Girls 101: Psychosocial and Clinical Characteristics of Girls (10-17 years) with Harmful Sexual Behaviours in New Zealand

A dissertation presented in partial fulfillment of the requirements for the degree of

Bachelor of Health Science (Honours)

in

Psychology

at Massey University, Albany,

New Zealand.

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2011

Abstract

There is a growing body of international literature about adolescent girls with harmful sexual behaviours (HSB) that identifies a number of contextual and experiential pre-disposing factors, including high rates of maltreatment – particularly experiences of sexual and physical violence - and family system and mental health issues. A clear shortcoming is that we still know relatively little about the clinical characteristics of adolescent girls in New Zealand with HSB, and the applicability of gender-responsive clinical approaches emanating from international treatment interventions.

This research aims to understand the New Zealand 'landscape fit' with the psychosocial and clinical characteristics of this population identified in international studies, and the subsequent call for gender-responsive treatment pathways. The descriptive statistics are intended to provide the New Zealand sexual abuse treatment sector with relevant information for treatment planning and the development of gender-responsive services in New Zealand.

Established in the early 1990s, SAFE Network Inc. in Auckland, WellStop in Wellington, and STOP in Christchurch act together as the three key community-based treatment programmes in New Zealand providing services for youth with HSB. To begin to understand the specificity of girls in NZ (10-17 yrs.) with HSB this study considers a national sample of clinical files (*n*=44) for those girls that were assessed for their suitability for treatment in one of these programmes over a 20-year period.

Mirroring the findings of international research, the majority of girls with HSB seen in NZ community-based sex-offender treatment programmes experienced high levels of maltreatment, displacement from families, mental health issues and exposure to multiple family stressors - in particular domestic violence. The key differences in offending patterns, clinical characteristics, and histories of multiple abuse are evidence of systemic differences between boys and girls that support a gender-responsive approach within clinical pathways.

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Acknowledgements

Firstly, I would acknowledge the members of the New Zealand Vodafone Foundation who awarded me the Vodafone 'World of Difference' grant in 2010. The opportunity they provided made it possible to conduct this research to further understand girls with harmful sexual behaviours.

For their availability, support, and guidance during the course of this research project, I would like to thank my supervisor Dr Leigh Coombes, Kathryn McPhillips of the Auckland Sexual Abuse HELP Foundation, and Marlyn Robson.

Finally, I would like also to thank the staff at WellStop, SAFE Network Inc. and STOP for their availability, generosity, and support during the course of this project. I would particularly like to thank Gabrielle Whitehead and Martin Putt of SAFE Network Inc. in Auckland, Lesley Ayland and Lyn White of WellStop in Wellington, and Don Mortensen and Maureen Lorimer of STOP in Christchurch.

To Phil Weedon and my family for their support – thank you.

Specialist Treatment Providers in New Zealand for Adolescent Girls with HSB

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Chapter One: Introduction

Adolescent Girls with HSB in New Zealand

Research suggests that one in 3 to 4 girls and one in 6 to 8 boys in New Zealand (NZ) have experienced sexual abuse by the age of 16 (Fanslow, Robinson, Crengle & Perese, 2007; Fergusson, Horwood & Woodward, 2000). Although the effects of such experiences vary between individuals, research continues to establish generalised adverse consequences for individuals.

Working to prevent the sexual abuse of children across NZ, SAFE Network Inc. in Auckland, STOP in Christchurch, and WellStop in Wellington act as a 'National Sector' of specialist community-based treatment providers for sexually abusive behaviour. Since the early 1990s they have been providing services to adolescent boys and men, and on a much more sporadic basis, they have also provided treatment for adolescent girls.

Over the last 20 years, and particularly since the 2005 law change that recognised sexual offences by women and girls (Chisholm, 2011), non-government (e.g. survivor agencies and private practitioners) and government agencies (e.g. Child, Youth and Family, Special Education Services, Mental Health Services and the New Zealand Police) have begun to acknowledge that women and girls also carry out a very small, but not inconsequential amount of child sexual abuse (CSA).

Lambie and Seymour (2006) provide guiding principles for the treatment of adolescent harmful sexual behaviour (HSB) in New Zealand, and recognise that adolescent girls with HSB are a 'special population' with systemically based treatment needs that are unable to be catered for effectively within the current configuration of multimodal mainstream services for adolescent boys. Furthermore, another New Zealand study (Geary, 2007) identified that no specialised treatment programme for girls existed in the 'National Sector'.

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Between 1993 and January 2011, the largest of the three treatment providers, SAFE Network Inc., received 29 referrals for adolescent girls with HSB (Weedon, 2011a). In recognition of the need to develop specialised services for girls with HSB in NZ, SAFE Network Inc., successfully sought funding from the New Zealand Vodafone Foundation in 2010 to develop and establish the Sapphire Programme, a gender-specific intervention pathway for girls (11-17 years) with HSB. This progression of developments has created space to conduct research on girls in New Zealand with HSB.

Sexual Abuse Terms

Although variably the context of sexual abuse has been established, the term sexual abuse itself is informed by a number of definitions (Pereda, Guilera, Forns & Gomez-Benito, 2009). The following explanation of terms has been provided to contextualise language relevant to the practice of working with adolescent girls with HSB.

At a basic level, the term 'Sexual Abuse' describes sexual behaviour that is exploitative and/or lacks mutual consent (Weedon & Barriball, 2010). For those in NZ who provide treatment to perpetrators of sexual abuse, sexually abusive behaviour is often conceptualised either as a 'hands on' sexual offence (involving physical contact such as unwanted kissing, touching genitals, digital penetration and rape), or a 'hands off' sexual offence (no physical contact but involves exposure to a sex act) (Ryan, 1991). Promiscuity is *not* sexually abusive behaviour.

The language used to describe sexually abusive behaviour also shifts across contexts. 'Sexual Offending' is a legal term used in the criminal arena to describe sexually abusive behaviour. The use of this term alone does not capture all sexually abusive behaviours, for example, grooming (Weedon & Barriball, 2010). In more recent times, the term 'Harmful Sexual Behaviour' has been adopted to describe sexually abusive behaviour perpetrated by youth, as one strategy to shift the stigma associated with the term 'sex offender'. The term 'Sexual Violence' is referred to in services to make sense of the experiences of survivors of sexual abuse.

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This shift in language creates a paradox for adolescent boys and girls with HSB, where they are perpetrators of sexual abuse, and also hold the identity of survivors of sexual violence. The differences in meaning between the behaviours of sexual harming and the experiences of surviving sexual violence are often blurred.

The term 'Female Sex Offender' is a frequently used term that collectively describes both women and adolescent girls with HSB. The term is problematic as it ignores the significant developmental and offence specific differences between adolescent girls and women. The lack of recognition of the differences between women and adolescent girls is not a practice taken up to describe adolescent boys and men with HSB where these differences are acknowledged. While it is likely to be a result of the combination of small sample numbers and the need to have generalisable findings in the field, it loses any meaning for treatment.

To understand the relevance of a gender analysis for girls with HSB, two more distinctions require conceptualising here. Firstly, I use the terms 'boy and girl' refer to differences between experiences based on gender socialisation, and secondly, use the terms 'male and female' refer to biological differences.

These types of distinctions are in not intended to reduce or minimise the impact of sexual abuse perpetated by girls, rather they are required to shed some light on the importance of considering the gendered lived experience of girls and their gender-specific pathways to offending (Bloom & Covington, 2001). To ignore such salient issues could prevent gaining a full picture of the dynamics that are unique to girls' lives based on the interplay of female biology, gender socialisation and adverse experiences.

The Current Study

This research project seeks to understand the unique population of girls (10-17 years) with HSB in New Zealand, to inform and assist professionals in understanding their particular treatment needs, and to gauge the applicability of internationally recognised

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responsive approaches based on a feminist perspective (Hubbard & Matthews, 2008) when working with girls in New Zealand.

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Chapter Two: Literature Review

The Literature in this Review

The literature available at the time of writing on adolescent girls with HSB consists of a very small number of book chapters, treatment resources, and studies.

Delimitations

To gauge an accurate a picture as possible of the population under study, research that focused primarily on adolescent boys with HSB, girls under the age of 10 with problem sexual behaviours, or contrasted girls with adult women who have sexually abused children have been excluded from this literature review. To include such studies would distort an already limited picture when clear developmental differences exist between women, girls under 10 and adolescent boys (for example, dependency on families). Furthermore, Bloom and Covington (2001) extend the concept of adolescent developmental differences for girls to include the influence of their lived gender experiences and the influence of gender-specific sociocultural scripts.

Research, Book Chapters and Resources on Girls with HSB

A comprehensive search for research focusing on adolescent girls with HSB identified 30 studies conducted in the period from 1988 to 2010.

The book chapters and resources have been written by a combination of practitioners and academics in the field, and largely depend on their clinical experience, combined with a synthesis of relevant research (Blues, Moffat, & Telford, 2006; Bumby & Bumby, 2004; Ford, 2006; Hunter, Becker & Lexier, 2006; and Weedon 2011a; 2011b). Drawing on a feminist epistemology to make sense of the research and practice in the field, two key practitioners, Counseling Psychologist Lisa Frey (2006; 2010) and Clinical Social Worker Susan Robinson (2002; 2005; 2006; 2009) provide extensive accounts of the gendered specificity of the experiences of girls who have sexually harmed.

When combined, this knowledge base acts as a platform for understanding the experiences of girls with HSB. As a new and emerging field, it is not possible to infer a

complete picture of the experiences of girls. However, this material clearly provides valuable insights into research findings, repeat themes and clinical observations.

Literature Review Structure

The first part of this literature review considers information on the incidence and prevalence rates of adolescent girls with HSB, and contextualises these findings within the wider realm of girls youth offending and gender-responsive approaches in clinical interventions. The second part of this literature review contains an integrative commentary on the available research on girls with HSB. Further information regarding the studies on girls with HSB (including information on the origin, sample, the focus and key findings, and maltreatment, psychosocial histories, and HSB characteristics) is located within the appendices (see appendix A, B, C and D). The intention of providing a literature review in this way is to provide both a broad view, and an understanding of the more specific nuances that result from such a small body of literature when understanding adolescent girls with HSB.

Incidence and Prevalence Rates

International researchers estimate that adolescent boys are responsible for approximately 20% of child sexual abuse offences (Centre for Sex Offender Management, 1999; Davis & Leitenberg, 1987; Ford & Linney, 1995). While the number of studies on adolescent girls with HSB has slowly begun to increase, the full extent and nature of their HSB is yet to be established. Available international statistics on adolescent girls' HSB are rare and largely based upon data from residential treatment programmes, a small number of research studies, and statistics collected from police and social service records. From this data, it is estimated that between 2% and 11% of adolescent HSB towards children is carried out by adolescent girls (Matsuda, Rasmussen, & Dibble, 1989; Righthand & Welch, 2004; Roe-Sepowitz & Krysik, 2008; Vandiver, 2010).

New Zealand statistics mirror this low but significant estimate. The largest national study on adolescent HSB identified 13 girls in a community sample of 702 children and

adolescents referred to specialist treatment providers in NZ (Lambie, Geary, Fortune, Willingale & Brown, 2006). New Zealand police statistics suggest that adolescents carry out 15% of the HSB in New Zealand (Statistics New Zealand, 2005). During the 2000 to 2010 period, the New Zealand Police documented 179 (5%) female apprehensions[1] and 3420 (95%) male apprehensions in the 10-16 year old age group for HSB. During the same period apprehensions for girls in the 17-20 year old age group was recorded as 50 (1.4%) and for boys 3500 (98.6%) (Statistics New Zealand, 2010).

Based on these figures, the large gender disparity in offending apprehensions becomes apparent. What is excluded from these figures are the gender-specific differences in patterns of offending (e.g. number of victims and the nature of the offences) and an analysis of the story behind the disparity (Chesney-Lind & Pasko, 2004).

The Meaning of the Large Gender Disparity in Offence Statistics

Using a 'gender looking glass' (Goldberg Leong & Lang, 2004) to understand the meaning of the gender disparity that exists, offence statistics may assist in further understanding the unique characteristics of girls with HSB. Under-reporting, social meanings about gender, recognising that girls can and do offend, and inconsistent professional responses to disclosures of HSB by girls, are thought to be the main reasons for less reported offences by girls (Frey, 2010). This raises questions about the meaning of these gendered disparities.

Frey's (2010) understanding of the gendered differences in offence statistics is based upon a view that girls are being processed differently than boys in the justice system, possibly due to inconsistent professional responses to disclosures of HSB, based on social meanings of gender. Gender bias is dependent on discourses of role expectations, heterosexual norms, female sexuality, and sexual scripting that affect girls experiences.

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[1] "An 'apprehension' means that a person has been dealt with by the Police in some manner (e.g. A warning, prosecution, referral to youth justice family group conference etc) to resolve an offence" (Statistics New Zealand, 2010).

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Creating space to acknowledge the gendered pathways influencing statistics is undoubtedly necessary, although there is a danger that a face-level misinterpretation of these complex and relevant gendered histories could exacerbate the over-emphasis on offending perpetrated by girls because they are girls (Bloom & Covington, 2001). Offences by boys, regardless of pathways, are overwhelmingly visible in victimisation studies. Practices that sensationalise girls offending should not, however, overshadow the necessity to identify the gendered pathways HSB by girls.

There has also been research that supports differences in the gendered experiences of trauma. Mathews, Hunter and Vuz (1997) found that that girl's HSB is likely to be the result of significant trauma in the absence of protective and/or 'buffering factors', or other factors that support recovery such as positive female role models.

Studies that continue to find sex differences through the identification of particular features of psychopathology without considering the interrelationship with the lived experience of gender will miss the nuances that may lead to better treatment outcomes (Hubbard & Matthews, 2008). It is the meaning of the gendered difference behind the statistics that Weedon (2011b) argues needs to be the focus of research. She recommends that researchers continue to enquire and understand the underlying issues of gender disparity, rather than looking for overlaps with boys to justify unisex approaches based on commonality, as that is the key site for treatment.

Contextualising Treatment Responses to Girls' HSB

To date, treatment responses to adolescent girls' HSB appear to have taken one of two directions. The first is the unisex approach (Weedon, 2011a) where treatment pathways are based on commonality with boys, and therefore minimise gendered difference. They are not well adapted to accommodate gender-specific variables and within group variability amongst girls. The second is the adoption of gender-responsive approaches, where understanding girls' HSB, from a feminist epistemological viewpoint, enables the lifespan and socialisation issues for girls and the conditions through which they live their lives, to become visible. It may then

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become possible to recognise the specific risk factors for girls' HSB and recognise resiliency and develop gender-responsive rather than 'what works' treatment based on the norms for boys (Hubbard & Matthews, 2008).

There is yet to be any evidence showing the effectiveness of using unisex models for the treatment of girls' HSB, and there are no empirically validated risk assessment instruments for girls with HSB. The Juvenile Sexual Offense Recidivism Risk Assessment Tool (J-SORRAT-II; Eperson, Ralston, Flowers, DeWitt & Gore, 2006), the Juvenile Sex Offender Assessment Protocol (J-SOAP-II; Prentky & Righthand, 2003) and the Estimate of Risk of Adolescent Sexual Offense Recidivism (ERASOR 2.0; Worling & Curwen, 2001) are all clinical instruments developed for the assessment of adolescent boys HSB, and are used variously in New Zealand. Their use with adolescent girls necessarily excludes the effect of gender, and other gender-specific factors for girls' youth offending, such as sexual victimisation, and the sociocultural inequities that are known to exacerbate girls antisocial behaviours generally (Covington & Bloom, 2003).

New Zealand treatment approaches for HSB (including 'culturally sensitive' models) have historically evolved in masculine environments from work with adult men and adolescent boys (Weedon, 2011a; 2011b). For this reason, the generalisability of psychological theories created within such gender-specific contexts, and how the context itself has shaped practice, are epistemological issues that require consideration - as gender itself is complex and multifaceted.

Gender-responsive Approaches

Although there are many similarities between boys and girls, there are also key differences. These differences are located in a combination of biological (e.g. hormonal and genital), developmental and socialisation factors, and gender-based inequities. Clear examples can found in sexual scripting, gender identity development and role stereotypes, and the rapid early sexualisation of girls (American Psychological Association, Task Force on the Sexualisation of Girls, 2010; Robinson, 2006). Gender-responsive approaches (GRA) not only acknowledge these types of differences, they

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also consider the implications of the diverse personal and contextual experiences that shape the identities of each girl and contribute to their offending (Bloom & Covington, 2001; Weedon, 2011a).

Gender-responsive approaches reject the imposition of masculine practices onto girls with HSB, and require a gender-analysis to acknowledge the relevant gender-based issues influencing girls' pathways to youth offending (Bloom & Covington, 2001). It also questions the meaning behind girls' and boys' sexually abusive behaviours, and the implications for clinical practice. Frey (2006; 2010) and Robinson (2002; 2005; 2006; 2009) have written extensively on girls' HSB and also suggest that to account for the unique pathways to HSB by girls, and the identification of distinct risk and protective factors, gender-responsive approaches to treatment are recommended.

GRA use a feminist epistemology to consider the social, sexual scripting, educational, cultural, developmental and psychological components of girls' wellbeing (American Psychological Association, Joint Task Force of American Psychological Association Divisions 17 and 35, 2007; Totten, 2004). From this standpoint, problems, causality, and attributions can become meaningful. For example, negative societal and cultural messages about girls' bodies and worth impacts on identity development, self-image and behaviours (Brown & Gilligan, 1993). What this means for the intervention and treatment of girls is that their experiences have gender-specific consequences and these have implications requiring the integration of strength based, relational and trauma theories (Bloom & Covington, 2001).

The only available gender-responsive model specifically designed for girls' HSB is the Offence-Relational Model (Robinson, 2002). Based on the use of positive female role-modeling, female development, learning styles and issues relevant to girls wellbeing (including physical and psychological safety, and biological specificity), this model addresses girls' HSB by promoting healthy female identity formation, sexual efficacy, relational development and recovery from trauma (Robinson, 2006).

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This research investigates the relevance of the growing body of literature on girls' youth offending and gender-responsive approaches, for girls with HSB in New Zealand.

Previous Studies on Adolescent Girls with HSB

In contrast to studies on adolescent boys with HSB, studies on girls are far more limited and often lack the consistent application of evidence-based criteria to assist in the generalisability of findings (Weedon, 2011a). To understand the characteristics and commonalities of this unique population based on research, it is useful as a starting point, to look very closely at the studies themselves while considering five key issues in relation to the context in which they have arisen.

The first key issue is that nearly all of the studies have been conducted within offender-orientated services, using file reviews and clinical observations. This creates a partial picture, and still little is known about girls who may receive treatment through victim or mental health services. In addition, there are yet to be qualitative studies that have been able to source retrospective narratives directly from the girls themselves addressing their own explanations for 'why they did what they did'. Data is typically collected from client interviews using structured clinical interviews, surveys and measures that focus on offences and individual histories, rather than gathering an individual and uninterrupted narrative for analysis. This can result in using 'researcher hypothesis' based on the available interpretation of data on limited understandings of the characteristics and psychological histories that combine with generalised theories to make inferences about girls' HSB.

The second key issue is that a large proportion of these studies have been conducted in the United States (*n*=17), where repeat use of samples has occurred in order to look at characteristics and treatment implications by way of retrospective file reviews. For example, both Hirschberg and Riskin (1994) and Howely (2003) examined data from the same residential treatment programme. While this is not an unusual practice in

research, it holds relevance for this group as the numbers remain small and specific to treatment. Given the connected pathways between legal systems, social services and treatment providers, the same issue also presents itself in the samples drawn from statutory agencies. What we can infer from these studies is partial.

The third key issue is that the sample sizes across the studies are relatively small, ranging from a single case study (Higgs, Canavan & Meyer, 1992) to 177 (Vandiver, 2010), with an average sample size of 44.64 (*SD* 50.8). A further analysis reveals that the four larger studies included either children or women in their samples (Roe-Sepowitz & Krysik, 2008; Dowdell, Cavanaugh, Burgess & Prentky, 2009; Schwartz, Cavanaugh, Pimental & Prentky, 2006; Sigurdsson, Gudjonsson, Asgeirsdottir, & Sigfusdottir, 2010), and in a separate study (Vandiver, 2010), the sample included those informally handled with a warning without charge. Removing these five studies would reduce the average sample size to 24.34 (*SD* 22.82).

The fourth key issue is that some studies are drawn from quite limited and specific contexts. For example, at least nine of the samples are drawn from residential treatment facilities, nine are drawn from statutory agency records, and six from community outpatient programmes. Treatment programmes cover a broad spectrum of clinical presentations that can complicate a clinical picture with respect to HSB.

The final key issue lies within the data collection; a number of studies have ambiguous processes and clear inconsistencies in the data collected – particularly demographic information. There are also conflicting operational definitions of sexual abuse/offending.

Having considered these issues, the context is set to introduce an integrative commentary of what is known about girls with HSB and the complexities at hand based on research.

Maltreatment Histories

Child Sexual Abuse

Commonality

Based on the reported results, the most common background variable identified across the studies for adolescent girls with HSB is a history of child sexual abuse (CSA). In the twenty-five studies that collected information on CSA, the available prevalence of CSA was between 28-100%, with an average of 77.03% (*SD*=17.75). In these studies, CSA was mostly described as chronic (with an early onset). It was most often incestual, committed by multiple male offenders, and involved either vaginal or anal rape (Bumby & Bumby, 1997; Dowdell, et al., 2009; Evans, Cosgrove, Moth & Hewitson, 2004; Fehrenbach & Monastersky, 1988; Fromouth & Conn, 1997; Hendriks & Bijleveld, 2006; Hickey, McCrory, Farmer & Vizard, 2008; Howley, 2003; Hunter, Lexier, Goodwin, Browne & Dennis, 1993; Kubik, Hecker & Righthand, 2002; Mathews, et al., 1997; Micco-Fonseca, 2000; Tardif, Auclair, Jacob, Carpentier, 2005; Thompson, 2010).

Hickey et al. (2008) compared adolescent boys and girls with HSB. In this study, the most significant difference between genders was the differential rates of CSA they had experienced, and the chronic nature and severity of the experiences for girls. This is supported by findings in earlier comparison studies (for example, Bumby & Bumby, 1997; Kubik, et al., 2002).

While the gendered effects of sexual violence, especially those characterised by vaginal rape and incest are well documented in sexual victimisation research, what is important here is the prevalence and severity of CSA within these studies. Furthermore, both victimisation and trauma histories are linked to girls' youth offending in international studies on girls' criminal activity (Bloom &Covington, 2001).

Offender Gender

Little is known about the effects that the gender of the perpetrator has on girls' HSB. In their study, Mathews, Hunter and Vuz (1997) found that of 67 girls, 50 had a history of CSA; 29 were abused by males, 19 by both males and females, and 2 by females

only. This finding is consistent with research that shows that the majority of sex offences against girls are perpetrated by men (Hickey, et al., 2008; Kubik & Hecker, 2005; Mathews, et al., 1997; Tardif, et al., 2005) and offences by women, alone, remain small. A related study that questioned the effect of sex of offender found that abuse by males (not females) predicted girls' HSB against more victims and greater seriousness of HSB (Thompson, 2010).

Under-reporting

To better understand the link between maltreatment and HSB, Roe-Sepowitz and Krysik (2008) used a non-clinical sample to compare maltreated and non-maltreated girls with HSB (*n*=118). This was the only study to show a significantly lower rate of CSA (28%). Discrepancies in disclosure are an ongoing problem in the field, and this may be present in a non-clinical example. Influential factors include the dynamics of intra-familial abuse that can affect the survivor's ability to disclose CSA, and developmental factors that affect a child's ability to understand and articulate CSA across the lifespan.

Research suggests that girls are more likely to experience intra-familial sexual abuse, and on average take 16 years to disclose (McGregor, 2003). This may be due to the perceived consequences of disclosures by victims on their families with the additional complexities of the nature of the relationship to the offender (Fergusson et al., 1996).

Turner and Turner (1994) explored the CSA dynamics within families, and theorised a causal link between unresolved CSA and HSB for girls and suggested a more detailed link with inter-generational, unresolved abuse (both physical and sexual) occurring to such a degree that it had become a normal family pattern. This pattern adds negative complexities to the mother-daughter relationship and impairs healthy female relational development processes. If this is normalised in culture, for example, where the social media's repetitive display of simulated sexual intercourse can be understood as socially sanctioning, it may contribute to difficulties differentiating between simulation and reality. Mathews et al. (1997) also proposed a link between CSA and

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HSB, and proposed that girls have a higher threshold for the externalisation of their CSA onto others through their HSB, than boys.

It has been repeatedly recognised in the research literature on girls' HSB that effective assessment requires 'shifting the lens' to accommodate gender-based abuse dynamics (particularly the effects of sexual abuse) and their possible influence on the etiology of HSB (Blues et al., 2006; Bumby & Bumby, 2004; Frey, 2010; Ford, 2006; Hunter et al., 2008; Robinson, 2009; Weedon, 2011a). If sexual abuse has been a contributory factor to the trajectory of the HSB, it needs to be better understood. In this study the presence and extent of CSA experiences is explored.

Research on the Sexual Victimisation of Girls

One major gap in the research on girls with HSB is that the studies themselves rarely go beyond naming victimisation, and often only provide limited data on the perpetrator. There is large body of empirically validated research that has found gender-specific differences in the mental and physical effects of CSA on girls.

When compared to boys, the psychological and physiological consequences of CSA on girlhood and into adulthood of CSA include more experiences of major illnesses, education problems, PTSD symptoms, self-mutilation, teen mothering, drug and alcohol problems, and experiencing domestic violence. Of particular relevance for girls are the 'sleeper effects', which on awakening see girls becoming increasingly deviant in their developmental trajectory; hyper-sexuality, risky sexual behaviour, and earlier onset of puberty, maladaptive sexual development, and differential thinking about sex (Trickett, Noll & Putnam, 2011).

To exclude the gendered meaning of this body of knowledge does little to build a sound understanding of relevant clinical and developmental trajectories for girls' HSB. Despite the high number of girls who experience CSA, most girls do not engage in HSB. This research is interested in moving beyond any consideration of the basic concept of the "victim-offender cycle" (Lambie, Seymour, Lee & Adams, 2002, p. 32), to considering the constellation of CSA and other maltreatment factors rather than just

the commonality of CSA itself.

Child Physical Abuse

Child physical abuse (CPA) featured in twenty of the studies on girls with HSB. For the most part, the studies simply identified whether or not CPA had occurred, rather than an analysis of the dynamics and their impact. The occurrence of CPA ranged from 83.6% to 13%, with an average of 59.5% (*SD*=22.89) between the studies (Bumby & Bumby, 1997; Evans, et al., 2004; Fehrenbach & Monastersky, 1988; Hendriks & Bijleveld, 2006; Fortune, 2007; Hickey, et al., 2008; Howley, 2003; Hunter et al, 1993; Kubik & Hecker, 2005; Kubik, et al., 2002; Mathews, Hunter & Vuz, 1997; Roe-Sepowitz & Krysik, 2008; Schwartz et al., 2006; Tardif, et al., 2005; Thompson, 2010).

In one study by Thompson (2010), 65.9% of the girls with HSB (*n*=88) were physically abused as children, and 39 girls had experienced this before the age of five. Dowdell et al., (2009) also found high rates of CPA in their sample of girls with HSB. In this study 83.6% of the sample reported CPA with an average onset of 4.8 years of age.

The research findings on CPA and CSA are problematic because although repeat CPA and/or CSA from an early age is identified, there does not appear to be any acknowledgement of neuropsychological damage or possible gendered effects of physical damage, including vaginal damage from physical injury - particularly when the added complexity of a parent as a perpetrator is present.

Neglect

As found with CPA and CSA, high levels of emotional and physical neglect also featured in 12 of the studies (Bumby & Bumby, 1997; Dowdell, et al., 2009; Fortune, 2007; Hendriks & Bijleveld, 2006; Howley, 2003; Kubik & Hecker, 2005; Kubik, et al., 2002; Taylor, 2003; Thompson, 2010). For example, Hickey et al. (2008) found that 90.9% of their sample experienced emotional neglect and 77.3% physical neglect. A larger study by Schwartz, et al. (2006) found neglect in the histories of 95% of girls with HSB (*n*=154). What this neglect means to the experience of girls has not been discussed in the HSB literature.

Multiple Maltreatment Experiences

Many international researchers have found that maltreatment can affect cognitive, physical, emotional, social and/or independent functioning. This issue is compounded by the complex biological and behavioural changes that occur at the onset of puberty. CSA particularly, has been found to affect a child's ability to develop empathy, to regulate their emotions, and thus influence the development of healthy relationships and healthy coping skills (Cloitre et al., 2005). When maltreatment is present to such a large degree, the current research on neurobiology, maltreatment and complex trauma presentations requires consideration – yet remains for the most part absent in the literature. This research considers the effect complex trauma bring to understanding girls with HSB.

Although the prevalence of maltreatment appears significant in the research literature, the data has been largely based on information from files. Schwartz et al. (2006) for example, used samples drawn directly from social welfare files where neglect is one of the criteria for intervention. In the study by Ray and English (1995) one of the criteria for inclusion was a history of child abuse and neglect, and in the care and protection of the State. It is more likely, however, that the prevalence of maltreatment is underestimated, based on the criteria for inclusion in studies. A large number of the studies used retrospective data from statutory agency files or from treatment facilities where mandatory reporting operates.

Harmful Sexual Behaviours

Across the studies, the data collection of HSB characteristics was varied, inconsistent and in some studies absent. Of the available descriptors, it was not always clear if they were referring to a first offence or an index offence. The following part of the review focuses on HSB characteristics and is based on the available and most prominent findings.

Onset of HSB

A number of studies found that when compared to adolescent boys with HSB,

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adolescent girls begin offending around 1-2 years earlier in the pre-adolescent (10-12 yrs.) and early adolescent (12 – 14 yrs.) age groups (Fehrenbach & Monastersky, 1988; Fromouth & Conn, 1997; Hendriks & Bijleveld, 2006; Hunter, et al., 1993; Ray & English, 1995; Thompson, 2010; Vandiver, 2010; Vandiver & Teske, 2006). This finding resonates with research on the general criminal activity of adolescents that suggests girls tend to begin their offending at younger ages when compared with their male counterparts (Chesney-Lind & Pasko, 2004).

Victim Selection

Most of the studies found that adolescent girls sexually abuse both males and females at similar rates (Hendriks & Bijleveld, 2006; Vandiver & Teske, 2006), however there is some evidence that girls may select younger victims than boys (Vandiver & Teske, 2006).

Although there is a wide range in age across selected victims, nine of the studies reported that girls with HSB tend to select victims under the age of 6 (Fromuth & Conn, 1997; Hickey et al., 2008; Howley, 2003; Hunter, et al., 1993; Mathews, et al., 1997; Ray & English, 1995; Roe-Sepowitz & Krysik 2008; Tardif, et al., 2005). However, three studies found that victim selection by girls with HSB was likely to be peers (Evans, et al., 2004; Ray & English, 1995; Roe-Sepowitz & Krysik, 2008; Vandiver (2010). Such diversity among studies may suggest differences among girls that need to be understood.

It is difficult to make sense of victim selection with those girls who commit their offences as a group. In five of the studies, co-offending featured as a characteristic of the sexually abusive behaviours (Henriks & Bijleveld, 2006; Kubik & Hecker 2006, Roe-Sepowitz & Krysik, 2008; Taylor, 2003). A more detailed contextual analysis of the dynamics between the perpetrators was for the most part absent, apart from one study by Vandiver (2010) who found that 84 girls in a sample of 177 girls with HSB co-offended. The sexually abusive behaviour in this study took place predominantly in a residence, school or college. This study found that when co-offending occurs the dynamics of the offences shift. More specifically, the HSB is often more serious, co-

offenders are usually male, and the victims are usually female. The victim is also likely to be close in age and an acquaintance or known to the offending girls in some way. Moffit, Caspi, Rutter and Silva (2001) have argued that social amplification may be a motivational factor among girls who co-offend in a group context.

At the time of writing this review, there are no large or repetitive findings on girls coming together in groups, and violently and repetitively raping either children or peers. There is also no clear pattern in current research that identifies a 'particular' relationship with victims. Some studies found that victims are more likely to be intra-familial (Hendriks & Bijleveld, 2006; Micco- Fonseca, 2000; Turner & Turner, 1994); some studies found that the victims could be a friend or acquaintance (Kubik, et al., 2002; Kubik & Hecker, 2005). Stepping back, it seemed that victims are more likely to be well known rather than strangers (eg., Bumby & Bumby, 1997; Henriks & Bijleveld, 2006; Hunter et al., 1993; Roe-Sepowitz & Krysik, 2008; Tardif, et al., 2005; Vandiver &Teske, 2006).

Only four studies identified babysitting as a context in which the HSB took place, and the findings are mixed (Bumby & Bumby, 1997; Fehrenbach & Monastersky, 1988; Kubik & Hecker, 2005; Roe-Sepowitz, 2008). Popular belief is that girls access their victims in traditional baby-sitting situations, although it is more likely that access to victims comes in various forms. The studies do not account for the gendered experience of childcare for girls in the home, blurring the definition of 'babysitting', and what is known about access to victims.

Sexually Abusive Behaviours

The range of sexually abusive behaviours girls engage in is similar to that of boys, including; genital touching, digital penetration, forced vaginal and/or anal penetration (Fehrenbach & Monastersky, 1988; Hickey, et al., 2008; Howley, 2003; Hunter, et al., 1993; Knopp & Lackey, 1987; Kubik & Hecker, 2005; Kubik, et al., 2002; Thompson, 2010; Vandiver, 2010). The difference between boys and girls' HSB is measured through girls' differences in patterns and frequency of behaviours. The most commonly occurring HSB for girls across the research is genital touching, followed by

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oral sex (Hickey, et al., 2008; Hunter, et al., 1993; Kubik & Hecker, 2005; Mathews, et al., 1997; Tardif, et al., 2005; Thompson, 2010; Vandiver, 2010).

Relational and Physical Aggression

To understand the dynamics commonly understood to be present in HSB by girls, nine studies were able to collect information on the presence of aggression within sexually abusive behaviours. Aggression, represented by such measures as verbal coercion/threats, physical coercion/threats, physical aggression, force or bribes, was present in between 9% and 40% of offending by girls (eg., Hickey, et al., 2008; Kubik & Hecker 2005; Fromuth & Conn, 1997; Mathews, Hunter & Vuz, 1997; Hunter, et al., 1993). More specifically, Roe-Sepowitz and Krysik (2008) concluded that the earlier the girl's own victimisation history began, the more coercion in their HSB toward others was present. A small number of girls (4.2%) used intimidation/threats, and 11% used physical force/violence in this study. Although there is a lack of definition of 'force' in the study by Vandiver (2010) that focused on co-offending, it was a strong characteristic in the sample. Within these results, the analysis about the degree, duration and shape of the aggressive behaviours surrounding the HSB is absent, as are the gendered dynamics of aggression within co-offending, and the gender differences that may influence the recognition of disclosure of aggression, for example, testosterone levels, physical strength, and the social acceptance of boys' aggression compared with girls (Weedon, 2011a).

Use of Pornography

Compared to boys, the use of pornography associated with HSB is infrequent and rare in the studies on girls with HSB. The only study to specifically address the presence of pornography was in the study by Mathews, Hunter, and Vuz (1997) who were unable to meet the criteria for statistical analysis. However, on face value, they found that 34 of the 67 girls with HSB in their sample used pornography. This is an area that needs to be further explored, as a gender analysis of pornography is likely to show how pornography is meaningful to girls.

Motivations

The motivations for girls' HSB are yet to be fully understood. Varying explanations appear in the research. For example, in the study by Fromuth and Conn (1997), a small number of girls reported sexual attraction to their victims. In the study by Hunter et al. (1993), 80% of the sample fantasised about the HSB, and 60% did so before they acted. Howley (2003) identified anger as an underlying factor for the HSB of some girls. The presence of cognitive distortions such as attributing responsibility for the HSB to victims, and perceiving HSB as consensual rather than coercive were also identified (Kubik & Hecker, 2006; Kubik et al., 2002; Roe-Sepowitz & Krysik, 2008).

Motivations are also thought to be influenced by childhood experiences, cumulative developmental disturbances (Miccio-Fonseca, 2000), compromised sexual identity, conflict associated with maternal identity (Tardif, et al., 2005), and sexual dysregulation (Sigurdsson, 2010). A combination of dysregulated emotions and cognitive distortions stemming from unresolved trauma histories and marked childhood adversity may also be a primary motivation for HSB, rather than sexual motivation, however empirical research has yet to investigate this.

Subgroups

Mathews, et al. (1997) conducted a study as an attempt to generate typologies using interviews and file reviews on girls with HSB. By analysing the offense dynamics, background variables and psychological profiles, typological impressions and some understanding of the possible pathways to HSB produced three distinct groups. The first group experienced less maltreatment and minimal psychosocial problems and their HSB was likely to be motivated by experimentation and sexual curiosity. They were more likely to offend within the context of care giving/babysitting. These girls were described as naive and sexually inexperienced in the research. Viewed as 'sexually reactive', the second group experienced mild levels of maltreatment and relatively normal levels of psychosocial functioning. Understood to be a reflection of their own victimisation experiences, their victims were mostly younger children. The girls in the third group were girls with the most severe maltreatment histories and developmental traumas. Their offences were often extensive, repetitive and the most

severe.

The identification of typologies or 'subgroups' for girls with HSB remains a blueprint rather than a clear, sound and complete representation of girls with HSB. This of course is likely to be the result of research in the field continuing to be in the early stages of understanding the population. This study is interested in further understanding the nuances of girls' pathways to engaging in HSB, and the heterogeneity amongst girls with HSB.

Psychosocial, Contextual, and Developmental Characteristics

Mental Health

Clinically significant presentations are well documented across eighteen studies (see Appendix C). There are high levels of post-traumatic symptoms and other problems, for example post-traumatic stress disorder (PTSD), conduct disorder (CD), attention deficit and hyperactivity disorder (ADHD), mood disorders, substance abuse, high rates of suicide, suicidal ideation, poor self-image, and low self-esteem (eg., Bumby & Bumby, 1997; Henriks & Bijleveld, 2006; Hickey, et al., 2008; Hunter, et al., 1993; Kubik, et al., 2002; Mathews, et al., 1997; Micco-Fonseca, 2000; Tardif, et al., 2005; Turner & Turner, 1994; Thompson, 2010 Roe-Sepowitz & Krysik, 2008). Robinson (2009) stipulates that high rates of co-morbidity, and this particular configuration of mental health issues are not unusual for girls with significant developmental traumas, and these are more extensive than for boys. For this reason, she points to the relevance of gender-specific research on the etiology and prognosis of mental health problems, their co-morbid existence, and the cascade of gender-specific issues they bring to the assessment and treatment for girls with HSB. This degree of clinical significance also sheds some light on the multiple agency involvement (both statutory and community based) demonstrated by the high number of girls in residential programmes for co-morbid emotional and behavioral problems. This study is interested in the presence and co-morbidity of clinically significant mental health issues, and the gender-specific meaning this may have for clinical interventions.

Family Context

A consistent finding in the research with girls with HSB is the prevalence of unstable and/or inconsistent home environments and living situations. Displacement from families was evident by the foster-care rates in the following studies: Roe-Sepowitz and Krysik (2008) 40.3%; Evans et al., (2004) 80%; and Kubik et al., (2005) 45.5%. Dowell et al. (2009) found that foster placement instability and a high risk of multiple foster care placements were common among this population. The high number of displacements are not well accounted for in the research.

One example is the study by Schwartz et al., (2006), who found caregiver instability and multiple changes in caregivers featured, with an average of 11 changes of living situations. Although alarming, a closer look at the sample demonstrates that this is not necessarily representative. The age range is 3-18 years. The sample is drawn from file data of children in the care of the a social welfare agency, where the mere location of the data and agency mandate will suggest more presence of instability. The same issues exist for Dowdell et al. (2009), where all the girls in their sample were displaced from families and living in foster-care (n=155).

Five studies took samples from residential treatment programmes where girls were not living with their families because of emotional, behavioral and/or HSB (eg., Mathews, Hunter & Vuz, 1997; Fehrenbach & Monasttersky, 1988). The location of specialised residential treatment programmes may contribute to an already growing compromised family belonging and contribute to ongoing displacement. In contrast, Thompson (2010) analysed the records of girls (*n*=88) who were assessed in outpatient treatment facilities, where numerous changes in caregivers and living situations were still evident.

The studies that gathered information about family life described chaotic, disorganised and unstable families, with a lack of consistency, single parenting, maternal mental health issues, high rates of dysfunction, parent (mostly maternal) and child conflict (eg., Sigurdsson, et al., 2010; Hendriks & Bijleveld, 2006; Thompson, 2010; Tardif, et al., 2005; Turner & Turner, 1994). For instance in the study by Hirschberg & Riskin

(1994) none of the girls had come from a home where they were living with both of their biological parents, and mental health problems were found in at least one parent. It is difficult to gauge the reason for the high rates of mother/child conflict without understanding the influence of being a single mother, intergenerational sexual abuse and maternal mental health problems and exposure to domestic violence and other gendered experiences.

Immediate family problems included the exposure to primary caregivers with substance abuse issues (Hisrchberg & Riskin, 2005, Turner & Turner, 1994; Hendriks & Bijeveld, 2006) and sexualised home environments, such as those exhibiting poor sexual boundaries (77.3%), intergenerational sexual abuse (22.7%) (Hickey, et al., 2008) and witnessing sexual deviance in the home (42%) (Schwartz, et al., 2006).

Exposure to Domestic Violence

Where data on domestic violence was collected, exposure to domestic violence was prominent in 16 of the studies (Dowdell, et al., 2009; Hendriks & Bijleveld, 2006; Hickey, et al., 2008; Fehrenbach & Monastersky, 1988; Fortune, 2007; Higgs, et al., 1992; Hirschberg & Riskin, 1994; Hunter, et al., 1993; Kubik, et al., 2005; Kubik & Hecker, et al., 2002; Micco-Fonseca, 2000; Schwartz, et al., 2006; Taylor, 2003; Tardif, et al., 2005; Sigurdsson, et al., 2010; Thompson, 2010). There was no discussion on the effects of domestic violence on girls' development or mental health, or consideration of the possibility of sexual violence as an extension of the domestic violence, which is well documented in domestic violence literature (Fanslow & Robinson, 2011).

Education

In the nine studies that collected data on education, it was found that school was typified by factors such as truancy, general learning difficulties, academic underachievement, learning disorders, and expulsion and/or suspension (Bumby & Bumby, 1997; Evans, et al., 2004; Hendriks & Bijeveld, 2006; Higgs et al, 1992; Hunter et al., 1993; Kubik et al., 2003; Ray & English, 1995; Roe-Sepowitz & Krysik, 2008; Schwartz, et al., 2006; Thompson, 2010). Expulsion and truancy can also be factors for

boys with HSB (Fortune, 2007).

General Problem Behaviours

General problem behaviors included internalising and externalising behaviors. These were linked to antisocial behaviours (Kubik et al, 2003; Micco-Fonseca, 2000; Roe-Sepowitz & Krysik, 2008;) such as; theft (Bumby & Bumby, 1997; Ray & English, 1995), interpersonal difficulties with peers (Kubik et al., 2003; Roe-Sepowitz & Krysik, 2008; Schwartz et al., 2006; Sigurdsson et al., 2010), substance abuse issues (Bumby & Bumby, 1997; Hunter et al., 1993; Sigurdsson et al., 2010; Thompson, 2010), fighting (Kubik et al., 2002; Ray & English, 1995), absconding (Bumby & Bumby, 1997; Kubik et al., 2003; Mathews et al., 1997; Ray & English, 1995), sexually inappropriate behaviours such as prostitution and poor sexual boundaries (Ray & English, 1995; Sigurdsson et al., 2010) and chronic health issues (Dowdell et al., 2009). Girls with HSB appear to have borderline personality traits such as black and white thinking, strong emotional reactions, poor relationship skills, hypersensitivity, over dramatic presentations, and engage in relational aggression, all of which are related to trauma (Weedon, 2011a). This particular constellation of problem behaviours commonly features in the presentations of girls involved in more general types of criminal behaviours (Covington & Bloom, 2001).

International research suggests that compared with boys, girls who engage in youth offending are more likely to have complex and overlapping externalising and internalising diagnoses (Wasserman, McReynolds, Ko, Katz & Carpenter, 2005); clinical symptoms, mental health diagnoses, difficult relationships with their mothers, and greater rates and severity of maltreatment histories (Daigle, Cullen & Wright, 2007; McCabe, Lansing, Garland & Hough, 2002). Hubbard and Pratt (2002) conducted research on girl's delinquency using a meta-analysis to look at the factors for girls delinquency. They found that school problems, difficult family relationships, CPA and CSA are predictors of girls' engagement in criminal activity.

The studies of girls with HSB have much in common with the backgrounds of girls found in youth offending. It may also be possible that for some girls, HSB is an

extension of complex trauma and externalising problems. Understanding the protective factors that buffer the development of HSB and/or those that create the particular constellation leading to HSB for girls, may also be useful to the prevention of CSA.

Research Limitations

There are clearly a number of relevant clinical observations in the general literature, particularly in relation to the interface between sexual victimisation and HSB. However, as a field of enquiry a number of additional and more unspoken shortcomings continue to exist in the research particularly in relation to the missing voices of girls with HSB.

Matching Boys and Girls

In the comparison studies by Bumby and Bumby (1997), Hickey, et al., (2008), Micco-Fonseca (2000), Ray & English (1995), Schwartz et al., (2006), and Sigurdsson, et al., (2010), the ratios between boys and girls are not matched, nor has the effect of this on findings been accounted for. When looking at the histories of individuals in comparison studies, the girls and boys are most often matched on HSB alone, rather than on gendered histories. One exception is the study by Vandiver and Teske (2006) who matched boys and girls on race, date of birth, and age range at the time of the arrest for HSB. The gender-specific developmental differences between boys and girls remain for the most part unaccounted for.

Heterogeneity Amongst Girls

Two samples are drawn from college or tertiary students (Fromuth & Conn, 1990; Sigurdsson, et al., 2010) and may not be representative of the large group of girls from other studies that have mental health impairments, low IQ's, and/or school problems that exclude them from higher education. However, they also introduce and element of diversity into the samples available; this group is educated and offend, a group of which we know little about given the context of most of the studies. There is also an absence of samples drawn from victim services. Research using samples from victim

services may also identify differences between girls. Although there is commonality in the studies in terms of maltreatment, it is likely that girls with HSB are a much more heterogeneous group.

Gender Analysis

The use of a gender analysis to understand the possible influences of gender-based socialisation factors, and the objectification and sexualisation of girls remains in its infancy. What results is a somewhat superficial snapshot of this unique population without a sufficient body of contextual information on the gender-specific pathways to offending, and their implications for clinical interventions.

Complex Trauma Presentations

Based on the research and literature, the most common factor between these girls is a history of CSA and CPA, though there is a lack of research acknowledging the gendered experience of sexual and physical violence on girls' development, or its relevance to complex trauma. It is the extent of the histories of CSA and CPA that marks girls' difference.

Summary

Although there are clear limitations in relation to the applicability of the research reported in the literature, the commonality across studies does mean that we can begin to speak in terms of a platform of knowledge about clinically significant presentations, highly likely background variables, etiological factors, and presenting issues for girls with HSB.

The clinical picture that presents itself from the available literature is one that identifies a number of pre-disposing and maintaining factors for this population, for example, high rates of CSA, CPA and neglect. Additional factors include a high level of psychiatric co-morbidity, exposure to family violence and abuse dynamics, family system and mental health issues, caregiver instability, displacement from families and difficult intra-familial and extra-familial relationships. Such experiences may explain

the prevalence of both internalising and externalising problems, multiple service involvement, and school related issues.

International researchers have provided a wealth of literature on gender disparities and youth offending. In the youth offending population, girls are more likely than boys to have clinical symptoms, mental health issues, difficult maternal relationships, and more extensive maltreatment histories (McCabe et al., 2002). To treat girls with HSB successfully the dynamics of girls' lives, both the commonalities and diversities seem essential for successful short and long-term treatment outcomes.

The body of knowledge about adolescent HSB in NZ has evolved predominantly from work with boys – within a gender-specific context. A clear shortcoming is that we know relatively little about the characteristics of girls with HSB. Two previous New Zealand studies identifying and describing girls with HSB have created space to start understanding girls in NZ with HSB.

The first study, by Evans et al. (2004) used a survey to engage community-based practitioners who have worked with girls with HSB. Practitioners provided information relating to 8 girls with known or suspected HSB and were asked questions about characteristics of those girls. Practitioners identified girls CSA histories, notable mental health presentations, poor academic achievement, multiple social service involvement, and compromised family belonging by way of displacement from families. They also identified coercion and force in offending.

Fortune's (2007) research which compared histories of 13 girls with HSB to boys (children (*n*=35), youth (*n*=518), and special needs (*n*=136) with HSB. She found that girls came from unstable homes that featured mental health issues, domestic violence, single parent families, substance abuse, other markers of criminality and sexual victimisation. Girls were younger than boys at point of referral.

This research is interested in building upon these patterns for girls with HSB through a larger sample, to bring attention to the necessity for making the differences

meaningful for girls.

Aims of this Study

Since 1993, a small number of girls have been referred to New Zealand's three specialist treatment programmes. Using a national sample drawn from the three treatment providers, this research aims to better understand the relevant psychosocial and clinical characteristics present for girls (10-17 years) in NZ, and based on this clinical picture, the applicability of a gender-responsive approach within clinical pathways.

More specifically, this research seeks to address the following objectives;

1. To understand the psychological and clinical characteristics of girls in New Zealand with HSB
2. To consider the similarities of the psychological and clinical characteristics to those found in international studies on girls with HSB
3. To identify complex trauma experiences
4. To identify gender-specific patterns
5. To identify contextual patterns
6. To gauge the relevance for the development of gender-responsive psychological practices for clinical pathways in NZ for adolescent girls with HSB

Overall, this research seeks to provide the wider New Zealand sexual abuse treatment sector with relevant information for gender-responsive treatment planning and provision to girls and to support the prevention of child abuse.

Chapter Three: Methodology

This study aims to build on a very limited knowledge base by examining the data from three community based treatment programmes to further understand girls' HSB in the New Zealand context. Using a national sample, this research project was designed to provide a basic descriptive analysis of the key psychosocial and clinical characteristics of girls' (10-17 years) with HSB in NZ.

Established in the early 1990s, SAFE Network Inc. (based in Auckland), WellStop (Wellington), and STOP (Christchurch), are the three key agencies in New Zealand providing treatment for HSB. Working together as a 'sector', these community-based agencies provide specialised assessments and clinical interventions for the majority of youth in NZ with HSB (Lambie & Seymour, 2006). Clinical services are provided in Auckland, Wellington, and Christchurch, and within smaller communities, such as Gisbourne, Hamilton, Napier, Northland, and Waikato by way of satellite programmes.

Sample

A national sample was created by collecting secondary data from the client records of girls with HSB who had been referred to one of these three community based agencies since their establishment for an assessment of their suitability for treatment. The period for file auditing dated back to 1993 and ended 11 February 2011.

The literature indicates that most girls with HSB begin their offending during early adolescence, in the age range of 10-12 years. Alongside this, girls who have experienced chronic CSA can have an earlier onset of puberty, bringing forward developmental factors that usually arise within the traditional adolescent age bracket. Together, these two factors underlie the decision to lower the age range to 10-17 years in this study, rather than use a traditional 12-17 year adolescent age range.

Collectively, there have been 58 referrals between the three agencies. This study relied on retrospective data, therefore when girls were referred more than once to the same agency or they had been seen at more than one agency, this was counted as one referral and the data was merged (*n*=2). Clients who did not commit HSB, and had been referred because of their 'unmanageable promiscuous behaviours' were excluded (*n*=2). These criteria reduced the sample to 54. All 54 girls had engaged in HSB. Of the 54, 44 had been assessed, and 34 received treatment. Ten girls were referred and were not assessed.

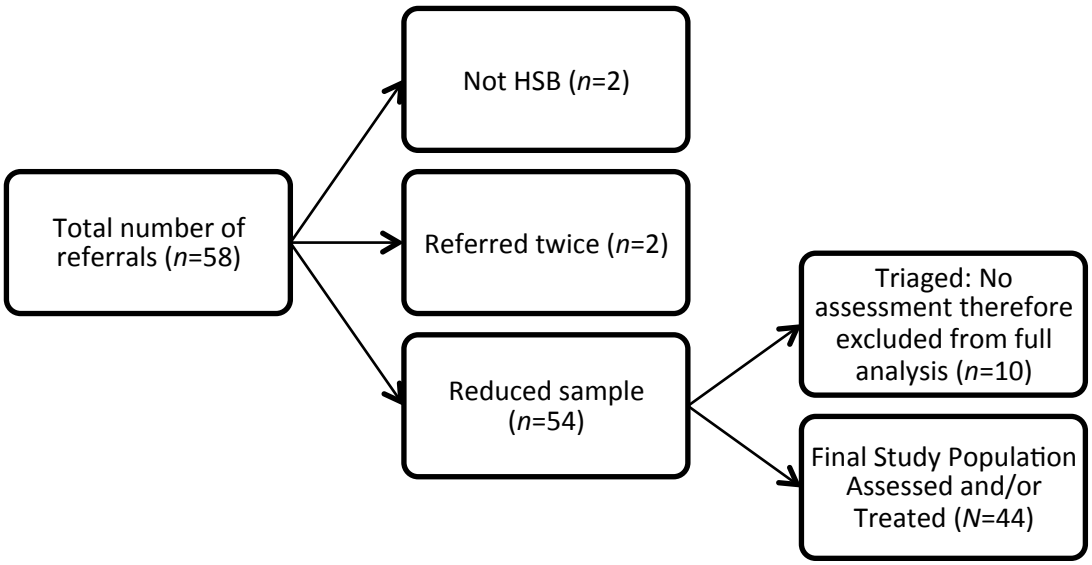


Figure 1. Summary of study population inclusion and exclusion process

The categories of ethnicity used in the initial description of the study sample are premised on ethnicity as it appears across the data reviewed in each file, and not how the referrer or specialist agency has captured ethnic identity for programme entry criteria or funding purposes. To merge data on ethnicity can skew useful statistical information by identifying client ethnicity as singular, when culturally they identify with both Māori and Pākehā descent. The categories used within the final population under study include a distinction between Māori (Māori and Māori/European) and 'non-Māori'.

Procedures

Based on the literature review in this study, a data collection form was created to reflect the key clinically relevant inferences identified in relevant research (see Appendix E). The core areas for collection were: general referral and demographic information, family backgrounds, maltreatment histories, HSB characteristics, placements, education, problem behaviours, health related problems and sexual behaviours (non-HSB).

The researcher travelled to each of the sites identified by Safe, WellStop and STOP as the locations that held client data. A request was made to the clinical directors for the file numbers of the girls who had been referred, to ensure only relevant records were accessed.

The records of all 58 girls referred for an assessment of HSB between 1991 and 2011 were reviewed. All three sites held client information on variations of computer databases and hard copy client information in paper files. The researcher conducted a manual review of the paper files (twice) that was followed by a cross-reference process using the agency databases. The complete data set available for review varied and ranged between referral information only, and/or contained assessment reports, treatment progress reports, data forms, treatment ending reports, client session notes, psychometric and risk assessment tools, and previous reports.

A data form was used to manually record the presence of variables before they were transferred onto an Excel sheet. Each file was assigned a code to protect anonymity. The data was organised into the relevant categories on the data form. It was then sorted and prepared for analysis in several key areas under the categories of "Evidence" or "No Evidence" to prepare for a statistical analysis.

To reduce the human error found in both the databases themselves and the collection of data in this study, a consultation meeting was held with the clinical leader and/or relevant key staff member at each site, before and after the data collection process to

review the data. This process was used to clarify items and collect missing data identified in the file review. Changes were made as necessary to build confidence in the data itself.

Analysis

Basic descriptive information and percentages based on frequency were drawn from the reduced sample (*n*=54). This included identifying the group of girls with HSB who were referred, but not assessed or treated (*n*=10).

For a more detailed analysis, the data set for the final population under study (*n*=44) was transferred from the Excel sheet and entered into the Statistical Package for Social Sciences (SPSS) Version 17.0 and the clients and categories were re-coded and assigned with numbers.

Descriptive statistics and percentages were used to describe the frequency of the characteristics collected on the data form (see Appendix E). The core areas of data collection were further examined to ascertain the frequencies, commonalities and to identify possible patterns in the relationship between a small number of the sub-categories within each characteristic. This included an independent calculation on exposure to multiple family stressors, to multiple traumas, and to determine whether there was any difference for girls with particular constellations of experiences and their HSB characteristics. While the sample population was national, the number of clients was small, and because of anomalies in the data, the analysis can only infer patterns of interest.

Ethical Considerations

This study was approved by the Massey University Human Ethics Committee Southern A (11/02). Approval and consent to proceed with the collection of data was gained from SAFE, WellStop and STOP, and appropriate confidentiality agreements were

made. Permission to use the assessment and treatment data for research purposes had been established as part of the assessment agreement process with clients at each site.

During the first phase of data collection, codes were created to differentiate clients from one another and to identify the programme they attended. The data is aggregated for analysis and in the reporting of findings to protect the anonymity and confidentiality of the clients.

Chapter Four: Results – Psychosocial and Clinical Characteristics of Girls (10-17 years) with Harmful Sexual Behaviours in New Zealand

General Description of Reduced Sample

This section provides a general description of the *'reduced sample'* (*n*=54) of adolescent girls with HSB referred into one of the three main treatment providers for an assessment of their suitability for treatment. This is followed by a more detailed analysis of the *'final population under study'* (*n*=44). Table 1 illustrates the number of cases per region.

Table 1
Cases Per Region

Regions	Cases	
	n	**%**
Auckland	19	43.2
Christchurch	11	25.0
Gisborne	2	4.5
Napier	7	1.6
Northland	3	6.8
Waikato	2	4.5
Wellington	10	22.7
Total	**54**	**100.0**

Age and Cultural Affiliation

The age range of the reduced sample (*n*=54) at the time of referral was 10-17 years (*M*= 12.77, *SD*=2.08). To be more specific, the girls fell into the following age categories; 53.7% 10 to 12 years (*n*=29), 11.1% 13 to 14 (*n*=6) and 27.8% 15 to 17 years (*n*=15). A further analysis of age revealed differences in the age range of referrals within each region. Auckland ranged between 10 to 16 years (*M*=13.26, *SD*=2.02), Christchurch ranged between 10 to 15 years (*M*=11.90, *SD*= 1.97), Napier ranged between 10 to 15 years (*M*=12.57, *SD*=2.07), Northland ranged between 10 to 17 years (*M*=14, *SD*=3.60), and Wellington between 10-17 years (*M*=12.50, *SD*=2.17).

Demographic data indicates that the cultural affiliations were as follows; 51.0% European (*n*=28), 25.9% Māori (*n*=14), 14.8% Māori/European (*n*=8), 3.7% Pacific Island (*n*=2), 1.9% Pacific Island/European (*n*=1), and 1.9% Asian/European (*n*=1).

Multiple Agency Involvement

Multiple agency involvement was a strong characteristic of this sample. Child, Youth and Family (CYF) referred 46 of the 54 girls for an assessment of their suitability for treatment. Of this group (*n*=46), 22 girls were involved with other government and non-government services, and 16 were involved with other government services only. Two girls were community referred and had no other agencies involved in their care. Māori and non-Māori differed with regard to the frequency of their involvement with both government (other than CYF) and non-government organisations at the time of referral: While 72.7% (*n*=16) of Māori girls were involved with government and non-government services, only 28.1% (*n*=9) of non-Māori (*n*=32) had that experience.

Prior involvement with CYF for concerns excluding HSB was evident for 68.5% (*n*=37) of the girls and their families. This was particularly evident where Māori girls were concerned. The results show that 95.5% (*n*=21) of Māori and 50% (*n*=16) of non-Māori had previous CYF involvement in their families.

One third of the sample, 35.2% (*n*=19), had received prior counselling through the Accident Compensation Corporation's sensitive claims scheme (Māori *n*=9 and non-Māori *n*=10).

Referral Time Delays

Most of the girls with HSB (75.9%) were referred for an assessment of suitability for treatment within 2 years of their first known offence (*n*=41). The age at the time of their first known HSB ranged between 9 to 16 years (*M*=12.41, *SD*=2.02), and the age at the time of first referral ranged between 10 to 17 years (*M*=12, *SD*=4.73). Nearly all this group (n=37) had prior CYF involvement with their families.

For the remaining 24% of the girls with HSB (*n*=13) there was a time delay of between two and nine years from their first known incident of HSB and referral for assessment. Furthermore, the age at time of the first known HSB occurred between 7 to 13 years (*M*=10.53, *SD*=2.10), and the time of first referral ranged between 11 to 17 years (*M*=14, *SD*=1.77). Nine of these thirteen girls had prior CYF involvement with their families.

General Description of the Final Population Under Study

This section provides a more detailed investigation of the 'final population under study' (*n*=44). Table 2 illustrates the distribution of ages at the time of first referral, and indicates that a little over half of the girls were referred between the ages of 10-12 years (54.5%, *n*= 24). The age range was 10-17 years (*M*=12.81, *SD* 2.11) and the cultural affiliations were as follows; European (*n*=25), Māori (*n*=10), Māori/European (*n*=5), Pacific Island (*n*=2), Pacific Island/European (*n*=1), Asian/European (*n*=1). The categories used for analysis within the final population under study include a distinction between Māori (*n*=15) and 'non-Māori' (*n*=29).

Table 2
Age at Time of First Referral

Age (yrs.)	*f* (*N*=44)
10	6
11	9
12	9
13	3
14	4
15	8
16	3
17	2

Family of Origin Contact

Although not indicative of a problem in itself, more than three quarters of the total sample (86.4%, *n*=38) come from families where their biological parents are separated. The majority of girls do not have regular contact with their biological parents. Only three girls were in regular contact with both biological parents. Data on siblings indicated that 68.2% (*n*=30) had at least one sibling, although information about contact with siblings (if any) was not routinely collected.

Family Stressors (Quality of Life)

As demonstrated in Table 3, information collected on family stressors suggests that girls originate from environments saturated by exposure to abuse and a generally poor quality of life. The most prevalent stressors pose, at the least, safety issues, and include 70.5% of girls being exposed to domestic violence (*n*=31), 56.8% with at least one parent with a substance abuse problem (*n*=25), 31.8% with a parent with criminal history (*n*=14), and/or 26% had a close family member who is a known sex offender (*n*=26). Almost half of the sample lived in sexualised family environments (*n*= 21, 47.7%).

In this sample 47.7% of mothers (*n*=21) and 11.4% fathers (*n*=5) had at least one mental health issue. For two girls both parents had mental health problems, and one girl showed evidence of a parent with a mental health problem but did not specify which parent. Overall, nearly half of the girls (40.9%) came from families where intergenerational sexual abuse was present for their families (*n*=18). More specifically, sixteen of the eighteen girls had mothers who experienced intergenerational sexual abuse (36.4%).

Table 3
Family Information

Characteristic	*f* (*N*=44)	%
Parents separated	38	86.4
Regular contact with biological mother	8	18.2
Regular contact with biological father	7	15.9
Siblings	30	68.2
Family Stressors		
Exposure to domestic violence	31	70.5
Mental health issue (MHI)	26	59.1
Other abuser in family (sexual)	26	59.1
Substance abuse	25	56.8
Sexualised family environment	21	47.7
Intergenerational CSA	18	40.9
Criminal history	14	31.8
Significant death	5	11.4

Exposure to Multiple Stressors

The most common environmental stressor, exposure to domestic violence (DV) (70.5%, *n*=31), was most frequently paired (although not exclusively) with substance abuse (47.7%, *n*=21), followed by parental MHI (50%, *n*=22), other sex offender in family (50%, *n*=22), sexualised family environment (40.6%, *n*=18), and criminal activity (31.8%, *n*=14). Of the 31 girls in the sample exposed to DV, over half were also physically abused (54.5%, *n*=24).

Table 4 provides information on the number of 'family stressors' the girls in the final population under study (*n*=44) experienced. Three quarters of the group (75%, *n*=33) experienced at least three or more stressors in their family environments. For the four girls where there was 'no evidence' of family stressors, there was either little or no information on family characteristics within files.

Table 4
Frequency of Multiple Stressors

Number of Stressors	Final Population under study (*N*=44)
7	6
6	4
5	7
4	6
3	11
2	3
1	3
0	4

Table 5 shows differences between Māori and non-Māori in terms of the frequency of multiple stressors these two groups experience, illustrating that the frequency of family stressors is not specifically located with Māori, and is a feature of the group as a whole.

Table 5
Frequency of Multiple Stressors Based on Ethnicity

Number of Stressors	Māori (*n*=15)	non-Māori (*n*=29)
7	3	3
6	2	2
5	4	3
4	1	5
3	2	9
2	1	2
1	1	2
0	1	3

Placements

Almost three quarters of girls have experienced displacement from families/whānau in this sample. This is evidenced in that 72.2% (*n*=29) of girls were living in placements away from their biological parents at the time of assessment. The number of

placements for each girl ranged from 1 to 26 (*M*=4.13, *SD*=5.44). Only 10 girls were living in placements because of HSB itself.

Over half of the sample (52.3%, *n*=23) was living in non-family/whānau placements. For this group, their ethnicities are as follows; non-Māori (*n*=13) and Māori (*n*=10) indicating that displacement is not a feature of one ethnic group over another.

Academic Performance and IQ

Information on academic performance was inconsistently recorded. Available records indicated that 63.3% (*n*=19) of girls were performing below average academically and 33.3% (*n*=10) were comparable to their same age peers.

In the available records 13.3% (*n*=4) of the girls had been assessed to have an IQ below 70, and 3.3% (*n*=1) were assessed to have an IQ ranging between 80-89,

It is possible that those without IQ measures are those who did not present with an assessment need.

Problem Behaviours

Table 6 illustrates the presence of a number of interpersonal relational difficulties. These are specifically evidenced by the most frequent problem behaviours, 68.2% poor peer relationships (*n*=30), 63.6% social skill problems (*n*=28), 65.9% anger (*n*=29), 61.4% violence (*n*=27), 59.1% difficulty regulating emotions (*n*=26) and 56.8% social isolation (*n*=25).

A number of oppositional, defiant behaviours and antisocial activities also feature, but none more prevalent than stealing at 52.3% (*n*=23). Only four girls are diagnosed with conduct disorder (table 12), yet a number of conduct disordered type behaviours are present (aggression, destruction of property, deceitfulness and defiance of rules) as shown in table 6, and this needs to be considered.

Table 6
Problem Behaviours

Behaviour	*f* (*N*=44)	%
Poor peer relationships	30	68.2
Social skills problem	28	63.6
Anger	29	65.9
Violence (non-sexual)	27	61.4
Difficulty regulating emotions	26	59.1
Social Isolation	25	56.8
Stealing	23	52.3
Mood swings	22	50
Lying	20	45.5
Self-harming	19	43.2
Relational aggression	15	34.1
Impulsivity	15	34.1
Absconding	14	31.8
Suicidal ideation	13	29.5
Verbally abusive	11	25
Food related problems	10	22.7
Truancy	8	18.2
Animal Cruelty (sexual/physical abuse)	8	18.2
Substance abuse (alcohol)	8	18.2
Homicidal ideation	7	15.9
Fire setting	7	15.9
Suicide attempts	6	13.6
Substance abuse (drugs)	6	13.6
Vandalism	3	6.8

Table 7 illustrates that in this sample a number of girls have experienced both physiological and psychological problems. Of particular concern is the high number of psychopathology categories signposted by the 72.7% of girls ascribed one or more mental health diagnoses. The most frequently diagnosed mental health issues were PTSD (31.8%), followed by ADHD (25%) and Depression (25%). Alarmingly, 52% of girls were dealing with at least two mental health issues (*n*=23).

Table 7
Health Related Problems (*N*=44)

Problem	*f*	%
Medical problem	16	36.4
Poor hygiene/self-care	14	31.8
Sexual health problem	8	18.2
History/presence of Enuresis	5	11.4
History/presence of Encopresis	5	11.4
Head Injury	2	4.5
Mental health issues	32	72.7
Post Traumatic Stress Disorder (Inc. traits)	14	
Attention Deficit Hyperactivity Disorder	11	
Depression (Inc. traits)	11	
Anxiety	6	
Hears Voices	6	
Conduct Disorder	4	
Reactive Attachment Disorder	2	
Oppositional Defiant	3	
Borderline Personality Disorder Traits	3	
Developmental Disorder	2	
Autism	2	
Dyspraxia	2	
Asperger's Syndrome	1	
Alcohol Fetal Effect	2	
Learning Disability	1	
Tourette's Syndrome	1	

Sexual Behaviours

Information concerning sexual behaviours (not HSB) are highlighted in table 8. Numerous behavioural configurations feature here, although the most noteworthy of which are the 43.2% of girls whom the clinician had concerns about being sexually re-victimised (*n*=19), the 9.1% of girls who expressed a desire to be pregnant (*n*=4), and the 34.1% of girls who sexualised older men (*n*=15). All of these configurations have implications for both safety and clinical interventions. For example, at least one third of the girls (34.1%, *n*=15) considered highly sexualised, also displayed poor personal boundaries and had evidence of clinician concerns in relation to sexual re-victimisation.

Table 8
Sexual Behaviours

Sexual Behaviours	*f* (*N*=44)	%
Highly Sexualised	20	45.5
Clinician concerns of re-victimisation	19	43.2
Poor personal boundaries	18	40.9
Sexualises older men	15	34.1
Sexualised clothing	13	29.5
Unsafe sexual encounters	10	22.7
Sexualises boys (peer aged)	9	20.5
Excessive masturbation	6	13.6
Wants to be pregnant	4	9.1
Sexualised use of social media	5	11.4
Accessing pornography	3	6.8
Sexualises women	3	6.8

Maltreatment Experiences

The frequency of maltreatment experiences is shown in table 9. These results indicate that emotional abuse is the most common maltreatment experience, closely followed by CSA. Furthermore, over half of the girls in this sample experienced CPA and neglect.

Table 9
Maltreatment Experiences

	f	%
Emotional Abuse	34	77.3
Child Sexual Abuse	32	72.7
Child Physical Abuse	29	65.9
Neglect	27	61.4

Multiple Traumas

When looking at the number of girls who had experienced a combination of maltreatment experiences, Figure 2 shows that 43% (*n*=19) of girls had experienced all four maltreatment experiences, 22.7% had experienced three (*n*=10), 15.9% had experienced two (*n*=7), and 9.1% had experienced a single trauma (*n*=4). Of the 9.1%

in the 'no evidence group' (*n*=4), two girls were suspected to have experienced maltreatment - although this was not disclosed.

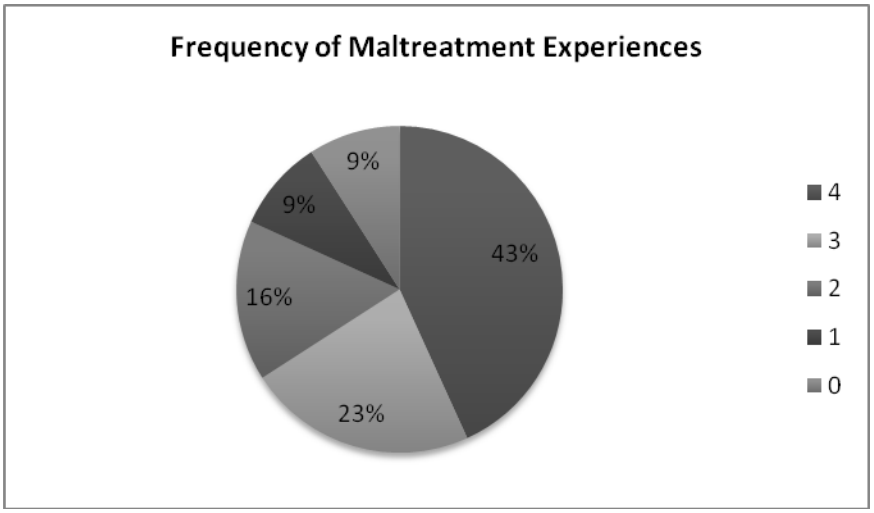
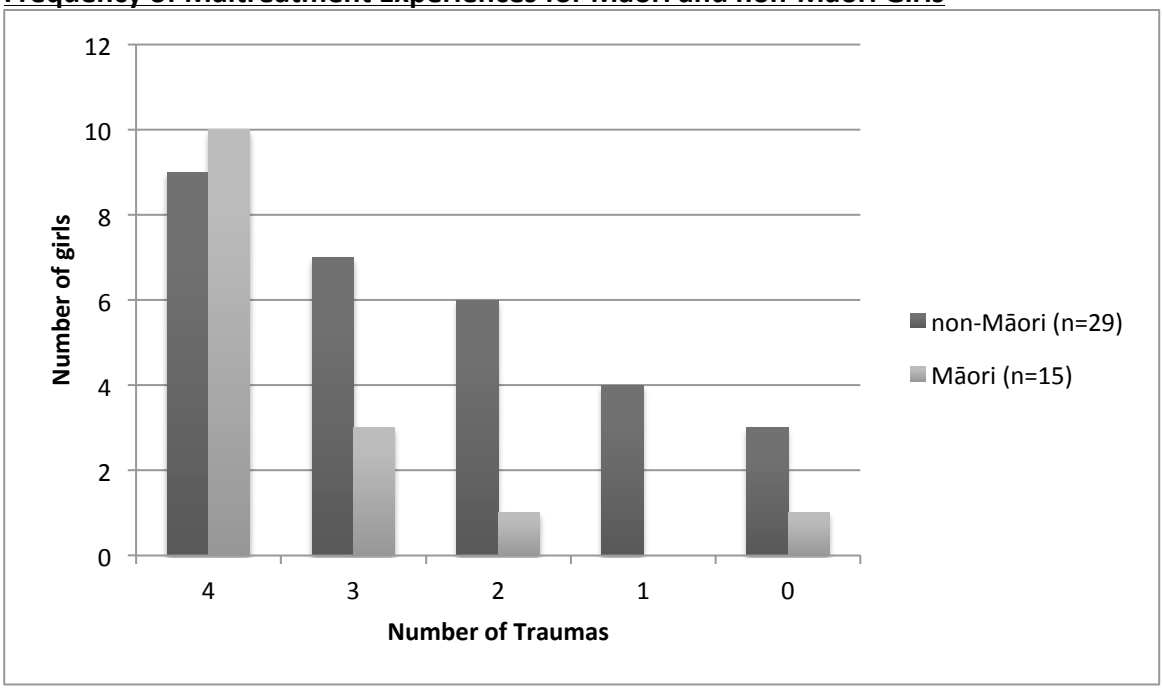


Figure 2. Frequency of maltreatment experiences

Table 10 shows that both Māori and non-Māori girls experienced multiple traumas. For non-Māori girls in this sample a little over half (55.17%) experienced 3 to 4 maltreatment experiences, whereas more than three quarters of Māori girls (86.6%) in this sample experienced 3 to 4 maltreatment experiences.

Table 10
Frequency of Maltreatment Experiences for Māori and non-Māori Girls



Child Sexual Abuse

It is no easy task to accurately gauge the incidence of CSA in any sample accurately. In this study, 72.7% of the girls' had experienced CSA (*n*=32). In the 'no evidence' group, 13.6% (*n*=6) were suspected to have been sexually abused, though this was never disclosed. Of those girls who were sexually abused, 54.5% (*n*=24) experienced extra-familial CSA, 52.3% (*n*=23) intra-familial CSA, and 34.1% (*n*=15) experienced both. The number of perpetrators ranged from 1-6 (*M*=2.81, *SD*=1.44). A quarter of this sample had experienced rape (*n*=11, 25%).

High rates of father/daughter incest featured in this sample, with 22.7% (*n*=10) of girls sexually abused by their biological father, and in four cases, this included rape. European girls (*n*=8, 18.2%), experienced more father/daughter incest than Māori girls (*n*=2, 4.5%). Only two girls reported CSA by females.

The age of onset for CSA was only available in twenty cases. Eight girls were under 5 years old, with at least two under 2 years. Eight girls were aged between 6 to 8 years, and two between 9 to 12 years.

HSB Characteristics

Sexually Abusive Behaviours

As outlined in table 11, the HSB characteristics of girls in this study varied, although they were heavily weighted in particular areas. The HSB engaged in most frequently was genital touching at 70% (*n*=31), followed by kissing 29.5% (*n*=13), oral sex 22.7% (*n*=10), and simulated intercourse 22.7% (*n*=10), with the remaining distribution of acts dropping in frequency.

Table 11
Harmful Sexual Behaviours

HSB Characteristics	*f*	%
Sex of Victim		
Male	16	36.4
Female	12	27.3
Both male and female	13	29.5
Relationship to Victim		
Intra-familial	21	47.7
Extra-familial	18	40.9
Both intra-familial and extra-familial	5	11.4
Acts		
Genital touching	31	70.5
Kissing	13	29.5
Oral sex	10	22.7
Simulated intercourse	10	22.7
Digital penetration	5	11.4
Group situation	4	9.1
Exposure to sex act	3	6.8
Touching breasts	3	6.8
Flashing	3	6.8
Anal penetration of victim	2	4.5
Vaginal penetration with object	1	2.3

Age, Onset and Frequency of HSB

Information on the age of onset was unavailable for five girls. Based on the available data, more than half (63.6%, *n*=28) of the girls in this sample began their offending aged 12 years or under. More specifically, the age of girls at the time of their first recorded HSB are as follows; 8-9 years (*n*=4), 10-12 years (*n*=24), 13-14 years (*n*=6), and 15-16 years (*n*=5).

Over half of the sample (52.2%, *n*=23) offended on multiple occasions. For 59.1% (*n*=26) of girls there was more than one victim.

Victim Selection and Offence Location

The age of the victims suggest that 56.8% (*n*=25) of the girls chose victims 5 years old or under, 45.5% (*n*=20) between 6 to 9 years, and 34.1% (*n*=15) 10 years of age or over. Although the selection of victims based on age varies, twelve girls exclusively

abused children 5 years old or under, nine girls exclusively abused children 6 to 9 years, and six girls exclusively abused children 10 years old and over. Ten girls offended across two age ranges, and only three girls offended across all three age groups. On four occasions, the victim was intellectually impaired.

The location of sexually abusive behaviours was not consistently recorded in files. What can be gauged from the available data on the location of HSB (*n*=29), is that of the eight offences against peer-aged victims, six took place at school and only two occurred in out of home care. Twenty girls in this sample engaged in HSB where they resided (home/placement), with seven girls offending in school, and one while babysitting.

Sexual Abuse, General Maltreatment, Family Stressors, and Offence Characteristics

Independent calculations to determine whether there was any difference for girls with a particular constellation of experiences and their HSB characteristics (onset under 12 years, presence of multiple incidents, victim intra familial, victim extra familial, and aggression - threats, injury and/or force) were conducted. Some girls fitted more than one group. The groupings were as follows.

1. The girls with 3 to 4 maltreatment experiences (Group 1)
2. The girls with 0 to 2 maltreatment experiences (Group 2)
3. The girls with a combination of 3 to 4 maltreatment experiences and 3 or more family stressors (Group 3)
4. The girls with 0 to 2 experiences combined with 0 to 2 family stressors (Group 4)
5. Girls who had experienced CSA where there were 2 or more offenders (Group 5)

Table 12
Group Combinations and Offence Characteristics

Offence Characteristic	Group 1 (*n*=29)	Group 2 (*n*=15)	Group 3 (*n*=24)	Group 4 (*n*=20)	Group 5 (*n*=20)
Onset < 12 years %	69	53	62.5	65	75
Multiple Incidents %	58	40	62.5	40	70
Intrafamilial %	55.2	33.3	58.3	35	45
Extra familial %	27.3	40	37.5	40	30
Aggression %	20.7	6.7	25	5	20

As shown in Table 12, girls who experienced less than 2 maltreatment experiences (Group 2) and less than two family stressors (Group 4), less frequently displayed aggression in their HSB than those girls in other groups. The number of incidents and the early onset of HSB were elevated for girls who had been sexually abused by more than one perpetrator (Group 5). Girls who had experienced 3 to 4 maltreatment experiences more often sexually abused family members than non-family members.

Smaller Patterns of Difference for Girls' HSB

In five cases, either an older adolescent boy or adult male was present during the HSB. In three of these cases the girls and victims were sexually abused together prior to the initiation of her own HSB against the same children on separate occasions. In two cases an older adolescent boy was thought to have coerced the girls into HSB.

All of the girls who carried out HSB that involved either force or threats, or resulted in an injury to the victim - or a combination of these - were also identified to also have a poor performance at school or to have a low IQ.

Summary of Results

Girls with HSB were likely to be referred for an assessment during the pre and early adolescent age period. A little over half of girls in this study committed their first known offence, and presented for an assessment between the ages of 10-13 years. Māori were disproportionally represented at 34.1%, though 65.9% non-Māori make up the body of referrals.

In this sample, girls with HSB have some clear patterns of commonality and difference between particular groupings of characteristics. Displacement and multiple agency involvement are both clear themes. Over three quarters of the girls come from single-parent families, though very few girls had regular contact with their biological parents. Almost three quarters of girls were living in placements away from their biological parents at the time of assessment. For the most part, this displacement was the result of interventions before the index offence occurred.

Alarmingly, 70.5% of these girls were exposed to domestic violence. Other prevalent and concerning family stressors included having a parent with a mental health issue, parental substance abuse, having a known sex-offender in their family, and sexualised family environments. Over three quarters of the girls in this sample had experienced at least three or more family stressors in their family environments.

Emotional abuse, at 77% was the most common maltreatment experience, followed closely by CSA at 72%. Over three quarters of the girls had experienced two or more maltreatment experiences. The average number of CSA perpetrators was two, and a quarter of this sample had experienced rape. There was a high level of father/daughter incest, with 10 of the girls sexually abused by their biological father.

Interpersonal relational difficulties were evident, with well over half of this group presenting with poor peer relationships, social isolation, difficulty regulating emotions, social skills problems, and anger. Externalising problems other than HSB such as violence and stealing were present for over half of the girls.

A number of girls had experienced both physiological and psychological problems. Nearly three quarters of the girls had been ascribed at least one mental health diagnosis, with one third experiencing PTSD, one quarter ADHD and one-quarter depression. The most concerning sexual health issue was the likelihood of re-victimisation.

The sexual offending patterns of girls within this sample varied, though the most frequently occurring behaviour was genital touching, followed by kissing, oral sex, and simulated intercourse. Aggression featured for some girls as an offence characteristic, and varied depending on the degree of developmental trauma they had experienced. Most victims were under the age of five, though some were also older children, including their peers. Over half of the girls selected multiple victims and/or offended on multiple occasions. Most of offences occurred where they lived, with some occurring at school and other places. The heterogeneity of offence patterns was also evident, and there are questions about the number of cases where older adolescent boys or adult men had been involved.

Chapter 5: Discussion

Major Findings

The current study sought to understand the New Zealand 'landscape fit' with the clinical characteristics of girls' HSB identified in international studies to inform treatments that recognise gender-responsive approaches for working with girls. The research questions, understanding the clinical characteristics and their similarities and differences, are discussed alongside the international literature. Complex trauma experiences, especially histories of emotional, sexual, and physical abuse and other clinical indicators were found to be higher for girls when compared to studies with boys, suggesting differences in experiences. The key differences in offending patterns, clinical characteristics, and histories of multiple abuse are evidence of systemic differences between boys and girls that support a gender-responsive approach within clinical pathways.

The overall picture that emerges from this sample reflects the key findings on psychological and clinical characteristics of girls with HSB in internationally based samples. Furthermore, the majority of girls with HSB seen in NZ community-based sex-offender treatment programmes experienced high levels of emotional abuse (77.3%), CSA (72.7%), CPA (65.9%), and/or neglect (61.4%). Additionally, the number of experiences of displacement from families (72.2%), relational difficulties (34.1%), mental health issues (72.7%), and exposure to multiple family stressors - in particular domestic violence (70.5%) - also reflected similarities with international research on girls. The level of displacement, family stressors, and maltreatment in this sample did not feature more strongly in any ethnic group; rather it was a characteristic of the group itself. However, the over-representation of Māori in the overall sample and in the group of girls that experienced 3 to 4 maltreatment experiences requires further investigation to understand any meaningful difference.

Taking into account the lifespan and socialisation issues for girls with sexually abusive behaviours, and the conditions responsible for their lives, means considering the personal, social and cultural experience as factors in girls well being. Understanding girls with HSB in this way, places value on understanding the influence of relevant systemically based factors, and gendered socialisation experiences - as a group and individually. To effectively deal with girls' sexually abusive behaviours, the gender-specific manifestations of the presenting clinical issues clearly require an understanding of research on gendered development and sexual behaviours, within a gender-responsive intervention (Robinson, 2009). Furthermore, the gender-specific impacts and issues of displacement, violence (sexual and physical) and other traumas are salient features of girls' difference in HSB.

Pathways to Sexually Abusive Behaviours for Girls

International researchers have found that girls follow different pathways to HSB than boys (Hickey, McCrory, Farmer & Vizard, 2008), and are within themselves a heterogeneous group (Roe-Sepowitz & Krysik, 2008). Likewise, the results of this study also suggest that girls in New Zealand with HSB show some diversity, though much commonality exists in their experiences of displacement, developmental traumas and family life.

Research also suggests that adolescent aged boys with sexually abusive behaviours also share commonality, though as a group the presence of heterogeneity is far greater (Moore, Franey & Geffner, 2004). Furthermore, boys also remain the perpetrators of a vast majority of sexual abuse by young people. These factors support the view that an analysis of gender and masculinity is required when responding to sexually abusive behaviours alongside the dominant traditional psychological approaches (Boyd & Bromfeild, 2006; Chung, O'Leary & Hand, 2006).

This study identified a number of explicit differences when read against studies that have focused on boys. Focusing on explicit differences alone does little to account for

the implicit nuances of girls' individual lived experiences and the influence of gender on the trajectory of HSB.

Sexually Abusive Behaviour by Girls in New Zealand

The findings on offence patterns tell us that girls with HSB in NZ share similar offence characteristics to those found in previous studies. These findings also highlight some explicit differences for girls compared to boys with HSB.

Age of first known offence

Consistent with international samples (Thompson, 2010; Vandiver, 2010; Vandiver & Teske, 2006) information on the age of first known offence in this sample indicated that most girls began their HSB in the pre-adolescent age group of 10 to 12 years (63.6%), more than half offended on multiple occasions (61%), and more than half had more than one victim (59.1%). Around the age of 14 has been argued to be a peak time during adolescence for offences by boys to occur (Nisbet, Rombouts & Smallbone, 2005). In one NZ study (Fortune, 2007) on male youth with HSB, 120 boys fell into the 10-12 year age group, compared with 226 boys in the 13-16 year group (*n*=518). International studies also indicate that for the most part, girls' HSB started at an earlier age than that of boys (Howley, 2001; Ray & English, 1995).

The meaning of this difference is not clearly understood, although biological, hormonal, behavioural, and social changes that come into play with the onset of puberty for girls may account for some of the difference. The early onset of puberty has been established as a risk factor for girls' antisocial behaviours (Chesney-Lind, 2004). Girls with HSB are likely to face the challenges of puberty (e.g. regulating emotions) with the effects of chronic maltreatment experiences shaping their behaviours.

Victim selection

As discovered in previous studies on girls with HSB (Fromuth & Conn, 1997; Hickey et al., 2008), many girls selected victims under the age of 5 years though only a small number did so exclusively. In this study, victim selection varied across age groups

although the majority of girls selected victims under the age of five years (56.8%), 45.5% selected victims 6 to 9 years, and 34.1% selected victims 10 years of age or over. A quarter of girls selected victims from more than one age group. International studies on victim selection by boys suggest that the majority of victims were likely to be between 6 and 9 years (Flanagan & Hayman-White, 1999; Fortune, 2007). The age of victims for girls appears to be younger, and this difference may be understood through the environment in which the offending occurred.

Consistent with international research on girls, the majority of girls offended where they resided (home/placement) with only seven girls offending in school, and one while babysitting. This suggests the possibility of a blurring of the boundaries of babysitting, and the gendered 'nurturing' role girls might hold where they reside. This relationship may provide an account of girls' access to victims.

As found in this study, most international studies showed that adolescent girls sexually abuse either boys and girls at similar frequencies, with no clear distinction between victims that were family or non-family members (Hendriks & Bijleveld, 2006; Vandiver & Teske, 2006). Only one third of the girls sexually abused boys and girls. While a number of boys also select male and female victims, previous studies comparing victim selection between boys and girls with HSB suggest that boys are more likely to select female victims, with a high number of peer aged sexual assaults against girls (Vandiver & Teske, 2006). This difference needs to be understood through the number of boys who offend, and the number of girls who are victims.

Sexually abusive behaviours

The distribution of HSB acts in this study were varied, however the most frequently occurring sexually abusive behaviour was genital touching, followed by kissing, oral sex, and simulated intercourse, similar to international studies (Hickey et al., 2008; Hunter et al., 1993). These patterns are also found for boys with HSB, although penile penetration (rape) frequently reported as an act by boys (Fortune, 2007; Vandiver, 2010). It is difficult to infer meaning from this data without understanding the

gendered specificity of the experience of rape. The abusive behaviours need to be understood alongside issues of violence.

Relational and physical aggression

As with international studies (Hickey et al., 2008; Kubik and Hecker 2005; Fromuth & Conn, 1997; Thompson, 2010) aggression was present and elevated in cases where childhood adversities such as chronic CSA and/or maltreatment and family stressors were also present. Though relational aggression has been found in both boys and girls offending patterns, Fortune (2007) found that physical aggression (violence) is more often a characteristic of boys' offence patterns than that of girls. There is no question that girls can be aggressive and violent, though how the aggression dynamics present themselves within sexually abusive behaviours requires further investigation.

Further considerations

Examples in this study of exceptions to the general HSB characteristics were found, firstly with the girls who have been sexually abused by an older man alongside other children, and then continued to abuse them alone; and secondly by the girls who were forced to participate in the sexual abuse of children by an older adolescent boy. The gendered dynamic of girls being both offenders and victims in the offending needs to be understood.

There are misunderstandings of HSB within professional networks, in particular in relation to the issue of promiscuous behaviour. For some girls, the focus from referring agencies was concern with managing girls' sexual behaviours (non-HSB) rather than previously noted sexually abusive behaviour. This may be related to the time lapse between index offence and referral, instigated when promiscuity is identified. Furthermore, some offences were recorded on referral as engaging in sexual activities with older men, understood as promiscuity rather than sexual (re)victimisation. Sexual promiscuity is not a sex offence, or HSB, however it specifically relates to girls and locates the problem in their behaviour.

Psychosocial, Contextual, and Clinical Characteristics of Girls in New Zealand with Harmful Sexual Behaviours

Displacement and Multiple Family Stressors

In this study, multiple agency involvement was a strong characteristic of the sample, though the most frequent referral source to 'the sector' for girls with HSB was Child, Youth, and Family (85%). Girls in NZ with HSB primarily come from unstable and/or inconsistent home environments. Most were displaced from their family of origin (72.7%) and had little or no regular contact with both biological parents (93.1%). The average number of placements is four, with over half the sample living in non-family placements. These levels of displacement are in keeping with the previous findings of overseas researchers for girls with HSB (Roe-Sepowitz and Krysik, 2008). The level of displacement for these girls is very different from the boys with HSB living in non-familial placements in NZ. Fortune (2007) found that 27% (of 518) of boys were living in non-familial placements with the average number of a placements featuring at 'just under 2'.

A large number of girls in this study came from environments saturated by multiple family stressors. Three quarters of the group experienced at least three or more family stressors, but none more so than exposure to domestic violence (70.5%). For girls in this study that were exposed to DV, over half were also physically abused. They were also frequently (but not exclusively) exposed to a close family member who was a sex offender, a parent with substance abuse problem, sexualised family environments, and/or intergenerational sexual abuse. Not surprisingly, international researchers identified similar issues, and found exposure to DV to be prominent (Dowdell, et al., 2009; Hendriks & Bijleveld, 2006). Importantly, the number of girls exposed to sexual violence, frequently paired with domestic violence (Fanslow & Robinson, 2011) remains unaccounted for. The complexities of the gendered asymmetry in DV, and the likelihood of other forms of abuse to be present in that asymmetry need to be understood.

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Furthermore, the very high levels of displacement coupled with maternal mental health issues are also likely to compromise belonging and care from positive relationships with female role models - a core component of healthy female development for girls with HSB (Frey, 2010; Robinson, 2006; Turner & Turner, 1994). The absence of positive relationships with female role models is a risk for girls with HSB (Mathews, Hunter & Vuz, 1997).

Safety Concerns

Concerns around the immediate care environment and functioning also arose in this study. The particular constellation of family stressors in this sample is similar to international research that identifies this constellation as a particular set of risk factors for CSA for girls (Fergusson et al., 1996; Finkelhor, 1993; Mian, Marton, Le Baron & Birtwistle, 1994; Mullen, Martin, Anderson, Romans, & Herbison, 1993; Nelson et al., 2002). When risk factors of CSA are combined with weak or non-existent protective factors, such as the quality and nature of peer and family relationships, additional concerns for ongoing safety become apparent (Lynskey & Fergusson, 1997).

Complex Presentations

Girls with HSB referred to treatment programmes in New Zealand have very high frequencies of mental health issues (72.7%) and multiple maltreatment experiences (81.1%), with nearly half having experienced CSA, CPA, neglect, and emotional abuse. Much higher levels of severe and pervasive physical violence (by mothers and fathers) and sexual violence (by multiple male perpetrators, often located within the family, with high rates of vaginal penetration) are also the most frequently reported background variables in previous studies that compared girls with boys (Frey, 2010; Robinson, 2009). New Zealand research also suggests boys levels of CSA (33% to 47.1%) and CPA (36.5% to 45.6%) are lower than for this group of girls (Fortune, 2007).

The majority of girls in this study appear to fit more succinctly into the sub-group of girls with HSB proposed by Mathew's and colleagues (1997), of those experiencing severe maltreatment and developmental traumas. However, it is the configuration of

the multiple maltreatment experiences and exposure to family stressors, combined with recent trauma research, that poses implications for clinical interventions.

The development and maintenance of mental health problems and general problem behaviours is complex due to their high co-morbidity and interlinked causal factors. A single theory approach to understanding these complex interactions is insufficient due to the varying experiences, developmental levels, biological, physical and social variables found in young people (Briere & Langtree, 2008; Ministry of Health, 2008). Using a transdiagnostic lens, combining relevant theory and research findings, is therefore useful to begin understand the presenting complexities and the relevance of gender-responsive approaches for girls in NZ with HSB.

Mental Health Issues

The mental health of girls in this study varied, though the most frequently presenting diagnosis was PTSD, followed by depression and ADHD. These results are, for the most part, consistent with international research findings (for example; Bumby & Bumby, 1997; Henriks & Bijleveld, 2006; Hickey et al., 2008; Hunter et al., 1993; Kubik et al., 2002; Mathews et al., 1997). The high rates of post-traumatic symptomology found both in this sample and previous studies (Schwartz et al., 2006) may be explained, in part, by the presence of chronic maltreatment. PTSD is also prevalent in adolescents exposed to DV (Margolin & Vickerman, 2007). These links across research boundaries need to be explored given the high frequency of DV in these girls' lives and its relationship with sexual and physical abuse.

Collectively, the mental health and problem behaviours of girls with HSB in this study are more easily conceptualised by three clear themes. Firstly, the number of girls experiencing interpersonal relational difficulties, secondly, by the presence of internalising problems (eg., depression and anxiety), and thirdly, by the presence of externalising oppositional and defiant antisocial behaviours - all of which have been found to manifest in gender-specific ways.

Interpersonal relational difficulties

The 'interpersonal difficulties' in this sample are captured in the high rates of girls experiencing poor peer relationships, self-harm, anger, social skills problems, difficulty regulating emotions, and mood swings. CSA (particularly rape) has been associated with self-harming behaviours (Romans, Martin, & Mullen, 1997). Some of these presentations have been commonly categorised as 'borderline personality traits' where women are over-represented, and are frequently experienced by women and girls who have been sexually abused (Briere & Spinazzola, 2005; Igarashi et al., 2010). These levels of interpersonal difficulties are also linked to a high frequency of physical and sexual abuse experienced by multiple perpetrators (Western, Ludolph, Misle, Ruffins & Block, 1990), both of which feature in this sample.

Internalising problems

Girls who have experienced both physical and sexual abuse are more likely to experience depression (Meyerson, Long, Miranda & Marx, 2002). Internalising behaviours themselves are generally twice as common for girls than boys (Fergusson, Swain-Cambell & Horwood, 2002), and this was a pattern in this study although for girls with HSB in New Zealand many externalising problems (of which HSB is one) also feature.

Externalising problems

The 'externalising difficulties' are evidenced in this sample by the number of conduct disorder type problems, for example; violence (non-sexual), stealing, relational aggression, verbal abuse, animal cruelty, and fire setting. These behaviours have been found in previous studies on girls with HSB (Robsinon, 2009). One international study by Seto and Lalumiere (2009) found that adolescent boys with HSB also had substantial histories of conduct type problems, although they argued that framing HSB through research on antisocial behaviour alone is too basic.

Recent research examining gender based variables in conduct disorder indicate that the developmental trajectories of antisocial behaviours in girls follow different pathways, have gender-specific risk factors, and are more likely to present with co-

morbid internalising problems, than boys (Berkout, Young & Goss, 2011; Wasserman, McReynolds, Ko, Katz & Carpenter, 2005). Furthermore, CSA has been associated with girls' early conduct problems and can exacerbate their antisocial activities (Fontaine, Carbonneau, Vitaro, Barker & Tremblay, 2009; Javdani, Sadeh & Verona, 2011). The gender-based outcomes for girls diagnosed with ADHD, indicate that girls are 40 times more likely to develop a conduct disorder than boys (Szatmari, Boyle, & Offord, 1989). When a particular diagnosis is more prevalent in boys than in girls (eg., ADHD, CD), the prognosis for girls is often poorer (Loeber & Keenan, 1994; Zoccolillo, 1993). These links across research boundaries need to be explored through a gender-responsive approach given the high frequency of conduct problems in these girls' lives and its relationship with the index offence.

Girls who engage in non-Sexual Offending

It is important to consider the research on the criminal behaviours of girls who engage in non-sexual offending that has found differences in patterns of aggression between girls and boys. Robinson (2009) states that there is now a pattern in the research that shows girls who engage in non-sexual offending, have developmental pathways that are often saturated with victimisation experiences, mental health problems such as depression and PTSD at much higher rates than boys. They are also more likely to have dysfunctional families engaged in criminal behaviours, and families where domestic violence is systemic. Girls in New Zealand with sexually abusive behaviours also present with these background experiences. Boys with sexually abusive behaviours share much in common with young people who engage in non-sexual offending (Nisbet, Wilson & Smallbone, 2004), though unlike girls, mental health issues are not greater than those found in the general population (Epps & Fisher, 2004).

Child Sexual Abuse

As previously discussed international samples suggest that the most common background variable amongst girls with HSB is a history of CSA. Likewise, close to three quarters of the girls in this sample experienced CSA. It is important to recognise that CSA is a complex life experience with a range of outcomes that may not always lead to negative consequences (Putman, 2003) or to HSB, however girls are the most

likely victims of CSA and the gendered difference in victimisation needs to be recognised. Therefore, understanding the sexual abuse of girls with HSB involves considering the dynamics of each individuals experience (e.g., relationship to the perpetrator, frequency, duration, onset etc.), and the meaning of the physical consequences of experiences that involve the specificity of girls anatomy, for example vaginal rape and/or vaginal digital penetration and/or fondling of breasts.

Although the rates of intra versus extra familial abuse in this study are not dissimilar, one third of the girls experienced both. In this sample, all 32 girls with a history of CSA were sexually abused by men, with only two girls sexually abused by women (both of whom had male co-offenders). Most girls experienced chronic CSA, by two or more perpetrators and a quarter experienced rape (25%). In one New Zealand study on CSA (Anderson, Martin, Mullen, Romans, & Herbison, 1993), the ratio of father daughter incest was found to be 1 in 100; in this sample 22.7% of girls were sexually abused by their biological fathers. Research suggests that intra familial abuse that also includes vaginal penetration can produce more severe outcomes for survivors (Barker-Collo & Read, 2003; Fergussson, Horwood & Lynskey, 1996; Kendall-Tackett, et al., 1993).

The association between CSA and the consequential psychological and health outcomes for girls has been widely documented in research. Many of these also appear to be characteristics of girls in NZ with HSB. For example, a recent international longitudinal study (Trickett, Noll & Putnam, 2011) on girls with a history of intrafamilal CSA found that cognitive deficits, depression, PTSD, dissociative symptoms, maladaptive sexual development, high rates of obesity, more major illnesses, school related problems, self-mutilation, substance abuse and gynecological problems are effects commonly experienced by girls.

Girls are also more likely that boys to engage in internalising behaviours that are evidenced through depression, suicidal ideation, disordered eating, substance abuse, anger, anxiety and poor self- esteem (Romans, Gendal, Martin & Mullen, 2001), delinquency and school problems (Chandy, Blum & Resnick, 1996). In a cross-sectional study on women's (18-44) histories of CSA in New Zealand, intrafamilial abuse was

linked to conduct disorder symptoms, substance abuse, depression, and eating disorders (Bushnell, Wells & Oakley-Browne, 1992).

Sexual Behaviours

In this study, sexual behaviours that were non-HSB raised a number of concerns. A number of girls presented as highly sexualised, with poor personal boundaries, sexualised clothing, and/or who sexualised older men. Clinical concern oriented toward concerns around re-victimisation and safety. This study suggests that the relationship between CSA and re-victimisation needs to be understood through gendered social relationships, sexual health, development, and general safety.

A strong association has been found between girls who have experienced CSA and specific outcomes (Trickett, Noll & Putnam, 2011; Noll, Haralson, Butler & Shenk, 2011). In a NZ study (Fergusson, Horwood & Lynskey, 1997) it was found that the specific re-victimisation patterns for these girls were: they were likely to engage in sexual risk taking behaviours during adolescence; their first wanted sexual experience was often forced; and they were at increased risk of physical violence in future relationships, and of sexual re-victimisation into adulthood. This suggests a clear and extended vulnerability for women and girls.

Sexual Health Issues

In this study around one fifth of girls engaged in unsafe sexual encounters and/or had a sexual health problem, and 9.1% of girls expressed the desire to be pregnant. Forced sexual intercourse (rape) has also been found to increase the rates of teenage pregnancy and self-harming behaviours (Romans, Martin, & Morris, 1997). Research on sexual health issues for girls who have been sexually abused indicates that young women reporting chronic CSA were found to have earlier onsets of puberty (Romans, Martin, Gendall & Herbison, 2003; Trickett, Noll & Putnam, 2011), multiple sexual partners, and more sexually transmitted diseases (Fergusson et al., 1997) than their peers. Other specific health effects were associated with sexual behaviours such as the engagement in high risk sexual behaviours (Noll, Shenk & Putmen, 2009) including prostitution and greater likelihood of experiencing sexual dysfunction (Romans,

Gendall, Martin, Mullen, 2001). Girls who have been sexually abused also have an increased risk for teenage pregnancy (Fergusson et al., 1997; Fiscella et al., 1998; Herrenkohl et al., 1998; Rainey et al., 1995; Romans et al., 1997; Stevens-Simon & Reichert, 1994), and have been found to express an increased desire to be pregnant, possibly to substitute unmet psychological needs (Rainey et al., 1995). Sexual health issues have been identified in previous studies for girls with HSB, and differences in outcomes for girls with CSA and their peers are primarily located in gynecological problems (e.g. more sexual illnesses) (Miccio-Fonseca, 2000).

Summary

There is no doubt that experiences of maltreatment and family stress have adverse impacts for both boys and girls, but it is the combination of 'complex trauma' experiences and their gender-specific meanings that are important for understanding the experiences of this group of girls. Assessment and treatment pathways for girls with HSB need to be understood through girls specific histories and gendered social relationships; their sexual development histories, sexual decision-making processes and sexual health issues, and the gendered differences in their victimisation through which these issues interact.

Clinical Implications: Gender-responsive Approaches

Collectively, the findings in this study suggest much commonality with girls in internationally located samples. Gender-specificity is indicated through clear differences in trajectories for girls with sexually abusive behaviours compared to boys in terms of their pathway to offending and general clinical picture. No doubt, future research is likely indicate a more heterogeneous group, yet for many girls there are a number of pre-disposing factors such as maltreatment experiences and poor quality of life, that are likely to have contributed to the trajectory of sexually abusive behaviours. At this point it is difficult to gauge the exact precipitating and maintaining factors, however they are likely to result from the complex gendered experiences of a particular constellation of events, combined with an absence of protective factors, rather than a single simple explanation, such as a high frequency of CSA.

The findings for girls in NZ with HSB, combined with the gender-specific manifestations of the problems and the evident gender disparity in offence rates, bring forward a number of clinical considerations. These girls have sexually abused others, yet most of them have grown up in adverse circumstances and have been the victims of chronic maltreatment. When adolescent HSB is viewed within clinical approaches that take the 'snapshot approach', that is by way of the HSB itself and are absent of contextual analysis using a 'gender looking glass' (Goldberg, Leong & Lang, 2004), it is easy to view boys and girls in a similar fashion, and impose unisex approaches (Weedon, 2011a). To do so may address the short-term issue of children's safety; however, it is unlikely to address long-term recidivism issues and the well being of the girls themselves as they grow into women.

In relation to clinical interventions for HSB, gender-responsive approaches require the ethical stance of shifting the lens to accommodate the gender-specific consequences and dynamics of experiences, and their implications for effective short and long-term treatment. This stance requires compassion for their life experiences, validation of the consequences of such experiences to their everyday functioning, and accountability for the HSB itself (Weedon, 2011b). Holding this type of sequential view provides the space to acknowledge the individual voice of each girl and the relevance of her gender-specific pathway to sexually abusive behaviour.

Covington and Bloom (2001) describe the importance of acknowledging the overlap between life circumstances of girls and boys with youth offending problems, but also hold the view that the gender based differences require acknowledgement in clinical practice and research. Robinson (2009) supports this view, and proposes that it is only by knowing the differences between boys and girls with HSB that an effective assessment and treatment intervention for girls can occur. We need to develop a gender-responsive lens that promotes the incorporation of relevant international and NZ psychological literature on girls to conceptualise and understand the nuances of girls in NZ with HSB for effective clinical pathways (Weedon, 2011b).

One of the aims of this research project was to offer a new window to view and discuss the relevant information about treatment planning and provision to girls with HSB to better meet their needs within the sexual abuse treatment sector. The patterns that have emerged through this study acknowledge clear differences between girls and boys, and therefore support the need for different understandings of the experiences of girls to inform treatment.

The high level of maltreatment histories for girls in this study, combined with the research which identifies risk factors for girls youth offending warrant interventions based on a gender-responsive dual specialisation (complex trauma approaches and offence specific approaches) informed by research. To provide effective short and long term interventions, the impact of complex trauma and the gender based nuances of violence in the lived experience of girls well being and developmental pathways must be incorporated into interventions.

Study Limitations and Strengths

The strength of this study lies in the relatively larger sample size than those in previous studies on this population, and the patterns that have emerged provide a framework for understanding the specificity of girls with HSB in New Zealand. This sample draws from three community-based agencies (creating some demographical variability), rather than representing a singular residential sample where other emotional and behavioural problems are also treated.

Like earlier studies, representativeness and generalisability of findings are two key issues that also exist here. However, the sample size remains too small to generate results of significance, therefore this research can only add to the knowledge of girls through patterns of difference. The sample is also limited in that it only accounts for offender populations.

Another limitation of the present study is that conducting a retrospective file audit from a 20-year period will have implications for the quality and the consistency of the

data and statistics kept in files, and changes over time. Technology and clinical practice has shifted during this time, influencing the way in which data is collected, recorded and kept. For example, a number of files were in traditional paper form only, and files that are more recent were located on three variations of computer databases where structural templates were in place to record specific information.

A further limitation is that the training backgrounds and professional affiliations of staff vary, for example, between clinical psychology, social work, counselling and psychotherapy, reflecting disciplinary differences in how to capture clinical issues, and the ways in which issues are recorded in notes and assessment documents. The use of psychometric measures and risk assessment tools has not been consistent over time or across sites.

In addition, human error and subjective interpretation in the data entry process of both the researcher and the clinicians working with clients cannot be ignored. Both processes of data collection may have had a contaminating effect. There is no inter-rater reliability in this study, and statistical analysis to a level of significance between variables was not possible.

In terms of recording contentious issues such as maltreatment, where 'no evidence' is found may be correct reflection, however it also depends on memory of trauma, under-reporting and problems with mandatory reporting processes across agencies. In one New Zealand study (Mullen et al., 1991) it is suggested that fewer than 40% of survivors of CSA are likely to disclose their abuse. A second New Zealand study on women with histories of CSA found that on average it took 16 years before they disclosed (McGreggor, 2004). Where intergenerational maltreatment exists, it also may be likely that the girls themselves are not able to define what abuse is when it is normalised within their families.

Future Studies

Insufficient information and data sources on girls with HSB have negatively influenced the number of studies that compare and contrast girls with other groups. To go forward with these types of comparisons restricts our understanding of the relevant developmental, etiological, and cultural and gender based variables. There is a risk of forgoing a gender analysis all together to better understand the causal relationship between the high frequency of maltreatment and the trajectory and maintenance of HSB. More recently, the research on girls with HSB has shifted to include a greater analysis of within-group differences. This is still predominantly comparative, and gender-responsive analysis is rare.

It is recommended that future research prioritises understanding the meaning behind the gender disparity in adolescent HSB rates. Apart from the obvious biological differences between boys and girls, there are likely to be gendered configurations within the patterns of HSB, particularly in the histories of CSA. A gender analysis in any future research will assist in better understanding the uniqueness of girls' HSB, by moving away from a surface level focus on the offending and clinical characteristics themselves to a focus on the specificity of the lived experience of girls, and their trajectory into womanhood. It may be useful to make sense of HSB through an analysis of the retrospective narratives of women who have survived the experiences.

In order to advance clinical interventions in this developing field, future research that integrates notions of gender identity development, the influence of gender role stereotypes and attitudes, gender-specific protective factors, personal traits and experiences, and gender-responsive treatment outcome evaluations is required (Frey, 2006; 2010). This would allow space to acknowledge the importance of cultural scripting and socially constituted sexual scripting for making meaning of the abuse between girls and boys, girls and girls, and the complexities of co-offending with others.

Conducting research in services for survivors may widen our understanding of typologies beyond that offered by Mathew, Hunter and Vuz (1997). It may also improve our understanding of the causal relationship between sexual victimisation and sexual offending for girls. For example, moving beyond acknowledging experiences of childhood sexual abuse to looking at the constellation of systemic based events around the CSA that lead to HSB may explain how HSB becomes a particular behaviour.

Another issue that cannot be ignored is the escalating sexualisation of girls and how this is shaping their sexuality (American Psychological Association, 2010), coupled with the effects of globalisation, and computer and mobile technological advances. These factors will no doubt interplay with youth culture in the future and shift the manifestations and definitions of HSB.

Of additional consideration for this study and any future research is the inclusion of 'highly sexualised girls' in samples. Most of the girls in this study did not begin their offending as children, and there is a need to be careful not to label girls and create fixed pathways, particularly when sexualised behaviours are not uncommon for girls who have experienced chronic CSA. Prostitution and promiscuous behaviours, although highly concerning, are more likely to be a danger to girls themselves than to others (Hubbard & Mathews, 2008). Treating girls for sexualised behaviours in offender-based services can blur the boundaries of HSB and create unwarranted stigma, regardless of the term used to describe the service. Furthermore, some consideration for cases where girls have been coerced or sexually abused themselves as part of the offence is also required.

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Appendix A: Studies on Girls with Harmful Sexual Behaviours

Descriptive Studies

Authors/ Year	Age Range (Yrs.)	Country/ Participants/ Data Source	(*n*)	Study Focus	Key Findings
Bumby & Bumby (1997)	Juvenile	United States of America (USA) In patient psychiatric facility	12	*Study (1)* Descriptive	○ 100% sexually abused; 75% physically abused ○ 42% emotional or physical neglect ○ 83% had received prior mental health treatment and had histories of depression; 58% previous suicide attempts ○ 58% had histories of drug use; 75% abused alcohol; 58% had run away; 58% had been truant ○ 11 out of 12 offended while babysitting
Dowdell, Cavanaugh, Burgess & Prentky (2009)	4-17 yrs. (*m*= 11.5 yrs.)	USA Convenience sample drawn from a larger study (*n*=822) by Prentky, Schwartz, Pimental, Cerce & Cavanaugh (2003) using archival records	155	To describe the characteristics of girls in foster care who had sexually abused children	○ Significant histories of maltreatment, chronic health issues and foster placement instability ○ High risk of multiple foster care placements
Evans, Cosgrove, Moth & Hewitson (2004)	12-19 yrs.	New Zealand (NZ) Survey sent to health professionals working with adolescents in the Christchurch region	8	Looking at the need for a programme within the Canterbury region and to gather clinical characteristics of girls in the community with HSB	○ Maori (*n*=3)/European (*n*=5) ○ Clinical characteristics included high rates of maltreatment and displacement similar to that found international studies

Fehrenbach & Monastersky (1988)	10-18 yrs.	USA/University of Washington Juvenile sexual offender outpatient clinic Clients seen over a seven year span	28	Interviews with subjects, families & a file review	○ In comparison to adult female offenders who have high rates of co-offending, most offences occurred without a co-offender ○ In comparison to adolescent boys with HSB, offences began at younger ages, and the victims were younger children
Fromuth & Conn (1997)	17-21 yrs.	USA College students who were part of a larger study (*n*=546)	22	Self-report survey identifying HSB in childhood & adolescence	○ Girls with HSB are more likely than non-perpetrating peers to have been sexually abused as children
Hendriks & Bijleveld (2006)	11-18 yrs.	Netherlands HSB registered by public prosecutor	10	Gender comparison Analysis of psychological screening data	○ Most co-offended, and in most cases force was used ○ Victims were both boys and girls ○ High rates of neglect, sexual victimization and neuroticism
Hirschberg & Riskin (1994)	11-17 yrs.	USA Germaine Lawrence Incorporated Residential Treatment Programme	20	Girls with HSB in residential treatment - characteristics and treatment implications	○ Most of the girls first offended under the age of 13, and were also victims of CSA by multiple perpetrators ○ All of the girls experienced either sexual and/or physical abuse ○ None of the girls had come from a family where they were living with both of their biological parents ○ High rates of substance abuse and mental illness were found in one or both parents ○ Interventions require both offense specific and trauma components

Howley (2003)	10-18 yrs.	USA Germaine Lawrence Incorporated Residential Treatment Programme	66	Case review of girls with HSB in residential treatment: characteristics and treatment implications	○ 97% had sexual abuse histories ○ For 75%, their CSA began under 5 years of age (*m*=3.8), and was carried out by multiple perpetrators over a long period ○ 32% of the girls were sexually abused by a female perpetrator ○ 82% experienced physical abuse ○ 71% experienced neglect ○ HSB was often driven by anger (approximately 61%) ○ HSB linked to CSA
Hunter, Lexier, Goodwin, Browne & Dennis (1993)	13-17 yrs.	USA Residential treatment facility for behavioural & emotional disorders	10	Structured interviews to examine psychosexual, attitudinal and developmental characteristics	○ 80% Caucasian ○ High rates of CSA from a young age by multiple perpetrators ○ All of the girls were abused by males, some of which included abuse by females (*n*=6) ○ Arousal was present during at least one experience of sexual victimization ○ Victimization was particularly distressing when the offence was committed by another female ○ The nature and patterns of HSB were similar to boys & contained fantasies ○ Victims were both boys and girls
Taylor (2003)	4-16 yrs.	United Kingdom (UK) Review of social service files	19	Examining HSB, family backgrounds & factors related to recidivism in adulthood	○ No firm findings yet, study ongoing ○ This study also contains 208 boys
Turner & Turner (1994)	12-17 yrs.	USA Group Treatment Programme	8	Exploratory study of mother daughter dynamics	○ The personal histories of both the mother and daughter, and the impact on their relationship has implications for both treatment planning and interventions

Comparison Studies

Authors/ Year	Age Range (Yrs.)	Country/ Participants/ Data Source	(*n*)	Study Focus	Key Findings
Bumby & Bumby (1997)	Juvenile	USA In patient Psychiatric Facility	18	*Study (2)* Comparison of non-offending girls (*n*=26), boys with HSB (*n*= 18), non-offending boys (*n*=24)	○ Compared to boys with HSB, girls with HSB had higher CSA rates - 100% for girls vs. 63% of boys ○ Girls with HSB abused drugs at a higher rate than boys with HSB, and had higher truancy rates ○ Girls with HSB were retained at least one grade in school at a significantly higher rate than boys with HSB
Fortune (2007)	10-17 yrs.	NZ Community-based Treatment Programmes for sexual offences	13	File audit, part of larger evaluation study. Comparisons with boys and other special populations (*n*=702)	○ Younger at point of referral than boys ○ Multi-problem and chaotic families ○ High rates of divorce/separation amongst parents ○ Family members with mental health problems ○ Substance abuse, non-sexual and sexual offending, and witnessing domestic violence within the family ○ Higher rates of sexual victimisation than male youth
Hickey, McCrory, Farmer & Vizard (2008)	Juvenile	UK specialist community-based forensic Service File review 40.9% of girls and 23.2% of boys had an IQ under 70	22	Comparison with adolescent boys who had HSB (*n*=254)	○ HSB is similar to boys, however girls have higher rates of CSA, which occurs at younger ages by a greater number of perpetrators in comparison to boys ○ Girls follow different pathways to HSB and are more likely to come from homes with poor sexual boundaries ○ 91% of girls and 82% of boys were Caucasian

Kubik, Hecker & Righthand (1) & (2) (2002)	13-18 yrs.	USA - Maine Department of Corrections Archival Study	11	(1) Comparison with non-abusing delinquent adolescent girls (*n*=11) (2) Comparison with adolescent boys who have sexually abused (*n*=11)	○ (1) Fewer antisocial problems, younger onset of offending ○ (2) Remarkably similar in offences and backgrounds, apart from experiencing more severe and pervasive maltreatment than boys ○ All of the girls & boys with sexually harmful behaviours in this study were Caucasian
Kubik & Hecker (2005)	13-18 yrs.	USA Recruited through the department of Corrections and residential programmes for emotional and behavioural disorders	11	Comparison with delinquent (*n*=12) & non-delinquent girls (*n*=21) Looking for cognitive distortions Analysis of responses to 12 vignettes that describe sexual contact between an adolescent girl & a younger boy	○ Girls with HSB displayed more cognitive distortions about responsibility for the HSB when vignettes were presented ○ The majority of participants were Caucasian
Lindquist (2001)	Adoles cents	France Group Treatment	15	Comparison with adult women, Semi-structured interviews	○ *(Unable to access study)*
Mathews, Hunter & Vuz (1997)	11-18 yrs.	USA Minnesota Residential programme (*n*=51) Community- based programme (*n*=16)	67	Gender comparison with 70 boys across three areas; developmental and psychiatric factors, maltreatment histories & offence characteristics Client interviews & File reviews	○ Girls had more severe & chronic maltreatment histories ○ Girls were mostly sexually abused by males ○ Girls were more frequently sexually abused by females than boys were ○ Girls offending characteristics suggested psychological disturbances on par with the comparison group of males ○ Like males they had also been exposed to the modeling of interpersonal aggression by both

					genders ○ A larger number of the girls had repetitive patterns of sexual offending ○ Three sub-types proposed. Those with *'little to none'*, *'mild to moderate'* or *'severe'* psychopathology, maltreatment and/or dysfunctional families ○ 86.6% Caucasian
Miccio-Fonseca (2000)	Adult and adolescents (*n* = 22)	USA Southern California Psychiatric Facility	18	Comparison with boys (*n*=332) and non-offending girls (*n*=215) on several variables Client interviews Part of larger 7 year study	○ Significant differences on numerous psychological, life-stressor & sexual variables across both groups ○ Girls with HSB had poorer sexual health, and differences in gynecological problems, e.g. more sexual illnesses ○ Both family therapy and individual therapy is required for the level of trauma resulting from high rates of sexual victimization amongst girls with HSB ○ Significant differences on suicide histories: Girls with HSB had higher rates of suicide attempts (44% vs. 15% males), and 50% of the girls came from families where someone had attempted suicide (only 8% for males)
Ray & English (1995)	Children & adolescents	Current active public agency caseloads of social workers statewide To be part of this study participants had HSB, and were victims of	17	Part of a study that also looked at HSB for girls under 12 (*n*=17), boys under 12 (*n*= 72), and adolescent boys (*n*=165)	○ Girls' HSB started younger than that of boys ○ Higher rates of maltreatment than boys ○ Acting out behaviours differed to boys ○ System responses to adolescent girls differed to boys. This may be due to

		child abuse and neglect			their young ages and not being able to charge them, and/or inconclusive information ○ 66% of the girls (*n*=34) were Caucasian
Schwartz, Cavanaugh, Pimental & Prentky (2006)	3-18 yrs. (*m*=9.5 yrs.)	USA - Massachusetts in the care of the Department of Social Welfare Data drawn from evaluations of case files	154	Gender comparison with 659 boys with HSB who also had adverse life experiences Comparable I/Q and levels of education between groups	○ High rates of chronic and severe CSA for girls in comparison to boys ○ High rates of caregiver instability, severe maltreatment and subsequent psychiatric sequelae amongst boys and girls ○ Girls witnessed more domestic violence and sexual deviance at home in comparison to boys ○ 60% Caucasian
Sigurdsson, Gudjonsson, Asgeirsdottir & Sigfusdottir (2010)	16-24 yrs.	Iceland Data drawn from a larger sample of students in further education (*n*=10,515) In 2004 93% of all 16 year olds in Iceland attended further education Sample seen as representative Looking at backgrounds, behaviours and mental health Self-reports of HSB were sought	86	Gender comparison with 212 boys with HSB Looking at background variables in sexually abusive youth in comparison to non-offending youth, as identified in the Beech & Ward etiological model of risk (2004)	○ Of most significance a history of sexual abuse, followed by delinquent peers (and their influence on HSB) ○ Poor self-regulation is a predictor variables across both genders ○ Violence in the home is not a significant predictor for girls, but is for boys ○ Prostitution and the use of sedatives and amphetamines were also factors for girls
Tardif, Auclair, Jacob & Carpentier	12-17 yrs.	Canada - Montreal Outpatient clinic for sexual offending	15	Comparison with adult female sexual offenders (*n*=13) 5 year age difference between	○ There were cumulative developmental disturbances across both groups effecting their sexual identity development. For example;

(2005)		Sample drawn from assessment & treatment over a 10 year period		subjects and victims in both groups Looking at relational problems present in both childhood and adulthood and how this links to their own victimization	parental abandonment, conflictual relationships with mothers, and physical and sexual victimization. This was linked to the relational component HSB and how they channeled their aggressive impulses o High rates of intra-familial offending for both groups o Girls' HSB was often repetitive and precocious
Vandiver (2010)	12-17 yrs.	USA - Texas FBI incident information from 22 States	177	Gender differences in adolescents arrested for sex offenses, and a comparison of co-offending patterns Boys randomly selected (*n*=177)	o Gender differences exist in offence patterns o Girls were younger at time of first offence, and more likely to have a co-offender (mostly male) o Girls are less likely to rape o Girls are also less likely to be held accountable by legal processes o 'Social amplification' may be a factor for girls co-offending o A large portion of girls in this study were Caucasian (84%)
Vandiver & Teske (2006)	12-17 yrs.	USA - Texas	61	Gender comparison Overview of sex offender registration data & criminal history records 122 boys Each of the girls was matched with 2 boys (based on year of birth and race)	o Girls were younger at time of first offence Victims were boys and girls, as opposed to boys who had more female victims (offense characteristic modalities differ) o The victim's gender & the length of sentence predicted offenders gender (management strategies differ between genders) o 51% Caucasian or Hispanic (one category)

Within Group Differences

Authors/Year	Age Range (Years)	Country/ Participants/ Data Source	(n)	Study Focus	Key Findings
Roe-Sepowitz & Krysik (2008)	7-17 yrs. (*m*= 13.9 yrs.)	USA - Florida Drawn from statewide database (1999-2005) Non-clinical sample of girls charged with sex offenses	118	Within group comparison of maltreated (*n*=60) & non-maltreated girls (*n*=58) with HSB	○ Adolescent girls with sexually harmful behaviors are a heterogeneous group ○ Those with maltreatment histories are more likely to present with mental health diagnoses and clinical symptoms ○ Those with sexual victimisation histories used higher levels of coercion ○ Treatment needs to emphasize both the maltreatment and the sexually harmful behaviors, and take place within a gender-responsive intervention ○ 61% Caucasian
Thompson (2010)	9-17 yrs.	USA - Records of girls who had been referred for the evaluation of sexually inappropriate behavior by outpatient sexual offender treatment facilities (between 1990-2008)	88	1. Predictors of internalising and externalizing behaviors in girls with HSB 2. Characteristics of CSA and links to later HSB	There is a relationship between: ○ Severity of CSA and internalising behaviors ○ Neglect/changes in living circumstance) and externalizing behaviors ○ CSA characterized by penetration & seriousness of HSB ○ CSA by males (rather than males and females) predicted more HSB victims and seriousness of HSB ○ A large portion of girls in this study were Caucasian (56%)

Case Study

Authors/Year	Age Range (Years)	Country/ Participants/ Data Source	(n)	Study Focus	Key Findings
Higgs, Canavan & Meyer (1992)	14 yrs.	USA - Texas In-patient clinic	1	Case Report	○ Highlighting links between severe victimisation & later HSB

Studies using data drawn from practitioners and treatment providers about interventions with girls presenting with harmful sexual behaviours

Authors/ Year	Age Range (Years)	Country/ Participants/ Data Source	(n)	Study Focus	Key Findings
Knopp & Lackey (1987)	11-17 yrs.	USA 19 States Predominantly community based outpatient programmes	130	35 respondents who work with adolescent girls with HSB filled in a 4-page questionnaire circulated to SAFER-Society members who identified they worked with females. The intention was to identify sexual offences and assessment/treatment considerations	○ The majority of the 130 girls identified as clients were adjudicated, and were victims of CSA ○ The majority of HSB was hands on (76.5%) and against an acquaintance (67%) ○ Cognitive, behavioral and family systems were the most popular interventions
Vic, McRoy & Mathews (2002)	Adolescents	USA Clinicians fro outpatient treatment center's, private practice &, residential treatment	332	Nationwide survey of clinicians working with girls (0-18 yrs.) with HSB, followed by a smaller number of phone interviews (n=15)	○ There are a lack of tools, assessment and treatment procedures available to work with girls who have HSB ○ Perceived differences exist in the work with girls compared to boys, although reported background differences were few ○ Cognitive- behavioral therapy was the most used intervention ○ Girls should be asked in the assessment process if they have ever been sexually abused, this will encourage openness about the issue ○ Treatment should include working with past victimisation

Appendix B: Offence Characteristics found in studies on Girls with Harmful Sexual Behaviour

Authors/Year	Age at Time of Offence	Victim Age	Victim Gender	Offence Characteristics	Relationship with Victim
Thompson, L. (2010)	10-11 yrs. (Av)	Average of age of first victims 5-6 yrs.	Both	Only 80 of the 88 had engaged in 'substantiated HSB'. 8 were included based on suspicions of sexual acting out Predominantly touching 33% inclusive of penetration	Mostly family members Victims in foster home Some peer-aged but Mostly younger children
Vandiver (2010)	14 yrs. (Av)	62% 12-17 yrs. 18% 6-11 yrs. 16% 0-5 yrs. 48% victims same age or older	Co-offending 62% female 32% both Acting alone 42% male 50% female	41% forcible fondling 20% forcible rape 10% forcible sodomy 52% at least one co-offender 32% of which were male	76% known 23% related
Dowdell, E., Cavanaugh, M., & Burgess, D & Prentky (2009)	Not Collected (N/C)	N/C	N/C	100% exposure, sexually aggressive remarks, sexual touching without permission, genital touching without permission 34% fondling 35% abused 3 or more children	N/C
Hickey, Mc Crory, Farmer & Vizard (2008)	N/C	6 yrs. (Av)	59.1% abused only male victims 86.4% abused only female victims 50% abused male and female victims	77.3% fondling 40.9% oral genital contact 31.8% any penetration 27.3% verbal coercion/threats 9.1% physical coercion threats	45.5% abused relatives 81.8% friends or acquaintances 9.1% strangers

Roe-Sepowitz & Krysik (2008)	N/C	21 % same age or older 59% younger 44% of the girls had a victim that was more than 5 years younger	56% female 26% male (primary case only)	For 81% this was their first offence and 78% had only one victim 16% fondling 16 % oral sex 10% exposure to sex act 39% no force/consensual 10% physical force/violence 14% committed offence in a group	48% related 32% of which were siblings 47% known 10% babysitting 44% friends
Fortune (2007)	10-17 yrs.	At first offence: 32.1% 5-9 yrs. 17.9% < 4 yrs.	23.1% male only 38.5% female only 38.5% male and female	Number of known victims ranged from 1 to 4 30.8% 'Hands on' offences only 46.2% 'Hands off' offences only 23.1% both hands on and hands off	35.7% family 60.7% known, unrelated 3.6% strangers
Vandiver & Teske (2006)	49.2% 11-13 yrs. 44.3% 14-16 yrs.	34.4% 0-5 yrs. 51% 6-11 yrs.	59% female 41% male	N/C	N/C
Hendriks & Bijleveld (2006)	50% less than 13 yrs.	Average: Primary school age	Both	Violence & co-offending present for a significant portion of this group	Almost always a family member or acquaintance
Schwartz, Cavanaugh, Pimental & Prentky (2006)	N/C	N/C	N/C	N/C	N/C
Tardif, Auclair, Jacob & Carpentier (2005)	11 yrs. (Av)	86% 0 to 5 yrs.	60% male 13% female 26% male & female	93% sexual fondling 66% masturbation by victim 46% masturbation of victim 33% oral/genital abuse of victim	N/C
Kubik & Hecker (2005)	N/C	N/C	N/C	90% fondling 45% digital penetration 45% kissing 27% physical aggression 18% verbal threats 33% motivate by anger 22% considered it mutual 18.2 % co-offended (*n*=2)	72% acquaintance 36% sibling 9% cousin 27% while babysitting

Evans, Cosgrove, Moth & Hewitson (2004)	N/C	(*n*=3) 1-5 yrs. (*n*=3) 12 plus	50% Male (n=2)Both (n=1) Female	Some co-offending	N/C
Kubik, Hecker, & Righthand (1) & (2) (2002)	11 yrs. (Av)	N/C	36% Male 27% Female 36% Both	27% exhibitionism 36% kissing 27% fondle breasts 90% fondle genital 27% intercourse 54% repeat offenses 27% verbal threats 54% minimal physical aggression	72% casual acquaintance 27% relative 27% sibling
Howley (2001)	10-13 yrs. Average age of first offence: 10.65 57% offended between ages of 10-13 yrs. 30% offended prior to the age of 10	7.1 average age	Both equally 48% males 52% females	Usually occurred in own home & victims home Multiple victims Multiple times Tendency to sexually offend alone	Victims known, primarily siblings
Miccio-Fonseca (2000)	N/C	N/C	N/C	N/C	20% female family member 50% male family member
Bumby & Bumby (1) & (2) (1997)	N/C	N/C	42% female 25% male 33% both	90.9% fondling 27.3% vaginal intercourse 18.2% anal intercourse	83% family members 16% exclusively nonfamily members None of the victims were strangers
Fromuth & Conn (1997)	12 yrs. (mean)	6 yrs. (mean) 1-9 yrs. (range)	70% Male	50% fondling 8% force	N/C

	9-18 yrs. (range) 89% 10-14 yrs.	68% 5-7 yrs.		17% bribes	
Mathews, Hunter & Vuz (1997)	N/C	52% under 5 yrs.	44% male 23% female 31% both	77% fondling 50% viewing pornography 47% oral sex 19% used force	35% sibling 25% relative
Ray & English (1995)	11.6 (mean)	Peer aged males and younger girls and boys were most likely victims	Peer aged males and younger girls and boys were most likely victims	Noted: molesting public masturbation exposure	N/C
Turner & Turner (1994)	N/C	N/C	N/C	75% simulated intercourse	87% family members
Hirschberg & Riskin (1994)	13 girls were under 13 at age of first know offence Average age just under 11	2-12 years (Range) Average age just under 6	50% girls 50% boys	75% genital contact without penetration 70% fondling 45% oral sex 30% vaginal penetration with finger and/or object 55% of the girls offended over for a period of more than 6 months on multiple occasions 30% used force 1 girl committed hands off offences with her boyfriend present	85% offended a younger sibling Mostly family members
Hunter, Lexier, Goodwin, Browne, & Dennis (1993)	9.5 yrs. (median)	5.5 yrs. (median)	60% male 39% female	100% fondling 70% oral 70% vaginal 60% fantasies prior to offense 40% used force	30% sibling 39% stranger
Higgs, Canavan & Meyer (1992)	12	Present	Male	Intercourse	Cousin
Fehrenbach & Monastersky	13 Yrs.	N/C	35% males 51% females	53% rape (oral, anal or vaginal intercourse, or penetration with object or finger)	67% during babysitting

(1988)				46% indecent liberties	
Knopp & Lackey (1987)			56% female 44% male	76.5% hands on (child molestation /161 and rape/28)	67% acquaintances 28% incest related 5% strangers

Appendix C: Psychosocial Histories found in studies on Girls with Harmful Sexual Behaviour

Author/Year	Current/History of Mental Health Diagnosis	Living Situation	Family Characteristics	School Problems	Peer Relationship Issues/ Delinquent Peers	Other Problem Behavior
Thompson (2010)	83% had at least one or more diagnoses 33% depression 27% PTSD 21% CD 20% ADHD 15% ODD 14% RAD 17% learning disability FASE (*n*=13)	Numerous changes in caregivers and living situations	44% living with a caretaker who was drug/ and or alcohol impaired	School behavior problems present	N/C	Drug & alcohol use Self-harm Sexually proactive Property crimes Non-sexual assaults
Vandiver (2010)	N/C	N/C	N/C	N/C	N/C	N/C
Sigurdsson, Gudjonsson, Asgeirsdottir & Sigfusdottir (2010)	4% serious conduct disorder 29% previous suicide attempt	N/C	86% serious arguments with parents	N/C	59% rejected by peers 84% delinquent peers	20% prostitution High rates of drug abuse
Dowdell, Cavanaugh, & Burgess & Prentky (2009)	67% PTSD 54% mood disorders 43% oppositional defiant disorder 76% on psychiatric medication 12% psychosis	64% had 9 or more changes in living circumstances 72% were place in 3 or more foster homes 98% separated from biological parents, 32% had been	N/C	N/C		29.8% enuresis 29% chronic medical illness 20% learning disorder 21% drug abuse history

		separated between 6-10 yrs.				
Hickey, McCrory, Farmer & Vizard (2008)	40% IQ less than 70 59.1% PTSD 40.9% RAD	N/C	77.3% poor sexual boundaries 81.8% inconsistent parenting 22.7% intergenerational sexual abuse 77.3% parental separation/divorce	N/C	N/C	N/C
Roe-Sepowitz & Krysik (2008)	49.2%	40.3% unstable	51% limited parental control	16% truancy 33% suspended or expelled	62% negative peers	52% prior delinquency 7.7% property damage
Fortune (2007)	84.6% history of generalized behaviour problems 61.5% history of one or more mental health problems 46.2% History of suicidal thoughts, suicide attempts and/or deliberate self harm	69.2% divorced/separated	46.2% sexual offences 38.5% domestic violence 30.8% non-sexual offences 30.8% substance misuse 23.1% mental health issues	15.4% expelled/suspended 15.4% truancy	15.4% poor peer relationships 23.1% low self-esteem	38.5% dishonesty 46.2% social skills deficit
Vandiver & Teske (2006)	N/C	N/C	N/C	N/C	N/C	N/C
Hendriks & Bijleveld (2006)	Many had serious neurotic disorders A form of psychopathology	N/C	Dysfunctional Alcohol abuse & divorce	2/3 of this group were in special education	At least half bullied or harassed	N/C

	present in half the cases			Over 50% below average intelligence	regularly by peers	
Schwartz, Cavanaugh, Pimental & Prentky (2006)	27.3% experienced birth complications 15% alcohol abuse and 20% drug abuse during pregnancy 15% history of head injury trauma	Caregiver instability, multiple different caregivers Average of 11 changes in living situations	42% witnessed sexual deviance	20.5% learning disorder 66% in special education classes	(N/C)	(N/C)
Tardif, Auclair, Jacob & Carpentier (2005)	20% PTSD 46.7% violence against others and drug consumption 33.3% ADHD & Suicide 80% learning disorder 26.7% dysthymic disorder 26.7% conduct disorder	(N/C)	73% separation, death or abandonment by one parent 60% conflictual relationship with mother 40% no contact with father	(N/C)	(N/C)	(N/C)
Kubik & Hecker (2005)	N/C	N/C	N/C	N/C	N/C	N/C
Evans, Cosgrove, Moth & Hewitson (2004)	(*n*=7) Current (*n*=1) previously involved	80%	(N/C)	Low academic achievement (*n*=5)	N/C	N/C
Taylor (2003)	N/C	N/C	N/C	N/C	N/C	N/C
Kubik, Hecker & Righthand (1) & (2) (2002)	90% previous outpatient treatment 36% previous inpatient treatment	45.5% history of foster placement	63% history of protection issues 18% parents marriage intact	54.5% special classes 27.3% disruptive school	50% problems with peers	45% absconding 30% fighting 27% serious anger problems 30% vandalism/property destruction

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	50% PTSD 45% suicide attempts 36% self mutilation 36% ADHD 36% mood disorders			behavior 9.1% suspensions 18.2% truancy		60% previous non-sexual offense history 27% serious anger problems
Howley (2001)	32% PTSD 21% ODD 18% major depression 8% conduct disorder	N/C	62% witnessed domestic violence 80% had parents with substance abuse	50% received special education services 60% below average IQ 39% truancy 29% suspended or expelled	76% had aggressive peer relationships	49% run away 67% delinquent behaviour in the community (not necessarily arrested) 46% assault on family members
Miccio-Fonseca (2000)	44% history of suicide attempts 50% Come from families where someone had attempted suicide	(N/C)	(N/C)	(N/C)	(N/C)	(N/C)
Bumby & Bumby (1) & (2) (1997)	83% depression 58% attempted suicide 43.9% suicidal ideation	N/C	50% came from homes with domestic violence 83% had at least one parent who abused alcohol or drugs Nearly all came from divorced families	(1) 58% truancy 83% academic difficulties 1/3 had been retained a grade at least once 11/12 had significant problems with peers at school	75% were socially isolated 67% had a history of aggressive behaviours towards peers	75% alcohol abuse 58% drug abuse 33% arrested for stealing 58% history of running away

				67% had been suspended or expelled at least once		
Fromuth & Conn (1997)	N/C	N/C	N/C	N/C	N/C	N/C
Mathews, Hunter & Vuz (1997)	71% previous mental health treatment 43% suicidal ideation/attempts 50%+Mood disturbance Nearly half: PTSD	N/C	N/C	N/C	N/C	N/C
Ray & English (1995)	N/C	N/C	48.5% living with single parent	43.8% truant	N/C	39.4% bedwetting 70% physical fights 93.3% sexually inappropriate 82.8% verbally abusive 87.5% disobedience 64.5% property damage 40% shoplifting
Turner & Turner (1994)	37% PTSD 50% conduct disorder	N/C	Attachment issues Poor boundaries with mother Alcohol abuse Inconsistent & unstable father figures	N/C	N/C	(N/C)
Hirschberg & Riskin (1994)	N/C	N/C	70% at least one parent had substance abuse problems 45% at least one parent hospitalized use to mental illness 95% of the girls were the oldest girls in the	N/C	N/C	N/C

			household No girl came from an intact family			
Hunter, Lexier, Goodwin, Browne, & Dennis (1993)	60% history of suicide attempts/ideation 90% PTSD & mood disturbance	N/C	N/C	60% history of running away 50% Drug & alcohol 40% Learning disability	N/C	40% enuresis
Higgs, Canavan & Meyer (1992)	Present	Present	Present	Present	Present	Present
Fehrenbach & Monastersky (1988)	N/C	N/C	N/C	N/C	N/C	N/C
Knopp & Lackey (1987)	N/C	N/C	N/C	N/C	N/C	N/C

Appendix D: Summary of Maltreatment Histories found in studies on Girls with Harmful Sexual Behaviour

Authors/Year	Child Sexual Abuse (CSA)	Child Physical Abuse (CPA)	Exposure to Domestic Violence (DV) or criminal activity	Emotional &/or Physical Neglect
Thompson, L (2010)	90.9% experienced CSA 12.5% penetrative 78.4% non-penetrative 61.4% by one gender 29% both genders 60.2% males - mostly neighbors/acquaintances, followed by fathers and male family members Of the 42 girls aged 0-4 yrs. 26% experienced penetrative CSA	65.9% CPA 63% by mother 45% by father 39 girls had an onset between 0-4 yrs.	Low rates noted	Neglect was present across all age groups 53% experienced emotional neglect 42% experienced dangerous situations (0-4 yrs.)
Vandiver (2010)	Not collected (N/C)	N/C	N/C	N/C
Sigurdsson, Gudjonsson, Asgeirsdottir & Sigfusdottir (2010)	64% CSA	N/C	18% Domestic Violence (DV)	N/C
Dowdell, E., Cavanaugh, M., & Burgess, D & Prentky (2009)	80.9% (onset 5.1 yrs.) 68% more than one perpetrator 98% assaulted on multiple occasions 50% lasting more than 2 yrs. 64% vaginal/anal penetration	83.6% (Av onset 4.8 yrs.)	84.4%	95% neglect, onset at 2.8 yrs., 51% of which was severe and chronic, 85% more than 2 yrs. duration, 87% of neglect by mother 95% victims of ongoing abuse by biological parents
Hickey, McCrory, Farmer & Vizard (2008)	95.5% 4 yrs. (med age 1st experience) 3.5 (med number of abusers) 95.2% abused by males 57.1% abused by males and females 57.1% abused by females 76.2% penetration	63.6%	36.4% D/V	90.9% emotional 77.3% physical neglect
Roe-Sepowitz & Krysik (2008)	28% CSA	13%	N/C	N/C

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Fortune (2007)	77% CSA 50% first incidence 5 to 9 yrs. 30% first incidence 10-12 yrs. 80% CSA by adults 10% CSA by adolescents 70% known - relatives & 30% known - unrelated	61.5% CPA (50% by males and 50% by females) 25% onset 1 to 4 yrs. 37.5% onset 5 to 9 yrs. 62.5% by mother 37.5% by step/de factor mother or father	38.5% D/V	30.8% Neglect and emotional /verbal abuse
Vandiver & Teske (2006)	N/C	N/C	N/C	N/C
Hendriks & Bijleveld (2006)	Virtually all By family members	Virtually all By family members	50% plus DV	Virtually all By family members
Schwartz, Cavanaugh, Pimental & Prentky (2006)	81% experienced CSA Longer duration and significantly more severe than boys in study Multiple offenders 42% witnessed sexual deviance	83% CPA	84% DV	95% neglect
Tardif, Auclair, Jacob & Carpentier (2005)	60% CSA 11% mother 66% uncle 33% babysitter or acquaintance	40%	53% DV	N/C
Kubik & Hecker (2005)	63%	63%	62% DV	63%
Evans, Cosgrove, Moth & Hewitson (2004)	80% CSA 100% male	50%	N/C	N/C
Taylor (2003)	63% CSA	21%	(N/C)	10%
Kubik, Hecker, & Righthand	63.6% CSA 83% parent	63.6%	62% DV	63.6% CPA 70% neglect

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(1) & (2) (2002)	83% other family member 100% acquaintance 42% male 42% both males and females			
Howley (2001)	97% CSA 3.8 average age of victimisation 74% abused by 2+ perpetrators 68% high level of severity including penetration 21% severe, including ritual abuse or restraints 65% abused for 2 or more years Only 5% single sexual abuse incident 32% presence of a female perpetrator or co-perpetrator	82%	62% DV	33% emotional/verbal 71% general neglect
Miccio-Fonseca (2000)	72% CSA (64% of which were abused before age 5 yrs.) 33% incest 39% rape victims	N/C	56% DV	N/C
Bumby & Bumby (1) & (2) (1997)	100% CSA	75%		42% neglect
Fromuth & Conn (1997)	77% CSA	N/C	N/C	N/C
Mathews, Hunter & Vuz (1997)	77% CSA 64% < 5 yrs. (1st time) 58% male 4% female 38% both 42% father/stepfather 38% other relative 90% fondling 58% intercourse	60%	N/C	N/C
Ray & English(1995)	93.5%	90%	N/C	68% emotional 86.2% neglect
Turner & Turner	75% CSA 83% male family member	N/C	N/C	N/C

(1994)	16% female family member			
Hirschberg & Riskin (1994)	90% sexually abused, 10% suspected abuse by fathers as pre-schoolers 70% victim of family abuse 65% abused by more than ne perpetrator Mostly male relatives (Father, uncles, grandfathers)	55%	25%	25%
Hunter, Lexier, Goodwin, Browne, & Dennis (1993)	100% CSA 85% male 14% female 43% known acquaintance 27% other relative 12% father/stepfather Med age under 4.5 yrs. 90% vaginal/attempted/actual intercourse 60% anal attempted/actual intercourse 90% force	80%	N/C	N/C
Higgs, Canavan & Meyer (1992)	Present, by males	Present	Present	Present
Fehrenbach & Monastersky (1988)	50%	21.4%	N/C	N/C
Knopp & Lackey (1987)	93%	N/C	N/C	N/C

Appendix E: Data Collection Points

1.	General Information – Region, age at time of referral, cultural affiliation
	**Codes for the remaining categories was 'evidence' or 'no evidence'*
	Child, Youth and Family referral, involvement of other government and non-government agencies, previous ACC counseling, assessment, treatment or both
2.	Family Information - Parents separated, father contact, mother contact, siblings, known sex offender in immediate family, sexualised family environment, parental substance abuse, exposure to domestic violence, parental criminal history, parental mental health issues, significant death in immediate family, intergenerational CSA
3.	Placements -Number of placements, current placement with family, placements an intervention as a result of HSB?
4.	Education -Performance (below, comparable or above peers)
5.	Problem Behaviours- Difficulty regulating emotions, social skills problems, relational aggression (covert aggression or covert bullying within Interpersonal relationships - betrayal, exclusion/solitude, gossip, humiliation and lies), social Isolation, mood swings, anger problem, homicidal Ideation, verbally abusive, impulse control problems, substance abuse (alcohol and drug), suicide (attempts, ideation), self-harming (cutting, burning and other physically harming behaviours), food problems (over-eating, under eating, food hoarding), absconding, truancy
6.	Health Problems -Mental health (clinically significant problems), Physical health (medical problems, sexual health problems, enuresis, encopresis, poor hygiene/self-care, head injury)
7.	Anti-social Behaviours - Vandalism, lying, fire setting, non-sexual violence, animal cruelty (sexual and physical abuse), stealing

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8.	Sexual Behaviours - At risk of sexual re-victimisation, highly-sexualised behaviours, highly sexualised clothing, sexualises men, sexualises women, sexualises same aged male peers, engages in unsafe sexual encounters, poor personal boundaries, sexual health problems, wants to be pregnant, inappropriate use of social media, excessive masturbation, accessing pornography
9.	Maltreatment Histories - child sexual abuse, number of offenders, extra-familial, intra-familial, gender, onset, incest, rape, child physical abuse, emotional abuse, neglect
10.	Harmful Sexual Behaviours - Onset, incidents, gender, victim age, victim number, presence of impairment, location of offence, familial, non-familial or both, offence type (genital touching, touching breasts, forced to penetrate offender, digital penetration, kissing, oral sex, exposure to sex act, simulated intercourse, anal penetration, penetration with object, hands off), use of force, threats, injury to victim, group situation, flashing, sexualised talk, other
11.	Where relevant, information was also collected on motivations and other contextual issues

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