 2
Methods used in evaluations of interventions with YPHSB

<table>
<thead>
<tr>
<th>Study</th>
<th>Design</th>
<th>Sample size</th>
<th>Data Collection</th>
<th>Informants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gillis and Gass (2010)</td>
<td>Matched group design</td>
<td>95 males from each placement setting (range 8-18 years) White (n=62), African American (n=33) in each</td>
<td>Re-arrest rates from archival dataset</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Somervell and Lambie (2009)</td>
<td>Qualitative study</td>
<td>7 males (Mean age 16 years) (Range 13-18 years) Ethnicities include European, Maori, Tongan, Niuean and Indian.</td>
<td>Participant observation (4 day camp); semi-structured interviews (young people and therapists)</td>
<td>Young people and therapists</td>
</tr>
<tr>
<td>Grüring (2007)</td>
<td>Embedded case study</td>
<td>5 males (Range 15-17 years)</td>
<td>Single and group interviews; direct (field/participant) observation (total of 7 weeks camping); case files and therapy notes; psychological evaluations, police and court reports; client diaries</td>
<td>Young people</td>
</tr>
<tr>
<td>Lambie et al (2000)</td>
<td>Follow-up study</td>
<td>14 males (Mean age 16 years) (Range 13-19); 12 parents (8 mothers only, 2 fathers only, 2 both parents) plus 1 school housemaster.</td>
<td>Sexual Response Questionnaire (SQR) Rosenberg Self-esteem Scale Interviews (using a questionnaire)- Parent and Young person)</td>
<td>Young People Parents Child Protection Services computer records on reoffending (average 2 years post treatment)</td>
</tr>
<tr>
<td>Simpson and Gillis (1998)</td>
<td>Programme evaluation</td>
<td>24 males (Mean age 14.4 years) (Range not noted) 27.5% African American; 62.5% White</td>
<td>Minnesota Multi-Phasic Personality Inventory – Adolescents (MMPI-A) Tennessee Self-concept Scale (TSCS) at 0 months, 4 months, 8 months, 12 months.</td>
<td>Young People</td>
</tr>
</tbody>
</table>

Police, court and child protection service records were searched in three of the evaluations to determine whether young people had been arrested for, or convicted of, a sexual offence post-intervention (Gillis and Gass, 2010; Grüring, 2007; Lambie et al., 2000). Searches were also undertaken within case files, therapy notes and client diaries to provide additional information on
young people’s attitudes towards their HSB along with the impact these interventions may have had upon them (Grüring, 2007).

Somervell and Lambie (2009) used participant observation to learn about the SAFE program and to build rapport with participants, and Grüring (2007) employed this method to assess the role of AT in the wider treatment programme.

The young people’s post-treatment involvement with agencies, regarding any suspected offending, was an outcome measure in three studies (Gillis and Gass, 2010; Lambie et al., 2000; Simpson and Gillis, 1998). The young people’s broader psychosocial adjustment was assessed, either during treatment and/or after treatment, in four studies (Grüring, 2007; Lambie et al., 2000; Simpson and Gillis, 1998; Somervell and Lambie, 2009).

Outcomes for YPHSB

There were indications in three of the evaluations that interventions including AT/WT were associated with reduced sexual recidivism by YPHSB. The arrest rate for sexual offences, three years’ post-intervention, for young people who took part in AT (19%) was considerably lower than that of their counterparts who had been enrolled in ‘Youth Development Centres’ (35%) or ‘Other Specialised Programmes’ (33%) (Gillis and Gass, 2010). None of the participants in the evaluation by Lambie et al (2000) and Simpson and Gillis (1998) were known to have reoffended two years’ post-treatment.

Some of the young people exhibited improvements in other offence-related behaviours and attitudes post-intervention. This included accepting greater responsibility for their offending and behaviour more generally (Lambie et al., 2000); and disclosing previously undetected offences (Somervell and Lambie, 2009). Lambie et al (2000) reported that twelve of the fourteen young people in their evaluation could recall ways to keep themselves safe from reoffending and all fourteen had a good understanding of sexuality issues upon completion of the programme.

There were reports in a number of the evaluations indicating that many young people felt more positive in terms of various aspects of their psychological adjustment. This included greater connection with ‘emotions and sentiments’, ‘freedom of expression’, sense of belonging and personal responsibility (Grüring, 2007); enhanced self-view (increased self-confidence and self-efficacy) (Somervell and Lambie, 2009); and improved self-esteem and self-satisfaction (Lambie et al., 2000).

There were reports in some of the evaluations of improvements in the way in which young people related to others. The large majority of participants in the Lambie et al (2000) evaluation exhibited greater victim empathy. Somervell and Lambie (2009) found that young people were better able to form trusting and close relationships, and to work in teams. Parents in the evaluation conducted by Lambie et al (2000) reported improved relationships with their sons.

There was a suggestion in one evaluation that the intervention may have had some negative consequences. Simpson and Gillis (1998) reported that young people’s scores in anger, resentment and ‘projection’ increased, whilst their self-esteem decreased.

Limitations in the evidence-based studies

There was tentative evidence from these evaluations that treatment interventions that include AT/WT have a number of positive outcomes for YPHSB. These outcomes include reduced sexual recidivism rates, and improvements in wider psychosocial adjustment in respect of self-esteem and social relationships.

Caution should be exercised, though, in interpreting the results of these evaluations. Importantly, the most recent study was published eight years ago and the oldest 20 years ago, and only three of the five studies had been published in peer-reviewed journals. These two factors alone cast doubt on the rigor of at least two of the studies. The number of evaluations carried out (n=5) is small and all participants in the five studies were male so it may not be possible to generalise the findings to females with HSB. This is of particular importance as the NSPCC (2017, p. 2) recently stated that society ‘lacks understanding that girls can behave in a sexually harmful way’.

There are a number of additional methodological limitations with the evaluations. The studies used quite small samples, which means, even in
qualitative studies, difficulty in extrapolating from the findings and a greater risk of type 2 errors (Faber and Fonseca, 2014). The use of non-validated research instruments is of particular concern due the lack of evidence regarding the reliability and validity of the chosen instruments. Finally, there was a reliance on self-reporting in several of the studies. Even though this is a common approach for gathering data, the method has been criticised because of the bias that can occur. Althubaiti (2016 p. 212) stated that 'Bias can arise from social desirability, recall period, sampling approach, or selective recall' when relying on self-reported data. He adds that an over-reliance on self-reported data can lead to unreliable findings.

There was little attempt in any of the evaluations to examine the impact of AT/WT specifically upon the young people. In addition, none of the three studies that found reductions in recidivism clarified whether the additional components of the treatment process had accounted for the reductions (Gillis and Gass, 2010; Lambie et al, 2000; Simpson and Gillis, 1998). Grüring (2007), Lambie et al. (2000), and Somervell and Lambie (2009) suggest that AT/WT might have benefited this process with AT/WT enhancing engagement in the treatment process. Grüring (2007) also reported that young people’s engagement helped inform clinical assessments.

Conclusions

Although these evaluations do not represent a very extensive body of work, they do suggest that PA may be able to make a contribution towards treating YPHSB. Both Grüring (2007), and Somervell and Lambie (2009), argue that the adventure and wilderness elements of the programmes enhanced the engagement of YPHSB in the treatment process. Grüring speculated that this enhanced engagement was due to meeting ‘the young person on his own turf i.e. the world of action, wildness, thrill, risk……and uncertainty’ (p.109).

Positive psychosocial changes were reported in all studies that measured these outcomes (Grüring, 2007; Lambie et al, 2000; Simpson and Gillis, 1998; Somervell and Lambie, 2009). These changes included improvements in victim empathy, self-concept, self-esteem and social relationships. Enhanced social relationships may have come about as a result of the young people engaging in trust building and teamwork activities. All of these research teams reported that the YPHSB believed they were less likely to reoffend sexually owing to the prevention strategies they had been taught on the programmes. Evidence as to the specific contribution that PA made to these outcomes was not provided in any of the studies.

Although there is provisional evidence as to the efficacy of PA with YPHSB, Somervell and Lambie (2009) acknowledge that there may be practical constraints surrounding these interventions. These constraints consist of the high staffing and other resource costs involved in AT/WT-based programmes. Russell and Phillips-Miller (2002) argue that the main constituents of AT/WT could be ‘mimicked in outpatient or residential settings’ (p. 434) by using low cost, more traditional physical activities.

In summary, there are indications that PA may be a useful intervention with YPHSB, but there are many problems with the evidence base. There is clearly a need for more evaluations of treatment programmes with YPHSB that include PA at the heart of the intervention. Future evaluations need to avoid the limitations that have characterised much of the work to date.

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