Child Sexual Abuse: Knowing and Not Knowing in Social Work Practice and Education

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A thesis submitted for the degree of Doctor of Philosophy at the University of Otago, Dunedin, Aotearoa/New Zealand.

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Abstract

Child sexual abuse (CSA) is a pervasive yet elusive social problem, arguably crossing all domains of social work practice. Within the practice sphere of mental health and addiction CSA is particularly prevalent, however, research indicates that inquiry is not routinely undertaken. Dominated by a medical paradigm and impeded by barriers at individual and organisational levels, mental health services often fail to truly implement a bio-psychosocial model and provide trauma-informed services. Within undergraduate social work programmes, the topic of CSA and the wider field of trauma have garnered minimal attention. Consequently, national and international studies have identified the need for specific training in CSA for social workers and mental health professionals. However, it is unclear to what degree social work educators are engaging in the “painful pedagogy” of teaching about CSA, and what their views are regarding the issue. Similarly, there is a paucity of research which has sought to qualitatively explore social workers’ perceptions of CSA, the sources for their understanding, and the degree to which they encounter and work with clients who have been sexually abused. This qualitative, interpretivist study draws on hermeneutic phenomenological methodology and attempts to fill some of these research gaps. Taking a dialectical perspective, I utilise a theoretical framework drawn from attachment, psychodynamic, neurobiological, and trauma literature, while also turning to Goffman’s (1959, 1963) work on stigma and impression management.

Eleven social workers within youth and adult mental health or addiction services explored their cognitive and affective perceptions regarding CSA, across two semi-structured individual interviews. A second sample of eight social work educators discussed pedagogical and pastoral implications of teaching about CSA, and expressed opinions about the sufficiency, efficacy, and relevance of CSA training within their social work programmes. Finally, a focus group comprising a sub-sample of social workers and educators provided an opportunity for both professional groups to dialogue about the education and practice implications, and to consider future directions.

While both sets of participants offered a range of opinions and strategies to address CSA academically and professionally, they also cited barriers. Social workers clearly recognised that CSA disclosure was a difficult and often delayed process, and perceived an association between addiction or mental health problems and a CSA history. Yet sexual abuse inquiry was not routine, nor was it always considered necessary or appropriate. Social work
educators considered the topic of CSA to be relevant to social work, yet participants revealed significant professional, student-related, and organisational obstacles to a greater academic focus on CSA. Among both samples, participants understandably expressed or exhibited emotional or bodily discomfort when discussing CSA, particularly in relation to perpetrators. This thesis argues that the significant emotional costs in addressing CSA may lead to individual and organisational responses which marginalise CSA as a practice or educational concern. Participants’ suggestions regarding working with clients or teaching students about the issue of CSA revealed a number of parallel processes, and pointed to the merits of a trauma-informed framework for practice and education. Drawing on the findings, extant literature, and policy, the study makes recommendations for mental health and addiction services and social work education.
Acknowledgements

My first acknowledgement is to my Creator, who has been my steady source of strength, wisdom, and guidance throughout this project. I also salute the enormous strengths of survivors of CSA that I have come to know in my personal and professional life. At the same time, I acknowledge their physical, mental/emotional, and spiritual suffering, and the pillaging of their power, trust, voice, bodily integrity, and childhood.

I wish to thank all my supervisors who have guided me through this research pilgrimage: Anita Gibbs, Nicola Atwool, Rebecca Stringer, Amanda Barusch, and Nicki Taylor. They each brought different areas of expertise, experience, and foci to bear upon my thesis, which enhanced my capacity to draw together multiple threads in the findings and extant literature. I wish to thank Amanda and Rebecca for their unswerving encouragement and faith, and constructive feedback attending to the figure and the ground. Thank you also Amanda for constantly spurring me on to become a better writer. Special thanks to Nicki Taylor, who, at the latter stages of my writing, provided detailed editing and invaluable comments regarding the whole thesis.

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I am indebted to my research participants who generously gave their time to an emotionally difficult topic, grappling with its complexities and paradoxes. I hope that this thesis has captured the multiplicity of voices.

In writing this thesis I have gratefully stood on the shoulders of many giants. I thankfully acknowledge the huge body of work that has gone before me.

Thanks also to Josie Scott who provided various mediums for me to express, reflect upon, and discharge the inevitable emotional costs of conducting this research. Finally, I thank my children for their patience, and my friends, family, and neighbours for their moral and practical support.
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<td>Adult Attachment Interview</td>
</tr>
<tr>
<td>AASW</td>
<td>Australian Association of Social Workers</td>
</tr>
<tr>
<td>ABS</td>
<td>Australian Bureau of Statistics</td>
</tr>
<tr>
<td>ACC</td>
<td>Accident Compensation Corporation</td>
</tr>
<tr>
<td>ACE</td>
<td>Adverse Childhood Experiences Study</td>
</tr>
<tr>
<td>ADHB</td>
<td>Auckland District Health Board</td>
</tr>
<tr>
<td>ANZASW</td>
<td>Aoteoroa New Zealand Association of Social Workers</td>
</tr>
<tr>
<td>AOD</td>
<td>Alcohol and Other Drugs</td>
</tr>
<tr>
<td>ANS</td>
<td>Autonomic nervous system</td>
</tr>
<tr>
<td>APA</td>
<td>American Psychiatric Association</td>
</tr>
<tr>
<td>ASCA</td>
<td>Adults Surviving Childhood Abuse</td>
</tr>
<tr>
<td>ATRIUM</td>
<td>Addictions and Trauma Recovery Integrated Model</td>
</tr>
<tr>
<td>AQA</td>
<td>Academic Quality Agency</td>
</tr>
<tr>
<td>BSW</td>
<td>Bachelor of Social Work</td>
</tr>
<tr>
<td>CADS</td>
<td>Community Alcohol and Drugs Services</td>
</tr>
<tr>
<td>COPE</td>
<td>Concurrent Treatment of PTSD and SUD Using Prolonged Exposure</td>
</tr>
<tr>
<td>COPMIA</td>
<td>Children of Parents with Mental Illness and Addiction</td>
</tr>
<tr>
<td>CNS</td>
<td>Central nervous system</td>
</tr>
<tr>
<td>CSO</td>
<td>Child sex offender</td>
</tr>
<tr>
<td>CWSE</td>
<td>Council on Social Work Education</td>
</tr>
<tr>
<td>CYFS</td>
<td>Child Youth and Family Services</td>
</tr>
<tr>
<td>CSA</td>
<td>Child sexual abuse</td>
</tr>
<tr>
<td>CSAM</td>
<td>Child Sexual Abuse Myth scale</td>
</tr>
<tr>
<td>CUAP</td>
<td>Committee on University Academic Programmes</td>
</tr>
<tr>
<td>DAPAANZ</td>
<td>Drug and Alcohol Practitioners Association of Aoteoroa New Zealand</td>
</tr>
<tr>
<td>DBT</td>
<td>Dialectical Behaviour Therapy</td>
</tr>
<tr>
<td>DHB</td>
<td>District Health Board</td>
</tr>
<tr>
<td>DIPSW</td>
<td>Diploma of Social Work</td>
</tr>
<tr>
<td>DSAC</td>
<td>Doctors for Sexual Abuse Care</td>
</tr>
<tr>
<td>DSM</td>
<td>Diagnostic and Statistical Manual of Mental Health Disorders</td>
</tr>
<tr>
<td>HCPC</td>
<td>Health and Care Professions Council</td>
</tr>
<tr>
<td>HMO</td>
<td>Health Maintenance Organisation</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Full Form</td>
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<tr>
<td>HRC</td>
<td>Health Research Council</td>
</tr>
<tr>
<td>IICSA</td>
<td>Independent Inquiry into Child Sexual Abuse</td>
</tr>
<tr>
<td>IWM</td>
<td>Internal working memory</td>
</tr>
<tr>
<td>MHC</td>
<td>Mental Health Commission</td>
</tr>
<tr>
<td>MOH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>MOJ</td>
<td>Ministry of Justice</td>
</tr>
<tr>
<td>MSD</td>
<td>Ministry of Social Development</td>
</tr>
<tr>
<td>MSW</td>
<td>Masters of Social Work</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-governmental organisation</td>
</tr>
<tr>
<td>NHS</td>
<td>National Health Service</td>
</tr>
<tr>
<td>NSF</td>
<td>Nationwide Services Framework</td>
</tr>
<tr>
<td>NZ</td>
<td>New Zealand</td>
</tr>
<tr>
<td>NZQA</td>
<td>New Zealand Qualifications Authority</td>
</tr>
<tr>
<td>NZQF</td>
<td>New Zealand Qualifications Framework</td>
</tr>
<tr>
<td>PARSAC</td>
<td>Professional Attitudes Regarding the Sexual Abuse of Children</td>
</tr>
<tr>
<td>PTSD</td>
<td>Post-traumatic stress disorder</td>
</tr>
<tr>
<td>SAMHSA</td>
<td>Substance Abuse and Mental Health Services Administration</td>
</tr>
<tr>
<td>SBP</td>
<td>Sexual behaviour problems</td>
</tr>
<tr>
<td>SSP</td>
<td>Strange Situation Procedure</td>
</tr>
<tr>
<td>STS</td>
<td>Secondary traumatic stress</td>
</tr>
<tr>
<td>SUD</td>
<td>Substance use disorder</td>
</tr>
<tr>
<td>SW</td>
<td>Social worker</td>
</tr>
<tr>
<td>SWED</td>
<td>Social work educator</td>
</tr>
<tr>
<td>SWRB</td>
<td>Social Work Registration Board</td>
</tr>
<tr>
<td>TARGET</td>
<td>Trauma Adaptive Recovery Group Education and Therapy</td>
</tr>
<tr>
<td>TEO</td>
<td>Tertiary Education Organisation</td>
</tr>
<tr>
<td>TREM</td>
<td>Trauma Recovery Empowerment Model</td>
</tr>
<tr>
<td>UK</td>
<td>United Kingdom</td>
</tr>
<tr>
<td>UNCROC</td>
<td>United Nations Convention on the Rights of the Child</td>
</tr>
<tr>
<td>UNZ</td>
<td>Universities New Zealand</td>
</tr>
<tr>
<td>US</td>
<td>United States</td>
</tr>
<tr>
<td>VT</td>
<td>Vicarious traumatisation</td>
</tr>
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<td>WHO</td>
<td>World Health Organisation</td>
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</table>
# Glossary

**Māori**

<table>
<thead>
<tr>
<th>Term</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aotearoa</td>
<td>land of the long white cloud, New Zealand</td>
</tr>
<tr>
<td>aroha</td>
<td>love, compassion</td>
</tr>
<tr>
<td>atua</td>
<td>spirit</td>
</tr>
<tr>
<td>hapu</td>
<td>sub-tribe or clan</td>
</tr>
<tr>
<td>hauora</td>
<td>health</td>
</tr>
<tr>
<td>hinengaro</td>
<td>intellect</td>
</tr>
<tr>
<td>hui</td>
<td>conference, meeting</td>
</tr>
<tr>
<td>iwi</td>
<td>tribe</td>
</tr>
<tr>
<td>kanohi ki te kanohi</td>
<td>face-to-face</td>
</tr>
<tr>
<td>karakia</td>
<td>prayer</td>
</tr>
<tr>
<td>kaumatua</td>
<td>elder</td>
</tr>
<tr>
<td>kaupapa</td>
<td>ground rules</td>
</tr>
<tr>
<td>kia tupato</td>
<td>to be careful</td>
</tr>
<tr>
<td>koha</td>
<td>gift</td>
</tr>
<tr>
<td>korowai</td>
<td>cloak</td>
</tr>
<tr>
<td>mahi</td>
<td>work</td>
</tr>
<tr>
<td>māmae</td>
<td>hurt</td>
</tr>
<tr>
<td>mana</td>
<td>authority</td>
</tr>
<tr>
<td>manaakitanga</td>
<td>hospitality</td>
</tr>
<tr>
<td>marae</td>
<td>courtyard, open area for formal welcomes and debates</td>
</tr>
<tr>
<td>matapuna</td>
<td>principles</td>
</tr>
<tr>
<td>ngapuhi</td>
<td>a tribal group of Northland, New Zealand</td>
</tr>
<tr>
<td>ngati whatua</td>
<td>a tribal group of the area from Kaipara to Auckland</td>
</tr>
<tr>
<td>oranga</td>
<td>well-being</td>
</tr>
<tr>
<td>pakeha</td>
<td>New Zealander of European descent</td>
</tr>
<tr>
<td>pono</td>
<td>truth</td>
</tr>
<tr>
<td>pouri</td>
<td>sadness, sorrow, despondency, gloom, desolation</td>
</tr>
<tr>
<td>tangata</td>
<td>people</td>
</tr>
<tr>
<td>tangata whenua</td>
<td>people of the land</td>
</tr>
<tr>
<td>tapu</td>
<td>sacred</td>
</tr>
<tr>
<td>te reo Māori</td>
<td>Māori language</td>
</tr>
<tr>
<td>English</td>
<td>Maori</td>
</tr>
<tr>
<td>---------</td>
<td>-------</td>
</tr>
<tr>
<td>tika</td>
<td>right, true, correct</td>
</tr>
<tr>
<td>tikanga</td>
<td>correct procedure, custom or rule, right</td>
</tr>
<tr>
<td>toheroa</td>
<td>shellfish</td>
</tr>
<tr>
<td>tohunga</td>
<td>priest, skilled person</td>
</tr>
<tr>
<td>wairua</td>
<td>spirit</td>
</tr>
<tr>
<td>whakamā</td>
<td>shyness, embarrassment, shame involving varying degrees of withdrawal and unresponsiveness</td>
</tr>
<tr>
<td>whakapapa</td>
<td>genealogy</td>
</tr>
<tr>
<td>whakatauki</td>
<td>proverb</td>
</tr>
<tr>
<td>whanau</td>
<td>extended family</td>
</tr>
<tr>
<td>whanaungatanga</td>
<td>relationships</td>
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**Samoan**

<table>
<thead>
<tr>
<th>Samoan</th>
<th>English</th>
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<tbody>
<tr>
<td>fale</td>
<td>house</td>
</tr>
<tr>
<td>matua</td>
<td>elders</td>
</tr>
<tr>
<td>meaalofa</td>
<td>gift</td>
</tr>
<tr>
<td>malu puipuia</td>
<td>protection</td>
</tr>
<tr>
<td>palagi</td>
<td>a white or non-Samoan person</td>
</tr>
<tr>
<td>va</td>
<td>space</td>
</tr>
</tbody>
</table>
Chapter One: Introduction

Nothing is so difficult as not deceiving oneself. (Wittgenstein, 1980, p. 34)

Knowing and not knowing about child sexual abuse

History reveals that societal consciousness regarding child sexual abuse (CSA) has alternated between awareness and denial (Olafson, Corwin, & Summit, 1993; Conte, 1994). Ultimately no one is immune from this knowing/not knowing dialectic. In Richardson’s (2003) view the “constant tension between the willingness to know and the desire not to know condemns awareness of child sexual abuse to a fluctuating and conflicting state” (p. 198). Because knowing engenders such intense feelings of discomfort, anxiety, fear, shame, embarrassment, grief, and disgust, defensive processes of avoidance, minimisation and denial are often employed. As a result, the experience and issue of CSA may be banished from awareness in conscious and unconscious ways. Alternatively, anxiety, fear and anger elicited by increased awareness can lead to knee-jerk responses at societal and professional levels. These over-reactions contribute to backlashes and accusations of moral panics, which again suppress and deny the reality of CSA (Conte, 1994; Myers, 1994; Whittier, 2009). Thus, for bystanders at individual and collective levels, the enormity of sexual abuse often provokes “two opposing responses - disbelief or belief accompanied by an intense desire for retribution” (Faller, 1993, p. 11).

The tensions between knowing and not knowing occur for child victims, adult survivors, families, communities, professionals, and society, and are influenced by a range of discursive factors. A number of dominant discourses potentially distort societal perception and serve to silence or discredit victims, by questioning their victim status or obscuring the perpetrator. They may be internalised through various agents of socialisation, from the family to the media. Again, no one is immune to these subtle messages which permeate daily living. For example, intra-familial CSA challenges cherished beliefs regarding the sanctity of the family, and the family as a private sphere. Hegemonic notions of masculinity and femininity position males as perpetrators of CSA and females as victims. Stereotypes of perpetrators as monsters suggest that they are easily identified, and inflate the risk of stranger danger. This preserves the family domain as a safe-haven, and lulls people into a false sense of security regarding their ability to detect threat. The inherent societal taboo about discussing sexual
matters also serves to silence victims, and sits in stark contrast to a highly sexualised popular culture, which renders girls and women as sexual objects and men as consumers.

It is hard to imagine an issue more discombobulating than CSA and perhaps this is because of the specific combination of children, families, attachments, sexual acts, and abuse. Like other forms of childhood abuse, babies, children, and youth may suffer for months or years. In the majority of cases they are exploited and betrayed by trusted and significant others such as family members, family friends, teachers, coaches and pastors (Australian Bureau of Statistics, 2004; Bunting, 2011; Clark et al., 2015; Fleming, 1997; Radford et al., 2011). Lastly, and arguably most disturbingly, children are touched in sexual or genital regions; anally/vaginally/orally penetrated with fingers, penises, and objects; coerced to carry out sexual activities on others or animals; exposed to sexual activities and pornography, and/or become the objects of child pornography.

Children unable to tell or be heard are at risk of prolonged and cumulative suffering. The burden of disclosure remains largely with the child victim or even adult survivor, who faces ongoing and significant barriers to telling. These obstacles to bearing witness may be perpetrator-induced, developmental, familial, legal and socio-cultural, and include the risk or reality of poor responses to attempts to disclose. Children can and do recover from CSA with familial and/or professional support to process and regulate their emotional responses, and examine the validity of their meaning-making. However, a proportion of children enter adulthood suffering from unresolved developmental, emotional and psychological effects of CSA, exacerbated by unhelpful coping strategies, defences, and ongoing relational problems. Their capacity to survive reflects enormous strengths, but in many cases they did not thrive. For those sexually abused within the family, there are also ongoing relational tensions and dilemmas with regard to the degree of contact with the perpetrator.

In the context of the dialectical dilemma of knowing and not knowing about CSA, the survivor’s relationship with self and body, and with others is often difficult, conflicted, and fragmented. The tendency to engage in avoidant and defensive means of coping limits the possibilities for post-traumatic growth, increases distress, and elevates the risk of re-victimisation (Filipas & Ullman, 2006; Fortier et al., 2009). Consequently, these survivors may struggle with mental health problems, substance abuse, self-harm, and suicidal ideation. They may experience somatic symptoms and health problems. They may indulge in risky sexual behaviour and risk-taking, and they may struggle with parenting and intimate relationships.
Challenges in defining and responding to CSA

Although professionals and the general public recognise CSA as a social problem, opinions differ regarding the extent of the problem, what constitutes CSA, what causes it, and how to respond to the victim and the perpetrator (Doan, 2005; Gordon, 1988; Haugaard, 2000; Hechler, 1988; Mildred, 2003; Molina & del Rio, 2007; Purvis & Ward, 2006; Scott, 1995; Summit, 1988; Taylor-Browne, 1997). Debates have intermittently raged over prevalence, recovered memory, disclosure, suggestibility of children, impact, and treatment, with each camp holding firm, passionate, and often polarised positions. Consequently, CSA represents one of the most challenging issues for social workers to engage with and understand, despite permeating virtually all areas of the profession.

An operational definition of CSA remains elusive (Haugaard, 2000) and competing definitions operate within and between legal, clinical, and research domains, impacting on practice, policy, education, and research. Such differences are influenced by contradictory multidisciplinary perspectives and values, fluctuating social constructions and cultural, social and gender norms. Definitional inconsistencies occur regarding the age of a child/young person, the age differential between victim and perpetrator, whether the abuse includes non-contact1 offences, and whether the abuse was described as not wanted.

Although some have commented that there is a greater consensus in the research arena to limit the CSA definition to contact offences (Bolen, Russell, & Scannapieco, 2000), clinicians working in the field of CSA are generally guided by the level of trauma and distress experienced by the victim, which is likely to be affected by a range of other factors apart from the contact/non-contact variable (Hecht & Hansen, 2001; Holguin & Hansen, 2003). In addition, the definition of CSA within the United Nations Convention on the Rights of the Child (UNCROC) clearly includes both contact and non-contact offences: “(a) The inducement or coercion of a child to engage in any unlawful sexual activity; (b) The exploitative use of children in prostitution or other unlawful sexual practices; (c) The exploitative use of children in pornographic performances and materials” (UNCROC, 1989, Article 34).

1 Non-contact sexual offences are those which do not involve physical contact with the victim’s or perpetrator’s body. For example, a child may be exposed to adult and/or child pornography, witness sexual activity, or be photographed or videoed for pornographic purposes.
The Ministry of Social Development (MSD) extends UNCROC’s definition by delineating the range of offences that constitute contact and non-contact offences. Yet both definitions fail to discuss age and power differentials between victim and perpetrator.²

Sexual abuse can be any act that involves forcing or enticing a child to take part in sexual activities, whether or not the child is aware of what is happening. Sexual abuse can be, but is not limited to:
contact abuse: touching breasts, genital/anal fondling, masturbation, oral sex, penetrative or non-penetrative contact with the anus or genitals, encouraging the child to perform such acts on the perpetrator or another, involvement of the child in activities for the purposes of pornography or prostitution
non-contact abuse: exhibitionism, voyeurism, exposure to pornographic or sexual imagery, inappropriate photography or depictions of sexual or suggestive behaviours or comments (MSD, 2015a, p. 16).

In New Zealand (NZ), children’s legal status is inconsistent across different statutes, an issue which has been highlighted by the Law Commission (2012) and the Independent Police Complaints Authority (2010). Two pieces of legislation which arguably have the most impact on children’s rights, safety and wellbeing, the Crimes Act (1961) and the Children, Young Persons and their Families Act (1989) provide competing definitions of childhood, youth and adulthood,³ none of which is consistent with UNCROC (1989). The Care of Children Act (2004) lowered the age at which guardianship ends from 20 years to 18 years, in line with UNCROC (1989), and the Vulnerable Children Act (2014) also defines a child as under the age of 18. In addition, other pieces of NZ legislation define adulthood at age 18. NZ law prohibits persons under the age of 18 from voting, purchasing alcohol, and marrying without parental consent, yet defines a minor as under the age of 16 in relation to sexual activity. Advances in the field of neuroscience reveal that the reflective and logical capabilities of the frontal cortex are not fully developed until the mid-twenties (Johnson, Blum, & Gied, 2009). Presumably, although young people at age 16 are not expected to have the cognitive and emotional maturity to vote, marry, or consume alcohol responsibly, these views do not apply to sexual activity.

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² This issue is dealt with in a definition from the World Health Organisation (WHO) in 1999, which stated that CSA may occur between “a child and an adult or another child who by age or development is in a relationship of responsibility, trust or power, the activity being intended to gratify or satisfy the needs of the other person” (WHO, 1999, pp. 15-16).
³ The Crimes Act (1961) defines a child as under the age of 12 years and a young person as under the age of 16 years. The Children, Young Persons and their Families Act (1989) defines a child as under 14 years and a young person as over 14 years but under 17 years.
Prevalence

Prevalence refers to the proportion of the population who have a particular characteristic. This is generally estimated by determining the prevalence within randomly selected representative samples. Prevalence of CSA is mainly determined by retrospective studies of adults, using either quantitative or qualitative methodology. Results may be influenced by a range of variables such as sampling, method of data collection, the number and quality of screening questions, the age and gender of respondents, and the definition of CSA employed. For face-to-face interviews, the skill and training of the interviewer, the degree of gender and ethnicity matching of interviewer and respondent, and the context of the interview may influence findings (Bolen et al., 2000; Goldman & Padayachi, 2000; Holmes & Slap, 1998).

International prevalence rates for CSA are reported to range between 1%–62% for females (Bolen et al., 2000, Garcia-Moreno, Jansen, Ellsberg, Heise & Watts, 2005) and between 4%–76% for males (Holmes & Slap, 1998), although meta-analyses of prevalence studies suggest more narrow ranges. After analysing prevalence rates for 21 countries, Finkelhor (1994) suggested a statistical average of 20% for the prevalence of sexual abuse in women and 5%–10% for men. A more recent meta-analysis of 65 prevalence studies from 22 countries, suggested similar figures; 20% for females and 8% for males (Pereda, Guilera, Forns, & Gomez-Benito, 2009). However, a United States (US) survey of 34,000 adults elicited significantly higher prevalence figures. Utilising behaviourally specific questions regarding CSA within face-to-face interviews with experienced and trained interviewers, Pérez-Fuentes et al. (2013) found that 25% of males and 75% of females reported contact CSA. Perhaps the exceptionally high prevalence in this study was elicited by framing the questions in a way which normalised CSA, since all questions began with “how often”.

Questions asked in the Pérez-Fuentes et al. (2013) study were: “Before you were 18 years old: 1) How often did an adult or other person touch or fondle you in a sexual way when you didn’t want them to or you were too young to know what was happening?; 2) How often did an adult or other person have you touch their body in a sexual way when you didn’t want them to or you were too young to know what was happening?; 3) How often did an adult or other person attempt to have sexual intercourse with you when you didn’t want them to or you were too young to know what was happening?; and, 4) How often did an adult or other person actually have sexual intercourse with you when you didn’t want them to or you were too young to know what was happening? Responses to all four questions ranged from 1= ‘never’ to 5= ‘very often’” (p. 4).

Questions in the ACE study regarding CSA included: “Did an adult or person at least 5 years older ever: Touch or fondle you in a sexual way? Have you touch their body in a sexual way? Attempt oral, anal, or
is explored further in Chapter Three. In Australia, a telephone survey of 2564 adults found that 27% of women and 17% of men reported contact CSA (Werner et al., 2015).

In NZ, Fanslow, Robinson, Crengle, and Perese (2007) conducted face-to-face interviews with a random sample of 2,855 women aged 18 to 64 years in urban Auckland and rural Waikato. Participants were asked if anyone had touched them sexually as a child, or made them do something sexual that they did not want to do. The research identified an overall prevalence rate of 23% for the urban region and 28% for rural areas, however the prevalence for Māori women was 30% and 35% respectively. Focusing on male and female youth, another NZ survey of 1176 secondary school students found 9% of males and 20% of females reported being touched in a sexual way or made to do unwanted sexual things (Clark et al., 2013). Higher figures for females were found in a further NZ sample of 938 males and females, who have been involved in a longitudinal study since birth. At age 26, participants were asked behaviourally specific questions regarding CSA, with 30% of females and 9% of males reporting contact CSA (van Roode, Dickson, Herbison, & Paul, 2009).

Under-reporting of CSA constitutes a significant problem in attempting to produce reliable estimates of prevalence, and even the most rigorous methodology is unlikely to capture all CSA events, due to the likelihood of false negatives (Bolen et al., 2000; Oates et al., 2000; Pereda et al., 2009). Despite the use of up to 14 screen questions, Williams, Siegal, and Pomeroy (2000) found that among 136 women with documented histories of CSA, 12% failed to disclose within an interview. Methodological issues may have greater implications for male prevalence figures, because of the differences associated with the experience and interpretation of male sexual victimisation influenced by hegemonic notions of masculinity (Alaggia, 2005; Alaggia & Millington, 2008; Briggs & Hawkins, 1996; Dhaliwahl, Gauzas, Antonowicz, & Ross, 1996; Lisak, 1993, 1997; Romano & De Luca, 2001; Violato & Genius, 1993). Defining sexual abuse as “unwanted” may not capture a male’s understanding of sexual abuse, pointing to questions such as “Tell me about vaginal intercourse with you? Actually have oral, anal, or vaginal intercourse with you?” (Felitti et al., 1998, p. 248).

6 Screening questions for CSA involved “17 items asking about non-contact and contact sexual abuse and additional questions to determine the frequency of abuse occurring during various age periods” (Werner et al., 2015, p. 3).

7 Questions regarding CSA in the van Roode et al. (2009) study included: “Before you turned 16, did someone touch your genitals when you didn’t want them to? If the study member reported this, they were asked about the frequency of the abuse, their age at first and last abuse, the gender and age of the abuser, and their relation to the abuser. Similar questions were asked about being forced to touch someone else’s genitals, attempted intercourse, completed intercourse, and any ‘other’ unwanted sexual activity. Study members who indicated they had experienced ‘other’ abuse, were asked to select from exposure, pornography, sexual talk, oral sex, or other” (p. 163).
to the need to provide more specific and salient questions (Briggs & Hawkins, 1996). For example, van Roode et al.’s (2009) behaviourally specific questions which framed the abuse as unwanted did not generate as high prevalence among males as studies that eliminated such subjective appraisal (Dube et al., 2005; Pérez-Fuentes et al., 2013).

Large scale studies of male victims of CSA have found female perpetrators to comprise 17%–40% (Fisher, Goodwin, & Patton, 2008; Dube et al., 2005; Finkelhor, Hotaling, Lewis, & Smith, 1990; Lisak, Hopper, & Song, 1996), and male victims may define female perpetrated CSA as sexual experience and initiation rather than sexual abuse (Gartner, 1999, 2005). For both male and female victims sexually abused by females, stigma and the lack of societal and professional recognition of such abuse also pose significant barriers to disclosure (Clements, Dawson, & Das Nair, 2014; Deering & Mellor, 2011; Denov, 2001, 2003). Furthermore, homophobia, confusion regarding sexual identity, and conflicts regarding sexual arousal may prevent disclosure for males sexually abused by males (Alaggia & Millington, 2008; Dorahy & Clearwater, 2012; Gill & Tutty, 1997; Lisak, 1993, 1997).

**Delayed disclosure**

Many other factors are likely to inhibit disclosure in male and female CSA victims such as fear of not being believed, developmental limitations, fear of repercussions, absence of perceived support, shame, guilt, and loyalty to the perpetrator (Lyon & Ahern, 2011; Paine & Hansen, 2002; Pipe, Orbach, Lamb, & Cederborg, 2007; Tang, Freyd, & Wang, 2007). Studies indicate that a significant majority of victims fail to disclose as children (London, Bruck, Ceci, & Schuman, 2005, 2007). This is particularly the case for male victims (Ullman & Filipas, 2005), and CSA perpetrated by a family member (Goodman-Brown, Edelstein, Goodman, Jones, & Gordon 2003; Herschkowitz, Horowitz, & Lamb, 2005; Sjoberg & Lindblad, 2002; Smith et al., 2000; Lamb & Edgar-Smith, 1994; London et al., 2005). It is therefore not surprising that a significant number of participants have disclosed a history of CSA for the first time during a research interview (Barnett & Lapsley, 2006; Jonzon & Lindblad, 2004; Morris, Martin, & Romans, 1998).

Reporting of CSA may also be undermined by trauma-induced dissociation and denial leading to partial or complete amnesia (van der Kolk, 1994, 1996; van der Kolk & Fisler, 1995). Studies have found substantial rates of partial or total amnesia for CSA in general and clinical populations ranging from 19%–64% (Briere & Conte, 1993; Carlson, Armstrong, & Lowenstein, 1997; Chu, Frey, Ganzel, & Matthews, 1999; Elliott & Briere, 1995; Herman &
The fact that amnesia is also found in populations with physical abuse histories and other traumas (Carlson et al., 1997; Chu et al., 1999; Lowenstein, 1996; van der Kolk, 1996) lends credibility to recovered memories of CSA (Carlson et al., 1997). Neurophysiological responses to trauma also provide evidence of traumatic amnesia. Extreme emotional arousal elevates stress hormones and interferes with hippocampal memory functions, affecting normal information processing and the storage of information into narrative (explicit) memory (Bremner et al., 1997; van der Kolk, 1994; LeDoux, 1992; McGaugh, 1992; Nilsson & Archer, 1992). Hippocampal damage has been observed in studies of victims of severe childhood physical and/or sexual abuse, which show between 5%–12% less hippocampal tissue (Bremner et al., 1997; Bremner et al., 2003; Stein, Koverola, Hanna, Torchia, & McClarty, 1997). I discuss the neurobiology of trauma in greater detail in Chapter Two.

Disclosure may also be inhibited by the contemplation of further betrayal in the form of disbelief from non-offending caregivers. Yamamoto, Soliman, Parsons, and Davies (1987) carried out interviews with 1814 children in six countries, Australia, Canada, Egypt, Japan, the Phillipines, and the USA. Children were asked to prioritise the seven most stressful events in their lives from a list of 20 events, including parental death and parental separation. Displaying a high level of agreement, children universally rated in the top seven most stressful life events, “Not being believed when I am telling the truth”.

Incidence refers to the number of cases of a characteristic emerging within the population over a particular time period, for example a month or a year. Statutory authorities appear to represent even greater barriers to disclosure of CSA, reflected in the estimate that only 7%–9% of sexual offences are reported to NZ Police (Ministry of Justice, [MOJ] 2007, 2010; Law Commission, 2012). Consequently, incidence statistics for CSA tend to yield far lower rates of sexual victimisation than prevalence figures. Sexual offences constitute just over 1% of all recorded crime in NZ (NZ Police, 2015), with 2064 sexual offences against children under the age of 16 recorded in 2014 (Statistics NZ, 2016). A case is defined as resolved when Police apprehend an offender and decide how to intervene, which may or may not include prosecution. In 2014, only 48% of all sexual offence cases were resolved (NZ Police, 2015).

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8 The Crime and Safety Survey in 2006 found that 9% of sexual offences were reported in 2005 (MOJ, 2007), and the same survey in 2009 found that 7% of sexual offences were reported in 2008 (MOJ, 2010). The Crime and Safety Survey in 2014 stated that “an estimate for sexual offences in 2013 cannot be provided because of a high sampling error” (MOJ, 2015, p.106).
Painting a similar picture, are the statistics from the MSD. In the years 2002 to 2014, notifications to Child, Youth and Family Services (CYFS) have increased 222% (MSD, 2015b). Standing at 150,905 in 2015, these notifications represent 59,713 distinct children or young people. Yet it is concerning to note that the amount of cases requiring no further action has nearly doubled, from 25% in 2005 to 46% in 2015 (CYFS, 2016). Equally concerning, and perhaps related, is the finding that 64% of notifications in 2014 were for children who had previous involvement with CYFS (MSD, 2015b). Substantiated CSA represented less than 10% of the 13,833 children/young people with substantiated abuse in 2015 (CYFS, 2016).

The growing community and professional discontent in NZ regarding child protection prompted the government to issue the Green Paper for Vulnerable Children9 (MSD, 2012b). Developed from the analysis of Green Paper submissions, the White Paper for Vulnerable Children10 provided an action plan to identify and respond to at-risk children earlier, and more effectively, through the establishment of multi-disciplinary children’s teams,11 a lead professional to take on case management, and information sharing across agencies (MSD, 2012c). The White Paper noted that “the high level of notifications consumes a large amount of social work time and resources in assessing and screening, with only about 12 per cent of cases receiving ongoing services from Child, Youth and Family” (MSD, 2012c, p. 111). In addition, there was acknowledgement that CYFS “needs to improve the quality and depth of its assessments of the risks and needs of children and young people” (MSD, 2012c, p. 112). This naturally has implications for social work education, but it is also possible that the quality of assessments has diminished due to increasing workloads, therefore having organisational implications.

9 The Green Paper for Vulnerable Children was released in July 2011 in order to prompt “national discussion about how New Zealand can improve the lives of its vulnerable children” (MSD, 2012b, p. 4). This generated nearly 10,000 submissions from professionals and community members, and reflected a strong desire for reform (MSD, 2012b).
10 The White Paper for Vulnerable Children involved joint consultation among representatives from the MSD, Ministries of Education, Health and Justice, the Treasury, the New Zealand Police and Te Puni Kökiri (MSD, 2012c).
11 Two children’s teams were initially set up in 2013, and in 2017, 10 teams have been established around NZ. Children’s teams have yet to be formally evaluated, however a children’s team co-ordinator believes they are operating as ”the ambulance at the top of the cliff” (personal communication, T. Hay, Whangarei Children’s Team, 1/2/17). The teams respond to vulnerable children whose risks of maltreatment fall below the threshold requiring notification for statutory child protection. Following from the White paper, these children’s teams have three key responsibilities, a) to provide child-centred and whole-of-child assessments, b) to collate information from a variety of agencies involved with the child and co-ordinate services, and c) to establish a lead professional who conducts the assessment, provides case management, and reports to the children’s team panel made up of skilled professionals from a variety of disciplines (MSD, 2012c, 2012d).
The increase in notifications has been attributed to enhanced community awareness of child abuse (MSD, 2012a, 2012c; NZ Family Violence Clearinghouse, 2016). Yet statistics indicate that less than a quarter of all notifications come from the community (CYFS, 2016). Given the low rates of intervention and substantiated abuse, the assumption that greater community awareness is responsible for increased notification implies that the community and professionals are expressing an unwarranted level of concern. In contrast, the literature indicates that reticence tends to characterise reporting decisions (Berson, Berson, & Ralston, 1998; Bhaskett & Taylor, 2003; Delaronde, King, & Bendel, 2000; Hicks & Tite, 1998).

**Legal implications**

Given that physical findings diagnostic of CSA are reported in 10% or fewer of cases (Frasier & Makoroff, 2006; Heger, Tieson, Velasquez, & Bernier, 2002; Hermann & Navratil, 2004; Kelly, Koh, & Thompson, 2006) and perpetrator admission is rare (Law Commission, 2015), a child’s formal disclosure provides the main form of evidence for prosecution. Yet even with externally corroborated evidence of CSA such as medical evidence, perpetrator admission or videotape evidence, 23 studies revealed that only half of the children disclosed during formal interviews (Sjoberg & Lindblad, 2002; Lawson & Chaffin, 1992; Lyon, 2007). In a CYFS evidential interviewing unit, 32% of children, predominantly males, failed to disclose sexual abuse despite considerable concerns, and 8% of those children had medical evidence of CSA, their abuse witnessed by another person, or perpetrator admission (Basher, 2003, 2004).

Young children’s cognitive limitations also pose significant problems to disclosure. In general, children under the age of five, and perhaps up to the age of ten, have difficulty providing clear contextual details and determining temporal factors (Sas, 2002). This is because “they lack the meta-cognitive framework to organize the encoded information effectively” and the verbal skills to communicate “the memory trace” (Sas, 2002, p. 34). They also tend to “encode less information” because “they understand less about what is going on” and “their memory retrieval processes are less well developed” (Sas, 2002, p. 47). This means that young children often need specific cues to retrieve memories (Fivush, 1993; Sas, 2002). Consequently, they are less likely to be able to meet the requirements of an evidential interview. In an analysis of CYFS evidential interviews between the years 2000-2002, conducted in 90% of cases for concerns about sexual abuse, only 10% involved pre-schoolers aged two to four years, a group with the lowest rate of disclosure at 40%. Children aged five to seven years comprised approximately 20% of evidential interviews and disclosed abuse in 51% of cases (Basher, 2003, 2004). Yet it is young children who are at considerable risk of being sexually abused, with three
year olds constituting one of the largest age groupings for CSA in NZ (Kelly et al., 2006), and children aged between five to ten years represented just over half of the CYFS evidential interviews between 2000-2002 (Basher, 2003, 2004). Incidence studies from the USA also reveal that young children aged three and over are sexually victimised at the same rates as older children (Sedlak & Broadhurst, 1996; Sedlak et al., 2010).

Without evidence, children are likely to remain vulnerable to further sexual abuse, and nearly 20% of children who attended CYFS evidential interviews in Basher’s (2004) study had previously given an evidential interview. Even when children did make allegations of sexual abuse during an evidential interview, Basher (2004) found that only 36% of children were referred to counselling, and this may be due to the idea promoted in legal circles that therapy constitutes a suggestive intervention likely to contaminate the evidence (Law Commission, 2003). Basher (2004) concluded that “the optimum time for children and their families to receive support is soon after the allegations have been made. If the figures for children being re-abused are to decrease, we need to make sure that they have been given available and relevant support as soon as possible following the abuse and disclosure” (p. 14).

For those children and young people who do make formal disclosures, potential re-traumatisation may occur through giving evidence in court. Children’s and young people’s evidence is still heard within an adversarial system where children may be subjected to ruthless and developmentally inappropriate cross-examination to deliberately undermine their credibility as witnesses (Blackwell, 2007; Davies & Seymour, 1998; Davies, 1999; Eastwood, Patton, & Stacy, 1998; Eastwood & Patton, 2003; Taylor, 2004). The NZ Law Commission (2012) has suggested that a judge-led inquisitorial system may be better suited to CSA and sexual assault cases, with specialist training for judges and counsel, a specialist court, and the opportunity for risk assessment in cases of acquittal. Multiple misconceptions among jurors in CSA trials suggest the need for juror training as well (Blackwell, 2007), and the use of an intermediary for child witnesses has also been recommended (Hanna, Davies, Henderson, & Hand, 2013; Tillett, 2011).

It is clear that numerous factors present barriers in the disclosure process, and consequently prosecutions in NZ occur for less than half of all recorded sexual offences, and convictions, in half of all prosecutions (Law Commission, 2012, 2015; MOJ, 2012; Triggs, Mossman, Jordan, & Kingi, 2009). For the small minority of sexual offenders who are convicted, 65% will be imprisoned (MOJ, 2012). Similar figures are reported in Australia, and Eastwood, Kift, and Grace (2006) note:
If you are a child complainant, there is less chance of the offender being convicted than for any other criminal offence. If 100 children are sexually abused, it is likely that only about 10 of those children will actually report the abuse. Of those, only about 6 will reach committal proceedings in the lower court, and only 2 or 3 will reach the higher courts. Of those, only about 1 or 2 will result in a conviction. (p. 90)

Perpetrators of child sexual abuse

The vast majority of child sexual offenders (over 95%) are never held legally or morally accountable due to non-reporting, non-disclosure during formal interviews, lack of evidence and an adversarial, developmentally inappropriate legal system. As Nadesu (2011) has pointed out “significant attrition of cases … at every subsequent stage (identification and apprehension of the offender, charging of the offender, conviction of charged offenders)” has considerable implications for the validity of recidivism data (p. 14).

Among those child sex offenders who are apprehended, studies have identified large numbers of additional sex offences for which they have never been investigated and/or convicted. These studies also reveal a high degree of cross-over offending in terms of victim gender, victim age, and relationship with perpetrator (Abel et al., 1987, 1988; Ahlmeyer, Heil, McKee, & English, 2000; Emerick & Dutton, 1993; Groth, Longo, & McFadin, 1982; Heil, Ahlmeyer, & Simon, 2003; Weinrott & Saylor, 1991). In a study including 371 non-incarcerated child sex offenders, Abel et al. (1987) revealed an average ratio of nearly 30 additional sexual offences to each offence which led to conviction. Similarly, Weinrott and Saylor’s (1991) study of 67 incarcerated child sex offenders revealed an average of seven times the number of victims that had led to conviction. Many perpetrators begin their sexual offending in early adolescence, meaning that years or even decades of offending may elapse before apprehension (Simons, Wurtele, & Durham, 2008). In Ahlmeyer et al.’s (2000) study, 35 incarcerated sex offenders, involved in a prison therapeutic community for two years, revised their average age of first offending from age 28 to age 12.

While child sexual offences represent only a small percentage of reported criminal offences, convicted child sex offenders (CSO) make up a significant proportion of the total NZ prison population of 9,798 because they tend to receive substantial sentences (Department of Corrections, 2015, 2016). Sex offenders (against adults and children) constitute 20% of the prison population at any one time, of whom approximately two thirds are child sex offenders (Department of Corrections, 2015, 2016; Nadesu, 2011). Consequently, around 1300 incarcerated CSOs reside in NZ prisons, and only a small proportion are likely to complete
treatment. Participation is voluntary and only two prison based programmes operate with a total of 120 beds (Hudson, Marshall, Ward, Johnston, & Jones, 1995; Nathan, Hillman, & Wilson, 2003). Within other countries attrition rates in treatment programmes are reported to be between 30%-50% (Browne, Foreman, & Middleton, 1998; Moore, Bergman, & Knox, 1999; Ware & Bright, 2008). Additionally, concerns have been raised about the paucity of treatment for incarcerated sex offenders’ own victimisation (Bentovim, 2002; Craisatti, McClurg, & Brown, 2002; Levenson, 2014; Levenson, Willis & Prescott, 2015, 2016; Ricci & Clayton, 2008) and inadequate release planning (Willis, 2009).

Research has also challenged the notion that intra-familial and extra-familial CSA perpetrators represent discrete categories. Nearly 60% of a sample of 150 incest offenders in treatment subsequently admitted to further extra-familial sex offending (Studer, Clelland, Aylwin, Reddon, & Munro, 2000). In a further study, Simons et al. (2008) found that “after polygraph examination, few convicted child sexual abusers reported abusing children exclusively within the family” (p. 154). Incest offenders also reveal equal, if not higher paedophilic interests and sexual deviance as extra-familial offenders (Eher & Ross, 2006; Seto, Lalumiére, & Kuban, 1999; Studer, Aylwin, Clelland, Reddon, & Frenzel, 2002). In a sample of 104 incest offenders only 37% preferred adult sexual partners (Studer et al., 2002). In a further sample of 157 intra-familial sex offenders, 71% were classified with paedophilia as opposed to 66% of a similar sized sample of extra-familial offenders (Eher & Ross, 2006). The distinction made between intra-familial and extra-familial sex offenders in terms of victim preference and sexual deviance may therefore be unreliable, and have implications for perceptions of risk and recidivism. Incest offenders have been considered least likely to recidivate with studies estimating recidivism rates for this group at 8%-10% (Firestone et al., 1999; Hanson, 2002). Yet Eher and Ross (2006) noted that the time between the onset of offence and official conviction for intra-familial offenders within their study was about double that of extra-familial offenders (7 years versus 3 ¾ years). Intra-familial offenders tend to offend more frequently (Goodman-Delahunty, 2014) and higher rates of delayed disclosure among intra-familial victims suggest they also offend for much longer periods of time.

CSA prevalence and incidence rates paint vastly different pictures, with considerable implications for societal and professional perspectives on the scope of the problem. Certainly, the public are only going to hear of the CSA cases which merit the attention of the media, and such cases tend to create a skewed picture of the true nature of the problem (Kitzinger, 2004). The media continues to inflate the risk of “stranger danger”, to report sensationalised cases, and to concentrate on individual blame rather than considering societal implications (Cheit, 2003;
Kitzinger, 2004; Weatherred, 2015). However, strangers account for approximately only 10% of CSA perpetrators, while half of sexual offending occurs within families (Fanslow et al., 2007; Goodman-Delahunty, 2014; Richards, 2011).

Social work and child sexual abuse: The need for research

The prevalence of CSA, and its potential to have pervasive impacts across lifespans and generations, means that it is not only a child protection issue. It is relevant to social work practice within a range of other spheres, such as mental health and addiction, primary health, disabilities, parenting support, youth work, and youth and adult justice. Perhaps it would be fair to say that it is potentially relevant to any sphere of social work. Consequently, national and international studies have identified the need for specific training in CSA for social workers and mental health professionals (Alpert & Paulson, 1990; Breckenridge, Salter, & Shaw, 2010, 2012; Campbell & Carson, 1995; Cavanagh, Read, & New, 2004; Day, Thurlow, & Wooliscroft, 2003; Kenny & Abreu, 2015; Leech & Trotter, 2006; Mansfield, Meehan, Forward, & Richardson-Clarke, 2016; Martin et al., 2014; Read, McGregor, Coggan, & Thomas, 2006).

No study in NZ has explored social workers’ or social work educators’ perceptions and understandings of CSA, or investigated the extent to which CSA is addressed in social work practice and education. However, there are some NZ and international studies involving mental health professionals’ perceptions of adult survivors of childhood abuse, and/or practice issues related to abuse and trauma. While these are discussed within subsequent chapters, I provide a brief synopsis of relevant studies. Breckenridge et al. (2010, 2012) interviewed 15 alcohol and other drug (AOD) practitioners in Australia regarding their perceptions of the needs of clients who were survivors of childhood abuse, and also explored the experiences of 16 adult survivors of childhood abuse who had accessed AOD services. The AOD workers were aware of the high incidence of abuse histories among their clients, perceived significant and complex links between child abuse, trauma, and addiction, and understood the role of substances in avoiding emotional pain and managing trauma symptoms. However, screening for abuse histories was not routine across the AOD sector, and clients could be denied treatment because of trauma symptoms and trauma-related behaviour, such as self-harm. Workers identified the need for more training regarding abuse and trauma. Similarly, in McLindon and Harm’s (2011) Australian study of 15 Crisis Assessment and Treatment Service (CATS) workers’ responses to female clients disclosing sexual abuse, a need for further training was identified. Other studies
have identified a lack of knowledge and sense of competence regarding CSA among social workers in the United Kingdom (UK) and Denmark (Martin et al., 2014; Perry, 2006), among substance abuse counsellors in the US (Janikowski & Glover-Graf, 2003), and mental health professionals in the UK (Day et al., 2003) and NZ (Ashmore, 2013). In her master’s thesis, Ashmore (2013) interviewed mental health staff from inpatient units in NZ and Australia regarding their understanding and practice of trauma-informed care, and conducted a policy analysis. While only a small study, the findings indicated that knowledge and implementation of trauma-informed principles were in their infancy within both units, and that greater organisational support was required.

Relevant to social work education, there is a significant body of literature from academics in the field of social work arguing for the need to teach about CSA, other abuse, and trauma, along with useful recommendations (Abrams & Shapiro, 2014; Agllias, 2012; Breckenridge & James, 2009; Bussey, 2008; Carello & Butler, 2015; Cunningham, 2004; Kawam, 2014; Kenny & Abreu, 2015). Some authors provide anecdotal evidence of educators’ difficulties in teaching about CSA and other forms of abuse (Bussey, 2008; Kawam, 2014), or responding to students who have CSA histories (Barter, 1997; Humphrey, 2007). However, there does not appear to be any research which has sought educators’ perceptions of CSA, and how it is addressed within undergraduate social work curricula.

My qualitative research aims to contribute to the field by exploring how NZ social workers and social work educators perceive CSA, and how they address the issue in practice and education. I believed it was important to focus specifically on the issue of CSA, rather than including other forms of abuse, for a number of reasons. Firstly, CSA involves complex and unique dynamics such as grooming and the sexualising of attachments which are not found in other forms of abuse (Smallbone & Wortley, 2000). Secondly, there is a coercive, deceptive element to the perpetration of CSA. Unlike the sexual assault of adults, CSA does not always involve “violence or force” but may instead involve “coercion and threats” (Delahunty & O’Brien, 2014, p. xii). Grooming tactics normalise the abuse and create the illusion of participation, which can prevent victims of CSA being aware that they have been victimised (Craven, Brown, & Gilchrist, 2006). Thirdly, while the manifestation of trauma arising from CSA has some overlap with other forms of abuse, traumatic sexualisation is a particular feature of CSA which may involve hyper- and hypo-sexuality, sexual re-victimisation, re-enactment, and a victim-perpetrator cycle (Finkelhor & Browne, 1985; van der Kolk, 1989). In addition, CSA survivors appear particularly prone to remembering to much or too little through traumatic encoding of memory and dissociative processes (van der Kolk & Fisler, 1995; Lev-Wiesel,
Lastly, CSA is arguably the most hidden form of abuse due to the taboo, stigma, and shame surrounding it, along with societal discourses and defences which obscure or minimise its existence (Bloom & Reichert, 1998; Bloom & Farragher, 2013). Asking about CSA and responding to disclosures requires a particular skill set and knowledge base in order for social workers to overcome the inevitable discomfort that arises (Cavanagh et al., 2004). In addition, CSA perpetrators tend to generate the greatest societal repugnance and disgust, therefore the emotional work in professionally addressing CSA is considerable (Myers, 2008). I discuss these issues and complexities in Chapter Two and Three, and I argue that CSA deserves specific attention within social work education for these reasons.

From both personal and professional experience I have come to appreciate the wide-ranging impacts of CSA across the lifespan and across generations. Sexual abuse occurred within my birth family, a family I did not get to know until I was an adult, as I was adopted at birth. I have also witnessed the emotional and health impacts of CSA upon friends, and encountered many stories of CSA in my work as a naturopath and as a social worker. I originally trained as a naturopath in my early 20’s, and worked in the UK as a nutritionist at a health farm. I soon came to observe that clients’ eating problems and health issues, (particularly autoimmune disorders), were often associated with childhood trauma, including CSA. My desire to work holistically with clients led to me seeking training and work in mental health and counselling. I worked for the Richmond Fellowship in the UK within a therapeutic residential community for 14 young adults with mental health problems, half of whom were also offenders. Along with a range of other excellent one to three day workshops, the Richmond Fellowship provided a two day training in working with adult survivors of CSA, which further sensitised me to the links between CSA and mental health problems. I later went on to train as a social worker and counsellor in the UK, and returned to NZ to work as an alcohol and drugs counsellor.

My social work and counselling practice in adult mental health and addiction led to an increasing awareness that CSA was a common experience for many clients, and often highly relevant to their problems. These observations resonate with an extensive body of literature (Berry & Sellman, 2001; Boles et al., 2005; Brems, Johnson, Neal, & Freemon, 2004; Lab & Moore, 2005; Read, van Os, Morrison, & Ross, 2005). However, the literature also reveals that clients do not always make links between past sexual victimisation and current problems (Bloom & Farragher, 2013; Breckenridge et al, 2012; MacGregor, 2003), nor is CSA always assessed for or addressed in mental health and addiction services (Agar & Read, 2002; Ashmore, 2013; Boles, Joshi, Grelle, & Wellisch, 2005; Breckenridge et al., 2012; Gil-Rivas,
Fiorentine, Anglin, & Taylor, 1997; Read et al., 2006; Read & Fraser, 1998; Wurr & Partridge, 1996). My decision to interview 11 social workers in the fields of addiction and mental health, within a district health board (DHB), was influenced by my knowledge of the literature highlighting CSA as a relevant, yet perhaps neglected, issue within these areas of practice. The first interview focused on victims, while the second focused on perpetrators of CSA. I was interested in understanding how social workers perceived CSA and disclosure, when focusing on the child or adolescent victim, the adult survivor, the bystander, and the perpetrator. I wished to understand how, and to what degree, clients with a history of CSA were identified, and how they were responded to.

Since it is unclear how CSA is addressed within NZ social work education, I conducted single interviews with eight social work educators, from seven universities or polytechnics in NZ. I was interested in educators’ views about the relevance, sufficiency, and efficacy of CSA training within their social work programmes. The complex and difficult dynamics of teaching and learning about CSA and trauma have been described as a “painful pedagogy” (McCammon, 1995, p. 109). Accordingly, I wanted to know how educators delivered CSA training and/or their views with regard to process issues, as well as content. Knowing that CSA was an emotionally painful topic, I was interested in social workers’ and social work educators’ emotional, and therefore embodied responses, and my own. I also sought to explore the various sources and discourses participants drew on, or rejected, in understanding and addressing CSA. These included professional and personal experiences, education, research, the media, culture, socialisation, gender, and ethnicity. Lastly, in order to understand the effects of group processes on participants’ perceptions, and to provide an opportunity for the two professions to dialogue about the issues that emerged, I facilitated a focus group. This was comprised of a sub-sample of social workers and social work educators.

Chapter overviews

The iterative and dialectical nature of the research involved recursive loops between the literature and the data. Thus, as well as informing analysis, the review of the literature was shaped and re-shaped by the data. Child sexual abuse is an inter-disciplinary field and is informed by a range of theories and paradigms. Consequently, I drew on sociological and psychological literature, qualitative and quantitative studies, and perspectives and practices from a wide range of professionals. In Chapter Two, I take a trauma-informed perspective taking into account victims, perpetrators, non-offending caregivers, professionals, and society.
My theoretical framework includes attachment theory, contemporary psychodynamic theory, the neurobiology of trauma, Finkelhor and Browne’s (1985) traumagenic dynamics, Goffman’s (1963) work on stigma, and relational dialectics theory (Baxter & Montgomery, 1996). By taking a dialectical approach, I highlight the relational and intra-psychic tensions that contribute to the traumatic impact for victims. I also look at the significant cognitive and emotional shifts likely to emerge through engaging with the topic of CSA, when assumptions about the world, self, and others are shattered and mourned for (Cunningham, 1999; Janoff-Bulman, 1992; Pearlman & Saakvitne, 1995). In Chapter Three, I discuss how CSA is addressed within mental health and addictions services and social work education, and the barriers that can emerge at personal, professional, and organisational levels. The literature points to the need for trauma-informed and process-oriented approaches when working with clients with CSA and teaching about the issue. In addition, the emotional and embodied realms emerge as important considerations when addressing CSA professionally and educationally. At the end of Chapter Three I introduce my research questions, and discuss how they were derived from the literature and theoretical ideas presented.

In Chapter Four, I argue that the emotional and embodied realms are equally important, though somewhat neglected considerations in qualitative research. I discuss my decisions regarding methodology, methods, and ethics in the light of my interest in seeking participants’ affective perceptions regarding CSA, as well as their cognitions and attitudes. I argue that a hermeneutic phenomenological approach best suited the goals of my research, given its attention to inter-subjectivity and embodiment, and I discuss key concepts which resonate with aspects of CSA. I give attention to the methodological challenges for analysing focus groups as I was conscious of the need to capture group dynamics, rather than falling into the trap of presenting focus group participants’ perceptions as if they were individual participants.

The findings are organised within five chapters, the first three relate to social workers’ perceptions of CSA. Chapter Five is entitled “Being a social worker” and encompasses social workers self-ratings of their knowledge of CSA, sources of knowledge, understandings of definition and prevalence, comments regarding CSA training within their own social work education, and suggestions for training in this area. In addition, participants’ views about CSA within previous and current social work roles are addressed. Chapter Six, entitled “To tell or not to tell”, reflects participants’ views regarding the dialectical dilemma of disclosure across the lifespan, and in Chapter Seven, social workers’ views and perceptions regarding CSA perpetrators are explored.
Following social workers’ perspectives, Chapter Eight presents educators’ views regarding CSA within three sections: personal, pedagogical, and pastoral perspectives. Lastly, Chapter Nine, entitled “Dialoguing together”, provides a process-oriented and chronological approach to presenting the focus group findings. Thus, this chapter documents interesting interactions between participants, while traversing five key issues that emerged from individual interviews as most deserving of further dialogue. These issues had an educational focus, but were underpinned by considerations for practice.

In Chapter Ten, key findings are explored in relation to the research questions, extant literature, and policy documents. I discuss how parallel processes, revealed in the barriers and the ways forward to addressing CSA in practice and education, provide a rationale for a trauma-informed framework and an explicit focus on the emotional realm. I look at the implications of my findings for NZ policy and legislation underpinning the new Ministry for Vulnerable Children, Oranga Tamariki, as well as recent mental health and addiction policy developments. In addition, I suggest potential research pathways and lines of investigation emerging from this study. Speculating about some of the broader implications from my small sample of social workers and social work educators, I make some recommendations for addressing the issue of CSA and trauma in mental health and addiction practice, and social work education.
Chapter Two: A Trauma-Informed Theoretical Framework

It is not just that the traumatized ones and the normals live in different worlds; it is that these discrepant worlds are felt to be essentially and ineradicably incommensurable. (Stolorow, 2007, p. 15)

Introduction

This chapter introduces a range of theories which assist in understanding CSA and trauma, taking into account the perspectives of victims, perpetrators, non-offending caregivers, professionals, and society. The metaphor of weaving is particularly apt where horizontal threads, or weft, are intertwined with an existing framework of vertical threads, the warp, ultimately creating something new. My weft consists of sociological, psychological, neurobiological, and developmental threads woven into a dialectical framework as my warp. These woven threads highlight inherent intra-psychic, physiological, embodied, and interpersonal tensions elicited through the experience and effects of CSA, and associated disclosure decisions. These threads informed data collection and the analytical process, and to some extent, were also informed by the findings. In addition, my attention to dialectical principles within this theoretical framework is consistent with my dialectical methodology, which I discuss in Chapter Four.

Firstly, I discuss the relevance of psychodynamic and attachment theories for CSA, emphasising contemporary developments which have been informed by the field of neuroscience. Drawing on psychodynamic principles, I also explore the professional and organisational implications of addressing trauma such as CSA. Next I introduce relational dialectics theory (Baxter & Montgomery, 1996) as a means of understanding and transcending contradictory relational and intra-psychic tensions that victims of CSA often experience. Dialectical tensions occurring at individual, embodied, interpersonal, and familial levels are also explored within Finkelhor and Browne’s (1985) seminal traumagenic dynamics model, which I extend with contemporary literature. In addition, I look at Goffman’s (1959, 1963) work on stigma and impression management, and traverse the extensive physiological and mental/emotional costs of concealing CSA from self and other.
In the latter half of this chapter, I discuss common physiological and neurobiological responses to trauma, and introduce the concept of post-traumatic stress disorder (PTSD). Originating from the Greek word “wound”, trauma suggests some form of injury. It has come to mean both the cause (the experience/s eliciting trauma) and the effect (the manifestations of trauma). An experience becomes traumatic when it threatens to overwhelm internal capacities to organise and process events and maintain psychological integrity (Briere & Scott, 2014). Drawing on attachment theory, Stolorow (2013) astutely notes “pain is not pathology” (p. 385). Rather, it is the lack of sensitive responsivity to another human’s pain, and thus opportunities to process the pain, that creates traumatic stress. Like the dilemma of disclosure, PTSD also represents an approach-avoidance dialectic. However, I refer to the literature which suggests complex PTSD and dissociation capture the more pervasive and subtle effects of chronic interpersonal trauma. I consider the fragmented and often insidious nature of traumatic memory, and its role in exacerbating distress and creating disconnections and confusions between past and present. The direct and indirect ways that trauma, such as CSA, can affect health are explored, and I argue that these issues emphasise body-mind connections, and demonstrate the need for multi-disciplinary working between health and mental health services. Finally, I introduce the concept of trauma-informed care which draws on all the theory discussed in this chapter. This sets the scene for Chapter Three’s attention to how CSA is addressed in mental health and social work practice and education.

**Attachment theory**

As discussed in Chapter One, CSA occurs mainly in the context of interpersonal relationships, involving severe boundary violations and a betrayal of trust. In many cases, children are sexually abused by a significant attachment figure. Attachment theory is therefore highly relevant to considering the developmental impact of CSA, emphasising how relational aspects may contribute to trauma as much as the abusive events. Because of the profound effects on the attachment relationship and the child’s sense of security and identity, caregiver-induced trauma is considered to have the most far-reaching consequences for the child (Davis & Frawley, 1994; Schore, 2001b). The child’s dependency and need for attachment, coupled with a relative lack of autonomy, provide limited options for responding to such relational trauma (Perry, Pollard, Blaicley, Baker, & Vigilante, 1995).

Informed by neurobiological and infant research, attachment theorists posit that early attachment relationships have a profound influence upon psycho-social development, affect-

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regulation, empathy and mental health (Fonagy & Target, 2007; Perry, 2008; Schore & Schore, 2008, 2014; Schore, 2002, 2003a; Siegel, 2012). Unable to sufficiently regulate their positive or negative emotional arousal, infants and young children are easily overwhelmed psychologically and physiologically. Good enough caregivers modulate the child’s emotional states through their own affect regulation, sensitivity, and emotional availability. This occurs through periods of affective synchrony, followed by inevitable interactive ruptures and repair, much of which occurs on an unconscious, non-verbal implicit level mediated by the right hemisphere of the brain (Schore, 2003a, 2012; Tronick, 2007). Attachment behaviour is motivated not only by needs for safety and security, but also playful and joyous interaction (Schore, 2012; Stern, 1985, 1995). Born into a world of inter-subjectivity, a child’s neurobiological, emotional and personality development occurs in the context of self-other relationships. Attachment is therefore a dynamic and reciprocal process, with intergenerational influences upon the quality of attachment dyads.

Through internal working models (IWM) or mental representations of attachment relationships, the child gradually develops an intra-psychic and interpersonal template for perceptions about self, others, and the world (Bowlby, 1973, 1979, 1980, 1982). These internal representations and corresponding attachment patterns are subject to revision, impacted by positive or negative alterations to the quality of attachment relationships across the lifespan (Weinfield, Sroufe, & Egeland, 2000). Far from being only relevant to infancy and childhood, the attachment system continues to be activated “from the cradle to the grave” (Bowlby, 1979, p. 129).

**Attachment measures and classifications**

Infant attachment status was originally classified using the Strange Situation Procedure (SSP) (Ainsworth, Blehar, Waters, & Wall, 1978). According to their behaviour during separation and reunion, infants were classified as having one of three organised strategies for attachment: secure, insecure-avoidant, insecure-ambivalent. While the three organised attachment strategies appeared sufficient for low-risk samples, it became apparent that a considerable proportion of infants from high-risk and clinical samples did not have any coherent strategy for attachment, resulting in a further insecure classification entitled disorganised attachment (Main & Solomon, 1986, 1990). In order to regulate anxiety elicited by

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12 The SSP is a laboratory procedure involving two brief separation/reunion episodes between 18 month old infants and a caregiver over a period of 20 minutes.
less-than-ideal caregiver behaviour and responses, insecurely attached children develop various attachment strategies as shown in Table 1.

**Table 1: Infant attachment status**

<table>
<thead>
<tr>
<th>Infant attachment status and IWM</th>
<th>Infant behaviour at SSI</th>
<th>Infant attachment strategy</th>
<th>Caregiver behaviour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organised secure</td>
<td>Cries at separation, comforted at reunion</td>
<td>Balance between proximity seeking and exploration</td>
<td>Sensitive, responsive, adequate affect regulation and reflective functioning</td>
</tr>
<tr>
<td>Self is lovable, other is trustworthy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Organised insecure-avoidant</td>
<td>Doesn’t cry at separation, avoids caregiver at reunion</td>
<td>Suppresses expression of attachment behaviour, repression of attachment affects</td>
<td>Distant, rejecting, uncomfortable with physical/emotional closeness</td>
</tr>
<tr>
<td>Self is undeserving of attachment, other is uninterested</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Organised insecure-ambivalent/resistant</td>
<td>Cries at separation, but reunion is also distressing, not easily comforted</td>
<td>Hyper-activates attachment system, ambivalence, push-pull behaviours</td>
<td>Inconsistently responsive, insensitive to infant’s cues, intrusive</td>
</tr>
<tr>
<td>Self is lovable and undeserving, other is unpredictable</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disorganised</td>
<td>Simultaneous approach and avoidance, freezing, approaching backwards, trance-like states, incomplete movements, fear of parent, disorientation</td>
<td>No coherent strategy for activating attachment system</td>
<td>Frightening, hostile, insensitive, abusive and/or frightened, helpless, unresponsive, trance states, deferential to infant, role-reversal, neglect</td>
</tr>
<tr>
<td>Multiple, contradictory representations of self and other</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

These highlight defensive processes and internal conflicts. For example, avoidant attachment reflects minimisation and denial of the need for attachment, whereas children with ambivalent attachments are conflicted between the need to gain a caregiver’s attention and to reject attention. Those with disorganised attachments are so conflicted and overwhelmed by needs to approach and avoid a caregiver they may physically and psychologically shut-down.
A variety of attachment measures have been developed across adolescence and adulthood, however I will limit discussion to the Adult Attachment Interview (AAI) (George, Kaplan, & Main, 1985), because of its attention to the impact of unresolved trauma and loss. This is an hour long semi-structured interview which assesses the process and content of adults’ narratives regarding early attachments, and assigns them to one of four categories: secure-autonomous, dismissing, preoccupied and unresolved. Adult attachment status, derived from the AAI, has theoretical and empirical links with infant attachment (see Table 2).

Unresolved attachment is determined by attention to the process of adults’ narratives of loss or abuse in childhood. Momentary lapses in discourse are believed to represent the intrusion of unassimilated traumatic material in the form of affects, sensations and memories (Hesse, 1996, 2008). As can be seen from Table 2, the fragmentation, disorientation and incoherence apparent within unresolved attachment presentations is remarkably similar to the behavioural manifestations of disorganised attachment in infants. A growing body of researchers consider such presentations to be dissociative processes elicited by conflicted, unintegrated internal representations of self and other (Anderson & Alexander, 1996; Hesse & Main, 1999, 2000, 2006; Liotti, 1992, 2004, 2006; Lyons-Ruth, 2003; Lyons-Ruth, Bronfman & Parsons, 1999; Lyons-Ruth, Dutra, Schuder, & Bianchi, 2006; Main & Morgan, 1996; Ogawa, Sroufe, Weinfield, Carlson, & Egeland, 1997). Bowlby (1980) alluded to the presence of dissociation within insecure attachments when he discussed separate, contradictory, and unintegrated internal working models.

14 Meta-analyses of longitudinal attachment studies, while acknowledging a transmission gap, have revealed the intergenerational transmission of attachment. Caregiver’s adult attachment status is associated with the corresponding infant attachment status in their child, although the association is stronger for secure attachments (van IJzendoorn, 1995; Verhage et al., 2016).
Table 2: Adult attachment status derived by AAI

<table>
<thead>
<tr>
<th>Adult attachment classification</th>
<th>AAI attachment narratives</th>
<th>Likely attachment status of own children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Secure autonomous</td>
<td>Integrated attachment memories, readily accessed, able to reflect on attachment memories and relationships without distortion</td>
<td>Secure</td>
</tr>
<tr>
<td>Dismissing</td>
<td>Minimise importance of relationships and any negative aspects, idealise attachment figures, poor access to attachment memories, intellectualisation regarding attachment relationships</td>
<td>Insecure-avoidant</td>
</tr>
<tr>
<td>Preoccupied</td>
<td>Chronically worried about attachment relationships, preoccupied with value and meaning of attachment relationships, poor emotional regulation, emotional involvement creates incoherency and lack of objectivity in attachment narratives</td>
<td>Insecure-ambivalent</td>
</tr>
<tr>
<td>Unresolved</td>
<td>Unresolved attachment-related childhood loss or abuse; brief but significant lapses in reasoning, reality testing or discourse when discussing experiences of trauma/abuse/loss; trance-like states, confusion, incoherence, odd words/phrases for abuse, disorientation to space and time in trauma narratives</td>
<td>Disorganised</td>
</tr>
</tbody>
</table>

Babies and children develop disorganised and other insecure attachments when they face the unresolvable paradox of a primary attachment figure who is both the source of safety, and the source of fear and unpredictability (Main & Hesse, 1990; Hesse & Main, 2006). The attachment research has suggested that not only may overt forms of abuse provoke internal conflict in the child, but that a caregiver who is frightened, withdrawn, dissociative, or emotionally unavailable is also traumatic to a young child (Hesse & Main, 2006; Lyons-Ruth, 2003; Lyons-Ruth et al., 1999). Obviously the latter may occur in parents with unresolved trauma and/or significant stress. Either form of behaviour simultaneously invokes innate but competing mechanisms within the child: the threat system (flight/fight/freeze) and the attachment system (safety/secure base/bonding) throwing the child into a chasm between approach and avoidance. Main and Hesse (1990) described this untenable position as “fright without solution” (p. 163). These unresolved conflicts can contribute to poor self-concept and ongoing problems with affect regulation (Mikulincer & Shaver, 2007, 2008, 2012; Schore, 2003, 2012; Siegel, 2012). Insecure attachments confer vulnerability to mental health problems through emotional over-regulation (internalising) and/or under-regulation (externalising),

**Psychodynamic theory**

The relational turn in psychoanalysis has shifted the focus from fixed and repressed intrapsychic phenomena to the fluid, intersubjective context of peoples’ lives. In this latter view the social worker is not an objective observer, but an active participant, and the casework relationship itself is a major resource in healing. Attachment theory is an essential cornerstone within this new paradigm, highlighting the relational substrate of mental/emotional health. While past relational templates or IWM’s are believed to influence the present, they may also be modified by current relationships (Mitchell, 2000; Schore, 2003b, 2012; Stolorow & Atwood, 1992; Stolorow, 2013). Thus, interdependency between inner and outer worlds, past and present, and self and other is emphasised. These intersubjective and relational psychodynamic approaches have considerable points of convergence with constructivism (Wachtel, 2014) and hermeneutic phenomenology (Atwood & Stolorow, 2014; Stolorow, 2011, 2013). They are also informed by infant research, developmental theory, neuroscience, and embodiment (Ammaniti & Gallese, 2014; Fisher, 2016; Ginot, 2015; Ogden & Fisher, 2015; Ogden, Minton, & Pain, 2006; A. Schore, 2012; J. Schore, 2012). I discuss a number of key concepts and their relevance for the phenomenon of CSA.

**The unconscious**

Neuroscientific findings suggest that the right hemisphere of the brain, involved in implicit learning and memory, and non-verbal and emotional communication and information processing, is the seat of the unconscious realm (Gainotti, 2005, 2012; Ginot, 2011, 2015; Sato & Aoki, 2006; Schore, 2009, 2012, 2014). This has led to an expanded view of the unconscious which includes the “implicit processing of cognitions … and affect … not because they are repressed, but because bodily based affects are expressed rapidly and spontaneously … beneath levels of conscious awareness” (Schore, 2015, p. xii). From an attachment perspective, the unconscious also includes early relational experiences and associated relational templates, described by Bowlby (1979) as IWM’s. These are “imprinted and stored in implicit-procedural memory systems” (Schore, 2003, p. 53). In addition, thoughts and feelings may be repressed, suppressed, or dissociated because they were invalidated, and/or threatened vital attachment relationships (Freyd, 1996; Schore, 2012, 2015; Stolorow, 2013; Stolorow & Atwood, 1992).
Transference and countertransference

Transference involves unconsciously transferring feelings, internalised expectations, and relational ways of being that were experienced in formative early relationships into present, here-and-now relationships. These emotional and embodied triggers from the past “create a bodily state that regulates approach or avoidance towards an object” (Schore, 2003a, p. 53). When the professional experiences his/her own transference to the client, or the professional unconsciously reacts to the client’s transference it is referred to as countertransference. The first form of countertransference is applicable to professionals whose own trauma histories are triggered by client’s material, or by aspects of the client that are reminiscent of their abuser. Not only may strong affect be produced in the professional in response to the client, but conscious and unconscious defences may be employed to deal with such affect (Pearlman & Saakvitne, 1995; Ruch, 2010, Trevithick, 2011). A third form of countertransference, described by Pearlman and Saakvitne (1995) is elicited by the need to “maintain professional self-esteem and identity”, which can evoke “strong dynamics of shame, competition, pride and envy”, severely limiting the professional’s capacity for authenticity (p. 47).

Failing to be aware of, and understand countertransference reactions has considerable implications for responding to disclosures, and working with clients with a history of CSA. Irrespective of the professional’s personal history, the incest taboo is a particularly potent source of countertransference, since intra-familial CSA challenges internalised expectations regarding the family as a haven of support and nurturance. “We hold strongly to these imagoes because they come from our own real, defensive, and fantasised early experiences and beliefs and our own roles as adults and parents, and they are integral parts of our psychic structures” (Pearlman & Saakvitne, 1995, p. 80).

Countertransference responses may involve “distancing and intrusive errors” (McGregor, Thomas, & Read, 2006, p. 56), which suggest an approach/avoidance dialectic. Distancing reactions can include excessive objectivity (known as a “blank screen” approach), passivity, and rejecting or punitive responses, while intrusive reactions involve overly directive responses, a need to rescue, over-identification, over-involvement, and expression of strong feelings (Dalenberg, 2000; McGregor et al., 2006; Pearlman & Courtois, 2005; Wilson & Lindy, 1994). Lending further support for an approach/avoidance dialectic, Cramer (2002) has noted professionals’ “concomitant desires to rescue and desert” clients with mental health and addiction problems (p. 194), and Najavits (2002) has described the “paradox of countertransference” in relation to working with clients with traumatic stress and substance
abuse (p. 11). In Najavit’s (2002) view, clients’ trauma “tends to evoke sympathy and identification with patients’ vulnerability”, while their substance abuse elicits anxiety, sometimes leading to “harsh judgment and confrontation” (Najavits, 2002, p. 11). In addition, Pearlman and Courtois (2005) have noted that risks of burnout from over-involvement can potentially lead to “negative, rejecting countertransference … being enacted against the client in a way that reinforces negative relational experiences and messages” (p. 455).

The idea of a relational unconscious whereby one unconscious mind affects another unconscious mind (Schore, 2012, 2015), highlights the potential for somatic countertransference (Dosamantes-Beaudry, 1997; Gubb, 2014). Orbach and Carroll (2006) describe this as “the therapist’s awareness of their own body, of sensations, images, impulses, and feelings that offer a link to the client’s healing process and the intersubjective field” (p. 64). Yet, as Wallin (2007) points out, there is a need to “differentiate empathic resonance from the projection of our own feeling states onto the patient” (p. 296). Embodied resonance with, or reactions to, the client need to be recognised to be therapeutically helpful (Gubb, 2014; Ogden & Fisher, 2015; Ogden & Minton, 2000; Schore, 2012), and to prevent secondary traumatisation (Forester, 2007; Pearlman & Saakvitne, 1995; Rothschild & Rand, 2006). Empathy, enhanced by our mirror neuron system15 (Ammaniti & Gallese, 2014), is unfortunately a double-edged sword.

**Vicarious traumatisation**

Vicarious traumatisation (VT) is defined as “the transformation that occurs” within professionals “as a result of empathic engagement with clients’ traumatic experiences and their sequelae” (Pearlman & McIan, 1995, p. 558).16 Being deeply affected by the pain of others is a normal empathic response, however the cumulative exposure to clients’ traumatic material over time takes its toll. When this toll is minimised or ignored, and/or there are inadequate support mechanisms for processing reactions, professionals are more vulnerable to developing disrupted schemas about self, others, and the world. Assumptions about the world being safe and just are shattered (Janoff-Bulman, 1992), leading to a grief process involving denial, anger,

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16 I include VT within this section on psychodynamic theory because it is related to countertransference (Pearlman & Saakvitne, 1995; Saakvitne & Pearlman, 1996) and it is based on constructivist self-development theory (CSDT), which “blends object relations, self-psychology, and social cognition theories” (McCann & Pearlman, 1992, p. 389).
sadness, depression, disillusionment, and cynicism (Cunningham, 1999). Professionals may also experience trauma symptoms such as intrusive thoughts, nightmares, emotional numbing, dissociation and somatic symptoms, such as nausea and headaches. Other related terms are secondary traumatic stress (STS), compassion fatigue and burnout (Figley, 1995, 2002; Malasch, 2003).¹⁷

Involving countertransference, VT occurs over time and over the course of many relationships with clients. A lack of awareness of countertransference reactions increases susceptibility to VT, while experiencing VT can lead to more intense countertransference responses (Pearlman & Saakvitne, 1995). Understanding and managing “vicarious brain activity” (Keysers & Gazzola, 2009, p. 666), and the resulting “embodied simulation” (Gallese, Eagle & Migone, 2007, p. 131) is crucial. As Hodges and Wegner (1997) astutely recognise “automatic empathy” is like “tumbling downhill” while “controlled empathy is as effortful as climbing up a mountainside” (p. 320).

The degree to which professionals experience VT is thought to depend on a number of interacting personal, professional, client, and work variables (Pearlman & Saakvitne, 1995). It is an ever present challenge for professionals and researchers working with the pain of clients’ lives, whether they have been personally affected by such issues or not (Bride, 2004; Bride, Hatcher, & Humble, 2009; Draucker, Martsof, & Poole, 2009; Coles & Mudaly, 2010; Cunningham, 1999; Pearlman & Saakvitne, 1995). Though not a trauma survivor, Knight (2013) has described the “core beliefs” she is susceptible to as a sexual abuse therapist and social work educator:

Anyone is capable of anything. The more innocent someone looks, the less she or he can be trusted. Anyone—anyone—could molest (my son). The world is basically an unsafe place and one must always be vigilant. As soon as one lets her or his guard down, something bad will happen. (p. 227)

Some of the literature on VT suggests that unresolved psychosocial trauma, such as CSA, may be a confounding variable which puts social workers at further risk (Cunningham, 2002).

¹⁷ The construct of STS highlights the similar trauma symptoms emerging in response to direct and indirect trauma (Bride, Robinson, Yegidis, & Figley, 2004). Compassion fatigue emphasises the reduced capacity for empathy that can occur from the cumulative exposure to others’ pain and trauma (Figley, 2002; Stamm, 2002a). Burnout involves emotional exhaustion, cynicism, and a sense of personal inadequacy (Maslach, 2003). While there is considerable overlap between the terms, VT appears to be the most inclusive construct, addressing traumatic symptoms and the cognitive and emotional changes that can occur. I primarily use the term VT, however I refer to STS if the study has used a scale measuring STS.
2003; Follette, Polusny, & Milbeck, 1994; Pearlman & Maclan, 1995). However, other studies have found no relationship between clinicians’ history of childhood maltreatment and vicarious trauma effects (Benatar, 2000; Schauben & Frazier, 1995; Way, VanDeusen, Martin, Applegate, & Jandle, 2004). There appears to be a gap in the literature regarding the moderating influences of personal therapy/informal support, and effective supervision, on survivor clinicians’ vulnerability to VT. One study has attempted to address some of these gaps. Among 64 NZ Victim Support volunteers, who had all experienced one or more traumatic events, those who described trauma histories as resolved had significantly less symptoms of STS (Hargrave, Scott, & McDowell, 2006). The authors suggested that trauma histories may constitute a “deficit or an asset” depending on the degree of resolution (Hargrave et al., 2006, p. 51).

Caseloads predominantly focused on CSA have been associated with higher VT symptomatology (Cunningham, 2003; Pack, 2012), however Pearlman and Maclan (1995) found that trauma therapists experienced more disrupted cognitions when spending less time working with trauma. Human induced trauma, particularly enacted on children, appears to increase the risk of VT, as opposed to trauma resulting from “acts of nature” (Cunningham, 2003). Working in the field of CSA and trauma over time has been found to be negatively correlated with VT, suggesting that social workers and therapists learn to develop strategies to manage and resolve the negative effects (Cunningham, 2003; Pearlman & Maclan, 1995).

Resolving VT depends on the social workers’ willingness and ability to recognise its impact and address its effects, along with supervisors, and the workplace culture as a whole (Cunningham, 1999; Knight, 2013; Pack, 2012, 2013). Adamson’s (2005) doctoral research found that an inadequate organisational response to traumatic events in the mental health workplace was a more crucial determinant of negative outcome, than the context of the incident or the client. Without organisational support, social workers may deny the impact of their clients’ CSA upon them, because of expectations to be professional and maintain boundaries, often reinforced by supervision (Browne, 1995; Cunningham, 1999; Knight, 2013). Consequently, several authors have highlighted the need for organisational support to address the impact of VT, through supervision, support groups, education about VT and self-care strategies, and case management (Bell, Kulkarini, & Dalton, 2003; Bride, Jones, & McMaster, 2007; Collins & Long, 2003; Knight, 2013). Trauma-informed supervision normalises and validates the effects of indirect trauma, giving supervisees permission to express the emotional toll, and to collaboratively find ways to mitigate the effects (Berger & Quiros, 2014; Bride & Kintzle, 2011; Bride & Walls, 2007; Fontes, 1995; Knight, 2013; Pisani, 2005; Sommer, 2008).
Similarly, support groups help normalise workers’ experiences, reduce isolation, counter stigma, correct cognitive distortions, and provide education and accountability (Catherral, 1999; Clemens, 2004; Cunningham, 1999; Fox & Cooper, 1998; McCann & Pearlman, 1990). Organisational support and individual commitment to process and manage the negative impacts of indirect trauma, makes room for appreciation of the positive impacts of working with trauma. These include compassion satisfaction\(^{18}\) and vicarious resilience.\(^{19}\)

Psychodynamic theory is intrinsic to understanding how the emotional toll of working with others’ pain may be defended against, and ultimately exacerbated, through poor coping strategies (Pearlman & Saakvitne, 1995). Social workers who fail to address the impact of their clients’ traumatic material may replicate the maladaptive coping mechanisms of their clients, utilising dissociation, denial, detachment, avoidant coping, and substance abuse (Cunningham, 1999; Figley, 1995; Pearlman & Saakvitne, 1995). Unremitting traumatic stress tends to reinforce “attention to ontological survival at the expense of connectivity” (Adamson, 2006, p. 55), with considerable deleterious effects on clients. Given that the average professional life of a social worker is about seven years (Furness, 2007), self-management strategies and emotional intelligence are now considered crucial protective factors (Grant & Kinman, 2012; Grant, Kinman, & Baker, 2013; Rajan-Rankin, 2013). While VT was originally conceived of as occurring within direct practice with clients’ trauma, many authors now consider it to be a potential risk for students learning about trauma, such as CSA, and therefore an essential component of a trauma curriculum (Agllias, 2012; Bussey, 2008; Carello & Butler, 2015; Cunningham, 2004; Zlosky, 2013; Zurbriggen, 2011). The implications of VT for social work education will be taken up in Chapter Three.

**Defences**

Defence mechanisms in the form of feelings, thoughts, and behaviours function to protect the self from awareness of anxiety and pain. While they are employed to regulate emotions they are in essence a form of self-deception. The more a person resorts to defence mechanisms the less attention is directed to present reality and the greater the potential for distortion and misunderstanding. Permeating all defence mechanisms is the defence of denial, simply, we may consciously and unconsciously deny and avoid what we believe or sense, is too painful or anxiety-provoking to bear. While denial is an immature defence mechanism

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\(^{18}\) Compassion satisfaction is described as the sense of satisfaction, meaning and achievement derived from helping others (Stamm, 2002).

\(^{19}\) Vicarious resilience is the positive transformation in professionals’ attitudes, behaviours, and emotions as a result of observing and appreciating clients’ resilience (Hernandez, Gangsei, & Engstrom, 2007).
associated with early childhood (Cramer, 2006), victims and perpetrators of all ages may deny CSA occurred or minimise its impact (Lab & Moore, 2005; Lyon, 2007; Schneider & Wright, 2004; Ware, Marshall, & Marshall, 2015). Societal and professional denial and minimisation is also well documented with regard to CSA (Denov, 2001, 2003; Olafson et al., 1993; Richardson, 2003; Summit, 1983, 1988). Related to denial is the primitive defence mechanism of dissociation which will be discussed later in this chapter. However, at this juncture, it is timely to consider the defensive role of emotional numbing, detachment, and dissociation that can occur when practitioners or students are vicariously traumatised.

Acting out is another defence utilised by victims of CSA to express and manage unwanted thoughts and feelings. This may take the form of risk-taking, sexual promiscuity, or aggressive and delinquent behaviour (Ray & English, 1995; Runtz & Briere, 1986; Swanston et al., 2003). Perpetrators may employ rationalisation, in order to convince themselves and others that their acts were socially acceptable. They may assert that they were educating a child about sexuality, or loving them, rather than abusing them (Schneider & Wright, 2004). Survivors of CSA may avoid internal conflicts and emotions by focusing on the needs of others, a more mature defence known as altruism. This is relevant to the significant prevalence of trauma histories among social work students, and the findings that such histories often constitute a motivating factor in career choice, which I discuss in Chapter Three.

Understanding of defence mechanisms helps to situate service users’ challenging, resistant, or counter-intuitive behaviour within the larger psychosocial context. This reduces the likelihood of reactive responses from professionals, and reveals the need to ultimately address underlying anxiety among clients and staff. The universality of defences reminds social workers that they are not immune from defensive, avoidant behaviours; neither are their supervisors or managers.

**Social defences**

Socially structured defence mechanisms are externalised through the culture, policies, and functioning of organisations as a means to defend against work-related anxiety experienced by its members (Jacques, 1953; Menzies Lyth, 1960). Built up over time through conscious and unconscious collusive processes between members, a culture or status quo is established. Thus social defences are often hidden from awareness through their projection onto the external reality of the organisation, which new members are indoctrinated into. Initiated at the individual level, defences are maintained and often strengthened by constraining and coercive
group dynamics. In the absence of opportunities to hold, contain, manage, and process anxiety, social defences may exacerbate problems. They may lead to restricted and routinized roles and organisational silos. These “defensive routines” (Argyris, 1990, p. 25) create low morale, increase staff turnover and burnout, inhibit organisational learning and functioning, and limit multi-disciplinary collaboration (Argyris, 2010; Armstrong, 2004, 2005; Armstrong & Rustin, 2014; Bain, 1998; Bloom & Farragher, 2010; Diamond & Allcorn, 2009; Hyde, 2005; Kahn, 2012; Menzies Lyth, 1960; Obholzer & Roberts, 1994).

Menzies Lyth’s (1960) study of student nurses identified a range of social defences operating within the organisational culture of the hospital. Denial of the importance of relationship and depersonalisation of the patient, denial of emotion and the fostering of detachment, diffusion and confusion regarding issues of responsibility, and ritualised and rigid procedures characterised the hospital milieu. The concept of social defences has resonated with observations and concerns regarding social work and mental health practice. As Megele (2015) observes, “social work operates at the sharp end of society’s fears, anxieties and traumas, and intervenes in people’s lives at a time when they may be overwhelmed by dysphoric emotions and distress” (p. 1). Drawing on social defences, many consider that the anxiety generated in working with ambiguity, complexity, pain, and risk has prompted defensive, routinized, and risk-averse practice (Bloom & Farragher, 2010; Cooper & Lousada, 2005; Deacon, 2004; Lees, Meyer, & Rafferty, 2013; Ruch, 2005; Ruch & Murray, 2011; Taylor, Beckett, & McKeigue, 2007; Waterhouse & McGee, 2009; Whittaker, 2011; Whittaker & Havard, 2015).

Mental health services are charged with the primary task of containing and treating anxiety and distress, which in itself is likely to elicit considerable anxiety in professionals. As discussed previously, anxiety may have personal and professional origins, but may also arise from societal pressures and expectations, which are likely to feed into organisational defences. The creation of institutions invested with the responsibility for various aspects of human welfare, such as mental health, primary health care, child protection, and criminal justice effectively splits off societal responsibility for those aspects. In regressive patterns of denial, society tends to locate responsibility and blame within such institutions, and upon professionals (Hyde, 2005). The dominant disease model within mental health can be viewed as a social

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20 Winnicott’s (1965) concept of “holding” and Bion’s (1962) concept of the “container/contained” are consistent with the attachment literature in emphasising the importance of attuned and sensitive caregiving, as a means of emotionally regulating the infants’ psychobiological states. These concepts have been applied to the therapeutic relationship and the supervision relationship. Within social defence theory, these constructs are also applied to the organisational culture as a means of supporting organisational change and promoting reflective, emotionally intelligent practice (Armstrong & Rustin, 2014; Diamond & Allcorn, 2009; Hinshelwood & Skogstad, 2000; Kahn, 2001, 2012; Ruch, 2007).
defence system, protecting against the anxiety of acknowledging and addressing the impact of trauma. It may also represent a response to societal expectations and pressures to contain and treat mental illness. Highlighting genetic aetiology, symptom-based diagnosis, pharmacological interventions, and the use of seclusion and restraint, the medical model reflects a splitting of “madness” and “sanity”, “us” and “them”, “normal” and “abnormal”. Thus, professionals and society are safeguarded from existential anxiety inherent in the realisation that we are all vulnerable to mental distress. As Hyde (2005) has noted, “mental health services generate anxieties for staff arising from fears of being contaminated by madness, being attacked or losing control over oneself” (p. 8). Similarly, within child protection, the increasingly tick-box, proceduralist approach can be perceived as a social defence system, with multiple purposes and dimensions:

a) it attempts to suppress anxiety elicited by the nature of the work,

b) it protects against the anxiety of addressing the individual, systemic, and intergenerational impact of childhood trauma,

c) it is a response to anticipatory anxiety about societal judgement.

Social defence theory suggests that safe forums are needed professionally and educationally for tolerating and exploring multiple and inter-related sources of anxiety. This would enable approach rather than avoidance; facilitating a willingness to know, to witness, and to respond to the experiences and impact of trauma. It is not anxiety, per se, which is the problem; it can be a stimulus to greater achievement, creativity, depth of thinking, and emotion (Hirschhorn & Horowitz, 2014; Rustin, 2015). In addition, professional anxiety regarding people’s suffering and level of risk reflects empathy and concern. Rather, it is the personal, professional, organisational, and societal defences against anxiety which create havoc, by reducing the capacity for reflexivity, empathy, and appropriate intervention. As Rustin (2015) notes “a latent belief that anxieties are … intolerable can itself support organisational defences against anxiety, as in the many instances of ‘turning a blind eye’ that have recently come to light” (p. 240).

**Utilising a dialectical framework for CSA: Relational dialectics theory**

Given the threats to self, family, and society, it is not surprising that dissension rather than consensus has characterised the field of CSA, as discussed in Chapter One. Making sense of the contentious nature of CSA is aided by a dialectical framework which attends to the
affective, cognitive, and somatic realm, and considers the often competing contexts of gender, culture, and individual and societal histories. Numerous contradictory tensions abound in the experience and interpretation of CSA, disclosure decisions, and subsequent adaptation and adjustment. As discussed earlier, an approach/avoidance dialectic permeates attachment and psychodynamic theory. In addition, these intersubjective theories emphasise a dialectic between self and other, or intra-psychic and interpersonal spheres. Thus relational dialectics theory provides a particularly salient and useful framework to more deeply understand the complex, shifting, and multiple perspectives of victims and perpetrators. Perceiving the relationship dynamics of CSA from a dialectical perspective helps survivors make sense of their experience, and informs academic and clinical realms (Ford, Ray, & Ellis, 1999). Dialectics provide a way of engaging with the numerous professional and societal CSA debates, potentially offering a means to understand and transcend polarised views (Erbes, 2004), and the oscillations of denial and recognition of CSA (Conte, 1994; Herman, 1981, 1997; Olafson et al., 1993; Perry & DeLillo, 2007).

Relational dialectics theory draws on dialectical philosophy and suggests that human relationships have four core features: contradiction, change, praxis, and totality (Baxter, 1990; 2006; Baxter & Montgomery, 1996, 1998; Buss, 1979; Rawlins, 1992, 1998). Each will be introduced and then discussed in the context of CSA. Contradiction applies to the myriad of opposite intrapersonal and interpersonal needs and drives found in human relationships, such as the desire for expression versus concealment, identification versus differentiation, collectivism versus individualism, and approach versus avoidance. They all reflect consistently shifting boundaries between self and others, and within self. Contradictions may occur at the micro, meso, and macro levels, may attend to the particular and the universal, and are a natural part of social life. Each dialectical pair is interdependent and could not exist without the other, and it is the interplay between them that creates the second feature of dialectics, change (Baxter & Montgomery, 1996, 1998).

Dialectical relational theory is not immune from its own debates, and the nature of change is viewed somewhat differently among dialectical theorists. Bakhtin (1981) posited that there is a central and irresolvable human dialectic involving emotional forces tending towards unity (analogous with centripetal forces) and emotional forces tending towards divergence (analogous with centrifugal forces). Drawing on Bakhtin’s (1981) dialogic perspective, Baxter (2004) has criticised the Hegelian notion of thesis-antithesis-synthesis as being too simplistic and mechanistic, and challenged the idea that contradiction can be eliminated or resolved. In this view, change is indeterminate and fluid, a spiralling phenomenon involving the centripetal-
centrifugal flux of ongoing and irresolvable dialectical tensions (Baxter, 2004; Montgomery & Baxter, 1998; Bochner, Ellis, & Tillmann-Healy, 1998). Others have suggested that some periods of equilibrium within dialectical tensions are possible through acknowledging their both/and status rather than a polarised either/or perspective (Conville, 1998; VanLear, 1998). This view is also held within another dialectically informed perspective. Dialectical behaviour therapy (DBT) promotes synthesis and balance of the dialectical tensions of acceptance and change, universal and relativist truth, and whole and part (Linehan, 1993; Lynch, Chapman, Rosenthal, Kuo, & Linehan, 2006). Perhaps some degree of transcendence of dialectical tensions is only possible through awareness and acceptance of opposing intra-psychic, interpersonal, and societal forces. As Ko (2010) notes: “While the Western tradition has regarded the paradox as something pathological, the Eastern tradition has regarded it as the basic method and starting point for creative process” (p. 55). Such reflective dialectical thinking is characteristic of Piaget’s (1972) formal operations stage. However, young CSA victims are developmentally unable to apply dialectical thinking to their predicament. In addition, their developmental needs in early childhood privilege many dialectical poles over others, such as identification over differentiation, approach over avoidance, and connection over autonomy. The field of relational dialectics has arisen out of the study of adult couples, but has started to be applied to adolescents and children (Allen, Chango, & Szwedo, 2014; Rafferty & Parcell, 2016). There does appear to be a need to apply developmental theories to relational dialectics in order to further understand the ways in which children and adolescents manage dialectical tensions.

The managing of contradictions is known as praxis, and in a sense deals with the existential, phenomenological dimension of dialectics. It highlights the duality of human perception and interaction, simultaneously experienced as both subject and object; acting and being acted upon. Praxis involves oscillation between these two experiences: subject (proactive, choice-making, acting on) and object (reactive, choice-constrained, being acted upon). Individuals make choices to manage relational dialectical tensions (Baxter & Braithwaite, 2008) but may also deny that tensions exist (Wilson & Sabee, 2003). Each choice or response recalibrates dialectical tensions and influences the overall interpersonal tone (Dumlao & Janke, 2012). Yet the objectifying nature of CSA, the power imbalance, and the exploitation of children’s developmental needs is likely to limit children’s ability for choice-making. Praxis also attends to temporality, addressing contradictions within and across time, and considering how people “construct meaningful continuities and discontinuities in past, present and future” (Baxter & Montgomery, 1998, p. 10). This has considerable implications for an adult CSA
survivor looking back to their praxis as a child, as well as its effects on their current dialectical relational tensions.

The last feature of dialectical theory, totality, suggests that contradictions are inseparable from each other, and the social, cultural, physical, temporal, and spatial context from which they arise. The concept of totality attends to the inter-relationship between social units, whereby a dyad is mutually influenced by the quality of relationships with one’s family, friends, community, and culture. Some dialectical theorists consider contradictions are intra-psychic and located within the individual (Dindia, 1998; Ford et al., 1999; VanLear, 1998), whereas others site contradictions primarily within interpersonal fields (Baxter & Montgomery, 1998; Rawlins, 1998). In keeping with a both/and perspective and an intersubjective lens, it seems specious to privilege self over other, or the intra-psychic realm over the interpersonal, as both mutually influence each other.

The position taken in the research acknowledges that dialectical tensions arising from the experience of CSA may be expressed interpersonally and arise from relationship, but are also felt and located intra-psychically (Ford et al., 1999). The way in which contradictions manifest and are expressed in each individual will depend on the complex and multiple contexts in which they are embedded. The literature points to many abuse-specific variables affecting the experience, meaning, and outcome of CSA such as the relationship with the perpetrator, developmental stage, length and severity of abuse, and gender of victim and perpetrator (Nash Hulsey, Sexton, Harralson, & Lambert, 1993; Yancey & Hansen, 2010). Complex matrices interact with abuse-specific factors over the lifespan to mediate the effects of CSA. These include other adverse experiences or abuse, temperament, disclosure experiences, attributional style, family functioning, parental trauma and mental health, peer relationships, attachment history of child and parents, and socioeconomic status (Collishaw et al., 2007; Fergusson, Horwood, & Lynskey, 1996; Lynskey & Fergusson, 1997; McGloin & Widom, 2001; Romans, Martin, Anderson, O’Shea, & Mullen, 1995; Rutter, 1985; Yancey & Hansen, 2010).

The dialectic of disclosure

Disclosure of CSA involves the dialectical dilemma of revealing/concealing for both the victim, and who the victim chooses to tell. Rather than being a one-off event, disclosure is a dynamic, ongoing intrapersonal and interpersonal process across time and across relationships, reverberating throughout a person’s life (Dindia, 1998; Ford et al., 1999; Petronio, 2002; Ray, 1996; Reitsema & Grietens, 2015). Dialectical tensions between approach and avoidance
characterise the dilemma of disclosure, whereby victims “test the disclosive waters” (Ford et al., 1999, p. 146), constantly evaluating the receptivity and trustworthiness of the potential recipient. Information may be incrementally revealed in the form of hints, behavioural signs, and indirect disclosure (Alaggia, 2004, 2005; Flam & Haugstvedt, 2013). However, the shuttling back and forth between revealing and concealing involves a spiralling rather than linear or cyclical process because each dialectical movement is unique and unrepeatable (Dindia, 1998; Limandri, 1989). The nature of the verbal and non-verbal response will affect victims’ future disclosure decisions, and may also influence the decision to retract previous disclosures (Malloy, Lyon, & Quas, 2005; Staller & Nelson-Gardell, 2005; Sorenson & Snow, 1991). Children of intra-familial sexual abuse may consequently feel both powerful and powerless in considering the consequences of disclosure, such as the potential disintegration of family structure, or being ostracised and disbelieved by family (Ford et al., 1999; Ray, 1996).

Expanding Finkelhor and Browne’s traumagenic dynamics: Dialectical tensions

Finkelhor and Browne (1985) developed a robust model to demonstrate the pathways CSA trauma may take in psychologically and physically affecting children. The traumagenic dynamics of traumatic sexualisation, betrayal, powerlessness, and stigmatisation create cognitive and affective distortions which lead to unhelpful ways of “coping with a world where abuse is not the norm” (Finkelhor, 1987, p. 355). These pathways significantly overlap and have implications for childhood and adolescence as well as long-term adjustment in adulthood. The model attends to the mediating effects of developmental stage, prior traumatic history, gender, disclosure dynamics, and the role of the family, community, and professionals. Finkelhor and Browne’s (1985) seminal model provides a useful framework to understand the phenomenological experience of the child, discuss relevant literature, and highlight some of the dialectical tensions. While the model was developed to describe the short- and long-term impacts of CSA upon victims, issues pertaining to a subset of perpetrators are interwoven at relevant junctures, particularly the dynamics of traumatic sexualisation and stigma. In addition, I extend the role of shame across all four traumagenic dynamics and discuss the impact across the lifespan.
Traumatic sexualisation

The first dynamic, traumatic sexualisation, refers to the developmentally inappropriate sexual awakening and eroticisation of children, leading to a continuum of hyper-sexualised and hypo-sexualised behaviours and thoughts. Children may exhibit sexualised behaviour and increased focus on sexual issues, or display extreme anxiety and aversion regarding sexual matters. Confusion regarding sexual identity, sexual norms, and the relationship between love and sex is likely to affect both children and adults (Finkelhor & Browne, 1985). Traumatic sexualisation involves an approach/avoidance dialectical tension with regard to sexuality, due to the ambivalence created by negative and sometimes positive associations with CSA, on somatic, affective, and cognitive levels. Finkelhor and Browne (1985) implied the prostituting implications of CSA when observing that children “have traded sex for affection” (p. 534). Herman (1981) also commented on the theme of prostitution in father-daughter incest:

The actual sexual encounter may be brutal or tender, painful or pleasurable: but it is always, inevitably, destructive to the child. The father, in effect, forces the daughter to pay with her body for affection and care which should be freely given. In so doing, he destroys the protective bond between parent and child and initiates his daughter into prostitution. This is the reality of incest from the point of view of the victim. (p. 4)

The dynamics of grooming behaviour provide a means to sexualise children and encourage their participation or at least compliance, and are therefore included as part of traumatic sexualisation (Finkelhor & Browne, 1985). However, the manipulative and devious nature of grooming involves deception and duplicity which is part of the phenomenon of betrayal, and is likely to lead to shame. Finkelhor (1987) alluded to the shame of betrayal when discussing the effects of being taken in, manipulated, and exploited by a CSA perpetrator. Intra-familial sexual abuse also provides ample opportunities for sexualised touching at a very early age in the context of caretaking, which may be perceived by the child as pleasurable and normal. The goal of the CSA perpetrator is to deliberately blur the boundaries between affectionate touch and sexualised touch, and between “accidental” touch and intentional touch (Craven et al., 2006; Smallbone & Wortley, 2000).

Sexual arousal is not uncommon when children have been gradually desensitised to sexualised touching over time in the context of a relationship that they value. Perceived as a betrayal of the body, sexual arousal evokes distrust, confusion, and shame regarding one’s own body and sexuality (Salter, 1995). In her harrowing autoethnographic account of sexual abuse by her mother and father, Ronai (1995), an academic, notes the dialectical tension in her
memories of sexual arousal. These memories simultaneously acted to discredit her “victim status” as well as highlight how “victimised” she was (Ronai, 1995, p. 417). In a study of male victims of CSA, sexual arousal increased a sense of complicity and ambivalence arising from dialectical tensions between “pleasure and revulsion; desire and guilt” (Alaggia & Millington, 2008, p. 270). In addition, sexualised and erotic intrusive thoughts and fantasies are likely to provoke shame when children realise that they fail to conform to societal norms, reinforcing the need for secrecy. Finkelhor and Browne (1985) suggested that children who are groomed to participate, are sexually aroused, and have some sexual awareness, are more at risk of being traumatically sexualised. This may manifest in later life as compulsive and/or high-risk sexual behaviour such as sexual addiction, multiple partners, unprotected sex, and prostitution. While these behaviours in no way make victims accountable for being sexually re-victimised, they may increase the risk. For others, the negative associations with sex may lead to sexual dysfunction and/or avoidance of sexual relationships. Hyper- and/or hypo-sexualised behaviours are common among survivors (Schwartz & Galperin, 2002; Vaillancourt-Morel et al., 2015), and suggest an avoidance of intimacy.

Traumatic sexualisation may also act as a potential pathway to sexually victimising others. Up to 40% of known CSA perpetration occurs at the hands of other children or young people, which tends to be described as sexual behaviour problems (SBP) rather than offending (Hackett, 2011; Hutton & Whyte, 2006; Erooga & Masson, 2006; Veneziano, & Veneziano, 2002). Reports of sexual victimisation among these children and young people are substantial, varying between 38%–95% (Burton, Nesmith, & Badten, 1997; Burton, Miller, & Shill, 2002; Gray, Pithers, Busconi, & Houcens, 1999; Hickey, McCrory, Farmer, & Vizard, 2008; Matthews, Hunter, & Vuz, 1997; Ray & English, 1995; Silovsky, & Niec, 2002; Veneziano, Veneziano, & LeGrand, 2000; Vizard, Hickey, French, & McCrory, 2007; Worling, 1995). Developing SBPs which harm others has been associated with the severity of CSA, such vaginal or anal penetration, abuse by close relatives, multiple perpetrators, threat of violence, and frequent abuse over a long duration (Bagley, Wood, & Young, 1994; Burton et al., 2002; 21 The wide range of sexual victimisation reported is likely to be influenced by the age range of the sample, criteria for substantiation of reports, and whether research is conducted pre- or post-treatment. For example, Silovsky and Niec (2002) reported 38% of pre-school children with SBP had substantiated histories of CSA with authorities, but acknowledged that CSA was suspected in 76% of cases. Conversely, Gray et al., (1999) relied on substantiated and unsubstantiated reports of CSA (84%) among children with SBP aged 6 to 12 years, and Veneziano et al., (2000) included parental substantiation of youth CSA reports (92%). Highlighting different findings pre- and post-treatment, Worling’s (1995) review of sexual victimisation rates among youth with SBP found an average of 22% prior to treatment and 52% following treatment. Worling’s (1995) empirical research with male youth with SBP (12-19 years) collected data midway through treatment and found that 43% reported CSA histories. Determining prevalence of CSA among children and youth with SBP’s is also likely to be influenced by the same factors impacting community prevalence studies.

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Cosentino, Meyer-Bahlburg, Alpert, Weinberg, & Gaines, 1995; Friedrich, Urquiza, & Beilke, 1986; Hall, Matthews, & Pearce, 1998). The link between CSA and the sexual abuse of others has been conceptualised in various ways, such as a form of re-enactment (Longo, 1982; Prendergast, 1993; van der Kolk, 1989), a learned behaviour (Burton, 2000; Burton & Meezan, 2004; Ryan, 1989), a desire to achieve mastery (Ryan, 1989; Watkins & Bentovim, 1992) and the pairing of sexual arousal with sexually aggressive fantasies (Bentovim, 1995, 2002; Hunter & Becker, 1992). Specific factors in 68 male adolescents’ CSA histories such as age of abuse, gender of perpetrator, and type of abuse were replicated in their abuse of other children, lending support to the notion of re-enactment (Veneziano et al., 2000).

Research focused on adult male and female child sex offenders suggests a significant proportion have a history of CSA, with studies varying between 38%–92% (Briggs & Hawkins, 1996; Craissati, McClurg, & Brown, 2002; Dhawan & Marshall, 1996; Levenson et al., 2015, 2016; Simons, Wurtele, & Heil, 2002; Simons et al., 2008; Smallbone & Wortley, 2001; Stirpe & Stermac, 2003). Higher rates of reported CSA among offenders appear to be elicited by concrete, descriptive questions about acts of sexual abuse (Briggs & Hawkins, 1996; Simons, 2007). However, problematic sexual behaviour and CSA perpetration are not always associated with a history of CSA, and may be best conceptualised as indicative of some form of child maltreatment (Bonner et al., 1999; Levenson et al., 2015, 2016; Merrick, Litrownik, Everson, & Cox, 2008; Silovsky & Niec, 2002).

On the other hand, it is important not to conflate CSA victim and offender populations which can lead to inaccurate societal perceptions about the inevitability of a victim to abuser cycle. Prospective studies focused on victims of CSA indicate that the vast majority do not go on to sexually abuse others (Glasser et al., 2001; Kaufman & Zigler, 1987; Ogloff et al., 2012). Nevertheless, the risk of CSA perpetration appears to be higher for males who have been sexually abused than males who have not. In a large scale longitudinal study of male and female CSA victims, rates of subsequent sexual offending were seven times that of a matched control group, however only 0.1% of females went on to sexually offend compared to 5% of males (Ogloff et al., 2012). In a further longitudinal study of sexually victimised boys, 12% subsequently sexually abused children (Salter et al., 2003). Child sexual victimisation is therefore considered to be a risk factor for developing problematic sexual behaviour (DeLisi, Kosloski, Vaughn, Caudill, & Trulson, 2014; Elkovitch, Latzman, Hansen, & Flood, 2009; Putnam, 2003), which appears to be gendered (Plummer & Cossins, 2016).
Several factors are posited to account for the greater risk of male victims becoming perpetrators. Gender socialisation may render males more likely to respond to CSA with externalising behaviour, whereas females respond more frequently with internalising behaviour (Friedrich et al., 1986). Eroticisation has been reported to occur more frequently in males following sexual abuse (Feiring, Taska, & Lewis, 1999), and male survivors of CSA have reported fears about sexually victimising their own children and/or sexualised thoughts about children (Alaggia & Millington, 2008; Denov, 2004; Gartner, 1999; Mendel, 1995). Reframing and normalising of CSA is also considered to increase the likelihood of sexually offending against others (Briggs & Hawkins, 1996), and male CSA victims appear less inclined to label CSA as abuse (Widom & Morris, 1997). The shame arising from all four traumagenic dynamics may affect males differently, with males more vulnerable to rage and females to depression (Lewis, 1992). Exacerbating the situation further for sexually abused males is the lack of societal acknowledgement compared to females victimised by males, making it less likely that they will seek therapeutic support (Gartner, 1999; Spiegel, 2003). Masculinity norms are likely to exacerbate emotional isolation, and attempts to compensate for the perceived loss of masculinity may evoke hyper-masculine behaviour, and increase the tendency to identify with one’s aggressor (Dorais, 2002; Lisak, 1995; Gartner, 1999). All of these factors suggest that, in the absence of protective factors, male CSA victims may be more vulnerable than females to sexually victimising others.

Betrayal

The traumagenic dynamic of betrayal is necessarily associated with CSA by a known and trusted perpetrator. Depending on the developmental stage of the child, and the degree of grooming, the betrayal may be felt at the time of the abuse, or at a later stage. Sexual abuse by a trusted adult presents a contradiction for the child, a caregiver who is both abuser and protector (Ford et al., 1999; Hesse & Main, 1999, 2006; Ray, 1996). Such a conflict is likely to be felt more acutely in cases of intra-familial sexual abuse, due to the developmental needs for attachment. The dialectical tension between the need to belong and to maintain attachment versus the need for integrity, is highlighted most clearly within Freyd’s (1996) betrayal trauma theory. This has implications for behaviour and disclosure decisions as well as memory. Betrayal trauma (Freyd, 1996) has been posited as the particular mechanism by which sexual abuse, perpetrated by a close attachment figure, is dissociated by the child in order to preserve the attachment relationship. This theory draws strongly on attachment theory. By keeping the

22 However, there is also an equal lack of societal acknowledgement of female victims sexually abused by females. See Denov, 2001; Ronai, 1995.
betrayal out of awareness, children are not confronted by the irresolvable approach/avoidance dilemma that abuse by caregivers elicits.

When betrayal remains in awareness, constantly alternating positive and negative experiences within an abusive attachment relationship create a lack of object constancy. The resulting ambivalence towards an abusive caregiver may ultimately be redirected towards self, through the need to maintain the attachment relationship (Fonagy, Jurgely, Jurist, & Target, 2002). The cognitive developmental stage of young children (and even adolescents), makes them more vulnerable to dichotomous thinking (Stallard, 2003). This may be employed as a defence against the overwhelming and unbearable experience of ambivalence towards an attachment figure. Consequently children and adolescents may locate blame, shame, and a sense of badness within themselves (Feiring & Cleland, 2007; Quas, Goodman, & Jones, 2003). Experiencing love and loathing, honour and disgust, trust and anxiety about an internalised other is likely to be intolerable for adults as well. Dichotomous thinking and self-blame thus perpetuate into adulthood, when there is no opportunity to process and integrate affect and cognition regarding CSA events, leading to a fragmented sense of self and the world (Feiring & Cleland, 2007).

Betrayal from non-offending caregivers’ inappropriate responses are also part of this traumagenic dynamic. This has been more recently conceptualised as double betrayal in cases of CSA perpetrated by a trusted adult (Wager, 2013). While Freyd (1996) has identified betrayal trauma as a possible precursor for dissociative amnesia, Wager’s (2013) findings have suggested that double betrayal may be more specifically linked to amnesia than betrayal trauma alone, and is also significantly associated with sexual re-victimisation for both males and females. Disturbingly, Wager (2013) found that in three cases involving male CSA victims, their disclosure as children to a supposed non-offender was met with the response of further sexual abuse. In this study, a negative response to a disclosure of CSA perpetrated by a trusted adult was associated with a heightened tendency to experience amnesia, and an elevated risk for penetrative sexual assault during adolescence, often while the young person remained amnesic about the original abuse (Wager, 2013). As Wager (2013) points out, previous theories of amnesia for CSA have suggested that disclosure of abuse in childhood could not occur in amnesic cases; however, the responses to her survey suggest otherwise. It appears that a negative response to a disclosure made in childhood may actually increase the risk of developing amnesia for the abuse (Wager, 2013).
This finding has resonance with Freyd’s (1983) theory of shareability which suggests that being inhibited from sharing information verbally prevents opportunities for the rehearsal and encoding of memories, potentially affecting recall (Freyd, 2006). In addition, the non-offending caregiver’s betrayal through a response of denial, minimisation, inaction, or further abuse must also be defended against in order to maintain the attachment relationship. The child receives a message that the abuse was unimportant and/or that his/her perceptions were unreliable, reinforcing conscious and unconscious forms of forgetting.

Perpetrators not only groom their victim, but also significant others and the community (Craven et al., 2006). The caregiver who denies the perpetration of a loved and trusted other may have been completely deceived. To be aware of such betrayal evokes intense grief and numerous layers of loss, such as safety, trust, control, and family unity (Hooper, 1992). Assumptions regarding others and the world as safe and just are shattered (Janoff-Bulman, 1992). Non-offending mothers in emotionally and financially dependent relationships with alleged perpetrators have been found to be more conflicted in their response to their child’s disclosure of CSA (Pintello & Zuravin, 2001). In addition, mothers with sexually abused children are significantly more likely to have a history of CSA than mothers of children who have not been sexually abused (Kim, Noll, Putnam, & Trickett, 2007; Oates, Tebbutt, Swanston, Lynch, & O’Toole, 1998; Pintello & Zuravin, 2001). For some mothers, unresolved trauma regarding their own childhood sexual victimisation may undermine their ability to engage and respond appropriately to their child’s disclosure of CSA (Green, Coupe, Fernandez, & Stevens, 1995; Hiebert-Murphy, 1998; Timmons-Mitchell, Chandler-Holtz, & Semple, 1997). In intra-familial cases, mother and child may have been sexually abused by the same perpetrator (McClosky & Bailey, 2000). While the failure to provide an immediate supportive response to their child is often viewed pejoratively (Bolen, 2003; Breckenridge, 2006; Breckenridge & Baldry, 1997; Joyce, 1997), clearly there is a need for support for non-offending mothers following their child’s disclosure of CSA (Breckenridge & Davidson, 2002; Deblinger & Heflin, 1996; Kilroy, Egan, Maliszewska, & Sarma, 2014, McLaren, 2013). Whether betrayal is by a perpetrating or non-offending trusted other further layers of shame are likely (Freyd, 1996; Freyd & Birrell, 2013; Platt & Freyd, 2015; Wager, 2013).

Both in the short- and long-term, the child’s betrayal is likely to lead to problems with trust and intimacy, again contributing to the dialectic between approach and avoidance. Children may exhibit extremely clingy, needy behaviour, manifested in adulthood as the need for an intimate relationship at any cost. Alternatively, CSA victims may avoid intimacy and/or exhibit anti-social behaviour in an attempt to protect themselves from further betrayal.
(Finkelhor & Browne, 1985; Finkelhor, 1987). Betrayal may lead to extreme hypervigilance about others, whereby sexually abused children and adults pay close attention to the emotional states and non-verbal cues of others (Perry, 1997). Conversely, betrayal which has engendered denial, minimisation, and dissociation, characterised as betrayal blindness (Freyd & Birrell, 2013), may become habitual. This may disrupt the ability to detect danger and impair judgement about others, increasing the risk of re-victimisation for self or one’s children.

The traumagenic dynamics model does not specifically discuss the betrayal from professionals, yet such betrayal in the form of disbelief, minimisation, reframing, and neglect has been extensively documented (Denov, 2001, 2003; Holmes, Offen, & Waller, 1997; Taylor, 2004). Such betrayal is particularly relevant for male CSA survivors (Alaggia & Millington, 2008) and males and females sexually abused by females (Denov, 2003). Males face added betrayal by communities because of the paucity of therapeutic support for male CSA victims, a societal perspective which associates CSA with male perpetrators rather than male victims, and a gender/cultural stereotype which promotes all sexual experience as beneficial for males (Gartner, 1999; Spiegal, 2003).

Powerlessness

Powerlessness is viewed by Finkelhor and Browne (1985) as the main pathway to PTSD symptoms because of the overwhelming fear and anxiety it evokes. Although PTSD has been originally associated with fear and anxiety, more recent studies have identified a significant link between shame and PTSD (Feiring & Taska, 2005). Finkelhor (1987) alluded to the embodied nature of powerlessness, reflected in the inability to stop the “invasion of body territory” (p. 360). Dissociative responses to trauma such as numbing and immobilisation increase a sense of powerlessness, and lack of control over psychological and body boundary violations. The passive nature of these embodied responses to trauma may evoke shame, potentially more so for males due to socialisation processes. These passive responses can also be viewed pejoratively by professionals and society. The inherent powerlessness in the experience of CSA may increase the risk of re-victimisation through low self-efficacy and assertiveness (Finkelhor, 1987; Zerubavel & Messmann-Moore, 2013), and/or traumatic reactions such as immobility (Gidycz, Wynsberghe, & Edwards, 2008).
Stigmatisation

The final traumagenic dynamic, stigmatisation, arises from the explicit and implicit messages that the perpetrator gives to the victim, the secrecy around the CSA, societal attitudes to CSA, and inappropriate responses from non-offending caregivers. Gender differences in negative attributions are acknowledged, with males considered to be more vulnerable to homophobia and females more vulnerable to the “damaged goods” attribution. In the vast majority of cases, CSA involves a relationship. The stigma of CSA rarely rests on the perpetrator alone, but is transferred in a metaphorical osmosis to the victim. Children become aware of their stigma when they understand the taboo and condemnation around CSA, when they feel complicit through participation or the internalisation of implicit or explicit messages from the perpetrator, when they blame themselves for being unable to prevent the experiences, when they feel dirty and tainted, and when they experience developmentally inappropriate sexual awakening and eroticism (Finkelhor & Browne, 1985). Children sexually abused by a family member suffer the added stigma of the violation of the sanctity of the family (Ford et al., 1999; Ray, 1996). In the absence of opportunities to process the abuse, this “spoiled identity” (Goffman, 1963) may stay with them all their lives.

Stigma is defined as an essential physical, psychological, or moral characteristic that is perceived by self and society as undermining to the individual’s reputation (Dindia, 1998; Goffman, 1963). Three types of stigma are noted by Goffman (1963), those which affect the body such as disabilities, diseases, and deformities, those which reflect immoral or unstable aspects of character such as criminal activity or mental health problems, and those which affect groupings and affiliations such as race, religion, culture, and family. People who are unable to conceal their stigma are described by Goffman (1963) as discredited, such as people with an obvious physical disability. In contrast, those with a concealable stigma are discreditable, living with the potential of revealing, and managing the constant tension between whether “to display or not to display, to tell or not to tell, to let on or not let on, to lie or not to lie, and in each case to whom, how, when and where” (Goffman, 1963, p. 42.)

Stigma only comes into being by identification by self and other, that one’s thoughts, behaviour, and presentation have failed to live up to normal and acceptable standards. Being perceived and accepted as normal is an essential human need (Asch, 1954; Goffman, 1963), as is the need to belong (Baumeister & Leary, 1995; Maslow, 1943). Yet Goffman (1963) perceptively noted that all people have some experience of a flaw or perceived negative attribute which can be experienced as stigmatising, suggesting that the division between normal
and stigmatised is somewhat of an illusion. Perhaps deep existential fear of being viewed as abnormal and excluded motivates discrimination against others:

The attitudes we normals have towards a person with a stigma, and the actions we take in regard to him, are well known, since these responses are what benevolent social action is designed to soften and ameliorate. By definition, of course, we believe the person with a stigma is not quite human. On this assumption we exercise varieties of discrimination, through which we effectively, if often unthinkingly, reduce his life chances (Goffman, 1963, p. 15).

For the individual with a concealable stigma, such as victims and perpetrators of CSA, evaluation of self and subsequent presentation is built on the imagined and perceived attitudes and responses of others to the stigma. The threat to self and sense of belongingness consequently generates considerable concern about revealing to close and significant others (Goffman, 1963). Successful attempts to conceal the stigma are described as “passing”, finding membership and acceptance by simultaneously passing into normal social categories and passing out of the stigmatised group, aided by a growing realisation that the stigma is not readily apparent to others (Goffman, 1963).

Dialectical tensions arise from ambivalence towards self and stigmatised group, resulting in approach/avoidance or identification/differentiation oscillations regarding the relationship with the stigmatised group (Goffman, 1963). Identity ambivalence may lead to the paradoxical experience of being at once repulsed by and affiliated to a stigmatised group, having considerable implications for CSA victims and perpetrators. In speaking about offenders in general, Goffman (1963) noted: “his social and psychological identification with these offenders holds him to what repels him, transforming repulsion into shame … he can neither embrace his group nor let it go” (p. 132). Some CSA perpetrators do appear to embrace their group to some extent in the form of online chat groups, pornography rings, and organised child sexual exploitation. Normalising effects of affiliation with other CSA perpetrators have been found to alleviate isolation, anxiety, and shame (Durkin & Bryant, 1999; Bourke & Hernandez, 2009; Taylor & Quayle, 2008), and the social validation of CSA through such affiliation presents a risk factor for recidivism (Hanson & Buisierre, 1998).

Yet for CSA perpetrators the façade must still be erected for the majority of the world. Those with a concealable stigma that deviates most seriously from the norm are, paradoxically, most likely to be attuned to concepts of normality, and most concerned about fulfilling social norms (Goffman, 1963). Compensatory behaviour in the form of competitiveness and
perfectionist standards may therefore be employed to mask stigma and shame (Nathanson, 1987, 1992; Gilbert, 1998). While incarcerated sex offenders exhibit a range of psychiatric disorders, addiction problems, and attachment and intimacy deficits (Hudson & Ward, 1997; Marshall, 2007; Marshall & Barbaree, 1990; Abracen, Looman, DiFazio, Kelly, & Stirpe, 2006; Ward, Keenan, & Hudson, 2000), reports exist of popular, well-functioning, religious, and respected CSA perpetrators who often mask their sex offending careers with philanthropic work (Burkitt & Bruni, 2002; Greer & McLaughlin, 2013, 2015; Instone, 2011, Middleton et al., 2014a, 2014b). The need to create a favourable impression, found within the theories of social desirability (Paulhaus, 1984, 2002), and impression management (Goffman, 1959, 1967), clearly has implications for child sex offenders (Jones, 2008; Tan & Grace, 2008).

**Shame**

For all Goffman’s (1963) sensitive and penetrating insights about stigma, it is surprising that so little attention was given to the emotion of shame, given that stigmatisation is likely to promote a pervading sense of shame (Pachankis, 2007; Scheff, 1988). Shame is defined as one of the moral or self-conscious emotions, and is possibly the most reflexive of emotions, since it involves perceiving oneself through the eyes of others, often in a recursive feedback loop (Lewis, 1992). For example, shame affect and attendant physiological and behavioural responses can promote further shame, such as blushing because one is blushing, as well provoking other emotions such as anger and anxiety (Scheff & Retzinger, 1997).

The idea of the “looking glass self” (Cooley, 1922) best describes our capacity for self-consciousness and consequent self-monitoring: “in imagination we perceive in another’s mind some thought of our appearance, manners, aims, deeds, character” (p. 182). Such imagination involves not only how we appear to others, but envisaging how others will evaluate our presentation, leading to positive or negative feelings and appraisals about self, such as “pride or mortification” (Cooley, 1922, p. 184). When self is not threatened, self-consciousness recedes to the background, which Cooley (1922) eloquently expressed as “living in the minds of others without knowing it” (p. 208).

Normal shame is adaptive, providing a relationship thermostat to regulate and maintain relationships and social distance, and serving an appeasement function (Ferguson, 2005; 23 For example, institutional cases of CSA abound across the world, such as the Jimmy Savile scandal (Greer & McLaughlin, 2013), and high profile cases within religious groupings, sports, and social service organisations.)
Keltner, 1995; Scheff, 1988). Early attachment relationships provide the first experiences of shame, and the context for learning to cope with shame (Schore, 1998) which, in normal interactions, is a fleeting event. This led Lewis (1987) to conclude that shame represents one of the major causes of treatment failure, particularly if clinicians are not able to tolerate their own shame and/or be sensitive to the shame of others.

Shame-rage cycles are implicated in narcissism, domestic violence, sexual offences, other violent crime and war (Morrisson, 1989; Nathanson, 1992; Scheff & Retzinger, 2002; Scheff, 2006). Scheff and Retzinger (1997) have suggested that male sexuality is vulnerable to a shame-rage feeling trap, whereas female sexuality is vulnerable to a shame-shame feeling trap. It may well be that rage is evoked in both males and females in response to an extremely shaming experience such as CSA, but gender socialisation would suggest that rage and anger are more acceptable emotions for males to express. In females, the rage and anger at being shamed is possibly more likely to be suppressed by the shame at being angry, whereas the reverse is likely to be true for males (Lewis, 1992; Scheff, 2006).

Shame cuts much deeper than guilt, since the focus is on how actions, traits, or states reflect on a person’s essential being, through the constant imagining of how one presents to others. The power of shame lies in its silent and cumulative ability to undermine self, even if unjustified. Shame tends to involve global, internal, and stable negative attributions about self as essentially flawed (Van Vliet, 2009), is experienced physically, emotionally, and cognitively (Andrews, 1995), and evokes a deep need to hide oneself from the perceived threat of exposure (Lewis, 1992). Shame represents a continuous thread through all four traumagenic dynamics. Because of the threat shame poses to identity, self-esteem, and a sense of integrity, people experiencing shame are considered particularly vulnerable to an avoidant response to stress (Feiring, Taska, & Lewis, 1996; Tangney, 1995).

**Coping with concealment**

The experience of being continuously on guard in order to manage and conceal stigma, shame and other negative affect exacts considerable psychological and physical costs (Pennebaker, Kiecolt-Glaser, & Glaser, 1988; Wegner & Lane, 1996). Drawing on Goffman’s (1959) dramaturgical analysis of social interaction, Freund (1982) coined the term “dramaturgical stress”, highlighting the emotional and physiological costs of a disjuncture between one’s inner world and outer presentation. On a psychological level, the continuous
maintenance of secrets requires illusion and fragmentation and elicits isolation. This affects one’s sense of integrity and identity, in other words a coherent and integrated self; it also inhibits friendship and relationship intimacy, thus reducing the opportunity for social support, all of which ultimately raise anxiety levels and psychological distress (Beals, Peplau, & Gable, 2009; Bosson, Weaver, & Prewitt-Freilano, 2012; Frable, Platt, & Hoey, 1998; Kelly, 2002; Pachankis, 2007). Emotional and cognitive suppression exact a considerable toll not only on mind but also body (Pennebaker et al., 1988; Richards, Beal, Seagal, & Pennebaker, 2000; Ulrich, Lutgendorf, & Stapleton, 2003), since high levels of stress and anxiety adversely affect immune functioning, gastrointestinal, cardiovascular, and nervous systems (Fleshner & Laudenslager, 2004).

**Avoidant coping**

For victims of CSA, the potentially overwhelming nature of negative affect such as guilt, shame, fear, and rage, to both the events of CSA and their memories, is likely to lead to avoidant ways of coping (Polusny & Follette, 1995; Polusny, Rosenthal, Aban, & Follette, 2004). The term avoidant coping covers conscious and unconscious cognitive strategies to alleviate negative affect such as thinking about something else, numbing, denying, and dissociating, as well as behavioural strategies such as substance abuse and self-harm (Spacarelli, 1994). In essence, victims conceal CSA from themselves as much as from others. Cognitive strategies for avoidance of negative internal states are common in CSA victims, and for children they appear to have a somewhat adaptive purpose and protective effect, allowing children to appear to continue to function reasonably normally (Chaffin, Wherry, & Dykman, 1997). In a study of 84 sexually abused children aged seven to twelve, avoidant coping was used by all the children and found to be related to fewer behavioural problems, but more negative attitudes about sexuality and greater sexual anxieties (Chaffin et al., 1997). It appears that for children, the more subtle internalised aspects of experiencing CSA are often not apparent to others, which may help to explain how 30%–50% of children known to be sexually abused have been found to be asymptomatic (Finkelhor & Berliner, 1995; Kendall-Tackett, Williams, & Finkelhor, 1993).

Although adaptive in the short-term, avoidant coping has been noted to become increasingly maladaptive in the long-term (Coffey, Leitenberg, Henning, Turner, & Bennett, 1996; Perrot, Morris, Martin, Romans, 1998; Spacarelli, 1994). In adults and adolescents with CSA histories, the benefits of avoidant coping appear to reduce, and instead such behaviour may militate psychological distress (Bal, Van Oost, De Bourdeaudhuij, & Crombez, 2003;

Several factors are thought to contribute to the ineffectiveness of avoidant coping over time. Firstly, avoidant coping prevents cognitive and emotional processing of CSA events, required not only for the ultimate resolution and integration of trauma, but also awareness of cognitive distortions and attributions regarding self and the event/s (Briere, 2002; Chaffin et al., 1997). Furthermore, an over-reliance on avoidant coping paradoxically increases intrusive thoughts, thereby exacerbating post-traumatic symptoms and anxiety (Rosenthal, Cheavens, Lynch, & Follette 2006; Fortier et al., 2009; Shipherd & Beck, 1999; Smart & Wegner, 1999; Wegner, 1994; Wegner & Erber, 1992; van der Kolk, 1994). A preoccupation model of secrecy has been suggested to explain the hyper-accessibility of suppressed thoughts, leading to alternate cycles of thought intrusion and thought suppression (Lane & Wegner, 1995; Wegner & Lane, 1996), with implications for both victims and perpetrators of CSA. Lastly, running away from oneself is a risky business. Avoidant coping reduces awareness of associated mood and affect (Brand & Alexander, 2003). Such reduced self-awareness is thought to increase the likelihood of risk-taking behaviour and re-victimisation (Filipas & Ullman, 2006).

The coping literature suggests that in the absence of support, adaptive and understandable responses to overwhelming stress become increasingly unhelpful and self-sabotaging over time. Conscious and unconscious efforts to cope with unresolved CSA often create additional problems and further layers of stigmatisation. These include substance abuse, self-harm, eating disorders, prostitution, gang membership, pornography addiction, mental health problems, re-victimisation, victimising others, and incarceration (Glasser et al., 2001; Paolucci, Genius, & Violato, 2001; Polusny & Follette, 1995; Roodman & Clum, 2001; Smolak & Murlen, 2002; Tyler, 2002).

Conversely, healthy and stable attachments act as positive buffers for child victims of sexual abuse. One of the most important factors in reducing the intensity and duration of the response to trauma in children is the availability of a responsive caregiver (Tremblay, Hebert, & Piche, 1999; Spacarelli & Kim, 1995). Secure attachments which provide appropriate nurturance and support reduce hyperarousal and/or dissociative responses in a child (Perry 1996; Twait & Rodriguez-Srednicki, 2004; van der Kolk, 2006). The construct of resilience in relation to children is best understood as “an ongoing process of developing the competencies
necessary to form, maintain and benefit from supportive interpersonal relationships” (Collishaw et al., 2007, p. 226). In these views, resilience is developed according to the quality of attachment relationships, rather than being an inherent attribute. Thus, it is more realistic to describe children as innately malleable rather than resilient (Perry, 1997; Schore, 2012).

The neurobiological impact of trauma

In both children and adults, threats to psychological or physical survival initially evoke a hyper-arousal response mediated by the energy mobilising sympathetic branch of the autonomic nervous system (ANS). This response is known as “fight or flight” and elicits increases in heart rate, blood pressure, and respiration, as well as reducing blood flow to visceral organs and increasing blood flow to muscles in order to take action. However, when the threat is overwhelming and inescapable, (the experience for many children sexually abused), a more primitive response mediated by the dorsal vagal branch of the parasympathetic nervous system creates a state of hypo-arousal, characterised by immobilisation and submission (Porges, 2011). On a metabolic level, energy is conserved through decreased heart rate, blood pressure, and respiration. At psychological and emotional levels, there is disengagement, withdrawal, and numbing, facilitated by an increase in the body’s natural painkillers, the endogenous opiates (Schore, 2012).

The term “freezing” has often been associated with a parasympathetic response because it is conflated with immobility, but there has always been recognition of an initial freeze response of “alert immobility” and preparedness for action as part of the sympathetic response (Scaer, 2001a). In a similar vein, Schore (2012) has described such freezing as “frozen fight or frozen flight” and as a ”state of high arousal immobility” (pp. 192-193). This important distinction between types of freezing or immobility is significant. When the initial freeze response is unable to be resolved by fulfilling the action tendency for fight or flight, parasympathetic mediated incapacitation occurs. This is a more catastrophic and potentially life-threatening form of immobility, which occurs in the metabolically conservative state of hypo-arousal, and elicits the psychological defence of dissociation.

Not only does traumatic stress disrupt homeostatic processes within the ANS, it also profoundly impacts central nervous system (CNS) development and functioning. Prolonged traumatic stress at critical developmental periods compromises prefrontal cortex development, which is essential for emotional and behavioural regulation, cognitive capacities, insight, and
reality testing. At the same time, traumatic stress increases amygdala activity, leading to more primitive, unconscious, and reactive emotional responses (Arnsten, 2009, 2015; Arnsten, Raskind, Taylor, & Connor, 2015). Because their brains are still developing, children and young people are particularly vulnerable in the face of chronic traumatic stress, which has the potential to transform adverse brain states into traits (Perry, 1996, 2008, 2009). The change in brain activity during traumatic stress can be seen in Figure 1 (Arnsten, 2015, p. 1377).

![Figure 1: Comparison of brain activity in alert and stressed states (Source: Arnsten, 2015, p. 1377. Copyright permission granted).](image)

**Post-traumatic stress disorder and complex trauma**

Highlighting significant body/mind connections, PTSD influences three main areas of biological functioning:

- a) “alterations in body’s stress response systems
- b) alterations in brain chemistry, structure and functioning
- c) physical health problems or diseases” (Ford, Grasso, Elhai, & Courtois, 2015, p. 34).

The diagnosis of PTSD was originally conceived as involving three main symptom clusters: intrusive memories, avoidant/numbing symptoms, and hyper-arousal symptoms (APA, 1980, 2000). Many people experience some form of traumatic stress involving one or more of
these symptom clusters after a traumatic event, though for most this is short-lived (Ford et al., 2015). In order for PTSD to be diagnosed, symptoms must be experienced for over a month (APA, 2000, 2013).

Many have argued that this symptom constellation for PTSD does not adequately capture the impact of chronic interpersonal trauma (Cloitre et al., 2009, 2011, 2012; Courtois & Ford, 2009; D’Andrea, Ford, Stolbach, Spinazzola, & van der Kolk, 2012; Herman, 1992, 2012; van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005). As Briere and Spinazzola (2005) have noted, the response to a one-off traumatic event occurring to an adult with a healthy developmental trajectory through childhood and good mental health is likely to be significantly different to the responses of a young person or adult whose early life was characterised by multiple and prolonged episodes of trauma inflicted by significant others. Similarly, D’Andrea et al. (2012) have argued that the PTSD diagnosis is not developmentally sensitive, failing to consider the impact of prolonged trauma at an early developmental stage. Complex PTSD, first defined by Herman (1992), extends the framework of PTSD to document the profound disturbances to self and self-other relationships developed in the context of prolonged relational abuse. These include problems with affect regulation, boundaries, identity and self-perception, systems of meaning, attachment and intimate relationships, attention, learning and memory, and physical health via somatic symptoms (Briere, Hodges, & Godbout, 2010; van der Kolk et al., 1996, 2005).

The under-recognised role of dissociation

Dissociation may be broadly defined as an involuntary process involving partial or complete disruption of normally integrated mental/emotional and physical processes such as consciousness, identity, memory, perception, sensation, and motor control (Spiegel et al., 2011; Spitzer, Barnow, Freyberger, & Grabe, 2006). When there is no opportunity to take action physically the child or adolescent inevitably flees mentally and emotionally. Dissociation, mediated by the dorsal vagal parasympathetic response, has been described as “the bottom-line survival defence against overwhelming unbearable emotional experiences” (Schore, 2012, p. 60). Internal and external worlds become severed to varying degrees, with sensory, emotional, and/or cognitive information being split off from experience. Somatoform dissociation involves the lack of integration of somatic information. This type of dissociation may manifest as an absence of somatic experience such as analgesia, or increased somatic experience (somatisation) such as chronic pain without medical explanation (Waller et al., 2001). These various forms of divided awareness also have CNS correlates with functional and structural
changes in the cerebral cortex, limbic area, and hemispheric communication (Bob, 2003; Diseth, 2005). Alterations to the somatosensory and limbic regions of the brain are implicated in increased or decreased sensitivity to pain (Heim, Mayberg, Mietzko, Nemeroff, & Pruessner, 2013; Kong et al., 2013; Younger, Shen, Goddard, & Mackey, 2010).

Dissociative responses at the time of trauma such as sensations of floating to the ceiling or going somewhere else in one’s mind are commonly reported by survivors of CSA (Gelinas, 1983; Putnam, 1997; van der Kolk, 2014; Young, 1992). Such disconnection with one’s body can remain for many years afterwards, part of the phenomena of depersonalisation and derealisation described as “experiences of unreality or detachment from one’s self” (APA, 2013). Traumatic amnesia is a negative dissociative symptom involving partial or complete blockage of the retrieval of traumatic memories. In contrast, positive dissociative symptoms involve the recurrent, involuntary re-experiencing of fragmented sensory and affective memories within body and mind. These include flashbacks, nightmares, somatic symptoms, and panic attacks, which may precipitate hyper-arousal or further dissociation and hypo-arousal (Nijenhuis & den Boer, 2009). On a more subtle level, dissociated affects may be evoked by a range of triggers which have some similarity to the traumatic events of the past, but the similarity may not be consciously perceived (Schore, 2012). Thus, for clients suffering from traumatic stress, transference may well involve dissociative processes. The concept of dissociation helps to understand the impact of trauma on mind and body, the nature of traumatic memory (involving hypermnesia and amnesia), and the role of the unconscious.

Dissociative processes are pervasive in the approach/avoidance dialectic of PTSD. Many have therefore argued that PTSD is fundamentally dissociative, reflected by the failure to integrate traumatic events (Ginzburg et al., 2006; Nijenhuis & van der Hart, 2011; Sar, 2014; Spiegel, 1988, 2006; van der Hart, Nijenhuis, & Steele, 2005; van der Kolk & Fisler, 1995). In this view, the intrusive symptoms of PTSD such as flashbacks and nightmares represent fragmented and dissociated cognitive, affective, and somatic memories attempting to pierce consciousness, while efforts to numb and distance oneself from the trauma, such as amnesia, restricted affect, and detachment reflect emotional and cognitive compartmentalisation. This sets in motion a rollercoaster of hyper-arousal and hypo-arousal states and behaviours found in PTSD such as hyper-vigilance, sleep problems, anger/aggression, self-harm, risk-taking behaviour, and poor concentration (APA, 2013).24

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24 In DSM-5, PTSD has been removed from its place within anxiety disorders to a chapter on trauma and stress-related disorders, and been expanded to four symptom clusters with the addition of “negative
Several authors have highlighted the role of dissociation as a mediator of PTSD, substance abuse and other mental health problems, somatisation, mood swings, risk-taking and aggressive behaviour, self-harm, and re-victimisation in sexually abused populations (Chaplo, Kerig, Bennett, & Modrowski, 2015; Egeland & Susman-Stillman, 1996; Farber, 2008; Franzke, Wabnitz, & Catani, 2015; Kisiel & Lyons, 2001; Moskowitz, 2004; Ozer, Best, Lipsey, & Weiss, 2003; Putnam, 1997; Rodriguez-Srednicki, 2002; Sar & Ross, 2006, Wager, 2012). This constellation of emotional states, behaviours, physical, and mental health problems are considered secondary, yet observable responses to the more subtle manifestations of dissociation, and may not appear until adolescence or early adulthood (Putnam, 1997). This hierarchical model of dissociation lends support to the concept of “sleeper effects” as previously discussed in relation to coping, whereby the effects of CSA may not be apparent until a later developmental stage (Putnam, 2003). Children who initially appear asymptomatic may be most at risk of developing problems at later stages of development (Putnam, 2003).

Essentially, the literature points to the elusive nature of dissociation, manifesting in complex, varied, and implicit forms not always within conscious awareness, but with far-reaching impact on mental, emotional, and physical health.

The toll on the body

The body and mind are not equipped to deal with prolonged periods of extreme alterations in arousal. Survivors of CSA face increased risk of chronic disease such as cancer and other auto-immune disorders, asthma, gynaecological, gastro-intestinal and bladder problems, and cardiovascular disease (Banyard, Edwards, & Kendall-Tackett, 2009; Dallam, 2001; Drossman et al., 1990; Felitti et al., 1998; Irish, Kobayashi, & Delahanty 2010; Leserman, 2005; Romans, Belaise, Martin, Morris, & Raffi, 2002). Medically unexplained symptoms and somatisation are also prevalent among children and adults with CSA histories (Leserman & Drossman, 2007; Nelson, Baldwin, & Taylor, 2012; Paras et al., 2009; van Tilberg et al., 2010). In a longitudinal study, unexplained nausea, vomiting, and stomach pain were associated with a history of CSA in children, the CSA preceding symptoms in 91% of cases (van Tilberg et al., 2010). Far from being “all in the mind”, these conditions have very real effects on the body (Spence, 2006).
Childhood sexual victimisation may affect physical health through a number of pathways. Firstly, traumatic stress disrupts hormonal balance and immune system functioning, as well as over-stimulating the sympathetic nervous system, all of which can have detrimental effects on other systems in the body (Shonkoff, Boyce, & McEwen, 2009). Unresolved and particularly chronic forms of CSA are therefore likely to wreak havoc with the body, impacting normal brain development, short circuiting homeostatic processes, and affecting pain sensitivity (Kendall-Tackett, 2002, 2003, 2009; McFarlane, 2010; Putnam, 1997; Shonkoff & Garner, 2012). It may appear facile to state that CSA, in most cases, is perpetrated on the body. Yet the possibility of body memories as a source of bodily pain and discomfort has received only sparse attention in the literature. Scaer (2001b, 2005) has discussed the potential neurobiological pathways which might lead to embodied re-experiencing at the specific sites of bodily trauma. Similarly, other authors have noted the “body keeps the score” (van der Kolk, 1994, 2014) and “remembers” (Rothschild, 2000), through the encoding and triggering of implicit somatosensory memories.

In addition, Nelson (2002) has pointed out that some children and young people may suffer physical injury during CSA, resulting in ongoing back, neck, facial, or jaw pain. She argues that “the possible long-term effects on a small child’s back or pelvis of being crushed repeatedly by a 12-stone man do not appear to be considered” (Nelson, 2002, p. 53). Based on accounts from clinical practice with adult survivors, she focused on the physical effects of oral sexual assault or “throat rape”. Such “penetration down the throat” caused “near suffocation”, and created ongoing physical problems with “vocal cords … and the ability to swallow”, pain to “jaws, necks, shoulders and backs”, and even led to the dislocation of the jaw (Nelson, 2002, pp. 57-58).

Ineffective methods of coping such as substance abuse, smoking, eating problems, self-harm, and risky sexual behaviours constitute a further potential pathway for health problems (Chartier, Walker, & Naimark., 2009; Kendall-Tackett, 2002). Furthermore, survivors of CSA may compromise their health by avoiding certain aspects of healthcare which are reminiscent of their abuse. For example, dental fear is common among CSA survivors (Hayes & Stanley, 2007; Larrijani & Guddisberg, 2015; Leeners et al., 2007a). The experience of having a penis forced into one’s mouth as a child creates a context and logic for such fear. Similarly, it becomes understandable that female survivors shun cervical smear testing and breast cancer screening (Farley, Golding, & Minkoff, 2002; Farley, Minkoff, & Barkan, 2001; Gesnick et al., 2014, 2016), and feel anxious and often triggered by gynaecological examinations (Leeners et al., 2007b). Male and female survivors also avoid colon cancer screening (Gesnick et al., 2014).
The mutually influencing social and psychological impacts of unresolved trauma therefore impact the body in numerous direct and indirect pathways. Clearly, there is a need to consider the presence of trauma in primary health care (Gallo-Silva, Anderson, & Romo, 2014; Havig, 2008; Larijani & Guddisberg, 2015; McGregor, Julich, Glover, & Gautam, 2010; Spiegel et al., 2016; Springer, Sheridan, Kuo, & Carnes, 2003), and to work in ways that transcend mind-body dualism.

Reframing CSA as a public health issue

Given the pervasive and detrimental neurobiological and developmental impacts of CSA on physical and mental/emotional health, many argue that the sexual abuse of children and youth needs to be recognised as a public health issue, and prevented via a public health model (Bloom, 2016; Brown, O’Donnell, & Erooga, 2011; Freyd et al., 2005; Letourneau, Eaton, Bass, Berlin, & Moore, 2014; Mercy, 1999; Quadara, Nagy, Higgins, & Siegel, 2015). Mercy (1999) has imagined what the world’s response might have been if CSA was a disease that negatively impacts up to 20% of the population, and “replicates itself by causing some of its victims to expose future generations to its debilitating effects” (p. 317). Instead, he describes the societal and professional response to CSA as “anemic” (Mercy, 1999, p. 318), and others have highlighted the role of societal denial in preventing more appropriate responses (Bloom, 2016; Freyd et al., 2005).

What is trauma-informed care and why is it important?

The literature regarding trauma-informed practice has emanated primarily from the mental health and substance abuse fields, as a response to the exceptionally high prevalence of trauma among clinical populations, which I discuss in Chapter Three. One of the most succinct definitions of trauma-informed practice comes from the Substance Abuse and Mental Health Services Administration (SAMHSA) in the US:

A program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for healing; recognizes the signs and symptoms of trauma in staff, clients, and others involved with the system; responds by fully integrating knowledge about trauma into policies, procedures, practices, and settings; and seeks to actively resist re-traumatisation. (SAMHSA, 2015)
Recognising the prevalence of trauma and its potential effects, a trauma-informed lens ensures that policies, practices, and processes are not in themselves re-traumatising or invalidating of trauma. Key issues for trauma-informed practice are safety, relationship and trust-building, and collaboration and empowerment, underpinned by an awareness of the impact of trauma for self and client (Bloom & Farragher, 2013; Fallot & Harris, 2006, 2009; Harris & Fallot, 2001; Hopper, Bassuk, & Olivet, 2010). Principles of safety and empowerment apply to professionals, who may also experience trauma symptoms arising from the nature of the work, and/or unresolved personal histories (Bloom, 2003; Bloom & Farragher, 2010). Therefore, the emotional toll of addressing trauma and the risks of VT are important considerations within a trauma-informed paradigm.

The central question for clients is not “what is wrong with you?” but “what happened to you?”. Assessments include routine screening for trauma and ongoing assessment of trauma symptoms, with referral to therapeutic interventions that address and resolve the consequences of traumatic stress. Clients suffering from complex trauma, such as CSA, often have difficulties with emotional regulation and trusting others in relationships. Having this knowledge increases understanding and empathy, reducing judgemental and impatient responses to clients’ “crises and disconnections in the therapy relationship” (Abrams & Shapiro, 2014, p. 410). When survivors’ coping strategies are recognised as understandable and normal responses to abnormal, yet common events, the pathology is shifted from the client and their behaviour to the abusive acts that impacted their development and behaviour. In addition, clients’ enormous strengths in having survived such events can be respected. Thus, a trauma-informed paradigm acknowledges clients’ pain and suffering, while also appreciating and tapping into their resilience.

Trauma-specific services are trauma-informed organisations that offer specific therapeutic interventions to treat the effects of trauma (SAMHSA, 2014a). Herman (1997) developed a tri-phasic, non-linear model for treating trauma, particularly complex trauma. Considered a seminal work, her model is widely accepted as best practice. The first stage involves establishing safety and stabilisation through psycho-education, skills training, and the therapeutic alliance. The second stage, entitled remembrance and mourning, involves processing and integrating trauma. Finally, the last stage of reconnection focuses on relationships with others, in the light of increased self-awareness and knowledge of victimisation and trauma. Courtois (2004) notes that not all clients may have the capacity and/or willingness to achieves all three stages. However, the principle of establishing safety is paramount to trauma-informed care and trauma-specific services. This stage involves
professional awareness of trauma prevalence and symptoms, and professional knowledge of those clients with trauma histories and symptoms, through routine assessment. It also involves discussion with clients about the impact of trauma, negative adaptations to trauma, and establishing more positive coping strategies to achieve safety. In essence, trauma-informed and trauma-specific services both attend to Herman’s (1997) first stage.

**Conclusion**

In this chapter I have taken a developmental perspective, drawing on attachment theory, psychodynamic theory, and the neurobiology of trauma, underpinned by a dialectical framework. Following on from Chapter One, I have continued the task of scoping out the problem of CSA for victims, and attempted to enter the phenomenological world of CSA perpetrators, recognising they are also likely to have experienced less than ideal childhoods. Clearly, an approach/avoidance dialectic stands centre stage. It assists understanding the dilemmas for children in managing relationships with significant others who abuse them, their difficulties in integrating the trauma, and telling someone about the abuse. It is also central to the construct of PTSD. However, an approach/avoid dialectic also emerges for professionals exposed to the trauma of their clients, characterised by over- and under-reactions. The concepts of VT, countertransference, and individual and social defences, reveal the negative impacts of working with pain and trauma upon social workers, supervisors, and organisations. The tendency to defend against pain, whether directly or vicariously experienced, closes the gap between professional and client, student and educator. Trauma-informed care provides a framework for organisations to address and mitigate the impact of trauma upon clients, professionals, and the organisational culture. This chapter has therefore set the stage for understanding the disproportionate representation of CSA survivors within mental health/addiction services, and the barriers to addressing CSA within such services. In the next chapter, I explore the issue of CSA within mental health/addiction services, and discuss the implications of addressing CSA in social work practice and education.
Chapter Three: Addressing CSA in Social Work Practice and Education

There can be no learning without some toleration of the anxiety of not-knowing. (Rustin, 2015, p. 243)

Introduction

Chapter Two provided a theoretical framework to understand the problem of CSA and its traumatic impacts. This chapter begins by focusing on survivors of CSA who enter mental health and substance abuse services, and unveils some of the practice and organisational challenges of working with this group. In writing about mental health issues, I have positioned myself closer to a socio-cultural model for mental health, recognising the neurophysiological effects of mental/emotional distress rather than emphasising biological causation. I am very conscious that language reflects one’s positioning and may impact clients’ identities; for example, there is a big difference between describing someone as “schizophrenic” or “having schizophrenia”. Clearly, the discussion regarding stigma in the previous chapter is a particularly salient issue for people with mental health and substance abuse problems, and doubly so for those who have a history of CSA. I therefore avoid using the term “mental illness”, preferring to link mental health with concepts such as needs, issues, and problems. Where possible, I use the latter descriptions to refer to mental health diagnoses, and the vast array of experiences of mental/emotional distress which may not receive a formal diagnosis.

In the first half of this chapter I focus on the issue of CSA within mental health and addiction services. While clients with CSA histories are disproportionately represented within these services, and the literature identifies CSA as a non-specific risk factor for a number of mental health diagnoses, clients’ CSA histories and trauma symptoms often remain unrecognised. I explore NZ mental health policy and workforce expectations that were in place prior to my research, and briefly introduce subsequent mental health policy, which will be discussed further in Chapter Ten. Professional barriers to addressing CSA, societal and professional attitudes, and survivors’ views and experiences regarding professional responses are also traversed in this chapter. Lastly, I look at the literature regarding CSA inquiry and response training.
In the latter section of this chapter my focus shifts to the issue of CSA for social work education. I explore the prevalence of CSA among social work students and the implications for gatekeeping and pastoral support. Students’ personal histories of abuse emerge as a significant motivation for choosing social work as a career and a gatekeeping dilemma for educators, which is sometimes avoided rather than addressed. Next, I revisit the concept of VT in relation to students’ reactions to learning about abuse and trauma, and explore challenges in teaching reflexivity. Finally, I discuss the rationale for teaching about abuse and trauma, and utilising a trauma-informed framework. Drawing on Herman’s (1997) three stage model for working with trauma, I present the literature within social work, but also psychology and counselling, regarding trauma-informed education. This highlights the parallel processes between direct and indirect trauma; working with trauma and teaching about trauma.

Mental health and addiction services in NZ

Within community populations in NZ, Australia, UK, and US, around 20% suffer from at least one mental health problem meeting diagnostic criteria (ABS, 2007; NHS, 2009; Oakley-Browne, Wells, & Scott, 2006; SAMHSA, 2014c). In NZ, the Ministry of Health (MOH) has responsibility for the statutory provision of substance abuse and mental health services, which operate as separate organisations. Mental health service delivery is primarily focused on the 3% of the NZ population who have a serious or enduring mental illness25 (Mental Health Commission [MHC], 2012a). Therefore, the vast majority of people with mental health needs are likely to appear on social worker caseloads in a range of other settings. While a proportion may have mild to moderate mental health issues, Oakley-Browne et al. (2006) found that 42% of those with serious mental health problems in NZ do not attend clinical services. Māori and Pacifica are even less likely to access mental health services and have higher rates of suicidal ideation and suicide completion (Oakley-Browne et al., 2006). Māori and Pacifica worldviews, which emphasise the importance of holism, interconnectedness, context, familial relationships, and spirituality, are a poor fit with the dominant medical model, affecting uptake of services and mental health outcomes following interventions (Durie, 2011, 2009; MHC, 2001; MOH, 2008b; Todd, Sellman, & Robertson, 1998).

25 However, Te Pou (2009f) notes that “it is estimated that in fact there are 4.7% of such people. Included in this group of severe disorders are schizophrenia and bipolar disorder, severe anxiety and depression, alcohol and drug abuse. Eating disorders can also fall into this category at times, as can complex personality and post-traumatic problems” (p. 5).
Social workers form part of multi-disciplinary teams within a range of inpatient and outpatient mental health services for children, youth and adults in statutory26 and non-governmental organisations (NGO). In statutory settings particularly, the discourse intrinsic within mental health has situated illness within the individual, which sits in sharp contrast with social work’s attention to the wider familial and social context (Kirk & Kutchins, 1992; McQuaid, 1999). Despite the lack of evidence for biological markers for any DSM disorder in DSM-5 (Frances, 2009), an implicit biological determinism has predominated since DSM-III (Breggin, 2003; Kutchins & Kirk, 1988). The resulting over-reliance on psychopharmacology has led to accusations of an unholy alliance between the psychiatric profession and the pharmaceutical industry, reflected in financial ties, research funding, and the proliferation of DSM diagnoses (Carlat, 2011; Cosgrove, Krimsky, Vijayraghavan, & Schneider, 2006; Cosgrove & Wheeler, 2013; Fava, 2006, 2007). When the therapeutic focus remains primarily on identifying and treating symptoms and disorders, underlying antecedents to mental/emotional suffering are less likely to be acknowledged or responded to. Consequently, relationships between presenting issues and past trauma, such as CSA, often remain implicit. A small number of psychiatrists and psychologists have called for psychiatric reform across the decades (Andreason, 2007; Bentall, 2003, 2008; Bloom & Farragher, 2010; Breggin, 1994, 2008a, 2008b; Middleton et al., 2014a; Moskowitz, 2011; Moskowitz, Schaefer, & Dorahy, 2008; Read, Agar, Barker-Collo, Davies, & Moskowitz, 2001; Read & Bentall, 2012; Read, Dillon, & Mosher, 2013; Read, Fosse, Moskowitz, & Perry, 2014; Szas, 1973, 2007). However, the status quo remains.

Child sexual abuse: A risk factor for mental health/addiction problems

Survivors of CSA are disproportionately represented in mental health settings. Compared to the prevalence of CSA within non-clinical populations discussed in Chapter One, prevalence rates within clinical populations are almost double. A review of 46 international studies (n = 2604) of female in-patients and out-patients and 31 studies (n=1536) of male in-patients and outpatients, found that 48% of females and 28% of males had histories of CSA (Read et al., 2005). Further similar studies not included in Read et al.’s (2005) review also reveal high CSA prevalence rates for females, 44%–70% (Briere & Runtz, 1987; Briere, Woo, McLae, Foltz, & Sitzman, 1997; Briere & Zaidi, 1989) and males, 31% (Lab & Moore, 2005). High prevalence rates for CSA have also been found within substance abusing clinical populations, with figures between 27%–75% for females, and 6%–56% for males (Berry & Sellman, 2001; Boles et al., 2005; Brems et al., 2004; Cosden, Larsen, Donahue, & Nylund-Gibson, 2015; Farrugia et al., 2011; Gil-Rivas et al., 1997; 26 In NZ, statutory provision of mental health occurs through DHBs.
Janikowski, Bordieri, & Glover, 1997; Janikowski & Glover, 1994; Liebschutz et al., 2002; Pirard, Sharon, Kang, Angarita, & Gastfriend, 2005; Sacks, McKendricks, & Banks, 2008; Wilsnack, Vogeltanz, Klassen, & Harris, 1997). Focusing on 80 women attending a Community Alcohol and Drug Service (CADS) in NZ, Berry and Sellman (2001) found that 66% had experienced contact CSA before the age of 15 years with 51% “subjected to sexual abuse involving attempted or completed oral, anal or vaginal intercourse” (p. 361). In a larger US study of 732 predominantly male clients receiving substance abuse treatment across 35 treatment centres (71% male), 36% reported contact intra-familial CSA (Janikowski et al., 1997).

Data collected from mental health chart reviews are unlikely to reflect the true prevalence of CSA, given that CSA and other abuse inquiry is not always routine or consistent within mental health services (Agar, Read, & Bush, 2002; Hepworth & McGowan, 2013; Janikowski & Glover-Graf, 2003; Posner, Eilenberg, Havarky-Friedman, & Fullilove, 2008; Sampson & Read, 2016; Xiao, Gavrilidis, Lee, & Kulkarni, 2016; Young, Read, Barker-Collo, & Harrison, 2001). Studies which have compared the prevalence of CSA recorded on clients’ files compared to the prevalence identified through researcher interviews or surveys with clients reveal considerable discrepancies. The prevalence of CSA disclosures by clients participating in research has been found to be 3–11 times higher than the level recorded on client files (Briere & Zaidi, 1989; Goodwin et al., 1988; Lanktree, Briere, & Zaidi, 1991; Lipschitz et al., 1996; Read & Fraser, 1998a; Wurr & Partridge, 1996).

Retrospective quantitative studies comparing sexually abused populations with non-abused populations have identified a history of CSA as a non-specific risk factor for a range of mental health diagnoses. These include anxiety-, post-traumatic stress-, affective-, substance abuse-, eating-, personality-, dissociative- and psychotic disorders (Chen et al., 2010; Cutajar et al., 2010a; Molnar, Buka, & Kessler, 2001; Paolucci et al., 2001; Read et al., 2014; Read, Perry, Moskowitz, & Connolly, 2001b; Smolak & Murnen, 2002). Being sexually victimised as a child is also a risk factor for self-harm, suicidal ideation, suicide attempts, and suicide completion (Cutajar et al., 2010a; Lipschitz et al., 1999; Martin, Bergen, Richardson, Roeger, & Allison, 2004; Molnar, Burkman, & Buka, 2001; Read et al., 2001a).

Fewer prospective studies have been undertaken, yet they offer several methodological benefits compared to retrospective studies. As Cutajar et al. (2010b) have noted: “these include establishing temporal order, causal priority, control of confounding variables and avoidance of recall and sampling bias” (p. 814). Prospective studies with both male and female populations with documented CSA, compared to community population controls, have revealed a significant
association between CSA and mental health needs in males as well as females (Cutajar et al., 2010a; Fergusson, Boden, & Horwood, 2008; Spataro, Mullen, Burgess, Wells, & Moss, 2004). In such studies it is also possible that the association may have been under-estimated, as population controls are likely to include a proportion sexually abused as children. Significantly, Spataro et al.’s (2004) study identified that males were twice as likely as females to have had contact with mental health services. Given that studies suggest males are less likely to seek professional support than females (Oliver, Pearson, Coe, & Gunnell, 2005; Schafer & Wendt, 2015), this finding suggests male survivors may be experiencing considerable mental/emotional distress.

Twin studies examining the role of CSA in later mental health problems could provide the most effective means of controlling for confounding variables, such as family functioning. Discordant twin analyses (where one twin reported CSA and the other did not), allow comparison by using the non-abused twin as a control, thereby differentiating the direct effects of CSA from shared environmental factors (Dinwiddie et al., 2000; Nelson et al., 2006). However, the co-twin control methods face the same problems as other studies in reliably indicating CSA victims from non-victims. In addition, discordant twin analyses tend to utilise identical and fraternal twins in order to generate sample sizes large enough for statistical power, meaning that potential genetic risk factors are not controlled for. Nevertheless, among CSA-discordant twin pairs, higher rates of mental health disorders are found among those sexually abused (Dinwiddie et al., 2000; Kendler et al., 2000; Nelson et al., 2002), as well as higher rates of illicit drug use and abuse (Nelson et al., 2006).

Not only is CSA considered a risk factor for mental health and addiction problems, severe CSA is associated with more severe presentations (Zanarini et al., 2002; Zlotnick et al., 1994). Factors considered severe include CSA experienced frequently and over a long period of time, involving force and/or penetration, and by close and/or multiple perpetrators. More severe forms of CSA appear to create a further risk factor for developing mental health problems (Bulik, Prescott, & Kendler, 2001; Fergusson, Lynskey, & Horwood, 1996; Fergusson, McCleod, & Horwood, 2013; Mullen, Martin, Anderson, & Romans, 1994). Interestingly, Bulik et al. (2001) also included a poor response to disclosure as another factor constituting severe abuse, consistent with Finkelhor’s (1985) traumagenic dynamic of betrayal and Wager’s (2013) concept of double betrayal discussed in Chapter Two.

Furthermore, the outcomes for CSA survivors attending mental health and addiction services appear to be poorer than those without CSA histories. Sexually abused psychiatric inpatients compared to non-abused inpatients have been found more likely to self-harm and attempt
suicide, enter hospital at a younger age, experience more frequent hospital admissions and longer stays, receive more medication, gain multiple psychiatric diagnoses, and spend more time in seclusion (Beck & van der Kolk, 1987; Briere et al., 1997; Darves-Bornoz, Lemperiere, Degiovanni & Gaillard, 1995; Keeshin et al., 2014; Pettigrew & Burcham, 1997; Read, 1998; Tunnard et al., 2014). In Keeshin et al.’s (2014) study of 1433 hospitalisations of children and young people in the US, sexually abused children (compared to non-abused children) had a threefold risk of multiple psychiatric diagnoses, had longer hospital stays, and received 30% more medication, including “increased prescription of atypical antipsychotics” (p. 81). Compared to substance abusing clients without a history of CSA, those who have experienced CSA enter treatment at a younger age, have more severe alcohol and drug problems, are more likely to have additional and more serious mental health problems, and are less likely to maintain abstinence post-treatment (Boles et al., 2005; Brems et al., 2004; Pirard et al., 2005: Schneider, Cronkite, & Timko, 2008).

**Cumulative effects of trauma: The Adverse Childhood Experiences study**

Survivors of CSA may not only be dealing with the effects of childhood sexual victimisation, but the cumulative effects of multiple traumas across the lifespan. As noted in Chapter Two, a history of CSA is a risk factor for sexual re-victimisation (Koenig, O’Leary, Doll, & Pequenat, 2003; Messmann & Long, 1996; Messmann-Moore & Long, 2000, Ministry of Woman’s Affairs, 2012), with CSA survivors being two- to five-times as likely to experience sexual re-victimisation as non-survivors (Arata, 2002; Barnes, Noll, Putnam, & Trickett, 2009; Classen, Palesh, & Aggawal, 2005; Desai, Arias, Thompson, & Basile, 2002, Werner et al., 2015). In the latter two studies, involving large community samples of men and women (n=4000, n=2564), the association between CSA and sexual re-victimisation was stronger for men (Desai et al., 2002; Werner et al., 2015). Furthermore, retrospective and prospective studies indicate that CSA commonly co-occurs with other forms of childhood abuse or adversity (Finkelhor, Ormrod, & Turner, 2007; Ogawa et al., 1997). Described as poly-victimisation, this significantly increases the risk of all forms of re-victimisation in adulthood (Chiu et al., 2013), and is associated with increased levels of psychological distress, trauma symptoms, and poorer functioning (Classen et al., 2005; Finkelhor et al., 2007). One of the most compelling studies to identify the impact of multiple and cumulative forms of abuse and adversity across the lifespan, is the ACE study, which I briefly discussed in Chapter One (Anda et al., 2006; Felitti et al., 1998; Dong, Anda, Dube, Giles, & Felitti, 2003, Dube et al., 2009).
The ACE study was conducted by a major health maintenance organisation (HMO) in the US, and examined the relationship between ACE’s and social, psychological, and health problems with a gender-balanced sample of over 17,000 adults. A range of childhood experiences were defined as adverse for the purposes of the study: physical, emotional, and sexual abuse, neglect, parental separation or divorce, observing family violence, living with a family member who had been incarcerated, or had a mental health problem, or substance abuse problem. As discussed in Chapter One, nearly 25% of females and 16% of males reported contact CSA. ACEs commonly co-occurred and were found to be directly associated with social, health, and psychological problems across the lifespan. For example, those participants who had experienced four or more categories of ACEs were found to have a 4- to 12-fold increase for alcoholism, drug abuse, suicide attempt, and depression (Anda et al., 2006; Chapman et al., 2004; Dube et al., 2003; Edwards, Holden, Felitti, & Anda, 2003). Figure 2 clearly documents the potential pathways between childhood adverse experiences and poor outcomes in adulthood.

What is particularly compelling about the ACE study is the cumulative toll of dealing with the effects of trauma over time, upon self and others, and the potential intergenerational impacts of unresolved trauma. Coping behaviours to alleviate the effects of trauma such as substance abuse, risk-taking, aggressive behaviour, and poor relationship choices are likely to negatively impact children. Parents may transmit trauma directly by physically, emotionally, or sexually abusing their own children, or indirectly via traumatic symptoms and/or unhelpful coping mechanisms. The latter pathway may inadvertently put children at risk of victimisation by others. Both pathways have significant implications for children’s attachment relationships, and suggest multidisciplinary approaches to working with parents with mental health/addiction problems and their children are needed.

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27 This study, like many of the prevalence studies discussed in Chapter Two, involved retrospective uncorroborated reports. While false positives are possible, many authors consider false negatives to be a greater methodological concern (Fergusson, Horwood, & Woodward, 2000; Hardt & Rutter, 2004).
Figure 2: Impact of adverse childhood experiences across the lifespan (Adapted from chart created by Jennings (2010), http://www.TheAnnaInstitute.org and based on the findings from the ACE study [Felitti et al., 1998])

**Dual diagnosis**

A dual diagnosis involves co-existing addiction and mental health problems and poses considerable challenges to treatment since the two issues are often intractably linked, exacerbating each other in vicious circles. Todd (2010) has estimated that between a third and a half of clients in
NZ mental health or addiction services have a dual diagnosis. Other national and international studies indicate a dual diagnosis among one third to three quarters of clients attending either a mental health or addiction service (Adamson, Todd, Sellman, Hurawai, & Porter, 2006; Havissey, Alvidrez, & Owen, 2004; McGovern, Xie, Segal, Siembab, & Drake, 2006; Watkins et al., 2004; Weaver et al., 2003). Drawing on 105 clients from two CADS agencies in NZ, Adamson et al. (2006) found that 74% had a current psychiatric disorder. However, less than 10% of these clients had received out-patient or in-patient mental health care, and the authors argued that “AOD services need to be capable of comprehensive assessment and treatment planning” (Adamson et al., 2006, p. 164).

In a parallel process to the issue of CSA inquiry, despite the high prevalence of dual diagnosis clients identified by research, a dual diagnosis is not always evident in clinical services. Although integrated service delivery would appear self-evident, clients with a dual diagnosis often fall between the cracks because of differences in service provision, lack of training and resources, and lack of culturally specific services (Adamson et al., 2006; Matua Raki, 2013a; MHC, 2012a, 2012b; Todd, 2010; Todd et al., 1998; Todd, Sellman, & Robertson, 2002 ). Similar findings have appeared in Australia, US and UK about the lack of comprehensive assessment and integrated treatment (Flynn & Brown, 2008; Harris & Edlund, 2005; McGovern, Lambert-Harris, Gotham, Claus, & Xie, 2014).

The dual diagnosis of PTSD and substance abuse disorder (SUD) is particularly common, and clearly indicates the presence of trauma. Yet this dual diagnosis is also under-recognised because of the failure to routinely assess for traumatic symptoms in addiction services (Dansky, Roitzsch, Brady, & Saladin, 1997; Gielen, Havermans, Tekelenburg, & Jansen, 2012). Studies that have conducted trauma assessments in addiction services have found that 25%–62% of substance-abusing clients also suffer from PTSD, with higher rates found among women (Adamson et al., 2006; Brady, Back, & Coffey, 2004; Brown, Recupero, & Stout, 1995; Driessen et al., 2008; Gielen et al., 2012; McGovern et al., 2006; Reynolds et al., 2005; Thompson & Kingree, 1998). Similarly, clients with severe mental health problems also experience high rates of PTSD (between 30%–43%), although, again, it is commonly undetected (Cusack, Grubaugh, Knapp, & Frueh, 2006; Grubaugh, Zinzow, Paul, Egede, & Frueh, 2011; Howgego et al., 2005; Mauritz, Goossens, Draijer, & Van Achterberg, 2013; Mueser et al., 1998, 2004; Zanville & Catteneo, 2008). The proportion of clients suffering from traumatic stress is likely to be considerably higher, since not all children or adults experiencing trauma symptoms meet the full criteria for PTSD (Driessen et al., 2008; Perry et al., 1995). Many argue that there is a need for routine assessment of traumatic symptoms, as well
Substance abuse is often perceived as an avoidant strategy to escape from the effects of trauma such as CSA, in essence a form of self-medication (Khantzian, 1997, 2013; Khantzian & Albenese, 2008). Alcohol and/or drugs may help to numb and avoid intrusive memories of trauma, to arouse and provide relief from negative and diminished affect, or to relax and alleviate the constant feeling of hypervigilance. Many studies have identified that PTSD precedes the development of SUD (Back, Brady, Sonne, & Verduin, 2006; Chilcott & Breslau, 1998; Jacobsen, Southwick, & Kosten, 2001; Stewart & Conrod, 2003). In addition, increased PTSD symptoms precipitate increased substance abuse (Quimette, Read, Wade, & Tirone, 2010). The correlations between PTSD, trauma, and substance abuse are also significant within adolescent populations. In their study of over 4000 adolescents, Kilpatrick et al. (2000) found that PTSD “independently increased the risk of marijuana and hard drug abuse/dependence” (p. 19), and the average age of childhood victimisation was considerably lower than the average age of onset of substance abuse. In addition, youth with abuse histories had an earlier age of onset of substance abuse. While all forms of drug use are associated with high rates of trauma exposure, the use of opioids, sedatives, and amphetamines are particularly associated with PTSD (Mills, Teesson, Ross, & Peters, 2006). These studies lend support to the notion that clients attempt to manage traumatic symptoms with substances, and perhaps choose particular drugs to manage particular trauma symptoms.

Although providing limited and temporary relief, substance abuse ultimately exacerabtes PTSD symptoms (Dass-Brailsford & Myrick, 2010) and impairs trauma processing (Briere & Lanktree, 2014). Clients with this dual diagnosis often have more complex and severe presentations than those with SUD or PTSD only (Driessen et al., 2008; Quimette, Goodwin, & Brown, 2006; Schäfer & Najavits, 2007). Sequential models of treatment, where SUD is addressed first, remain common given concerns that continued substance use will undermine trauma therapy, and that addressing trauma will precipitate substance abuse relapse (Hruska & Delahanty, 2013). Clients with this dual diagnosis can make improvements regarding their substance abuse when this is treated first, however studies reveal that trauma symptoms often remain, putting clients at risk of relapse (Read, Brown, & Kahler, 2004; Hien et al., 2010). Consequently, there are growing calls for integrated treatment (Back, Waldrop, Brady, & Hein, 2006; Finkelstein et al., 2004; Gielen et al., 2014; Killeen, Back, & Brady, 2015; McCauley, Killeen, Gros, Brady, & Back, 2012; Mills, 2015; Torchall, Nosen, Rostam, & Allen, 2012).
Integrated approaches to mental health, substance abuse, and trauma increase treatment retention (Amaro et al., 2007; Ghee, Bolling, & Johnson, 2009), facilitate clients’ empowerment and collaboration in treatment decisions (Dass-Brailsford & Myrick, 2010), and are favoured by clients (Brown, Stout, & Gannon-Rowley, 1998; Clark et al, 2008; Gielen, Krumeich, Tekelenburg, Nederkoorn, & Havermans, 2016; Sanford, Donahue, & Cosden, 2014). Conversely, services which fail to address trauma histories may misattribute trauma symptoms to substance abuse or mental health problems (Breckenridge et al., 2012; Dass-Brailsford & Myrick, 2010), or inadvertently re-traumatise clients (Bloom, 2003; Harris & Fallot, 2001). Unresolved issues related to CSA may therefore precipitate relapse, and many have argued for the need for routine CSA inquiry, and CSA histories to be addressed within mental health and addiction treatment plans (Boles et al., 2005; Gil-Rivas et al., 1997, Hepworth & McGowan, 2013; Janikowski & Glover, 1994; Lipschitz et al., 1996; Nelson & Hampson, 2008; Read et al., 2001b; Read, McGregor, Coggan, & Thomas, 2006; Rohsenow, Corbett, & Devine, 1988; Rose, Freeman, & Proudlock, 2012; Rose, Peabody, & Stratigeas, 1991b; Scott et al., 2014).

A growing number of authors also assert that mental health and addiction professionals are well placed to carry out the work of making links between trauma, mental health, and substance abuse through integrated first stage treatment (Briere & Lanktree, 2013, 2014; Covington, 2003; Fallot & Harris, 2002; Ford & Russo, 2006; Haskell, 2003; Knight, 2015; Miller & Guidry, 2001; Najavits, 2002; SAMHSA, 2014a, 2014b; Veysey & Clark, 2004). Several manualised forms of treatment for trauma, substance abuse and mental health problems have been developed which can be administered in group settings or in individual work.28 These programmes provide psycho-education about traumatic impacts, identify the links between trauma and addiction/mental health problems, and teach affect-regulation skills and positive coping strategies to work with the effects of trauma in the here-and-now.29

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28 These include Seeking Safety (Najavits, 2002), Trauma Recovery Empowerment Model (TREM) (Fallot & Harris, 2002), Trauma Adaptive Recovery Group Education and Therapy (TARGET) (Ford & Russo, 2006), Risking Connection (Saakvitne, Gamble, Pearlman, & Lev, 2000), and Addictions and Trauma Recovery Integrated Model (ATRIUM) (Miller, 2002; Miller & Guidry, 2001). See Jennings (2008) for a comprehensive review of integrated treatment programmes for trauma and mental health/addiction.

29 While these models do not involve exposure to past trauma, Najavits (2009) emphasises that the Seeking Safety programme is not about “avoidance of the past” since clients are encouraged to “name their traumas” and “discuss how they impact them” (p. 329), in other words, “headlines, not details” (p. 328). Najavits (2013) has developed a further programme entitled Creating Change which does include an exposure-based component. Mills et al., (2012) have also trialled an exposure based programme called Concurrent Treatment of PTSD and Substance Use Disorders Using Prolonged Exposure (COPE).
Studies investigating the efficacy of these programmes in substance abuse and mental health settings, have found that the attention to trauma increases participants’ self-efficacy in reducing post-traumatic stress, thus improving mental health and/or enhancing ability to maintain abstinence (Frisman, Ford, Lin, Mallon, & Chang, 2008). In NZ, one study sought to assess the effectiveness of utilising the Seeking Safety programme with dual diagnosis clients. While the findings were promising, the study was not randomised and did not have a control group (Benton, Deering, & Adamson, 2011). Determining whether trauma-informed first stage treatment is superior to treatment as usual is confounded by a lack of methodological rigour in randomised controlled trials, as well as treatment retention challenges which reduce statistical power (Najavits & Hein, 2013; Torchalla et al., 2012). There is a need for high quality randomised controlled trials which consider specific strategies to increase treatment retention (Mills et al., 2012).

New Zealand mental health policy and workforce expectations

The notion of trauma-informed care has gradually entered NZ mental health policy discourse, moving from a few vague references to a more explicit focus. However, there still appears to be a lack of in-depth consideration as to how DHBs might truly implement such services. In 2005, the NZ Government launched Te Tāhuhu – Improving Mental Health 2005–2015: The Second NZ Mental Health and Addiction Plan (MOH, 2005). The following year, the government produced Te Kōkiri: The Mental Health and Addiction Action Plan 2006–2015, which was a joint initiative between DHBs and government to implement policy laid out in Te Tāhuhu. In these documents trauma is mentioned once or twice, and abuse is not mentioned at all. In Te Kōkiri, it was recommended that the Nationwide Services Framework (NSF)30 be revised to ensure that clients with experiences of trauma have their needs met, and in Te Tāhuhu, it was acknowledged that people suffering from trauma needed “focused expertise” (MOH, 2005, p. 10).

Ten years after Te Kōkiri’s recommendations, the NSF had still not been revised. Trauma is not mentioned and the only reference to sexual abuse is to note that DHBs “do not fund services for mental health and addiction when the service or support needs are solely oriented to sexual abuse” (MOH, 2015a, p. 15). This silo mentality is pervasive within mental health (and many other services), and it disregards the complexity of clients’ problems which may be multiple and inter-related. In Te Kōkiri, there was an attempt to recognise and address this complexity: “Inter-sectoral collaboration and co-operation across government agencies is

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30 The NSF produces guidelines such as service specifications which are used by the MOH and DHBs to support the funding, planning, and delivery of services.
key to the success of a shift towards more integrated service provision, including greater
linkages across health, education, social services, justice and corrections” (MOH, 2005, p. 18).
A central goal was to create integrated mental health and addiction services, given that co-
existing problems are the norm rather than the exception in both sectors.

In NZ, a number of national workforce development organisations for mental health
and addiction have produced a plethora of useful documents to assist practitioners.31 In 2008,
the MOH issued a quality improvement tool entitled “Let’s get real: Real skills for people
working in mental health and addiction”.32 Let’s get real expects that all mental health
professionals understand and work “to mitigate the physical, social and emotional effects of
trauma and abuse on people’s lives” (MOH, 2008a, p. 9), however there appears to be little
guidance or support as to how this will occur.33 Practitioners working for two years or longer
are to practise “the principles of trauma-informed care” and leaders should develop services
which provide “trauma-informed care” (MOH, 2008a, pp. 8-9). This is defined as “care that is
grounded in and directed by a thorough understanding of the neurological, biological,
psychological and social effects of trauma on people, as well as an understanding of the
prevalence of these experiences in those who receive mental health services” (MOH, 2008a, p.
27).

Te Pou produced learning modules for practitioners and leaders which were essentially
opportunities for self-reflection. The leader level learning module suggested mental health and
addiction services should identify trauma in clients and work with the effects. This is reflected
in the following statements: “early and rigorous diagnostic evaluation, with focused
consideration of trauma, in people with complicated, treatment-resistant illnesses such as
dissociative identity disorder and personality disorders” and “training and supervision in
assessment and treatment of people with trauma histories” (Te Pou, 2009e, p. 16). After an
“initial transition phase”, the “consolidation phase” of Let’s get real was to occur between
2011-2013. During this period it was envisaged that the framework would be “incorporated into
services’ organisational systems and processes, such as orientation programmes, training and
performance appraisals” (MOH, 2010, p. 4). The framework was also expected to be “reflected

31 Te Pou addresses adult mental health and Matua Raki covers addiction issues and dual diagnosis.
32 This was jointly developed in conjunction with Te Pou. There was an expectation for DHBs to
integrate the framework into their existing policies and practices, and it is mentioned in the NSF service
specifications for mental health and addiction.
33 While Te Pou, the national workforce development organization is aligned to the Let’s get real
framework (MOH, 2008a) they have only provided two trauma-informed workshops for DHBs which
occurred in 2011. Te Pou acknowledges that they are “not actively offering training” in trauma-informed
service delivery or “currently doing work” in this field, and the main thrust of prior work has been to
reduce seclusion and restraint (personal communication, A. Gruer, Te Pou, 4/2/16).
in curricula and course content” for relevant education providers, thus having implications for social work education (MOH, 2010, p. 4).

In 2012, a mental health and addiction service development plan for 2012-2017 was developed called “Rising to the challenge” (MOH, 2012a). This policy reflects significant shifts in recognizing issues which had previously been marginalized, such as parenting support for service users, physical health needs, and a focus on the training and provision of talking therapies. It also explicitly acknowledges the need for routine assessment of abuse and trauma. Trauma-informed services are defined as “services that ensure staff are aware of the high incidence of childhood trauma among people with mental health and addiction issues, inquire about trauma histories, are sensitive to trauma-related issues, and avoid re-traumatisation of people who use them” (MOH, 2012a, p. 64). Recognising multi-faceted needs among service users, the policy demands a “whole of government response to mental health and addiction issues” (MOH, 2012a, p. 64). A draft mental health and addiction workforce action plan has been generated to meet the requirements of this policy, highlighting the need for trauma-informed training in mental health and primary health services (MOH, 2015c). Again, this naturally has implications for social work education.34

Barriers to addressing CSA in mental health and addiction services

Despite the significant links between CSA, mental health problems, and substance abuse, mental health professionals often avoid addressing CSA at the level of inquiry and/or within treatment plans (Breckenridge et al., 2010, 2012; Day et al., 2003; Hepworth & McGowan, 2013; Mansfield et al., 2016; McLindon & Harms, 2011; Nelson & Hampson, 2008; Read & Sampson, 2016; Rose, Peabody, & Stratigeas, 1991a, 1991b; Young et al., 2001). In particular, clients who are male (Lab, Feigenbaum, & De Silva, 2000), and/or diagnosed with psychosis (Read & Fraser, 1998a; Read et al., 2005; Young et al., 2001) are less likely to be asked about CSA. Given that these two groups have high rates of suicidal ideation and completed suicide, and as discussed previously, histories of CSA are associated with suicide, the costs of not asking may be very high (Read et al., 2001a). While Bride et al., (2009) found 75% of 225 AOD counsellors in the US always inquired about CSA, only 41% always addressed clients’ trauma issues in treatment plans. They also identified significant rates of secondary trauma among AOD practitioners. In excess of a third of counsellors “reported a desire to avoid working with some clients, and more than a quarter … reported detachment, emotional numbing, or irritability” (Bride et al., 2009, p. 103).

34 Submissions regarding the draft workforce plan closed on 20 January 2016, however, a year later the workforce plan remains a draft.
Multiple and varied issues appear to impact mental health professionals’ and AOD clinicians’ decisions to refrain from CSA inquiry and/or addressing abuse in treatment plans. Table 3 highlights the vast array of anxieties, concerns, beliefs, and organisational factors which have been documented as constraining influences upon inquiry and response.

Table 3: Barriers to CSA inquiry and response in the literature

<table>
<thead>
<tr>
<th>Type of barrier</th>
<th>Issues cited</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Organisational and workplace issues</strong></td>
<td>Lack of training and/or experience; compartmentalisation of services/not part of work remit; time constraints; more immediate needs of client; short-term and under-resourced programmes; predominance group-work; lack of privacy; lack of supervision, policy and organisational support; preference for solution-focused present-centred approaches; expectations of abstinence before treatment for mental health; conflicting treatment philosophies in mental health and addiction services; lack of funding; lack of knowledge of resources available; lack of knowledge of protocols for responding to a disclosure; lack of integrated services, suffering from STS/VT.</td>
</tr>
<tr>
<td><strong>Beliefs</strong></td>
<td>Best to put past behind you, clients will tell when ready to, lack of connection between trauma and mental health/addiction, genetic aetiology for mental health problems, belief that client is responsible for their addiction, belief that trauma secondary to substance abuse problems, assumption client has already been asked.</td>
</tr>
<tr>
<td><strong>Client and/or professional characteristics</strong></td>
<td>Male clients, diagnosis of psychosis, elderly clients, professional being opposite gender to client.</td>
</tr>
<tr>
<td><strong>Fears, anxieties, concerns</strong></td>
<td>Increasing workload, opening up a can of worms, fear of experiencing VT, exacerbating client distress and/or instability, causing client’s relapse, being intrusive, offending client, knowing perpetrator in small communities, inducing false memories, avoidance of legal repercussions, lack of comfort and confidence in asking and/or responding to a disclosure, insufficient rapport, risk of undermining engagement.</td>
</tr>
</tbody>
</table>

These studies and reviews have not been focused solely on social workers, they have also included the views and practices of nurses, addiction counsellors, psychologists, and psychiatrists (Ashmore, 2013; Blakey & Bowers, 2014; Breckenridge et al., 2010, 2012; Bride et al., 2009; Cavanagh et al., 2004; Day et al., 2003; Eilenberg, Fullilove, Goldman, & Mellman, 1996; Everett & Gallop, 2001; Gielen et al., 2014; Harris & Fallot, 2001; Janikowski & Glover-Graf, 2003; Lab et al., 2000; Mansfield et al., 2016; McLindon & Harms, 2011;
In addition, the nature of traumatic stress and traumatic memory pose barriers to survivors’ awareness of the impact of past trauma upon present problems. Traumatic memories are often implicit, embodied, and state-dependent. They have a timeless quality, entering awareness unbidden as strong affects or bodily sensations, seemingly disconnected from the past. Qualitatively different to declarative or autobiographical memory, they tend to be composed of emotional and sensory slivers or remnants of the trauma, rather than a narrative account (Pain, Bluhm, & Lanius, 2011). Even when awareness of the trauma is continuous, there remains a tendency for it to be felt initially at a sensorimotor level (van der Kolk & Fisler, 1995). The lack of a coherent trauma narrative makes it difficult for survivors to connect their past experiences with their present distress. As Harris and Fallot (2001) have pointed out, clients seeking mental health or substance abuse services rarely front up asking for treatment for past sexual abuse trauma. Not only are the presenting problems more pressing, but past trauma may not appear obviously related. Bloom and Farragher (2013) have made similar observations regarding survivors within mental health inpatient treatment:

Despite the enormity of their experience, we saw that they were unlikely to make connections between their present problems and those previous experiences, as if the present and the past had become completely disconnected from each other. Early in our learning process, we were exposed to the memory problems associated with trauma and saw that our patients were often unable to remember, much less talk about, the worst parts of their experiences, while at the same time they were behaviourally re-enacting the problematic relationship dynamics, so that they ended up being hurt again and again. They usually had great difficulty communicating directly and openly about their needs, feelings, or perceptions. (p. 3)

Chapters One and Two highlighted the extensive intrapsychic and interpersonal barriers to disclosure. The combination of professional reticence with asking, and client difficulties with telling, may lead to clients’ histories of CSA becoming the elephant in the room. If clients do disclose, professional discomfort and other barriers to a validating response listed in Table 3, may silence and perhaps even re-traumatise clients, replicating perpetrator dynamics of secrecy, denial, and minimisation. Studies of clients’ files within mental health services reveal that the majority of disclosures are neglected within treatment plans, along with a lack of provision of therapy, and under-reporting to statutory authorities (Agar & Read, 2002; Posner et al., 2008; Read & Fraser, 1998b).
Attitudes and knowledge regarding CSA

Illuminating the picture further is the literature on professional attitudes, myths, and knowledge regarding CSA. These studies have employed vignettes and/or a variety of specially developed scales. Like the literature on professional barriers, very few studies have focused specifically on social workers, with most involving mixed samples drawn from a variety of helping professions or student populations. In this section, I primarily focus on studies which include social workers. However, given that social workers with little knowledge of CSA may well be impacted by societal attitudes and media representations, I also refer to other relevant research.

Several studies indicate that the gender of the professional influences attitudes. As opposed to males, female professionals or students have been found to perceive CSA as more widespread and serious, sex offenders as a more diverse group, and treatment for offenders as more effective (Hubbartt & Singg, 2001; Trute et al., 1992). Females also perceive children’s CSA allegations as more credible (Hicks & Tite, 1998; Jackson & Nuttall, 1993), are more likely to believe adults’ memories of CSA (Poluscny & Follette, 1995), and are more likely to report abuse, compared to males (Crenshaw, Lichtenberg & Bartell, 1994; Hansen et al., 1997). In relation to NZ social workers’ and social work students’ attributions for sexual offending, Ward, Connolly, McCormack, and Hudson (1996) found significant gender differences (in a total sample of 33 males and 69 females). Females primarily cited power and control, and males cited developmental issues, intimacy deficits, and sexual motivation as predominant factors in sexual offending. Among trainee and practicing psychologists, Collings (2003) found males more likely to accept CSA myths and stereotypes than females. However, there was a concerning degree of myth acceptance across both genders, and across all levels of experience. Consequently, Collings (2003) has argued for “specific educational interventions designed to target social attitudes to CSA” (p. 841).

Cromer and Goldsmith (2010) define CSA myths as “incorrect beliefs and stereotyped assumptions about CSA, victims, and perpetrators” (p. 619). They also argue that professionals

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35Collings (1997) developed the Child Sexual Abuse Myth (CSAM) scale which has been used on professional and student populations. The CSAM scale is a fifteen item measure with three factor scores: blame diffusion, denial of abusiveness, and restrictive stereotypes. See Collings (1997) for a full description of reliability and validity for this instrument. Trute, Adkins, and McDonald (1992) developed the Professional Attitudes Regarding the Sexual Abuse of Children (PARSAC) scale. This is a fourteen item measure involving three factor scores: extensiveness and seriousness, treatment versus punishment for offenders, identity of perpetrator.
are susceptible to being influenced by these myths in the absence of adequate training. Conducting a Google search, they identified 119 myths which they coded into four categories, and discussed in the light of empirical literature:

a) Minimisations or exaggerations of the extent of harm  
b) Denial of the extent of CSA  
c) Diffusions of perpetrator blame  

Not only may CSA myths affect professional responses to victims/survivors, they may also influence survivors’ willingness to disclose and seek help (Cromer & Goldsmith, 2010). For example, among social workers, teachers, and police, scenarios depicting 15 year old victims were less likely to be believed than those with seven year old victims (Hick & Tite, 1998). In addition, undergraduate students (n=404) assigned less blame to adults sexually abusing teenagers than children, particularly in cases involving opposite-sex interaction (Maynard & Wiederman, 1997). Adolescents are likely to be aware of discourses which characterise them as acting out and rebellious on the one hand, and yet increasingly autonomous, sexually mature, and able to give informed sexual consent on the other. Societal and professional expectations regarding adolescent’s autonomy and ability to offer resistance to sexual abuse, fail to take into account grooming dynamics, attachment relationships, and traumatic reactions such as immobility and dissociation, as discussed in Chapter Two.

Female perpetrated sexual abuse is another area subject to stereotypical attitudes. Among social workers and police (Hetherton & Beardsall, 1998) and social workers, psychologists, and psychiatrists (Mellor & Deering, 2010), CSA perpetrated by females was perceived as less serious than male-perpetrated abuse. Such attitudes can filter into practice, since Peter (2009) found that professionals reported only 35% of female perpetrated CSA to child welfare authorities, as opposed to 56% of male perpetrated abuse. Denov (2001) identified a “culture of denial” among psychiatrists and police officers, whereby traditional sexual scripts rendered female sexual assault as minimal and harmless, and even beneficial for male victims. Again, victims of female-perpetrated CSA are likely to be aware of such attitudes, which may inhibit seeking support. If they do disclose to professionals, they may be subject to responses which minimise harm, or deny that CSA occurred (Clements et al., 2014; Denov, 2004; Mellor & Deering, 2010).
Studies focused on professional attitudes and knowledge reveal that many professionals would value additional training in the field of CSA. Surveying a range of UK mental health professionals (including social workers) regarding their competence, comfort, and support in working with clients with a history of CSA, Day et al. (2003) found that over half of participants provided low self-ratings on all three dimensions, and 81% wanted more training. Another survey of 418 alcohol and drug workers in Australia, including social workers, found over one third had no trauma training, despite working with highly traumatised clients, and 20% experiencing secondary trauma (Ewer, Teesson, Sannibale, Roche, & Mills, 2015). Similarly, 121 substance abuse counsellors in the US believed they were only “somewhat competent” to work with clients with sexual abuse histories and identified the need for further training (Janikoskwi & Glover-Graf, 2003). Martin et al. (2014) conducted six focus groups with a total of 64 child protection social workers in the UK, regarding their knowledge and sense of confidence and competence in working with CSA. They found that social workers had not received any “specific or in-depth training in CSA” within social work education, and that “on-the-job training … was variable in terms of availability, access to training, focus of the training, format, quality and relevance to practice” (p. 13). Mandatory training on-the-job tended to be focused on procedures, while social workers identified a need for training which focused on “the therapeutic dimension of working with victims and families” (p. 16). Perry (2006) found that both Danish and English social workers had limited knowledge of CSA. Areas requiring further training included supporting the non-offending caregiver, signs and symptoms of CSA, prevalence, definition, communicating with children, and dynamics of CSA such as grooming and societal denial. Other gaps in knowledge that have been identified among social workers include:

a) awareness that children may have positive feelings about CSA (Hibbard & Zollinger, 1990)
b) awareness that a sexually abused child may have a normal medical examination (Hibbard & Zollinger, 1990)
c) cultural issues regarding CSA (Campbell & Carson, 1995)
d) female sex offenders (Campbell & Carson, 1995)
e) male survivors (Campbell & Carson, 1995)

Survivors’ experiences with professionals

Despite the emotional challenges of disclosure, survivors appreciate being sensitively asked about CSA and having the opportunity to tell someone (Barnett & Lapsley, 2006;
Chessen, Comtois, & Landes, 2011; Janikowski & Glover, 1994; Josephson & Fong-Beyette, 1987; Lothian & Read, 2002; Nelson, 2009; Nelson & Hampson, 2008; Nelson & Phillips, 2001; Scott et al., 2014; Scott et al., 2015). Conversely, failing to ask clients about CSA and/or include CSA in treatment plans can create frustration and distress about feeling silenced, and concern that mental health diagnoses do not adequately reflect their problems (Lothian & Read, 2002; Nelson & Phillips, 2001; Nelson & Hampson, 2008; O’Brien, Henderson, & Bateman, 2011). Lack of inquiry can also reinforce survivors’ silence (Scott et al., 2014). In addition, clients consider the lack of awareness of CSA and trauma leads to over-medication (Breckenridge et al., 2008; Nelson, 2009), and inadequate responses to their complex and multiple issues (Imkaan, 2014, O’Brien et al., 2011).

Disclosure can elicit relief, a sense of catharsis, and increased insight, but at the same time clients may feel a deep sense of vulnerability and exposure, not only through addressing painful material, but valid concerns about how their disclosure and very self are received (Farber, Feldman, & Wright, 2014; Harber & Pennebaker, 1992; O’Brien et al, 2011; Tener & Murphy, 2015). The possibility of feeling emotionally overwhelmed (Farber et al., 2014) highlights the need to sensitively contain the degree of disclosure, and assist the client to remain grounded (Najavits 2009). Positive and negative effects of talking about CSA may co-exist, however the degree to which they are amplified appears to depend upon the quality of the response.

A validating and sensitive response can mitigate the negative impact of disclosure, and enhance the therapeutic relationship (Farber et al., 2014; Martsolf, Draucker, Cook, Ross, & Stidham, 2010). Survivors value professionals who are sensitive, calm, respectful, empathetic, and non-judgemental, who share power, and have an informed understanding of abuse and trauma (Chouliara et al., 2011, 2012; Josephson & Fong-Beyette, 1987; Musik et al., 2011; Nelson & Phillips, 2001; Palmer, Brown, Rae-Grant, & Loughlin, 2001). They appreciate eye contact, body language which indicates attentiveness, appropriate tone of voice, and an even rhythm of speech conveying calmness (White, Danis, & Gillece, 2016). They also speak of the influence of lived space. Aesthetic and structural features of the work setting, such as visual and audio privacy, warm colours, artwork, posters, and/or printed materials that address and normalise the prevalence of CSA are helpful to survivors (Schacter, Stalker, Teram, Lasiuk, & Danilkewich, 2008; White et al., 2016).

Conversely, in their meta-summary of 31 qualitative studies, Martsolf et al. (2010) found that survivors reported feeling powerless in the face of negative and/or insensitive
professional responses, such as disbelief, minimisation, information overload, and sexual boundary violations. In addition, they felt humiliated by professional unwillingness to hear their disclosures, suggestions they were to blame, and disregard for gender issues. These feelings of powerlessness, humiliation, shame, and probably betrayal replicate the original traumagenic dynamics discussed in Chapter Two (Finkelhor & Browne, 1985). As Alaggia and Millington (2008) have noted, “the survivor may be exquisitely tuned in to discomfort and disbelief in others” (p. 274) and unfortunately, these fears may be confirmed.

For clients growing up in dysfunctional families and experiencing multiple adverse experiences across the lifespan, experiences of victimisation may be considered the norm. Survivors commonly report beliefs that CSA was normal and/or fail to perceive their experiences as abuse, which can be carried into adulthood (Alaggia, 2004; Allnock & Miller, 2013; Breckenridge et al., 2008; Draucker & Martsolf, 2008; Draucker et al., 2011; Lab & Moore, 2005; Mockus et al., 2005; Morrow & Smith, 1995; Roller, Martsolf, Draucker, & Ross, 2010). Professionals can clearly play a role in assisting clients to realise that their abuse was not normal or acceptable. However, there are also implications for the way in which clients are asked about abuse.

Direct inquiry using behaviourally specific questions, rather than labelling questions, elicits significantly higher rates of disclosure for both males and females (Briggs & Hawkins, 1995; Dill et al, 1991; Fricker, Smith, Davis, & Hanson, 2003; Lab & Moore, 2005; Martin, Anderson, Romans, Mullen, & O'Shea, 1993; van Roode et al., 2009; Wyatt & Peters, 1986). A labelling question merely asks if the client has been sexually abused and/or uses subjective language such as “unwanted”, “coercive” or “abusive”. This assumes that clients will understand what sexual abuse is, and that they will have defined their experiences as abusive.

**Implications for CSA inquiry and response training**

Research regarding the efficacy of training in CSA inquiry and response suggests that a one day training increases mental health professionals’ comfort and competence in asking about abuse, and responding appropriately to clients (Cavanagh et al., 2004; McNeish & Scott, 2008). Even one hour of training has increased professionals’ rates of inquiry (Currier & Briere, 2000). Areas covered in the former two studies include prevalence and impacts of CSA and trauma, disclosure difficulties, VT, and experiential training in asking and responding. In the UK, the one day inquiry and response training for mental health trust has recommended the following
question: “Have you experienced physical, sexual or emotional abuse at any time in your life?” (McNeish & Scott, 2008, p. 7). Yet as discussed, this broad, labelling question may limit disclosure, because survivors may not always define their experiences as abuse. In contrast, CSA inquiry and response training in NZ within the Auckland DHB (ADHB) utilised behaviourally specific questions which is considered best practice, and recommended a funnel approach (Cavanagh et al., 2004). This training is no longer being offered, although the Midland DHB offered a one day trauma-informed care workshop in 2014. This included defining simple and complex trauma and PTSD, biopsychosocial impacts, the ACE study, re-triggering and re-traumatisation within services, trauma-informed care, and trauma assessments. An internal evaluation of the training found that “discussion with other participants … research … and the neurobiological effects of trauma” was most useful to participants. However, they desired “more information on screening, assessing and trauma interventions” and “active group work”, and they noted “the lack of cultural, family whanau and consumer perspectives” (Midland DHB, 2014, p. 3).

_Hear no evil, see no evil, speak no evil_

Clearly, there is compelling evidence and increasing policy support for mental health and substance abuse assessments to include CSA inquiry (and other abuse) and screen for trauma symptoms, yet the literature indicates considerable professional and organisational reticence and discomfort. Mental health professionals, including social workers, have identified the need for training and the literature indicates they benefit from such training. However, Kezelman and Stavroupoulos (2012) have observed an “endemic myopia” pervading organisations with regard to the impact of trauma upon mental health. Frustration permeates Middleton’s (2012) reflections on helping organisations:

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36 In addition to the research cited on the previous page, the NZ Standard, “Screening, risk assessment and intervention for family violence including child abuse and neglect”, recommends using behaviourally specific questions (Standards NZ, 2006).
37 A funnel approach to inquiry moves from general questions about childhood, family relationships, forms of discipline and what was good and bad to specific questions about abuse (Cavanagh et al., 2004; Read et al., 2007).
38 The ADHB developed a policy in 2000 for routine inquiry and response regarding abuse accompanied by a mandatory one day training to equip all staff. The policy does not exist any longer, the training has not occurred for “a number of years” and there has been “a significant change in leadership for mental health at ADHB”. However “all clinical staff receive orientation and training in the use of recording assessments”. One of the mandatory fields in the assessment form involves taking a trauma history which is “an expected part of routine practice prompted by the forms”, but there is not a “specific policy about it” (personal communication, M. West, ADHB, 2/2/16).
Even when there is an abundance of evidence that delineates the types and extent of abuses of children and others in our society, even when the clinical syndromes experienced by such abuse victims have been meticulously and repeatedly documented, and even when the sorts of symptoms and phenomena encountered make perfect sense in light of the sorts of trauma experienced and their duration, our mental health and child safety systems can rebrand or invalidate to an extent that maintains collective silence. (p. xi)

This re-branding of trauma into a vast array of psychiatric diagnoses and maladaptive behaviours shields society from complicity and shame (Kezelman & Stavropoulos, 2012; Middleton, 2012). However, it may also represent a form of collective denial serving to protect against the anxiety of bearing witness to human-inflicted atrocities. The seemingly incomprehensible and counterintuitive professional response to people’s mental/emotional distress is best understood through the lens of psychodynamic theory, specifically the role of anxiety and defences as discussed in Chapter Two. Bloom and Farragher (2010) make the strong case that much of our mental health system has become trauma-organised (reacting and defending against the presence of unresolved and non-verbal manifestations of trauma) rather than being trauma-informed.39 Bearing witness to others’ pain and distress pushes empathic capacity to its limits and has considerable costs, yet as Bloom and Reichert (1998) point out “disavowing emotional experience is, itself, a traumagenic force that pervades the entire cultural milieu” (p. 30) with arguably greater costs. The remainder of this chapter focuses specifically on the social work profession, and the implications of addressing CSA and trauma within education and practice.

**The call for a trauma-informed social work curriculum**

In this chapter, and Chapters One and Two, I have provided evidence supporting a clear rationale for addressing CSA in social work practice and education. This includes the high prevalence of CSA within community populations, the significantly higher prevalence of CSA among clinical populations, and the extensive mental, emotional, physical, social, and intergenerational impacts of unresolved CSA across the lifespan. Social workers are therefore likely to encounter clients experiencing the adverse impacts of CSA in any social work domain. As Marlowe and Adamson (2011) note “the experience of living through loss and trauma is one of the few strands that retains salience across the whole social work curriculum” (p. 630). In addition, this chapter has revealed that in the absence of knowledge about the dynamics of CSA

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39 Bloom and Farragher (2010) describe the impact upon chronically stressed organisations who work with traumatised populations, whereby parallel processes between organisations and clients can occur with regard to the manifestation of trauma. These ideas also highlight collective responses to VT. For a further discussion of trauma-organised systems see Bloom (2010, 2011, 2012).
and traumatic impacts, social workers may feel ill-equipped to inquire about and address
clients’ abuse histories. They may even hold pejorative and dismissive attitudes about victims,
influenced by societal myths and stereotypes. Lastly, practitioners may experience VT and/or
re-traumatisation in response to clients’ traumatic material. Consequently, a growing number
of authors have argued for the need for social work education to include abuse and trauma in
curricula, and to teach within a trauma-informed framework (Abrams & Shapiro, 2014; Agliias,
2012; Breckenridge & James, 2009; Bussey, 2008; Carello & Butler, 2015; Courtois, 2002;
Courtois & Gold, 2009; Cunningham, 2004; Didham, Dromgole, CSIernick, Karley, & Durley,
2011; Gilin & Kaufman, 2015; Kawam, 2014; Kenny & Abreu, 2015; Knight, 2013; Layne et
al., 2014; Marlowe & Adamson, 2011; Shannon, Simmelink-McCleary, Im, Becher, & Crook-

**Students’ trauma histories: Gatekeeping responsibilities**

Nearly one in four (20%–25%) of social workers and students report a history of CSA
(Black, Jeffreys, & Hartley, 1993; Gore & Black, 2009; Jackson & Nuttall, 1994; Russel, Gill,
Coyne, & Woody, 1993). While these figures are similar to the community prevalence of CSA
for females, male social workers have a significantly higher prevalence of CSA than the general
male population, with figures equal to those reported by females (Black et al., 1993; Jackson &
Nuttall, 1994; Nuttall & Jackson, 1994). Those who engage in postgraduate study, and/or
specialise in working with CSA survivors, appear to have even higher rates of CSA, and other
forms of child abuse. Among Masters of Social Work (MSW) students, 69%–73% revealed
family-of-origin dysfunction, such as addictions, violence, and psychopathology (Russel et al.,
1993; Sellers & Hunter, 2005). Compared to findings in the original ACE study discussed
earlier in this chapter, Gilin and Kaufman (2015) found that twice as many MSW students
(27% vs. 12%), reported four or more adverse childhood experiences. In a similar study,
Thomas (2016) found that over three times as many MSW students (42% vs. 12%) reported
four or more adverse childhood experiences, with 27% reporting CSA. Although not
differentiating profession, 76% of a sample of 383 clinicians working with CSA survivors or
offenders reported some form of childhood maltreatment, with CSA histories found in 44% of
females and 30% of males (Way, VanDeusen, & Cottrell, 2007).

Several authors have noted that social work students cite a history of family problems
and dysfunction, including CSA, as a major influence in pursuing a social work career
(Adamson, 2006; Christie & Weeks, 1998; Czikai & Rozensky, 1997; Humphrey, 2007; Nuttall
& Jackson, 1994; Olsen & Royce, 2006; Regehr, Stalker, Jacobs, & Pelech, 2001; Rompf &
Royce, 1994; Sellers & Hunter, 2005). In one study, social work students with childhood trauma were three times more likely to cite their family of origin as impacting upon career choice, than students without early adverse experiences (Rompf & Royce, 1994). Choosing social work may reflect existential quest for meaning to overcome and transform difficult family-of-origin experiences, through understanding self and helping others (Buchbinder, 2007). However, drawing on attachment and psychodynamic theory, Vincent (1996) has suggested that these motivational processes may sometimes be unconscious. She comments that: “those who have not had their needs met in childhood may have difficulty acknowledging and attending to their own neediness” (p. 67). Students may therefore require considerable support to identify and recognise how their own issues may be impacting on their work with clients (Bogo, 1993; Regehr et al., 2001; Russel et al., 1993).

There are many informal and formal ways to address and resolve psychosocial trauma, however, in social work education “the critical use of life experiences cannot simply be assumed” (Christie & Weeks, 1998, p. 66). While wounded healers may have increased empathy and understanding towards clients with similar backgrounds, if they have not had opportunities to address their own issues to some extent, they are at risk of countertransference reactions, VT, and boundary issues, as discussed in Chapter Two (Black et al., 1993; Gore & Black, 2009; Lackie, 1983; Lafrance, Gray, & Herbert, 2004; Newcombe, Burton, Edwards, & Hazelwood, 2015; Regehr et al., 2001; Sellers & Hunter, 2005, Zerubavel & Wright, 2012; Zosky, 2013). They may also be at risk of mental health and substance abuse problems (Horton, Diaz, & Green, 2009). Triggering and/or re-traumatisation may also occur in the classroom setting, through exposure to traumatic material reminiscent of students’ own experiences (Carello & Butler, 2015; Kawam, 2014; Knight, 2013).

The degree to which social work students’ traumatic histories are explored in the admission process, and dealt with in social work programmes, represents a gatekeeping issue. This generates conflict between a student’s right to privacy, respect, and anti-discrimination, and the social work programme providers’ responsibility to prevent harm to both the student, and the clients the student will come in contact with (Barter, 1997). Gatekeeping sits uncomfortably with strengths-based and social justice values in social work (Grady & M.S, 2009). Consequently, admissions processes have tended to avoid selection criteria focused on students’ personal qualities and issues, yet many argue that these factors need to be operationalised and screened for, in order to maintain the quality of the profession (Gibbs, 1994; Gibbs & Blakely, 2000; Gibbons, Bore, Munro, & Powis, 2007; Lafrance, Gray, & Herbert, 2004; Ryan, Habibis, & Craft, 1997; Ryan, McCormack, & Cleak, 2006).
Gatekeeping plays an important role in maintaining ethical, professional, and educational standards in social work. Therefore, academic and field placement assessments must take into account student behaviour, temperament, and mental health (Urwin, Van Soest, & Kretzschmar, 2006). However, it is often a difficult and nebulous area for social work faculty to engage with (Koerin & Miller, 1995; Lafrance et al., 2004, Regehr et al., 2001), often exacerbated by a lack of clear policy (Humphrey, 2007). Christie and Weeks (1998) question whether difficult life experiences are given voice within social work selection procedures and education, given that “poverty, violence, abuse and death are difficult elements in peoples’ stories, which sit uneasily with dominant understandings of competence and acceptability, negotiation and exchange” (p. 65). Like clients’ trauma histories within mental health services, student difficulties arising from a personal history of trauma can become the elephant in the room:

There is a culture of open secrecy in the academy. Everyone knows that a proportion of students will be carrying a legacy of trauma, but no one knows whether or how staff should be addressing this; everyone witnesses distress or disclosures from students but no one knows whether or when to share these concerns; in practice it seems that such matters are left to the discretion of individual members of staff. (Humphrey, 2007, p. 205)

Just as clients experience barriers to disclosure, so do social work students. They may not disclose a history of CSA through fear of rejection from the programme, feeling educators are unapproachable, stigma, denial, shame, lack of trust, fear of being judged and treated differently, lack of readiness, repressed memories, fear of being forced into treatment, protection of the abuser, and fear of being perceived as a perpetrator (Barter, 1997; Didham et al., 2011; Kawam, 2014). However, when disclosures do occur within admission forms, or perhaps later in essays, or directly to educators, gatekeeping responsibilities suggest the need for follow up. In Barter’s (1997) view, educators should “seek evidence of steps taken to address the abuse and its consequences, the progress made, and the ability to make links between those experiences and career choice” (p. 120). Similarly, Kawam (2014) notes that educators need to follow up regularly with such students, responding with “empathy and compassion”, “conveying support, value and respect”, and “paying attention to verbal and non-verbal communications”; while also documenting “mental health and productivity changes over time” (p. 130).
Vicarious or indirect trauma in the classroom

Students may experience intense, adverse reactions in response to learning about abuse and trauma. Strong, and sometimes competing, emotions, feelings, and psychological responses often emerge, which may alternate with emotional numbing. These include grief, anger, fear, confusion, shame, denial, despair, depression, exhaustion, disgust, a desire to flee, helplessness, powerlessness, shock, dissociation, and other trauma symptoms (Agllias, 2012; Gore & Black, 2009; Jones, 2002; Knight, 2013; Leech & Trotter, 2006; Miller, 2001; Myers, 2008; Shannon et al., 2014a, 2014c). Intense and uncomfortable physiological responses are also common, including nausea, sweating, and muscular tension (Agllias, 2012; Myers, 2008; Shannon et al., 2014a, 2014b, 2014c). Cataloguing an array of students’ responses within reflective journals, Shannon et al. (2014c) have described these as “an assault on the senses”, and they describe “numbness in the face and body, feeling a knot in the stomach or throat … chest tightness, clenching teeth, holding breath … rapid heart rate, physical pain and discomfort, feeling sick, skin crawling” as common responses (p. 686). Students’ worldviews and beliefs about others may be shattered, disorganised, and re-organised by information about the prevalence of CSA, the degree of intra-familial CSA, and the realisation that anyone may be a perpetrator. This grief and shock process involved in the loss of assumptive worldviews (Cunningham, 2003, 2004; Janoff-Bulman, 1992) can be greater for students relatively free of childhood adverse experiences (Agllias, 2012). As a result, students may have problems sleeping, and use alcohol, drugs, or food to cope (Agllias, 2012; Didham et al., 2011; Kawam, 2014; Shannon et al., 2014). In essence, students often show evidence of VT, not through contact with clients, but merely through exposure to information and traumatic material via lectures, articles, texts, videos, and websites. Carello and Butler (2015) have noted “the emotional toxicity of some experiences, even simply in their description, cannot be overstated, nor can the minimal exposure conditions under which vicarious trauma can develop” (p. 269). Similarly, Knight (2013) recounted students’ continued intrusive re-experiencing and distress, related to traumatic case material presented months earlier within a guest lecture on indirect trauma.

The idea that indirect trauma may not always require cumulative exposure has implications for the construct of VT, and other similar constructs discussed in Chapter Two. Knight (2013) considers the term indirect trauma to be more inclusive and appropriate, however, many other authors describe students’ adverse reactions in class as VT (Agllias, 2012; Carello & Butler, 2015; Cunningham, 2004; Dane, 2002). Following the majority, I use the term VT within the rest of this chapter to refer to students’ immediate and more cumulative reactions to trauma material presented in class. While I also use the terms triggering and re-
traumatisation to refer to students who are distressed because of their own trauma histories, this differentiation can only be clear if students disclose this information. Thus, if students do not disclose the negative impact of their own personal history, their distress may be perceived as VT reactions. Equally, as discussed in Chapter Two, professionals with trauma histories may experience VT. For example, students with histories of abuse may, like any other student, experience strong emotions and intrusive imagery related to traumatic material discussed in class, rather than re-experiencing their own abuse. What is clear from the literature on VT, and its application to students’ reactions to trauma material, is that such reactions are normal and expected. These responses reflect the capacity for empathy, and while they are the cost of caring about the pain of others, they can be mitigated through a variety of strategies. However, the prevalence of CSA and other abuse among social work students suggests that educators “should formally assist students in recognising significant previous trauma” that is “not resolved” (Didham, 2011, p. 533). This requires educators to have an understanding of trauma, and ideally to apply trauma-informed principles in responding to students (Kawam, 2014).

**Challenges of teaching reflective practice**

Although the concept of reflective practice is a key component in social work education, concerns have been raised about qualifying social workers’ ability to achieve critical reflection in increasingly procedure-driven and competence-based agency cultures (Adamson, 2006; Beddoe, 2009, 2010; Munro, 2010; Wilson & Kelly, 2010). There appears to be a lack of clarity regarding the definition of reflective practice, inconsistent implementation in, and across academic and fieldwork settings (Wilson, 2011), and insufficient specific instruction on developing reflexivity (Shier & Graham, 2011). Many have lamented the decline of psychodynamic principles within social work education, suggesting that the relational and intersubjective focus of contemporary psychodynamic theory needs to be reclaimed for relationship-based practice, supervision, and the reflective use of self (Applegate, 2004; Brandell, 2002; Goldstein, 2007; Howe, 2014; Megele, 2015; Mishna, Van Wert, & Asakura, 2013; Rasmussen & Mishna, 2003; Ruch, 2000, 2002, 2005, 2007, 2010, 2012; Ruch, Turney, & Ward, 2010; Sudberry, 2002; Trevithick, 2003; Urdang, 2010). In Urdang’s (2010) view, transference and countertransference are “indispensable in developing self-awareness” (p. 531). In addition, she suggests that “learning psychodynamic theories can enable students to navigate a whirlpool of complex client personalities, affects, defences, relationships, and behaviours”, as well as assisting students to “become comfortable tolerating affects and utilising them constructively” (p. 531). Reflexivity, informed by psychodynamic theory, provides a means to address and
resolve individual and collective anxieties, rather than defend against them. As Gursansky, Quinn and Le Sueur (2010) note:

The centre of reflection seems to be a positive embracing of the doubts, anxieties, uncertainties and contradictions which are an integral part of the human condition and … it is the effort to make sense of these and use them for constructive change (for the self and others) that requires reflection. (p. 779)

Several authors have pointed to the academic classroom barriers to students’ reflective learning and practice, when the affective component of learning is ignored or avoided (Barlow & Hall, 2007; Mishna & Bogo, 2007; Sullivan & Johns, 2002). Despite the fact that experiential learning theory is an intrinsic part of social work education, Barlow and Hall (2007) have observed that “affective support for transformation of experience into knowledge is seldom on the classroom agenda, which stresses cognitive and skill development” (p. 399). Some surmise that educators’ lack of comfort and skills in working with process issues, and fear that student safety will be compromised, may lead to the emotional climate of the classroom being suppressed (Grant, Kinman, & Alexander, 2014; Grant, Kinman, & Baker, 2013; Light & Cox, 2001; Mishna & Bogo, 2007). However, Abrams and Shapiro (2014) suggest that “social work faculty may bring a well-honed skill set”, since “basic social work skills include attentive listening, sensitivity to group process and managing uncertainty” (p. 416).

Social work pedagogy often focuses on the concept of a safe space for classroom interaction, although its definition has been unclear (Holley & Steiner, 2005; Ixer, 2010). Several authors contend that the unrealistic focus on classroom safety, as a static feature, creates false expectations and potential suppression. Truly encountering and dialoguing about oppression, abuse, trauma, and diversity is likely to elicit conflict, discomfort, anxiety, shame, anger, defensiveness, and grief (Boostrum, 1998; Mishna & Bogo, 2007; Mishna & Rasmussen, 2001). Some have instead promoted a “pedagogy of discomfort”, which invites students to “leave the familiar shores of learned beliefs and habits, and swim further out into the ‘foreign’ and risky depths of the sea of ethical and moral differences” (Boler, 1999, p. 181). Redmond (2010) argues that a pedagogy of discomfort facilitates true critical reflection, and acknowledges unequal power relations between students, and between educators and students. Critical reflection is considered essential in promoting social justice (Brookfield, 2009; Ruch, 2009; Urdang, 2010), therefore facilitating balance between student safety and discomfort when discussing sensitive issues appears vital.
Concepts such as embodied knowing and embodied practice are slowly emerging within the discourse regarding social work practice, argued as essential but relatively neglected facets of a social work epistemology that privileges cognitive rationality and control (Marlowe & Chinnery, 2011; Peile, 1998; Saleeby, 1992; Tangenberg & Kemp, 2002). As Tangenberg and Kemp (2002) note: “Social workers are routinely involved with clients whose lives are profoundly influenced by traumatic, painful or degrading bodily experiences, such as poverty, violence, addiction, chronic illness or child maltreatment” (p. 9) which regularly elicit a sense of the body “being out of control” (p. 11). Developing reflexivity through embodied practice,\(^{40}\) emotional intelligence,\(^{41}\) and mindfulness,\(^{42}\) promotes wellbeing and resilience (Brown & Ryan, 2003; Chinnery, 2011; Grant et al., 2014; Hick, 2009; Howe, 2008; Morrison, 2007; Shier & Graham, 2011), and facilitates post-traumatic growth (Linley & Joseph, 2004; Wild & Paivio, 2003).

**Using trauma theory to deliver trauma training**

Several authors have drawn upon Herman’s (1997) tri-phasic trauma model when teaching about trauma (Agllias, 2012; Bussey, 2008; Shannon et al., 2014b). However, O’Halloran and O’Halloran (2001) have used this framework to teach about indirect trauma. They emphasise the parallel process involved in working with trauma and abuse, and teaching/learning about trauma and abuse, given the clear similarities between direct trauma, indirect trauma, and re-traumatisation. Other authors have also discussed these parallel processes (Agllias, 2012; Carello & Butler, 2015; Knight, 2013). I therefore present the literature regarding trauma-informed education within Herman’s (1997) three stages of trauma recovery: safety, remembrance and mourning, and reconnection. Establishing safety involves adequate preparation of students, classroom management, and attention to process issues. This stage elicits educators’ dual, and sometimes competing, pastoral and gatekeeping

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40 Embodied practice is located on multiple dimensions: attendance to the lived body of client and social worker within current interactions and past experiences, the body as a vehicle of social, emotional and political expression, the influence of inscribed cultural and socio-political discourses upon the body, and interventions which acknowledge the body as an agent and site of knowledge, meaning-making, healing, individual and collective change, and activism (Cameron & McDermott, 2007; Tangenberg & Kemp, 2002).

41 Emotional intelligence involves four inter-related capacities: “to perceive feelings in oneself and others; to use emotions mindfully to facilitate problem solving and creative thinking; to appreciate the causes and effects of specific emotions and appreciate their complexity; and finally, to manage emotions effectively through reflection and self/other awareness” (Grant et al., 2014, p. 877). See also Goleman (1996, 1998, 2006); Howe (2008); Mayer, Salovey, and Caruso (2008); Sluyter and Salovey (1997).

42 Mindfulness, in its broadest sense, attends to the phenomenology of the here-and-now experience, and gives equal attention to sensory, affective and cognitive modes of understanding and insight (Birnbaum & Birnbaum, 2008; Chinnery & Beddoe, 2011; Lynn, 2010; Siegel, 2007; Wong, 2004).
responsibilities. These tensions may be invoked in managing the welfare of students, and the clients they come into contact with. The stage of remembrance and mourning highlights the cognitive, emotional, and embodied reactions that students often experience in response to their exposure to traumatic material in the classroom. This stage also attends to the content of curricula, as well as pedagogical strategies for delivering content and managing classroom dynamics. Lastly, the stage of reconnection offers possibilities for social justice, advocacy, and abuse prevention, as well as developing trauma-informed organisations.

**Safety**

By introducing the concepts of VT, re-traumatisation and self-care at the outset of trauma and abuse courses, educators argue that a framework is established to acknowledge students who are survivors, and validate and normalise students’ emotional and embodied reactions to learning about abuse and trauma (Aglllias, 2012; Breckenridge & James, 2009; Cunningham, 2004; Knight, 1999; Shannon et al., 2014a, 2014b, 2014c). All students are at risk of engaging in avoidant behaviours and responses to negative emotions, such as skipping classes, minimising psychological and social effects of CSA, denying the extent of the problem, detaching from the issue and involvement in the class, and dissociating (Alpert & Paulson, 1990; Cunningham, 2004; Humphrey, 2007; Jones, 2002,; Leech & Trotter, 2006; Miller, 1999; Shannon et al., 2014c). Addressing and normalising negative affect provides learning opportunities for students to tune into, tolerate, express, and manage difficult emotions, increasing emotional intelligence, embodied awareness, and resilience. Courtois and Gold (2009) argue that “trauma and its impact” can only be truly understood at this “experiential level”, which inevitably requires a “personal transformation” (p. 17). Strategies that de-stigmatise, normalise, and manage the negative impacts on students include self-care plans (Agllias, 2012; Bussey, 2008), providing information about resources on and off campus (Cunningham, 2004; Jones, 2002, McCammon, 1995), and framing counselling and other support as healthy, normal, and professional self-care decisions (Didham et al., 2011; Sudberry, 2002).

Bussey (2008) also notes that educators may themselves be triggered, and others have highlighted the risks of VT for educators and the need for self-care (Kawam, 2014; O’Halloran & O’Halloran, 2001). Lessons in relaxation, grounding, and mindfulness not only help manage VT and re-traumatisation (Shannon et al., 2014b), but this experiential learning translates into useful skills to teach clients. Thus, the classroom provides a vital safe space for students to explore intense emotions, and learn to manage traumatic stress before working with clients.
Collaboratively discussing and creating a supportive classroom culture provides an opportunity for students to embody social justice principles, practice social work skills, attend to group affect, and respond to other’s distress (Agllias, 2012). The possibility that a student may publicly disclose a personal history of abuse suggests that this should also be a consideration within ground rules. Agllias (2012) asked students to brainstorm “the positive and negative aspects of self-disclosure” and “possible alternatives”, but did not address ground rules for possible disclosure (p. 266). Given that some student survivors may over-identify with their own issues, and personalise material presented, there is always the possibility of self-disclosure (McCammon, 1995; Miller, 1999; Jones, 2002). This may lead to poor responses from fellow students, both in and out of class (Miller, 2001; Cunningham, 2004). It is also possible that the training may elicit sensations and images of abusive experiences previously unrecalled (Barter, 1997; Gilin & Kaufman, 2015; Miller, 1999; Shannon et al., 2014). In addition, increased awareness regarding what constitutes abuse, and the dynamics involved, may lead to “shocking realisations” regarding “previously unnamed or unrecognised violence” (Agllias, 2012, p. 266).

Remembrance and mourning

The vast range of emotional, psychological, and embodied responses to learning about trauma have already been covered. This learning involves grief because it evokes loss of previously held worldviews for those with little experience of abuse and trauma, and reminds or assists survivors to recognise the losses associated with their own abuse. Herman’s (1997) trauma recovery model is cyclical rather than linear, and safety remains a constant consideration. In her model, the needs and responses of the client, or in this case, student, determine the level of focus on safety throughout all three stages. However, several educators discuss the need to clarify the boundaries between therapeutic and academic settings, and the limitations of the educators’ role (Agllias, 2012; Barter, 1997; Black, 2006; O’Halloran & O’Halloran, 2001). This has led to some debate about the usefulness of small groups for processing emotions, discussing sensitive issues, and debriefing. Some advocate the use of small groups for these purposes (Bussey, 2008; Jones, 2002), while others are concerned that such forums may cross into therapeutic territory (Agllias, 2012; Black, 2008).
Most educators have focused on a curriculum for teaching about trauma, including a range of abuse, rather than specifically focusing on CSA. As well as teaching about VT, vicarious resilience, and self-care, trauma curricula often include the neurobiology of trauma, different types of trauma at individual and community levels, the manifestations of simple and complex trauma, and learning how to take a trauma history, and assess for trauma symptoms (Breckenridge & James, 2009; Bussey, 2008; Shannon et al., 2014). Some consider the concepts of transference and countertransference essential in promoting reflective practice and managing VT (Carello & Butler, 2015; Courtois & Gold, 2009; Didham et al., 2011).

A smaller number of authors have focused on CSA training. In Kenny and Abreu’s (2015) view, training regarding CSA needs to occur within social work education, as well as in-service training and continuing education. Topics suggested include definition, prevalence, symptoms, developmental impacts, assessment, dynamics of CSA and grooming, offenders, gender issues, blaming the victim and/or non-offending mother, values and beliefs, gender issues and sex-role stereotypes, and self-care and VT. Several other authors have argued that social work curricula need to include significant teaching about sexual abuse perpetrators (Grady & Abramson, 2011; Hirst & Cox, 1996; Lancaster, 1997; Lowe & Bohon, 2008; Myers, 2008). In addition, Miller (1999) has recommended that teaching about CSA should include Finkelhor and Browne’s (1985) traumagenic dynamics, complex trauma, and dissociation.

As several authors note, the degree and pace of exposure to traumatic content involves a delicate dynamic between exploration and containment (Agllias, 2012; Black, 2006). This requires being attentive to the level of affect in the classroom (Cunningham, 2004; Miller, 1999). Titrating traumatic content prevents students becoming emotionally overwhelmed, and is a parallel process to professionals pacing their work to prevent VT (Agllias, 2012). It also mirrors the pacing of clients’ exposure to their own traumatic material. Pacing involves considering the traumatic content of the material, and the way it is delivered. The latter include role plays, guest speakers, DVDs, and agency visits. Nevertheless, Agllias (2012) argues that students should not be “overly protected from the reality of trauma work” (p. 265).

Several educators have highlighted the need for students to have some level of choice and control over their exposure to traumatic material. They highlight the importance of preparing students in advance regarding course material (Adamson, 2006; Barter, 1997; Carello & Butler, 2015; McCammon, 1995; Miller, 1999). Some educators suggest that it is acceptable for students to miss lectures/presentations/videos, if they feel it will unduly trigger them (Agllias, 2012; Black, 2006; Carello & Butler, 2015; Cunningham, 2004; Jones, 2002;
McCammon, 1995). While choice and control are important aspects for survivors of trauma (Herman, 1997), there are gatekeeping implications. Agllias (2012) assured students that choices to refrain from attending or participating in lectures would not “affect their academic success” (p. 271). Similarly, Carello and Butler (2015) have reassured students that “it is okay to tune out or leave the room briefly” and that this may indicate “self-protection rather than … resistance, or … lack of preparation” (p. 270). In contrast, Barter (1997) believes educators need to “be vigilant to spot the students who struggle emotionally” and follow up with such students (p. 122). In retrospect, Aglias (2012) acknowledged that students identified negative repercussions for leaving a class or not attending, and suggested that screening of students prior to such courses may be needed.

McCammon (1995) has suggested that educators should display comfort and openness regarding sensitive material. While Cunningham (2004) agrees that modelling some level of comfort through body language, tone of voice, and facial expressions is important, she notes that too much detachment insufficiently prepares students for the emotional impact, and may be emotionally inhibiting and invalidating. Courtois and Gold (2009) discuss the need for educators to “model humanness” and “acknowledge their own struggles” with countertransference and vicarious trauma (p. 17). Similarly, Carello and Butler (2015) suggest that “discussion of one’s own strong reactions can model self-reflection” (p. 271). Ultimately, these issues suggest the need for educators’ emotions to be regulated, yet authentic. Excessive or minimal displays of emotion “mirror the flooding and avoidance symptoms associated with traumatic stress and both styles pose risks for the listeners” (Cunningham, 2004, p. 310).

Several authors recommend, or have effectively utilised reflective journals for students. These provide a tool to assist students to attend to and process emotions, record self-care strategies, integrate own trauma histories with learning, and recognise positive responses and growth over time (Gilin & Kaufman, 2015; Leech & Trotter, 2006; Shannon et al., 2014a, 2014b, 2014c). Concerns have been raised that reflective journals treated as part of the assessment may inhibit self-exposure and the expression of feelings, because of the need to present as competent (Boud & Walker, 1998; Taylor, 2006). However, in assessed journals, students’ entries were extremely candid (Shannon et al., 2014a, 2014c). On the other hand, failing to include reflective journals in the assessment process may result in low rates of completion (Wilson, 2011). Leech and Trotter (2006) appeared to overcome this by getting students to complete non-assessed journals in class time, and, at the same time, completing their own journals.
Reconnection

Several educators discuss the importance of equipping students to use their knowledge of trauma and abuse to increase social, political, and organisational consciousness, advocate for survivors, and work in ways that promote social justice (Agllias, 2012; Breckenridge & James, 2009; O’Halloran & O’Halloran, 2001; Marlowe & Adamson, 2011; Shannon et al., 2014). Drawing on a human rights framework, Breckenridge and James (2009) focus on “how people’s positioning in relation to power and resources impacts on their vulnerability to traumatic events” (p. 261). Similarly, Adamson (2006) suggests utilising a person-in-environment or ecological framework to counter tendencies to individualise traumatic experience. For Shannon et al. (2014c), “grounding teaching … in social constructivist and critical race theories” is essential in highlighting the “complex interaction of processes and contexts that give rise to the oppressive conditions associated with trauma in marginalized groups” (p. 690). Furthermore, Lancaster (1997) has pointed out that learning about CSA perpetrators provides a fertile ground for truly implementing anti-oppressive practice. Clearly, there is considerable potential for graduates to draw on their knowledge of abuse and trauma to promote the welfare of clients, workplaces, and communities.

Addressing CSA in NZ social work education

In NZ, two different quality assurance bodies approve and moderate tertiary education programmes, and the qualifications are then listed on the NZ Qualifications Framework (NZQF). For universities, this body is Universities NZ (UNZ),43 while all other tertiary education organisations (TEO) are overseen by the NZ Qualifications Authority (NZQA),44

43 UNZ was previously called the New Zealand Vice-Chancellors’ Committee (NZVCC). UNZ has set up the Committee on University Academic Programmes (CUAP) which has representation from all eight universities in NZ. CUAP acts for UNZ “as the body” which NZQA will “consult about policies and criteria for the approval of courses of study and their accreditation in the universities” (UNZ, 2015, p.11). Furthermore, UNZ set up the Academic Quality Agency (AQA) to regularly audit universities. Proposals to substantially change programmes or create new programmes go through an internal approval process, and are then subjected to a ten week online peer review process with academics from all other universities able to make suggestions, and query or challenge decisions. The CUAP only becomes involved when resolution about the programme cannot be resolved through peer review, and has the final binding decision. Comments and responses from the peer review process are made available to the CUAP three weeks before their meeting (UNZ, 2016).

44 NZQA (2016) states that “degree programmes (at level 7-10 on the NZQF) are approved if they have appropriate learning outcomes and content, delivery methods, equipment, facilities, staff, regulations, assessment and moderation” (p. 24). After degrees are approved “NZQA appoints an independent monitor for the degree. The monitor visits the TEO annually to check if the degree is being delivered as approved and reports back to NZQA. NZQA follows up any recommendations from the
which also administers the NZQF. Both quality assurance bodies rely largely on education providers’ self-assessment, and expect adequate stakeholder and student consultation, regular monitoring, and reviews regarding the currency and efficacy of programmes. However, educational institutions have considerable latitude regarding what they teach, particularly the specifics of papers (NZQA, 2016; UNZ, 2015). In addition, occupations requiring compulsory registration to practice, such as law, medicine, teaching, and engineering, have greater input into educational institutions’ programme development (UNZ, 2015). Social work registration in NZ, which is not mandatory, involves an approved qualification and annual demonstration of ability to fulfil a number of core competencies or practice standards, set out by the Social Work Registration Board (SWRB) or Aoteoroa New Zealand Association of Social Workers (ANZASW). These practice standards are broad and generic with no reference to abuse or trauma (ANZASW, 2014; SWRB, 2014). Conversely, in the UK, Australia, and the US, practice standards and competencies make varying degrees of acknowledgement that abuse and trauma issues are social work practice considerations.

The NZQA provides 14 comprehensive unit standards for undergraduate social work training in abuse, neglect, and violence. These education standards require knowledge and skills to identify, assess for, and respond to abuse, awareness of abuse-related myths, and knowledge of relevant service providers in the community, as well as the gaps in services (NZQA, 1998b, 1998d, 1998e). In addition, there are unit standards that analyse the impact of abuse on human development across the lifespan, examine the historical and contemporary contexts for abuse to occur, identify traumatic and intergenerational impacts, and risks of re-victimisation (NZQA, 1998a, 1998b, 1998c). At level seven, three units attend to counselling
victims and perpetrators of abuse (NZQA, 1998f, 1998g, 1998h). There is also the requirement to engage with these topics in a deeply personal and subjective way. Elements within the unit standard for safe practice include the capacity to “demonstrate knowledge of … own experiences, attributes, values and beliefs related to abuse”, to specifically describe “personal experiences related to abuse”, the “impact” of these experiences, and “healing from abuse” (NZQA, 1998d, pp. 5-6). In doing so, students may uncover unresolved trauma, and/or become more aware of the influence of dominant discourses and stereotypes upon their beliefs. The extent to which these unit standards or similar papers are effectively implemented in social work degree programmes in NZ does not appear to have been researched. Between 2012 and 2016, 110 social work students completed the unit standard regarding undertaking assessments in abuse, neglect, and violence, with the vast majority, (90 students), doing so over 2015-2016. None of the other unit standards that I have discussed were completed by any social work student over this period (personal communication, V. Fergusson, NZQA, 7/2/17). Over two decades ago, Ward et al. (1996) noted that the social work programme at Canterbury University devoted very little time to CSA education. There is clearly a need for research to ascertain how the issue of CSA is perceived and understood among social workers and educators, and how CSA is addressed within social work practice and education. This research attempts to fill this gap.

**Conclusion**

This chapter has revealed that a history of CSA is a risk factor for developing mental health and addiction problems, and that CSA histories are highly prevalent among clients presenting to such services. In addition, these clients may have experienced multiple traumas and adverse experiences across the lifespan. It builds on the discussion in Chapter Two regarding the intergenerational impacts of CSA. The neurobiological effects of trauma on developing brains, coupled with physiological responses to overwhelming threat and betrayal, have ripple effects across the lifespan, negatively impacting mental/physical, social functioning.

From a social work perspective, mental health problems move into the realm of social justice and consciousness-raising when a trauma-informed lens is applied. Not only does such an approach loosen the yoke of biological determinism, it empowers clients to take control of trauma triggers that exacerbate their mental health problems. Survivors of CSA can find their voice and break vicious cycles, when the historical abuse of children is perceived as a central and relevant issue, not only for mental health policy and services, but also for wider society.
Poor mental health, often concomitant with poor physical health, is likely to adversely impact earning ability, and therefore socio-economic status. Given the ubiquity of mental health problems in the community, the high rates of CSA and other trauma in community and clinical populations, and people’s aversion to entering the mental health system, there are clear implications for social work practice and education.

This chapter has also revealed a high prevalence of trauma histories, such as CSA, among social work students, which emerge as a significant motivation for social work training. Clearly, there are emotional costs in addressing CSA in practice and education, potentially evoking countertransference and VT, and shattering assumptions about self, world, and others. Not only may students and social workers be impacted emotionally by CSA, but as the literature on professional attitudes reveals, they may be influenced by a range of dominant discourses and stereotypes, particularly with limited knowledge.

The tendency for academia to privilege content over process marginalises the emotional realm of social work education. When affect is not addressed in the classroom, particularly when engaging with sensitive issues, learning outcomes may be diminished. While there is a universal expectation for reflexivity among social work programmes, the concept is poorly defined. It is sometimes insufficiently taught, and is difficult to achieve in the context of minimal attention to emotions, and students’ fears of being negatively assessed. Nevertheless, there are some promising developments in social work education. The increasing use of a trauma-informed framework assists students to understand the impact of trauma on clients and themselves. In addition, the literature reveals a proliferating number of strategies and concepts to enhance self-care and self-awareness, and promote safe practice and true critical reflection. These include mindfulness, transference and countertransference, VT and vicarious resilience, embodied practice, emotional intelligence and a pedagogy of discomfort.

This chapter concludes the review of the literature and provides an appropriate point to introduce my research questions. My interest in participants’ affective perceptions regarding CSA emanates from the literature pointing to the emotional costs of addressing CSA in practice and education, and concepts such as VT, countertransference, and social defences. In Chapter Two I drew on psychodynamic and attachment theory, traumagenic dynamics, relational dialectics theory, and the neurobiology of trauma to discuss how an approach/avoidance dialectic may occur for victims/survivors, and for professionals who work with them. A hermeneutic, constructivist lens, along with the literature regarding professional attitudes, influenced my desire to understand the varied sources for participants’ perceptions. Lastly, my
understanding of the trauma-informed literature in relation to social work practice and education informed my research focus on both spheres.

How do social workers and social work educators perceive CSA on cognitive and affective levels, and what educational, professional, and personal sources do they draw on in understanding CSA?

How and to what degree is CSA addressed within their practice or education sphere of work?

What implications do social workers’ and social work educators’ understandings and perceptions of CSA have for social work practice and education?

In the next chapter, I discuss my rationale for the methodology and methods I drew on to inform and guide the research process. In addition, I explore the ethical issues that I anticipated, and that emerged. In a parallel process to the emotional costs of addressing CSA in practice and education, I also give attention to the emotional costs of researching a sensitive issue.
Chapter Four: Methodology and Methods

*Rigour alone is paralytic death, but imagination alone is insanity.* (Gregory Bateson, 1979, p. 215)

**Introduction**

In this chapter, I explore the strengths and limitations of the constructivist paradigm, and introduce the dialectical approach of hermeneutic-phenomenology as a means to address some of them, and to provide a critical lens. I discuss the particular strategies I employed with regard to sampling, data collection, and analysis, and highlight the dynamic nature of ethical decision-making throughout the process of research and writing. Given that ethical considerations are ongoing throughout the research process, I locate the ethics section in the latter portion of this chapter. I also take stock of my role as researcher and my positionality, and discuss the emotional challenges of conducting the research.

I considered that a qualitative approach, which is idiographic and emic, most effectively enabled me to respond to my open-ended research questions regarding a sensitive, and emotionally laden topic. This allowed for in-depth multiple interviews eliciting thick, rich descriptions from small samples of participants. Importantly, Denzin (1989) adds that such descriptions “evoke emotionality and self-feelings” (p. 83). Describing these researcher-participant interactions as inter-views, Kvale and Brinkmann (2009) highlight their inter-subjective, dialogic nature and the role of researcher as instrument. While I had initially considered a constructivist paradigm, it became apparent in the course of undertaking the research that a purely constructivist framework did not do justice to the richness and complexity of the study. Data collection and analysis examined not only participants’ cognitions, but also their affective and therefore somatic responses to engaging with the subject of CSA. Leonard (1994) notes that:

Too often researchers facilely seize on a method without considering the more profoundly important philosophical assumptions that undergird the method, and whether those assumptions are consistent with the researcher’s own view of what it means to be a human being. (p. 440)

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48 Morrow (2005) defines thick descriptions as “detailed rich descriptions, not only of participants’ experiences of phenomena, but also … the multiple layers of culture and context in which the experiences are embedded” (p. 252).
The research methods required further explication of the theoretical and philosophical underpinnings that captured the experiential, existential, dialectic, and dialogic aspects of the interviews, and the meaning they generated. Hermeneutic-phenomenology complemented and extended the original constructivist framework, providing a worldview more consistent with the aims of the research, one which seemed to resonate with Māori and Pacific Island worldviews, as well as my own. These expansions to my methodology led to a change in the title of the research and wording of research questions, moving from “constructions” to “perceptions”.

**Constructivism**

An interpretivist/constructivist paradigm recognises the relational and contextual nature of meaning construction. Such a position acknowledges that every research act, observation, or description is ultimately an act of interpretation. An interpretivist stance challenges the epistemological status of empiricism. Rather than uncovering or discovering a single reality, empiricism actually co-produces multiple realities in the context of a temporal relationship between two or more individuals (Stahl, 2003).

Social constructionism\(^{49}\) encompasses a diverse and sometimes conflicting range of perspectives, often framed along a realist/relativist dichotomy (Cromby & Nightingale, 1999). More radical versions promote a relativist ontology whereby social constructions not only describe but constitute reality. Ultimately, such a position becomes untenable in its slide towards solipsism or even nihilism (Alvesson & Skoldberg, 2009; Nightingale & Cromby, 1999; Stahl, 2003).

The more realist ontological perspective taken in my own research acknowledges a reality independent of human consciousness, including physical laws such as gravity and magnetism, and the materiality and corporeality of existence. In this view, the perception of reality is contingent upon the consciousness of the perceiver, and thus reality can only ever be

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\(^{49}\) I use the terms “constructivism” and “social constructionism” in this chapter to foreground their similarities and inter-relatedness rather than their differences. While acknowledging that both involve meaning-making processes, McNamee (2004) has commented that constructivism focuses on “internal, cognitive processes of individuals” whereas social constructionism has a focus “on discourse or the joint (social) activities that transpire between people” (p. 37). In a sense they are chicken versus egg arguments, constructivism privileges the individual internal world, while social constructionism privileges the social and relational realm. The focus on inter-subjectivity within contemporary psychodynamic theory highlights the interdependence of individual and societal constructions of meaning, rendering such arguments obsolete (Mitchell, 1988, 2000; Stolorow & Atwood, 1992, 1996; Stolorow, Atwood, & Branchaft, 1994; Wachtel, 2008, 2014).
partially and imperfectly apprehended. This leads to a moderate rather than extreme relativist epistemology, having some points of similarity with a critical realist position (Houston, 2001, 2005, 2010). Knowledge of reality is therefore postulated as multi-faceted, contextual, transitive, and inter-subjective.

While some discursive practices have brought underlying social structures into awareness, they have in the process made the body, emotions, and the environment largely invisible (Cromby & Nightingale, 1999). For example, the social constructions of CSA and childhood often appear to neglect corporeal and emotional dimensions. Social constructionism’s lack of attention to embodiment, emotions, materiality, and power has been widely critiqued (Butt, 1999; Cromby & Nightingale, 1999; Freund, 1990; Houston, 2001; Nightingale & Cromby, 1999, 2002; Willig, 1999). Perhaps the growing focus on relativism and discourse in the social sciences has led to privileging the abstract at the expense of the concrete. Yet “discourse is always situated in the material world, it is always already the product of embodied beings” (Cromby & Nightingale, 1999, p. 9).

Cromby and Nightingale (1999) go as far to suggest that power cannot be fully addressed without attending to embodiment, materiality, psycho-social history, and subjectivity. One can perceive the sense of this assertion in analysing power dynamics of CSA. Power can be asserted bodily by virtue of physical strength and size, it can be asserted materially by rewards or punishment, and it can be asserted socially through age difference, status, authority, and the exploitation of relationships. The more subtle uses of power in CSA increase a sense of complicity and impair claims of victimhood (Briere, 1989; Holmes, Offen, & Waller, 1997).

**Hermeneutic-phenomenology**

Many of the concerns regarding social constructionism are addressed, and to a large extent, resolved by hermeneutic-phenomenology. Social constructionism has a need to return to its phenomenological roots to find a balance between the abstract and the concrete, discourse and materiality, and realism and relativism. The work of Heidegger, Gadamer, and Merleau-

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50 Social constructionist and post-modern theories were initially influenced by phenomenology. For example, Berger and Luckmann (1966) drew strongly on phenomenological theory to develop their ideas regarding social constructions (Alvesson & Skoldberg, 2009). Likewise Foucault (1969), who contributed to our understanding of post-modernism through his ideas regarding the power of discourse to influence thought and behaviour, was a student of Merleau-Ponty (1962), whose focus on embodiment highlighted the dialectic of self and other.
Ponty are drawn upon below to discuss the hermeneutic-phenomenological methodology utilised to extend and enrich constructivist theory.

**Heidegger**

Heidegger (1962), originally a student and proponent of Husserl’s (1989) transcendental phenomenology, perceived several limitations to his work: a) the failure to situate phenomena in context, b) the impossibility of phenomenological bracketing or reduction whereby preconceptions are set aside, c) the emphasis on description rather than interpretation. Consequently, Heidegger integrated hermeneutics, or the interpretation of texts with phenomenology to provide a methodology that rejected the subject/object divide. Heidegger’s ontological focus on Dasein or “being-in-the world” departed from Husserl’s epistemological focus on the relationship between knower and object of study. For Heidegger (1962), being-in-the-world represented the experience of person and world co-constituting each other, and lived experience was essentially an interpretive process between self and other. “So far as Dasein is at all, it has being-with-one-another as it’s kind of being” (Heidegger, 1962, p. 155). The notion of Dasein is similar to Māori worldviews where aspects of the environment are internalised and fused with self (Rossouw, 2008). For Māori, “people are the land and the land is the people” (Durie, 2004, p. 1139).

Hermeneutics provided Heidegger with a means to incorporate temporality, embodiment, and context into phenomenological inquiry, which acknowledged the developmental and cumulative effects of historical and socio-cultural meanings on individuals and society. Hermeneutical analysis also provided Heidegger with a means to privilege language. As Dreyfus (1991) noted “For Heidegger, a vocabulary, or the kinds of metaphors one uses can name things into being and change the sensibility of an age” (p. 274).

Much of one’s socio-cultural history is beyond one’s control, and Heidegger (1962) used the term “thrownness” to describe the way individuals are thrown into familial, cultural, linguistic, and historical worlds. No one is able to choose their parents or the colour of their skin, or the environment into which they will be born. The idea of “thrownness” has particular relevance for CSA, especially when a child’s perpetrator is a family member. However human existence allows for the possibility for Dasein “to be itself or not itself” (Heidegger, 1962, p. 3), and authenticity is achieved by taking responsibility for one’s being. Heidegger (1962) believed that individuals often relinquish responsibility by giving others power to decide “who and how one should be” (p. 14). This inclination is exacerbated by what Heidegger described as
“distantiality” or the tendency to “constantly take measure of the way we differ from the normal, average, ordinary ways of being” (Dreyfus, 1991, p. 56). The concept of distantiality resonates with Goffman’s (1959, 1963) ideas regarding stigma and impression management, and Cooley’s (1929) notion of the “looking glass self”, discussed in Chapter Two. The notion of distantiality is therefore also relevant to victims and perpetrators of CSA. Although Heidegger (1962) accepted the benefits of conformity in creating an organised society, he was aware of its potential for limiting authenticity and self-assertion. As Dreyfus (1991) notes, “our distantiality tends to level down our practices, understandings and expectations to the ‘average’ – that is to something comprehensible and acceptable to the great mass of our fellows” (p. 56).

Heidegger (1962) discussed the primordial concealedness or hidden nature of being-in-the-world which hindered the uncovering of ultimate truth. However, Dasein also has the potential to be a “clearing” or space for other beings to reveal and disclose themselves. Human beings’ tendency to take things at face value, and to “cling to what is readily available” can result in disclosures being misinterpreted and closed down (Heidegger, 1977, p. 136). The clearing allows beings “to be more and other than what they have so far shown themselves to be” (Bontekoe, 2000, p. 85). This notion of a clearing has implications for the disclosure of CSA and points to the importance of the receptivity of the listener.

Rejecting the notion of bracketing of personal assumptions and preconceptions, Heidegger (1962) maintained that self and experience were inextricably intertwined. For Heidegger (1962), “an interpretation is never a presuppositionless apprehending of something presented to us” but always “grounded in something we have in advance – in a fore-having” (p. 191). Therefore complete objectivity becomes impossible, as elegantly explained by Horn (1998): “The assumptions, biases and a priori knowledge of the researcher cannot be bracketed, since the ontological status of the observer influences the resulting epistemology” (p. 608).

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51 When I came to read about Heidegger’s extensive connections with the Nazi party I felt dismayed and disappointed. I struggled with understanding the disconnect between Heidegger’s philosophy and his own morality and values. Gadamer, a student of Heidegger at Freiberg, also continued teaching throughout the Third Reich, being promoted to posts taken from Jewish academics (Shalin, 2010). Perhaps they had fallen prey to the concept of distantiality, conforming to, and absorbing “the nation’s mood and its regnant prejudices” (Shalin, 2010, p. 18).
Gadamer

Gadamer (1989) concurred with Heidegger that prejudice or bias was an unavoidable condition of knowledge, since understanding and interpretation are always influenced by the cumulative effect of past experience. Dispensing with the pejorative use of the word prejudice, Gadamer (1989) instead argued that “if we want to do justice to man’s finite, historical mode of being, it is necessary to fundamentally rehabilitate the concept of prejudice and acknowledge the fact that there are legitimate prejudices” (p. 277). Fore-understandings or prejudices therefore become potential allies in interpretation by making them explicit, and examining them in terms of their origin and validity in the light of the analysis (Bontekoe, 2000).

For Gadamer (1989), an individual’s consciousness was viewed as a horizon, encompassing the outer limits of a person’s cultural and historical experiences. Borrowing from Husserl, Gadamer (1989) used the metaphor of horizon to discuss the dynamic interplay between experience and interpretation: “Applying this to the thinking mind, we speak of narrowness of horizon, the possible expansion of horizon, the opening up of new horizons and so forth” (p. 302). Interpretation occurs by a fusion of horizons. The testing of the researcher’s prejudices creates a dialogue between the particularities of the researcher’s and participant’s horizons, promoting reconciliation to a higher universality of understanding (Bontekoe, 2000; Gadamer, 1989).

Horizons are never static entities but dynamic and constantly changing. Prejudices and traditions from the past inform the present, and are continually being modified in the light of present experience (Gadamer, 1989). A hermeneutic circle is therefore constantly operating within each person’s horizon, whereby familial and cultural traditions are re-examined in the light of new experience. This has important implications for acculturation. Gadamer (1989) suggested that ‘tradition is not a permanent precondition; rather, we produce ourselves in as much as we understand and participate in the evolution of tradition, and hence further determine it” (p. 293).

Merleau-Ponty

Like Heidegger and Gadamer, Merleau-Ponty (1962) also highlighted the role of language and inter-subjectivity in understanding human experience, but it is argued that his attendance to embodiment transcended and deepened their work. For Merleau-Ponty (1962), embodiment mediates between the world and consciousness, therefore subjectivity is always an
embodied experience, actualised in four inter-related life-worlds: space, time, body, and human relations. The universality of embodiment is often taken for granted in daily life and in research (Butt, 1999; Denham & Onwuegbuzie, 2013; Sandelowski, 2002; van Manen, 1997). However, an awareness of corporeal subjectivity in research contributes to understanding by highlighting embodied relationships, and implicit emotional and non-verbal dimensions.

Merleau-Ponty (1962) emphasised the “gestural or existential significance to speech” which encompasses both its expression and reception, and produces the ability to go beyond the words expressed (p. 225). Our body is the vehicle to both experiencing and communicating with the world. The body as “expressive space” (Merleau-Ponty, 1962) opens the door to considering non-verbal, enacted, gestural, and somaticised revelations of CSA (McLane, 1996; Young, 1992). In addition, Merleau-Ponty (1962) drew upon psychoanalytic concepts, such as the way in which experiences and things are “internally taken up by us”, to explicate phenomenological perspectives (p. 381). However, he acknowledged a somatic rather than purely cognitive aspect to internalisation noting “my body is the fabric into which all objects are interwoven” (Merleau-Ponty, 1962, p. 273). This idea of inter-corporeality signifies the indivisibility of embodied and relational experience, and the way in which interpersonal trauma such as CSA may be inscribed on and within the body (Johnson, 2009; Kirkengden, 2001).

In relation to sexuality, Merleau-Ponty (1962) attempted to reconcile Cartesian dualism by stating that “the significance of psychoanalysis is less to make psychology biological than to discover a dialectical process in functions thought of as ‘purely bodily’, and to reintegrate sexuality into the human being” (p. 182). For Merleau-Ponty (1962), sexuality did not just reside in the genitals and breasts, but in one’s relationship to the world expressed through the whole of the body. By locating sexuality as a central, existential feature of human life, his ideas broaden the potential impact of CSA to include a range of cognitive, emotional, and physical manifestations that may not always be directly related to sexual matters.

Merleau-Ponty’s (1962) focus on the body therefore transcends both Cartesian subject-object dualism and the realism/idealism debate by revealing the inter-penetrating relationship between the body and the world, mediated by intentionality, memory, and temporality. “Each present can take on its reality only by excluding the simultaneous presence of earlier and later presents, and thus a sum of things or of presents makes nonsense”, therefore “the ideal of objective thought is both based upon and ruined by temporality” (Merleau-Ponty, 1962, pp. 388-389). It is precisely because our temporal horizons contain the past, present, and future through memory, perception, and intentionality that objectivity becomes impossible.
Having trained as a naturopath 30 years ago, my understanding of the indissoluble unity of body-mind and emotional-physical health, are implicit features of my philosophy of human nature. In addition, as a social worker and counsellor, I naturally pay close attention to the non-verbal realm of communication. The body has been under-theorised in the academic and clinical realms (Sandelowski, 2002; White, 2014), yet all of what we are, do, feel, and experience is mediated by our bodies. Qualitative research privileges subjectivity and therefore the emotional life of participants, but authors have critiqued the narrow focus on the verbal realm (Denham & Onwuegbuzie, 2013; Sandelowski, 2002). As Schore (2003b) has noted “much of the exchange of essential subjective information in human relationships is non-verbal, and includes dynamic changes in facial expression, prosodic tone of voice, touch, gesture, and bodily state” (p. xv). These non-verbal domains of emotional experience, expression, and reception are rapidly processed in the right hemisphere of the brain, and are implicated in implicit forms of learning, perception, and memory (Schore, 2003b, 2012). Intuition or gut feelings about self and others reflect this tacit and embodied form of relational knowing.

In reality, perception is always embodied, involving interoception (awareness of sensations within the body), exteroception (awareness of stimuli outside the body) and proprioception (awareness of the body’s position in space). Emotions are experienced in concert with a range of visceral and musculoskeletal sensations (interoception), and elicited by sensory perception of others and the world (exteroception). This points to the phenomenology of perception, however perception inevitably draws psychodynamic theory into the picture. Experiencing and expressing emotion, as well as the reception and interpretation of others’ emotion sometimes occurs outside conscious awareness, at least initially (Damasio, 2000; Howe, 2012; Porges, 2009, 2011; Schore, 2012). Damasio’s (2000) distinctions suggest there can be limited awareness of interoceptive cues to emotion and the emotions themselves: “a state of emotion, which can be triggered and executed non-consciously; a state of feeling, which can be represented non-consciously; and a state of feeling made conscious, i.e. known to the organism having both emotion and feeling” (p. 37).

As Merleau-Ponty (1962) noted, past experiences and relationships are internalised and woven into our corporeal selves. This view is supported by attachment theory and the research on the neurobiology of trauma discussed in Chapter Two. Hermeneutic phenomenology therefore emphasises the constant interaction of past experiences upon current perception and interpretation, reflected in Gadamer’s (1989) metaphor of horizons, and Heidegger’s (1962) inter-subjective notion of being-in-the-world.
Embodiment is a central consideration within my methodology and methods as means of enhancing my reflexivity and empathy. My embodied and emotional responses and/or those of participants’ alerted me to pay attention to what was being said (Shaw, 2011; Walsh, 1995), and increased insight into participants’ verbal responses (Denham & Onwuegbuzie, 2013; Sandelowski, 2002). It also helped me to be more aware of my influence on the data collection process (Carroll, 2012). Lastly, my body revealed to me the toll of conducting sensitive research. These issues will be taken up further in later sections.

**Implications for my own critical research**

Critical theory highlights the influence of power and political factors which may lead to certain discourses being privileged over others, yet the field has been divided by debates between human agency and structural/historical determinism (Horn, 1998). Hermeneut-phenomenology takes a balanced position acknowledging that understanding is created through interaction with others, and that the “other”, be it individual or societal, is a central part of self. Human agency may therefore be influenced, but not necessarily determined by social and cultural factors (Gadamer, 1989; Heidegger, 1962).

The “critical turn” in research challenged me to examine the foundations for social constructions, and the factors which allow them to be accepted at one point in time, and to be rejected at another point (Stahl, 2003). Critical theory also examines the psycho-social effects of social constructions (Willig, 1999). In particular, “a Gadmerian dialectic inquiry based within hermeneutics confronts the power exerted by societal narratives interpreting reality” which are ultimately created from “unequal social, political, cultural and gendered relations” (Dybcz & Pyles, 2011, p. 311). Exploring tacit and taken for granted knowledge helped excavate the ‘cultural bedrock’ lying underneath (Sandage, Cook, Hill, Strawn, & Reimer, 2008). The dialogic nature of hermeneutic phenomenological research provides an opportunity for self-interpretation and change: “In this dialogic perspective, the agent can be both critical toward the normative system he was born to and constrained by his embeddedness in it” (Marcel, 2001, p. 14.) Participants often expressed this internal conflict and I also felt it at times. Many took a standpoint in opposition to societal views, yet equally felt the overwhelming force of such views.
Research design

Several authors have attempted to create or revise criteria and methods to ensure the trustworthiness of qualitative research (Cho & Trent, 2006; Creswell, 1998; Creswell & Miller, 2000; Lincoln & Guba, 1985; Morse, Barrett, Mayan, Olson, & Spiers, 2002; Seale, 1999; Whitmore, Chase, & Mandle, 2001). One of the best known set of criteria is that from Guba and Lincoln (1985), who suggested parallel concepts to quantitative notions of internal and external validity, reliability and objectivity. Respectively, these are credibility, transferability, dependability, and confirmability.\(^{52}\) My research design sought to increase credibility through methodological triangulation, that is, multiple in-depth interviews, reflective journals, and a focus group; and data source triangulation through overlapping social worker and educator content.\(^{53}\) By creating thick descriptions of my participants and their views, my methods, research decisions, and journey of reflexivity, I hoped to engender the “phenomenological nod” from the audience. This is another way of describing the concept of transferability, bridging the universal and the particular, so that readers may make connections between this study and their own experience.

I attempted to make reflexive research decisions, use methods reflexively, and privilege methods which enhanced reflexivity, taking into account the epistemological underpinnings of the methodology, and the idiosyncrasies of the study (Armour et al., 2009; Thorne, 2016). Yet this is not a sanitised and unquestioning account of the methods used; I discuss the messiness, dilemmas, and limitations, and the lessons learnt throughout the research process. For example, I believe that my use of a reflective journal and an attitude of “self-critique and self-appraisal” (Koch & Harrington, 1995, p. 883) enhanced my awareness of my impact on the research, and the research’s impact on me. I also valued supervision, conferences, and a peer review group as forums to broaden my horizons. However, I also discuss threats to my reflexivity that emerged in the research.

\(^{52}\) Some have questioned the logic of parallel criteria for such fundamentally different paradigms and accusations of “methodolatry” and “criteriology” have emerged (Chamberlain, 2000; Janesick, 1994; Schwandt, 1996), with Barbour (2001) describing this tick-box approach as “the tail … wagging the dog” (p. 1115). While I do consider Guba and Lincoln’s (1985) concepts to have value, I acknowledge the concerns. I concur with authors who suggest that qualitative methodology must be underpinned by researcher reflexivity in order to ensure authentic, plausible research (Armour, Rivaux, & Bell, 2009; Koch & Harrington, 1998; Morrow, 2005; Sandelowski, 1993; Morse, Barrett, Mayan, Olson, & Spiers, 2002).

\(^{53}\) Several authors argue that the metaphor of the crystal is more apt for qualitative research (Ellingson, 2009; Richardson, 2000; Sandelowski, 1995). This reflects the “infinite variety of shapes, substances, transmutations, multi-dimensionailities and angles of approach” which provides “a deepened, complex, thoroughly partial, understanding of the topic” (Richardson, 2000, p. 934). I retain the more familiar term “triangulation”, while acknowledging its limitations.
Sampling and recruiting

Social workers

The first stage of the research involved recruiting a purposive sample of 11 qualified social workers working in addiction and/or mental health within a DHB. Purposive sampling was necessary in order to obtain maximum variation in age, ethnicity, experience, and job description, as well as a balance of gender. Cultural and gender differences in professionals’ constructions of CSA have been noted (Christopherson, 1998; Ward et al., 1996), and I sought to explore the influence of participants’ demographics upon their perceptions.

I previously worked in the DHB over a decade ago, and had a point of contact with a previous colleague, who circulated the information sheet (see Appendix A) and consent form (see Appendix B) to all qualified social workers, once ethics approval was obtained. Seven social workers chose to participate as a result of receiving the information, and another four were recruited through direct contact with me. I travelled to meet two prospective Māori participants, and following their agreement to participate, another Māori participant was recruited through snowball sampling. Once consent forms were returned, participants were asked to complete a written form regarding demographics (see Appendix C).

As can be seen from Table 4, participants’ demographics reflect considerable diversity with regard to age, ethnicity, qualifications, post-qualifying experience, professional role, time in current position, and previous positions. Their roles at the time of the research included working in mental health, dual diagnosis, a methadone programme, a DBT programme for clients with borderline personality disorder and AOD problems, services for families with a substance-abusing member, and individual work with adult and youth with AOD problems. Unfortunately, there were no qualified social workers of Asian ethnicity, and this represented a significant gap in the research. While one social worker’s ethnicity included Chinese heritage, he identified most strongly with his Samoan heritage, and worked in Pacific Island services.
Table 4: Social worker demographics

<table>
<thead>
<tr>
<th>Demographics</th>
<th>Range or breakdown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>35-62 years</td>
</tr>
<tr>
<td>Gender</td>
<td>Female (6), male (5)</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>Pakeha (6), Māori (3), Pacific Island (1), Mixed ethnicity (1)</td>
</tr>
<tr>
<td>SW qualifications</td>
<td>Dip SW (5), BSW (4), Undergraduate degree in another field and Masters of Applied Social Work (2)</td>
</tr>
<tr>
<td>Location of SW training</td>
<td>Auckland College of Education (5), Unitec (2), Massey University (2), overseas (2)</td>
</tr>
<tr>
<td>Post-qualifying experience</td>
<td>5-26 years</td>
</tr>
<tr>
<td>Other qualifications</td>
<td>Post-graduate counselling diploma (3), counselling as major part of social work degree (2)</td>
</tr>
<tr>
<td>Current positions held</td>
<td>Mental health (2), dual diagnosis adults (1), dual diagnosis youth (2), family services (1), DBT programme/AOD clinician (1), methadone programme (1), AOD clinician (3)</td>
</tr>
<tr>
<td>Time in current position</td>
<td>1-21 years</td>
</tr>
<tr>
<td>Previous positions</td>
<td>Child Youth and Family services (CYFS) (3), Rape Crisis (1), SAFE54(1), other child protection services (2), HIV/AIDS (1), residential substance abuse treatment (2), sexual abuse therapy (1), disabilities (1), elderly (1), mental health (3)55</td>
</tr>
</tbody>
</table>

**Social work educators**

I recruited a second purposive sample of eight social work educators, from the social work departments of seven NZ universities or polytechnics. This occurred by direct email or phone contact with educators and/or heads of departments. An information sheet, consent form, and demographic form were sent to educators, and are included as Appendices D, E and F respectively. Table 5 reflects the considerable diversity of demographics for educators, in terms of age, ethnicity, previous social work positions, current teaching position, and the length of time worked in the position. Educators had previously worked in child protection, mental health, and other fields.

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54 SAFE is a community based treatment service for adolescent and adult CSA perpetrators, now called Safe Network. For further information see http://www.safenetwork.org.nz/professional-services

55 These figures do not add up to 11, as social workers discussed more than one previous position.
health, foster care, and in therapeutic roles with victims and perpetrators of CSA. Their teaching roles at the time of the interviews included part-time tutor, lecturer, senior lecturer, and programme convenor. Four educators held an MSW, two had a PhD, and five educators were undertaking doctoral study at the time of the interviews, though not in the field of CSA.

Table 5: Social work educator demographics

<table>
<thead>
<tr>
<th>Demographics</th>
<th>Range or breakdown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>38-65 years</td>
</tr>
<tr>
<td>Gender</td>
<td>Female (5), male (3)</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>Pakeha (6), Māori (1), Pacific Island (1)</td>
</tr>
<tr>
<td>Undergraduate SW qualifications</td>
<td>Dip SW (3), BSW (3)</td>
</tr>
<tr>
<td>Location of SW training</td>
<td>Massey University (3), University of Otago (2), Canterbury University (2), overseas (1)</td>
</tr>
<tr>
<td>Post-graduate SW qualifications</td>
<td>Post-Grad Dip SW (2), MSW (4), PhD (2)</td>
</tr>
<tr>
<td>Previous SW positions</td>
<td>Child protection (4), mental health (2), foster carer (1), private therapist including CSA survivors (1), therapist CSA perpetrators (1)</td>
</tr>
<tr>
<td>Current position</td>
<td>Part-time tutor (1), lecturer (4), senior lecturer (2), programme convenor and lecturer (1)</td>
</tr>
<tr>
<td>Time in current position</td>
<td>3-16 years</td>
</tr>
</tbody>
</table>

Focus group

I mentioned to all participants the possibility of taking part in a focus group discussion following conclusion of all the interviews. I was aware that over-recruitment of 10%–25% is generally necessary in focus groups because of the likelihood of non-attenders (Raibee, 2004). Invitations had originally been extended to 10 participants; however two social workers and one educator were unable to attend. I also considered diversity when recruiting. Too much heterogeneity within focus groups may interfere with group cohesiveness and functioning, leading to censoring or conformity (Carey, 1999). However, greater heterogeneity is often sought within exploratory groups because of the interest in divergent perspectives (Fern, 2001).
Participants were homogenous in that they had all qualified and practiced as social workers, so I felt this would enhance group functioning. I decided to recruit for heterogeneity with careful consideration to the balance of personalities, ethnicities, gender, and work experience. This attempt at balance was somewhat thwarted by the inevitable difficulties with participant attendance, given busy and sometimes crisis-laden work schedules. The final group comprised four Pakeha, one Pacific Island, and two Māori participants, with two being male and five female. Five were recruited from the original social worker sample and two from the educator sample. Some participants had previously met or worked together, but others had only heard of each other.

Data collection

Social workers

Interview guides were initially piloted with a sample of three MSW students, two Pakeha males and one Pacific Island female, and feedback resulted in some minor alterations. The semi-structured interview guides for social workers were based on themes drawn from the academic literature, the media, and popular culture. They also explored policy/education/practice issues, as well as personal/familial influences that contribute to an understanding of CSA. Social worker participants were interviewed for 60–100 minutes on two separate occasions at the workplace. The first interview focused primarily on victims and the second on perpetrators of CSA, and all interviews were audio-recorded. The two interview guides for social workers are included as Appendices G and H. Areas covered in the first interview included training regarding CSA, self-assessed knowledge, perceptions regarding relevance of CSA to their work, definition, prevalence, the terms victim and survivor, signs of CSA, trauma, disclosure and credibility, how CSA was addressed in current practice, timing of CSA and substance abuse treatment, and emotional reactions and feelings elicited in the interview. I also encouraged participants to complete reflective journals over a period of three to six months, and provided guidelines on completing journals (see Appendix I). In addition, I supplied participants with two vignettes highlighting contested and/or under-recognised issues related to CSA, and a series of questions for them to comment on in the second interview, or write about within their reflective journal (see Appendix J). While I noted that the degree to which participants shared reflective journals was at their discretion, I hoped some entries would provide a further layer of data, or at least facilitate increased reflection during the second interview. For seven social workers, the first interviews occurred in April and May 2011, and the remaining four were interviewed in July or August 2011.
The second interview occurred three months later for the original seven participants, that is, July or August 2011. However, interviews occurred just a week later for the four participants who were recruited at a later point. I asked participants to comment on reflections elicited from the interview, vignettes, or their work, and asked about reflective journals. I let participants know that they could submit journals up to three months after the second interview. However, only two participants completed reflective journals, along with comments regarding vignettes. While social workers have been found to value the opportunity to engage in reflective learning opportunities in the workplace, they often feel constrained by work commitments (Beddoe, 2009). In addition, participants may also have felt vulnerable in submitting private thoughts and emotions. The two journals submitted provided rich, evocative, and deeply moving material. One social worker used the journal as an opportunity to disclose experiences of CSA as a child which had not been discussed in the interview. I found myself sobbing as I read his story written through the eyes of a child. The other journal also explored emotions and thoughts related to personal experiences of CSA and how this affected practice.56

In the second interview I focused primarily on perpetrators. Initially, I asked participants for their views regarding children’s sexuality and sexual knowledge, and the influences of sexualisation, socialisation, and gender. Next, I sought their perceptions regarding sexual offenders/perpetrators; the term paedophile; influences, motivations, and dynamics related to offending; prosecution, conviction, and treatment of offenders; and participants’ emotional and embodied reactions to discussing perpetrators. At the end of the interview, I brought the focus back to victims and attempted to end on a more positive note, seeking perceptions regarding the role of meaning-making.

The interviews were underpinned by social constructionist theory and interpretive phenomenology, seeking to uncover the perspectives and perceptions that social workers had with regard to CSA, as well as the corporeal, material, temporal, and socio-cultural contexts from which they arose (Benner, 1999; Burr, 2003). They also sought to capture participants’ experiences of discussing CSA in the interview, as well as retrospective reflection. The benefit of a semi-structured interview using open-ended questions and probes is the ability to produce a richness and depth of data unavailable through standardised instruments. Its flexibility allows for unanticipated responses, as well as a greater degree of participant control over the process. It is well suited to the discussion of sensitive topics (Rubin & Rubin, 1995). Johnson (2002) also notes that in-depth interviewing is particularly appropriate where:

56 Given that only two social workers completed reflective journals and that the data in the journals were highly personal, I made the decision not to include this data in the findings.
a) “the knowledge sought is often taken for granted and not readily articulated”
b) “the research question involves highly conflicted emotions” and
c) “individuals or groups involved in the same line of activity have complicated,
multiple perspectives on some phenomenon” (p. 105).

While I provided opportunities within interviews for participants to verbalise their
affective and bodily responses to the topic of CSA, I also collected a small amount of non-
verbal data which appeared to signify emotional responses.57 As Morley (1980) has asserted “it
is not simply the substance of the answer which is important, it is also the form of the
expression which constitutes its meaning” (p. 40). Such expressions of emotion regarding
engaging with a sensitive issue such as CSA are to be expected, and reflect participants’
humanity and capacity for empathy. I also attempted to be conscious of my own non-verbal
communication, noticing times when I mirrored the participants with body language or
cathartic laughter. Sometimes when the interview highlighted the depth, complexity, or even
intractability of the problem of CSA, I found myself sighing through a sense of resignation
and/or frustration. At other times my non-verbal communication was evoked by empathy for
the participant’s experience, such as my own eyes filling up with tears at the same time as the
participant’s. These data made an important contribution in understanding the emotion work in
engaging with the topic of CSA.58

Denham and Onwuegbuzie (2013) found that 24% of 299 qualitative research articles
attended to non-verbal data. However, “the degree of discussion varied greatly from a mere
mention to substantive integration and interpretation” (p. 670). Of those articles collecting non-
verbal data, less than 10% addressed the data in the analysis section. Denham and
Onwuegbuzie (2013) suggested several methodological purposes for collecting non-verbal data.
Such data might assist researchers to: “a) corroborate speech narrative … (b) capture
underlying messages … (c) discover nonverbal behaviours that contradict the verbal
communication … (d) broaden the scope of the understanding … and (e) create new directions
based on additional insights” (p. 674). They argue that being able to “justify”, “integrate”, and

57 The information sheet, consent form, and guidelines for the reflective journal highlighted my interest
in participants’ affective responses to CSA, and acknowledged the potential for emotional distress or
tension. Emotional responses manifested as deep intakes of breath, exhalations or sighs, cathartic
laughter (which I define as laughter incongruent with content and used to discharge emotional tension),
tone and speed of voice, facial expressions, tear-filled eyes, and gestures. They were often clustered
around times when participants explored difficult and detailed parts of CSA, such as perpetrator
dynamics, victims’ experiences, or activities that constitute CSA.
58 While it could be said that the meaning of participants’ non-verbal data can only be surmised, we all
constantly interpret non-verbal data at subliminal and conscious levels in daily interactions, including
social work practice and education.
“interpret” non-verbal data significantly increases understanding of participants (p. 682). Yet they also note that there is little academic credence or support given to non-verbal data collection and analysis:

> From the numerous qualitative research textbooks and syllabi that we have examined, we have come to the conclusion that, at least among qualitative researchers from Western nations, the spoken and written word is privileged over nonverbal communication. The questions to be asked here are: Why is this the case? and Is this justified? (Denham & Onwuegbuzie, 2013, p. 689)

**Social work educators**

The second stage of the research involved single semi-structured interviews with social work educators lasting 60–100 minutes. The interview guide (see Appendix K) was developed after initial analysis of the data from social work participants, and piloted on a social work educator, providing useful feedback. Like social workers, social work educators were asked to provide a self-assessment of their knowledge regarding CSA, and to provide views regarding definition and prevalence. The interview then focused on how, and to what degree CSA was addressed within the curriculum. I sought educators’ perceptions about the relevance of CSA for social work, an evaluation of the sufficiency and efficacy of CSA education, how students with personal histories of CSA were identified and responded to, and how educators managed emotion and process issues in the classroom.

These interviews were conducted by Skype video conferencing and were audio-recorded. A truly face-to-face interview was infinitely preferable and did occur for one educator. However, given that participants resided all over NZ, I made a pragmatic decision to conduct these interviews via Skype. Such “pixillated partnerships” provided challenges (Seitz, 2015, p. 1). When temporarily deprived of non-verbal data because of connection problems I realised how much I relied on these cues for conducting interviews and relationship-building. Yet I also found that being deprived of visual cues during an interview by phone increased my perception of prosody. I noted in a reflective memo that the animation in this educator’s voice had led me to yield to his digression which turned out to be an important contribution: “finding the balance between the questions and the side roads. Intuition – being alert to the emotional valence of what’s being said”. I lean towards the notion of face-to-face interviews representing

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59 Skype is a a popular Voice over Internet Protocol (VoIP) technology.
60 All Skype interviews were limited to a view of the upper body at most, and one participant’s skype interview had to be abandoned halfway in favour of a telephone interview because of poor quality. Connection problems with Skype only occasionally affected sound and/or picture quality, however in such cases it was impossible to perceive non-verbal responses.
the “gold standard” of qualitative data collection because of the immediacy in perceiving and conveying non-verbal cues. Nevertheless, I recorded salient visual cues in memos directly after interviews, and auditory cues during transcription. Consent forms and information sheets for educators explicitly addressed my interest in affective responses, and several educators verbalised their own or others’ emotional challenges in engaging with the topic.

Focus group

I facilitated the focus group of seven participants at the workplace of one of the social worker participants and it lasted for 90 minutes. The interview guide was developed from themes arising from the social work and educator interviews in relation to education and practice regarding CSA. It focused on the implications for the future, as well as the current challenges facing social workers, students, and educators. At the beginning of the focus group I provided a handout to participants regarding the purpose of the group, and topics for consideration (see Appendix L). The topics were:

- does CSA represent a core or specialist topic for education?
- what level of preparation and support is needed for students?
- what is appropriate to teach about CSA?
- what are the implications of use of self and reflexivity for CSA education?
- how should CSA material be taught?

The purpose of the focus group was to explore participants’ perceptions regarding the content and process of social work education in the field of CSA. The semi-structured format allowed for discussion of a broad agenda of items while also permitting discussion of related issues, including professional and personal anecdotes. Participants also took opportunities to question each other. They were encouraged to consider and debate the macro issues affecting education, as well as the particular challenges of delivering training in CSA. I verbally summarised comments and perceptions from previous individual social worker and educator interviews related to each main topic, and sometimes particularly salient points were reframed as questions. Participants were also asked to consider how culture, gender, age, power, personal abuse histories, and group dynamics may impact in CSA education. Broadly defined as
exploratory, the focus group included tasks such as “creating new ideas; collecting unique thoughts;” and “identifying needs, expectations and issues” (Fern, 2001, p. 5).

Some debate whether the use of focus groups is appropriate in phenomenological research (Bradbury-Jones, Sambrook, & Irvine, 2009; Webb & Kevern, 2001). The emphasis on participant interaction within focus groups is considered by some to be methodologically incompatible with the emphasis on individual lived experience within phenomenological research, because group interaction is thought to have a ‘contaminating’ effect (Webb & Kevern, 2001). Others have argued that although the analytical focus of phenomenological research is individual, idiosyncratic perspectives, methodological rigour may be enhanced by considering individual perspectives within a group context (Bradbury-Jones et al., 2009).

The interpretive nature of hermeneutic phenomenology, resting on the inter-subjective concept of “being-in-the-world” highlights the relational and socio-cultural context of individual experience and meaning. Focus groups undertaken within a phenomenological framework are situated at the nexus of self and other, uncovering the relational influences on individual accounts. Therefore, the phenomenological focus group is not necessarily an oxymoron (Bradbury-Jones et al., 2009), as long as the methods of data collection and analysis are consistent with the epistemology, issues which will now be explicated.

Decisions about facilitation were cognisant of the challenges in ensuring all participants a voice. Focus group participation will inevitably be influenced by:

- the researcher’s questions and reactions but also by the degree of shared experiences among participants, the nature of pre-existing relationships, the sensitivity or privacy of the subject matter, the positions opened up and closed down by other participants’ contributions, and the developing dynamic of the interaction itself. (Palmer, Larkin, De Visser, & Fadden, 2010, p. 101)

Consensus-building was not the ultimate goal of the focus group, and in fact any attempt at group consensus is fraught with difficulties given that members’ silence does not always connote agreement (Sim, 1998). Participants were therefore informed that there was no expectation of consensus and that varied opinions were welcomed. However, Hollander (2004) has provided a different and perhaps more realistic stance on group dynamics, suggesting that conformity and censoring are inherent and reflect “important elements of everyday interaction” (p. 611). Rather than perceiving the focus group as a research instrument, it “may be best conceptualised as a research site … a place where we can observe the processes of social interaction” (Hollander, 2004, p. 631). Goffman (1959, 1981) has also noted the performative
aspect of all social interaction, belying any ultimate distinction between natural and institutional conversation. Understanding and managing the focus group as both a contrived and facilitated forum and a place of spontaneous exchanges was a key element in data collection.

Data generated from focus groups tend to create more challenges for both researcher and participants. Since it is difficult to think about one’s own ideas as well as listen to others, two forms of “production blocking” can occur. On the one hand, the delay between an idea generated and the opportunity to discuss it can lead to thoughts being forgotten or suppressed, in the attempt to listen to the speaker. Alternatively, the rehearsal of thoughts while waiting to speak can result in failure to listen fully to other participants (Fern, 2001). I was also conscious of these issues in individual interviews, however they were particularly salient in a group situation where even greater delays between speaking occur. Knowing when to intervene and when to allow the group to guide the process required me to draw on group work skills and reflexivity grounded in my research methodology. I strove for careful facilitation that balanced the effects of waiting time to speak and changes of subject matter, but I did not always achieve the ideal balance of active and passive roles. Certainly such issues could have been more effectively addressed with the support of a co-facilitator, but the introduction of an unknown person may equally have inhibited the group.

Although focus groups are often conducted at the outset of research, the decision to convene the focus group at the end of the project had several purposes. Positioning the focus group at the last stage of data collection provided an opportunity for member feedback (Guba & Lincoln, 1989), allowing participants to comment on the data collected in individual interviews. The value of member checking has been debated since it assumes unchanging perspectives and similarity between participants, and may privilege consensus-seeking over difference (Sandelowski, 1993; Padgett, 2008). Koelsch (2013) argues that “the member check is a useful tool for both seeking accuracy and assessing change” (p. 176). Given the possibility of change, Sparkes (1998) has suggested that member checking therefore constitutes further data. I perceived the opportunity for participants to comment upon my interpretations as a valuable process which promoted collaboration. Since this occurred within the focus group, a forum where I did not expect consensus, I treated participants’ responses to themes as a further data layer, and posited there may be elements of divergence and convergence.

Secondly, the timing of the focus group provided a future-focused forum for the discussion of social work education between the two professional groups providing an opportunity for refinement, clarification, or revision of ideas they had already considered. It
also allowed observation of the way in which participants altered or maintained their positions across individual and group settings. Carey (1999) has noted that focus groups can complement other qualitative methods by allowing for further exploration of research results, which can be particularly useful in understanding contradictions. Although groupthink may alter participants’ individual perspectives, there is also evidence that the focus group provides opportunities for participants to reflect on their positioning and their relationships with others, discovering new things about themselves (Madriz, 2000; Kitzinger, 1994; Smithson, 2007). For several participants, the focus group context did appear to facilitate new understandings and self-revelation.

Lastly, with regard to a sensitive topic such as CSA, the opportunity to observe how group dynamics influence meaning construction added another dimension to the study. Given that the focus group was a one-off event, I felt that participants would feel more comfortable having already built a research relationship with me, and thus participate more effectively in the group. A group forum highlighted the way issues were voiced and how they were attended to, diverted, or ignored, revealing what was said and what appeared to be muted. My awareness of the intra- and inter-subjective aspects of knowledge construction guided my decision to both audio-record and video-record the focus group, and enabled me to review both the content and process of group interaction.

Data analysis

Social workers and educators

In total, I conducted 31 interviews involving over 40 hours of audio-recorded data. Transcribing interviews is an important first stage of analysis. In keeping with my commitment to corporeal reflexivity I drew on Brooks’ (2010) concept of embodied transcription. This is described as “utilising the researcher’s body as an epistemological tool” (p. 1227). It involved listening to the recorded interviews on a headphone with a built-in microphone, and speaking the words out loud which were transcribed by voice recognition software. It was a profoundly enriching experience to vocalise the participants’ words, which highlighted the embodied and performative aspects of language that are omitted from traditional transcription.61 On several occasions my voice cracked or I became tearful at the same place as the participant had. By

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61 I also faithfully recorded conversation fillers such as “um”, “ah” and “you know”, because such information often pointed to the difficulties or discomfort participants had articulating certain thoughts. However, when presenting the findings I found that these conversation fillers detracted from the data and, on the whole, they have been removed.
repeating the words in the same rhythm, tone, and speed of voice, I was able to tune in to the emotional aspects of the data, and I would pause to make memos of my intuitions and understandings. Memo-writing occurred at every stage of the research as a reflective and analytical tool (Birks, Chapman, & Francis, 2008). These included thoughts, intuitions, observations, emotions, and bodily responses. Compared to subsequent listening, I found that the first listening to an interview recording created a surge of sensory and cognitive memories, as well as insights which needed to be recorded before they faded.

Drawing on principles of thematic analysis, the first stage involved identifying sub-themes by manually segmenting text firstly into descriptive categories arising primarily from the interview guide (Braun & Clarke, 2006; Thomas, 2006). Rather than line-by-line coding, segments were as large as they needed to be to maintain meaning and context, consistent with hermeneutics. My desire to maintain a holistic picture of each participant led me to procure a large role of newsprint. I used this to map out on large pieces of paper the descriptive categories and associated text for each participant’s interview, highlighted with various markers. This was a particularly time-consuming method, but I became very familiar with the data, and produced many analytical memos over this period. By creating a type of case summary, I was able to observe how much each subject was discussed by each participant, where strengths and interests or gaps lay, and to compare text between the first and second interviews, and between participants.

Constant comparative analysis, initially emanating from grounded theory methodology (Glaser & Strauss, 1967), has been appropriated by many qualitative researchers, and is certainly consistent with a hermeneutical approach. I searched for patterns and contrasts, particular incidents and their different contexts, and horizontal and vertical relationships between concepts. Continual reference was made back to the research questions and the literature. By explicating the reasons and influences for my understanding of the text through memo writing and a reflective journal, I sought to enhance the credibility of my analysis. Constant comparative analysis, while varying slightly in method, is essentially dialectical:

The deconstructive-reconstructive process which is at the heart of dialectical analysis involves a constant shuttling backwards and forwards between abstract concepts and concrete data; between social totalities and particular phenomena; between current structures and historical development; between surface appearance and essence; between reflection and practice. (Harvey, 1990, p. 21)

In attending to the dialectical tensions between surface appearance and essence, or manifest and latent content (Boyatzis, 1998), I also considered intra-psychic and inter-
subjective processes, verbal and non-verbal data, and the relational dance of concealment and disclosure. Dialectical inquiry involves a movement from thesis to antithesis to synthesis, embracing contradiction and paradox, and potentially transforming dichotomies into separate sides of the same coin. Using multiple hermeneutic circles I moved from a descriptive to interpretive analysis. These involved moving between the parts and the whole of the text (Bontekoe, 1996), between the universal and the particular (van Manen, 1997), between “staying close to the data” versus “thinking abstractly and conceptually” (Padgett, 2008, p. 131), and between fore-understandings and the reading of the text (Gadamer, 1989).

Holistic immersion in the data yielded seven major themes. Much has been written about the insufficient detail given to thematic analysis and the passive description of themes miraculously emerging from the data, generating considerable scepticism and criticism (Attride-Sterling, 2001; Braun & Clarke, 2006; Ely, Vinz, Downing, & Anzul, 1997; Morse, 1994; Thorne, 2000). Although ‘eureka’ moments of intuition and creativity tended to evade description, I attempted to justify and make transparent my analytic decisions by keeping an audit trail and reflective journal. Qualitative analysis follows iterative cycles of inductive and deductive thought, employing theoretical, empirical, and personal knowledge to form ultimate interpretations (Gadamer, 1989; Padgett, 2008). Both logic and intuition, or scientific rigour and creativity, therefore contributed to themes “emerging”.

The seven original themes to emerge from the analysis of interviews were: being a social worker; to tell or not to tell; discourses and silences; being healed; illusions, delusions and elusiveness; embodiment; being normal/abnormal. They were then mapped out on another large piece of paper with their associated concepts to observe their inter-relationships, and to assess how well the themes addressed all the salient information. In order to more fully understand their roles and implications for conceptualising, each theme was then mapped out on its own piece of newsprint. It was only at this point that I utilised word-processing software to segment the data into the seven themes. A process of re-reading of the data within themes, and a comparison of data across themes informed the beginning stages of writing, and excerpts which best captured the sub-themes and themes were identified. Writing and re-writing represent a further tool of analysis, whereby I sifted, compared, and reflected upon the data in a cycle of creation and re-creation (van Manen, 1997, 2014). While themes appeared robust at the initial stages of analysis, writing is where the rubber meets the road.\(^{62}\) This led to the seven

\(^{62}\) Relinquishing data and amalgamating themes is a necessary yet painful part of the process. Consequently, not all data gathered could be presented in this thesis.

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themes being reduced to five, and ultimately to three. Nevertheless, subsumed themes are addressed as vital threads in the discussion chapter.

Data from social work educators were analysed using the same methods. With both sets of data I asked and recorded questions of the text to refer back to in recursive loops. Kvale and Brinkmann (2009) highlight the role of researcher as co-producer and co-author of the interview, and observe the analysis as a “continuation of the conversation started in the interview situation” (p. 193). Hermeneutic phenomenology promotes the idea of entering into a dialogue with the text and its author, keeping the transcript alive rather than reducing it to a mere collection of statements. A fusion of horizons occurs through numerous spirals between researcher and text, self and other, and each transition broadened my horizon of understanding of the complexities and tensions of the issue at hand.

**Focus group**

With regard to the focus group analysis I referred to a wide range of literature, as I was concerned that analytical methods for individual analysis may not be entirely appropriate for the complex dynamics of a group. Many focus group analyses have been criticised for failing to capture the interactive nature of focus groups, thus failing to treat the group as a unit of analysis (Kitzinger, 1994; Smithson, 2000, 2007; Wilkinson, 1998). In a review of 40 focus group studies, Kitzinger (1994) found that focus group participants were primarily represented as if they had participated in individual interviews: “I could not find a single one concentrating on the conversation between participants, and very few that even included any quotations from more than one participant at a time” (p. 104).

The goal of the focus group data analysis and its presentation was to primarily locate and analyse individual accounts within the group process (Kitzinger, 1994), however, there were considerable challenges in doing so. Completely different analytical strategies were required for the analysis of focus group content as opposed to process, and consequently the dual activities of analysis tended to remain parallel rather than integrated. Although thematic analysis provided a framework for analysing content data, as it had done in individual interviews, the fragmentation of text was in complete opposition to the holistic approach necessary for the analysis of process. With regard to group process, I made reflective journal entries about my own responses, my perceived impact on the group, my perceptions of other participants' interactions, and the changing dynamics of the group. Just as with individual
interviews, I recorded non-verbal communication and multiple viewings of the DVD pinpointed emotional fluctuations and body language within the group.

A literature search pertaining to analytical strategies for analysing focus group process revealed several different frameworks. Eventually I created my own framework which combined aspects of several strategies along with innovations that I developed, such as consideration of the roles that participants performed in the group and the dynamic nature of group process. I looked to the concept of emotional contagion\textsuperscript{63} (Barsade, 2002; Bono & Ilies, 2006; Hatfield, Cacioppo, & Rapson, 1994) to provide a framework for the analysis of the emotional life of the group. Clear moments of emotional contagion occurred over the course of the focus group with varying effects upon the level of functioning.

A number of “pertinent analytical questions” proposed by Stevens (1995, p. 172) were utilised such as:

- What statements seemed to evoke conflict?
- How did the group resolve disagreements?
- What were the contradictions in the discussion?
- What topics produced consensus?
- What common experiences were expressed?
- Was a particular member or viewpoint silenced?
- How were emotions handled?
- Whose interests were being represented in the group?

\textsuperscript{63} Emotional contagion is simply defined as “the process by which the emotions expressed by one individual are “caught” by another” (Bono & Ilies, 2006, p.320). Emotions are expressed and understood primarily through non-verbal cues, while words are considered to be only responsible for 7% of emotional understanding (Mehrabian, 1972). Emotional contagion is thought to occur predominantly at an unconscious level, involving autonomic somatosensory and motor responses (Hatfield et al., 1994, Nummenmaa, Hirvonen, Parkkola, & Hietanen, 2008) and to be influenced by the valence and energy level of the emotion expressed (Barsade, 2002).
I also considered several relevant analytical issues proposed by Krueger (1994, 2002) such as focusing on the words participants used, the context for their comments, the frequency of statements or opinions, the extensiveness of discussion on particular topics, and the level of emotional intensity. Lastly, I drew on the dynamic concept of “positionality”\(^\text{64}\). Analysis focused on the manifestation of social identities and the impact of group dynamics not just on what was discussed, but how it was spoken, as well as what was unspoken (Farnsworth & Boon, 2010; Hyden & Bulow, 2003).

**Ethics**

A full discussion of the ethical considerations of the research is canvassed in the ethics application (see Appendix M). The University of Otago Ethics Committee gave ethics approval on 21 March 2011 (reference code 11/051). Letters from the Committee approving the research and extending the approval are also included in Appendix M. Ethics approval by the DHB followed (reference code RM 0980712013).\(^\text{65}\) In maintaining the ethical principles of beneficence and non-maleficence, I felt it important to consider the potential harm and benefits to participants at every stage of the research. I was explicit in my commitment to prioritise the welfare of participants over the research process, and to build open and effective research relationships. I treated consent as an ongoing dynamic process, rather than a one-off event, recognising that the process of engaging with a difficult and potentially emotive subject such as CSA could precipitate some level of tension and/or distress in some participants. However, I also recognised that respondents were engaging with challenging and sensitive issues in workplaces, and presumably had good personal and professional support systems in place. Therefore, a balance needed to be achieved between protection and paternalism.

Qualitative interviews offer a range of benefits to participants such as providing a sense of purpose, increasing self-awareness, facilitating catharsis, and promoting empowerment

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\(^{64}\)Positionality is defined as “the experiential meaning of one’s stance in relation to a given phenomena” or “a participant’s relationship to, or involvement in, a given matter of concern” (Palmer et al, 2010, p. 108). Similarly, to understand the shifting positions participants may take in representing themselves individually or as group members and/or representing others, Hyden and Bulow (2003) have suggested that “a central methodological question in analysing focus group material is who’s talking – that is, in what way are the utterances of individual members of focus group to be interpreted” (p. 306).

\(^{65}\)I received a letter approving my research from the Clinical Advisor within the DHB service on 1/3/11, after meeting with her to discuss my research proposal and provide her with a copy of my University of Otago ethics application, consent form and information sheet. My understanding at that time was that I had approval by the DHB to proceed with my research once obtaining University of Otago ethics approval. However, I was not made aware of a separate department which dealt with research applications for the DHB, until two weeks after starting interviews. This meant that formal approval for the research was not gained until 1/6/11.
Feedback from participants confirmed that the research provided opportunities for reflection, increasing clarity and self-awareness. Participants were not directly asked whether they had a personal history of CSA. However, some chose to disclose this information, and explored how their experience mediated their understanding of CSA. Six of the eleven social workers and one of the social work educators disclosed personal experience of CSA. In addition, one educator and one social worker alluded to a personal history.

Pseudonyms chosen by participants were used for both sample groups but were not used for the focus group. Tolich (2009) has noted the inherent ethical difficulties in attempting to achieve complete confidentiality within focus groups. Although I introduced some ground rules for the group at the outset, including an expectation that what was discussed in the group remained in the group, there was no means to enforce such a request.

Māori perspectives of ethical research

Māori research consultation initially began with an application to the Ngai Tahu Research Consultation Committee. Entering into the world of Māori is certainly aided by some appreciation of the culture, and the language which expresses the culture. Moewaka Barnes, McCleanor, Edwards, and Borell (2009) define tikanga as “wise action and thought” which “draws on theory and practices validated by Māori” (p. 452). Tikanga could be viewed as the Māori equivalent of ethics, and is also a dynamic process, but Moewaka Barnes et al. (2009) stress that it is based on relationship rather than partnership, and is often at cross purposes with pakeha ethics committees. Tika (truth and correctness), pono (honesty) and aroha (love) are proposed as matapuna (principles) to provide an ethical framework for research involving Māori (Moewaka Barnes et al., 2009). Having been involved in whanaungatanga (relationship-building) camps at my children’s school, I have come to truly appreciate how these values constitute their meaning through relationships.

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66 In order to preserve confidentiality regarding the original pseudonyms used in individual interviews, focus group participants used their real names. After the focus group had ended, I assigned numbers to each participant for the purposes of analysis and presentation of the data (SW 1-5 to denote social workers, and SW ED 1-2 for educators).

67 My research proposal was approved by Ngai Tahu Research Consultation Committee on 8 March 2011, with recommendations for further local consultation with Māori.

68 I was aware of tikanga Māori through my children’s school which operates a bilingual unit and has close links with local marae. I was also learning te reo through the school during the year that I collected data.
I spent a considerable amount of time researching Māori models of health, (Durie, 1998, 1999, 2001; McNeill, 2009; Pere, 1982, n.d.) and counselling (Drury, 2007; Durie, 2003), Māori perspectives of addiction (Cave, Robertson, Pitama, & Huriwai, 2008), Māori perspectives on sexual violence (Te Puni Kokiri, 2009a; Terry, 1995), and kaupapa Māori research (Cram, 2009; Mead, 2003; Moewaka Barnes et al., 2009; Te Puni Kokiri, 2009b). I also sought direct advice and information from Te Puni Kokiri and the Health Research Council (HRC). This led to referrals to other useful organisations such as the Social Policy Evaluation and Research Committee (SPEAR), and the Rangahau website.

Māori consultation

Prior to data collection, I gained cultural advice from two Māori mentors. The first was a local kaumatua of Ngapuhi descent, who had supervised masters and doctoral students regarding studies of the toheroa. The second was a local Māori healer and consultant practicing rongoa medicine of Ngati Whatua descent. Both mentors provided initial feedback on the research design, ethics, and interview guide.

The kaumatua taught me the metaphor of the korowai or cloak which represents the wisdom and knowledge of Māori passed down from generation to generation. He explained that Māori would not readily give away their korowai, and alerted me to the differences between Western-enlightenment notions regarding knowledge acquisition and Māori perspectives. Manihera (1992) echoes this view noting that “knowledge that is profane has lost its life, lost its tapu” (p. 9). This points to the importance of the concept kia tupato, to be careful, described by Cram (2009) as endeavouring to be culturally safe and reflective about one’s status as a researcher, and is linked to the need to be careful not to trample on the mana of the participants, “kaua e takahia te mana o te tangata” (Cram, 2009, p. 316). The sensitive nature of the research required consideration of the principles of tapu, sanctity or restriction, and mana, authority or power. Edwards, McManus, and McCreanor (2005) differentiate between tapu atua

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69 Kaupapa Māori research is culturally safe research, based on a number of key principles. These include the Treaty of Waitangi, tino rangatiratanga (self-determination), te reo Māori (Māori language), whanau (extended family) and atu (respectful relationships). For further information regarding kaupapa Māori research see: http://www.rangahau.co.nz/research

70 Te Puni Kokiri, a NZ government agency, is the principal advisor to the government on government-Māori relationships, monitoring relevant policy and legislation, advising on and amending policy, and administering relevant legislation.

71 The HRC operates to support and manage the NZ government’s investment in health research, including ethics processes and issues.

72 SPEAR is another NZ government agency to support and manage the NZ government’s investment in social policy research and evaluation.

73 The Rangahau website has been set up to support kaupapa Māori research.
and *mana atua*, which are derived from the spiritual realm, and *tapu tangata* and *mana tangata* which are dependent upon the person’s interactions with others. Yet I also found it important to refrain from making any cultural assumptions about Māori participants’ connections to *tikanga*, *te reo*, or *whakapapa* (Durie, 2001). Sometimes Māori participants wanted to identify issues from a Māori perspective, and at other times drew on more universal notions of what it means to be human. For one participant, *karakia* or prayer was an essential start to the research process.

The *rongoa* healer taught me the need to travel and meet prospective Māori participants, face to face, *kanohi te kanohi*. Establishing my trustworthiness and authenticity as a researcher was particularly important for Māori participants, one because of the sensitive nature of the research, and secondly because of the potential for *pakeha*-led research to hold Eurocentric and racist perspectives (Cram, 2009; Moewaka Barnes et al., 2009). I was prepared to be more transparent about myself than I had been in recruiting other participants, and I saw this as a valid and necessary step in engaging with Māori as a *pakeha* researcher. Finally, Cram (2009) has discussed the importance of *manaaki ki te tangata* or the hosting and generosity of the researcher to the participants. A *koha* or gift was given to all participants at the end of the interviewing stage, and I provided a range of food and liquid refreshments at the focus group.

**Pacific Island perspectives on ethics**

Although I did not obtain face-to-face consultation to prepare me for my research with Pacific Island participants, a similar process of research and consultation with organisations occurred prior to the interviews. Again, I spent considerable time researching Pacific models of health (Suaalii-Sauni et al., 2009), research (Tamasese, Peteru, & Waldegrave, 1995), and Pacific perspectives on sexual violence (Ministry of Pacific Island Affairs, 2008, 2010; United Nations, 2006, 2009). Cultural practices among Pacific Islanders are both ethnic-specific and context-specific (HRC, 2005, 2014), and the impact of acculturation created yet another context which affected participants, their families and friends, and their clients or students to varying degrees.

The protection of knowledge is also a very important part of Pacific Island culture, whereby the ownership of knowledge is familial and collective, and transmitted only to those

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74 Cram (2009) quotes a *whakatauki* (proverb) which highlights the importance for Māori of face to face interaction, enabling the use of all one’s senses to assess a situation. “*He reo e rangoa, engari, he kanohi kitea*” translated as “A voice may be heard but a face needs to be seen” (p. 314).
able to care for it. Reciprocity does not just encompass the giving of a gift or meaaloafa, but the way the research is reported and disseminated (HRC, 2005, 2014). In the Samoan language, malu puipuiapua, (protection), takes into account “the safeguarding and preservation of human dignity expressed in ritual, behaviour and language” (HRC, 2005, p. 37). Pacific models of research therefore also highlight the importance of meaningful and respectful relationships, and the ability of the researcher to demonstrate authenticity, which requires face to face interaction (HRC, 2005). A Pacific Island social work educator requested a face to face interview, rather than an interview by Skype, and I travelled to meet her at her workplace. A similar level of trust and disclosure was unlikely to have occurred through a virtual interview.

Reflexive methodology

My commitment to reflexivity was designed to promote rigour in all facets of the research including cultural competence. I sought to remain aware of how my presentation, age, ethnicity, gender, and subjectivity affected every stage of the research, and to act on this awareness (Fook, 2001; Nash, 2011). Symonette (2009) emphasises the need for a high degree of self-awareness and “empathic perspective taking” which involves both “cognitive and affective frame-shifting” resulting in an ethnorelative rather than ethnocentric stance (pp. 285-286). Shifting my frame of reference from a white, middle-aged female to a Māori or Pacifica male or female was only possible by building trust through clear displays of both empathy and humility. This led participants to feel safe enough to share their cultural worlds with me, to correct and teach me when there were inevitable ruptures in my empathic perspective taking, and to at times criticise elements of their own culture or mine.

I respected my participants as collaborative research partners and I undertook to build real and empathic relationships of emotional depth, maintaining a willingness to discover new things about myself as well as the topic of study. Described by Finlay (2005, 2006) as “reflexive embodied empathy”, my body became a research instrument to empathically tune in to my participants, and also connect with myself. I write about some of these embodied experiences in the findings. The voices of my participants would frequently vie for my attention, confirming Ely and Vinz’s (2005) concept of the “field as internal” (p. 32). From a psychodynamic perspective, Cooper (2009) defines such a stance as “practice near” research. He discusses some of the consequences of this approach, all of which I experienced:

a) the experience of participants in a “visceral, bodily, and … live emotional
way”

b) the “losing of our minds” as researchers as we become “psychically mixed” with our participants

c) “the inevitability of personal change”

d) “the discovery of complex particulars” with the potential to illuminate universalities (p. 432).

The torrent of stories of CSA coupled with my desire to attend to participants’ emotional and non-verbal communication, as well as my own, was exhausting. In retrospect, I had not always allocated sufficient space between interviews to process them, something other researchers also learnt too late (Etherington, 2001, 2007; Rager, 2005). Yet, at the point of analysing social worker interviews, I saw the implicit reference to a personal history of sexual abuse within the very first interview I had conducted. The participant had casually slotted a statement about “some personal experience” among other sources of knowledge of CSA. When I look back, I believe I had been unprepared for participants’ disclosures. I failed to respond to this subtle reference, and the conversation moved on. While “reflexive embodied empathy” did occur, it certainly did not here. Disclosures from subsequent participants were more explicit, and several participants referred to their own abuse multiple times throughout the interview. However, in this first interview, my failure to acknowledge this potential “test” of “the disclosive waters” (Ford et al., 1999, p. 146), led to it disappearing into the ether, never to be referred to again by the participant, and failing to register in my own mind as indicative of a personal history of CSA. On seeing what I had previously not perceived or heard, I wrote with astonishment: “It hit me like a ton of bricks. How did I miss it? I heard it, I transcribed it. How did I miss it? Now it stands out in the text with flashing lights”. This unconscious form of avoidance at the points of data collection and transcription was a humbling, yet illuminating experience, which informed my analysis of the data.

The emotional challenges of sensitive research

While all researchers have periods of feeling overwhelmed by the sheer volume of data (Morse, 1993), researching a sensitive and distressing issue has particular challenges. A memo written on 11/4/14 while writing the social worker findings captures my predicament, embroiled in an internal world full of horror: “Woke up this morning feeling I was drowning in a sea of child sexual abuse … so immersed in the data, finding it hard to keep my head above water”. At times I experienced periods of aversion to the data in the analytical writing process.
These episodes of “researcher saturation” (Wray, Marcovic, & Manderson, 2007, p. 1397) which manifested as tiredness, heaviness, emotional numbing, and muscular pain (particularly in the chest) were also largely avoided and ignored initially. Rather than perceiving my emotional numbing as a red flag, I viewed it as a welcome relief from the emotional rollercoaster that the research engendered. My emotional disconnection had bodily correlates, I disregarded my body’s messages and began living in my head. I had consistently journaled emotions when they came up, but failed to document these periods of emotional numbing. In retrospect, journaling my emotions was a helpful but not sufficient outlet, and I needed opportunities to verbalise the emotional toll that the research took.

When I came to write my discussion chapter, emotional numbing had become the new norm, a solution to my lack of voice, and it presented a significant block to my writing. My silencing was partly self-imposed through notions regarding professionalism and competency, and perceptions that supervision was primarily a task-driven process. But it was also influenced by my personal circumstances as a distance student, single mother, and lone researcher living in an isolated part of NZ. It took several bouts of influenza and chest infections for me to recognise the impact of the research upon my emotional and physical health. While my reduced capacity for self-care no doubt contributed to my recurrent chest infections and muscular chest pain, I found it interesting that I felt grief in my chest throughout the research process.

In my search for other researchers’ emotional and embodied experiences of conducting sensitive research, I was both reassured and surprised to find a substantial body of scholarship dedicated to the topic (Bloor, Fincham, & Samson, 2010; Coles, Astbury, Dartnall, & Limjerwala, 2014; Coles & Mudaly, 2010; Dickson-Swift, James, Kippen, & Liamputtong, 2009; Emerald & Carpenter, 2015b; Fitzpatrick & Olson, 2015; Gilbert, 2001; Hubbard, Backett-Milburn, & Kemmer, 2001; Jackson, Backett-Milburn, & Newall, 2013; Rager, 2005; Sanders, Munford, Liebenberg, & Henaghan, 2014; Stoler, 2002; Wray et al., 2007). Despite attempts at emotion management during interviews, researchers’ bodies express emotions in a variety of ways including hand tremors, flushing, bodily tension, and a lump in the throat (Dickson-Swift et al., 2009; Malacrida, 2007). Embodied sensations of heaviness, tension, and pain along with intense feelings of anger, horror, fear, sadness, hopelessness, powerlessness, guilt, and disgust emerge during fieldwork, transcription, analysis, and even secondary analysis (Coles et al., 2014; Etherington, 2007; Fincham, Scourfield, & Langer, 2008; Gregory, Russell, & Phillips, 1997; Jackson et al., 2013; Kiyimba & O’Reilly, 2015; Malacrida, 2007). Researchers may also experience physical symptoms such as gastro-intestinal problems, insomnia, and headaches (Coles et al., 2014; Dunn, 1991; Jackson et al., 2013; Rager, 2005;
Wray et al., 2007), and at other times feel desensitised from the pain of participants (Fitzpatrick & Olson, 2015; Jackson et al., 2013; Malacrida, 2007). Physical symptoms related to participants’ experiences have also been documented, such as breast pain in qualitative research with breast cancer patients (Rager, 2005).

Many researchers have spoken of feelings of powerlessness in being aware of the suffering of participants, yet feeling unable to intervene (Etherington, 2007; Jackson et al., 2013; Malacrida, 2007; Sanders et al., 2014). Moving from the role of counsellor to researcher evoked feelings of powerlessness for Etherington (2007), who struggled with being unable to support male survivors of CSA. Similarly, Sanders et al. (2014) felt a sense of impotence regarding the plight of vulnerable youth who often fell between service gaps. This deeply disturbed them and kept them awake at night. In some instances they did intervene to assist youth, but were not always able to do so. On hearing second-hand yet often current stories of clients, who were not my participants, I also experienced powerlessness and distress. Sometimes the stories evoked powerful imagery, particularly when the stories reminded me of clients I had worked with in the past. I could not support these clients or even bear witness to their stories in my research, and held their suffering inside me. Jackson et al. (2013) also experienced “visual and auditory sensations” during their secondary analysis of children’s accounts of CSA (p. 6). Images and voices for children they had never met nor heard emerged involuntarily, which enhanced empathic connection, but was also profoundly disturbing.

The longitudinal and iterative nature of qualitative research creates cumulative exposure to distressing material (Coles & Mudaly, 2010; Stoler, 2002; Woody, Williams, Wittich, & Burgio, 2011; Wray et al., 2007), which may occur in the absence of personal or professional experience with the topic (Jackson et al., 2013, Malacrida, 2007). This emotion work is often unrecognised by research institutions, universities, and ethics committees (Bloor et al., 2010; Dickson-Swift, James, & Kippen, 2005; Lee-Treweek & Linkogle, 2000; Malacrida, 2007). Equally, researchers may not be cognisant of their potential vulnerabilities until embarking on the research (Bloor et al, 2010; Dickson-Swift, James & Liamputtong, 2008). Even those who have worked in the field of trauma and abuse have been unprepared for the emotional toll of sensitive research (Coles & Mudaly, 2010; Etherington, 2007; Stoler, 2002).

I learnt that VT is an ever present risk when conducting sensitive research, just as it is for social workers, educators and students. The deep immersion in the phenomenon of CSA can distort one’s perspective of the world (Coles et al., 2014; Stoler, 2002) and this can also be true
of other distressing topics (Fitzpatrick & Olson, 2015; Malacrida, 2007). Increased sensitisation to the topic disrupts assumptions about a just, safe, and predictable world (Janoff-Bulman, 1992) or one’s “ontological security” (Laing, 1960, p. 39). When working with children at school or watching various children’s performances I found myself wondering how many had been sexually abused, and how would I be able to tell. While my perceptions regarding daily life were skewed by my research, at the same time I received a number of disclosures of CSA from business clients and associates, neighbours and acquaintances, some of whom I had little previous connection with, and not all knew of my research. These periods of sensitisation which alternated with periods of desensitisation are common responses to sensitive research (Fitzpatrick & Olson, 2015; Jackson et al., 2013; Stoler, 2002).

I drew on the lessons learnt by a range of researchers to develop more specific strategies for self-care. Utilising a variation of the “pomodoro method” of writing I kept to strict work and break schedules (Cirillo, 2006), built in exercise every day, and blocked out time for friends. However, many researchers argue that these strategies alone may be insufficient, and that researchers need opportunities to debrief and process the emotional effects of the research through clinical supervision, peer debriefing, and counselling (Coles et al., 2014; Coles & Mudaly, 2010; Corden, Sainsbury, Sloper, & Ward 2005; Dickson-Swift, James, Kippen, & Liamputtong, 2008; Etherington, 2007; Gilbert, 2001; Hubbard et al., 2001; Jackson et al., 2013; Rager, 2005 ). As Rager (2005) points out “Unlike qualitative researchers who conduct emotionally laden research, therapists would not be allowed to work in similar situations without proper preparation and without strategies in place for handling their own emotional reactions” (p. 25). Feeling silenced is a common experience among researchers whose focus of study is socially taboo, feared, and/or stigmatised. Etherington (2007) reflected that “many people did not want to listen, but I needed to talk about my thoughts and feelings” (p. 86). Friends that I would normally turn to for support were inappropriate given the privacy issues and their layperson status (Coles & Mudaly, 2010; Stoler, 2002).75

There is a lack of academic discourse regarding the emotional toll of qualitative research, despite recognition that it is an inter-subjective and empathic endeavour. The positivistic paradigm, which polarises emotionality and rationality and privileges the latter, still tends to dominate higher education (Bloch, 2012; Boler, 1999; Clegg, 2013; Dickson-Swift et

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75 I found it important to engage a therapist to bear witness to the emotional challenges I was facing and I used this time to process, integrate and make sense of the range of often conflicting emotions that emerged during the research process. I chose a therapist who utilised creative arts, and I found this to be a profoundly effective means to work through emotions and cognitions, which involved unconscious as well as conscious mechanisms.
al., 2009; Emerald & Carpenter, 2015b; Leathwood & Hey, 2009; Widdowfield, 2000; Wincup, 2001). This Cartesian dualism has perpetuated disembodied research accounts where “bodily knowledge has been systemically denied as oxymoronic” (Ellingson, 2006, p. 300). Boler (1999) has discussed the “absent-presence” of emotion in academia (p. xv) and Clegg (2013) describes universities as “affectless spaces” (p. 75), both implicating patriarchy in pejorative attitudes towards emotionality. Others believe an increasingly neoliberalist culture within universities has inhibited the expression and acknowledgement of emotions (Emerald & Carpenter, 2015a; Marginson, 2013).

Whatever the cause, as Collins and Cooper (2014) observe, “the idea of accounting for the emotional aspects of the work has been regarded as overly subjective, narcissistic, and even navel-gazing” (p. 90). These perceptions and institutionalised norms perhaps lead many researchers to keep their emotional challenges to themselves (as I did initially), thus perpetuating the wall of silence (Emerald & Carpenter, 2015b; Rager, 2005). However, universities and research institutions ultimately have a duty of care to researchers (Coles et al., 2014; Dickson-Swift et al., 2005; Emerald & Carpenter, 2015b). Just as Chapter Two and Three highlighted the importance of normalising direct and indirect responses to trauma for clients, social workers and students, so is there a need to normalise the potential for VT among researchers. My own experience, and that of others, suggests that strategies to mitigate the potential emotional impact of sensitive research should be identified within research proposals, ethics applications, and supervision agreements, as well as throughout the research process.

While the focus of much of the literature is on the negative impact of researching emotionally sensitive topics, several authors have highlighted the potential for researchers’ emotions to provide analytical power to findings, enriching and informing the data and deepening understanding (Emerald & Carpenter, 2015b; Fitzpatrick & Olsen, 2015; Holland, 2007; Hubbard et al., 2001; Jackson et al., 2013; Lorimer, 2010; McLaughlin, 2003; Sanders et al., 2014). Acknowledging the emotional and corresponding physical toll of the research sensitised me to the dialectic of approach/avoidance which informed my analysis. Similarly, attending to the distress elicited by their research with vulnerable youth assisted Sanders et al. (2014) to produce “more nuanced and subtle understandings” of their data and to communicate “rich” and “real” knowledge to promote “advocacy and change” (p. 11).

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76 It was only by connecting with other researchers’ accounts of their emotional difficulties that I was able to legitimate my own struggles, and take the risk of exposing my own vulnerability to my supervisors. I did this by sending this piece of writing to them. They responded with concern, empathy and understanding, and supported my desire to seek some therapeutic support.
Conversely, the failure to acknowledge and process emotions during research may not only have adverse effects on the researcher, but potentially undermine the quality of the research. A rational/emotional binary runs the risk of reducing accounts of emotional reflexivity to mere emotional regulation whereby researchers attempt to set aside emotions from the data (Burkitt, 2012; Jackson et al., 2013). Far from being “undesirable forces that wreak havoc on the rational being” emotions are intrinsic to cognitive processes such as reasoning, memory, and perception (Le Blanc, McConnell, & Monteiro, 2015, p. 265). I therefore attempt to highlight the epistemology of emotion in my research methodology, as well as argue for its central place in social work practice and education.

Limitations of the research

This study provides insight into the perceptions of a small group of social workers and social work educators with regard to CSA. My decision to employ purposive sampling was made in order to gain maximum variation across samples in relation to such issues as age, culture, and work experience as well as a gender balance. This was achieved in all areas except with regard to recruiting social workers with Asian heritage, which represents a limitation, given that Asian people make up 12% of the NZ population (Statistics NZ, 2014). In addition, the ANZASW (2008) have reported that Asian social work students made up 4% of the total students enrolled in social work programmes in 2007.

Qualitative research sacrifices breadth for depth and while the samples are small, as discussed earlier, participants were involved in individual interviews lasting anywhere between 60–180 minutes. Nevertheless the data are context-bound, have limited generalizability, and have temporal limitations, given the social world is fluid rather than fixed. Even over the few months between interviews with social workers, it was possible for perceptions and awareness regarding CSA to be altered. At one level, I employed thick description in giving equal attention to embodied, discursive, and emotional realms, and the multiple contexts and sources for participants’ perceptions. However, I did not have the opportunity to observe participants interacting in the workplace, apart from the contrived setting of the focus group, which represents a limitation in the research.

While the study achieved methodological triangulation through individual interviews and a focus group, the opportunity for further triangulation through reflective journals and

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77 In addition, the ANZASW (2008) have reported that Asian social work students made up 4% of the total students enrolled in social work programmes in 2007.
78 The higher figure reflects social workers who had two longer interviews of 90 minutes each. In addition, participants who contributed to the 90 minute focus group created further depth of findings.
responses to vignettes was thwarted by the lack of completion by most participants. As discussed earlier in this chapter, the flexibility of semi-structured interviews create a number of benefits to participants and for data collection, however I found that such interviews also created limitations to data collection and analysis. When comparing participants’ perspectives regarding various issues I sometimes found that I had not asked certain questions to all participants, given the inevitable byways that each research interview took.

I made a pragmatic decision to conduct skype interviews with all but one educator, which may have been more inhibiting for participants than face-to-face interviews, and at times made it more difficult to perceive and respond to body language. However, I do not consider this to be a significant limitation as I do believe I was able to collect rich data and maintain productive research relationships. Similarly, the decision to conduct social workers’ interviews and the focus group within the workplace may have led to more cautious and constrained responses. One social worker had suggested that meeting at her home would have been preferable, and it is possible that interviews conducted in a more relaxed and personal environment may have been less inhibiting. Not only were participants conscious of being in their work environment, but they also needed to manage their emotions in preparation for their next client or meeting.

My commitment to the privacy and confidentiality of participants also took precedence over research concerns. One social work educator was unwilling to participate unless all academic institutions remained anonymous, pointing out that the academic community of NZ is a small and closely connected forum. After discussing the issue with the other educators, an agreement was made to refrain from any identification of social work programmes. This decision has detracted from my ability to comprehensively report findings, but without this agreement I would have lost a participant, and perhaps other educators may have been more constrained in evaluating their programmes. The protection of confidentiality and privacy also limited the degree to which I was able to utilise anecdotes. A compelling anecdotal narrative has the power to involve the reader personally, leading to reflection, interpretation and potential transformation (Ely et al., 1997; Rosen, 1986; van Manen, 1997). While I was able to use anecdotes related to participants’ lives, many fascinating and compelling anecdotes regarding practice and education had to be forsaken. This was an ethical and moral decision to protect the interests of clients and students who were not consenting participants to the research.
Conclusion

In this chapter, I have traversed the methodology employed in this research, highlighting points of resonance with the issue of CSA which made it particularly suitable for the purpose of the study. This included concepts such as distantiality, thrownness, the clearing, embodiment, and the fusion of horizons. Being aware of my role as research instrument at all stages of the research, I drew on methods which enhanced my reflexivity such as embodied transcription, attention to the emotional and embodied realm, a peer review group, memo writing, and a reflective journal. Nevertheless, there is a cumulative emotional toll to conducting sensitive research, and I have explored my own emotional journey navigating this difficult terrain. I believe my decision to utilise a therapeutic forum to express and process my emotional reactions was not only an effective means of self-care, but another tool to enhance my reflexivity. My commitment to cultural and ethical issues led to ongoing research decisions to honour those obligations. Sometime ethical decisions created limitations, as did other facets of the research. In the next chapter, entitled being a social worker, I introduce the first of three findings chapters related to social workers’ perspectives.
Chapter Five: Findings – Being a Social Worker

Introduction

This chapter is the first of three chapters presenting the findings from social workers. These have been collated into three main themes: being a social worker; to tell or not to tell; and delusions, illusions, and elusiveness. The first theme traverses social workers’ perceptions about the profession of social work, their identity and role as social workers, and their views regarding the relevance of CSA within social work practice and education. Participants discussed their experiences of social work training and the degree to which CSA was addressed, and provided perspectives on the appropriate level of CSA education. Views and practices regarding CSA inquiry and response emerged as a central aspect with important implications for social work education and practice. Participants cited numerous personal, professional, and organisational factors which constrained or facilitated CSA inquiry and response. They also explored perspectives regarding definition and prevalence of CSA; the nature of resolution; perceptions about clients’ readiness; efficacy and availability of therapy; and the timing of therapy in relation to substance abuse treatment. These factors were relevant to the response to disclosures of CSA, but potentially also influenced inquiry.

Knowledge of CSA

Participants’ understanding regarding CSA inevitably flowed from multiple and varied sources. These included current and previous social work roles, supervision, reading, seminars, under-graduate and post-graduate education, clients, colleagues, friends, family, the media, internet, research, and their own personal experience. I encouraged social workers to make a self-assessment of their knowledge and skills in the field of CSA, including gaps and strengths in their knowledge base. Participants either chose to rate their knowledge base regarding CSA numerically out of ten, or provided various descriptions. As can be seen in Table 6, participants’ self-assessments ranged from minimal to substantial. Seven referred to personal experience of CSA, and all but two drew on knowledge of friends and/or family members who had been sexually abused. However, these social workers did not necessarily equate personal histories with a high self-rated knowledge of the topic.
Table 6: Social workers’ self-rated knowledge of CSA

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Self-rated knowledge&lt;sup&gt;79&lt;/sup&gt;</th>
<th>CSA content in lectures</th>
<th>CSA learnt in placements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jill</td>
<td>pretty high</td>
<td>minimal, basic</td>
<td>Rape Crisis</td>
</tr>
<tr>
<td>Robin</td>
<td>10</td>
<td>none</td>
<td></td>
</tr>
<tr>
<td>BJ</td>
<td>very good</td>
<td>nothing specific</td>
<td>CYFS, Presbyterian Support -youth</td>
</tr>
<tr>
<td>Pinchas</td>
<td>quite good</td>
<td>doesn’t recall any</td>
<td>CYFS</td>
</tr>
<tr>
<td>LMG</td>
<td>basic working knowledge</td>
<td>within several papers</td>
<td>Trauma counselling service</td>
</tr>
<tr>
<td>Leah</td>
<td>good basic knowledge</td>
<td>trauma module (Applied MSW overseas)</td>
<td>Women’s prison</td>
</tr>
<tr>
<td>Amy</td>
<td>lot of experience</td>
<td>doesn’t recall any</td>
<td></td>
</tr>
<tr>
<td>Siaki</td>
<td>6</td>
<td>doesn’t recall any</td>
<td></td>
</tr>
<tr>
<td>Molly</td>
<td>3 or 4</td>
<td>none</td>
<td>NGO children and adults</td>
</tr>
<tr>
<td>Jack</td>
<td>not very knowledgeable</td>
<td>nothing specific</td>
<td>Child family unit</td>
</tr>
<tr>
<td>Elvis</td>
<td>low</td>
<td>nothing (Applied MSW)</td>
<td></td>
</tr>
</tbody>
</table>

A personal history of CSA was one knowledge strand among many, and ratings may also have been influenced by the degree to which they had explored their own sexual abuse experiences. The knowledge derived from personal experience may also have been accorded varying status across the group. In addition, two participants specifically stated that, because of their own personal history, they had deliberately avoided working directly with sexual abuse.

Eight social workers were working in a counselling role, and five had trained in counselling. This group of social workers therefore had a more therapeutic orientation and tended to identify themselves as counsellors as much as social workers, and in some cases more so. Jack commented “Probably in (our service) there’s more of a counselling culture here … and people are much more interested in counselling really”. Similarly, Amy’s observation of the literature reflected her counselling identity: “well, we do know that with counsellors right,

<sup>79</sup> For social workers who rated their knowledge out of ten: (1= low, 10=high).
the research has been done that the most healing thing, doesn't matter what the technique … it is the relationship”.

Three social workers, who had purposefully sought out opportunities to work directly with victims or perpetrators of CSA, had greater knowledge bases. However, one still rated herself in the mid-range because of the period of time she had not been working in the field. Nine participants noted that their social work training had contained very little, if any, CSA education. Some were quite clear about the level of CSA training, while others stated that they couldn’t remember any training. It is possible that some participants failed to recall all training related to CSA, given considerable time periods that had elapsed since qualification. Nevertheless, only two were able to recall significant attention to the topic of CSA within their social work education, with only one being in NZ.

Despite most participants appearing to have received little academic training in CSA, seven commented that relevant placements and/or high quality supervision provided some degree of learning. This ranged from becoming more aware of the prevalence of CSA to receiving specific in-house training, depending on the placement. In addition, comments by three social workers highlighted the generalist nature of undergraduate social work education. The social work qualification was viewed as “generic training” which provided a “professional framework”. It was “just the beginning” and “a licence to practice”.

Robin held an expectation that workplaces would provide the necessary in-depth training for more specialist areas of practice, and BJ also envisaged that CYFS social workers get CSA training on the job. Yet with regard to work-based training, Molly noted a two week care and protection course run by CYFS only “touched briefly” on CSA. She also described a trauma-informed workshop which focused on coping in the here-and-now, rather than addressing past abuse.

Participants were generally circumspect about media representations of CSA. However, those who identified having less knowledge of particular facets such as perpetrators, or controversial issues such as ritual abuse or recovered memories, were more likely to use the media as a reference point. For example, Molly stated “What constitutes a paedophile … I’ve taken most of it from the media”. With regard to ritual abuse Amy commented “the only thing I’ve ever known about that is the media around that”. In contrast, Leah surmised the media may have exerted a greater influence “if I hadn’t the learning and the experience that I’ve had”. All but one social worker identified less knowledge of perpetrators in comparison to victims,
particularly female perpetrators. Other topics and practice areas which often constituted gaps in participants’ knowledge included male victims, forensic interviewing, and legal processes, ritual abuse, and recovered memories. These issues are explored in Chapters Six and Seven.

**Challenges in defining CSA**

Participants not only discussed their own definitions of CSA, but also positioned themselves in relation to societal and legal definitions, and associated perceptions about levels of severity. They brought up a range of scenarios representing definitional challenges. As Jill noted, “there’s a lot of different definitions depending on what the context is, and what the source of it is, and whether it’s a legal definition versus … ACC’s definition, versus a therapeutic definition”. Cathartic laughter and pauses punctuated four participants’ attempts to define CSA, highlighting the emotional work; and two became quite flustered trying to find words. After discussing the various ways in which children could be penetrated, Pinchas observed: “sexual abuse … God it’s not a comfortable thing to talk about at all, is it?” Similarly Leah commented “God, that was difficult to get to” (laughs).

Three definitions encompassed a phenomenological viewpoint of the child, with descriptions of “feeling uncomfortable inside”, “disempowered”, and “helpless”, but two participants noted that young children may not always feel uncomfortable. Others perceived CSA as “taking a child’s trust” and “convincing the child that it is normal, acceptable, and appropriate”. These ideas suggested that children may experience conflict between what they feel on a bodily and emotional level, and their indoctrination in terms of the normality of CSA.

Defining what age range the term ‘child sexual abuse’ referred to, proved difficult for many participants. Leah aligned her upper age limit of child with the age of consent, yet acknowledged it was a grey area and required attention to power and age differentials. Jack felt that the law rendered the definition of “child” within child sexual offences fairly black and white. Yet LMG pointed out clear inconsistencies in the law with regard to the differentiation between child and adult, and drew on her observations of her daughter’s development:

LMG: Well I find that quite fascinating, because in this country you have to be 18 to vote and you're not really considered an adult until then … You’re still under the CYFS Act until the age of 18 … so where does the 16 come from? I don't know. How’s that decision made? In fact, I don't even think you can get married until you're 18 can you, without parental consent.
Six participants highlighted a power differential as a key factor in defining CSA, and three of this group also identified an age differential. A challenging area for identification was concerns with young children. As two participants commented, naive sexual curiosity and experimentation could occur, but “sexually aggressive or exploitative” behaviour in the absence of a significant age difference was also possible. Jill noted that teenagers are “often mutually engaging in sexual activity for mutual pleasure much younger than the age of consent”, which may sometimes involve a “degree of age difference”. However, she added “I’d always have my radar up about anything like that”.

Participants’ definitions varied considerably in their attention to the sexual aspect of CSA, and their willingness to be explicit about sexual activities. Some avoided using the word sexual at all, preferring terms such as “unwanted touch”. In other cases the sexual aspect was broadly mentioned as “an act of a sexual nature” or “inappropriate or unwanted sexual behaviour”. Others were more specific, but not necessarily relaxed. Elvis laughed nervously at the end of his definition:

Elvis: I guess the sexual part … would be primarily touching, but I guess it could also be … talking or grooming … or um manipulating … I guess we’re talking about the pubic, and the anal and the breasts … But … I’m thinking if a 45 year old man was to kiss a 7 year old boy that he met in the playground, then that also encompasses child sexual abuse, so I guess there’s a lot to it (slight laugh).

Jill appeared to approach her definition in a very matter-of-fact way, which may have reflected her experience in the field: “it could include anything from … non-contact kind of stuff like flashing or being made to watch pornography … through to full anal, oral, vaginal rape”. Molly drew on previous workplace training and also provided an unsentimental definition of the sexual nature of CSA: “inappropriate touching … like … rubbing someone’s bottom to touching someone’s breasts, to using your finger to full on … intercourse, or using other objects”.

All participants held a broad definition of CSA, although two commented that non-contact activities were often initial strategies to groom the victim. As Jack noted, the potentially ambiguous nature of non-contact activities made them more difficult to identify and prosecute, “probably you wouldn’t get a conviction out of it”. Six participants felt that a broad definition acknowledged that the victim’s perceptions of impact did not always align with legal and societal views of severity. For this reason, they avoided a continuum of seriousness. Amy stated “it’s an umbrella for a whole range of practices and I’m not saying that … any one of them is
worse than another one”, and went on to elaborate “I might not consider something abuse perhaps, but the person who has been abused may well do”. Similarly, Jill privileged the victim’s subjective appraisal of impact over societal or clinical expectations.

BJ drew on his own experience of having been sexually abused on one occasion to provide an example of the danger in assuming the impact of CSA, based on the sexual offence. “It was a one off time, and, but the impact was, you know, it was huge … the feelings, and the experience, and the recall, and all the stuff around that is huge”. Robin considered that the relationship between victim and perpetrator had more impact on the victim than the acts defined as CSA. However, she did qualify her opinion with the observation that highly violent acts of sexual abuse also had a serious impact. In her mind, the betrayal of the relationship was traumatic, which challenges the notion that trauma must always involve terror and fear: “to me it’s the closer - the more traumatised and pouri people are, it’s because the closeness of the person, that is the betrayal. And to me … that’s more of a damage”.

**Ideas about CSA training within social work education**

I asked participants for their thoughts about CSA training within social work education in the first interview, then re-visited the topic for further consideration at the beginning of the second interview. Participants held a range of ideas related to content, process, and timing of CSA education. There were thoughts about what “the basics” of CSA education constituted. BJ felt CSA should be taught within a mandatory paper on all forms of abuse which prepared students with “some theory” and “some skills … around helping people”. In Jill’s mind, an understanding of trauma provided a grounding to appreciate the impact of CSA. While she discussed the need for training in responding to disclosures, there was no mention of inquiry.

Jill: I think there definitely has to be a reasonable amount of basic training in … the reality of child sexual abuse and the potential impact of it, how to handle a disclosure, what kind of resources are available…. But also I think there needs to be more training generally about … trauma and abuse, and the impact.

Leah also felt that social workers needed an adequate understanding of the impact of trauma, in order to respond appropriately without causing the client further harm. Ideally, she believed “there should be a trauma and abuse module as a mandatory part of all social work training”.

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Leah: At the minimum I think there needs to be a module … that addresses trauma, its effects, how it presents, and how to respond … if we suspect, or have a disclosure made to us of this event, because that is likely to happen, you know.

Emerging from the first interview, Leah’s comments about suspecting CSA may have been an implicit reference to inquiry. However, in the second interview she did not mention the need for training regarding inquiry, and could not recall whether training in inquiry had occurred in the trauma module of her post-graduate degree. She commented that her suggestions were the types of issues covered in her trauma module: “how do you create safety and what are the things that could make the situation unsafe, and dealing with disclosure.” Jill also made additional comments in the second interview regarding process issues for education, such as professional comfort with the topic, sensitivity, and the need to be attentive to the pacing of questions and discussion.

Jill: I suppose the thing that tends to not be covered so well in training that … I have learnt quite well, but through experience, is really around how to talk about sexual abuse issues with people.

Interviewer: Right.

Jill: How to lead into asking questions or talking about things, ways of wording things that are … sensitive to where someone is at with the issues themselves … that whole thing around pacing … because it, it can be such a fraught thing for people. And … if someone … is really pretty traumatised about their experience, it’s obviously really important not to … re-traumatise them unnecessarily.

Jill’s suggestions were in the context of her observations in the 1980’s and 1990’s of over-zealous therapists who believed CSA “should be talked about, but didn't necessarily have an understanding of trauma and dissociation, how triggered people could get”. She highlighted the importance of knowing “when to leave something, or the value in taking things slowly, and building safety and trust first”. In this second contribution, Jill certainly makes reference to inquiry, perhaps involving both initial inquiry and follow-up questions to a disclosure.

Molly reflected upon where CSA training would fit within the under-graduate curriculum focused on “social practice and theories and ... social justice”. She suggested it was offered as an “elective paper” but believed the “basics” were relevant to “all” social workers. She also highlighted the “different skill set” in working with children/youth as opposed to adults, in terms of developmental issues and the currency of disclosed CSA. For children and youth, formulating appropriate follow up questions to determine what happened was crucial in order to make a notification. Molly drew on a previous work role in considering these issues.
Molly: The basics on how to ask the question … and what I mean by basics is for all social workers, if child sexual abuse is raised, how do you address it? How do you respond? How do you keep probing? How do you check that they’re going to be safe … I mean, I’m thinking about me and the child and adolescent team. If you’re assessing a 13-year-old that says, “Oh, by the way, you know, I’ve been sexually abused or inappropriate touching” … where do you go with that?

In contrast, Robin felt it was important to ground students in a basic understanding of CSA in the first year “what it is … the effects on whanau … what you do if you discover it, who’s in the community”. She felt this should occur before any training on inquiry, which perhaps could occur in second or third years. LMG believed the topic of trauma deserved “more time and attention”, but observed there was little space in the under-graduate curriculum. In her mind, training might be better served through the provision of a year’s post-graduate training in trauma.

Highlighting further process issues such as emotional availability and receptivity, Pinchas wondered whether these were inherent qualities, implicitly conveyed, rather than teachable constructs. The night before our first interview, two complete strangers, unknown to each other, and to Pinchas, had disclosed a history of CSA to him in a takeaway shop. In trying to understand what had happened, Pinchas highlighted the ontological status of the social worker, in the same way a qualitative researcher is regarded as an instrument. He felt that social workers’ ways of being provide a clearing or openness for clients to disclose CSA, similar to Heidegger’s concept of the clearing. He surmised that his thought processes, regarding his recent involvement with two clients who had disclosed CSA, perhaps meant “people get that they can share this with me”.

Pinchas: I thought, “I wonder if I’m just the clearing for these sort of things right now” … and I think that’s what happens. People do pick up things, they get perceptive to stuff, and sometimes it’s not even on an intellectual level, sometimes it’s just on an emotional level … I think people know that this is a person I feel safe with … can share with, which is really interesting … I didn’t get any training for that.

The notion of receptivity and consciousness regarding CSA emerged as a pertinent theme for four other participants. For example, Jill described being “a little bit more conscious of sexual abuse issues when I was with clients” in the month following her first interview. Similarly, Elvis was able to offer support to other staff in a very emotionally challenging case review involving CSA, because of his conversations with me in the first interview. He commented: “I felt like a tape recorder, saying that, because it was kind of a déjà vu moment.
We’d sat here and we’d had exactly the same conversation”. Amy reflected that the interview process was an “awareness raising thing”, which caused her to be more conscious of the potential for CSA. Receptivity for Amy involved being open to the possibility that any client may have been sexually abused. For Jack, it involved keeping the topic in mind and being prepared to respond. While these discussions were not directly related to suggestions about social work education, participants’ comments suggest that exposure to the topic of CSA sensitises practitioners to the potential presence of CSA, and/or assists in responding. Yet such effects may not be sustained in the absence of ongoing organisational support. Three months had elapsed between Jill’s interviews, yet she only described being more conscious of CSA with clients over the first month.

Two participants strongly felt that social work education needed to address the reality that a significant proportion of social work students will come with a CSA history. Amy raised the possibility that some social work students could even be child sex offenders. She commented that there had been no expectation within her social work education for students to address their own personal issues. In her view, social work schools perpetuated the silence around CSA by failing to address the personal impact of CSA on students.

Amy: With a group of people who are learning stuff like counselling or social work … you're going to have a bunch of those people, probably quite a high representation of people in the room, who had, had been affected by their own or someone else's use of substances, their own or someone else's abuse … someone close to them. So it is interesting isn’t … because there is a silence that goes with it, and maybe it’s something that gets carried through in the … learning establishments as well.

Similarly, Robin talked about “screening” social workers so they did not go out into the field “wounded” or “unhealed”. In her view, inquiry about CSA without adequate training and resolution of one’s own sexual victimisation had the potential to cause the client harm.

Robin: If you’re not healed, if you’re not trained … and you delve into people’s most pouri parts … if you open something or try to open something … there’s a fine line. It’s having an understanding before you make the inquiry … if you inquire without the understanding, there will always be damage.

Amy believed that wounded healers had the potential to silence clients, who would sense their discomfort and tension. She described it as a “recipe for transference”.

Amy: I am hard line around this stuff, otherwise it is talking the talk and not walking the walk, and on some level whether it’s spoken or not … our clients
will know of our authenticity … At the end of the day, if I'm not prepared to talk about my own sexual abuse with someone, somewhere, then I am going to silence the person who is sitting in the room with me.

While speaking about practice, BJ also endorsed the view that social workers needed to be aware of how their own trauma histories may be impacting their relationship with clients. His comments highlight the importance of reflexivity and emotional intelligence within social work education. As a supervisor, he had advised staff to address their own issues when it became apparent it was impacting upon their work.

BJ: I’m always wary that if someone comes in and they’ve gone through their own stuff, to examine that, and to be very clear about the boundaries … not to … bring your stuff. I mean, of course we get triggered with transference, but it’s recognising that stuff, and … I think I’ve seen better therapists than others in terms of … they’ve been through their own stuff.

Pinchas noted the importance of including a Maori world view in social work training on CSA including *Whakawhanaungatanga*, and Robin discussed the need for awareness of how racism can permeate institutions. Reflecting upon process issues for Pacifica students, Siaki suggested that the presentation of information and the language used was just as important as the content. This assisted students to “connect with” and “digest” the content on an emotional level as well as cognitively. He drew on experiences at school with sex education: “as young Samoan males, you don't talk about that stuff in front of people, you keep it private…. So when they brought it out, they talked about it freely, it was too much”.

**“Holes inside”: Perspectives supporting CSA inquiry and response**

As can be seen in Table 7, seven participants perceived CSA to be more prevalent within the addiction and mental health sector than in the general community, with percentages 2–8 times the prevalence they gave for community populations. A further three estimated CSA prevalence to be similar in community and clinical populations, and the remaining participant had no knowledge of prevalence figures. Clearly, the vast majority perceived significant links between CSA and addiction or mental health. In addition, five participants commented about the relevance of CSA for other fields of social work. Understandably many mentioned child protection, but other fields were also cited such as HIV, elderly, disabilities, and corrections.
<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>CSA prevalence in mental health/addiction</th>
<th>Relevance of CSA to addiction/mental health</th>
</tr>
</thead>
<tbody>
<tr>
<td>LMG</td>
<td>80%</td>
<td>“highly likely” issues are linked</td>
</tr>
<tr>
<td>Jack</td>
<td>“hugely prevalent” 80% females, 40% males</td>
<td>“they try to fill (holes inside) with alcohol and substances”</td>
</tr>
<tr>
<td>Leah</td>
<td>60%</td>
<td>“extremely relevant”, “highly interlinked”</td>
</tr>
<tr>
<td>BJ</td>
<td>60%</td>
<td>“their sexual abuse is a trigger and they use”</td>
</tr>
<tr>
<td>Amy</td>
<td>“very high proportion”, “we get a high percentage”</td>
<td>“really important” to have “some (CSA) knowledge and understanding”</td>
</tr>
<tr>
<td>Jill</td>
<td>at least 50%</td>
<td>“very inter-related”</td>
</tr>
<tr>
<td>Molly</td>
<td>“pretty huge”, “we don’t gather those stats”</td>
<td>“hugely relevant”</td>
</tr>
<tr>
<td>Elvis</td>
<td>“significantly higher” than community prevalence</td>
<td>“potentially quite a strong link” “alcohol and drugs is … a coping strategy”</td>
</tr>
<tr>
<td>Pinchas</td>
<td>25% females, 12% males in community, clinical “assuming same or slightly higher”</td>
<td>recent disclosure from mental health client after 2 ½ years “it explained so much”.</td>
</tr>
<tr>
<td>Robin</td>
<td>25% “some are not ready to (disclose)”</td>
<td>“avoid (CSA) by using alcohol and drugs”.</td>
</tr>
<tr>
<td>Siaki</td>
<td>No knowledge of prevalence, “in clinical reviews …now and then”</td>
<td>Not “specifically child sexual abuse...but certainly child abuse”</td>
</tr>
</tbody>
</table>

Jill’s cathartic laughter discharged the tension of acknowledging that no area of social work is free of CSA.

Jill: I’m pleased that I’m not actually working fully in the sexual abuse field at the moment … I think it’s a field that it’s quite good to have a bit of a break from it, but if you want to be a social worker or a counsellor, you can never completely have a break from it (laughs).

Seven participants believed that clients often self-medicated with alcohol and drugs in order to cope with the impact of CSA. Elvis considered the abuse of alcohol and drugs to be short-term fixes for dealing with trauma which became less effective strategies in the long-term, yet as BJ pointed out, the anaesthetising effects of substance abuse were compelling.
BJ: So underneath a lot of our drug users, a lot of our alcohol binge users, there’s a lot of abuse … there’s sexual, there’s neglect … so there’s a lot of … the child stuff … it kind of just gets numbed, and kind of put to the side.

Leah highlighted the need to understand what clients were “trying to cope with” before expecting them to attempt abstinence or harm reduction of substances. Using the language of trauma, she observed that alcohol or drug abstinence may precipitate an increase of sexual abuse memories or the recovery of memories.

Leah: Substance misuse and past experiences of trauma are so closely linked … often times when people are actually starting to get sober … some of those … memories of those experiences come back in an extremely powerful way…. You take away this thing which clouds, keeps me fuzzy, keeps me sort of derealised, depersonalised, and … all of a sudden, it’s warts and all.

Two participants recounted instances where clients had directly or subtly identified their use of alcohol and drugs as a means to manage their memories, and/or emotions regarding CSA and other abuse. Working with youth, Jill noted the implied links in their narratives: “I drink so much because I don’t want to think about stuff, I don’t want to remember stuff that has happened to me, it helps me sleep better”. While she used the language of post-traumatic stress such as “flashbacks”, “triggers” and “hyper-arousal”, she pointed out that clients did not use that language, and perceived links between past and present in very general terms. In discussing the idea of self-medication, participants tended to focus on the need to calm the effects of hyper-arousal and intrusive thoughts, rather than the alternate need for stimulation in response to a pervasive sense of numbing and hypo-arousal. However, Jack’s comments regarding “holes inside” and “something robbed” suggested a dissociative response. With a deep intake of breath, Jack reflected on the void created by the withered self, and the imagery evoked a sombre mood, which he attempted to lighten with cathartic laughter.

Jack: What you get is … people with … (breath inwards), kind of holes inside them basically … emptiness or whatever … something … robbed, and what do they do, they try to fill it with alcohol and substances (laughs) … in mental health it’s … that kind of breakdown of reality … coping with the trauma of that, and the associated depression.

All participants believed that disclosure was difficult at any age and that delayed disclosure was common. They revealed considerable understanding of the multiple and complex barriers to disclosure, which are discussed in Chapter Six, to tell or not to tell. Yet despite these insights and a mandatory risk assessment, none of the participants routinely
inquired about CSA with clients. Participants discussed personal, professional, and organisational barriers from their own perspectives, and those of others.

**Practice issues regarding CSA inquiry**

*The dissenters*

For various reasons, five participants believed CSA inquiry was not appropriate in their current social work role. Their self-rated knowledge spanned all three levels previously discussed. Elvis stated he would be “hesitant to do that” because he had observed that “one way … people deal with trauma in their past is that they … put it in a box and leave it there”. He went on to comment: “as far as kind of digging further back, that’s not really the way that I work, not really where my strengths are, or my training”. For Siaki, his practice of not inquiring about CSA was due to being more “AOD focused”. He stated “I don’t look for it … but if it comes up, I will explore it”. Pinchas, who worked in mental health, commented that the workplace had not equipped him with policies and training to inquire and respond regarding CSA. He experienced the organisational culture as unsupportive regarding CSA inquiry, and he felt the mental health assessment was already overwhelming for clients. His tone and speed of voice, facial expressions, and body language suggested his anxiety about the idea of inquiring:

Pinchas: It’s not one of the questions we generally ask … it’s just not asked. I only know from those who have disclosed.… There isn’t anything in place for that, so to just go ahead and ask people, and then you have to say, “Now what, now what do we do?” … I don’t think we’ve got a mechanism in place to go ahead and cover the responses we could get … and there’s certainly no training as well. So before we even start asking I think we need a load of training.

The remaining two participants who did not inquire about CSA believed it was important to respect a client’s readiness and capacity to address such issues. They advocated establishing a relational space which allowed clients to disclose in their own time. Amy noted that the broad questions in the risk assessment rarely elicited a disclosure. In her view, building a relationship allowed her to intuit the potential for CSA, and provide a safe space for the client, who ultimately chose whether or not to disclose.

Amy: We always do a risk assessment…“are you, or have you ever been at risk of harm from others?” … but … in my experience that’s something that gets disclosed later with engagement … maybe … I’ve thought to myself … “there must have been some abuse here … what can I do to elicit it … without rushing them?” … to prepare people to be able to get to a point where they can
recognise it, and say it…. I don’t mean leading people in that direction, but certainly leaving the space open for that, and it either comes or not.

Robin held a similar view, and in her mind, delving into unresolved areas may hinder therapeutic engagement. Her reference to surviving and the “core” being hidden suggest an unhealed wound and defensive, avoidant coping, perhaps leading clients to cycle in and out of services, until they were ready to address their inner world. In this view, surviving did not align with concepts of success and adjustment commonly associated with the term “survivor”.

Robin: Some of them are not ready to.
Interviewer: Disclose?
Robin: Yeah, and some of them are still surviving…. Even though they’re older and … that’s finished … you know that they’re going to come back again, ’cause … the core is still hidden, and they’re not ready.
Interviewer: Right.
Robin: So you just get a sense that, oh well, okay.
Interviewer: Yeah, and you feel that it’s best to wait, rather than -
Robin: Oh no, you don’t push anyone.
Interviewer: Yeah, okay, yeah.
Robin: You encourage them to engage, you encourage them in their potential, but putting pressure on people, it’s very hard to come in here.

Paradoxically, Robin condoned CSA inquiry by well trained professionals. Despite previously rating her own knowledge of CSA as 10/10, she did not appear to identify herself within this category of professionals.

Robin: I guess for me I prefer that people were asked than not asked. It’s better to ask than not ask, because that’s an opportunity. But it has to be by a trained, well highly qualified … professional … that understands the dynamics of abuse.

The assenters with stipulations

A further four participants stated that they did not routinely inquire about CSA with clients. While all four discussed their competence in CSA inquiry and response, with such comments as “reasonably comfortable” and “reasonably confident”, all were more likely to inquire if the client’s presentation pointed to CSA. For example, LMG stated that it felt easier to inquire if there were “things … that might kind of indicate that it's been happening”. Similarly, Leah noted “I wouldn’t necessarily inquire directly about that, unless there were things that were suggesting to me that that was an avenue of immediate concern”. In keeping with previous comments by Robin and Amy, Jack discussed the role of intuition and relationship-building: “you get that kind of feeling … you know, do it by sense”.

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The very “things” that might suggest trauma also emerged as barriers to inquiry for two participants. Leah cited concerns for stability and safety as reasons for not inquiring: “I mean some of the folks that we’re working with are extremely dysregulated, so I don’t know that I would be heading there initially”. The metaphor of a revolving door comes to mind in Leah’s account of repeated hospitalisations for clients diagnosed with “severe enduring mental illness”. In a vicious circle, those suffering with the most extreme and chronic dysregulation, while pointing to trauma histories, appeared least likely to have opportunities to address the impact of the past upon their present distress.

Leah: Our engagement with clients can be quite long term in dual diagnosis, in that we can work with the same person for years at a time … our client group is … severe enduring mental illness … that usually means … things are very unstable. If we’re engaged that long … it’s not because there’s … this consistent piece of therapeutic work that we’re able to do, it’s because they’re in hospital, they’re in and out of … emergency rooms … there’s a lack of stability that allows for the kind of work that we’ve been talking about.

In a similar vein, Jill discussed the need to prioritise safety during initial assessment, and noted that a considerable proportion of clients were “really, really risky”. Discourses of risk and vulnerability, while entirely valid concerns, tended to dominate these accounts, obfuscating notions of resilience. For clients who managed prior trauma in unhelpful ways that defined them as “risky”, the risk of asking about CSA appeared to be greater than the risk of not asking. Jill also discussed the need to reduce risk when a CSA history was already recorded on the client’s file. She commented “the last thing I want to do is refer to … years of being raped … when actually our first priority is to get them to not be blacked out tonight”. This example of extreme insensitivity was completely uncharacteristic of Jill’s practice, leaping over the middle ground of careful use of language and pacing which she endorsed. The justification therefore didn’t seem to ring true. Jill went on to summarise the many factors informing her decision when, how, and whether to inquire. Like Robin, Jill implied that asking about CSA at early stages might undermine relationship building and the client’s willingness to engage.

Jill: It just depends on the client, and what sort of language I think they’ll respond to, and where things are at in my relationship with them, and … what they’re presenting … I’m thinking about … what is this client here for, how engaged are they about being here at all, what’s my role with them, what is the most important things we need to … address … and what is the best timing for that … the best approach … and it’s got to have a purpose too.

Jill’s last comment about purpose suggests that in some cases there may not be any purpose to ask about CSA, or address it if it was on the file. Jill had suggested that clients with
less serious alcohol and drug problems might have a lower prevalence of CSA than those with severe addiction issues. She had observed these were often clients who were ordered by court to attend one or two sessions. Along with Jack, she felt it was inappropriate to ask about CSA with such clients, many of whom were male.

Like Siaki in the dissenter’s group, Leah also identified the constraints of her role as a factor in not inquiring. In contrast to previous discussions about instability, she cites a presentation of stability and containment as a reason not to inquire. Yet there is also a suggestion that inquiry could rupture the sense of containment, opening up a can of worms. In this account, she tends to conflate response with treatment, disregarding the middle ground of trauma-informed practice, which she endorsed at earlier points in her interview. For example, Leah previously discussed the need to appreciate what clients are coping with and assist them in understanding the links between addiction, mental health, and CSA.

Leah: I’m a little more hesitant around those inquiries because our role is quite circumscribed. So unless I’m getting some kind of a sense that this is part of the picture … I wouldn’t necessarily go there … if it is part of someone’s experience, it’s well-contained, and it’s not causing an issue at this stage of the game. I’m not able to offer support around it, if I opened that up, I mean, I am of course, but I can’t offer an ongoing dialogue, or piece of treatment around that.

The initial assessment process offered several opportunities for asking about CSA, yet all four participants did not tend to ask about CSA at this early stage. Jack stated “I mean I think you should probably ask it right at the beginning anyway, I can’t say I always do”. Jack was the only participant in the whole sample to note the importance of continuing to inquire at various points in the relationship. He commented “just because you ask it once doesn’t mean to say you shouldn’t ask it later on down the line”. Participants asked broad questions about childhood such as “what was it like growing up in your home?” and “good stuff and not so good stuff”. In keeping with Amy’s previous comments about risk assessment, LMG noted the lack of specificity “we ask about …general risk concerns”. In her experience it rarely elicited disclosure, “not usually in the first meeting”. Likewise, in relation to questions about childhood, Jill commented: “it doesn’t necessarily mean that they’re going to tell me, especially not at the first appointment”. In summary these four participants appeared unlikely to inquire about CSA within the first two sessions, and also perceived that clients were unlikely to disclose CSA in initial sessions, perhaps creating a self-fulfilling prophecy.
While these four participants were not completely averse to asking about CSA, three appeared to prefer indirect strategies. Jill stated “I don’t absolutely always ask that overtly” and similarly LMG noted “I wouldn't necessarily ask that specifically, you know, “have you been … in the past?” Normalising the links between substance abuse and past abuse, Jill described the type of subtle inquiry she might have with substance abusing youth:

Jill: Lots of people that we see … might have had some difficult stuff or bad stuff happen to them when they were younger in their lives … like people doing stuff … to them sexually that they didn’t want, or didn’t understand, or was confusing for them or … being hit, or feeling unsafe, or being bullied … we kind of ask about that stuff because sometimes that … stuff can … hang around and … affect how people feel about themselves or their lives, and some people find they drink more, or … do drugs more, if they are stressed, or have difficult memories, or stuff to deal with.

Two further participants did not specifically discuss their own practice with regard to CSA inquiry. Molly had endorsed training in CSA inquiry, and could potentially be included in the group of assenters, although this was not entirely clear. She did not appear to inquire in her own practice, possibly because of her low self-rated knowledge; and she drew on a previous role to discuss experiences with disclosure. BJ illustrated his willingness and comfort to respond to disclosures, and drew on two disclosures in his current role, but did not explicitly discuss inquiry.

While the topic of inquiry was discussed hypothetically, no one gave a concrete example of recent inquiry with a client. Despite the belief by some participants that clients would disclose when ready, disclosures appeared rare. Only two female and two male participants made reference to receiving a disclosure of CSA in their current role. Male participants, who predominantly worked with males, appeared less likely to embark on any form of CSA inquiry with only one out of five stating that he had occasionally done so. Despite being the only male to sporadically ask about CSA with male youth Jack noted: “since I’ve been here … no one has actually disclosed”. Having worked in mental health for over 18 years, Pinchas highlighted the small number of disclosures he had received: “just recently, I’ve had two disclose to me. But otherwise, overall … I’ve had 15 disclose to me, but that’s out of a case load of, God, hundreds”
Working within silos: Passing or holding the hot potato of disclosure

Molly used the metaphor of silos to highlight the rigid division of roles and services which impacted the way in which CSA was addressed. Speaking about previous experience in child and adolescent mental health, Molly described how such compartmentalisation shut down disclosures: “they disclosed … we had to shut that down, and this is the way you would go … So we specifically deal with mental health. Sexual abuse is a whole, another pathway”. The disclosure of sexual abuse and in effect, the client, became a hot potato to be immediately passed on elsewhere. In her experience, CSA was not dealt with in mental health treatment plans: “we would either close the file or we would do some further work, but around mental health, not around the abuse”. The metaphor of services as silos, enclosed and sealed off from each other, highlighted minimal communication and a lack of multi-disciplinary working between child protection and mental health services. While this obviously concerned Molly, who brought up the issue in both interviews; she felt a sense of resignation and lack of hope that the status quo would change.

Seven other participants cited the compartmentalisation of services as a major determinant of their ability to address CSA, either at the point of inquiry as previously discussed by Siaki and Leah, and/or in addressing CSA as part of the treatment plan. Their attitudes towards the organisational culture of silos ranged from acquiescence to resistance. Displaying varying degrees of willingness to work with the issue of CSA, common comments were: “it’s not my primary role here”, “it’s very compartmentalised”, and “we’re working in the context of AOD”. In Elvis’ view, the constraints of his role necessitated immediately passing the hot potato. Imagining his response to a disclosure he emphasised the specialist nature of the field of CSA. There didn’t appear to be any middle ground to discuss CSA in the context of substance abuse, rather it was deemed to fall into the realm of counselling:

Elvis: If one of my clients was to come to me and say, “look I have issues around child sexual abuse”, then I wouldn’t see my job to counsel that person, I would see my job to refer them to a specialist.

LMG’s use of the word “injury” suggests a more trauma-informed approach rather than a sickness model, yet she juxtaposes the centrality of the injury against the organisational expectations for the “core” focus to be substance abuse, and a sequential model of treatment.

LMG: It is really difficult because obviously when you've got to engage with somebody, you get to a certain point in your work, and they naturally want to
go to where … the injury is, but our core business is drug and alcohol isn't it, once they’re stabilised, people are in a position to go elsewhere then.

Jack believed the tendency to pass the hot potato immediately reflected the discomfort professionals felt in addressing CSA. After many years of previous work in mental health he had observed that CSA was “just not recognised … and … when it is … it’s not dealt with”. In his view, professionals “genuinely find it so kind of frightening” and consequently “some people would be a bit more reluctant” to address CSA in the treatment plan, and would be “quicker to refer on to other agencies”. BJ held a similar view, and discussed examples that came up in team supervision:

BJ: What often happens is … if someone is not that competent, and brings up, “oh there’s sexual abuse in this history”… they tend to kind of leave it a little bit, kind of more just offer, “are you, have you got somewhere you can go to get some help?”

As a supervisor he described taking on an educative role with staff to help them recognise the links between sexual abuse and substance use, and to use this awareness to inform their practice. In his own practice he assisted clients to connect the dots: “their sexual abuse is a trigger and they use, and we unpack it. I would say that the majority of it is about awareness, and it’s about helping them to gain some insight to the links between both”. In his view, the compartmentalisation of services was particularly problematic for Pacifica clients who preferred a holistic service.

BJ: That’s the primary focus … contracts … it’s alcohol and drugs, gambling and smoking … but … as Pacific … people are holistic … it comes out, it comes up, and the clients overwhelmingly always say “can we just deal with it now, I don’t want to retell my story to someone else”.

BJ highlighted the difficulties people with CSA histories often faced in building trust, and discussed the need to sensitively transition clients to specialist services which may take some time. This idea of gradually transitioning to other services, and working with clients to identify links between addiction/mental health and CSA, was taken up by two other participants. For Leah, psycho-education, commonly utilised in the field of addiction, was a useful intervention which normalised “the linkages”. She commented, “I know for me … there’s a big psycho-ed piece there around the ways in which … the symptoms of trauma can be alleviated by substance use” Within the sphere of motivational interviewing for substance abuse, Jill discussed how specific tools, such as the use of timelines, also assisted clients to make links, and understand the impact of past abuse.
Jill: One of the things that we do with our clients is a timeline … that can be a very powerful tool for helping them see that actually, since they were 11, and they were … raped by Uncle John … that it was after that they started sniffing … and that it helped them forget about it. Or that’s when they started getting into trouble a lot, or missing school, or getting angry…. So sometimes that will help to … make a link … and it’s not until you actually lay it out, that they can go, “Oh”.

In Jill’s view, clients’ self-understanding was a key to making informed choices: “I think the more people understand themselves and their own kind of processes and reactions and connections, the more they’re able to begin starting to make choices about that”. Three participants commented that, for a proportion of clients, a history of CSA was already recorded on file. These represented an indirect or second-hand disclosure, which may not always be addressed. Leah’s observation that “for most of our clients, it’s in their file” implicitly suggested that the work of inquiry had already been done. She noted that clients with recorded histories of CSA came with “different levels of understanding” about the impact, which was influenced by “different levels of willingness” to approach the topic. Self-understanding could therefore be blocked by defensive processes such as avoidance and minimisation.

Leah: Getting a sense from them about … how that fits into the picture … For some people that may be an extremely prevalent part of this, and for some people it may not be, either because they’re not acknowledging it at present, or simply because they’ve done what they need to do with that, and they’ve moved on … So … assessing where that fits in the grand scheme of things is an important part of … treatment planning.

The place of CSA histories within treatment plans therefore varied considerably and was a little nebulous. It appeared to often be client-led, focused on the client’s self-assessment of the impact of CSA, and their readiness and willingness to address those issues. However, it also involved assessment and intuition on the part of the social worker, of the clients’ awareness and understanding of the impact of CSA, their capacities for addressing CSA, and what type and level of work would be most appropriate.

BJ: I’m a firm believer that the client directs, so it’s client-centred in that sense, and I try and always work out, “what … does this person need?” Is it just … insight-focused … do they have to gain that insight and understanding and awareness … as opposed to doing the work, and really dealing with the emotion and the pain around it.

Understanding where CSA fitted into the whole picture for clients necessarily required further exploration. However, this elicited a range of concerns for participants, such as moving into the realm of counselling, destabilising the client, and being intrusive. While all participants
perceived links between CSA and addiction and mental health, only a minority discussed using specific interventions to help clients make the links.

**Timing of CSA therapy and substance abuse treatment**

The nine participants who worked in addiction were acutely aware of the catch 22 for clients with a history of CSA. They noted that substance use often interfered with trauma processing, but also recognised that abstinence commonly exacerbated distress by removing an effective numbing strategy, and potentially increasing abuse-related thoughts and affect. Consequently, they held mixed views about the timing of CSA therapy. Some strongly felt it should occur after achieving abstinence, whereas others felt that harm reduction was a more realistic goal allowing concurrent treatment. Although some believed in the benefits of integrated treatment, the reality of service constraints meant that it was unlikely.

Those participants who felt that addiction issues needed to be dealt with first, often highlighted the need to create stability through effective coping strategies, as a means to support clients to engage with the challenging work of sexual abuse therapy. They perceived substance abuse as a “coping mechanism” or a means of self-medication, which needed to be substituted with other more helpful coping strategies.

LMG: I definitely hold an idea that it is not advisable … or useful, for somebody to start looking at the trauma issues when they don't have the coping strategies to manage that.

Interviewer: Right, so the safety and stability are kind of basics?
LMG: Yeah, for somebody who's … using and abusing substances, it's generally … some kind of coping mechanism.

In Amy’s view, it was preferable that clients have a substantial period of abstinence before engaging in sexual abuse therapy, because of the danger of relapse. She perceived substance abuse as a coping mechanism for managing “feelings” and “fears”, and as part of a “self-destructive” and “abusive” pattern towards self, which could be intensified by therapy. However, she acknowledged that therapy may be needed before abstinence was achieved, if the client was experiencing a high degree of intrusive thoughts.

Other participants felt that sexual abuse therapy and substance abuse issues could be dealt with concurrently, because of the inter-relationship between issues. Leah believed that continued substance abuse shouldn’t prevent access to sexual abuse counselling. In Jill’s view, it was important to assess and work with the unique interaction of the two “very inter-related”
issues for each client, which prevented one issue sabotaging the other. In her mind, one issue might have a greater therapeutic focus than the other, depending on what was “most helpful in … stabilising and supporting” the client. In a similar vein, BJ discussed the problems clients encountered when attempting abstinence without having approached their previous sexual victimisation: “they’ve decided, ‘I’m going to reduce my cannabis use, but oh no, the sexual abuse comes back up … the anger comes back up, the bitterness comes back up’”. Like Jill, BJ believed that treatment needed to address both issues, and that some cases required a deeper focus on one issue. In his view, sometimes the emotional pain associated with CSA needed to be the greater therapeutic focus to help resolve alcohol and drug problems.

Methadone clients participated in a legitimised form of substance use, which in Elvis’ mind, provided no barrier to concurrent CSA therapy. Harm reduction, rather than abstinence, was the predominant goal for most methadone clients, and few were observed to exit the programme. Consequently, the medicating and stabilising role of methadone was potentially encouraged while CSA therapy occurred, as a means of regulating emotions. He suggested “if there’s other factors in their life that are kind of ramping their emotional side up, then they may want to just hold on their methadone, and continue reducing when they feel the time is right for them”.

Healing from CSA: Layers and pathways

Responding to disclosures of CSA naturally evokes consideration of potential avenues for support, which raises questions regarding professionals’ beliefs regarding the nature of resolution. Participants were asked about their perspectives regarding CSA therapy, meaning-making, and the concept of healing. All had some knowledge of support services available to clients, but two participants identified the need for further knowledge about resources in the community for victims. Identifying gaps in services and those services which operated poorly also emerged as an important consideration. Siaki expressed concern about inappropriate responses from Pacifica services for victims of CSA. In his view, when such cases arose, personal needs ultimately took precedence over cultural needs, sadly meaning that palagi services were preferable routes for referral. Other participants discussed the scarcity of services for male victims of CSA, which had to be sought out. In BJ’s view, men had to work harder to find services, commenting “I wouldn't say there’s a light out there”. Likewise, Robin noted, “there’s bugger all for men”. At the time of the interviews the Accident Compensation
Corporation\textsuperscript{80} (ACC) had significantly tightened their criteria for sensitive claims. Robin’s voice cracked with emotion, when discussing watching a news report of an older man’s difficulties in trying to obtain funded therapy.

Two participants had experiences of clients who had not benefited from therapy. Elvis discussed a client who had felt harmed and re-traumatised, and he personally doubted the benefits of addressing trauma through counselling. Molly discussed several clients who had little knowledge or awareness of what therapy entailed or what they could expect from it. Without any understanding or expectations, she highlighted clients’ vulnerability, drawing on the example of a client who had seven years of psychotherapy, which never properly addressed her history of CSA. Molly felt that part of her role was providing clients with education about the different therapeutic focuses within therapy models available, so that they could make an informed choice.

In previous roles, one participant had provided CSA therapy and another had worked closely with CSA survivors. Those with personal histories of CSA often drew on their own experiences of healing, but participants also drew on feedback from clients and colleagues, as well as observations from media reports, and literature. Two participants were not in favour of therapy which revisited the CSA events in detail, because it was considered likely to re-traumatise the client. Speaking about his own experience of a Christian therapy called re-focusing BJ stated:

\begin{quote}
BJ: I’m not a big fan … of revisiting … re-traumatising … so for me personally, going back into that moment and feeling all the emotions, it was just too painful … the … process of refocusing, was that I was on the outside, and there was … a part of me … that I was able to … keep separate and keep safe … it was … like God going in there for me.
\end{quote}

Similarly, Leah didn’t think it was necessary to re-experience the trauma of CSA. She believed that the traumatic impact could be effectively reduced through “management in the here and now, and integration, but integration through acceptance, acknowledgement and coping; unless for you it’s something that needs that deeper level of exploration”.

\begin{quote}
Leah: I don’t think they need to relive it to feel it … people are feeling it all the time, which is why they’re downing their drinks or their drugs… they’re feeling in a way that is incredibly destructive…. Just learning to contain, and manage, and acknowledge, and accept is enough for a lot of people, at least for a while, and for some people, that’s enough forever.
\end{quote}

\textsuperscript{80} The ACC has a sensitive claims unit which funds sexual abuse counselling in New Zealand.
In contrast, Amy endorsed the processing and integration of emotions in therapy, which suggested support for controlled exposure to the CSA events. She strongly felt it was necessary in sexual abuse therapy “to feel it to heal it” and commented “the volume really needs to be turned up, so that they can front up.” Speaking about her own therapy, and that of her daughters, her comments indicate a painful but necessary process of saturation: “we were all going to sexual abuse counselling until it all came out of our ears, we were all having a gutsful of it, but just had to keep going really”. Robin differentiated between the metaphors of luggage and baggage to highlight the journey towards integration. Like Amy, her comments suggested a process of re-visiting traumatic events, implying the sense of mastery gained over luggage as opposed to the effects of unintegrated baggage.

Robin: It becomes all tied up … in a Boeing 747 of baggage that you carry around with you. And then when you want to pull a bit out and have a look, you rearrange it, and you still carry it, but it becomes luggage, not baggage.

Interviewer: So how do you differentiate luggage from baggage?

Robin: Well baggage is something … that you haven’t opened, that you haven’t sorted through. Luggage is when you actually have the courage to open it, and to pull each … piece out as you want to, and then repack it back in.

Siaki’s concept of healing was focused on acceptance of self, which helped him to be “a bit more grounded … not so anxious”. While attending therapy at two different points in his life, he found a Christian based therapy which identified emotional “echoes” from the past was the most helpful. He explained how he learnt to transform intrusive negative cognitions and the associated affect, drawing on the phrase: “trace the lie, face the lie, and replace the lie”. It enabled him to escape from the crushing weight of self-condemnation: “I felt a lot more released … there was no longer that pressure, that guilt … the kind of mixed negative feelings you get when you are a victim”.

Participants often spoke of, or evoked imagery of layers and depths of healing. In this view, people reached different levels of healing depending on their internal and external resources, motivations and circumstances. These different depths were subjectively experienced, and assessed by others, and two participants offered opinion about whether complete healing was possible. While Robin believed “you’re never going to get a stamp that says ‘cured’”, BJ held a different perspective. He stated “I know there’s layers, and depths, and stuff that some people never get to … but I wanted to be completely healed … from my perspective”. Leah noted that long-term therapy was costly both financially and emotionally. Also drawing on the idea of healing involving addressing different layers, Leah spoke of the benefits of repeated brief interventions:
Leah: Some people … can … benefit from doing that … huge piece, but … I think that there are just as many benefits to doing a piece, and a piece, and a piece … walking away feeling good about the piece of work you’ve done, and integrating that into your life, allows for that next piece of work to happen … in a different way … allows for that depth to come.

Conclusion

This chapter has highlighted the various ways that 11 social workers have come to know about CSA, how they rate their knowing, and how they use their knowing in practice. To know is to perceive, be aware, and be conscious of. Knowing is cognitive and emotional, involves reasoning and experience, logic and intuition. All of these facets of knowing came into play with participants. Perhaps this was influenced by the reported paucity of formal social work education regarding CSA, but even those participants who had received training drew heavily on experiential and intuitive forms of knowledge in practice. Whether they felt they knew a great deal or very little about CSA, all participants provided significant insights and contributions. While one interpretation may be that self-rated knowledge was not entirely accurate, the findings raise questions about the status of various knowledge strands and their interaction. This aligns with social work education’s emphasis on the mutuality of academic and practice based forms of knowledge, and the importance of reflexivity and emotional intelligence. In this view, academic knowledge is a necessary, but insufficient condition in the social worker’s toolkit.

In general, social workers who had more experience and training in the field of CSA, felt more comfortable discussing the range of practices that define CSA, and felt more comfortable responding to disclosures. Yet they were no more likely to inquire about CSA. In addition, participants preferred indirect methods of inquiry, believing this to be in the client’s best interests, but perhaps it also reflected their own discomfort. The thought of inquiry often elicited significant anxiety and appeared to fragment participants’ thought processes, resulting in incongruities regarding attitudes, knowledge, and practice. For example, the reported prevalence and impact of CSA, its inter-relatedness with addiction and mental health, and the need for social work education in CSA, stood in sharp contrast with the lack of routine inquiry during assessment or ongoing work. All social workers perceived the inherent vulnerabilities and difficulties associated with disclosure, with observations that many victims felt silenced, and paradoxically, this led to some questioning the appropriateness of CSA inquiry at all. In this view, inquiry was an unwelcome and potentially harmful intrusion, which trampled over the client’s readiness and capacity to disclose. In addition, risk-taking behaviour, while often
associated with a history of CSA, impeded inquiry. These perspectives tend to privilege the harm of inquiry over the benefit.

Organisational constraints posed another major barrier to inquiry and to addressing CSA as part of the treatment plan. While participants perceived significant links between CSA histories and mental health and addiction problems, only three discussed interventions to assist clients to make the links. Many expressed concern about moving outside their work remit. Participants expressed a range of views about therapy, which potentially impact their responses to clients. While the majority perceived therapy to have value, they gave accounts of clients being re-traumatised and harmed by poor responses, gaps in services, and therapy which provided too little, or too much focus on CSA experiences. These issues indicate the need for education for clients about what types of therapy are available, as Molly suggested, and sensitive transitioning to other services, as BJ suggested. In essence, the findings suggest that holding the hot potato of disclosure, whether received directly or indirectly via recorded case notes, is an important intervention involving psycho-education, advocacy, and even social justice.

The role of receptivity and openness to the potential for clients to enter services with a history of CSA emerged as a vital concept in this chapter, and this theme is expanded in Chapter Six, which explores participants’ perceptions regarding CSA disclosure. Participants point to an approach/avoid dialectic for victims, manifesting at both intra-psychic and inter-subjective levels. Their recognition that victims also use intuition via non-verbal information to gauge the receptivity of the respondent also has implications for practice.
Chapter Six: Findings – To Tell or Not To Tell

Introduction

Juxtaposed against the justifications for not routinely inquiring about CSA in the previous chapter, this chapter foregrounds participants’ perceptions that disclosure of CSA is a difficult process at any age, and within any context. I encouraged participants to contemplate the experience of CSA from the perspective of the child or adolescent victim, as well as the adult survivor. This chapter focuses on their knowledge of the developmental, contextual, and interpersonal factors which may facilitate or hinder disclosure. Furthermore, participants reflected upon the consequences and potential outcomes of disclosure for the victim, perpetrator, and families, such as professional and familial responses. Participants generally had little knowledge of formal investigative procedures, such as medical examinations and forensic interviewing, but some drew on their experience of legal proceedings. In addition, they explored issues potentially impacting victim credibility, such as age and gender of victim, gender of perpetrator, false allegations, recovered memories, and ritual abuse.

On an individual level it became clear that some participants had less experience or knowledge about children’s disclosure and, at least initially, felt ill-equipped to comment. All participants inevitably identified or displayed gaps in knowledge about aspects related to disclosure or credibility, and sometimes these were filled with unreliable sources of information, such as the media and popular culture. Yet at other times, participants’ struggles to grasp a particular issue led to fruitful opinions and insights, particularly when they emotionally engaged with the topic. It appeared that the process of talking about these issues helped them to unravel thoughts, feelings, and values, and several participants attested to this. The findings therefore move back and forth between individual perspectives and collective contributions, and pay attention to unique ideas and perceptions, as well as those more commonly expressed. Knowledge strands were intricately bound, perhaps in ways that participants were not always conscious of. Taken as a whole, participants’ contributions foreground the phenomenological experience of the child, adolescent, or adult, and the dialogic and relational nature of disclosure. Receptivity and response enter a dialectical dance with disclosure, influencing spectrums of CSA disclosure from full to incomplete, prompt to delayed, spontaneous to elicited, and consistently maintained to being retracted. Participants collectively paint a picture of
disclosure as a process over time, involving recursive cycles of approach and avoidance, within intra-psychic and interpersonal realms.

**Nature of disclosure**

Four participants with training and/or experience in the field of CSA offered the majority of contributions to the topic of disclosure. Yet at times they prefaced their responses with “this is a guess” or “I wonder”, suggesting a level of uncertainty. Conversely, those who had little or no exposure to the issue of disclosure struggled to provide responses. Jack and Elvis commented that they had never worked with children, and had no understanding of how children disclosed. Somewhat surprisingly three participants who had previously worked with children and young people also expressed limited understanding. When I asked Molly “what’s your understanding about how children disclose and over what period of time?” she replied “Yeah, I don’t know. I don’t know, to be honest”. Similarly, when I asked Robin the same question she stated “I’m not sure … that’s left to specialist services … so experts in the area, with the disclosure, any disclosure”. There was a sense that knowledge and practice regarding children and young people’s disclosures of CSA was the ring-fenced domain of experts. Yet when Robin emotionally engaged with the issue she provided a compelling picture of children’s disclosure, and the familial and professional implications. Similarly, Molly’s willingness to imagine herself from the perspective of a child enabled greater insight into the way children might disguise their distress. This is discussed later in this chapter.

Five participants felt that delayed disclosure was common. As Leah noted: “I mean you can go ages and ages without telling anybody… some go their whole lives and don’t say anything to anybody”. In Jill’s view, children often don’t tell: “well, one, they often don’t disclose … I certainly think there is a lot of child sexual abuse that doesn’t get disclosed until the person is much older … either in their teens or adults”. When disclosures did occur, six participants believed they were often indirect. As Jill noted, “they may disclose indirectly, or not fully, or in a way that isn’t always clear to the people around them”. In Leah’s view, indirect disclosures may be due to developmental limitations:

Leah: Many children don’t have the words to just say “I’m being sexually abused” … they may have words to describe what’s happening to them, or the

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81 Delayed disclosure refers to a significant period of time between the act/s of sexual abuse and the child’s disclosure of abuse, which may be months, years, or decades (Alaggia, 2004; Paine & Hansen, 2002).
way that they’ve come to understand it, but it isn’t necessarily a direct disclosure.

However, other participants felt that indirect disclosures may occur at any age, and were often a means for the person to assess the trustworthiness of the person receiving the disclosure. In this view, disclosures were believed to be purposefully tentative and veiled, such as LMG’s perceptions that children and young people’s disclosures could be “coded”. Adult clients were also observed to “test the waters” and “drop hints”, and to be very sensitive to initial responses from professionals. This pointed to the dialectic between disclosure and response. Robin felt that clients assessed professionals for their receptivity, sensitivity, and trustworthiness before, and during disclosure:

Robin: Just testing it, you know, “have I got a good response?” … I think people are really astute – they’ll assess you while you’re assessing them, to see if you can handle it. And they’ll suss you out, and if you can handle it, they’ll just tell you anything.

Disclosure was therefore described as a process highly dependent on the verbal response, and the subtle non-verbal reactions. These explicit and implicit responses to the unfolding disclosure were crucial influences, affecting the nature and degree of further disclosure, and potentially even leading to retraction.

Jill: What happens with whatever they attempt to disclose, or do disclose, is likely to have an impact on how much more they’ll disclose, and whether they’ll stick with their story or retract, or how they’ve coped with the whole thing.

Siaki suggested that a lack of response or reaction gave a message to the victim that CSA was unimportant or irrelevant; reinforcing minimisation, silence, and compartmentalising. Siaki had never felt able to disclose his own CSA to his parents, and his comments about dropping hints may have been personally salient, indicated by the deep intake of breath. He stated “I understand that some people will disclose or drop hints, and all that type of stuff, but if there’s no reaction, then … they won’t care about it too much, or it’s left (deep breath)”.

Three felt that disclosures from younger children were more likely to be elicited by inquiries and concerns about children’s behaviour. In this way, behavioural signs successfully alerted adults that something was amiss. BJ thought it was unlikely that children would “volunteer the information”. He believed the opportunity for children to disclose depended on those around them noticing changes in behaviour, and being willing to check things out. Leah
held a similar view: “they may more likely come as a result of someone having picked up on some sort of behavioural issue that … is concerning, and sort of querying …what’s going on”.

**Potential signs of CSA**

Participants cited a range of signs which children, adolescents, and adults may display in response to, and as a means of coping with CSA. Signs of CSA were not only perceived as a potential gateway to inquiry and disclosure, but several participants also considered behavioural and non-verbal signs to represent an implicit form of disclosure, either a conscious or unconscious cry for help. For example, three talked about tell-tale signs coming out in children’s drawing or play.

Those with more training and experience were able to make greater contributions. As a whole, their views comprise a huge range of signs children or adults displayed, moving from subtle to severe. For children, participants drew on observations and understanding to cite a vast array of cognitive, emotional, physical, behavioural, and relationship changes. These included: clinginess, irritability, loss of confidence, withdrawal, lack of trust, over-sleeping or under-sleeping, wearing lots of clothes, fearfulness of touch or over-familiarity with physical contact, boundary pushing/rebelliousness, tantrums, poor attachments, nightmares, poor social and academic functioning, over- or under-eating, poor relationships with adults, aggression, dramatic changes in personality, vomiting and other somatic symptoms, depression, suicidal ideation, conduct disorder, sore genitals, bruising, faecal oozing, sexualised behaviour, and sexually transmitted diseases.

In relation to children, participants commented that most signs merely reflected distress and disturbance, rather than being indicative of CSA. As Jill noted, “it’s just a sign that something’s not right, and whatever it is, it should be addressed”. In Pinchas’ view, the lack of specificity among signs meant that it was really important not to make assumptions: “Check it out, check it out, never assume, because otherwise you’re just going to apply a judgement to it, and suddenly you could create something that doesn’t even exist”. However, LMG considered sexualized behaviour to be a red flag, as she felt such children would have been exposed to sexual activity in some form.

While overlapping somewhat with childhood, the dysregulated presentation of adolescents and adults contained less behavioural signs, and a greater number of mental health diagnoses. For example, over- or under-eating in childhood became eating disorders in
adulthood. Somatic symptoms were readily cited for children, however, only Jill noted somatic symptoms in adults. Another area receiving little recognition was the area of re-victimisation which only Leah referred to. The following signs were noted: being closed down, self-blame, shame, disconnection from self, self-denigration, difficulties in sexual relationships (either dissociating or being hyper-sexualised), re-victimisation (sexual and physical), eating disorders, substance abuse, somatic symptoms, depression, self-harm, suicidal ideation, dissociation and memory loss, psychosis and other mental health problems.

All adult and youth clients attending addiction or mental health services inevitably presented with some of these signs. Highlighting the survivor’s self-alienation and a tendency to turn on and punish the self in conscious and unconscious ways, the signs suggest unresolved and re-enacted trauma. In this chapter, participants reveal that telling requires someone willing to bear witness, and convey that willingness, evidenced by attunement, receptivity, and preparedness to check things out. Yet, as revealed in Chapter Five, the walls of participants’ organisational silos, set in the concrete of the medical model, directed attention to the presenting problem or diagnosis. Despite participants’ awareness of the links between CSA and mental health and addiction, the signs did not warrant routine inquiry.

Participants varied in beliefs regarding the degree to which children exhibited signs potentially indicative of CSA, and even shifted in their perspectives during the interview. Molly began discussing examples of behavioural signs: “One of the big ones is just … the behaviour just flips. So, tantrums, unexplained behaviours, can lead to … children being inappropriate with adults”. She went on to discuss a case with a child with “faecal oozing”, who was constantly “peeing himself in class”. At a team meeting an experienced CYFS social worker had stated that it was “classical sexual abuse”, and that a notification needed to be made. Molly initially felt that signs would always be apparent “in some form”, yet she then reflected on how a child might deal with being sexually abused by their father. This reflective process, which sought to understand the phenomenological experience of the child, was unprompted. It precipitated a deeper, more nuanced perspective, leading her to question her initial assumption.

Molly: I’m thinking about if it was your father … how would you behave?
Interviewer: How would you behave?
Molly: How would you behave? … that’s your father who’s supposed to love you and protect you, and yet he’s been really inappropriate, or he’s abusing you…. How do you respond to that, because you’re daddy’s … you know, those scenarios so … “don’t tell anyone” because … “our family would blow to bits”.

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Several other participants felt that children always manifested some sign. Jack stated: “my feeling is that it will manifest itself at some point, somewhere in something”. A similar belief was initially expressed by BJ: “you’re always going to see that something’s not right”, yet he later noted that the signs may be subtle, and he wondered if it depended on “the age of the person, and the kind of the level of shame they might feel”. He went on to describe his own experience of attempting to hide and contain his experience of being sexually abused. His compulsive washing of himself demonstrated the way in which the experience of, and reactions to CSA are embodied. Washing represented the embodiment of psychologically cleansing from feelings of abnormality, shame, and guilt, as well as providing a buffer against vulnerability and exposure. But the word “scrub” seems somewhat harsher, as if somehow the sexual abuse represented a stain to his very being. BJ took a deep intake of breath as he described this scrubbing. Over time he found it increasingly difficult to hide and contain his pain, suggesting that signs may become more apparent in the long-term.

BJ: I think my sister noticed that I was different … she was able to pick it up, my parents just thought … nothing was different, so there’s little subtle things that can change … and I do wonder … the older you get, depending on how you viewed what’s happened, you can take that on as if it’s your fault, then you can easily want to hide it, and keep it in … wash yourself excessively … keep … the protection on board … (deep breath), kind of scrub themselves off, and that’s what I used to think, “I’ll just wash myself, and scrub myself up, and then … I’ll feel better”. So internally, you’ve got this pain, but you just kind of, you know - Interviewer: Putting on a veneer? BJ: Yeah, and then I couldn’t, and I mean that’s what happened after a while, I couldn’t, I couldn’t put on that.

Other participants also felt that signs may not always be apparent. Siaki commented, “I think that they may not show symptoms” and suggested this may occur when young people lead a “double life”. Pinchas agreed, stating:

Pinchas: I don’t think there’s always clear signs … just like there’s not always clear signs that a person’s going to commit suicide…. So there are some things that are just not given away, and some things that you just can’t tell.

However, some participants also commented that children’s appearance as asymptomatic may be more a function of people’s lack of attention and awareness. LMG stated, “I think it is possible that there would be some children that are asymptomatic … or might appear to be … if you're not conscious of what to be looking for”. In her view, the degree to which children exhibited behavioural signs also depended on the context of the abuse, and the
nature of support available to the child. BJ also observed that signs may go unheeded: “Some parents are more vigilant than others at picking up the changes”.

Children who were pre-verbal or with limited vocabulary, were often thought to utilise non-verbal means such as drawing, and/or to exhibit behavioural signs of distress, representing conscious and unconscious attempts to draw attention to their predicament. However, Robin strongly disagreed with the notion that children’s signs were subtle. In her mind, children consciously or unconsciously, verbally or non-verbally drew attention to their predicament, yet she observed that “sometimes people don’t notice”. This contribution is in stark contrast to her initial reticence in answering a question about how children disclose. Like BJ and LMG, Robin felt that not noticing may be through a lack of attention, but that it might also be a conscious avoidance, because the sexual abuse was occurring in the family. Her tone and speed of voice, her eyes, and her face expressed the force of feeling tied up with her opinions, which appeared to be a mixture of anger and grief.

Robin: I believe that children disclose the best way they can.
*Interviewer: OK.*
Robin: Whether they get heard or not, or whether … people want to recognise, because they may be the perpetrators, and the family secret may have to stay and be, I believe that every child in some way speaks out.
*Interviewer: Tries to speak out.*
Robin: Whether it’s verbally, non-verbal, behavioural, yeah.
*Interviewer: Okay.*
Robin: Yeah, if you have a child, you know when their behaviour changes. And you may be busy with your own life or doing things, but you understand when it, you know.
*Interviewer: Right.*
Robin: So I’m saying no, let’s stop letting the families off…. People choose to disclose in adulthood, because no one was open to what they were, in their childhood, trying to say, in the only way they could.

**Barriers to disclosure**

Participants collectively described a heady mix of cognitions, emotions, and sensations, which effectively straitjacketed a child into silence and submission. These could emanate not only from the experience of sexual abuse, but by perpetrators’ spoken or unspoken messages, as well as the internalisation of socially transmitted norms. They described the perpetrator’s modus operandi as involving various explicit and implicit strategies to silence children. These included telling the child that it was a secret, that no one will believe them, threatening the child or child’s family, and promoting a sense of complicity. The latter tactic is traversed
further in Chapter Seven focusing on perpetrators. Participants believed children to be highly sensitive to the level of perceived support and response to their predicament from non-offending caregivers. In addition, they often reflected upon the constraining effects of familial, gender, cultural, and societal attitudes and discourses upon disclosure. The result as Leah put it was that “the silence is self-reinforced, as well as reinforced by the perpetrator”.

Another way that silence could be self-reinforced was through physiological responses to genital stimulation. Only three participants discussed the issue of sexual arousal during sexual abuse, but all three believed it to be a distressing and perplexing experience for victims. They noted that children often failed to differentiate between physiological and emotional responses to CSA, leading to ambivalent feelings about the sexual abuse, and a sense of complicity. Reflecting upon the physical response to sexual abuse as a child, one participant noted “the sexual release, it was like, you know, that actually feels good.” This conflict between body and mind impacted developing sexuality, and raised questions about what was normal. As Jill put it, “their body’s kind of let them down too, in a way.” She felt this betrayal of the body increased self-blame and self-hatred, silencing the victim further. Hatred of oneself in this context suggested a hatred and distrust of one’s body, a site of pleasure in the midst of pain. Jill also commented that the possibility of sexual arousal during CSA was a key area for professionals to understand, so that they didn’t respond with “surprise or shock or disgust”. Understanding sexual arousal as an involuntary response alleviated self-condemnation:

Leah: We all have bodies that were made to feel these things, we don't have any control over the physical sensations that we experience ... I mean, we still have the same number of nerve endings in ... all the same places.

In Leah’s view, shame was the predominant emotion that prevented children and young people disclosing. For Jack, it was about, “feeling guilty about it, feeling they’re to blame.” Amy also cited self-blame, but considered terror to be another key constraining factor.

Amy: It’s really hard ... it’s terrifying. Because they’ve had very, very strong messages that if you do that, then this, and those messages might have been said directly, or they may have just been unspoken ... They feel so bad, they think it’s their fault anyway. They just, they really do believe that somehow it’s their fault.

Similarly, in Jill’s mind, fear was an over-riding emotion for children. Despite whether the fears were legitimate or unfounded, whether the result of threats or sensed; they were likely to remain very real to the child in the absence of reality testing.
Jill: Oh, I think fear would be the biggest one, and it could be fear of … anything from … just the fear of having to get the words out, and just how hard that is to talk about, because it’s confusing and uncomfortable, through to fear that they’re actually going to get killed if they disclose, through to fear that it’ll upset someone, or they won’t be believed, or … it’s going to cause more fighting … it could be fear of anything.

Six participants commented that the absence of a sensitive and supportive person in the child’s life impacted on the timing, nature, and process of disclosure. As BJ commented: “I think they can take years before they say anything … they keep it hidden for years. It does depend on the people around them.” In Leah’s view, children were particularly isolated by a lack of close family relationships and an “invalidating environment”, which was likely to have ripple effects on all other relationships. Similarly, Siaki pointed to family dynamics which inhibited disclosure “if their family environment doesn’t encourage that, it would be really hard”. In the context of unsafe and unsupportive family dynamics and relationships, intra-familial sexual abuse significantly narrowed a child’s options for disclosure.

Jill: Another really key protective factor is kids having other safe adults in their lives, that they could talk to if they didn't feel able to talk to parents, because sometimes it’s those other supposed safe adults that are the ones that are abusing them too.

Participants discussed other barriers to disclosure for children sexually abused within the family. Jack believed that delayed disclosure or non-disclosure was more likely when the child was old enough to apprehend the potential consequences to the family, and themselves, should they disclose. As he noted: “the kind of risks that the child runs in disclosing is this whole blow-up, the whole family type thing, and they can attract that, they’ve got to be taken into care”. Both Pacific Island participants felt that family loyalty was potentially magnified in Pacific families because of a collective identity. BJ stated: “And so I wonder if culturally, that whole sense of, like if I tell anyone, my whole family is going to bust up, and it's going to cause such a ripple effect, because the family is so collectively connected”. The message Siaki received as a child was that his individual needs were not as important as the collective needs of the family unit and community. However, Siaki also highlighted a universal issue for all children sexually abused by a close family member, loyalty to the perpetrator, which elicited a deep intake of breath: “loyalty, you know to the family, loyalty to the perpetrator (deep breath), … I mean I know from personal experience”. Both Jack and BJ emphasised catastrophic effects of intra-familial CSA disclosure with metaphors of explosion. Molly also drew on this metaphor, and their accounts highlight children’s motivation and sense of responsibility to maintain their family, and/or maintain their family’s respectability.
Participants varied in their perceptions of the ways in which developmental factors might create barriers to disclosure. Several commented that although younger children had limited verbal capacities, they were potentially less inhibited about disclosure. As Jill reflected, “I suppose there might come an age where children might in a way disclose more easily, because they are too young to realise the implications”. LMG made a similar observation, “I mean a young person might not have the same concerns … whereas, maybe an older child has more concerns about how that might be received”. In contrast, Jack felt that increasing knowledge of sexual matters in later adolescence would lead to greater disclosure. However, his previous observations about barriers to disclosure in intra-familial CSA, suggest that with increasing age there are competing insights. Greater awareness of the consequences to the family would inevitably coincide with increasing awareness of the inappropriate nature of the abuse, creating intolerable conflict.

Jack: Young kids don’t have the words for it, and are not quite sure what’s happening and what’s going on … when you get to teenage years you begin to appreciate what is appropriate, what isn’t appropriate, and I would say you’re probably much more likely to. From the people I know who have disclosed they have been 15 … or a bit older.

Participants also noted the constraining influence of repressive family attitudes towards sexuality upon disclosure. Many believed that parental discomfort and shame regarding sexual matters were easily transmitted to the child. In the absence of positive messages about their bodies and their sexuality, distorted messages could thrive in children’s minds.

Leah: I think … shamefulness around bodies is really dangerous for kids…. And if that sense of shame is instilled by the family, it's hard, because if something happens to them, involving those parts of themselves … the sense is that “I’ve done something wrong, because people are touching me, these bad parts of me already”.

Both Pacific Island participants noted that sexual matters were particularly taboo within Pacifica families with Island-born parents. In the absence of guidance from parents, children learnt about sex from the media, siblings, and peers. Siaki received clear silencing messages from his parents regarding anything sexual, which he believed made him more vulnerable to sexual abuse. Speaking about this cloak of silence appeared to evoke emotional and bodily tension, a mixture of frustration and pain showed in his face, and he took a deep intake of breath.

Siaki: Sexuality is never talked about.
Interviewer: So it’s not, even in a positive way, sexuality at all is never discussed?
Siaki: No. So we’re left with questions … I just (deep breath), and so for me, my parents, it was … sensitive, meaning … we knew we weren’t allowed to watch anything rude on TV … even passionate kissing was considered rude. We were asked either to leave the room or whatever. But we weren’t given any explanation, or any kind of understanding … so anything sexual … we learnt behind doors.

Interviewer: Which might have been distorted and not the whole truth either?
Siaki: Yeah. Yeah. And so no one really kind of taught me how to … protect myself, set boundaries, what is appropriate, and what’s not appropriate.

Without any knowledge of sexual matters, Siaki had no means to evaluate what was normal and not normal.

Siaki: I don’t think it was normal, but certainly there was no gauges to whether it was normal or not. And I think that’s probably why my childhood is a bit of a blur … I could have been absolutely okay, if someone had told me, “well this is normal, and this is not normal”. But … no one told me anything or coached me through that.

A lack of openness and willingness to discuss sexuality with children potentially shut down many other relational aspects between parent and child, including the opportunity for a child to disclose.

Robin: It’s not okay to talk about sexuality … it’s not okay … to talk about sex. It’s not oaky to talk about emotions … it’s not okay to talk about love, respect … because that all ties in with it. If you don’t talk about sex, sexuality, then you actually close off a whole lot of other areas that you talk about with your children.

Males were generally considered more reluctant to disclose than females, and in Robin’s view males were less likely to be asked, stating “I don’t think that males are encouraged”. Participants cited the role of gender socialization in creating expectations for males to contain feelings and avoid showing vulnerability, which contributed to silencing males. Molly talked about the strong messages males received: “a man’s a man … you know, don’t cry, don’t talk about what’s going on. I would imagine it would be just as hard, oh, probably harder”. Male participants tended to perceive a greater polarity between genders than female participants, and drew on their own experiences as males, as well as that of friends and colleagues. They believed males were less able to express themselves verbally and emotionally. Elvis commented: “I guess also as a man I’m not a particularly good communicator”, and Pinchas observed that “men express their emotions through sports and through physical, doing
things”. Hiding behind masks, layers and “machoness”, BJ perceived males often lived in an emotional straitjacket.

BJ: You know, men … you get the mask wearing, not just men but … there’s an absolute build up, and then emotionally … it … puts layers and layers and layers, that they can't necessarily be emotionally free, and who they are, and express themselves.

Drawing on training from a suicide workshop, Pinchas commented on statistics indicating that a higher proportion of males with CSA histories go on to complete suicide, as opposed to females with CSA histories. As a heterosexual male, he expressed a very candid opinion regarding males’ disclosure difficulties, and increased risk of suicide. In Pinchas’ view, being sexually abused by another male cut to the very core of one’s being, since male identity was centred on the penis.

Pinchas: For a male, your identity - it is penile…. And so, if sex is had with you …if it’s with your anus or something … it’s not just that it’s so wrong, but … it’s not the contract you signed up for … so it stuffs you up completely … it’s mind-fucking.

Leah perceived that men were constrained by the internalisation of dominant social norms about sexual victimisation, which rendered them invisible: “I think they’re barriers they set for themselves, because of … the societal norms … around sexual victimisation”. As Jill pointed out, the survivor movement remained principally a female domain, because of the feminisation of victimisation. These factors not only inhibited males from disclosing, but potentially affected professionals’ willingness to inquire and respond.

Siaki believed that females were more likely to utilise social support than males. Drawing on his own experience, he felt that teenage males sexually abused by their own gender were particularly likely to feel silenced. While recognising his “distorted thinking” regarding a preference to be sexually abused by a female, he highlighted the power of dominant discourses reinforced in social groups.

Siaki: (silence) … Yeah, part of me’s saying it would be harder for a male to disclose. I know I had issues around … being abused by another male … it was kind of embarrassing…. If I was going to be abused, I’d rather be abused by a female. Oh … and that’s just my distorted thinking … and yet I wouldn’t tell that to my friends. So, as a teenager … it’s probably harder … for a male to disclose (deep breath).
Siaki’s deep intake of breath at the end reflected the emotional toll of contemplating the pressure he felt to conceal his experiences of same-sex abuse. He went on to discuss his confusion about his sexuality following his sexual abuse “I questioned my own sexuality, because I didn’t believe I was gay, but I started to think, ‘well am I gay?’” Despite his continued heterosexual orientation, his fears of being labelled a “faggot” prohibited disclosure. Hegemonic masculinity, which demanded heterosexuality, toughness, confidence, and restricted emotionality, dominated the culture of his “macho” teenage peer group. Consequently, there was no space for a young male to disclose sexual abuse: “your ego’s quite big … under the influence of your peers … your image…. It was something that you never talked about … you don’t just go up and say, “hey guys, man, my uncle’s been doing stuff”.

**Costs of disclosure**

Disclosure wasn’t always observed to be a panacea; it was a process which sometimes failed to stop the sexual abuse, and potentially created more problems. As Jill noted, “there’s no guarantee that if they disclose it’s going to make things better in the short-term … or the long-term”. Participants noted significant costs to disclosure in all cases of sexual abuse. Even if the response was supportive, several participants commented on the emotional costs in going through legal proceedings. One noted that this may result in children experiencing delays in obtaining therapy. Bursting the bubble of intra-familial sexual abuse potentially had more far-reaching consequences. Jill drew on her observations of youth and adult survivors:

Jill: Well just thinking about clients that I’ve seen over the years where they’ve disclosed, they maybe have been believed, maybe the authorities have become involved, and the young child or young person’s life has been hell, because of all the backlash and repercussions.

*Interviewer: Um, in terms of being separated from their family or…?*
Jill: Or being blamed and ostracised by family … I’ve had clients that have … gone through, disclosed incest, gone through the whole CYFS and court process, and family won’t speak to them because of that.

In Jill’s mind, the costs to disclosure were potentially as great as the cost of continued sexual abuse. Non-disclosure therefore was a valid choice, an unavoidable cost to belonging. Similarly, when a child experienced the costs of disclosure, retraction was an understandable and quite rational response.

*Interviewer: So the costs are so huge.*
Jill: Huge costs, huge costs, you know, just the impact on the feeling of belonging … like the cost of belonging really is accepting this abuse, and
keeping quiet about it really. And they haven’t done that … for whatever reason, it’s come out, and … there’s been another whole lot of devastating hurt and pain from the disclosure. So … sometimes disclosing is tough to do, and tough to live with. Yeah, so it’s not surprising that there are retractions at times.

When the fear of not being believed turned out to be legitimate, it was a further attack to a child’s sense of integrity, when their sense of self was still developing in the context of attachment relationships. In BJ’s view, lack of belief from those closest to the child effectively re-victimised the child. Alienating their only source of support, the child then had to deal with the trauma of being rejected and potentially physically or emotionally punished. Children therefore experienced a second betrayal, potentially as traumatic as the CSA.

BJ: Not believed … so you’re almost re-victimised … like … “what are you talking about, so and so wouldn’t do that to you” … yeah, ostracised, and probably in Pacific culture, there might be a fear that they’re going to … I’ve heard scenarios where the person gets … a physical beating.

Leah echoed many of Jill’s and BJ’s concerns, again highlighting the delicate balance between the costs of disclosure and non-disclosure. However she also pointed to the loss of relationship with the perpetrator as another cost of disclosure. While participants recognised children’s attachment needs as a binding force, the notion that the relationship had genuinely positive qualities was not commonly discussed.

Leah: Oh, there are as many costs to disclosing as to not disclosing … the risk of sanction … judgement … not having anything done … not being heard … feeling even more responsible or guilty than you already feel … losing the person who’s been abusing you, if they are prosecuted and going away, if this was a relationship that actually had value for you on some other level.

**Factors impacting on credibility**

I asked participants whether there were any aspects of disclosure or the context of the abuse, which undermined the credibility of a disclosure. I also sought their views on particular debates related to credibility. Participants cited many different reasons why victims might retract their disclosure, and generally didn’t believe retractions reduced credibility. Jack believed victims retracted because they felt “it’s too difficult to deal with this”. For Leah and Jill, negative or inappropriate responses to disclosure impacted victims’ decisions to retract. Leah posited that pressure to embark on legal proceedings may precipitate retraction, or conversely children and youth could experience pressure to withdraw allegations. While
retractions didn’t reduce credibility in LMG’s mind, she noted they were likely to be met with much greater suspicion in legal circles, and potentially in wider society.

Two participants did have experience of client’s retractions which possibly pointed to a false disclosure, but these cases were considered to represent an extremely small minority. In general, participants believed false disclosures to be rare. Amy described the possibility of false disclosures arising from messy relationship break-ups, but pointed to the allegation coming from a parent rather than the child: “one parent might accuse the other of sexually abusing the children perhaps”. She also discussed her experience of some clients who had disclosed very quickly and expansively, which “rarely” caused her to wonder about the credibility of their disclosure. However, she also noted that it can “be a sign that they’ve been really badly abused” and that “it comes from such a deep place inside usually”.

Three participants felt that severe mental health problems, particularly psychosis, reduced the credibility of the disclosure. One participant discussed a client with extreme dissociative episodes culminating in severe self-harm. In this context, there was some uncertainty about the credibility of the client’s disclosure of sexual abuse. Another participant discussed a client with episodes of psychosis which appeared to somewhat undermine the credibility of a disclosure of CSA perpetration. There were questions of whether the disclosure was a “delusional system” despite being “tortured by these beliefs”. However, the client was able to gain treatment, and steps were put in place to ensure that the client had no unsupervised access to children. BJ also expressed caution: “you’ve got to weigh up mental wellness ‘cause there’s cases in mental health where … people have been accused of sexual abuse, and it’s been … a psychotic … belief”. Elvis believed when clients were “experiencing a psychotic episode”, such as “hallucinations” and “delusional” beliefs, the lack of shared perception of “reality” discredited any disclosure.

Only one participant, who had worked in mental health for decades, strongly refuted the idea that psychosis reduced the credibility of disclosures. Believing his opinion to be a minority view, Jack’s tone and speed of voice expressed the emotion work in challenging the dominant medical model. This appeared to be a mixture of anger and frustration. He then used sarcasm and cathartic laughter to discharge the tension, which I mirrored.

Jack: I don’t think I’ve ever met anyone that’s disclosed that I haven’t actually believed in … I have been in arguments about, “is this kind of psychotic?” … I think it’s a load of crap basically.

Interviewer: Do you?
Jack: Yeah, I think when people do disclose, they are disclosing … But there are people who believe they can tell whether it’s real or not real (laughs).

Interviewer: And what’s their criteria for determining, (laughs), determining what’s real?

Jack: Who knows, having an MD (laughs).

I also asked participants how age might affect credibility and therefore victim status, such as any perceived differences between a five year old versus 15 year old victim of CSA. Although a five year old was viewed as “vulnerable” and “defenceless”, therefore clearly gaining victim status, many participants commented that a 15 year old may be just as vulnerable. LMG’s reference to “flirtatiousness” suggested female victims and a vulnerability to judgement and condemnation emanating from ‘Lolita’ discourses:

LMG: I think it's harder to look at a five-year-old, and not feel or see that person as being more vulnerable somehow, because they’re five, but … I think the reality is that the 15-year-old is more vulnerable. A different type of vulnerability … there's that borderline consent age … flirtatiousness, the kind of perception that there might have been something that was wanted, or somehow elicited.

Participants perceived both male and female older victims as vulnerable to scepticism of their CSA victim status through expectations of increased autonomy and the “power to push back”. However, they highlighted differences in the assumed power of male and female teenagers. Older male victims were increasingly subject to norms regarding masculinity, which expected male physical strength and invulnerability, thus invalidating their status as victims. As BJ noted: “especially if it’s a male and 15 … I think society looks at it, ‘well how did you let that happen?’”. Jill cited a piece of gendered legislation which had marginalised older boys who were victims of sexual offences: “I can't remember what the name of the offence was, but it was relevant for a girl under the age of 16 and a boy under the age of 12”.

Females were subject to dominant notions of female sexuality, which assumed their sexual power through enticement and seduction. Jill observed that 13 year olds were already vulnerable to the gaze of others: “they may not themselves be experiencing those as sexual outfits or … sexually provocative, but the reality is that a proportion of society will perceive them … as sexually available, because of what they’re wearing”. All participants felt that children were being sexualised at increasingly earlier ages, and several commented that this may contribute to society’s perception of a teenage female victim’s culpability. Participants’ positioning against such dominant discourses highlighted the paradox of a society which routinely sexualises female children, yet blames a teenage girl’s sexuality as contributing to her sexual victimisation.
Siaki alluded to the sense of entrapment that may occur from early gradual grooming: “I mean a 15 year old could have been groomed since they’ve been two, or something like that (deep breath).” Without an appreciation of the underlying dynamics of grooming, older victims of both genders were more vulnerable to societal judgement about their lack of agency to stop the abuse. Several participants implied the difficulties of challenging and transforming the status quo. As Jack noted, “I think people see the five year old as much more of a victim than a 15 year old … which is unfortunate really”.

Teenagers who acted out were at particular risk of being perceived as less credible. Any previous history of making unsubstantiated allegations or false stories was also considered likely to reduce credibility. However, participants generally positioned themselves against societal discourses regarding the “acting out teenager”.

Jill: If they’re already a bad kid … and they’ve been getting in lots of trouble, and drinking and drug using, and then they come out and say they were raped, I think there’s a greater chance they might not be believed … or if they’ve got … any history of making stuff up.

Leah pointed to the importance of understanding the impact of CSA upon the developmental trajectory through adolescence. Behaviour which appeared counter-intuitive or discrediting could be comprehended more fully through a trauma-informed lens.

Leah: If they have a history of telling tales that aren’t true or that appear to be untrue … if they have a history of acting out in other ways … sometimes that’s interpreted as nullifying what they’re actually saying, as opposed to explaining what they’re actually saying.

Siaki discussed the challenges in child protection in navigating the truth through a minefield of behavioural problems and opposing stories. The reference to some adolescents having been “sexually abused as a child” was not explored further. It suggested substantiation, but equally it may have reflected that a child’s allegation held more credibility than the allegation of a troubled and sexually active teenager. The potential influence of past sexual victimisation upon teenagers’ current presentations was latent in the narrative.

Siaki: My experience has been more … false allegations … when I was at CYFS … teenage females … They would make allegations of this and that … against stepfathers and … their own relatives… Some of those cases were quite hard to kind of work with, ’cause you’re trying to be protective. At the same time … the same girl has a reputation for being rebellious … so that was quite hard … involved with alcohol or sexually active. In some of the cases, they had been sexually abused as a child … and … five years later, they’re still involved
with CYFS … but they were sexually active, and then making allegations ... and the adults were totally … denying that anything’s happened.

Two participants noted that the presentation of the alleged perpetrator potentially compromised the perceived trustworthiness of the victim. Jill felt that perpetrators who were “well respected or quite powerful” or someone “everybody loves”, were likely to sabotage the victim’s credibility. In a similar vein, Leah observed:

Leah: Unfortunately I think that … the credibility of young people is often undermined by the credibility of the alleged perpetrator … if it’s Father Mike who’s beloved by everybody, or Dad who’s a Cub Scout leader … it becomes about the credibility of the perpetrator, rather than the credibility of the allegations.

Focused on societal responses, not her own views, LMG also noted that mental health problems, substance abuse, and promiscuity could reduce credibility, but also felt that “being female” potentially discredited victims. She noted that the legal profession perpetuated the idea that the CSA victim’s credibility was on trial, observing that “the main vehicle for proving or disproving, is really proving or disproving the credibility of the witness”.

Participants commonly observed the silencing and camouflaging effects of dominant discourses regarding femininity and female sexuality upon female perpetrators of CSA. These discursive influences impacted upon the victim’s ability to identify victimization, to disclose, and to be responded to appropriately. Jill noted that women were perceived as “nurturing and more empathetic”, and while she believed males viewed their sexuality as “something to be proud of and strong about”, she noted that “females are not really taught to be sexually that way, or they weren't in my day (laughs)”.

Questioning the validity of female-perpetrated sexual abuse naturally led to questioning the status of the victim. Leah commented that female-perpetrated sexual abuse threw “accepted gender norms on their head”, challenging dominant notions of women as nurturing and more empathetic. She noted society’s “tremendous discomfort” with the acknowledgement of female perpetrators which compounded the experience of CSA as “horrible” and “shameful” for both male and female victims. Elvis thought that female-perpetrated sexual abuse may not be as aggressive or physically damaging, but noted how such a perspective obscured consideration of emotional harm.
Three participants commented on the diminished victim status of male children sexually abused by females, muted by societal discourses and legal responses. Elvis noted previous gaps in legislation which clearly reflected societal perspectives about gender: “it is interesting to note that before 2005, there was not a law in NZ, prohibiting any form of sexual relationship between adult women and male minors”. Older male victims abused by a female became subject to dominant discourses regarding male sexuality. As BJ noted, “the belief in society is if you can get an older woman as a young man, well then you’re a stud”. To challenge such a discourse, by asserting victimhood as a male sexually abused by a female, resulted in having one’s sexual identity questioned, “what’s wrong with them?”, the expectation being that they should have enjoyed the experience, and suffered no emotional harm. An internal conflict occurred in standing against such dominant and potentially internalised discourses, and asserting a minority view:

BJ: As a male I think, I’ve got to keep going (punches into his hand) yes, no, that’s right … there is some power and control going on here … I have to keep challenging that, because the wave of society’s thoughts are strong … you’ve got to be able to kind of stand your ground and go “that would have really impacted you”.

Most participants had little knowledge and no direct experience of satanic or ritualised abuse. Only two participants had encountered clients who had experienced some form of ritualised sexual abuse, but such cases represented a very small minority. A further two participants, both Christian, strongly believed that satanic ritual abuse was a genuine phenomenon. In Siaki’s view, it was purposefully under-reported: “I don’t think it’s a myth … I think it’s sinister … that’s probably the power of the media… I just don’t think it gets … exposed”. Molly commented that she was glad to have not encountered such a phenomenon and had no knowledge, and Robin had never heard of the term satanic ritual abuse. Another four participants stated their only knowledge came from high profile cases reported in the media, with two mentioning the Christchurch civic creche. However, only one participant displayed overt doubt, which was in relation to media reports of satanic ritual abuse in Scotland. Although stating he held an open mind, there was considerable sarcasm in Jack’s observation of the professional response: “We had whole islands cleared in Scotland … and communities … in

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82 In 1993, the Christchurch Civic Creche case resulted in the conviction of Peter Ellis for 13 of 25 counts of sexual abuse against seven children in day care. The children’s evidence included ritualistic elements and described the involvement of several female staff at the day care centre. Following two failed Appeal Court hearings, former Chief Justice Sir Thomas Eichelbaum conducted a ministerial inquiry in 2000. He determined that the interviewing of the children had been appropriate, and upheld the conviction.
usually working-class areas, I have to say. I can’t remember much satanic ritual abuse in middle class families, surprise, surprise (laughs)“.

Contemplating the credibility of recovered memories of sexual abuse elicited a range of opinions. For some participants, their only exposure to the issue was through the media. Unlike his previous scepticism about satanic ritual abuse gleaned from media coverage, Jack reserved forming an opinion about credibility of recovered memories, solely on the basis of media reports: “I think I kind of wonder about that false memory syndrome stuff, it’s kind of hard isn’t it really … yeah, I’m not sure”. In contrast, Robin’s exposure to the media led to a cynical attitude, suggesting that recovered memories had become culturally popular, and potentially represented a means of evading responsibility: “That’s what the stars are doing in America, weren’t they, when they get busted for, for drugs or drinking, isn’t that what they do … they come out with … recovered memory?”

Elvis drew on personal experiences of memory to highlight its potential unreliability. He recalled “I believed that I saw Santa Claus flying on a sleigh one night … I absolutely believed that for many years … so we can believe things that aren’t actually true.” Yet he also went on to discuss the dynamic state of memories, relating an experience of his father’s recovered memories following a stroke, which led him to state that memories were “tricky things”. Siaki suspected his sister had recently recovered a memory of sexual abuse. The memory had a dream-like quality which confused his sister about its’ reality. However, Siaki felt the memory was credible because he and his brothers had been sexually abused by a family member.

Amy was the only participant to have personal experience of recovering memories of sexual abuse. She went through 39 years of her life with no awareness that she had ever been sexually abused as a child, then two years after maintaining sobriety, the memories flooded her consciousness. Amy’s recount of moving from total amnesia to sudden recall of CSA is described in a very simple and straightforward way. There was no indication that she questioned the validity of the memories in the way that Siaki’s sister did. Following her recovered memories, Amy engaged in sexual abuse counselling. Had there been time to more fully explore Amy’s reactions, it is possible that a more complex and nuanced relationship with these memories may have been revealed.

Amy: I remember being in treatment … in the late 80’s and I think I was in a group with about 20 other people … a women’s group … and I thought “my God, I’m the only person in this whole group who hasn’t been sexually
abused”. Now two years later, I was sitting in my bath in London actually, and it was just “whish” like that (arm movement across face), like a video, plus all these memories like that.

Jill maintained a neutral position and an “open mind”, although stated she may have doubts if the recovery of memories had occurred through some “dodgy” method. She felt that the attention towards recovered memories had “faded away” and that this was “helpful”. She stated: “there’s been research done that shows clearly that memories … our memories aren’t that reliable. But there’s also been plenty of research done around traumatic memories, and how they are imprinted differently, because of the emotional content around them”. Jill’s understanding of the impact of trauma provided a framework for accepting the possibility of fragmented and compartmentalised memory. In her view, dissociation played a role in the way memories were formed and accessed. Additionally, the events of sexual abuse were considered difficult for young children to articulate and to assimilate into existing frameworks of understanding, further contributing to the problem of creating an accessible memory.

Jill: In some situations it’s just the brain and psyche’s way of surviving a really traumatic event to dissociate, and so I think either the whole memory might … be held in a different way than normal everyday memories, like what you had for lunch yesterday … the feelings might be split off from the narrative … or the physical sensations might be held … separately to all the rest of it … Children often don’t have the language or the knowledge about sexual behaviour, to be able to kind of understand and contextualise it, so it’s no wonder that kids don’t necessarily always have a coherent narrative and memory, or that that it gets pieced together over time, or … just comes out years later.

In Leah’s mind, dissociated or repressed memories were an “effective coping strategy” which made complete sense to her. She stated “why wouldn’t you want to forget that, and stuff that stuff as far away as you could?”. In her experience of clients with recovered memories, there was generally a “trigger”, which might be an event reminiscent of the trauma, or a life change including abstinence from alcohol or drugs, such as Amy’s experience. She held the possibility that false memories existed but believed they represented a “small percentage” of recovered memories.

For LMG, the truth of the recovered memory was irrelevant. On the one hand, such a position highlights the fact that most CSA disclosures received by participants are unlikely to be corroborated. Ultimately, participants may never really know the truth of any disclosure, but this factor alone did not tend to constrain belief. For example, with regard to retractions, LMG stated “for me, it doesn't reduce the credibility”. Implicit in this statement is a belief in the
client’s original disclosure, not a stance of neutrality. In contrast, LMG’s comments below suggest that it is possible to work effectively with a client, while indefinitely maintaining neutrality about the validity of the disclosure.

LMG: If somebody is presenting this, and it's distressing them, then that’s the thing you need to be working with, whether it is recovered or false or what have you, is really in a sense irrelevant.

Interviewer: Okay, so from a clinical perspective it's still something to work with, whatever?
LMG: Yeah, in a way, and it's not my place to decide, to make that call, and it's not a judgement that I'd be willing to make.

Over the course of this chapter participants highlighted the victim/survivor’s attunement to responses to their disclosure, and their need to test the waters. Certain issues regarding credibility were clearly unexamined, leading some participants to almost unquestioningly buy into discursive influences, such as Robin’s perspective on recovered memories and Jack’s views about satanic ritual abuse. Alternatively, some participants attempted to remove themselves from debates and maintain neutrality, such as LMG and Jack in relation to recovered memories. This lack of knowledge and their positioning clearly have implications for clients. In the process of analysis, I wondered how clients like Amy or Siaki’s sister might perceive professionals’ neutrality or internally held doubt.

Sometimes participants positioned themselves against dominant societal and professional discourses which reduced victim credibility, such as BJ in relation to female perpetrated sexual abuse against a male, and Jack with regard to disclosures from clients with psychosis. When such discourses saturated gender socialisation processes, standing one’s ground, as BJ put it, took emotional work and reflexivity. In summary, participants’ perceptions illuminated the nexus of competing discourses influencing credibility and the attainment of victim status, internalised to various degrees by professionals and clients. Multiple and intersecting variables impacted credibility such as the victim’s age, gender, and behaviour; the perpetrator’s age, gender, and presentation; and the context of CSA. Although participants didn’t personally subscribe to the notion, the ‘ideal victim’ was revealed to be blameless, powerless, coherent, and a young female child abused by a male extra-familial perpetrator. This construct sat at one end of a continuum of credibility while participants sometimes located and/or observed less acknowledged forms of CSA, such as ritual abuse or recovered memories, at the other end of the continuum.
Conclusion

Participants collectively identified a range of intra-psychic, interpersonal, and discursive barriers to disclosure. They discussed how the nature of CSA often created a web of complicity which hindered disclosure, filling the internal world of the victim with guilt and shame. In many cases, participants appeared to present as many costs as benefits to telling. Victims were perceived as constantly assessing their situation and those around them, and weighing up the costs and benefits. Participants also observed that indirect disclosures and behavioural indicators of distress and dysregulation were common, yet may be ignored. Some thought these behaviours represented subtle, sometimes even unconscious forms of disclosure seeking to draw attention.

Throughout this chapter, participants pointed to the various ways in which intra-familial sexual abuse presented greater barriers to disclosure. Using Heidegger’s metaphor, children were “thrown” into an inescapable situation; they could not choose the families they were born into. Children sensed dynamics of poor communication and taboos, felt the effects of poor attachments, experienced ongoing implicit and explicit threats to self, and in the context of an abusive familial relationship they had difficulty discerning what was normal. Their ability to disclose was affected by these subtle, often non-verbal dynamics, and as they got older they felt the pressure to preserve family cohesion and respectability.

Over time, the costs of not telling or not being heard appeared greater, and potentially manifested in substance abuse, mental health problems, self-harm, and promiscuity. The experiences and effects of being silenced impacted on the victim’s perception of self as normal or abnormal, and CSA as normal or abnormal. In addition, these ‘abnormal’ forms of behaviour and presentation often reduced the person’s credibility in the eyes of professionals and family. Individually and collectively, participants held a diverse array of opinions regarding aspects of CSA which have been known to impact credibility. Participants could be informed about some aspects and without knowledge about other aspects. In the absence of experience or knowledge, some participants drew on discursive influences promulgated by the media. Being sceptical about the credibility of certain aspects of CSA runs the risk of being unconsciously conveyed to a client, but perhaps the desire to appear neutral may also be perceived as invalidating.

Participants’ accounts suggested that emerging discourses may be subjugated by dominant constructions and thus effectively silenced. The silencing may occur as a means to
resolve cognitive dissonance and/or to defend against facing unpalatable realities, such as female perpetration of CSA or male victims. These silences were even represented in previous legislation. The flux of dominant and subjugated discourses had implications for victim status, particularly teenagers, therefore also impacting on CSA inquiry and response. Various forms of media represented an insidious and desensitising form of socialisation, which had shifted the goalposts about what was considered normal and acceptable regarding sex and sexuality. Not only may prevailing discourses have silencing and invalidating effects on victims’ CSA experiences, but they may also affect victims’ lifetime interpretations, as well as societal and professional understanding, recognition, and response. Therefore, to tell or not to tell not only reflects the victim’s approach/avoidance dilemma, but also that of society as a whole. Shifting the lens to CSA perpetrators, Chapter Seven weaves in intra-psychic, interpersonal, and discursive elements to reveal a pattern of delusions, illusions, and elusiveness.
Chapter Seven: Findings – Delusions, Illusions, and Elusiveness

Introduction

While Chapter Six focused primarily on victims’ cognitions, affect, and presentation during CSA and in its aftermath, this chapter shifts attention to the many faces of CSA perpetrators. The word play in this chapter’s title reflects participants recurring comments regarding the delusional and illusory nature of CSA perpetration, and the victim/perpetrator relationship. Their comments suggest these intrinsic factors enhance the elusiveness of perpetrators, and thus perpetuate CSA. This chapter covers participants’ perspectives and understanding regarding male and female perpetrators of child sexual abuse, their modus operandi, and possible influences and motivations to sexually offend. Moving from individual vantage points to imagining themselves from the perspective of victims and sometimes even perpetrators, participants also positioned themselves in relation to dominant discourses regarding perpetrators. Only one participant had directly worked with CSA offenders, however all but one discussed personal or professional experience of perpetrators.

Embodied and emotional reactions

With regard to child sex offenders, participants used such words as “vaguely grossed out”, “uncomfortable”, “tense”, and “nauseated” to describe their body feelings and reactions. They expressed feeling a range of emotions from sadness to anger, revulsion, and disgust; and in most cases, they felt these emotions in the stomach. Jill reflected at the end of her interview that the immersion into the phenomenology of child sex offenders was unsettling: “I just kind of realised that … if you really think and connect too much with the reality of … getting sexual gratification from something that’s hurting a child … it is deeply disturbing and upsetting”.

Jill and Molly had watched a documentary about Jaycee Dugard83 and the man who repeatedly raped her and kept her locked up for years. This CSA perpetrator fitted several stereotypical constructs such as “stranger danger” and “monster”. Reflecting upon thoughts and

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83 Jaycee Dugard was abducted in the US at age 11 and kept in captivity for 18 years, enduring multiple rapes and giving birth to two children (Dugard, 2011).
feelings about him, Jill highlighted her internal conflict: “I sort of had this mix of responses to him, you know, what an evil man, and also … trying to understand what would make someone do that kind of stuff”. Molly stated that she had more of a knee-jerk reaction to sexual offenders when she had young children and less life experience. Nevertheless, she experienced intense negative feelings about Dugard’s perpetrator, calling him a “freak”, and stating “he just totally just freaked me out”, and “if that was my kid, I’d want to kill him”. Many other participants found it difficult to have compassion for perpetrators, and some expressed aversion at the thought of working with this client group.

LMG: It's not very pleasant … honestly it’s a group that I find it difficult to have a lot of compassion for … I feel a bit nauseated … I don't know whether that’s to do with my own personal experience, because obviously those words kind of trigger me back into that, to some extent. Or whether that's, you know, just about that perception of that group of people, yeah.

Yet LMG went on to express sadness, and one could say, a sense of compassion for the isolation that perpetrators inevitably experienced, as well as grief that CSA occurs.

LMG: On the whole, it makes me feel quite sad … because … somebody who's engaging in that sort of behaviour is … not integrating well into society … I don't know if they're completely honest and authentic about their life experiences, experience of sexuality … they're not likely to be accepted by people, and I think that's got to be a very uncomfortable and difficult place to be.

Interviewer: Yeah, okay.

LMG: Um, and sad in general that we actually have such a society, that that kind of thing takes place.

For Leah, embodied responses were impossible to control, and interfered with attempts at neutrality and objectivity.

Leah: My gut reaction … is not a pleasant one. There … is a level of professional detachment I can attain, but I think in part because of the work I've done with survivors … I have quite a visceral response sometimes to that … Sort of can feel that in my stomach … I find that's a group of people that I have a great deal of difficulty having compassion for.

BJ’s anger arose from his awareness of the long-term impact for the victim and the violation and distortion of sexual intimacy.

BJ: There's anger at the level of destruction … there’s an element of anger … I don't have a sense of rage … that they're the worst of the worst, as society might look at them. I have a sense of anger, particularly from the victim
perspective of the damage … the destruction that has … left a remarkable imprint … negatively in that person's life … and just because how precious sex is meant to be, and then how it has just been violated … so randomly.

For Pinchas, grief for the perpetrator outweighed the disgust. He also noted that he made some attempt to disregard the feelings of disgust, perhaps because they didn’t sit well. Similar to LMG, Pinchas pointed to the destructive effects of sexual abuse for both perpetrator and victim.

Pinchas: I was just noting a gut reaction in my stomach … churning inside … and it was really funny, because my ears just didn’t want to even listen or hear … and yet, the same time in my head, I was … feeling really sad … there was some revulsion and disgust … but more sadness … because it seems … like a waste of a life, not just the child’s life, but also the paedophile’s life. It seems like a … pathetic lifestyle.

**Knowing and not knowing about CSA perpetrators**

Apart from the social worker who had worked with sexual offenders, participants consistently identified less knowledge of CSA perpetrators, compared to CSA victims. This included participants who had previously rated their knowledge of CSA highly. For example, Robin commented “I’m not that familiar with offenders”. Similarly, Leah observed “all the offender stuff is stuff I don't know as much about”. Jill’s reflections suggest the fluidity and uncertainty of her perceptions: ‘you know, I've just got these opinions that are kind of forming”. Additionally, participants expressed greater difficulties in trying to understand this client group, more reliance on the media as a source of information, and less willingness to work with perpetrators. Leah’s acknowledgement highlighted her difficulty with engagement: “I couldn't, I wouldn't work with paedophiles, because I don't think I could do that well, and … I don't think I could be empathic and caring”. In Amy’s view, paedophiles were an enigma and she expressed reluctance to even attempt to understand them: “As far as where paedophiles are coming from, who knows where they’re bloody coming from. Why would you even understand it?”.

Despite the professed lack of knowledge about CSA perpetrators, no one held stereotypical views about perpetrators being strangers or monsters, or fitting a particular profile. Drawing on professional or personal experience, they all expressed the perception that the majority of CSA was perpetrated by someone who had formed a relationship with the child. Yet thinking about that relationship often elicited negative affect. In thinking about father-child incest, BJ surmised “I wouldn't be surprised if there was no attachment to it”. However, Siaki
alluded to the way in which attachments could be sexualised stating, “my thinking is that when those kind of family roles become mixed up with romance, and it becomes quite sexual, I think that’s crossing the boundary”. Jill commented that some perpetrators may love the child, and in Chapter Six, Leah discussed positive aspects of the relationship which the child would perceive as a loss. In expressing the other side of the coin, Jill and Leah were not endorsing pro-paedophilia views, but merely pointing to complex and competing dynamics. This more nuanced view of the relationship between victim and perpetrator was particularly relevant to sexual abuse within families, where children may continue to have a relationship with the perpetrator.

Participants held mixed views about whether intra-familial and extra-familial offenders represented discrete categories, although some refrained from expressing an opinion, because they felt they had insufficient knowledge. Based on accounts from survivors she had worked with Leah felt that intra-familial offenders “tend to keep it in the family”. She also drew on her personal knowledge of a school teacher who had sexually offended against teenage girls and had not, to her knowledge, sexually abused his own children. Elvis believed they were more likely to be discrete categories, because CSA in the family was easier to “conceal”, whereas extra-familial offending was “more risky”. However, this argument only applied one way, and perhaps suggested the inverse for offenders who first sexually abused an extra-familial victim. In contrast, five participants suspected there would be cross-over offending, sometimes drawing on common sense or intuition. In Pinchas’ view, “if you can get away with it in your own family, you’re gonna see if you can get away with it elsewhere”. Similarly, Jill stated “I must say, someone who committed incest, I wouldn't trust them with any child”. This seemed to come from a gut level as she commented several times “I don't know enough about it really”. Throughout this chapter knowing and not knowing enter a dialectical dance. Not knowing sometimes led to emotional and intuitive forms of perceiving, yet at other times the desire to avoid approaching a difficult topic significantly limited the capacity to know.

**Pathways to offending: Nature versus nurture**

Leah believed that child sex offenders fell into “two separate groups”, the first being “young people who have been victimised, who go on to victimise, because they lack the boundaries”, and the latter being “people who are in fact sexually attracted to children” including “young paedophiles”. Leah went on to express the view that some “people are genetically wired to have that attraction”. She referred to an article she had read which
suggested that paedophilia was a “hard-wired” sexual orientation: “I believe, like being heterosexual, or homosexual, for some people it is hardwired in … but that doesn’t mean that’s an acceptable behaviour to act on. And in our society, it isn’t, at least right now”. The last comment highlights the reality that societal attitudes regarding sex and sexuality are subject to significant variation across different periods and cultures in human history. Leah illustrated the notion of hard-wiring with the case of a 15 year old boy who had been sexually abused, and gone on to sexually offend against children. In this example, Leah’s two “separate groups” merged, with nature being privileged over nurture. The boy’s own sexual victimisation cemented an “innate component” because she had observed he was “just drawn to children”. Using Heidegger’s metaphor of “thrown”, Leah’s views painted paedophiles as thrown into a body hard-wired with a sexual orientation towards children: “I think that that’s sad because … you spend your life fighting against your nature, trying to live well”.

In contrast, seven other participants highlighted the influence of nurture upon child sex offending. They believed that CSA perpetrators had invariably experienced some form of childhood abuse or dysfunctional family upbringing, which contributed to their offending. In this view, a cycle of offending encompassed varied forms of abuse, not only a history of CSA. Pinchas suggested that repressive family attitudes towards sexuality and poor attachments contributed to sexual offending, and Siaki felt that too little or too many boundaries regarding sexual matters was a factor. In BJ’s view, childhood needs were not met, and perpetrators sought to meet these needs through the sexual abuse of children. This position suggested that exerting power and control was a means to satisfy a range of relational needs: “some form of abuse or hurt … is then taken into the context of using power and control over a victim to satisfy that unmet need, whether it be … from physical abuse or … sexual abuse or neglect”.

These participants varied in the degree they supported the idea of a CSA victim to perpetrator cycle. BJ, Siaki, and Jill believed CSA perpetrators may be just as likely to suffer other forms of abuse, whereas four other participants believed that a history of CSA was a common and highly influential factor. LMG drew on her own personal experience stating “I do know that perpetrators tend to have a history of their own, and that's been reflected in my experience as well”. She imagined the cycle operated in a similar way to domestic violence, intimating that social learning theory had a part to play. Similarly, Pinchas believed normalisation of CSA perpetuated the cycle which reduced empathy, but he also believed it was influenced by attempts to regain power.
Conversely, Robin and Amy, who both had CSA histories, felt offended by the notion of a victim-perpetrator cycle. In their minds, it suggested that victims inevitably became abusers, and provided an excuse for offenders. Yet Robin did feel that support from significant others and the opportunity to heal from sexual victimisation, may prevent young people sexually abusing others. This latter view was shared by Molly, Pinchas, and Siaki.

Seven participants commented that the cycle of sexual abuse appeared to be gendered, with males being far more at risk of perpetuating the cycle. Jack stated he drew on the media in understanding that “it does seem to be a kind of pattern in blokes”. Four men candidly discussed at length the power of the male sex drive. Jack described sexual fantasies and sexual thoughts as normal and ubiquitous, occurring “every five or six seconds” among male youth. These four men described the sex drive as hormonally driven, stimulated visually, and encouraged by peer pressure, therefore having social and biological origins. Siaki, BJ, and Elvis believed these factors constituted vulnerability for male CSA victims. BJ stated “I hold the view around males being highly sexualised … so there’s that tendency maybe to act out inappropriately through sex”. Pinchas thought that men tend to express power physically, and to use power as a means of avoiding thinking and feeling what happened to them. However, Jack suggested perpetrating CSA could be an expression of anger about sexual victimisation. Jill believed that men were more likely to externalise and act out their hurt against others, whereas women and girls were “possibly more likely to act out against themselves or internalise” their pain. She felt these differences could be due to “conditioning and socialisation, and maybe biological differences”.

In attempting to understand the trajectory to sexual offending, participants drew on mechanisms related to attachment theory, social learning theory, biological and socialisation processes, and psychosexual development. The majority described CSA perpetrators as people who had been hurt or abused in some way in childhood, and many suggested that this negatively impacted sexual development. Participants recognised the existence of female perpetrators, but believed the majority were male, and five suggested that social and biological processes rendered male victims of CSA more vulnerable to offending.

Despite the recognition of developmental influences on sexual offending, the majority of participants hadn’t ever given much thought to the prevalence of adolescent offenders, or the age of onset of offending. Regarding prevalence, Leah believed it was “not inconsiderable” and Jack guessed it was a “reasonable proportion”. Drawing on professional experience, LMG and Pinchas noted that perpetrators may be children or adolescents. LMG guessed the “thinking,
behaviour starts quite young”, although was unsure “whether that translates into action straight away”. In contrast, BJ, who had worked with CSA perpetrators, suspected as many as 80% of child sex offenders started offending in adolescence.

**Motivations, triggers and opportunities**

Participants cited a variety of internal and external factors which might precipitate sexual offending. The idea that CSA was first rehearsed in the mind was endorsed by eight participants to varying degrees. Four out of five male participants, compared to one out of six females, believed sexual fantasies played a significant role in offending. Other female participants guessed it might play some role, but had “never thought about it”, “didn’t know”, and only “suspected”. BJ candidly discussed perpetrators’ sexual arousal, which he believed was reinforced by fantasy coupled with masturbation.

BJ: I would say 100% of the time there was a level of fantasy, thought life around that. I think every behaviour has got a thought somewhere … It doesn't just come out of thin air, there would have been some level of fantasy around because … the actual act of sexual … there is an element of pleasure for the man so … often the fantasy might be combined with masturbation to reinforce that … so they’ve already got some experience of knowing that, “okay, if I act on it…” , otherwise it's kind of like, “why would I offend, it's not going to be pleasurable”. You know, “how do I know it's pleasurable?”

Perhaps Leah’s views regarding a genetic causation for child sex offending led her to more clearly associate child sex offending with sexual fantasy and sexual arousal. Like BJ, she discussed the build-up of “desire” and “arousal” which “psyched” perpetrators up and inevitably couldn’t be “contained”. LMG suggested that the build-up of tension may be emotional rather than sexual, however she and Siaki believed substance abuse played a disinhibiting role, overcoming the internal conflict created by sexual attraction towards children. Yet Siaki also commented that anyone might be capable of sexually abusing a child: “I don’t fully understand the paedophile’s mind … I just think as humans we probably have the potential to do anything … if we’re under extreme pressure, or under … heavy influence … like drugs”. Four participants discussed the role of “triggers” or “cues” which might be quite subtle, as well as major stressors such as relationship break ups or job losses, which might precipitate offending. These latter views suggested that sexual offending against children was a means of relieving all types of stress and tension, rather than being about sexual attraction to children. Jill’s views reveal how she was working out what she believed as she talked about it.
While she suspected perpetrators had deviant sexual thoughts and fantasies, sexual acts were described as alleviating emotional stress rather than sexual desire.

Jill: I think that things like interpersonal stressors … like becoming unemployed or breaking up with a partner, or being ridiculed … something that sets off some … emotional imbalance, or … distress or anger … that the person then essentially uses the sexual contact with a child as … either an outlet for that energy, or a way of trying to make themselves feel better, or … compensate for something in some way. So that's just what I’ve made up, of how it might happen.

In identifying sexual arousal as a motivation for CSA, participants would necessarily have had to deeply consider the implications of adults being sexually attracted to children. The concept of an adult being sexually attracted to a child was profoundly disturbing for participants, reflected in the earlier section on emotional and embodied reactions, and the difficulties in providing a definition of CSA in Chapter Five. As Jill commented “sexual gratification … that bit I don't like thinking about so much (laughs)”. Amy pointed out that “paedophile has got the word about small children in it” which made it “emotionally loaded”.

Defining a paedophile for nine participants meant foregrounding the aspect of sexual attraction towards children, although three included adolescent victims. Perhaps other less emotionally disturbing factors were highlighted as a means to avoid negative affect. While they described a variety of precipitants to offending, sexual attraction sometimes appeared to be muted or blotted out in the process.

Four female participants and one male participants believed CSA was as much if, not more, about “power and control” than sexual needs or attraction. Although touching and penetration of genital regions were discussed, the sexual acts were not always thought to equate with the perpetrator’s sexual desire. LMG commented: “See it's difficult, because I don't think it is purely about sexuality either … oftentimes it is kind of power and control issue and … it could be how children are raised”. Amy struggled with thinking about motivation, and clutched at a concept to explain: “probably, power and control … don't know really, don't know why they do that”. Jill drew attention to the popular discourse that “rape’s not about sex, it’s about power, that kind of … concept that’s been around a long time.” She stated that she subscribed to that “to some extent”, and felt that CSA was not always about sexual gratification. Elvis moved from a position which considered CSA to be “a mix of the two” aspects, power and sexual arousal, to a position which clearly privileged power: “I see it … more as a power thing, than kind of a sexual thing”. In Elvis’s view, adults always abused their power in sexually abusing children, whereas the degree of sexual motivation was uncertain. Yet he also noted:
“primarily… men are the perpetrators of sexual crimes … I guess because of their sexual drives”.

Most participants found it difficult to understand what motivated female perpetrators, and had more difficulty applying concepts related to male perpetration of CSA to females. While two participants had experience of clients abused by females, they still struggled to grasp the dynamics. Elvis thought that abusing power and control was predominantly a male domain. He stated: “it is possible … for females to … want to develop, um controlling and powerful relationships over vulnerable people, so possible but less likely”. BJ felt female perpetrators were “highly sexualized” and likely to have been sexually abused, therefore suggesting that a victim perpetrator cycle could exist for some female victims. Jill commented on the limitations of historical radical feminist explanations for female perpetrators which highlighted a cycle of abuse originating from male CSA perpetration: “the man had done something bad to her in the first place, so it was still all the man’s fault (laughs)”. 

Eight participants believed child pornography was a risk factor for offending, while the other three weren’t sure. Jill believed it could “feed” and “stimulate” an already existing deviant sexual desire, and Leah felt it could “introduce” people to “things”. Three participants observed that some perpetrators defended against negative affect by normalising their offences through networks with other perpetrators. The internet and associated technologies provided a globalised virtual community for paedophiles to be accepted and validated. In BJ’s view, the greater the networking and involvement with other paedophiles, the more likely CSA would be normalised: “you do get this whole underground life of paedophiles … they’ll live the secret porn life … where they’ve almost convinced themselves that it is normal”.

**Delusions**

Participants believed that perpetrators held delusions about themselves, their victims, and CSA, which were often transferred to the victim, either consciously or unconsciously. Delusions represented the distorted inner world of the perpetrator, and the way in which this could be internalised by the victim. One of the main delusions that the perpetrator entertained was that the child enjoyed the sexual acts, and willingly participated, as candidly expressed by Robin: “Someone that thinks that a child, or a young person, or adolescent enjoys them violating their body, their mind, their spirit”. Leah suggested that delusions were also held
about the role of CSA as sexual initiation: “they've convinced themselves that it’s beneficial to the victim, or that this person wants it, or that it is their duty to awaken them sexually”.

The maintenance of delusions involved denial of any information which challenged the cognitive distortions. Jill discussed the founder of a well-known cult in NZ:

Jill: They've got a lot of ability to deny that it's going to actually harm this young person … delusions … you know, from everything you see or hear about him, it looks like he really deluded himself that this was a good thing for these kids, that he is having sex with.

The delusion of an equal consenting sexual relationship may have been consciously or unconsciously used to convince the child that they were a willing participant. The result was that the responsibility for the events and the burden of negative emotions were shared, rather than remaining with the perpetrator.

Robin: It is … about … instilling blame in the victim for the act that the adult is taking, that the adult makes the decision to take. And then manipulates the child or young person to feel that in some way that they’re to blame for the harm that was done to them.

Participants’ accounts also suggested that delusions about perpetrators could be held collectively within society. Three challenged the common societal delusion that sexual abuse perpetrators fit a certain profile, and were readily identifiable. LMG discussed the stereotypical portrayal of paedophiles as “men in parks”. As Jack noted, “like most other offending, it's just not one socio-economic group, or one type of person”. However, he described a profile that NZ customs had successfully used to detect paedophiles. Jack mocked the particularity of the profile, recognising that it was likely to represent a small minority of offenders.

Jack: So he’s a gentleman between the ages of 40 and about 55, he is English … not very well dressed and portly, okay, and he has expensive cameras, and he spends a lot of time abroad, in places like Thailand and Malaysia…. And they picked somebody out from the profile from a plane last week … and they discovered a memory stick … on him with child pornography on it…. I wanted to know, “is there hair growing out of his ears and his nose as well? (laughs).

The idea that CSA was normalised by perpetrators, and sometimes internalised by victims, was repeatedly expressed, yet a word count revealed significant gender differences. Three out of the six female participants each made one reference to the concept, whereas all five males made a total of forty-four references. Jack talked about perpetrators “kind of normalising it, normalising their past experience”. BJ believed that delusions had to be
particularly entrenched to overcome the incest taboo. In his view, the creation and re-living of fantasies represented the first step to integrating incest as an acceptable and normal activity: “you are looking at that end of build up to a point where they've almost accepted that that is normal, and it's okay … the fantasy has become okay in their mind”.

In Pinchas’ view, the perception by some perpetrators that CSA was normal negated any sense of wrongdoing.

Pinchas: They think it’s normal … they have no comprehension that there’s something wrong with what they’re doing … it could come down to their values, it could be because it’s been so normalised for them, they just don’t have a clue … that it isn’t.

Pinchas went on to draw on knowledge of a case of multi-generational female perpetrated incest, where there were no “victims”, only participants. The normalising and reframing of incest as beneficial initiation obfuscated any sense of victimisation and harm, undermining empathy for the reality of each victim’s experience.

Pinchas: None of them saw themselves as victims … they lack empathy, because for them … there was no victimhood there…. So when they do it, they don’t see it as an abuse, all they’re seeing is a continuation of what’s been considered to be normal … this is an initiation, this is how you get initiated into womanhood.

Similarly, Elvis believed that victims who internalised delusions regarding the normality of CSA were at greater risk of becoming perpetrators of CSA:

Elvis: I think a person's own sexual background has something to do with it, perhaps childhood experiences … that they grew up in a household … where CSA was … considered normal … then there’s more likelihood … to … carry on with those values, internalise those values … (intake of breath).

Their comments suggested that CSA which originated in the family environment was easily normalised and transmitted inter-generationally, since children looked to adults to determine norms and routines. Elvis narrated the anecdote of “fish eyeballs” which exemplified the ease to which children could be manipulated to accept something as “normal”. The disconcerting notion of parents betraying their children’s trust was discharged with cathartic laughter.

Elvis: I guess it would be bewildering … for childhood victims or … survivors because … for children, everything is normal. If they don't have any experience
or guidance around something, you know … humans are the most adaptable species on the planet and … children take that to the nth degree by being able to learn and adapt so incredibly quickly to stuff … for children everything is normal … Children can get used to things very quickly … part of my job as an adult is to get them used to stuff, like … “you’ve got to go to bed now … sleep now … get up now … eat now”, you know, “this is normal stuff, trust me” (laughs) … so we do it, as parents … I do it all the time … I taught my four-year-old, that it was normal to eat the eyeballs out of snapper once it is cooked … and she loves eyeballs … I eat them myself … I’ve told them it is normal … so that’s an indication of what you can teach children to do.

**Cultural delusions or cultural relativity?**

Cultural notions of what was considered normal or acceptable regarding sexual practices were also discussed by two participants, and raised issues regarding cultural relativity.

Siaki: My colleague who was born and raised in Samoa … said that it was kind of normal that boys would get together, you know … things around masturbation, and things like that … and so he looks at that as just kind of growing up experience.

As a NZ born Samoan, Siaki questioned whether such practices could be conceded as normal, or were in fact abusive. Determining whether the perceived legitimacy of these traditions was delusional or sound elicited a conflict between relativist and essentialist notions of morality.

Siaki: Talking with my colleague here, he says it’s quite common … things like masturbation and all that type of stuff, in the Islands … I kind of challenged him, cause I thought well … if someone else is kind of masturbating, and all that type of stuff, what is that … is that abuse or is that culture or is that?

*Interviewer: Right and what did he say?*

Siaki: He kind of, maybe not brushed it off, but he said “oh that stuff’s kind of normal”.

*Interviewer: What someone masturbating someone else?*

Siaki: Yeah … ‘cause you’re all sleeping underneath the same mat or whatever. And I was just saying “are you serious?”

As a NZ born Samoan, Siaki reflected on the implications of these practices for his uncle, one of his Island-born perpetrators. Although Siaki identified his experiences as abuse, he wondered if his uncle framed them as sexual initiation. Other participants had little qualms about identifying perpetrators’ beliefs about sexual initiation as delusions. However, Siaki held the possibility that his uncle had been the victim of culturally validated beliefs and practices, in order to absolve him and maintain a relationship.
Siaki: And was he taking advantage or was that kind of a normalised behaviour that he'd seen in Samoa?

Interviewer: Right.

Siaki: He might not have seen it as abusive, he might have seen it as a passageway to manhood … I don't know, I don’t fully understand that part.

Interviewer: Okay.

Siaki: So it releases me … it allows me not to get too angry or fully resent my uncle, ‘cause he’s still a family member.

BJ also attested to the normalisation of CSA among Island-raised professionals. He did not appear to struggle with the issue of cultural relativity as Siaki had done; in his mind it was clearly “faulty thinking.” BJ believed a group psycho-educational approach as part of team supervision respectfully challenged and transformed entrenched beliefs and cognitions.

BJ: In our Matua time … we have actually talked about this issue of sexual abuse in the Islands and how it’s talked about.

Interviewer: Okay.

BJ: So that’s one way we try and bring the topic out … the Island-born, raised, have a different way of looking at it. And so … we actually are able to bring out even faulty thinking amongst ourselves.

Interviewer: Right.

BJ: … some of the elders might say, “well I was always taught that this was normal.” And then we talk about, “actually well it’s … not” … so it’s education … we do it as … a team, it’s called Matua time, and it’s like team supervision.

From discussions with kaumatua, Pinchas had information which suggested some degree of cultural sanctioning of adult-child sex among Māori in early colonial and possibly pre-colonial times:

Pinchas: I’ve heard this from other kaumatua … that in the past there have been tohunga and kaumatua … who have taken sexual partners who were young children … children or teenagers …and … having sex with them. And it wasn’t deemed as if it were paedophilia, but … because these men were constantly doing … mahi wairua, jobs that were … deeply spiritual, really exhausting … very deep … work, profound … stuff, that this was their vice …They were in a different element, different world …and so this was the thing that … almost made them human in the eyes of other people.

Pinchas described an agreement between the girl’s family and the tohunga or kaumatua, which had the appearance of a legitimate transaction; the young girl offered as a type of reward for the spiritual work undertaken. Pinchas maintained a more detached position in relation to this information than Siaki had done. He neither condoned nor condemned the practices: “That was the only time it was considered … acceptable, … there …had to be an agreement”.

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In Robin’s view, “generational incest” occurred amongst Māori in “a culture that becomes normalised”. She discussed the case of a child growing up knowing that her “grandfather was also her father”. While Robin had highlighted the normalisation of CSA in some Māori whanau, her discussion regarding the naming of the child suggests resistance. Nevertheless, the child carried the burden in her name and very being: “She was given a name that means “revenge” in European. So she was the visual part of maybe three generational abuse … she was the visual form of that”.

**The sexualisation of children: Societal support for perpetrators’ delusions?**

Participants were asked to consider their views about children’s sexuality, and all participants raised concerns about the sexualisation of children, noting the implications for boys and girls being sexually socialised at earlier ages. In Pinchas’ view, hegemonic notions of heterosexuality cast females as temptresses and males as victims of their sex drive. His observations suggested that the sexualisation of children involves both boys and girls internalising adult expectations of sexuality at an earlier and earlier age. He believed the message boys got was “this is the way girls want to dress, they do this to entice you”.

Five participants discussed examples of corporate paedophilia, although did not use that term. Marketing of trainer bras, makeup, skimpy clothes, and dolls that looked like “crack ho Barbies” to eight year old girls was described as “sick”, “sad”, “concerning”, and “normal”. Teenage girls and boys were perceived to be subject to vastly different expectations with regard to physical appearance and expressions of sexuality, with girls expected to display a great deal more flesh. Jill focused on the potential messages young girls sent out in dressing in a sexualised manner, which rendered them available and vulnerable to the gaze and desire of adult males.

Jill: They may not themselves be experiencing those as sexual outfits or … sexually provocative, but the reality is that a proportion of society will perceive them … as sexually available, because of what they're wearing … because of how female sexuality is portrayed in the media.

There were a range of opinions as to who was responsible for the sexualisation of female children. Participants cited the music, fashion, and merchandising industries, parents, and the porn industry. In Jack’s view, the sexualisation of girls was driven by parent rivalry, where children were displayed as commodities. Molly believed it was “media-driven”, but Pinchas identified the sex industry as the ultimate culprit: “Well I think partially the fashion
industry. And I think also the music industry, big time … I think that is a sexualised thing actually coming from the sex industry”. Similarly, BJ commented: “I’m going against my own gender but … it's coming from the male adult porn industry that is out of control.”

Participants noted that children are inevitably exposed to the adult sexual world on a regular basis through the various forms of media that are available 24/7. BJ stated “we’re living in a very sexualised world, and it's just fanatical … and overboard, around what kids experience or what they can experience, if there’s no controls”. In Pinchas’ view, although the goalposts of morality had significantly shifted, they were presented as normal: “what’s now being told it’s considered to be normal, or actually decent, has really shifted, because there’s some things that I wouldn’t think are decent and, and I’m not a prude at all”. Pinchas discussed the way in which the almost omnipresent power of the media eroded individual values with verbs linked to war, trauma and brainwashing.

Pinchas: I think we’re getting bombarded with so many things … most people aren’t able to discern what’s important and what’s not important … if you’re getting it so much, it then becomes normalised. You … get desensitised to it. I think … we’ve all been saturated with stuff, and to the extent where it just becomes the normal.

Although participants were unsure as to how much, if any, the sexualisation of children affected the incidence of CSA, concerns were expressed about the blurring of boundaries between adulthood and childhood, potentially leading to young girls being viewed as sexually attractive. As BJ noted, “the boundaries get blurred between when’s a child a child, and then when’s an adult … it just gets so deviant and blurred”. LMG expressed a similar view: “I think sexual abuse would exist regardless, but I do think that it … blurs the boundaries a lot … about what is appropriate … I think it makes it hard then to distinguish … what the lines are”.

Children in turn became a product for another potential group of consumers. Discussing the sexualisation of young female models, LMG commented: “partly it is consumerism … sex sells, but also who you are selling to, we’re building consumers”. Amy made a similar observation: “well they’re sexualised through … our eyes … but it’s who’s viewing them isn’t it? … So at the end of the day, it's still the adults who have got the responsibility”.

LMG discussed the societal “silence” regarding the sexualisation of children, which she believed implicitly endorsed and provided “protection” to paedophilic interests. While causing
her some conflict to express, she believed that scapegoating the perpetrator as the monster effectively absolved society of responsibility.

LMG: I do think, (sighs), I'm kind of loathe to say it in a way, the offender is a kind of scapegoat … as a society … we’re structured in such a way that these things can happen, and it is legitimised in some way, we do in some ways implicitly participate in this behaviour.

Comments like these suggested that the sexualisation of children was sometimes overt, but often insidious. In a sense, young males and females were being groomed by society to accept and internalise dominant discourses regarding adult sexuality, proliferated within a highly sexualised popular culture. Multi-faceted influences converged upon children to encourage their sexualisation, the main heterosexual message being that males were rampant consumers, and females were seductive products. Participants indicated that the possible link between the sexualisation of children and CSA lay in the implicit acceptance of adult notions of sexuality imposed on children. Not only was this likely to render children vulnerable to the sexual gaze of adults, but it also tacitly validated sexual attraction towards children, and potentially created consumers.

**The illusion of normality**

Illusions represented the outer presentation of the perpetrator, society’s perceptions and preconceptions of the perpetrator, the relationship between perpetrator and victim, and the way in which all these factors were internalised by the victim. Four participants provided examples of CSA offenders who were well functioning, and respected and trusted professionally and personally. One had worked with a well-known social worker who had subsequently been convicted of multiple CSA offences against boys.

Jill: I'm thinking of a rather well-known man … from our profession who sexually abused children … boys and young men … over a long career … he certainly wasn't lacking in social skills … he was a very intelligent man … even after he'd been in prison … he managed to do it again.

Leah highlighted how adults and children, professionals and families could be convinced of the illusion of trustworthiness and authenticity, because of the positive attributes and qualities that were a valid aspect of the perpetrator’s character. She described a gifted and popular teacher at her high school who had sexually abused female students for many years.
Leah: There was an incredibly popular teacher … he was a fabulous musician … incredible history teacher. And … two years after I left, we discovered that he had been assaulting girls … for years and years and years … and I would never have guessed.

The illusion of trustworthiness, developed and maintained through the perpetrator’s significant contributions to society, served to increase their elusiveness, even when a disclosure occurred. Those nearest and dearest were obviously the ones with the most to lose, and therefore were most likely to cling to the illusion.

Jill: Some men who sexually offend, and probably women too, are very good at convincing the people nearest and dearest to them, and other people, that they are good upstanding people. And they may be … good upstanding people in other parts of their life … but they are still abusing kids … and so these men are not low functioning men, with a lot of inadequacies … they are well functioning men who can impress and convince.

Prior to challenging the notion of perpetrators as isolated and socially inadequate, Jill had discussed reading literature about perpetrators “inadequacy … to form meaningful relationships with other adults … particularly intimate … sexual relationships” and to sometimes have “low self-esteem”. Ultimately her experiential knowledge appeared to hold more weight than her academic sources of knowledge.

The relationship that perpetrators created with their victims was also perceived to be an illusion. Something that appeared to be safe, attractive, fun, and positive was gradually transformed into something entirely different. By the time victims were aware of the deception they had often been trapped in a web of complicity. Leah continued discussing the high school teacher:

Leah: I think the awfulness in his offending, and I think in other people's offending as well, is that he developed those nurturing, mentoring, caring relationships with people, and then transformed them into sexual relationships … everybody loved him, and they had this cool relationship with him, and then all of a sudden it was something else entirely, and how did they get there? Oh, just awful.

In Leah’s mind, grooming not only trapped the victim, but created the illusion of a safe and healthy relationship to those looking in:

Leah: So much of the sexual abuse that’s perpetrated against children is … that sort of grooming, gaining cooperation … this is part of what makes it really
hard, and why there are coaches and pastors … who are able to sort of continue, because everybody loves them, and all the kids love them. 

Interviewer: Right. 

Leah: And so they’ve negotiated this relationship in a way that masks what’s going on.

Participants commented that intra-familial CSA provided just as much an opportunity for illusion as extra-familial CSA. The normality of expressing attachment and love physically in intra-familial relationships could be easily exploited. Jack noted “it's kind of normal for children to … ride on granddad’s back or whatever, and do those kind of sexual development things as well, and … it was Granddad that was not normal … rather than themselves”.

Participants were asked to imagine observing the relationship between perpetrator and victim, and held varied perspectives about whether the illusion of normality could be maintained. In thinking about the nature of the relationship between child and perpetrator participants used a range of negative words. These included “sick”, “disgusting”, “sad”, “frightening”, “horrific”, “dysfunctional”, “exploitative”, and “manipulative”, and some expressed obvious disgust. Perhaps visceral reactions of disgust prompted more dichotomous thinking, yet as participants had previously pointed out, the child or young person may not always conceive the relationship in these negative terms, nor may it be perceived by others in that way.

On reflection, three participants felt that the illusion of safety and normality remained for anyone observing the relationship. Therefore, while they could retrospectively identify the negative aspects of the relationship, they believed it more difficult to prospectively identify concerns.

Amy: (silence) Well it’s very hard to tell … most things just look normal. That’s the way it looks. I mean if a kid said to me “no, no, no I don’t want to go to so and so’s place”, … of course I’d be checking that out, but … that’s not the way it goes.

In Leah’s view, the victim’s need to maintain an important attachment relationship created the outward appearance of a close, supportive relationship.

Leah: Probably it would appear to be a close relationship … a supportive relationship … a nurturing relationship … a mentoring relationship … that's … the awful thing about this …often those relationships … appear to be really loving relationships … Because … the trade-off … is that attention and being special, and all of that loveliness, and … you don’t know until you’re in it, what that means.
LMG believed that behaviour which indicated some problem between victim and perpetrator was likely to be subtle or non-specific, creating challenges in interpretation and response. She suggested the child might be “stand-offish” or “trying to escape” or the perpetrator “quite fixated on the child” but “not … necessarily either”. However, others thought that the child’s behaviour with the perpetrator would generally raise some red flags. BJ drew on intuition as a means of determining that something was amiss in the connection between victim and perpetrator. In his view, a child who was being sexually abused would not display love and respect towards their perpetrator or have a close relationship. His perspective about the lack of connection between victim and perpetrator elicited a deep intake of breath. In a similar vein, Jack discussed the absences in the nature of the relationship between victim and perpetrator, and for both Jack and BJ any displays of withdrawal by the child were potentially indicative. Jack also suggested that intuition came into play in noticing tacit signs: “you’re always looking at kind of the quality of the relationship … looking for … absences … something … ringing bells or … a bit bizarre … kind of a withdrawal”.

**The illusion of complicity**

Participants noted that perpetrators utilised a range of subtle grooming strategies to purposefully undermine the child’s awareness of victimisation. These included “coercion to participate”, “normalising” or “minimising” the abuse, “instilling blame”, or creating a transaction with gifts, money, affection, or attention. Several observed that many strategies were designed to make the victim feel complicit; in essence the perpetrator deceived the victim into believing they were an accomplice. By exploiting the child’s relational needs, their naïveté and their powerlessness, and establishing illusions of complicity and even culpability, an awareness of victimisation was diminished.

Leah: They participated willingly in their minds because they’ve wanted the candy … or they really liked the attention, or … time that they got … there’s something on offer, there’s a trade-off here … I don’t know if it’s designed to make them feel culpable, but it surely does.

Paradoxically, Jill believed that self-condemnation often increased with maturity as the victim/survivor took increasing responsibility for their perceived complicity.

Jill: I think it’s a relatively common dynamic … the … coercion to participate … Someone close to me was given money every time she was raped by this family member … That was quite an issue for … her healing … I think it’s very common … taking advantage of children’s innocence and naïveté. And if
the offender is someone … that's got a … close relationship, and has groomed the child as well, then there is more of a chance of getting some voluntary kind of cooperation … that later, this poor person as an adult … can end up really giving themselves an awful time about feeling complicit in it.

Elusiveness

The success of perpetrators’ illusions assisted their elusiveness, providing ample camouflage for CSA to go undetected and unreported. As Leah noted: “it is the people who are well embedded in communities a lot of the time, and who are well hidden, who are the most prolific offenders, because they've got the best covers”. BJ surmised that perpetrators were more skilled at deceiving over time: “I think the older they get, probably the more set in their ways … and I think they probably get better at being able to potentially manipulate the system”. In the view of five participants, elusiveness was more common in intra-familial sexual abuse. As Elvis stated, “I think … abuse that happens within a family is more easy to conceal … and I think easier to get away with probably”. LMG discussed her own experience of intra-familial sexual abuse happening under the noses of others, suggesting that the elusiveness of perpetrators may sometimes be a function of other family members’ purposeful blindness. Her wry laughter perhaps covered, as well as discharged, feelings regarding her experience of abandonment as a child.

LMG: I know from personal experience that can happen right under the nose of other people, and not be detected so, maybe not.
Interviewer: So it was able to occur without anybody noticing anything?
LMG: At the time … as I say, as far as I know (laughs)…nobody stepped forward and said “hey look, I know that this was happening”.

I did not follow up with LMG whether the identification of her perpetrator by other women had led to a conviction; however among known perpetrators discussed, the majority had eluded prosecution and/or conviction. Thus, they had also eluded any opportunity for rehabilitation. Either they were never reported, or they were not found guilty. Confronting the potential for perpetrators to have continued sexually abusing other children was deeply disconcerting to participants. This was also brought to the fore by estimating how many CSA perpetrators were reported to police and how many were subsequently prosecuted and convicted. Estimates for reporting ranged from less than 10% to 60%, while prosecution and conviction rates were believed to be “a fraction” of or a “big drop-off” from reports to authorities. Robin, who had estimated that 60% of CSA cases are reported to police, asked me what the statistics revealed. When I let her know that research suggested less than 10% were
reported to police she stated it was “devastating” and “disheartening”, and commented “you just totally depressed me”. Participants had little confidence in the court system, and described it as “soul-baring”, “abusive”, and “atrocious”, with the victim on trial as much as the alleged perpetrator. Jill commented that children and young people sometimes endured significant delays of 18 months or more to receive counselling, because of court cases. Based on a previous role, Leah believed women survivors rarely went through court.

Three participants had considered the possibility that a known perpetrator had continued offending, but there appeared to be active attempts to defend against such thoughts. As discussed in Chapter Six, Amy had recovered memories of sexual abuse at age 39. At the same time, both her daughters in their late teens, had disclosed previous sexual abuse by separate perpetrators, both of whom were prosecuted. Yet both cases failed to gain a conviction, despite one perpetrator abusing multiple victims. A range of emotions and cognitions permeated Amy’s account: powerlessness and resignation, assertiveness, anger, sarcasm, wishful thinking, and pain. The significant periods of silence indicated the emotional strain in contemplating the perpetrators’ potential continuation of sexual offending. Amy had “outed” one of the perpetrators at the time, in an attempt to warn those around her. However, the exposure was unlikely to have had much lasting effect, given the ability of perpetrators to reinvent themselves in new communities.

Interviewer: Did you get a conviction?
Amy: No … so one of them was a hung jury … for my youngest daughter, and the oldest daughter, it didn’t get out of depositions, even though five other young women were charging him as well. But you know, that law where you can only do one at a time, and they mustn’t know the other.
Interviewer: Right.
Amy: Yeah he was good, the police really wanted him, but they couldn’t get him … he’s probably still doing it, mmm … (silence).
Interviewer: Is that a hard thought to, to think about?
Amy: Well I don’t know, I saw him recently at a funeral … I mean if I saw him with a child, I would just say something.
Interviewer: Right.
Amy: I mean, I don’t know if he’s still doing it … but I certainly outed him at that time … it came out, not just me, but a lot of people … the parents of … those other kids, but um, mm, is it a hard thought, yeah, well it is.
Interviewer: Okay.
Amy: ’Cause he used to have access to a lot of children. I like to think he’s got less access these days.
Interviewer: Through work or through voluntary activities?
Amy: Mm…(silence)…The first one, the other one at the hung jury … he’s an addict as well … I think he got done for … drugs years ago, and his community service was working at somewhere like youth town, you know… and you think, “oh for fuck’s sake”, mm.
In BJ’s case, the matter was dealt with by his father excluding the perpetrator from any further involvement with his family. Thoughts about his perpetrator sometimes intruded, but they were avoided through compartmentalisation. The perpetrator’s life was “separate” and “distant”. BJ’s speech rate increased indicating his discomfort as he recounted his experience. He stated he was relieved not to have been forced to relive his ordeal through court. When I asked him if he was concerned that his perpetrator had continued offending he answered “Yeah … I hear different things … and I do wonder … sometimes I think about that, but then I just think, that’s not my place to … it’s distant”. Siaki, who was sexually abused by his father’s brother; a respected family member and a Samoan head chief, continued to have contact with his uncle at family events. He commented “when it comes to my own kids, and somewhat to the kids that are around him, I wouldn't trust him … but … I don't say, ‘I don't trust you’, I don't get angry”.

Six participants expressed the idea that CSA offenders were conflicted between their urge to offend and their realisation that such behaviour was socially unacceptable. In LMG’s view, the internal conflict created both shame and guilt. As revealed in Chapter Six, these same core feelings were experienced by victims. Trying to imagine what it might be like to be in the perpetrator’s shoes LMG stated “certainly I would feel conflicted if it was me”. Jill posited that perpetrators may experience the internal conflict as so traumatic and unbearable it may be escaped through dissociation at the time of the offence. While she had previously commented that CSA perpetrators could be well functioning, her personal knowledge of a perpetrator’s moral compass led her to believe he couldn’t live with the conscious awareness of what he had done. Perhaps Jill’s last comment about the man’s “difficult early childhood” suggested the possibility that dissociation had already been utilised as a coping mechanism.

Jill: A friend of mine … accused the father of incest, and the father has denied it all the way through, and you have to wonder whether he has actually blocked it out … or dissociated in some way… because what they’re doing is so traumatic for them, in a way.

Interviewer: That's a really interesting concept, yeah.
Jill: …his daughter and I have speculated as to whether he actually, literally doesn't believe he did it.

Interviewer: Right.
Jill: Because it's quite hard to think that someone like this man could keep functioning the way he does, if he faced up to what he's done.

Interviewer: Right, yes.
Jill: Um, because, he … is someone with a conscience and with morals and beliefs … and that man had a difficult early childhood.
Leah believed that societal condemnation contributed to perpetrators’ elusiveness by reducing opportunities for them to seek help.

Leah: At some stage people are going to realise that it’s not acceptable, and it needs to be secretive. But if it's become part of your functioning, if it's become part of how you relate and … understand things, then you just go underground with it, and carry on with the behaviour … Even if you did realise it was wrong, and were terribly ashamed about it, it would be an extremely difficult thing to rock up at a counselling office and say, “so here's the deal … I've been molesting my daughter … could you help me with that?”.

Jill noted the absence of a balanced discourse regarding perpetrators evidenced by a predominantly “demonising” rather than “humanising” script. BJ discussed the “It’s not OK” television campaign in NZ, which portrayed domestic violence perpetrators as ordinary humans in need of help. In his mind, a similar campaign was needed which portrayed sexual abuse perpetrators as ordinary humans in need of help rather than monsters.

BJ: I think the level of anger towards these guys from society … has backfired, because … it pushes them … into hiding to kind of go, well “I won’t be open, because I know how much I'll be hated if I’m actually honest with how I am”… like… the campaigns around violence… you know, “it's not okay, let's talk about it”, and so there's an awareness growing in the community that it’s happening … like back in the day, the violence, the man who assaulted his wife violently was seen as a monster, but now there’s been a little bit of a shift.

**Therapy for CSA perpetrators**

Participants had differing opinions on the degree to which healing was possible for perpetrators, however five participants saw similarities between recovery from addiction and recovery from sexual offending, at both the treatment and maintenance stages.

Leah: I think it can be effective … it's kind of like addiction, and … maybe even more important that there is an initial period of intensive treatment. And then a long period of continued support and follow-up and accountability … to contain those impulses … I mean it’s not a quick fix, you’re not going to do a 12 week programme and stop having those urges, and stop engaging in that behaviour.

Like people in recovery from addiction, participants believed that sexual offenders maintained a risk of relapse across the lifespan. Siaki stated: “it’s just total constant management … continually keeping themselves safe and keeping others safe as well”. Robin highlighted the similarities in treatment vocabulary: “when we talk about alcohol and drugs, we
talk about stresses, triggers. It’s the same kind of language that I hear for offenders as well. So there is treatment, therapeutic treatment. But they maintain that risk”.

Three participants believed treatment was probably more effective for younger perpetrators, and another three highlighted the importance of support from family or a significant other. In thinking about the possibility of rehabilitation LMG stated “my understanding is that it's not very …” and wryly laughed. However she went on to comment “maybe the younger that you kind of intervene, the better”. Jack held similar views about the increased likelihood of rehabilitation for young sexual offenders, and commented upon their desire for “normal sexual relationships”. Speaking about younger clients who had gone through community treatment he commented: “they just want to get down and be kind of normal really, or get a girlfriend … and normalise the whole bloody thing”.

Pinchas believed that sexual offenders who were able to maintain a sexual relationship with an adult were of less risk than those who had an exclusive sexual attraction to children.

Pinchas: I don’t think all of them are at heart really, really paedophiles, I think some of them would love to be in a relationship with another adult and have a normal ordinary adult life … I think if you can assist a person to …achieve that, then … job’s done … but … if you’ve got someone who really is … only hungry for children … only fantasizing about children … then I think that’s gonna be an ongoing thing for the rest of their life.

Both Jack and Pinchas’ accounts suggested a continuum of perversion. Perpetrators who had exclusive sexual interests in children were considered to be most perverted, most at risk of recidivism, and least likely to be rehabilitated. At the other end of the continuum were perpetrators who were ultimately seeking “normal” and fulfilling sexual relationships with adults, and were therefore most likely to be healed. The implication inherent in this view was that perpetrators would not be sexually attracted to children if they were sexually fulfilled by adults. Yet BJ pointed to the difficulties of successful rehabilitation, through entrenched psychological and physiological patterns, often driven underground by stigmatisation. In this view, the specificity of compulsions driven by body and mind may not be satiated by an intimate relationship with an adult.

BJ: I think particularly for sexual offenders, because of the negative thing from the community, the label, also because of … the huge emotional satisfaction and hormonal satisfaction, the body, the physiological side of it … “oh it felt so good … to go down that way … and now I'm being told to go this way”.
Motivation was considered important for successful treatment of sex offenders, but two participants did not believe it should be a condition for treatment. Similar to motivational interviewing within alcohol and drug treatment, Robin felt that motivation could be elicited and enhanced by interventions: “So whether they buy into the process because they self-refer or they’re ordered to, I think any exposure to therapy is good”. In BJ’s view, acknowledgement of wrong-doing laid the foundation for motivation to change.

Four participants discussed the need for ongoing monitoring of perpetrators in the community, but two highlighted the difficulties for perpetrators and the community. Siaki focused on the emotional effects of constraints to freedom on sexual offenders in the community. The community became a prison which potentially reinforced self-loathing: “I think with some offenders, it's almost like they hate themselves … being monitored … it’s like a monkey on their back”. Amy believed the “not in my backyard” or NIMBY attitude was common in society. Her perspectives indicated aversion, followed by compassion, and in quick succession sarcasm, with the realisation that those sexual abuse perpetrators nearest and dearest were unlikely to be convicted.

Amy: Would I want a convicted paedophile living next door to me? No, in one way, and then in another way, everyone deserves a break. And if I thought that that person was genuine then … would I want one living next to me? I could say no, but then again, for all I know there could be one living next to me, because that's only the ones that have come to the attention of the law that we ever hear about. And they’re living a hell of a lot closer than next door.

Two participants raised concerns about the paucity of community based treatment available for sexual offenders. Jill commented that the funding issues not only affected the provision of treatment for sexual offenders but access to funded treatment. Another participant commented that successful rehabilitation of offenders may be compromised by a lack of professional awareness of unresolved trauma. In one case, despite lengthy contact with criminal justice and mental health systems, an incest offender’s own sexual victimisation was not discovered until he later presented with gambling problems. The compulsion of his long-term sexual offending had elements of re-enactment of his own victimisation, yet it had never been discovered, and therefore never addressed. Prison’s hierarchical structure magnified societal attitudes whereby as a CSA offender, he was reviled by all other offenders. On his release from prison, gambling became an escape from the stigmatisation of abnormality; an attempt to regain a sense of a normal self. As BJ explained, “he goes to gamble as a place to just feel normal and escape and be accepted, and there’s no labels.”
Conclusion

Just as participants tended to avoid discussing the sexual aspect in their definitions of CSA within Chapter Five, they also tended to minimise or avoid the perpetrator’s sexual arousal towards children/young people as a motivating factor. While participants described a variety of legitimate precipitants to offending, sexual attraction towards children sometimes appeared to be muted or blotted out in the process. Either they privileged the abuse of power as a primary motivation, or believed power was used to satiate general sexual needs and tensions. Alternatively, some participants believed perpetrators offended to alleviate emotional tensions and life stresses. However, other strands of knowing conflicted with these views. The majority believed sexual thoughts and fantasies about children played a part in offending and that child pornography was a risk factor. They also believed that perpetrators generally spent time grooming their victim, and either felt conflicted about their sexual urges towards children or had accepted them as normal.

Perhaps other less emotionally disturbing factors were unconsciously highlighted as a means to defend against negative affect. Contemplating the idea that adults may be sexually attracted to children is naturally disturbing. The sexual nature of CSA may have remained a tacit strand in most accounts as a way of not knowing. By not knowing I suggest that participants relegated certain issues to the outskirts of consciousness. Other forms of diminished knowing appeared throughout this chapter. Participants depicted perpetrators successfully eluding detection or apprehension through their outer presentation, the relationship they created with the victim, and low reporting, prosecution, and conviction rates. Yet contemplating the possibility that undetected perpetrators may continue to sexually abuse children created considerable discomfort; it was therefore best not to know. In addition, female perpetrators of CSA remained an enigma, they could not be fully known because of the paucity of explanatory theory. Participants recognised, but were also subject to, dominant discourses regarding femininity and female sexuality which silenced and camouflaged female perpetrators.

Without exception, this sample of social workers held the belief that most CSA occurs in the context of a relationship. Over this chapter and Chapter Six, their perceptions regarding the use of power reveal a continuum from violence to the provision of money, attention, rewards, affection, support, and mentoring. Not only were the subtle uses of power less easy to detect but they were more likely to create a sense of complicity and potentially reduce credibility. Those participants who had personal and professional contact with CSA
perpetrators (other than those who had directly abused them), appeared more able to perceive genuinely positive aspects to perpetrators’ characters. These participants could more readily apprehend that the relationship between victim and perpetrator could be positive and at the same time abusive, creating an illusory snare for the victim, and an illusion of normality for those observing. By acknowledging the ways in which CSA perpetrators could be chameleons, they held knowledge which challenged societal expectations for victims to readily disclose and/or escape.

Participants suggested perpetrators’ delusional cognitions were conscious and unconscious strategies to enable perpetration. They represented perpetrator’s defences such as denial and projection, which overcame any intra-psychic conflict and effectively ensnared the child through a sense of complicity. Many participants highlighted the concept of normalisation, observing that delusions regarding the normality and acceptability of CSA could be transmitted inter-generationally and culturally, as well as being validated through perpetrator networks. In addition, participants believed that societal sexualisation of children implicitly normalised children as sexual objects available to the gaze of adults. Elvis’ salient anecdote about teaching his children to eat fish eyes highlighted the power of adults to define what is normal for children.

Thinking about how CSA may occur and contemplating the internal world of perpetrators was emotionally challenging and/or exhausting for participants. Negative affect and discomfort about perpetrators sometimes manifested powerfully in the body. These immediate visceral reactions sometimes contrasted with a more reflective attitude, highlighting the potential interference from lightning fast limbic responses upon the ability to engage slower but more reasoned activities of the frontal cortex. Yet when participants were fully engaged, even those who identified the least amount of knowledge such as Elvis, were able to provide valuable insights. This raises questions about knowledge status. Assisting participants to check in with their emotional and embodied responses appeared to facilitate greater appreciation of the complexity of the issues. In essence, knowing was facilitated by emotional and embodied awareness. While disgust towards perpetrators was a common initial emotion, grief often emerged, not just for the victim, but also for the perpetrator, and society as a whole. This grief allowed some to move from the position of bystander to consider the role of societal complicity. The process issues within the interviews therefore have important implications for social work practice and education. In Chapter Six, participants pointed to the ways in which victims and survivors of CSA are already likely to feel tainted by the acts of sexual abuse and the relationship with the perpetrator. In addition, they also highlighted the way in which
children and adults are highly attuned to the non-verbal as well as verbal reactions of others. The findings indicate social workers need opportunities to work through strong negative affect which may otherwise impact their work with clients. The next chapter explores social work educators’ perspectives regarding CSA and their views on the relevance, sufficiency, and efficacy of CSA training within social work education.
Chapter Eight: Findings – Educators’ Personal, Pedagogical and Pastoral perspectives

Introduction

In identifying the key issues regarding CSA education, three interdependent themes emerged from the analysis of social work educator interviews: personal perspectives, pedagogical issues, and pastoral responsibilities. Each theme will be briefly introduced followed by presentation of the major findings from the theme and associated sub-themes. The personal voice permeated all three themes and emerged in unexpected ways through emotional and somatic responses to the material discussed, although personal experiences were not discussed as often as they had been by social workers. Acknowledging that the reflexive use of self applies to educators as well as students, such data highlighted the impact of CSA on educators, with considerable implications for social work education. On occasion, I fed back to educators some of the social workers’ perspectives to gain comment, and these aspects are also included.

Personal Perspectives

Personal perspectives attended to familial, personal, professional, educational, social, and cultural influences and experiences in relation to CSA. The eight educators in this study self-rated their knowledge of CSA and discussed their understanding of and attitudes towards varied aspects of CSA, including definition, prevalence, and impact. In articulating perspectives regarding CSA, familial experiences were generally not drawn upon as often as they had been among the social worker sample. Most educators drew primarily on professional experiences, however, one educator stood out in her comfort in drawing on personal relationships and experiences to demonstrate her views regarding CSA. She discussed a non-contact personal experience of sexual abuse, as well as the sexual abuse of a family member and a partner.

Previous training in CSA

Very few social work educators recalled any specific training in CSA within their own social work education. Common comments were: “none at all”, “very little directly about that
topic”, and “I don't recall a specific paper”. Kantor had trained in the late 1980’s. She noted that although there was considerable legislative focus on the Children, Young Persons and their Families Act 1989, much less attention and “energy” was given to CSA as opposed to other forms of abuse. The time elapsed between completion of undergraduate social work education and the interview varied between 13–22 years, and it is possible that some failed to recall certain aspects of their training. However, three educators were certain that their social work training had given minimal or no attention to the topic of CSA. All participants discussed a range of other sources of learning about CSA such as workshops, conferences, and community based training as well as learning through experiences with clients in relevant positions. However, Bob described a case study presented at a three day CSA training he had attended in the 1980’s, which revealed presenters’ naïveté, rather than knowledge.

**Self-rated knowledge of CSA and definitions**

Five social work educators rated their knowledge of CSA as quite high, with ratings of 8/10 or 10/10 or descriptions such as “fairly solid”, “pretty good”, or “certain aspects quite high”. William commented that he knew more than he “would like to”, and Bob felt that although he had a lot of past practice experience within CYFS he needed a “catch up” and did not consider himself an “expert”. Only one educator rated themselves as considerably lower at 5/10.

Like social workers, all educators spoke of broad definition of CSA which encompassed both non-contact and contact offences. However, Alf commented that non-contact offences were likely to become contact offences over time. Bob, Clara, and Alf provided more comprehensive definitions of CSA, and perhaps this was a reflection of their previous experience in the field. Yet Bob also spoke of the “contested nature of what constitutes sexual abuse”, and Clara foregrounded the victims’ perspective suggesting that the definition was “often impacted by the person's experience of it”. Similarly, Laura was interested in “what the victim experiences that to be”, yet she also noted that victims may defensively minimise or deny the impact of CSA. For Lisa, the definition was very simple highlighting embodiment and emotions: “it’s whatever makes a child feel squidgy in their tummy”.

Daphne was the only participant to highlight the production of child pornography as a form of CSA, and noted that research revealed pornographers were often family friends or family members. She tended to use the term “child sexual abuse” for children up to age 12 and “sexual violence” for youth and adults. She stated “I delineate it by saying that, to me, violence
involves a weapon … so if somebody was … violated … on a date rape, the weapon would be the medication they were given to knock them out … or the weapon might be tying them to a bed … some sort of coercion or force, pressure”. In Daphne’s mind, the term “child” in CSA excluded youth. Although acknowledging that adolescents may be sexually abused, her predominant focus appeared to be on date rape among youth. I asked Daphne whether she thought that youth could experience incest, and she replied “yes, and I don't think it usually starts in youth (laughs)”. She went on to comment that incest was often a reason for youth to leave home, but also reflected that “people are coerced to stay, because … they don't want it to happen to a younger sister or brother”. Laura also focused on potential date rape when considering definitional issues related to CSA, in order to highlight grey areas regarding consent.

**Estimates of CSA prevalence**

All participants believed females experienced CSA at higher rates than males, although three posited that the gap between female and male sexual victimisation rates was much less than official figures suggest. When percentages were cited, estimates for prevalence from six educators ranged from 20%–30% for females and 8%–25% for males. However, Daphne appeared to refer to research reporting incidence, noting that 4% of women and 2% of men had “experienced one or more sexual offences”. She believed CSA was “probably a lot higher than what is captured in the statistics”, but she also felt there was “too much emphasis on the danger of sexual abuse, at the expense of other forms of abuse and neglect”. Daphne envisaged that the prevalence of CSA was higher within clinical populations, as did three other participants. Drawing on her experience working within a DBT programme, Clara commented that 80% of clients had a personal history of CSA.

Thinking about the prevalence of CSA as being “one in four” led Lisa to contemplate the implications: “when you're working with, in an after-school programme, or a sporting programme or a camp, and you’ve got 20 children and they’re running around, five”. As discussed in Chapter Four I found myself having similar disturbing thoughts about children, when contemplating the prevalence of CSA in the community. Bob’s wry observation captures the potential for societal and professional denial and minimisation: “it is more prevalent than most people realise I think, or are prepared to acknowledge”.
Male victims of CSA

Participants believed under-reporting of CSA was common, however five educators felt that male victims of CSA encountered more barriers to disclosure than females. They believed male socialisation processes influenced intra-psychic, interpersonal, societal and structural barriers to disclosure. Bob talked about the “taboo” nature of CSA and the “associated social difficulties” perhaps being even greater for boys. In Daphne’s view, males were “more vulnerable in a way” because of the pervasive social messages to “be strong and don’t talk about your feelings”. Alf believed that males sexually abused by females could easily reframe the experience as sexual initiation, and he suspected that the low statistics regarding female perpetrators did not reflect reality. In Laura’s view, the lack of male-centred support services also constituted a major barrier to disclosure and recovery. Clara posited that the pathways for men and women who were seriously impacted by CSA histories may be different, but implied that each of these pathways might mask underlying sexual victimisation. It was a tentative idea reflected by the repeated use of “I guess” and the possibility that it might have originated from “urban myth”.

Clara: I guess mental health populations are often … skewed towards women, especially with personality disorders, so I guess my assumption has always been that … the men end up in prison, and the women end up in mental health … centres.

Impact of sexual abuse and its manifestations

Participants drew on a range of practice experiences and training to describe the impact of sexual abuse on male and female victims. The psycho-social impacts of CSA across the lifespan were discussed by five participants. Bob considered CSA to be a “predisposing” factor for a “variety of … situations of social distress … later in life”. Daphne used metaphors of waves and notions of depth and surface to describe variations in impact across the lifespan. She noted that different “ages and stages” might present as triggers for memories of CSA, creating increased distress. These might include entering an intimate relationship, or a survivor’s child reaching the age that they were abused. In Alf’s view, the trauma of CSA often had ongoing relational implications: “it has an interactional impact, rather than just a direct, purely psychological way, you know, trauma … it's … more kind of systemic … than individual”. William focused on interpersonal and psychosexual issues for males, particularly when sexual abuse constituted the boy’s first sexual experience. He believed CSA profoundly affected peoples’ ability “to create deep, fully human relationships”. He commented that, for young men
he had worked with “some of their biggest hang-ups have been about what kind of partners they’re going to become … what kind of fathers are they going to be”.

Participants were divided about the outward signs of sexual abuse. Daphne felt that with “young children you see all these signs”, but it was harder to discern the cause of “at-risk behaviour” in the teenage years. In contrast, Lisa believed that children’s desire and ability to immerse their selves in the present may obscure outward signs of distress. Over time, like BJ’s account in Chapter Six, she felt that children’s ability to put aside abusive events decreased.

Lisa: Sometimes you can see it …when your children are not well and you see it in their eyes, sometimes it's there, but most times it isn’t, because they’re in a situation now where there making the best of it … The resilience, that bounce back stuff is just amazing, but eventually the bounce becomes quite leaden.

Five participants believed a history of CSA was associated with mental health and/or addiction issues. Using very similar words to Jack in Chapter Five, Daphne described CSA creating “a little hole in” people’s “hearts”, with addictions bearing the pain and filling up “what is hurting”. Similarly, Lisa commented that drug and alcohol abuse could manifest as a symptom of unresolved CSA, and Clara noted that “a lot of people who have mental health issues have been through histories of trauma”.

Influence of the media

Like social workers, educators in this study were circumspect with regard to the media’s portrayal and reporting of CSA. Six believed the media sensationalised cases. Kantor advised students to “look beyond” media representations, and commented on the media’s lack of clarity and tendency to polarise issues. Like Robin in Chapter Five, Lisa had also observed cultural bias with regard to reporting of child abuse in general, which lead her to develop a “cynical” attitude towards the media. Several participants also spoke of the extremely limited and stereotypical portrayal of perpetrators of CSA within the media, yet sometimes indicated their difficulties in separating themselves completely from dominant discourses. The emotional work necessary to fully contemplate the humanity of CSA perpetrators led to cathartic laughter for Laura, which I mirrored.

Laura: I personally hear very little about … child sexual abuse in the media, or if you do, I guess it is the most extreme cases, where it's about sensationalising and … usually showing what a demon the perpetrator was, and how depraved he was … Which he probably was, but … within the media realm, that's very much how it's portrayed.
Interviewer: Right. And that’s a good point isn’t it because, I mean are sexual abuse perpetrators … do they present as monsters?
Laura: Yeah, usually not … and often they’re also actually not (laughs).
Interviewer: Yeah (laughs).
Laura: (laughs) Often they, sure they present as not, and sometimes it’s manipulation and control, but often they have these good aspects of themselves as well, as well as this awful abusive and damaging behaviour.

For Alf, the inaccurate characterisation of perpetrators in the media prevented their apprehension. In his view, the apparent normality of CSA perpetrators assisted their elusiveness, and was perpetuated by a gap in the research. The stories of CSA perpetrators, which might lead to a more balanced perspective, were in Alf’s opinion, stories that no one wanted to hear.

Alf: …the common perception of sexual offender … against children … is … the man in the … gabardine trench coat.
Interviewer: Right.
Alf: And has lollies and waits behind a bush to jump out … that image persists … And I suspect that’s because … when a name is alleged or somebody is accused of offending … the first response of the people … who … know that person say, “look uncle XYZ isn't a monster, and therefore he isn't an offender, how can he be?” … and I think the media portrayal … is detrimental to the detection and prevention of abuse because … the story that we have of offenders are those ones that are presented by the media … researchers, or … clinicians … We don't hear the voice of the men who offend themselves … because nobody wants to hear that story.

Along with the notion that sexual abuse perpetrators were monsters, the dominance of public concerns regarding stranger danger ultimately obscured the reality of intra-familial sexual abuse. As William noted “in the public persona of … sexual abuse of children, it's almost divorced from the reality that it happens in our homes every day”.

Understanding CSA perpetrators and CSA perpetration

For all but one educator, the topic of CSA perpetration represented a gap in knowledge. Bob acknowledged that he found the “different categories of paedophiles … all a bit murky”. Conversations regarding CSA perpetrators sometimes generated emotional pain or discomfort. Physical signs of the emotional impact emerged such as voice cracking, moistened eyes, changes in breathing, and cathartic laughter. Kantor expressed her difficulty in working with CSA perpetrators and understanding their modus operandi. She had previously worked in a “child abuse team within paediatrics”, seeing cases of CSA occurring from infancy to 15 years, and had also worked for CYFS. However, she remained utterly confounded by the concept of
grooming. Her facial expressions and her voice conveyed the intensity of emotional pain she felt in grappling with the concept. While she was able to verbalise her fear and confusion, only her body expressed her grief. Like Amy in Chapter Seven, she expressed aversion at even trying to understand the minds of perpetrators.

Kantor: ...I think the one that scares me the most around sexual abuse is the grooming.
Interviewer: Right.
Kantor: That whole area of grooming, that I find really difficult to understand … I can't get the concept of why an adult would not see it as a child.
Interviewer: Okay ... so basically it's quite hard to get into the mind of a perpetrator?
Kantor: Oh, wouldn't want to ... because I remember being at a DSAC\textsuperscript{84} meeting where they had talked about this perpetrator who was known to be a groomer … I just felt quite unable to cope with that kind of concept … that you manipulate a child to that sexual degree was just too much for me, just amazed me (moistened eyes and pain in her face).
Interviewer: Okay, yeah.
Kantor: Because I kept thinking, how can they not see this six-year-old as a six year old child? (voice cracked)

Despite the difficulties expressed by Kantor, there was also an articulated commitment to treating CSA perpetrators as human beings. Although recognising that she could not work with CSA perpetrators, Kantor believed they deserved the same respect accorded to anyone else. Similarly, William noted that “the people that are undertaking this behaviour, and are victims of this behaviour have to be viewed as, and treated as fully human”. In his view, emotional reactions to perpetrators and their abusive activities obfuscated the more positive areas of perpetrators’ lives: “it’s such an emotive topic, people can't separate those things out”. Social work educators needed to be careful not to “collude with that public view of, hang them”, and to present perpetrators “as people that have a whole lot of other things in their lives that they do well, but this is just one part of their life, that they've messed up in”. For Lisa, social work practice had transformed her attitude towards CSA perpetrators. Echoing Kantor and William’s view, her revised perspective was assisted by giving perpetrators a human face, acknowledging that they are “sons and daughters of parents, and they’re brothers and sisters, and if you've learnt it, you can unlearn it”.

Four participants considered that a victim-perpetrator cycle operated to some extent within CSA, although this was identified from observations and opinions regarding rates of sexual victimisation among perpetrators, rather than the potential for victims of CSA to become

\textsuperscript{84} DSAC stands for Doctors for Sexual Abuse Care, a group of general practitioners and paediatricians in NZ who have completed training in medically assessing for signs of CSA.
perpetrators. Lisa commented that “perpetrators have been victims themselves, and that's how it’s manifested, through life type thing”. Kantor had a similar view stating “they often say that … sexual abusers have been abused themselves … you need to be able to understand the cycle in order to break the cycle”. Drawing on considerable professional experience working with CSA perpetrators, Alf believed that over half of perpetrators had a personal history of sexual abuse. He commented “I'd estimate that 60% of the men in the programme … they’ve probably been sexually abused”. However, Laura felt that sexual victimisation was only “sometimes” part of the personal history of CSA perpetrators. The idea that CSA perpetrators may have been adversely impacted by a range of abusive and dysfunctional experiences in childhood was encapsulated in William’s notion of “produced outcomes”.

Three participants took a collective view regarding the perpetration of CSA. Resonating with LMG’s views regarding societal responsibility for CSA in Chapter Seven, Kantor believed the “village” needed to take responsibility. However, she took a different slant, focusing on the “people who will report, and people who will protect”. Speaking about Pacifica, Lisa commented “when it’s ours, we have that collective guilt, whereas Pakeha don't feel it … they don't need to feel that guilt”. Similarly, William noted that “in Māoridom, we still have a place for that collective shame”. In William’s view, individualisation dominated the legal system, whereas CSA required a collective response.

**Pedagogical issues**

*Introduction*

Pedagogical issues encompassed structural aspects of social work programmes, the demographics of students, and participants’ perceptions regarding the relevance, sufficiency, and efficacy of CSA training. In addition, participants contemplated the appropriate location of CSA training within the social work curriculum. The content and dynamics of CSA education arose as two broad fields of inquiry, with a temporal field spanning from current provision to future directions. Knowledge of the content of CSA education within social work programmes emerged as a consequential issue, given that such knowledge varied considerably and was impacted by a number of factors. Participants discussed various pedagogical strategies to facilitate and manage process issues in order to enhance learning, as well as considering their own levels of comfort. Sensitivity to classroom dynamics also took into account cultural needs and gender issues.
Relevance of CSA to social work education

Perceptions regarding the relevance, sufficiency, and efficacy of CSA education were situated within a larger discussion regarding the structure and purpose of the social work programme as a whole, but were also affected by perceptions of the prevalence and impacts of CSA. All social work educators considered the topic of CSA to be relevant to social work practice and education, but there were differences in perceptions regarding the degree of relevance. Those who believed CSA to be highly prevalent and to have a widespread impact appeared more likely to perceive its effects across a wide range of social work domains. Five participants who held these views considered CSA to be highly relevant to social work education.

While believing CSA to be highly prevalent, Lisa also observed that it was often hidden and subsumed by other “life issues”, but “if you take away the layers, that's what's beneath it”. Based on community work, Daphne noted that CSA was often linked to, and sometimes subsumed by physical abuse, nevertheless she believed CSA was less prevalent than other forms of abuse. Consequently, she believed that other forms of abuse merited greater attention in the curriculum and that “neglect was neglected”.

Kantor surmised that the degree to which CSA was taught in various relevant papers depended on the educator’s “passion and drive” regarding the topic. There was support for this view within the findings. For example, Daphne’s “particular interest in neglect” led to creating an assignment for students in this area, while Alf created a specific question for students regarding CSA because of his commitment to promoting understanding in this field. Similarly, Bob created a scenario on CSA because he wanted students to keep their “minds open to the possibility” that CSA may be present. Table 8 summarises participants’ perceptions about the prevalence of CSA, and their views about its relevance for social work practice and education.85

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85 For practical reasons, I use the abbreviation SW for social work within Table 8, however this abbreviation is not used throughout the body of the thesis.
Table 8: Educators’ perceptions about prevalence of CSA and relevance to SW education

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>CSA prevalence</th>
<th>Relevance of CSA to SW practice and education</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kantor</td>
<td>“it can be pervasive in any field…”</td>
<td>“they… need… a core understanding”</td>
</tr>
<tr>
<td>Daphne</td>
<td>“in 2005, one in 25 women, so 4% and 1 in 50 men, 2% experienced one or more sexual offences … I think the other forms of abuse are more prevalent than sexual abuse”</td>
<td>“in community work … violence and abuse of all sorts”</td>
</tr>
<tr>
<td>Lisa</td>
<td>“it’s rampant … way more than what’s reported … one in four”</td>
<td>“it’s always on the fringes”</td>
</tr>
<tr>
<td>Clara</td>
<td>“one in four women…one in seven men”</td>
<td>“it’s relevant to all social work fields…it crosses all our practice… like mental health… goes across all spectrums”</td>
</tr>
<tr>
<td>Alf</td>
<td>“extraordinarily common … one in four”.</td>
<td>“extraordinarily relevant”</td>
</tr>
<tr>
<td>Bob</td>
<td>“one in four women … boys under-disclose”</td>
<td>“it’s important that people have an awareness of the particular dynamics that surround sexual abuse”</td>
</tr>
<tr>
<td>Laura</td>
<td>“20% of the women … 8-9% of men”</td>
<td>“relevant to our child and family stream”</td>
</tr>
<tr>
<td>William</td>
<td>“30% of young woman and girls … the figure for male victims will be coming closer and closer to female victims”</td>
<td>CSA “can just wreck so many other parts of their lives”</td>
</tr>
</tbody>
</table>

**CSA – a core or specialist issue**

For five educators, CSA represented a core issue in social work education because of its relevance across all social work domains, while also having some specialist aspects. In Alf’s view, the relational and inter-generational impacts of CSA required core knowledge:

Alf: I think they are both, I think there has to be some … core acknowledgement of it, because of its insidiousness, because it’s … often so hard to detect and … it is so pernicious … it affects individuals sometimes over a life course, it affects communities, and … inter-generationally.
While also acknowledging both core and specialist aspects to CSA education, Clara believed differentiating between core and specialist knowledge was “probably more a matter of depth”. Supporting the idea of a continuum from core to specialist knowledge, Kantor felt all social workers needed a certain level of knowledge regarding CSA:

Kantor: I think people need to have a baseline knowledge. If they choose to specialise in it in their work in the future, then they at least need to have like a core understanding, a core … standard of practice around it.

Laura didn’t believe CSA to be a core issue within all areas of social work practice, while Lisa took the position that it needed to be a core issue in education because “you never know how it’s going to manifest”. Focusing on children’s disclosures, Daphne felt CSA was a specialist issue, because cases were referred to specialist services. However, she did emphasise the importance of social workers knowing how to conduct “robust assessments” noting that “what happens to that referral depends on … the strength of your notification”. Bob commented that confining CSA to a specialist area of practice “could stop people thinking” and that “sometimes making an area the, the exclusive preserve of expert professional people can sort of close it off unnecessarily as well”.

**Sufficiency of CSA training**

Social work programmes were described as “congested” and “chocka”, even when extended to four year degrees, which meant that many areas of social work practice had very limited space within the curriculum. Four educators felt that CSA was not dealt with adequately in social work education:

Laura: Personally, I don't think it's covered very well in our programme … It probably needs a … bit more highlighting to be honest … that's one reason why we're restructuring our whole degree, is to … make sure all our bases are covered.

Participants commented that the generalist nature of social work education influenced the structure of programmes and the prioritising of subjects. As Clara commented: “so generally I don't think it's very well addressed … but that's not unique … many things … are not well addressed, because we are a really … strong generalist programme”. While acknowledging these difficulties, Lisa believed they needed to be overcome: “given the prevalence of it in the communities we’re going to work with … and the paucity of our
attention to it in the educating and training of it, it’s quite unconscionable”. Within the stream of children and families Lisa observed that “none of it is about sexual abuse”.

William also noted minimal attention to CSA within the programme, stating “in different papers I teach, we'll do a two-hour lecture on this … and a two-hour lecture just touches the surface”. He suggested that the subject of CSA did not have such a high priority within social work programmes as papers on “community development or organisational development”. For William, the small windows of attention given to CSA had implications for process issues not just content. He noted “if you open up a can of worms, you have to have the opportunity for people to deal with it”. Although he felt that CSA deserved a whole paper, he was also concerned for the welfare of students: “I think that the way we approach it at the moment, unhinges enough people. I would hate to unhinge even more, by going into it in even more depth in an undergraduate degree”.

Laura and Clara imagined that social work students would go on to learn about CSA on the job, if working in a relevant field, particularly if working for CYFS. Laura stated “you would hope they’re getting the more specific knowledges they need within specific roles”. However, Bob felt that there was little specific training in CSA within CYFS, and most training was focused on practice models and tools to assist with decision-making. He commented: “I think it's important …that people do have kind of good up-to-date research and information … and I suspect they don't particularly”. Similarly Kantor, who had also worked in CYFS, noted “you may be a person that is seen as a senior practitioner within an organisation, however that may be just years of service, as opposed to actually having good credentials and theoretical underpinning to do work”. Two educators spoke of a requirement from CYFS that social work programmes provide more extensive training in “child protection as a field of practice”. This suggested that CYFS required qualified social workers to have a reasonable level of knowledge and skills in relation to working with children, and awareness of abuse dynamics. Within one social work training institution, a senior CYFS social worker had been seconded to the department for three months to collaboratively work on a child protection/child abuse paper.

The other four educators felt that CSA was addressed sufficiently within their programmes. Two of these programmes were already providing significant content in relation to CSA within a child protection or abuse paper. Collectively these two programmes discussed CSA definitions, signs and symptoms, disclosure dynamics, impact, dynamics of intra- and extra-familial sexual abuse, different forms of sexual abuse such as ritual abuse and child pornography, and CYFS interventions including the role of the evidential unit, and forensic and
legal processes. Guest speakers were often utilised, including CYFS social workers, DSAC doctors, and police. Daphne and Bob were involved with these two programmes. Daphne stated she would “like to see more” training regarding other forms of abuse, but felt the focus on CSA was sufficient. Bob believed CSA was “addressed variably” with “bits and pieces” in various papers. He noted that the child protection paper contained “some content”, but was “very generic”. Nevertheless, he attempted to address less recognised aspects of CSA, such as “the common misunderstanding that medical examinations are … necessarily diagnostic of child sexual abuse”. He also gave attention to issues impacting upon credibility, such as retractions and adolescent behaviour which might lead to “confusion between symptoms and causes”. Bob noted that there was more attention to CSA within a post-graduate counselling paper, which brought in a guest speaker from SAFE. He commented that the undergraduate programme did not provide any training regarding CSA perpetrators. Kantor identified as having the least knowledge of the programme as a whole, so was reticent about judging the sufficiency of CSA training. She cautiously noted that “there was always room for improvement”. Alf believed the level of CSA was training was sufficient, and felt comfortable teaching the topic in the context of violence.

Sometimes papers such as human development were taught by other departments, and educators were unable to comment on the structure and content of such papers. While most educators believed they had a good understanding of their programmes as a whole, they were not always entirely sure of all the content in papers that they did not teach into. This had implications for all educators’ perspectives, whether they believed that their programmes sufficiently addressed CSA or not. For example, Clara, who believed CSA was not sufficiently addressed, acknowledged that she was unsure about the content of sexual abuse in one paper, where several lectures were given by a CYFS worker. Conversely, Alf who believed CSA was addressed adequately, expressed varying degrees of certainty about CSA content within other papers from “I’m sure it does”, to “I would imagine”, to “I’d be hesitant in having a guess”. Several social work programmes were undergoing restructuring at the time of the interviews, which raised issues about who oversaw the development and teaching of the programme as a whole.

Sufficiency of related practice areas

Several other practice issues such as mental health, counselling, and working with children received variable attention, and again generalist and crowded programmes were often
cited as reasons for a minimal focus in these areas. Interpersonal or communication skills touched on basic counselling techniques, but did not always address the particular skills needed to engage children. Kantor commented that “there's not a lot of work engaged in working with children”. Clara also believed students did not receive sufficient training in working with children, and Lisa envisaged students learnt on placement. Laura discussed a paper having “aspects of engaging with children”, but stated the programme acted as “a primer” to give students “basic theoretical ideas” and associated skills. Three programmes had a specific mental health paper, but in other programmes, mental health issues were interspersed within other topics. Clara gave a three hour lecture in mental health, which she believed was the only lecture across the whole programme. In her view, congested programmes were a major issue: “it's already hard to include the things that we're required to include”.

**Location of CSA training in the social work curriculum**

Participants were also asked to consider how CSA education should be delivered, whether it merited attention within one paper or should be interspersed within several relevant papers, whether as an elective or compulsory paper, and at undergraduate or masters level. Four participants considered that CSA education required some specific structured training, as well as integration within a number of papers. Clara believed that CSA education needed to be integrated “into day to day learning and experience”. However, she also acknowledged that “it probably, in terms of manageability, it sits easier within some structured lectures devoted to the topic, while at the same time, getting students to think about it critically, in terms of … all their learning”. For Alf, CSA was a “form of violence” and therefore was most appropriately situated within a paper on interpersonal violence, rather than being given “any kind of special flavour”. In keeping with his concern over specialisation, Bob considered that although the teaching of CSA required specific information, it was also important to connect CSA to other practice issues and contexts to prevent it becoming a “pariah subject”. Daphne believed that the topic was better addressed within a “concentrated paper” on abuse and neglect, although this did not preclude it being discussed within other relevant papers.

Only two educators discussed the need to deliver CSA as a separate paper, and both discussed the challenges of fitting it into existing under-graduate programmes. William believed that students were better able to cope with the emotional and cognitive demands of such a paper at masters level. In contrast, Lisa believed the topic of CSA needed to be at undergraduate level, but would have to be an elective paper because of the programme’s congested nature. She imagined it would be highly popular.
Suggested content of CSA education

While the majority of social work programmes did not appear to provide specific training regarding CSA, case studies in relevant papers would sometimes include scenarios which addressed sexual abuse. The old adage “a little knowledge is dangerous” was referred to by three participants. This highlighted concerns that students may assume that basic training in CSA equipped them with “the skills to do treatment”. All three emphasised the importance of letting students know the practice limitations of foundation level training in CSA.

Making inquiries with clients about a history of CSA did not appear to be taught within any of the social work programmes. Clara was the only educator to specifically suggest that CSA inquiry should be taught. However, Kantor noted the need for students to know how to take a “sexual history” as part of conducting psycho-social assessments.

Clara: I think it would be good to have … the … facts and figures … what sexual abuse is … the impacts on people … or the potential impacts … then … getting comfortable with asking and initial responding would be important.

Participants were asked whether perpetrator issues and dynamics should be part of CSA training, and four participants strongly felt that training needed to address both victim and perpetrator issues, in order to address CSA in its entirety. For Kantor, understanding the person of the perpetrator assisted in potentially identifying the genesis of offending, and therefore potentially played a role in prevention. Lisa felt that both victim and perpetrator issues needed to be taught in order to work “holistically”. William discussed the need to take a “broad view”, noting that “both practically and theoretically, it is a real weakness if all you can do is concentrate on the victim”. For Alf, perpetrator issues and dynamics informed the work with the victim, and an understanding of the victim’s experience. He believed further collaboration was needed between the two fields, suggesting that “those who work with offenders, and those who work with people who survived abuse, should work more closely together … because of the mutual understanding that can arise”. Similarly, Bob believed child protection could benefit from increased multidisciplinary collaboration regarding victims and offenders, in order to “understand each other a bit better”.

For Laura, academic attention to perpetrator dynamics depended on “what intervention you’re going to do”, however, she did feel that “you need to understand how those dynamics, or the perpetrator's way of thinking has impacted on the victim's way of thinking”. Clara considered it unlikely that staff had the specific knowledge and skills to teach perpetrator
dynamics, that it was a “fraught” area, and “probably a little bit beyond what we would expect our students to come out with”. As the conversation continued, her breathing became heavier.

The virtual face to face contact provided by Skype had certain limitations; body language and facial expressions were harder to apprehend, particularly with erratic picture quality. Being unsure whether Clara’s change in breathing had been elicited by the conversation, I did not draw attention to it, yet I felt increasing bodily and emotional discomfort, particularly in my chest. This motivated me to provide a monologue about the rationale of my question, and Clara’s breathing returned to normal. A condensed version of the conversation is presented.

Clara: We don't generally do a lot of talking about … perpetration of violence of any form actually … and I'm not sure that that would make it to the top of the list … in terms of the perpetrators … And I think that's probably reflective … of the social construction of … these evil people who are … perpetrators … In terms of the dynamics … I don't know that we, as staff, have the skill to teach it.

Interviewer: Okay.
Clara: And also … I think it’s a fraught area.

Interviewer: Okay, yeah.
Clara: (breathing heavily)

Interviewer: Yeah, true.
Clara: Mm. (breathing heavily)

Interviewer: True. (SWED continues to breathe heavily). I think, I think, I'm just asking that question because it has come up in the feedback...

Bob noted that within the field of CSA “knowledge changes”, therefore from both practice and educational perspectives, information needed to be updated, and systems needed to “be flexible enough to allow change”. Bob was also the only educator to note the specific practice and educational issues related to non-offending parents, which in Bob’s experience were mainly mothers. Arising as an interest within his own social work education, Bob had written about the need for cases of intra-familial CSA to ideally have a separate social worker for the mother, in order to enhance the mother’s capacity to protect her child. He argued that non-offending parents could benefit from psycho-education regarding the dynamics of CSA.

Bob: The mother, the non-offending parent … has a fairly short window to make this dramatic decision about whether she wholeheartedly believes the child, and will never … let the offender across the threshold again, or … not, you know.

Interviewer: Right, yeah.

Bob: And to expect that kind of … black-and-white … result, when … you've got a … long enmeshed relationship, economic, attachment … the child making disclosures … associated with other behaviours that … reduce the
credibility, you know, the whole raft of things that … make it easier not to believe.

Interviewer: Right, right.

Bob: There's a real kind of crash course in education work, and support work and stuff, that often helps the mother come around … so I do … bring that up as something for students to think about as well.

I fed back Robin’s observations that many mothers of sexually abused children have a history of CSA and can be triggered by their own unresolved issues, which prevent them providing appropriate support. Bob replied “that’s right … I’ve seen that in practice as well”. In a related discussion with Kantor, she also noted that she had seen this in practice.

Although educators had discussed constraints to delivering CSA education in greater depth, such as programme structure, educator knowledge, and student wellbeing, they discussed a range of suggestions regarding content for the future. In summary, ideas about what should be taught in relation to CSA included:

- Definition, facts and figures, impacts on victim and family, impact on development, ages and stages of sexual development, trauma, common and not so common features, attachment theory, asking and responding, victim and perpetrator dynamics, exploration of attitudes, values and stereotypes, how to report and what to expect.

Suggested methods of delivery of CSA education

Educators provided a range of different ideas or strategies for delivering CSA training, some of which were already being utilised. Guest speakers who were “knowledgeable in the field” lent more “credibility” and generated discussion and debate among students. Suggestions for guest speakers included people from CYFS, DSAC, Rape Crisis, Police, and other community groups working with CSA. Daphne discussed utilising relevant DVDs or YouTube clips, and Clara suggested an exercise utilising survivor websites which incorporated research and reflection.

Kantor: I think a lot of use of small groups … role-play, DVDs on the area of sexual abuse, interviewing skills … to incorporate those into the classroom, and then to have discussion … what were the highlights, what were areas of concern … As a tutor, you've got to look at all fields … written … oral … visual … so to me, incorporating all three elements within your teaching, is going to give them a better exposure. But it is also going to give them a better opportunity to debrief … and discussion and debate.
For Lisa, one of the key questions to ask students initially was “what do you know, what experiential knowledge are you coming with?”. Lisa suggested that students divide up into small groups and record their “thought showers” regarding their experiential knowledge on large sheets of paper, and post up on the wall to share with the class as a whole. She commented: “It's also an assessment tool, because you find who knows what, and who doesn't, and who knows a lot and who knows too little … and so it gives you a base … to deliver”. Many of the strategies utilised within other aspects of the curriculum were suggested, such as written handouts, reading lists, mock scenarios, case studies, assignments, use of small groups, and role play.

**Attending to process and dynamics within CSA education**

The dynamics of teaching CSA naturally pointed to potentially latent and implicit aspects of pedagogy. While participants discussed affective dimensions related to teaching about CSA and the influence of dominant discourses, the embodied realm was not explicitly discussed. Yet participants were likely to consciously and unconsciously draw on students’ facial expressions, body language, and tone of voice, in assessing that some students were having difficulties with class material. In considering classroom dynamics, participants took into account classroom safety, as well as the possibility that defensive and avoidant responses may create barriers to learning. All participants acknowledged the emotional difficulties for students in engaging with the topic of CSA. In fact, contemplating the depravity of humanity in general was perceived to be “disturbing” and in William’s mind distorted “what you think normal is”. Six felt it was helpful to openly acknowledge the potential difficulties associated with engaging with the topic of CSA at the outset, and in a sense normalise such challenges. Clara also felt it was helpful to normalise the prevalence of abuse, when introducing the topic of CSA.

For Alf, the sanctity of the family was an archetypal belief. His perspective pointed to the degree of emotional processing and cognitive shifts inherent in accommodating information about CSA which shattered this belief.

Alf: I think one of the things … about … sexual violence, it's harder for people to comprehend, it is not just harder for them to engage with … or confront, but it is more difficult for people to understand it, it’s a perplexing kind of idea. It … interferes and it cuts across our kind of cherished notions of intimacy and trust, and some of those really primary bonds that hold us together as a community, perhaps as a species.
Although observing some students’ avoidance with the topic of CSA, Alf felt that the “psychodynamics of denial” in relation to the subject of CSA were less common than it had been. However, he and five other educators also discussed the taboo around matters of sex and sexuality which impacted teaching about CSA, and I discuss this further at a later section. Students’ ability to engage with the subject of CSA was also considered to be dependent on the educator’s level of comfort and openness with the material taught. Alf and William discussed the need to be honest and open without being brutal, graphic or explicit. In William’s view there was no “nice way to talk about” CSA, and the subject would never be entirely comfortable to teach. Laura discussed the importance of pacing material, noting that she “didn’t talk about those issues in the first section of the course”. Similar to social workers’ preferences to building a relationship with clients before inquiring about CSA, Laura felt it was helpful to have built relationships with students prior to introducing the topic of CSA. She acknowledged that assisting students to address and process affect was challenging and sometimes avoided.

Laura: I think personally, it is difficult … you try not to avoid it, but perhaps occasionally I, you do, you do … you need to have a good relationship with your class built-up, so as people feel able to not have a big blocking reaction to it … I try and be very matter-of-fact about it as well … because then you hope you are modelling that to students.

The idea of modelling comfort to students was discussed by three other educators. Bob noted that those who had worked in the field of CSA for many years could be “inured” or “desensitised” with regard to the emotional impact of engaging with CSA, and therefore they may fail to recognise the impact of CSA material on students. This suggested that merely modelling comfort may be insufficient. Attending to classroom dynamics and students’ responses therefore required a dual focus on content and process, and an acknowledgement that process issues were dynamic and inter-subjective. As Bob noted, “whenever you're talking to a class … you've got one eye on … what you’re saying and another eye on how it’s being received”. Alf spoke about the need for educators “to model the level of comfort” which helped students become “familiar” with the topic but not “inured”. Kantor believed the key was being observant of individual reactions and classroom dynamics, and being willing and able to work with the process generated. She acknowledged the need to approach students after class if there were “obvious triggers”, and to direct to support if necessary.

Kantor: I would imagine … in discussing the area of sexual abuse that you would have instant reaction, because … there is that physical reaction of wanting to protect, there is the physical abhorrence to it … that energy has to come up. So I mean it is being observant of it, and working with it.
Utilising case study assignments which suggested that a child had been sexually abused, Bob believed a key pedagogical aim was to cultivate an “open mind” among students “to allow for the possibility in the first place”. Similar to Jack’s observations in the social worker findings, he noted that “a lot of people still shut that down … because it’s … too difficult. So … just making that whole point about …what you’re prepared to look for is going to influence what you find”. Laura and Alf discussed the importance of creating an environment of safety and openness. However, no participant offered specific strategies to address negative affect and avoidant responses.

Alf: We need to address that discomfort and that anxiety, and … if we teach in a context of safety … and I hope recognising and acknowledging … those difficulties, I think … it creates a platform where people can be more open … to the absorption of learning.

**Cultural and gender issues**

Six participants observed that the subjects of CSA and sexuality generated considerable discomfort among social work student and professional populations, as well as wider society. Daphne and William discussed the sexualised nature of Western culture and the proliferation of internet pornography. Juxtaposed against such liberal attitudes were observations of a Victorian stance towards sexuality, and an avoidance of all discussion about sexual abuse. These views mirrored the perceptions of social workers in the first sample.

Daphne: Social workers are not comfortable with talking about genitalia or anything like that, using the correct terms … I worked at in-patient mental health, and I found that … sexual abuse was an area that everybody avoided … And I say to the students … you have to get comfortable with it.

Kantor had observed that teachers and parents were uncomfortable discussing sexuality, and were unclear about stages of psychosexual and cognitive development, which led to fear and incapacitation regarding a child’s sexualised comments or behaviour. Four participants noted the challenges of teaching CSA to a class of mixed gender and a range of cultures. Laura felt that there were so many unknowns regarding the personal histories of students that could potentially create gender-related issues. Such unpredictability provided rationale for avoiding experiential approaches to learning.

Laura: It might make men … very uncomfortable discussing it, because they may feel like they're targeted as potential perpetrators … or they may be victims themselves, you just don't know … just don't know. That's another reason, I think, why I shy away a bit, from too much exposure, and too much of
that sort of … experiential approach in a group setting, just … so many things unknown about your students’ background … I don't know, maybe that's my own aversion (laughs).

In relation to cultural considerations, Bob and Alf noted that it was important not to make over-simplistic generalisations about different cultures. Kantor raised the possibility of notions of cultural relativity in relation to CSA, and the need for all students to “respect the law of the land”. In contrast, Alf did not believe CSA was “condoned by any culture”. Few strategies were articulated for managing gender and cultural sensitivities, however Kantor suggested getting students in small groups to imagine being another culture and dealing with CSA. Bob discussed an article he had read by Judy Mataia, which highlighted the power of metaphorical language when working with traditional Samoan families where CSA has taken place.

Bob: And the idea of … working with … family shame, and family protectiveness, and belief … using Samoan language … it's a very metaphorical language, as opposed to explicitly naming of acts and stuff … because the palagi perspective is that … unless you’re able to actually get things out there, and name the names, and say what's going on, then … you're getting involved in collusion and denial … She … had a different perspective that was … no less effective, I think.

Working with Pacifica students, Lisa noted that male students displayed most discomfort about discussing sexual matters. She attributed this to “the covenant between sisters and brothers”, which was generally extended to all platonic relations between males and females. In Lisa’s mind, the reticence among Pacific Island cultures in discussing sexual matters was due to Christianity, which had blended with pre-existing cultures to the point that they could no longer be differentiated. I witnessed Lisa’s strong expression of emotion in her face, eyes and voice, but it wasn’t verbalised. Her embodied reactions suggested frustration and perhaps grief.

Lisa: I mean Christianity, hit the shores … and it was all shut down … and I would have to say the outcome of that is that they did their job really well (voice cracked), because it isn’t spoken about … The not talking about it, it's not a cultural thing, it's been taught … It is Victorian, when I hear and see our elders talking about it, I think about piano legs having to be covered up, pinned, all that kind of stuff.

Although Lisa was open and direct in naming body parts, she considered that CSA training for Pacifica required a subtle approach, lending support to Bob’s views. Lisa noted that being “upfront” and “honest” about CSA was likely to generate resistance among Pacific Island
students, and noted that “they don't really want to be exposed to that”. She discussed an understated yet “impactful” DVD that she had shown to her students the previous week which implied that CSA had occurred. She noted that “it wasn't in your face, it couldn’t be”.

Although Lisa held hope that future generations would be less constrained, she recognised the unknowns in the class with varying levels of acculturation among Pacifica students. In her mind, CSA training should initially be taught within separate gender groups for Pacifica students, with preparation to bring males and females together at a later point.

Lisa: You've got multiple levels, cause you've got Island born NZ raised, you've got Island-born Island-raised, you've got NZ born and raised … any one of those might be fine, and might not be fine, though, I think, to save all, do it separately …“it is a learned, cultural … imperative that we don't talk openly about this in mixed company, but towards the end of this, we will be doing that”.

As a Māori educator, William also believed separate gender groups were preferable initially in order to help students break the ice, and begin to feel more comfortable discussing CSA. He commented that “in Māoridom … we would caucus the issue between males and females … we would … have a men’s hui and a women’s hui … and then have a combined hui”. However, Laura noted that victims of same-sex abuse were unlikely to benefit from separate gender groups. In addition, some educators noted they had small numbers of Māori and Pacifica students, making these ideas less practical in terms of separate cultural groups.

The research indicated that the polytechnic, classroom based style of learning may be more conducive to process-oriented pedagogy, than the university lecture theatre approach. As one educator pointed out, the polytechnic social work class comprised a group of students learning together for up to four hours a day in one setting, allowing greater opportunities for processing class material. However, class sizes could still be a challenge, as they varied between 20–130 students. As educators pointed out, larger class sizes impacted upon the ability to form relationships with students. Yet smaller class sizes also limited opportunities for separate cultural groups as discussed, or even separate gender groups, given that only one in five students were male. On the other hand, two educators stated that it was easier to identify student difficulties or poor attendance when class sizes were smaller. Not only did student numbers vary across social work programmes, but they also altered at different stages of each programme, sometimes depending upon the amount of field placements that could be offered on campus. This meant that at the professional stage of the programme, class sizes could be smaller, while numbers of distance students increased. Consequently, pastoral and gatekeeping
roles might fall more heavily on the shoulders of fieldwork supervisors. In addition, the age of students varied considerably among programmes, from a majority of young students to a majority of mature students, to a combination of both, creating different challenges. Kantor felt young students were more vulnerable because of their limited life experience.

**Pastoral responsibilities: Gatekeeping versus shepherding**

The terms gatekeeping and shepherding were chosen to reflect the varying attitudes and experiences of social work educators, and to highlight the connotations attached to each word and the tensions between and within academic and pastoral responsibilities. Often the line between support and education was perceived to be murky. This created challenges for educators in negotiating and navigating the tensions.

**Perceptions of social work educator role**

All educators perceived that part of their role involved pastoral responsibilities, although they varied in their degree of involvement and commitment to this role. While they all recognised the likelihood of distressing emotions being elicited in students through the course of social work education, none believed their role to be therapeutically oriented. There did not appear any clear institutional policies determining the level of support for, and involvement with, students’ personal difficulties. Instead, educators appeared to be influenced by personal attitudes and the degree of comfort. In relation to a pastoral role Bob commented “you always protest too much about the things that are challenging in the work … how much to get involved, and how much support you provide”. He went on to say:

Bob: It’s always a bit of a line between … you’re a teacher running an education service, and the process in generating lots of emotions and stuff. So there's a kind of support … role as well, but you need to be careful it doesn't flip over into a sort of counselling relationship … because that’s not really what it is supposed to be.

For three educators, relationships with students and responses to their distress exemplified social work practice with clients. Laura commented that teaching was “very similar to practice.” As Kantor noted: “I still think there needs to be that personal professional role within a, within lectureship, however … if you are working in social work, you cannot ignore the social needs of the students within your class.” Daphne stated that “it is not our job as educators to be a therapeutic session, and so we do encourage people to get help from the student support services”. However, she went on to discuss the responsibility of educators to be
aware of the emotional lives of their students: “As universities … our job is to stimulate the mind, but we can't overlook … the feeling factors in people either. So … we try and … develop a whole person, spiritually … mentally, and socially as well”. The idea of a holistic pedagogy was developed further by William. In his view, social work education was a purposeful catalyst for students’ exploration and resolution of personal issues, which enhanced their capacity to practice, and marked “the beginning of reflective practice”. It assisted students to live “a fully human life” and “get the best of every part of their lives”, but also considered the welfare of clients.

William: I purposefully do things that yeah, unhinge is the best word I can think of, because I want people to have dealt with those issues themselves, before they end up in situations with real people … so they have to have a way of thinking about them before they get in the situation.

Five educators discussed various transformational aspects of social work education, however in William’s view, the reparative function was under-recognised. In order to help students to address and resolve personal issues which might impact upon their practice, he believed course material had to “unhinge” to some degree and create some disequilibrium, without incapacitating.

William: One of my general observations of social work programmes is that they’re not seen as being places of healing … whereas I do see them as places of healing … places of emancipation …When I talk about healing … that's … why I talk about running that balance between … things that unhinge people, and things that they have to learn, and … process, you know.

Daphne also considered social work education to have a healing role:

Daphne: The healing in those four years, if it is needed …comes from the social network … social environment … and the environment … educators have been able to provide … such as student support services … It might sound idealistic, but I think we've got to be idealistic … and think positively for our students. And we have those mechanisms along the way to try and … support students that might have been hurt … so that doesn't cloud their judgement in the future.

**Admission process**

Initial enrolment varied among social work programmes, in terms of personal information required, and whether interviews were conducted. A small minority of programmes held interviews with students, and sometimes students would disclose personal histories of abuse within such interviews.
Daphne: We also ask in the acceptance interview … is there anything that they can see as a barrier to their learning … such as mental unwellness … and some of them talk about depression because of sexual abuse, or … other things …. And we think … that's good … because I think it's like a growth … if they're able to acknowledge that’s in the past, and they're now looking forward.

When asked if students always appeared to have resolved issues from the past, Daphne replied “sometimes we know they haven't, but we wouldn't deny them the chance on the programme ... I see it as a barrier to their learning if it’s unresolved”. In Daphne’s view an abuse history that did not appear to have been worked through sufficiently did not preclude students from acceptance on the programme, because of the potential for students to address issues throughout their training.

Most respondents reported that the programmes that they worked in knew very little about their students until they turned up for the first class. A common refrain echoed among four participants was “we don't know their history when they walk in the door”. Kantor stated that the students’ application “doesn't actually ask for a lot of historical stuff”. Clara noted that the lack of communication between faculty and students prior to admission also made it difficult to prepare students before enrolment, regarding the challenges of social work education. A second enrolment process occurred at the point of entry on to the professional programme, involving fieldwork placements. Interviews were often conducted at that point, and provided an opportunity to consider the student’s suitability to practice, and any barriers to their practice and learning.

**Students with CSA histories**

Most educators who estimated the prevalence of students with CSA histories believed it was similar to the community prevalence, which as discussed mainly varied between 20%-30% for females and 8%-25% for males. Apart from Daphne’s much lower estimated prevalence, this meant that perhaps one in four women and one in eight men entering social work education have histories of CSA. In contrast, Clara estimated that 50% of students may have experienced CSA.

Educators also varied in receptivity and perceptiveness to students’ potential trauma histories. Lisa observed that students with trauma histories, particularly CSA, often displayed a “shattered mirror effect” in their writing. She stated “I can pick it now when I’m reading people’s work”. Laura commented “I don’t want to know in a way”, but went on to state “I am always aware of that likelihood when I'm teaching”. Like many educators, Laura preferred that students discuss any distress or concerns elicited from personal histories with lecturers after
class if necessary. When asked about knowledge of students’ difficulties in response to CSA education, Laura appeared to exhibit some discomfort about the potential for students to approach her with disclosures of abuse.

Laura: No one's ever said that directly to me … I try not to force people to (choking noise) sorry, I always say to students about anything that we’re talking about … “there is no compulsion to … interact or get up and … talk about your personal history” …because … it's not really the space and place to do that.

Being cognisant of students’ personal histories of CSA required an implicit or explicit disclosure, something that only half of respondents had experienced.

Kantor: It hasn't … in my … working there … it may not be that … obvious, within our students. There may be many a student … but … if it's not raised or discussed with the lecturer, then I think we would have little view.

For Daphne, students’ disclosures of abuse and expressions of pain and distress were an important part of their academic journey and professional development. She commented “a lot of them do pour their hearts out about what's happened to them … there's been one or two that have cried … but … they have to do it, I think they have to do it’.

**Appropriate forums for students’ disclosures of CSA**

Participants discussed the appropriateness of varying forms of disclosure, and three educators felt that disclosure in a classroom setting was generally not appropriate. There was a concern that personal, and perhaps unresolved issues, may predominate and sabotage the academic learning.

Laura: I don't actually want people telling me in a classroom setting of 30 students … “yes, I was a victim of sexual abuse”, unless well, unless they're really, really cool about it … unless they've actually dealt with it to some extent, and they're happy to share that as part of … direct relevance to the conversation we’re having.

Sometimes disclosures in classrooms were non-specific and did not appear to pose a problem. Daphne noted “I've had students say that in class, “that's me … you're talking about me””. However, William recounted an experience of receiving a student’s disclosure of CSA in a classroom, coupled with the expressed opinion “string the bastards up”. The method and nature of the disclosure was perceived as unsafe for the student on many levels, and William
felt a need to “protect”, and “to switch from being a lecturer to a social worker”. The student eventually sought support and graduated.

In William’s view, the nature of the student’s disclosure rendered the student vulnerable to judgement from other students and possibly even lecturers. When talking to the student after class, William told the student: “the people that head into the professional programme are people that we trust to work with others … if you stand up and declare like this … others may view it as you not having dealt with these issues”. William viewed the reflective and relevant use of personal experiences in essay writing to demonstrate an understanding of theoretical constructs as “very healthy”. However, he saw self-disclosure in academic essays as a perilous exercise, requiring self-awareness about the degree to disclose, given the potential for judgement by faculty about suitability to practice. He commented that social work educators should have more “mercy” and “compassion than anyone else”. His perceptions suggested that gatekeeping possibly took precedence over pastoral roles, and functioned to discourage students from drawing upon trauma histories as part of developing reflexivity. In this view, gatekeeping ultimately became a barrier to the reflective use of self, and consequently diminished the need for pastoral care.

Other participants held different views about disclosures within written assignments or reflective journals. Laura felt such disclosures were more appropriate, because they afforded more privacy. Through discussions with colleagues, Lisa believed such disclosures were quite common in reflective journals. Clara observed that students tended to use such forums as ways of discussing adverse childhood experiences in more general terms. She commented “people don't tend to kind of actually disclose specifics in the assignment, but they'll certainly talk about … difficult childhood experiences, or … violence in their childhoods”. Bob talked about an “exploratory life-story essay” completed in the first year, which often generated personal accounts of adverse experiences and traumas.

**Student difficulties and the use of self**

All respondents recognised that social work education might trigger personal issues in students; however, the boundary between student’s personal and professional lives appeared unclear. On the one hand, students were expected to be aware of how their personal lives impacted their work with clients, but educators were also conscious of their student’s rights to privacy. Bob noted that the expectation for students to examine their personal lives and possible
abuse histories was more likely to occur within counselling programmes, rather than social work.

Bob: How much you delve into people's ... experiences of past abuse ... and ... how you kind of deal with that in the classroom setting ... I don't know. There's ... probably more of that ... in the postgraduate counselling programme. But ... I guess it's just something that you're aware of.

Clara discussed the need to normalise difficult life experiences, and constantly make links with the potential effects on practice.

Clara: We talk a lot about how our previous experiences impact on us as practitioners, and then how it has the potential to impact on the work we do, and kind of that transference, countertransference type stuff ... but again, it's not specific to sexual abuse. But it's certainly implicit in terms of our own histories, and we normalise that, that we've all gone through ... various experiences.

Daphne noted that students undertaking experiential exercises would often be triggered by “their own experiences”, but there was an expectation that students be dispassionate regarding social work practice. Similarly, for William, students’ excessive focus on personal issues was a red flag.

Daphne: We ... try and teach objectivity ... you're not helpful by unpacking your own bag, not helpful by just going back to your own experiences ... We keep on looking for that subjectivity being too strong, and ... try to get them to be more objective.

The degree to which experiential forms of learning were utilised varied across programmes. Kantor discussed the use of Kolb’s experiential learning theory in her programme. In Laura’s view, there were dangers in “unpacking a whole can of worms” in class, so more experientially based exercises purposefully focused on insignificant details of student’s lives. She considered that experiential forms of learning were not utilised as often in NZ social work education: “people think about social work education in different ways and different national contexts, but I think here in NZ, it’s perhaps not as experiential or therapeutically oriented as it may be elsewhere”. However, Laura stated that reflective practice meant “being aware of the ways our own histories ... might impact our response”, and that reflective learning journals encouraged students to apply theory to their own lives.

All social work educators considered reflexivity and the use of self to be central parts of social work education. These qualities were facilitated in different ways, to varying degrees,
and at different points of the programme. For example, educators commonly spoke of the use of
essays to facilitate student self-reflection, however, the degree of attention to the personal realm
of student’s lives varied. Two programmes drew on a range of strategies in the first year to
assist students to explore their life histories. These included genograms, timelines of significant
events, and life story essays. Interestingly, these two programmes, which Bob and Daphne
taught in, provided the greatest content regarding CSA. Bob and Daphne both discussed how
the focus on self in these first year papers increased the possibility of students identifying past
abuse histories. Just as some social workers had suggested there were opportunities for clients
to make links between past abuse and current problems, so were there also opportunities within
these self-exploratory first year papers for students to make links between past and present. In
other cases, assignments at various stages of the programme were specifically designed to
courage reflexivity. By the third or fourth year, all respondents reported that their
programmes instituted reflective learning journals, which encouraged the integration of theory
and practice, and the reflective use of self.

Four educators believed or observed that difficulties associated with students’ personal
histories of CSA led some students to take breaks, or drop out completely. Alf suspected that a
self-selection process operated to some extent whereby students either dropped out or changed
to a less emotionally demanding course. In such cases, educators may not have been aware of
the reasons for the student’s withdrawal. Bob held similar views and noted that for a variety of
reasons, not always known to educators, just under two thirds of students enrolled in his
programme actually graduated.

Bob: At the risk of labelling people … some people have … a lot of
unprocessed trauma in their life and … that kind of recurs, and they find …
they can't consistently apply themselves to the study because of that, and end
up leaving. So you get a handful of people in that situation.

Four educators commented that taking a break from study to address personal issues
was a healthy and responsible decision.

William: I had someone in here today … for something very similar … and the
person has decided to take … a break for a while. And I think that’s a healthy
thing because … some of the stuff that we've made them think about, has just
made them think about a whole lot of other things.

Kantor described a student whose fieldwork placement had broken down because of
unresolved personal issues. The student had chosen to take a year’s break to do some personal
work, which had clearly enhanced her capacity to practice. The students’ willingness to
approach her own issues increased her capacity to approach and empathise with the suffering of others.

Kantor: That student’s placement was deferred, and she went away and did some work for herself, which was great … that growth in that worker over that year … when she came back, what an amazing change, and sense of maturity and understanding. But also … there was more of a sense of humanity for difficulty.

Laura had observed that student difficulties were more likely to arise within fieldwork placements, often leading to referrals to counselling. She stated “the place I would expect that to happen, is … in fieldwork placements”. However, Kantor believed educators needed to be “alert” and “observant” regarding students’ responses to CSA education, and be willing to approach students who appeared to have difficulties. In her mind, it was preferable that difficulties were identified before field placements:

Kantor: I think lecturers really need to be aware that if they have a flag that pops up … to follow it up with the student … I would rather head it off at the pass, and actually have someone supported to do stuff … than a student go out and absolutely flail about in placement.

**Responding to students’ difficulties**

Five participants framed responding to students’ difficulties as a moral and ethical issue. Balanced against the responsibilities to the welfare of the student in difficulty and to fellow students, was the responsibility to “those recipients of service further along the track”. Concerns about a student could arise through written work, or behaviour within class or a fieldwork placement. The most common strategy for dealing with concerns was to initially set up an informal and private meeting with the student. For example, William stated “if I’m marking an assignment where a person has written some things that really worry me … I get in touch with them, and say look … can we talk about some of this”. While other educators had discussed students’ disclosures occurring in written work, William was the only educator to recount having a meeting with a student. Perhaps all other disclosures were not considered problematic, but this was unclear.

Three educators stated that communication with other lecturers was also important. In Kantor’s view, discussing concerns with other colleagues would tend to occur after an initial conversation with the student, which had not resolved the issue. Respecting a student’s autonomous right to reject the concerns inevitably placed the educator in the role of gatekeeper.
Daphne suggested that informal discussions with other educators occurred when concerns about a student arose. Examples were given of students with a variety of personal issues. These tended to predominate learning settings and alerted educators that there was an issue. Students did not always disclose abuse, but issues such as substance abuse and/or mental health problems suggested some form of distress.

Educators also discussed several examples of being approached by students facing hindrances to their engagement with course material. Sometimes the obstacles to learning and practice arose in the absence of personal trauma. Bob discussed a student whose experience of a positive and nurturing family environment led her to feel “shocked and appalled” and “sort of frozen” in response to the reality of child abuse. In other cases, it was clear that students’ personal histories impacted considerably on their ability to learn and practice.

William: I get students coming in here who … really struggle with some things, because of what it brings up in regards to their childhood … I had a student … who basically said.. “I don't think I could cope going into a family if I saw a child being abused, because the rage in me would just be so huge”. And I said … “well actually what would make you a good social worker, is that if you learn to deal with that rage, if you turn it into something that is positive and useful to other people”.

Attempts to accommodate students’ difficulties with course material sometimes failed to take into account the potential consequences to clients.

Daphne: One student had asked if we could send all our lecture notes beforehand, because she had been sexually abused. And she wanted to hold it all together when the topics came up … we think it's been helpful to her, and you would never know … which student it was … because she has been forewarned, so to speak.

I asked Daphne what the practice implications might be for this student, with regard to a potential disclosure of CSA from a client. Daphne reflected that the student’s need for forewarning was a “warning signal” which needed following up, because “if she can't cope with it in the classroom, how is she going to cope with it with a client”. William discussed preparing students for the emotional costs of learning about CSA or other sensitive issues: “if you need to get up and leave, feel free … if you’re struggling, come and see someone”. I did not explore further with William the implications of students needing to exit classes that triggered personal issues, nor was it clear whether students were aware of any implications. Rather than there being clear institutional guidelines, these gatekeeping and pastoral
responsibilities appeared to be dealt with on a case by case basis, and according to educators’ perspectives.

**Preparing students and providing support**

Student counselling services were available within all the institutions, and five educators commented that the quality of such services was high, although they only offered short-term counselling. Bob discussed a recent conversation with a colleague about the need to be more explicit about support services available off-campus as well. Educators varied as to how much they were involved in referring students to counselling. Students’ relationships with lecturers and the way that counselling services were presented to students appeared to influence students’ uptake of such services. All educators included information about support services in the context of preparing students for the challenges of social work education, or in relation to teaching about sensitive issues. Laura discussed the type of introduction she might provide: “if you feel something has triggered you … then this is the place to go and resolve it, in terms of being responsible as a practitioner”. Similarly Daphne also prepared students for the possibility of triggers.

Daphne: We warn them really, we say … “we cover a very broad range of social issues, there will be triggers for you, there will be times when … you feel that you're just not coping or … that it is pressing buttons”.

While all educators appeared to normalise the potential for students to be distressed by course material, only two educators commented that it was important to normalise the need for counselling or support. In their minds, counselling needed to be framed as healthy and responsible, rather than a sign of weakness or pathology. Kantor suggested counselling was just as essential and normal as any other housekeeping matter, and should be regularly repeated across all lectures, and across the course of the programme. She stated: “it is about making sure that it is normalised, that you are not seen as odd or needy as a student, that this is a normal process”. Clara went as far as to encourage all students to have the experience of being counselled: “we tell everyone that we think that everyone should do counselling, regardless … they don't all take that up, but certainly people who are triggered”.

**Perceptions regarding the resolution of CSA**

In considering the potential for students to have unresolved CSA histories and the implications for social work education and practice, participants discussed the issue from their
own perspective, that of their students, and also imagined social workers in practice. The topic generated discussion about the nature and degree of resolution, the rights and responsibilities of the student, the varied impact of CSA on individuals, and students’ motivation for training.

Four educators expressed reservations about classifying CSA survivors as one homogenous group. Bob stated it was important not to “over-emphasise damage” and a “victim-mode”, and Clara was concerned about “problematizing sexual abuse”. Laura commented that “you can't assume that everyone that's been sexually abused is going to have a similar response to it, or have a similar need to have it resolved in a particular kind of way”. Alf’s comments suggested that, like anyone else, students’ responses to CSA were influenced by their subjective appraisal of the events, and the nature of the abuse. Perhaps he was also referring to the level of support and response to disclosures, but that was unclear. As Alf commented “it depends on the degree of … impact and the influence of their experiences … clearly, for some … it’s not such a big issue, as it is for others”.

Some of these responses suggested participants assumed that the resolution of CSA equated to formal counselling, even though the association was never made in any of the questions. In retrospect, it would have been helpful to have asked participants to consider their own definition of the terms “resolved” and “unresolved”, with regard to a personal history of CSA. Two participants questioned the efficacy of talking therapies even though they had previously endorsed counselling. Laura suggested that discussions regarding the resolution of CSA made assumptions about the “goodness of talking”. Clara also felt that therapy was not the only means of resolution to ensure competent and safe practice.

As discussed previously, all educators commented on their programme’s commitment to enhancing students’ reflective use of self, and five believed this assisted students to be aware of vulnerabilities. Ultimately, students were considered to be responsible for their mental health and professional practice. Alf commented that “there’s a … limit of course to how much you can intrude … in student’s lives and to raising this, and so at some point, it's got to become their responsibility”. In a similar vein, Clara noted that “social workers have to be aware of the impact of all their experiences, and that unless they do that …they have a chance of having lots of blind-spots”.

Bob considered that it was always possible that students graduated without having sufficiently dealt with personal trauma such as CSA, because of the ability to suppress and compartmentalise distressing events. He noted the increased insight and empathy that arose
from having worked through trauma, but also commented that the processing of trauma was
cyclical rather than a linear and finite process. In Bob’s mind, self-awareness, self-care, and the
effective use of supervision promoted receptivity to potential triggers over the course of one’s
career. William also believed that there was no “fail-safe system” for identifying all students
who had unresolved trauma, and Daphne acknowledged “there could be a student that we have
no idea”.

In addition, participants discussed the importance of recognising and respecting
students’ varying levels of motivation and readiness to address personal issues. Three educators
believed that students’ readiness to engage with the topic of CSA by the time they graduated
varied, and that personal growth and professional development were evolving processes. Alf
speculated that teaching about emotional intelligence was probably as important as the content
of CSA education, in helping students identify the potential impact of the past on the present.

Laura: You would hope that they would have begun addressing those issues in
their training … I'd certainly hope that, but not … everyone is ready at the
same time to deal with those issues, depending on what else is happening in
their lives. And so you can't just say education was unsuccessful because these
people … didn't go and deal with their crap at that time … But … I accept that
as educators, we need to be … creating opportunities for people to deal with all
those kinds of issues.

Other participants discussed the potentially detrimental effects to clients if a personal
history of CSA was not sufficiently addressed by social workers. Kantor suggested that an
avoidant response to one’s own victimisation could potentially be replicated in the response to a
client, stating “they’re not going to actually recognise the need for the client, if they haven't
recognised their own need”.

Kantor: It's knowing what your own triggers are, and actually being aware of
them, you are then going to be more … able to see triggers in other people. If
you don't do your own work, you're kind of … disabled to work … you won't
do due diligence to the work with a client, because your own stuff is getting in
the way.

Lisa believed that social work education should explicitly encourage students to resolve
personal issues such as CSA. She felt it was important to acknowledge the potential difficulties
and resistance in addressing one’s own issues, but also spell out the implications for practice,
and for clients, in not doing so.
Lisa: If this is not resolved, what kind of practitioner are you going to be … because some people won't want to resolve it … So training is a really good time to actually front up, resolve those issues before you graduate.

While William’s views implied that students’ motivation for social work training sometimes arose from a need to resolve personal issues, Daphne provided the only explicit opinion in this area. She felt that her programme and support services recognised this possibility, and assisted students to work through personal trauma.

Daphne: I think what, what drives us is based on that recognition there are … a proportion of students that do come in to resolve their own issues or work through, or try and understand what's happened to themselves … But … our driving force is that … by the end of the course … they have grown so much … that baggage is not with them … not hampering them now, it’s enriching what they have to offer.

In Daphne’s mind further research was needed regarding “why … so many people attracted to social work … have issues”. She commented that “many a student” had said to her “I had things happen to me in my past, and I want to make sure it doesn't happen to other people”.

Conclusion

In this chapter, educators’ perceptions about CSA affected their perceptions about the degree of relevance of the topic within social work education, however all perceived the issue of CSA to have some relevance. In a parallel process, just as social workers described a number of professional and organisational barriers to addressing CSA in practice, educators also highlighted a range of barriers to teaching about CSA. Nevertheless, a number of useful strategies for delivering CSA training and suggestions for content were offered, some of which were already being taught. The findings reveal the potential tensions that may arise between gatekeeping and pastoral responsibilities when teaching about sensitive issues such as CSA, and the lack of clarity for students and educators regarding these responsibilities. While students were expected to demonstrate reflexivity, programmes differed in their attention to experiential forms of learning. The two programmes which appeared to provide the greatest attention to CSA and abuse also evidenced more extensive use of experiential strategies for learning. There also appeared to be implicit barriers to examining personal trauma histories within social work education, perhaps because of the gatekeeping and pastoral responsibilities that would inevitably be evoked.
In the next chapter, the findings from the focus group are discussed. A sub-sample of social workers and social work educators came together to dialogue about the issues raised in individual interviews. This provided a future focused forum for considering how CSA should be addressed in social work education, and an opportunity to observe group dynamics in relation to engaging with the topic.
Chapter Nine: Findings – Dialoguing Together in the Focus Group

Introduction

In this chapter, I present the findings from the focus group of five social workers and two educators. In keeping with the concerns about focus group analysis discussed in Chapter Four, I was conscious of providing excerpts of data which reflected interactional sequences and exemplified group process. I decided upon a chronological presentation of the data under the five main topics for consideration in the focus group. These were: whether CSA was a core or specialist topic, what should be taught in relation to CSA, preparation and support of students, the reflective use of self, and how CSA should be taught. This highlighted developmental aspects of the group and provided a framework for interweaving content and process data.

CSA – Core or specialist issue and what should be taught

The issue of whether CSA represented a core issue for generalist undergraduate programmes or a specialist topic better suited as an elective or at post-graduate level had been traversed with social work educators. The mixed forum of social workers and educators provided an opportunity to revisit the question, taking into account education and practice concerns. I drew on the findings from individual interviews to frame my question: “most people, participants, have said that it is a core issue that should be dealt with within social work education … but … at what point does it become a specialist field … what sort of level of knowledge is important for them (social workers/students) to know … in terms of practice?” The question was initially met with silence by the group.

The silence was broken by SW2 who continued to play the role of the “silence filler” over the course of the group. He felt education regarding CSA was most usefully situated within a framework of trauma. In his mind, the high likelihood of multiple trauma histories among client populations required understanding of the range of possible effects of trauma,

86 As discussed in Chapter Four, focus group participants used their real names in the group to protect the confidentiality of their pseudonyms, particularly since some members already knew each other. Numbers were then assigned to focus group participants after the interview, with social workers designated as SW and social work educators designated as SWED.
such as mental health and alcohol and drug problems. This assisted social workers to be “more empathetic”. He stated “even if … you're not addressing those issues perhaps directly for whatever reason … I think it's really … helpful to be aware that those issues exist”. His views received nods from other participants.

At that point SW2 was the only male participant. He attempted to elicit feedback from the group about the idea that team members with knowledge and commitment to the field of trauma and abuse could educate and support the rest of the team, and thus operate to some degree as specialists. However, his comments were met with silence. Perceiving the group’s initial inhibitions about participating I responded to SW2, reflecting back his suggestions, however the conversation remained between the two of us. I decided to move to a second agenda item. I fed back concrete suggestions from individual interviews about what should be taught with regard to CSA, along with participants’ comments about social work training being “generalist” and the programme being “very full”. I finished this with an implicit question directed to educators, and realised, in retrospect, that in doing so I located myself in the group of social workers: “so I suppose it’s how much can be fitted into a programme realistically. So I suppose our educators here today are going to give some reality checks to us around that”. The two agenda items were then discussed in tandem. The conversation began to flow more naturally, and participants increasingly addressed and asked questions of each other. Two other participants echoed SW2’s views that CSA was a core issue in practice and should be taught under the umbrella of trauma:

SW 1: I think what we’re teaching … depends on what the expectation is for social work training … social work roles … but the reality is that in social work roles, we are going to be encountering a high proportion of the population that have experienced trauma. So it is about … every clinician having those basic core skills. How to handle disclosure when it happens, what to do to support that, what not to do to support that, what does supporting somebody to create a sense of safety mean … some of those really basic skills are essential. And … link them specifically to experiences of trauma, because it’s that core experience of loss of power … we may not be expecting social workers to do trauma therapy as such, but … there's still going to be trauma work that they're going to do.

A discussion of the level of training in trauma and CSA required for social work education led to consideration of the role of social workers in NZ, and the degree of overlap with the counselling profession. Both social work educators felt that counselling and social work were treated as separate disciplines in NZ, however social workers who had trained in Canada commented that the professions were often more integrated. The conversation below
highlights observations that there was a sharp distinction between the fields of social work and counselling in NZ which was fairly entrenched:

SW1: Things seem more specialised here than, than they are at home (overseas) … roles are more defined … so … it would require a shift on a whole lot of levels, I don’t think it is just about social work. Like I think it would require a sort of rethinking of how counselling broadly is done, and I don’t know that the system is anywhere near that, or I don’t even know whether that would be beneficial to it … I don’t know SWED1 … what your perspective is on that …

SWED1: Yeah, there's a very, very different history here, in terms of education and expectations, and … the role of tangata whenua in terms of what is useful …. So I think it is very different here in terms of what we expect social workers to do. And traditionally education and registration … it's been a very slow process to have qualifications for people and registration for people … I don’t think we’re really trained here to do therapy … and whether it’s even seen to be appropriate a lot of the time …

SWED2: That's my feeling, that therapy and counselling in our school, it is a separate discipline. And so quite often one of the myths that are established when “first years” come in, they're thinking that's what social workers do, they counsel, when it isn't really at all. Not here anyway … but I was just thinking if there were to be some shifts and have it (CSA education) included, there would have to be that demarcation about therapy and social workers working with people disclosing.

SWED1 had spoken with resignation and restraint, looking down, carefully and slowly picking her words; and when not speaking she held her hand under her chin and over her mouth. An atmosphere of resignation increasingly permeated the room and the mood became quite sombre. The rigid expectations regarding the social work role in NZ felt like an insurmountable brick wall, with very little middle ground between social work and counselling. As SWED2 pointed out, this was something social work students soon learnt. The perception that social work had little to do with counselling possibly created a positive feedback loop between social work educators’ lack of attention to CSA and the wider field of trauma, and social workers’ reticence in engaging with clients regarding trauma. The idea that teaching about CSA might lead students to think that they could carry out therapy had been mentioned in individual interviews, and reflected the polarisation of social work and counselling.

However, as SW1 and SW2 had suggested, SW3 also asserted that working with trauma survivors encompassed more than therapy. While she agreed with SWED2 that social workers could learn on the job, there was an implicit suggestion that the learning curve might be at the expense of clients. Understanding the nature and manifestations of trauma and dissociation assisted social workers to respond to disclosures of sexual abuse, create safety, and develop empathy.
SWED2: So my experience is that, while it is not really addressed in social work training, it's definitely when people go out there to work that they'll find their niche.

Interviewer: Okay.

SW3: My sense still is that people are learning on the job … from their clients … supervision … colleagues. And to some extent, that's how I learnt, although I did have a placement which had a whole lot more training, and I pursued a lot more training because I was interested in the area. But … when I look back now to what I knew at the beginning when I was working with sexual abuse survivors, to what I understand now … there's a lot that I didn't know … I do think that there needs to be included in core social work training more about working with trauma. Particularly the kinds of things you were talking about, (looks at SW1) … responding to disclosures … helping … establish safety … some knowledge of things like dissociation and re-traumatisation … Even if social workers aren’t expected to do the ongoing therapy and longer term work, they need to know how to at least not … dive in and get someone really connecting with all their traumatic experiences, without realising actually that can be pretty harmful, and not having the skills to … contain that and assist the person to be okay at the end of talking about it … So I think at least that level needs to be in core social work training … the reality is social workers in any field in NZ are going to be encountering clients with sexual abuse histories.

It was at this point that one of the participants, (SW5) arrived about 15 minutes late. He was a particularly charismatic and positive person who immediately elevated the mood of the group leading to greater group interaction. He brought fresh strawberries and more juice which he explained as “appeasement” and “guilt.” At his first point of contact he attempted to create a group social work identity by stating, “so you know, we’re social workers, we can deal with guilt”. A further brief round of introductions was made with much laughter and smiles, and I provided a summary of the discussion so far.

The conversation continued regarding the essential requirements for CSA training, and this led to debate regarding the nature of sexual abuse disclosure compared to a disclosure of bullying or physical abuse. The energy had certainly been raised by the presence of SW5 and five participants were involved in the discussion. A condensed version of the debate is presented:

SW4: If you have rapport with people and you work with them, they are going to disclose to you … it’s a good start to … have … basic training in how to respond. It doesn’t mean that you fix it, it doesn’t mean that you specialise, let’s be counsellors …

SWED1: Do we need specialist training though to … learn how to respond to a disclosure of sexual abuse as opposed to a disclosure of bullying … teasing or … physical abuse? My worry is that we make this such a coddled … specialised thing, when as you say, we are all people, and several of us around
this table will have probably had experiences of sexual abuse. So I guess I'm a bit worried about this idea that this is a very special thing.

SW4: Yeah … I’m not saying it’s specialised … I think that's where people can get lost, just the basics would be a good start … I don't know if I can be more clear than that, just the basics on how to respond to sexual, physical, bullying, … whatever …

SW3: Yeah, I think the basic training in trauma and abuse generally, because there's a lot of common things between … impact of sexual abuse and physical abuse. There’s … little bits that are different about each of those that maybe … could be talked about, but not necessarily covered in depth … I think the basic stuff is really about trauma and abuse effects on people.

SW2: And the other thing is … to make sure … people when they leave … social work schools and go out there, are pretty well clued up about … legal obligations … and whatever agency they're working for, what their policy is in regard to disclosure.

Interviewer: Mm, sure.

SW1: I'm not sure (sigh), I mean I don't, I don’t (sigh), I'm not sure that all disclosure does, of all of those things, does happen in the same way though, especially if it is a disclosure of childhood sexual abuse from an adult who has secreted that for a really long time. And the implications of speaking that when you haven't can be … well, I don't know actually, and maybe I can ask the group, because I'm not sure, but I haven't heard a lot about people disclosing domestic violence who are dissociating in that moment, or people that disclose bullying who are dissociating in that moment.

(silence)

SW1: So, but I do know that’s a common thing for people who finally speak about something that's been held for so long … maybe that's what you are talking about, (speaking to SW3), that there may be, these are the differences that would need to be specifically addressed, so that people have some basic skills in recognising what's going on, and being able to respond to that … because the dynamics are a little bit, can be different around those disclosures. But I agree, if it becomes this sort of protected area then people are fearful of doing anything about … it all gets turfed to the specialist who will then have a waiting list that's a mile and a half long, and nobody is going to get helped.

Alternating and interwoven threads of positionality were apparent in the debate, at varying points the perspectives of the client, the student, and the social worker gained dominance and SWED2 attempted to collectivize the discussion with the words “we” and “us”. SW1 struggled emotionally with her need to dissent, there were several sighs and the repeated expression “I’m not sure”. However, SW1 paradoxically became stronger in her assertions despite being met with silence when asking the group for feedback, going on to say “I do know.” The discussion provided a clear example of the way that individual opinions may be elicited and influenced by group synergy. It also pointed to problematic aspects within the construct of specialism in relation to CSA.

Analysing what was said also required attention to what was unsaid. All of the discourse on disclosure within the focus group appeared to suggest spontaneous revelations
rather than those that were the result of inquiry. Consequently, the need for training in CSA was centred on responding to disclosures rather than learning how to inquire. An implicit assumption was that once a sufficient relationship was established clients would always disclose. There had appeared to be a reasonably strong culture among social worker individual interviews of preferring to allow the space for the client to disclose rather than make direct inquiries. Yet it was also clear from such interviews that receiving disclosures of sexual abuse was reasonably rare, particularly for male social workers. In retrospect it would have been helpful for me to clarify participants’ positions with respect to inquiry, in the mixed group setting. However, the debate was complex, fast-moving, intense and affect-laden. Data analysis begins within the focus group to the extent that the facilitator responds to, and directs the discussion and influences the process. My analysis of the focus group revealed several missed opportunities for intervention, clarification, and the challenging of discrepancies, but such omissions are much easier to perceive after the event.

**Preparation and support**

Comments and suggestions arising from individual interviews about strategies to prepare and support students with regard to CSA training were fed back to the group. The increasing number of very young social work students had been raised as an issue, and sparked a discussion regarding the challenges for young social workers working in multidisciplinary teams. Dealing with denial and minimisation regarding CSA within mental health teams emerged as a particular practice concern and shared experience for three participants, SW2, SW4, and SW5.

As I discussed in chapter four, I wished to incorporate into my analysis a focus on the words used, and it was clear that social work was often perceived as a battle in foregrounding child protection and sexual abuse issues within mental health teams. Imagery and metaphors associated with combat were regularly utilised such as “standing your ground”, the need to “step up to the mark” and “beat them up”, being “strong”, “fighting your corner”, and being a “bloody Rottweiler”. Participants described this battle as a “long process” requiring endurance and strength to withstand the injuries of being “cut across”, “not listened to”, and “dissed”. They described the inherent “denial”, lack of awareness of the impact of trauma, and lack of child protection focus in adult mental health teams. Many of the words highlighted the body and voice and marked the frustration of holding a minority, sometimes subordinate, and often unpopular position. Terms such as “banging your head against a brick wall”, and the need to “speak up against people” for clients who “have no one to speak up for them”, led to an
acceptance that “my job isn’t to be liked.” It was a passionate and telling discussion which suggested that students needed preparation for the war ground of multidisciplinary teams.

I intervened at the end of this lively discussion, summarising what I had heard and asking for further comments:

*Interviewer: So what I'm hearing is ... that to overcome denial ... societal, individual, across the board ... some foundation, some knowledge, some information is necessary. Without that, you haven't got that platform to kind of stand your ground on. Would that be a good way of summarising it? Is there anything else that someone would like to say about that?*

SW4 responded, saying: “We become part of the secrecy, the secrecy around abuse, we become part of it. We have even a little bit of information, then we are not part of it”. This view and the discussion preceding it suggested that knowledge regarding abuse and trauma prevented collusion with the societal tendency to deny, minimise, and silence these issues, and therefore had the potential to promote social justice.

Three different participants, SW1, SW3 and SWED2 then went on to discuss issues of preparation and support for students with “unresolved trauma histories.” The conversation was initiated by SW1 who drew on personal experience as a student of her observations of other students with trauma histories, some of whom had worked through issues and some who clearly hadn’t.

*SW1: I guess for people with their own trauma histories that may be unresolved, I think … one of the core things that you want to do in terms of preparation, is letting people know –

SWED2: Absolutely.

SW1: That this is the topic upcoming, and giving them an option to attend or not, so that if people don't want to come, they don't have to walk out of class that day, they can just not turn up for whatever portion, and speak to somebody about that if that is the situation. But if somebody has their own unresolved trauma issues, the last thing they’re potentially going to be able to cope with, maybe they will, is to be able to sit there and go through that process of how you do that work … I mean self-disclosure from someone who is in a good place with that stuff can enhance learning tremendously. But for somebody who hasn't had the chance to do it, that self-disclosure often becomes their process, and the classroom is not a good place for that. I've been in classes where that’s happened, and it's not a good situation for anybody.

SW 3: You definitely need advance notice I reckon, because if you are a survivor who has still not … maybe not even disclosed.

SW1 : Yeah.
SW3: And you're suddenly, you're in class and this is a topic for the day, that’s—
SW1: And there's no way out of identifying yourself.
SWED2: But then you’d hope that at some stage before you go out and work, you will have resolved that.
SW1: Mm, hopefully.
SWED2: So it’s a bit of a um —
SW3: Or at least made a start on that.
SWED2: Yeah.
SW1: And that may be, just that awareness may be the first step for some of those women, but again, we’re talking about really young people, you know. (slight break in discussion)
SW1: And it isn't even just young people, the experience I had, was … a woman who would not be considered young, but who hadn't … done what she needed to do for herself, and just couldn't cope with it being taught.

Preparing students by providing advanced notice of course material focused on the perspective of students, either those with abuse histories or consideration of the impact on the rest of the class through the student’s difficulties and/or disclosure in class. The invisibility of male student survivors exemplified by SW1’s gendered student survivor is a good example of how issues may be missed in the flow of conversation but stand out in the text. It is possible that the gendered profession of social work may have influenced SW1’s use of gender, but this was not clarified at the time.

Although SWED2 suggested consideration of future clients in the expressed hope that students would resolve trauma before entering the workforce, SW1 and SW3 suggested that social work education may only be the catalyst for students’ initial engagement with their own abuse histories and even precipitate first disclosure. Scarce attention appeared to be paid to the role of social work educators, apart from giving students prior notice of course material, and the education and practice implications of students’ non-attendance were not discussed. In order to draw out opinions regarding the balance of responsibilities between students and social work educators regarding student non-attendance arising from abuse histories and the implications for clients, I asked further questions of the group.

Interviewer: If people do have unresolved histories … going on to … our topic of use of self and emotional intelligence, reflective practice … how important is it … for students to identify vulnerabilities, and at what point in their … training … before placement, during the academic programme … during placement?

Two social workers and one educator immediately volunteered “before”.
I then asked: “So ... in terms of ... giving them prior notice of sort of some training around child sexual abuse and students not attending, then how much is it the responsibility of educators to follow that up?”. The initial response was silence. Finally, two participants ventured that “follow up” on the part of educators was important and one suggested “supervision”. In retrospect, it would have been helpful to have explored the precise nature of follow up and the gatekeeping implications. Another participant felt that the student had responsibility to inform “somebody” and “make a plan about how they’re going to cope”.

In SW3’s view, gatekeeping in relation to admission processes had changed considerably, from historically having required “an extensive personal history” to currently being about “just pay your fees and enrol”. Nevertheless, SW3 perceived that there was a clear educator role for preparation and support at the outset of social work training. She described the type of explicit discussion with students that could occur “at the beginning”, which encouraged and normalised seeking support for personal issues. Both social work educators endorsed SW3’s perspective.

SW3: “And through this course there’s going to be topics discussed that … are challenging, and we want to make sure that … there is support available, if stuff comes up”.
SWED2: Those things would be addressed in the interview process.
SW3: “And we expect you to address things … that might get in the way of how you're able to really be with your clients and be open to whatever they bring”. You know, just that kind of discussion early on … the environment is set where it is framed up that … getting support for dealing with your own issues is a positive thing.
SWED1: Mm.
SWED2: Yeah.
SW3: It’s a normal thing, it’s an expected thing, it’s a healthy thing, not something to be ashamed about.

Admission interviews were conducted at the social work education institution of one of the educators, as indicated above, but not the other. The degree of personal questions at the admission interview appeared to depend somewhat on the interview panel, but personal issues would often be disclosed. The interview also assisted educators in understanding students’ motivations for social work training and their expectations of social work. Because the interview was a two-way process, educators had an opportunity to give students a reality check about the programme and assess students’ readiness.

SWED2: It gives me a sense of whether they’re coming because they’re wanting to help and save the world, or whether they have issues that they
wanted to work through, or whether … they’ve got parents who are in that work…
SW1: That’s useful information.
SWED2: Or they just have to go in for something and “I think it would be easier than teaching because I don’t want to work with little kids”.
(laughter)
SWED1: Boy, they’re in for a shock.
(laughter)
SWED2: So for me the interview process is really about us letting them know, “are you sure?”.

Use of self/emotional intelligence/reflective practice.

Both educators spoke about the way in which student problems were identified or disclosed by students and how students were supported. The reflective use of self, which underpinned the whole social work education framework, provided a means for disclosure and a catalyst for seeking support. Disclosures regarding students’ vulnerabilities and personal abuse histories occurred within pedagogical strategies for increasing self-awareness, such as life-story essays and reflective journals. For one social work educator, emotional intelligence and the use of self were therefore aligned with an expectation that seeking support and/or counselling was normal and healthy.

SWED2: In our programme … in the first year, there is a fair amount of stuff around the use of self and self-awareness, and … the supposition that many, many people coming have had … negative early life experiences. And we put that out there that that’s often what brings people to social work, because they develop skills out of those experiences. And … I disclose that … in my social work training we all had to be engaged in counselling or therapy at some point, and that we would expect that our students would … We don't have any interviews, so we don't have any idea who is coming until they’re there … But our first assignment is, “who am I, where do I come from and what are the experiences that I’ve been through.” Obviously they're not likely to, some people do disclose then, but … a lot of people … will at least … know that there is an ethos of being able to talk about that, either with us … as lecturers … or they’re made aware of the counselling services … day one … I guess it's done differently, in different ways.

The supposition that a significant proportion of students may have difficult life experiences which motivated their career choice and were possibly unresolved, led me to ask a question based on perceptions expressed by two social work educators within an individual interviews.
Interviewer: I'm just wondering, this is a question, and it's quite a big question, but it is something that someone's raised is, are social work programmes places of healing?
(silence)
SWED1: For students, presumably?
SW3: That's a big question.
Interviewer: Presumably.
(laughter)
SW2: It didn't heal me because I'm still here (laughs).
SWED2: Not in my experience.
SW1: I think they're places of growth and development, and they're exciting because you kind of see possibilities and … maybe there's a healing aspect for some people, and maybe they go on and get what they need from that.

SW1 provided a lengthy monologue which actually provided an opportunity for her to articulate and explore her opinions regarding the issue. She reasserted her observation that students who had worked through their own issues “enhanced learning” for the rest of the class because the “healing was done”, but that the classroom was not the place for the processing of unresolved trauma. The focus group forum assisted SW1 to reflect on her own position and the depth of feeling she held regarding her position.

SW1: And, my God, we never would have had time to get through our content if people had needed a space for their healing … Turns out I have a strong opinion about that, now I know.
(laughter)
Interviewer: Anyone else?
SWED1: (bringing hands inwards to make an oblong shape) I find that I contain … disclosures in classroom situations and that my job isn’t about encouraging that in that forum. It's about encouraging that in other forums. Sorry SW4.
SW4: I didn't find my social work training as a healing place. I found it as a growing, challenging place …

At a later point in the conversation two more participants suggested that although healing may occur as part of social work education, it was not the “intent and purpose” of education institutions and they were “places of learning”. The issue of whether social work education was a place of healing established the clearest consensus within the whole focus group. Participants felt that although healing may occur concurrently with social work education, a pedagogical focus rather than a therapeutic focus was necessary in order to ensure that learning outcomes were achieved.

Nevertheless, the expectation for the use of self and emotional intelligence within social work education suggested an emotional facet to learning. I therefore asked “is sufficient attention paid to the emotional realm in social work programmes, do you think?”. SW3 stated
that “it wasn’t in my day” but SWED2 asked for further clarification of the question. I discussed two paradigms of teaching, the cognitive-based passive assimilation of material predominantly through lectures, and the more collaborative, transformational, “student-as-co-enquirer” approach which acknowledged the role of emotions in cognitive processing. While participants had agreed that social work education should be focused on learning rather than healing, I wanted to understand how they viewed learning, and the degree to which emotions played a part in learning.

In SWED2’s opinion, a transformational approach to teaching was “the ideal”. but in reality the “institutional system” was “more of a corporate machine than ever”. “Research outputs” rather than considerations of “how you teach” dominated the tertiary educational culture. Although SWED1 acknowledged that when she trained “it was here’s the book, here’s the facts”, she felt that the emotional realm had become an intrinsic part of current social work education.

SWED1: Well, we do everything now based on … reflective practice, so the idea is that your learning incorporates your life histories … emotions … values and … beliefs, and that you use that, in terms of when you have an experience of the client, you use all those things.

Discussing social work education overseas SW1 echoed SWED1’s perspective, noting that the training constantly encouraged an “awareness of our emotional lives and the emotional lives of other people”. However, SW1 did observe that the degree of attention to students’ emotional lives was dependent on the comfort of the educator: “the courses where it didn't flow were the ones that stood out because you could tell that the people teaching those courses weren't comfortable going there”.

Several other participants noted that their own experiences of social work education had provided little attention to the emotional realm or the reflective use of self. Social work education in the past was described as “political and issue-focused”, “sociological”, “radical”, and involving “practical sociology”, leading one participant to comment “I took a while to catch up with the emotional intelligence”. From individual interviews and the focus group discussion it appeared that social work education’s attention to the emotional realm had increased, but could vary according to the commitment of the educator and the institutional culture.
Delivery of CSA material and what should be taught

Issues of content and delivery of CSA material were interspersed in the final stage of the focus group because I had asked the group for comments about a common refrain expressed in individual interviews “putting a human face to perpetrators,” and their thoughts about the incorporation of both victim and perpetrator dynamics in CSA training. Additionally, participants felt spurred to provide a range of final comments knowing that the group was about to end. SW3 added that there needed to be a greater academic focus on male victims.

In response to my question regarding perpetrators, SW5 supported the notion of acknowledging the humanity of perpetrators because “it reminds us of the potential people have, regardless of who they are.” However, he also noted that the very humanity of perpetrators can obfuscate their abusive activities: “even someone … who’s deemed to be, or even seen to be good … can also be a perpetrator”. SW4 and SW1 both endorsed the idea of incorporating victim and perpetrator dynamics into training. SW1’s emotive monologue created the most powerful experience of group affect within the entire course of the focus group. Yet it was felt, not expressed, and it was processed individually and silently.

SW1: I guess again thinking from the perspective of working with survivors … helping them understand the ways in which … sexual offending behaviour happens, and the ways in which … when they’re children … their naivete, their interest in things can be manipulated. Because most survivors that I know are left with a tremendous sense of guilt and responsibility for actions that weren’t their’s. And so actually understanding the dynamics of perpetrator behaviour is a really important part in helping them to understand why they did the things they did.
SW2: Yeah.
SW1: Why they kept going back willingly … to see this person again and again, even though they knew that what was happening wasn't okay, those kinds of things … From the work that I did in the prison … those were the ‘aha’ moments in people's healing … when they kind of went, “yeah, I was just a little kid, (voice slightly cracking), what was going on.?” And … those were powerful moments for people.

Interviewer: Yeah.
(silence six seconds)

The emotion was palpable in the room, it hung there in the silence. No one named it, yet we all felt it. I felt it in my throat and my chest. I experienced it as deep sadness and grief. It was a collective, overwhelming grief for all children who had experienced sexual abuse. In retrospect, it was clear that a valuable opportunity to explore group affect regarding CSA was missed, as I struggled, like others to contain rather than express emotions. Yet the experience of
silence and the unspeakable was revelatory. The group, as a microcosm of society, pointed to a natural tendency to defend against grief and pain.

The silence was finally filled by the silence filler, SW2, who maintained the theme of perpetrators, but re-focused the group on a concrete aspect of delivery. There was relief and enthusiasm in the voices of the participants in the discussion below, the pall of pain had been lifted.

SW2: Yeah, getting SAFE in to social work schools to talk about the work they do would be really good.
SW1: Yeah, right.
SW3: Yeah, good idea.
SW1: SAFE does a lovely job of putting a very human, caring approach to perpetrator work.
SW3: I think introducing agencies is a really good idea, because … if social workers coming out of social work school with nothing else other than knowing the agencies that they can call on to consult with and refer to, then … at least that’s something pretty crucial.

The group ended with feedback from individual interviews about the range of possible methods of delivery of CSA material, which elicited further ideas about content and delivery. One participant suggested that not only should guest speakers from various agencies be utilised, but there was also value in social work students visiting agencies such as CYFS, including evidential units. Drawing on his own positive experience of agency visits he stated it was a “huge eye-opener”, “removed a lot of fear”, and transformed the perspective of CYFS as “this big faceless thing”. Another participant suggested that CSA education should acknowledge the links between CSA and a range of other issues that “tend to be stigmatised”, such as mental health, addiction, and incarceration. Chronic pain was a muted contribution, almost whispered, and slotted in between other’s expressed views. It was only heard with difficulty when transcribing and viewing the DVD, so may not have been heard by other participants at the time. Being alert to what is barely given voice to is revealing. Although the link between CSA and a range of physical problems such as chronic pain, gastrointestinal problems, and fibromyalgia is being increasingly recognised in the literature, there was only one reference to somatic complaints as an effect of CSA in the social worker individual interviews. This was understated in the same way by the same participant.
Conclusion

The focus group had elements of collective opinion and collective experience, but was also characterised by lively, and often unresolved debates. Rather than perceiving individual accounts as static preconceived opinions, there was evidence of the synergistic and interactive influences of the group upon each participant’s verbal and non-verbal expressions. Clearly, a focus group is more than the sum of its parts.

Views regarding CSA as a core issue and/or a specialist issue generated considerable debate, and many different facets emerged in response to the question. It also elicited interesting perceptions about the social work role. Perceived differences and similarities between bullying and CSA highlighted the nuances in perceptions regarding core and specialist knowledge. On the one hand, an educator was arguing about the danger of identifying CSA as purely the domain of specialists, and suggested that similar interpersonal skills were needed for both disclosures. On the other hand, a social worker suggested that there were often specific dynamics involved in CSA which required some specialist knowledge, and that the disclosure itself may be qualitatively different because of being withheld for many years. A dialectical perspective acknowledges the truth of both sides. The debate pointed to a more holistic view of knowledge which incorporated simple human qualities of being present and bearing witness, as well as more conventional sources of practice wisdom. It led to an acknowledgement that making CSA the exclusive domain of specialists was unhelpful.

An area of consensus among four social workers was the belief that CSA was highly prevalent and likely to come up in social workers’ caseloads, therefore it was a core issue. They all noted that addressing CSA in practice was unlikely to involve conducting therapy, but nevertheless required core knowledge and skills in understanding the impact of trauma, and knowing how to respond to a disclosure. Their views highlighted the welfare of the client, and the social worker’s relationship with the client, as central considerations that provided the rationale for teaching about CSA and trauma. However, no participant mentioned the need to train social workers to inquire about CSA, which had been mentioned by a small minority within individual interviews. While social workers believed that responding to CSA fell within the social work remit, the two educators commented upon the lack of academic middle ground between social work and counselling. This perhaps contributed to the lack of academic focus on CSA, given the concern voiced in the focus group and individual interviews that students might attempt therapy with clients, if they addressed CSA.
Participants interpreted the question regarding preparation and support for students from varying positions and perspectives. Several sub-groups developed, taking the question in different directions. The first discussion about preparation for the challenges of working in multi-disciplinary mental health teams highlighted power differentials, and the different foci of practice amongst professions. In the second conversation regarding preparation for students with unresolved trauma histories, the initial focus by social workers was on the welfare of the student in the class. An educator then suggested students should ideally address trauma histories before entering practice, shifting focus to the welfare of the client. This elicited differing opinions about the degree to which students needed to resolve personal issues, and the balance of responsibility between educators and students. Both educators and a social worker believed educators could play a vital role in normalising the need for students to address trauma histories. Admission interviews provided a clear opportunity for preparing students regarding the nature of social work education and identifying students’ vulnerabilities. However, participants observed that the corporatisation of educational institutions had perhaps influenced the abandonment of admission interviews within some programmes.

Students’ reflective use of self was believed to encourage their awareness of the impact of personal experiences upon practice. However, while this enhanced personal and professional growth, participants reached consensus that social work education was not the forum for healing. Varying perspectives emerged with regard to the degree to which the emotional realm was addressed in social work education. For those who had trained some time ago in NZ, emotional intelligence did not appear to be part of the curricula. One educator believed the emotional realm remained marginalised by a corporate and research-oriented culture within academia, while the other believed that the focus on reflective practice encouraged consideration of emotions. These differences of opinions may have been due to individual perception or reflected differing institutional cultures. In addition, the emotional intelligence of educators was also considered to be a variable affecting programmes’ attention to the emotional realm. It was interesting that after a focused discussion on the emotional realm that the conversation became highly emotionally charged, although this may have been due to my question regarding perpetrators. SW1 directed our attention to the plight of the child. This felt, but unspoken, emotion within the focus group highlights the emotional work in contemplating aspects of CSA, which students and educators are likely to experience. In the next chapter, I discuss the findings from all three sample groups in the light of the literature and policy.
Chapter Ten: Discussion – Weaving the Threads Together

Weaving involves crossing two threads, the warp and the weft, one vertical and the other horizontal, one stretched taut and the other undulating and intertwined with the first. To produce the textile it is necessary for these two threads to be bound, otherwise each will remain a fragile and fluttering potentiality ... if the meeting of opposites does not take place, nothing is created, for each element is defined by its opposite and takes its meaning from it. (Valcarenghi, 1994, p. 9)

Introduction

In this chapter, I return to the metaphor of weaving that I introduced in Chapter Two. Analogous to life, the finished woven piece of art reveals the interdependence and co-existence of opposites. This reflects the dialectical methodology in my hermeneutic phenomenological approach, and the numerous dialectics inherent in my theoretical framework. Several key dialectics emerged from and/or informed this analysis: revealing/concealing, body/mind, rational/emotive, knowing/not knowing, approach/avoidance, victim/perpetrator, normal/abnormal, denial/acknowledgment, acceptance/change. Some involve conscious and unconscious aspects, with the underlying thread serving as a metaphor for the latent aspects which are always in relationship with that which is manifest. The weaving metaphor therefore promotes attention to surface and depth, implicit and explicit ways of relating, involving verbal and non-verbal expressions. It also acknowledges the logic of both sides of the weave; telling and not telling, knowing and not knowing.

Yet, in relation to the process of analysis, the metaphor of weaving has evolved. My framework or warp is now constituted by my empirical findings. I then weave in developmental, psychological, neurobiological, and sociological threads that inform an understanding of CSA and trauma, as well as empirical research and policy related to practice and education in these fields, as discussed in Chapters Two and Three. I therefore revisit attachment and psychodynamic theory, the neurobiology of trauma, trauma-informed care, VT, social defences, Goffman’s (1959, 1963) work on stigma and impression management, Finkelhor and Browne’s (1985) traumagenic dynamics, and relational dialectics theory (Baxter & Montgomery, 1996, 1998) in the light of my findings. Making sense of the rich tapestry of data necessitated further hermeneutic circles between the research questions and the data, and
the data and the literature. I searched for common threads and points of convergence between
and within data sets, and between the data and the literature, and paid attention to taken-for-
granted themes, such as the ever present role of embodiment and the subtle power of discourse.

I primarily discuss how the findings have answered my research questions in relation to
social work practice within the mental health and addiction field, and undergraduate social
work education. Social workers in this study were potentially working with youth and/or adult
survivors of CSA, not children, although some had worked with children in previous roles.
Nevertheless, teaching about CSA involves consideration of the sexual abuse of children from
infancy, as well as the impact across the lifespan. With regard to education, I therefore consider
the implications for other spheres of social work such as child protection. I return to my
research questions:

How do social workers and social work educators perceive CSA on cognitive
and affective levels, and what educational, professional, and personal sources
do they draw on in understanding CSA?

How and to what degree is CSA addressed within their practice or education
sphere of work?

What implications do social workers’ and social work educators’
understandings and perceptions of CSA have for social work practice and
education?

In relation to the first question, I move beyond a simple stock-take of knowledge and
practices regarding CSA, to consider the dynamic influence of emotional and embodied
dimensions, and socio-cultural discourses upon engagement with the topic. Clearly, there is
significant emotional work in engaging with the topic of CSA, even when there is only short-
term exposure. In keeping with the metaphor of weaving, participants’ perceptions regarding
CSA consisted of multiple strands involving sensory, emotional, and intuitive experiences, as
well as cognitive processes. In addition, both sample groups discussed dominant discourses
related to gender and family, which constrained victims, concealed perpetrators, and
perpetuated societal denial. These dominant discourses were insidious because participants
noted they could be internalised at micro, meso, and macro levels through socialisation

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87 While I had extensively traversed the literature regarding CSA prior to data collection, participants’
 perspectives profoundly broadened my horizons, which naturally informed my literature review. For
example, my immersion in the data sensitised me to the numerous dialectics involved in the experience
of CSA, and the internal conflicts that are inevitably generated in the dilemmas of telling or not telling,
feeling/appearing normal or not normal. I looked to the theoretical frameworks of relational dialectics
theory (Baxter & Montgomery, 1996), and Goffman’s (1959, 1963) work on stigma and impression
management to make sense of these complex dynamics. This highlights the iterative and inductive nature
of qualitative research.
processes, and accepted as the status quo. This suggests that unconscious mechanisms may be at play, and is consistent with Farmer’s (2000) assertion that the unconscious influences discourse. He goes on to note that we have “limited opportunity to choose our discourses” and “each discourse is limited; it filters some information and arbitrarily excludes or marginalizes opportunities for knowing and doing” (p. 70). These observations resonate not only with participants’ perspectives regarding the subtle, yet almost omnipotent power of discourse, but also with Heidegger’s notions of thrownness, and the hidden nature of being-in-the-world. Social work’s attention to the reflective use of self opens the door to a more holistic and critical view of knowledge, which incorporates emotional intelligence, epistemic reflexivity, and embodied forms of knowing (Parton, 2008; Sheppard, 1998; Taylor & White, 2001, 2006; Trevithick, 2008). Thus, participants’ perceptions provide a window into the processes of knowing and not knowing about CSA. In addition, their multiple vantage points illuminate the phenomenology of CSA.

Secondly, participants’ perceptions and multiple perspectives regarding CSA provide a strong rationale for addressing the issue in social work practice and education, while also pointing to personal, professional, and organisational challenges. I discuss the implications of participants’ perceptions regarding the prevalence of CSA in community and clinical populations, the dilemmas of disclosure, and the potential consequences of coping with the impact of CSA without support. Drawing on the findings, mental health policy, and the literature, I argue for routine assessment of CSA, other abuse, and trauma symptoms within mental health and addiction services. However, I suggest that for such changes to have the greatest benefit to clients, professionals, and organisations as a whole, a trauma-informed paradigm is needed.

Next, I review participants’ perceptions regarding addressing CSA within social work education in the light of the literature, and reveal the parallel processes between teaching about CSA and addressing CSA in practice. Similar skills and strategies emerge at the stage of preparing students or clients, pacing material, teaching self-care, and working with affect. As is already the case within some programmes in this study, I argue that teaching about CSA should be part of the core curriculum for under-graduate social work education. Drawing on NZ policy within mental health and policy and legislation regarding vulnerable children, I highlight the responsibilities for social work education providers, and advocate for trauma-informed education. Finally, I make some suggestions regarding future directions for research, and recommendations for mental health and addiction service delivery, and for social work education.
Perceptions of CSA and sources of knowledge

The complexity and simplicity of CSA

Taking into account the perspectives of both samples, the findings reveal the vast range of contexts in which children are sexually abused and the many faces of perpetrators. Sexual abuse may occur from infancy at the hands of parents and potentially last for years, or it may be a one-off event perpetrated by an extra-familial adult. It may be tender, seductive, and have physiologically pleasurable aspects or it may be violent and even sadistic. It may be organised, perpetrated in intra-familial or extra-familial groups sometimes involving ritual aspects, or it may occur at the hands of one perpetrator, who may be another child or adolescent. The victim may or may not be the same gender as the perpetrator. The acts of sexual abuse may be an anomaly within an otherwise happy childhood, or may constitute one of many forms of abuse experienced.

In addition, participants often emphasised the human face of perpetrators, despite visceral feelings of disgust. They described perpetrators who presented very well and spent months or years grooming victims and the community. They also spoke of perpetrators behaving in an opportunist fashion, although several believed fantasy was likely to have been present prior to offending. Participants from both samples challenged the strict societal demarcations between victim and perpetrator. They noted that victims could become perpetrators of CSA and/or other abuse, and perpetrators could be victims of a wide range of adverse childhood experiences. Both male and female child sex offenders have been found to have three times the odds of CSA and a greater number of adverse childhood experiences compared to community populations (Levenson et al., 2015, 2016). As several participants noted, the victim and the perpetrator may be anyone, including a social work student, a social worker, or a social work educator. Challenging the victim-perpetrator binary, Lancaster (1997) notes: “Offenders can be both undeserving (they have harmed someone) and deserving (they are victims themselves), or powerful (they have abused their power) and powerless (they are children themselves)” (p. 207).

Clearly, the topic of CSA is vast and complex. But as both sets of participants revealed, even those who rated themselves the least knowledgeable were able to offer valuable insights about CSA, particularly when they were emotionally engaged. Social workers who voiced concerns about their lack of training nevertheless demonstrated their ability to offer support to
other colleagues, clients, and even strangers. While there was individual variation, perceptions regarding CSA among both samples often corresponded. This included:

a) estimates for the prevalence of CSA in the community
b) relevance of CSA for social work practice and education
c) minimal or no training in CSA within own social work education
d) difficulties of disclosure and delayed disclosure
e) under-recognition and under-reporting of male sexual victimisation
f) broad definitions of CSA which took into account victims’ subjective appraisal
g) caution regarding media representations of CSA
h) potentially pervasive impacts of CSA across the lifespan
i) CSA as a core practice and education issue as well as a specialist domain
j) emotional responses to discussing CSA, particularly regarding perpetrators

**Emotional costs**

A significant practice and education issue emerging from the research is the emotional toll of engaging with the topic of CSA. Participants’ high levels of empathy, willingness to immerse themselves in the topic of CSA, and their direct and indirect personal and professional experiences with CSA, led to a range of emotional and embodied responses. These findings are not surprising, in fact, it would be concerning if participants were emotionally unaffected (Barter, 1997). Participants’ visceral and physiological responses were involuntary, understandable, and one could say normal, in that they reflected their awareness of CSA as a reprehensible and immoral act causing deep distress to the child. This capacity for empathy rendered them vulnerable to experiencing bodily and emotional discomfort, which could not be entirely eliminated through knowledge and experience. Emotional and embodied reactions were expressed verbally and non-verbally during interviews, and in retrospective accounts of interactions with clients, students, and colleagues. There are also research implications, given that I have documented the emotional costs of conducting this research, and explored others’ emotional experiences of engaging in sensitive research. Clearly, the emotional toll of addressing the issue of CSA in practice, education, and research needs to remain explicit and be normalised. In this study, the potential for indirect trauma and shattered assumptions arose implicitly in participants’ accounts, such as an educator’s comment that knowledge of CSA changes what “you think normal is”. I argue in this chapter that VT is a relevant and useful concept for all three spheres. This provides a framework for understanding and managing the cumulative effects of engaging with the topic of CSA.
**Embodiment**

The thread of embodiment informed all aspects of this research. It is key to early attachment relationships, intersubjective psychodynamic theory, the neurobiology of trauma, the long-term impact of unresolved trauma on the body, survivors’ relationships with their body, and Goffman’s (1959, 1963, 1967) work on impression management and stigma, discussed in Chapter Two. Embodiment also emerged as a central issue in Chapter Three, for example, social workers’ and students’ bodily reactions to learning about trauma, and the concepts of embodied practice and emotional intelligence within social work pedagogy. In Chapter Four, my methodology and methods explicitly took the body into account (Denham & Onwuegbuzie, 2013; Merleau-Ponty, 1962; Sandelowski, 2002).

Within participants’ accounts, embodiment was not only a central issue in their own reactions to discussing and addressing CSA, but also manifested in children’s experiences at the time of the abuse and its aftermath. The body could feel pleasure and pain at the time of abuse, with the pleasure representing betrayal of the body, creating confusion and ambivalence (Alaggia & Millington, 2008; Ronai, 1995; Salter, 1995). In attempting to cope with CSA, the body might be scrubbed, numbed, cut, imbibed with alcohol and drugs, starved, forced fed, or treated as an object (Chaplo et al., 2015, Farber, 2008; Spacarelli, 1994). The body might reveal its pain through nausea, vomiting, and headaches (Kendall-Tackett, 2002; van Tilberg et al., 2010), and convey pain through behaviours and non-verbal expressions (Alaggia, 2004, 2005; Flam & Haugstvedt, 2013). Educators also discussed the embodied reactions of students, such as standing up and yelling in class, or feeling frozen and shocked. This corresponds with the large body of literature discussed in Chapter Three regarding students emotional and embodied reactions to learning about CSA (Aglilias, 2014; Myers 2008; Shannon et al., 2014a, 2014c). In addition, participants revealed that disclosure is a dialogic and embodied experience, necessitating the respondent’s awareness of their non-verbal responses, and those of the victim/survivor (Reitsema & Grietens, 2015; Staller & Nelson-Gardell, 2005).

**Addressing CSA in mental health and addiction practice**

**The dialogic nature of disclosure**

As participants pointed out and the literature reveals, delayed disclosure is common and occurs for many reasons (London et al., 2005). Not only is it emotionally painful and difficult for children to speak out, but they are constrained by developmental, interpersonal, and
socio-cultural influences, which often distort their perceptions of self, others, and CSA (Alaggia, 2004, 2005; Paine & Hansen, 2002; Pipe et al., 2007). Social workers in this study highlighted the numerous non-verbal and sometimes unconscious ways children, youth, and adults drew attention to their predicament. Several questioned the notion that children could be truly asymptomatic, suggesting that non-offending caregivers may benignly disregard or misinterpret subtle signs, or defensively minimise or deny signs when abuse occurred within the family. Children’s non-verbal and verbal cues tested out the persons’ receptivity, sensitivity, and capacity to bear the news. The response, which also involved verbal and non-verbal aspects, dictated whether further disclosure was safe or unsafe (Staller & Nelson-Gardell, 2005).

Participants’ views highlight the dialogic nature of disclosure and the dialectical dilemma of telling or not telling. This shifts a significant part of the responsibility for disclosure away from the victim/survivor. Respondents’ comments suggest that speaking about the unspeakable firstly requires someone willing to take notice of non-specific signs or the “test balloons” (Flam & Haugstvedt, 2013, p. 633) and check things out. However, this perception appeared to apply more to children and youth, than adults. Perhaps the imperative to inquire about signs of distress was greater for children and youth, because there was a high likelihood that they were still being sexually abused. This viewpoint ignores the possibility that many adult survivors may re-enact and re-live the past as if it were the present in all sorts of subtle, and perhaps unconscious ways. As Levine (1997) has pointed out “When it comes to trauma, what we don’t know can hurt us. Not knowing we are traumatised doesn’t prevent us having problems that are caused by it” (p. 46).

Consistent with the literature, participants believed that support from significant others following disclosure of CSA was one of the most significant factors facilitating a child’s adjustment and recovery (Elliot & Carnes, 2001). Yet they recognised that this was not always the case, particularly when CSA was intra-familial. Poor familial responses were observed to occur across all cultures and to elicit a sense of being re-victimised and re-traumatised. The family as the site of CSA, and the site of invalidation of CSA, clearly is an intolerable place for a child to be. On an emotional level, being disbelieved about being sexually abused, particularly by a trusted adult, is highly reminiscent of being sexually abused. Summit (1983) has discussed the child’s re-experiencing of “helplessness, hopelessness, isolation and self-blame” in the face of such disbelief, which could precipitate secondary trauma (p. 178). As discussed in Chapter Two, CSA by a trusted adult, coupled with a negative response from another trusted adult, is a “double betrayal”, which significantly increases the likelihood of
amnesia and the risk of re-victimisation (Wager, 2013). The potential for survivors to become isolated as result of invalidating, punitive, and rejecting responses from families obviously has implications for mental health, given that a key protective factor is the presence of social support (Leach, 2015; Thoits, 2011; Turner & Turner, 2013).

Relational and parental implications

These experiences of double betrayal and re-traumatisation naturally have long-term impacts across the lifespan and for the next generation. Intra-familial unresolved CSA requires survivors to make difficult decisions about the level of contact to maintain with families. Continuing contact with abusive families puts survivors’ children at risk of abuse (Duncan, 2005), and survivors may also be at risk of ongoing sexual abuse into adulthood (Middleton, 2013a, 2013b; Salter, 2013). However, severing contact puts significant strain on survivors to parent without familial support. Participants observed that some adult survivors geographically distanced themselves from family. Clearly, these added betrayals and familial ruptures, along with the lack of opportunity to process, make sense of, and integrate traumatic events, could render survivors more vulnerable to mental health problems and poor coping strategies. The challenges of dissociation, emotional dysregulation, and other trauma symptoms, coupled with poor coping strategies, naturally have considerable implications for parenting.

There did not appear to be much opportunity for participants to explore parenting issues with clients, or observe clients with their children. One social worker in mental health who previously worked for CYFS, appeared particularly attuned to the welfare of his clients’ children, intervening to uncover sexual abuse on one occasion. A telling discussion between three social workers in the focus group suggested that child welfare concerns could sometimes be marginalised within adult mental health services. This elicited metaphors of battle in standing up for the rights of children who were not clients. Recognition of the parenting challenges associated with addiction and mental health problems, and the potential negative impacts on children is reflected in the organisation Children of Parents with Mental Illness and/or Addiction (COPMIA). These issues highlight the importance of collaboration between child protection and mental health/addiction services, and the need to consider the role of parental unresolved trauma (Hunter & Price-Robertson, 2014; Jeffreys, Rogers, & Hirte, 2011; Matua Raki, 2013b; MOH, 2015b; MSD, 2015b, 2015c; Parsonage, 2015; SAMHSA, 2011; Templeton & Rea, 2015; Trifonoff, Duraisingam, Roche, & Pidd, 2010). Research in NZ has revealed that women with substance abuse problems attending a pregnancy and parental service within a DHB commonly have unresolved and often inter-generational histories of trauma and
abuse, and continue to experience interpersonal violence as adults (Parsonage, 2015). In addition, a significant proportion of parents coming to the attention of CYFS have unresolved personal issues, up to 60% (Kruse, 2005; Witten-Hannah, 2001), and 36% of children coming to CYFS attention have parents who were known to CYFS as a child (MSD, 2015b). The Vulnerable Children Act 2014, which took effect after the interviews were completed, legislates for a whole of government response to child protection, requiring all relevant government departments to have child protection policies. The new Ministry for Vulnerable Children, Oranga Tamariki, will share accountability for the protection and welfare of children with the Ministries of Education, Health, Justice, Social Development, and NZ Police. This legislation and associated policy emphasises the crucial need for multi-disciplinary working and information-sharing among agencies. Ultimately, this creates an expectation for all social workers (and other helping professionals) to have a knowledge of the signs of child abuse and how to respond (MSD, 2015d). In addition, the establishment of child-centred Children’s Teams, as discussed in Chapter One, could potentially involve mental health and addiction social workers as referrers, as members of Children’s Teams, or even taking on case management as lead professionals for those working with youth.

One social worker raised the issue of survivor parents, in relation to observations within CYFS that many children disclosing CSA had mothers with unresolved CSA. In the face of strong triggers to their own abuse, these mothers struggled to support their child. Based on their own observations in child protection, two educators supported this view. As discussed in Chapter Two, the prevalence of CSA among mothers of sexually abused children is much higher than accepted community prevalence figures (Faller, 1989; McCloskey & Bailey, 2000; Oates et al., 1998). While all parents are likely to suffer distress upon hearing that their child has been sexually abused, greater levels of distress and trauma symptoms have been found in survivor mothers, suggesting unresolved trauma (Hiebert-Murphy, 1998; Timmons-Mitchell et al., 1997). Interpersonal and intra-psychic difficulties, coupled with poor boundaries, can lead women who have been sexually abused to make poor decisions regarding intimate

88 Statutory child protection teams, youth justice, and adoption services will operate within the Ministry for Vulnerable Children, Oranga Tamariki from 1 April 2017. In addition, the new Ministry will oversee the Children’s Action Plan Directorate which oversees Children’s Teams across NZ, and fund and contract for family and sexual violence services for child victims and perpetrators. The MSD will continue to support adult members of at-risk families, requiring close liaison between the two departments (MSD, 2016a).
89 The new operating model for the Ministry will require information sharing between all statutory agencies and NGOs working with vulnerable children. Rather than “a passive regime where agencies have a discretion to exchange information”, there is an expectation to move to “a proactive regime where information should be exchanged unless there are compelling reasons not to” (MSD, 2016c, p. 2).
relationships. These may place their children or themselves at risk of sexual, physical, or emotional abuse (Sanderson, 2006). Several authors posit that survivors’ dissociative tendencies may impair their ability to detect risk and threat in social settings, thus increasing the risk of re-victimisation and betrayal (Freyd & Birrell, 2013; Gobin & Freyd, 2009; Hulette, Kaehler, & Freyd, 2011). In my study, these potential ongoing risks of interpersonal violence to survivors and their children appeared under-recognised.

Re-victimisation and poly-victimisation

Only one social worker mentioned sexual or physical re-victimisation as a sign associated with CSA, suggesting this issue was also under-recognised. As discussed in Chapters Two and Three, male and female survivors have a significantly elevated risk of sexual re-victimisation (Arata, 2002; Chiu et al., 2013; Classen et al., 2005; Desai et al., 2002; Fanslow et al., 2007; Werner et al., 2015). Female survivors are also at greater risk of domestic violence (Cannon et al., 2010; Coid et al., 2001; Follette et al., 1996, Messmann-Moore & Long, 2000). Another social worker, who had previously worked for CYFS, observed that it was quite common for female teenagers, who disclosed CSA, to have had previous involvement with CYFS for a disclosure of CSA as a child. This is consistent with CYFS findings, which reveal significant rates of sexual re-victimisation following evidential interviews as children (Basher, 2007). Re-victimisation regarding all forms of abuse remains a consistent issue for child protection in NZ as discussed in Chapter One (MSD, 2015b). Two social workers also suggested that CSA could often co-occur with a range of other abuse and/or adverse events. These views are consistent with the literature which reveals that many children and youth experience poly-victimisation (Dong et al., 2003; Edwards et al., 2003; Kellogg & Menard, 2003; Turner, Finkelhor, & Ormrod, 2010). As discussed in Chapter Three, poly-victimisation is associated with poorer functioning, greater trauma symptoms, and increased risk of re-victimisation (Chiu et al., 2013; Classen et al., 2005; Finkelhor et al., 2007). These issues highlight the importance of taking a full abuse history and assessing for current abuse and trauma symptoms.

A normal/abnormal dialectic

Participants commented that the desire to feel normal and appear normal was a recurring issue for both perpetrators and victims (Asch, 1954; Goffman, 1963). At the same time, both victim and perpetrator could feel a sense of abnormality to varying degrees (Finkelhor & Browne, 1985; Goffman, 1963). Certainly, perpetrators were perceived by society
as abnormal, but victims could also be perceived as abnormal if their behaviour violated social norms. The findings suggest that a dialectical tension occurs for victims of CSA on two separate but related poles, the concept of self as normal or abnormal, and the concept of CSA as normal or abnormal. The victim’s intra-psychic and inter-subjective navigation along these two poles appeared to be mediated by gender, culture, the context and dynamics of the abuse, attachment to the perpetrator, the level of prior and ongoing support, sexual knowledge, and their understanding and awareness of society’s views, norms, and expectations. These variables in turn influence the victim’s decision to tell or not to tell. The word normal is both noun and adjective, therefore we can describe ourselves or others as normal and we can be normal. The Penguin English Dictionary (2007) lists five possible meanings for normal, the last related to its use as an adjective:

a) conforming to a norm, principle or rule  
b) occurring naturally  
c) free from mental disorder  
d) having average development  
e) something or somebody that is normal (p. 871).

Victims negotiated their place on the first continuum, a sense of being normal or abnormal, through a dynamic interplay between their own self-assessment and their awareness of how others perceived them, including awareness of dominant societal discourses. Their place on this continuum was likely to change depending on their developmental stage, the nature of the abuse, their responses to the abuse, and the responses of others to their behaviour and any disclosure. Participants observed that victims of sexual abuse often appeared to carry shame, guilt, self-loathing and a sense of being tainted, which was embodied as well as cognitive (Hlvaka, 2010; Young, 1992). One social worker’s example of compulsively scrubbing his body signified the sense that the experience of CSA exuded from the very pores of one’s skin. Other coping mechanisms such as self-harm, substance abuse, promiscuity, acting out, and aggression pointed to the way that victims’ behaviours reflected their feelings of distress turned on self and others. Whether or not victims were conscious of their own feelings of abnormality, these behaviours violated social norms, thus rendering the victim abnormal in the eyes of others.

The second continuum represented victims’ perceptions about whether CSA was normal or abnormal. Although the notion that CSA could be perceived as normal may be unpalatable to many, the data and the literature suggest that normalisation processes occur
Participants highlighted younger victims’ vulnerability to the perpetrator’s presentation of normality, particularly when the perpetrator was a close family member. Elvis’ particularly compelling anecdote of teaching his children that eating fish eyeballs was normal highlights the almost omnipotent power of parents to determine the bounds of normality. The sexual abuse of very young children by parents, who set the margins of acceptable and normal behaviour, suggests that the phenomenon is entirely possible. However, as one participant noted, intra-familial sexual abuse also sexualises attachments, fusing two strong drives, and examples were given of inter-generational sexual abuse which had been perceived as normal. Bentovim (1995) has also described the sexualisation of attachment relationships within trauma-organised family systems. As discussed in Chapter Two, the intra-familial perpetrator has many opportunities to introduce and subtly blend sexual behaviour into normal affectionate contact (Craven et al., 2006; Smallbone & Wortley, 2000). While survivors of CSA may normalise their sexual victimisation, there was acknowledgement, particularly by male participants, that some survivors may come to view the perpetration of CSA as normal. Anecdotal examples of cultural and inter-generational practices which normalised and condoned CSA were discussed. Leland Ruwhiu, one of the Principal Advisors for Māori in CYFS, has spoken of his maternal grandfather’s decision to protect his family: “This was a display of courage and concern by a father who knew that his homeland was not a safe environment to raise his four daughters in because of the proliferation and also normalisation of sexual abuse” (Eruera & Ruwhiu, 2014, p. 5).

Participants observed that hegemonic masculinity was a powerful factor in creating normalising discourses regarding the sexual abuse of boys by females (Denov, 2001). One social worker was also aware of discourses and pro-paedophilia groups which define pederasty as a legitimate and consensual form of homosexuality. This normalises the sexual abuse of boys by adult males through reframing abuse and exploitation as love. Social workers’ concerns regarding a highly sexualised culture, the ubiquity of pornography, and the increasing sexualisation of children pointed to the metaphor of creeping normality. Like the boiling frog, society is exposed to imperceptible, uncontrollable, and yet inexorable shifts in the boundaries between what is normal and not normal, acceptable and not acceptable. Participants believed that the sexualisation of children blurred the boundaries of what is acceptable (normal) sexual behaviour in the eyes of perpetrators and society, which ultimately affected victims’ perceptions. Former British Prime Minister, David Cameron, expressed his concerns about the “sexualisation of children” in 2011:

(Breckenridge et al., 2008; Morrow & Smith, 1995; Young, 1997).
More and more today, sexual-provocative images are invading public space - space shared by children. In the Tube station, at the bus stop, on the billboard - there's the creeping sense that we're sleepwalking to a place where 'porn is the norm' (Cameron, 2011).

In this study, participants evidenced awareness of, and resistance to these societal shifts, but also expressed a sense of powerlessness. After interviewing 200 stakeholders working with CSA and reviewing ten years of child victims’ files in the UK, Goddard, Brennan, and Harewood (2015) observed “a sense of ‘normalisation’ and desensitisation around sexual behaviours and assault among professionals and young people” (p. 7).

While the most healthy emotional position after experiencing CSA would be to experience self as normal, and CSA (and the perpetrator) as abnormal, this realisation would be extremely difficult for children or even teenagers sexually abused by a significant attachment figure. Firstly, the nature of the relationship, gradual mixing of sex with affection and caregiving, and unequal power relations posed significant barriers to perceiving CSA and the perpetrator as abnormal. In addition, participants noted that the perpetrators’ gifts, money, attention, affection, and gradual grooming to participate created a sense of complicity that blurred the boundaries of normality (acceptability) and abnormality. These transactional and participatory aspects were illusions to mask any sense of victimisation. Furthermore, several respondents commented upon the lack of parental discourse regarding sexuality which created confusion for victims about was sexually normal. Participants suggested that victims often carried the shame, stigma, blame, and sense of badness regarding the abuse (Finkelhor & Browne, 1985). Attachment theory helps understand how children resolve their ambivalence towards abusing significant others by locating abnormality and badness within self (Fonagy et al., 2002).

Rosenhan and Seligman (1984) have suggested that abnormality has seven key characteristics: suffering; maladaptiveness; vividness and unconventionality; unpredictability and loss of control; irrationality and incomprehensibility; observer discomfort; and violation of moral and ideal standards. Perceptions regarding perpetrators highlighted their apparent normality. Far from being monsters, many were described as competent, often talented people who had gained the respect and trust of their communities and families. Hiding in plain sight, the most elusive perpetrators monopolised inaccurate societal perceptions regarding their abnormality. Such perpetrators were masters of impression management (Goffman, 1959, 1967). In contrast, participants’ perceptions regarding the impact of unresolved CSA revealed that some survivors might paradoxically deviate more obviously from notions of normality than
their perpetrator. Survivors’ mental health and addiction problems, self-harm and suicidal ideation, eating disorders, and aggressive, risk-taking, or criminal behaviour stood in stark contrast to the presentation of many perpetrators as respected, trusted “pillars” of the community. Thus, while it appeared many perpetrators successfully concealed their stigmatised identity, the ongoing problems which many survivors of CSA experienced served to magnify their “spoiled identity” and sense of abnormality (Goffman, 1963). These findings highlight the importance of a trauma-informed practice framework to counter stigma, by helping clients to recognise their coping strategies as understandable and normal responses to abnormal, yet unfortunately common events.

Signs become symptoms of abnormality and pathology

Participants’ perspectives about the nature and impact of CSA across childhood, adolescence, and adulthood in Chapter Five, highlighted the transformation of signs into mental health symptoms and diagnoses over time. However, the impact of CSA on physical health appeared under-recognised. Somatic symptoms of distress were identified for children, but only one participant noted such symptoms in adults. As discussed in Chapter Three, medically unexplained symptoms are commonly documented in children and adults with CSA histories (Leserman & Drossman, 2007; Nelson et al.; 2012, van Tilberg et al., 2010). In children, behavioural signs of CSA, while non-specific, were considered clear indicators of distress which needed to be checked out. Participants viewed these more readily as non-verbal cries for help. Yet youth were often subject to discourses regarding the “acting out” teenager, which some participants believed functioned to conceal underlying issues and reduce credibility, if a disclosure was made. For youth and adults entering mental health services dominated by a medical model, distress associated with unresolved CSA could easily be subsumed within mental health problems and substance abuse.

All participants perceived extensive and often complex inter-relationships between CSA, mental health, and substance abuse (Berry, 1998; Boles et al., 2005; Harris & Fallot, 2001; Harris & Landis, 1997; Hiebert-Murphy et al., 2000; Simpson & Miller, 2002). They often highlighted the survivor’s self-alienation, and a tendency for distress to be turned on the self in conscious and unconscious ways (Farber, 2008). In a vicious circle, the survivor’s sense of self could be seriously diminished by avoidant and dissociative strategies, such as emotional numbing and substance abuse. Thwarted opportunities for disclosure ultimately perpetuated the approach/avoidant dance with themselves and others. Consistent with the literature, these signs suggested complex trauma rather than just simple PTSD, with dissociation and disconnection
being common themes that could subtly manifest in behaviours and relationships (Pearlman & Courtois, 2005; Herman, 1992, 1997; Rodriguez-Srednicki, 2002; Sanderson, 2006). This recognition of the difficult relationship survivors often had with their self has significant ramifications for their relationships with others, including their capacity to enter into a working alliance with a professional. Bloom, Yanosy, and Harrison (2013) note the paradox in the reality that “relationship is at the heart of healing from traumatic experiences while relational damage is at the core of … clients’ problems” (p. 126).

In Chapter Five, participants observed that substances often had a self-medicating role for clients, generally for the purpose of numbing and avoiding emotional pain. They understood self-medicating tendencies from observations of clients and/or feedback from them, resonating with the views of AOD workers in Australia (Breckenridge et al., 2010, 2012). This is broadly in line with Khantzian’s (1997, 2013) self-medication hypothesis, which draws on contemporary psychodynamic theory, and attachment and developmental theories. Khantzian (2015) suggests that “addictive disorders are rooted in suffering…. The suffering is mainly a consequence of addicted individual’s inability to regulate their emotions, self-esteem, relationships, and behaviour, especially their self-care” (p. 813). This theory highlights the negative developmental impact of relational trauma upon the ability to regulate emotions, sustain healthy relationships, and care for self. Feeling either too much or too little emotion is a cardinal feature of traumatic stress. Khantzian (2013, 2015) posits that specific classes of substances offer some temporary, but ultimately ineffective relief from emotional extremes. Respondents’ views highlighted the dilemma of attempting to treat addiction without being aware of potential underlying antecedents.

**Marginalised accounts of CSA**

Participants’ perspectives suggest that CSA involving male victims, teenagers, clients with psychosis, female perpetrators, recovered memories, and ritual abuse may be particularly marginalised accounts. These aspects could be marginalised by a lack of discourse or dominant discourses, and by a lack of knowledge or reliance on unreliable sources of knowledge. Educators and social workers commented that CSA threatens internalised and often cherished socio-cultural beliefs and norms regarding gender, family, and what it means to be human. While often identifying and standing against dominant discourses and popular culture which marginalised CSA, these influences appeared to have greater leverage when there was a lack of professional knowledge and experience. Survivors of CSA commonly speak of the silencing
effects of these societal messages (Breckenridge et al., 2008; Martsolf et al., 2010). Therefore denial and silence can be seen to be socially reinforced (Zerubavel, 2006), with the most marginalised forms of CSA likely to be most silenced:

The conflict between the will to deny horrible events and the will to proclaim them aloud is the central dialectic of psychological trauma. People who have survived atrocities often tell their stories in a highly emotional, contradictory, and fragmented manner that undermines their credibility and thereby serves the twin imperatives of truth-telling and secrecy. When the truth is finally recognized, survivors can begin their recovery. But far too often secrecy prevails, and the story of the traumatic event surfaces not as a verbal narrative but as a symptom. (Herman, 1997, p. 1)

**Psychosis**

In this study, some participants questioned the credibility of disclosures of CSA from clients suffering with psychosis, consistent with other mental health professionals’ views (Agar & Read, 2002; Read & Fraser, 1998a, 1998b; Warne & McAndrew, 2005). Interestingly, one social worker with the longest experience of working with clients with psychosis, who was also aware of the association between trauma and psychosis in the literature, was the strongest advocate for believing their disclosures. Understanding the associations between prior trauma and psychosis would therefore assist social workers to hold the possibility that CSA may be a valid issue, and to be cognisant of the risks of re-traumatisation and re-victimisation (Ashmore, Spangaro, & McNamara, 2015; Barnett & Lapsley, 2006; Bloom & Farragher, 2010, 2013; Grubaugh et al., 2011). Without routinely assessing for the presence of trauma histories and trauma symptoms, any links between psychotic symptoms and past trauma remain unrecognised, a biogenetic paradigm is likely to dominate, and treatment may be ineffective (Larkin & Read, 2008; Morrison, Frame, & Larkin 2003; Moskowitz, 2011; Tucker, 2002).

**Recovered memories**

Participants’ perceptions regarding recovered memories of CSA ranged from personal experience to extreme scepticism about their validity. However, no social worker expressed a fear of inducing false memories through CSA inquiry and response, as has been found in other studies (Lab et al., 2000; Young et al., 2001). Participants who had little theoretical, professional, or personal knowledge to draw upon either sat on the fence or expressed doubt, with one drawing on popular culture. Conversely, those participants who had knowledge of trauma appreciated the potential for traumatic memory to be fragmented and compartmentalised. Without this knowledge, social workers are unlikely to be aware of the
ubiquity of fragmented memory and delayed recall among CSA survivors (Briere & Conte, 1993; Chu et al., 1999; Gold, Hughes, & Swingle, 1999; Herman & Shatzow, 1987; Schultz, Passmore, & Yoder, 2002; Williams, 1994; Wilsnack, Wonderlich, Kristjanson, Vogeltanz-Holm, & Wilsnack, 2002).

Amy’s detached recounting of her recovered memory of CSA at age 39 and subsequent therapy conveyed a straightforward process, yet the process was unlikely to be simplistic and conflict-free. At some point Amy had to take a position regarding the validity of this disturbing material in order to decide what she wanted to do about it. Clients may therefore need support “in tolerating the ambiguity of the situation” and managing their distress as they try to make sense of the material (Nelson & Hampson, 2008, p. 26). In reality, professionals will often be unable to discern the veracity of any disclosure, and this does not provide a barrier to a validating response (Kluft, Bloom, & Kinzie, 2000). As opposed to the ability to construct narratives from autobiographical memory, the sensory and fragmentary nature of traumatic memory might feel surreal, unreliable, and crazy-making (Morrow & Smith, 1995). Psycho-education about trauma and the nature of traumatic memory can therefore provide clients with important information to counter self-condemnation, and dominant discourses which medicalise misery.

Ritual abuse

Similar to the findings regarding recovered memories and psychosis, having some practice or personal experience of the topic of ritual abuse appeared to increase its credibility. This is consistent with practitioner perspectives regarding ritual abuse in other studies (Andrews et al., 1995; Bottoms, Shaver, & Goodman, 1991; Pack, 2009). Participants ranged from absolutely no knowledge to limited knowledge based on a small number of clients, media reports, or their Christian faith. For two participants, their knowledge as Christians informed their view that satanic ritual abuse was a very real phenomenon. Surprisingly, only one participant expressed scepticism, which was in relation to satanic ritual abuse reported in Scotland, while three other participants who drew on media reports remained neutral. Perhaps this was because of their previously stated caution regarding the sensationalised nature of media reports of CSA. It may seem incomprehensible, and therefore improbable, that babies and children are sexually abused and tortured in bizarre rituals organised by groups of adults vested with their care. Often reminiscent of a tacky horror movie, the ritual elements can obfuscate the acts of sexual sadism and torture of babies and children (Salter, 2012a, 2012b). The reality of the latter have certainly come to light in child pornography statistics, where 21%
of all pornography involves torture and bondage, and 19% involves children under three (Wolak, Finkelhor, & Mitchell, 2005). As Bloom (1994) has noted, perhaps the greatest danger is that “as we colluded for the last century in denying the reality of child abuse, so too will we deny the more flagrant examples of human evil” (p. 477). Like every other facet of CSA, ritual abuse remains a contested domain. Nevertheless, there is reputable academic and practitioner-based support, information, and research available.

**Gender implications**

Participants highlighted a range of social constructions and norms, as well as societal attitudes and stereotypes regarding gender which constituted barriers to disclosure. They noted that males were primarily positioned as perpetrators and females as victims. Yet participants also recognised that a highly sexualised popular culture and dominant discourses regarding male and female sexuality, positioned girls and women as sexual objects and men as consumers. They noted that young women wearing revealing clothing, and those who were sexually active and/or engaged in acting out and risk-taking behaviour, were especially at risk of being perceived as seductresses rather than victims. Sexually abused girls, who have internalised messages that they need to be the gatekeepers to male sexual desire, may therefore doubt their victim status, and instead blame themselves, or accept sexual victimisation as the norm (Hlavka, 2014).

Participants from both samples believed male sexual victimisation and CSA perpetration by females were particularly under-reported and under-recognised. They noted that hegemonic masculinity was likely to silence male victims through demands for restricted emotionality and toughness, and affect their interpretation of events because of expectations that all sexual activity should be enjoyed. The idea that men are trapped by these masculinity norms was expressed by several participants, and authors have noted the costs to male CSA victims in conforming to masculine stereotypes (Alaggia, 2005; Easton, 2014; Gardner, 2005; Lew, 2004; Spataro, Moss, & Wells, 2001). Similarly, participants noted that dominant

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90 For example, the Christchurch Civic Creche case in 1993 has continued to polarise the NZ nation, including academics (Davis & Masson, 2003; Hood, 2001; NZ Herald, 2007).

91 Two academics have written extensively about ritual and organised forms of abuse, based on personal experience of supporting a victim (Salter, 2012b; Scott, 2001). Many other clinicians have provided case studies and research regarding ritual abuse (Epstein, Schwartz, & Wingfield Schwartz, 2011; Miller, 2011; Noblitt & Noblitt, 2008; Ross, 1995). The International Society for the Study of Trauma and Dissociation (ITSSD) in USA has created a special interest group on ritual abuse and mind control (ITSSD, 2016), and Advocates for Survivors of Child Abuse (ASCA) in Australia have produced information for practitioners regarding ritual abuse (ASCA, 2002; ASCA, 2006).
discourses regarding femininity, which emphasise nurturing and empathetic qualities, obscure societal awareness of female perpetrators. This “idealisation of women” not only camouflages female perpetrators, but also trivialises any sexual abuse by women that does come to light, rendering it less harmful (Hetherton, 1999, p. 171).

In this study, participants appeared very aware of gender issues as barriers to victim status and disclosure, perhaps reflecting their self-selected participation and commitment to the topic of CSA. However, some male participants struggled to resist the dominant perception that female perpetrated sexual abuse was less harmful, particularly for male victims. This is understandable given that they were attempting to counter masculine and feminine sex-role stereotypes. Participants, in general, found female perpetrators an enigma, struggling to understand their motivation in the context of dominant perceptions regarding femininity and female sexuality. Other studies reveal that professionals are not immune from stereotypical notions and socio-cultural norms regarding male victims, and female perpetrators abusing male and female victims, which can lead to low rates of inquiry and poor responses to disclosures (Denov, 2003; Hetherton & Beardsall, 2003; Lab et al., 2000; Peter, 2009). These issues highlight the need to consider the influence of dominant discourses regarding masculinity and femininity, when addressing CSA in social work practice and education.

**Discourses and silences**

Several participants emphasised the importance of public campaigns and forums to provide a space for discourse about CSA to occur. Such forums could also challenge discourses which minimise, obscure, or endorse sexual victimisation, but several also commented on the need for more balanced discourse regarding perpetrators. One participant suggested launching a similar campaign for CSA as the anti-domestic violence campaign, “It’s not OK”, and this has also been suggested by the Ministry of Women’s Affairs (2009). However, in NZ, CSA continues to be an issue which receives comparatively little public or statutory attention. With regard to Vulnerable Children policy, the MSD has set a target of reducing physical abuse by 5%, but there is no mention of reducing CSA (MSD, 2012e). While widespread abuse of children in State care has been documented within NZ, with recommendations for an inquiry into institutional abuse (Henwood, 2015; Radio New Zealand, 2016a; Stanley, 2016a, 2016b), the NZ government does not believe an inquiry to be necessary (Radio New Zealand, 2016b).

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92 The “It’s not OK” campaign involved a series of television advertisements designed to make “the issue of family violence visible and relevant for New Zealanders” and, through a number of community surveys, it has been assessed as having had “a significant influence in motivating discussion and change” (McLaren, 2010, p. 3).
In contrast, Australia and the UK have initiated government inquiries regarding institutional CSA.\(^\text{93}\)

**Summarising the findings supporting routine inquiry**

Joining together all the threads reveals the multiple and sometimes insidious effects of CSA upon survivors, and the likelihood of poorer outcomes when children and youth have not had the opportunity to gain support. Clearly, participants acknowledged the potential negative impact of CSA upon the development and maintenance of clients’ mental health and substance abuse problems. The majority of participants in both sample groups offered estimates of community prevalence of CSA that were consistent with the research (Dube et al., 2005; Fanslow et al., 2007; Pereda et al, 2009). In addition, the majority of social workers believed the prevalence of CSA among clinical populations to be significantly higher, as the literature indicates (Read et al., 2005). Less recognised were the impact of unresolved CSA on parenting, relationships, and physical health, and the risks of re-victimisation and poly-victimisation. Participants’ perspectives suggest that CSA survivors who enter mental health and addiction services may have been silenced by familial and socio-cultural dynamics, and that attempts to disclose have not always led to support. Consequently, this group of survivors may be caught in a vicious circle of cumulative, unresolved, and sometimes inter-generational trauma, exacerbated by unhelpful coping strategies and relational difficulties. A paradox emerged in participants’ recognition that clients’ problems were often complex, multiple, and inter-related, rather than solely oriented to the experience of sexual abuse. In the absence of routine CSA inquiry and trauma assessments that explored and addressed the impact of all forms of abuse across the lifespan, the potential complexity of presenting issues could not be fully appreciated. Clients’ histories of CSA could therefore become the elephant in the room.

In summary, the finding that participants are aware of the potential links between CSA and mental health or addiction is evident in other studies with professionals (Breckenridge et al., 2010, 2012; Day et al., 2003; McLindon & Harms, 2011; Nelson & Phillips, 2001). However, in keeping with my findings, these studies revealed that, for many respondents, these links did not justify routine CSA inquiry and/or inclusion within treatment plans. In Chapter Three, I summarised the professional beliefs and concerns, organisational barriers, and client

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\(^{93}\) In Australia, a Royal Commission into Institutional Responses of Child Sexual Abuse has been set up (Middleton et al., 2014b; Palmer, 2016), and a similar inquiry entitled the Independent Inquiry into Child Sexual Abuse (IICSA) has been undertaken in the UK (IICSA, 2016).
characteristics that deter asking about abuse, or justify not asking. I turn to these issues in the light of my findings.

**Child sexual abuse and mental health and addiction practice**

Inquiry and response regarding CSA is a thorny and intricate issue, full of paradoxes and quandaries. I therefore unpack and examine each issue raised by participants, using a dialectical approach to move back and forth between seemingly opposing concepts, holding the truths of both in balance to develop a more nuanced picture. This study confirmed much of what has been found in other studies. Asking about a history of CSA and other abuse is generally sporadic and inconsistent in mental health (Cusack et al., 2006; Lab et al., 2000; Hepworth & McGowan, 2013; McLindon & Harms, 2011; Nelson & Hampson, 2008; Read & Fraser, 1998; Rossiter et al., 2015; Warne & McAndrew, 2005), and/or addiction services (Breckenridge et al., 2010, 2012; Chessen et al., 2011). Participants in this study expressed anxiety, discomfort, and even resistance at the thought of routine inquiry, and revealed that complex, and often inter-related barriers exist at personal, professional, and organisational levels.

**Client distress and stress associated with asking about CSA**

Many participants in this research were concerned that their clients may be offended, distressed, or de-stabilised by asking about CSA. Again, this is a common concern among mental health professionals often associated with the “can of worms” metaphor (Knight, 2015; Young et al., 2001; Nelson & Hampson, 2008). These apprehensions about the impact of asking about CSA on the welfare of the client appeared largely based on imagining clients’ reactions, rather than actually experiencing such reactions. Participants’ responses suggested that the traumatic effects of CSA could present as a reason to inquire and a reason not to inquire. Clients perceived as particularly vulnerable and “risky” through recurrent periods of crisis, hospitalisation, and/or detox appeared least likely to be asked. Those with the most serious mental health problems have been shown to have particularly high rates of CSA (Pirard et al., 2005; Courtois & Bloom, 2000; Mauritz et al., 2013; Meuser et al., 1998; Read et al., 2005; Schneider et al., 2008), and multiple forms of childhood maltreatment (Ford, Wasser, & Connor, 2011). In addition, penetrative forms of CSA have been associated with more severe mental health problems (Cutajar et al., 2010a, 2010b). Substance abusing clients with a history of CSA compared to those without histories also have more severe and complex presentations (Brems et al., 2004; Jarvis & Copeland, 2002). Again, there is a paradox that those potentially
most distressed by the impact of past abuse on present functioning, who may also have
experienced severe sexual abuse, may be the least likely to have their trauma histories
addressed. Without addressing the potential impact of CSA on clients’ addiction and mental
health problems, and assisting clients to manage the effects, therapeutic engagement, treatment,
and recovery are likely to be compromised (Boles et al., 2005; Brems et al., 2004; Knight,
2015; Markoff et al., 2005).

At the same time, participants’ concerns about establishing safety before inquiring are
clearly supported by the literature. Clinicians must have the flexibility to defer taking trauma
histories when clients are highly distressed (Briere et al., 1997, Read, Hammersley, &
Rudgegeair, 2007; Young et al., 2001). However, the metaphor of the “revolving door” draws
attention to the vicious circle created by the effects of unidentified and unresolved trauma,
perpetuated by well-meaning attempts to protect the risky, vulnerable client. This prevents
understanding potential traumatic antecedents to crises and diminishes the inherent opportunity
for clients to grow and learn from crisis (SAMHSA, 2009). Recurrent crises “signal a failure to
address underlying issues appropriately” and should lead to careful re-assessment (SAMHSA,
2009, p. 9). In addition, the emphasis on clients’ vulnerability may be indicative of a common
countertransference response to clients with trauma and substance abuse problems, as discussed
in Chapter Two (Najavits, 2002).

Practitioner and client perspectives regarding CSA inquiry and response were traversed
in Chapter Three. Bearing in mind the need for some flexibility, clients with serious mental
health problems can tolerate CSA inquiry and other trauma assessments, even when they have
never disclosed before (Briere et al., 1997; Cusack et al., 2006; Goodman et al., 1999; Lothian
& Read, 2002; Tucker, 2002). Just as participants believed children need someone to notice and
respond to conscious and unconscious cries for help which assist them to tell, Nelson and
Hampson (2008) argue that adult survivors with unresolved trauma are in similar need:

There is an anxiety that trying to help survivors explore issues can worsen
things and in some situations they may indeed feel worse before they feel
better. However, people who try to kill or mutilate themselves, seek oblivion in
drink or drugs, sometimes lose their children into care as a result, suffer
frightening hallucinations, have endless nightmares and flashbacks, or chronic
physical pain, are not feeling OK. They are also trying to tell us something, and
it is hard to imagine what more they have to do. (p. 17)
Clients will tell when they are ready

Participants’ belief that clients will tell when they are ready is another common perception among mental health professionals, often linked to concerns about distressing or offending clients (Nelson & Hampson, 2008). In this study, disclosures in the absence of CSA inquiry appeared sparse, resonating with other research (Agar, Read, & Bush, 2002; Briere & Zaidi, 1989; Read & Fraser, 1998a). Nevertheless, the literature also supports participants’ beliefs that some clients may not be ready or able to disclose, through lack of trust and sense of safety, denial, minimisation, shame, and dissociation of abuse experiences (Breckenridge et al., 2010; Collin-Vézina, De La Sablonnière-Griffin, Palmer, & Milne, 2015; Henderson & Bateman, 2010; Kluft et al., 2000; Knight, 2015; Lab & Moore, 2005; Rossiter et al., 2015; SAMHSA, 2014b). Some survivors may deny a history of sexual abuse at first contact (Schacter et al., 2008; Scott et al., 2014).

Survivors are caught in a “cruel paradox”; compelled to ruminate about and/or relive the trauma, yet equally compelled to suppress and avoid it (Harber & Pennebaker, 1992, p. 360). Certainly, all participants were aware of the range of negative emotions inhering in the decision and process of telling. Many were also aware that disclosure difficulties may be exacerbated by previous poor responses. One social worker suggested that clients can benefit from being asked again at later stages, if the initial response was negative, and there is also support for this in the literature (Kluft et al., 2000; Rosenhow et al., 1988; SAMHSA, 2014b). Routine, sensitive, and direct CSA inquiry gives clients the message that services consider such histories relevant, are willing and able to hear about clients’ experiences, and can provide support (Harris & Fallott, 2001; Knight, 2015).

Participants were concerned to give clients control of the timing and nature of their disclosure, given the powerlessness inherent in the experience of CSA. However, the literature suggests there are many effective ways to give clients power when inquiring about CSA. As part of assisting the client to retain control over their disclosure, clients can be given the option of declining to answer, along with an acknowledgement of the difficulties of disclosure (Elliot et al., 2005, Read et al., 2007; SAMHSA, 2014b).

One participant commented that mental health assessments were already lengthy and likely to be overwhelming for clients. Consequently, it has also been recommended that clients be given the option of taking a break in the assessment (Klinic Community Health Centre, 2013), and taking a trauma history over more than one session (Kluft et al., 2000; Tucker, 2002;
SAMHSA, 2014b). In other studies, mental health professionals have cited a lack of time within assessments to address abuse issues such as CSA (Read et al., 2007), and survivors may be inhibited by awareness of professionals’ time pressures (Schacter et al., 2008). Inquiring about CSA is not some tick-box affair, it necessitates adequate time for a sensitive and adequate response. If there is insufficient time for an effective response, Read et al. (2007) recommend deferring inquiry, recording that inquiry has not been made, and considering treatment plans incomplete until inquiry is completed.

**Indirect and selective inquiry**

Several participants identified a preference for indirect inquiry, normalising the links without always asking overtly, consistent with other studies (Breckenridge et al., 2012; McLindon & Harms, 2011). They were more likely to make this type of inquiry when they had a sense that CSA may be part of a client’s history. Clients with CSA histories could therefore fall through the net of selective and indirect inquiry. As discussed in Chapters One and Three, behaviourally specific questions are recommended because clients may not always define their experiences as abuse, and/or may utilise defences of minimisation and denial to protect against the pain of acknowledging that exploitation and betrayal occurred. Participants highlighted the challenges for males, not only in disclosing, but interpreting their experiences as CSA, particularly when abused by females. Asking in a clear and unambiguous way may therefore represent the first steps in initiating greater awareness of the impact of CSA, and its status as a crime.

In contrast, my findings suggest that the use of behaviourally specific questions may not be so appropriate for Pacifica cultures, and may increase denial. Two educators and one social worker discussed the need for more subtle and metaphorical approaches to addressing CSA in education and practice, for Pacifica students and for clients. The use of metaphor to address sensitive issues for Pacifica is supported by the literature (Makasiale, 2007; Matai’a, 2006). Respecting a Pacifica preference for indirect communication, and the use of metaphors as codes to address taboo or difficult topics, protects and opens the va’one space, a metaphor for the therapeutic alliance (Mila-Schaff, 2006; Mila-Schaff & Hudson, 2009). This has important implications for culturally sensitive practice and education, but perhaps also requires further research to ascertain metaphors alluding to CSA in each Pacific culture.

While participants preferred to build a relationship before inquiring about CSA, the initial psycho-social assessment provides a context for asking. It offers many natural
opportunities to make inquiry and may encourage rather than threaten rapport (Read et al., 2007; Young et al., 2001). Workforce development documents in NZ highlight the need to utilise assessment as the first stage of engagement and building a therapeutic alliance (Matua Raki, 2014). One participant provided an example of prefacing the inquiry with a normalising statement to highlight associations between CSA and mental health/substance abuse. This prepares clients, provides a rationale for asking, and indicates that inquiry is routine (Everett & Gallop, 2001; Knight, 2015; Schacter et al., 2008). Survivors appreciate an understanding of why the clinician is inquiring, reassurance about the routine nature of inquiry, and a clear definition of trauma (White et al., 2016). These aspects help clients retain control, reduce stigma, and approach inquiry within a psycho-educative framework.

Responding to clients’ disclosures of CSA

The literature on appropriate responses to disclosure is beguilingly straightforward, and in one sense it is, in that it is first and foremost, relationship-based and client-directed. Participants placed a high priority on these two factors in their practice, consistent with workforce expectations in NZ (MOH, 2008a; 2012a; Te Pou, 2010; Todd, 2010). Much literature exists to support the importance of the therapeutic relationship (Horvath, 2005; Lambert & Barley, 2001; Pearlman & Courtois, 2005; Nathan & Gorman, 2007; Norcross, 2002, 2010; Roth & Fonagy, 2006). Not only are mental health and addiction staff expected to be “well-trained in developing an effective therapeutic alliance” (Te Pou, 2009a, p. 26), but also to recognise factors which can hinder therapeutic engagement, such as “interpersonal and attachment style”, and “intrusive memories and thoughts connected to a history of trauma” (Te Pou, 2010, p. 20). The latter factor highlights the importance of understanding how trauma histories are impacting on clients in the present.

While some social workers felt ill-equipped to respond to a disclosure of CSA, several authors argue that many of the skills necessary for effective response are already within the social work toolkit. These include empathy, listening skills, being non-judgemental, and responding to feelings (Knight, 2015; Palmer et al., 2001). Social workers can do much to reduce a client’s sense of vulnerability by conveying receptivity, validation, sensitivity, and empathy. Ultimately, youth and adults with CSA histories value the simple human quality of being listened to above all else (Barnett & Lapsley, 2006; McNaughton Nicholls, 2012; Nelson, 2001; Nelson & Hampson, 2008; Smith, Dogaru, & Ellis, 2015). Several participants

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94 Matua Raki (2014) note that when assessments are carried out “skilfully and empathically” they may also be “therapeutic” (p. 19).
commented that clients were highly perceptive of non-verbal and implicit reactions to their disclosures and “tested the waters” regarding the worker’s receptivity and comfort (Ford et al., 1999). These observations correspond with survivors’ perspectives, who suggest that much of what constitutes helpful and sensitive inquiry and response relates to the non-verbal and emotional realm (Martsolf et al., 2010; Nelson, 2001, 2004; White et al., 2016).

On the other hand, one participant highlighted the need for skills and knowledge regarding the sensitive pacing of questions and grounding techniques following disclosure. This knowledge of the impact of trauma is consistent with a trauma-informed approach, as identified in the Let’s get real framework (MOH, 2008a, 2010). An understanding of trauma dynamics enables clinicians to assess for signs of traumatic stress in clients’ day to day living, as well as monitoring for hyperarousal and dissociation that emerge in the interview process, so as to pace the assessment process accordingly (Henderson & Bateman, 2010; Kezelman & Stavropoulos, 2012; Kluft et al., 2000). In this study, only a small minority of participants demonstrated a “thorough understanding of the neurological, biological, psychological and social effects of trauma on people” as identified in Let’s get real (MOH, 2008a, p. 27). It was unclear how many participants were aware of grounding techniques, however, assisting clients to develop coping skills is a core part of addiction and mental health work. Those working in AOD were already using motivational interviewing and other counselling models, and several also had postgraduate training in counselling. Planning for the possibility of increased distress after disclosure necessitates determining support networks, providing out of hours resources, and identifying self-care and coping skills strategies (Nelson & Hampson, 2008; Schacter et al., 2008). These issues are routinely addressed in mental health and addiction services as part of assessment and case management.

Some participants were concerned that they moved immediately into a therapy role by asking about, and potentially opening up the topic of CSA. Several authors suggest that it is not necessary or advisable to press for details of CSA following disclosure (Knight, 2015; Read et al., 2007; Schacter et al., 2008). Survivors also consider it unhelpful for professionals to push for details, or show an excessive interest in CSA (Martsolf et al., 2010). There is a fine balance in inquiry and response which requires being sensitive and attuned to individual needs. Probing too deeply is unhelpful, but shutting the clients down in any way, explicitly or implicitly, potentially re-enacts the silencing messages that clients may have received from perpetrators, family, and society (Elliott et al., 2005). Clients may need professionals to ensure they are not overwhelmed, but equally not given messages that discussing the abuse is dangerous.
Nevertheless, in this study, compartmentalised services led some participants to feel that they needed to offer immediate referral to a specialist agency upon a client’s disclosure. Clients may be made to feel like a hot potato if they are given the impression that the topic of CSA is not within the bounds of the service, and this was considered particularly problematic for Pacifica clients who prefer holistic services. As participants pointed out, disclosure is a process rather than a one-off event. Examples were given of clients who had never disclosed before, and were not ready to be referred. Recognising that not all survivors of CSA will want to immediately engage in specialist therapy after disclosure is consistent with the literature (Breckenridge et al., 2010; McLindon & Harms, 2011; Nehls & Sallmann, 2005; Schacter et al., 2008). The timing of this discussion will depend on the needs of the client, rather than being an automatic response to disclosure. As discussed before, participants were aware that clients may have previously experienced negative responses to disclosure and within therapy. Asking clients if they have ever disclosed before and, if so, what responses they received, and what help they have sought, is an important part of responding to a disclosure, which assists clinicians to understand the stage clients are at (Read et al., 2007).

One participant discussed the need to educate clients about the different types of therapy available and what to expect. This assisted clients to make informed choices about therapy and to ascertain whether their needs were being met. This is a practitioner skill under the Let’s get real framework (MOH, 2008a; Te Pou, 2009d), and information has been produced for clients regarding the various forms of therapy available (Te Pou, 2009b).95 Other participants felt they needed further information about the resources available in the community, and several discussed the paucity of services for male clients. From a social justice and empowerment perspective, social workers have a role to play in highlighting gaps in services and advocating for clients to receive services. Yet awareness of a lack of services perhaps also inhibited inquiry.

**The middle ground of trauma-informed practice: Making links**

One of the key ways in which some participants felt they could potentially address CSA was through assisting clients to make links between their past victimisation and present problems. While several participants appeared concerned that any discussion of a client’s history of CSA moved into the realm of therapy, and therefore beyond their work remit, others felt there was a middle ground. Participants who felt most competent and comfortable to

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95 This is a wieldy document and needs to be simplified in brochure form for clients.
respond to a disclosure of CSA, appeared most willing to help clients identify associations between past and present. Assisting clients to understand the impact of trauma upon their present functioning, relationships, and health is an empowering and destigmatising intervention (Breckenridge et al., 2010; Kluft et al., 2000; Nelson & Hampson, 2008). Many do not perceive or appreciate the links between a past history of CSA and current problems (Bloom & Farragher, 2013; Courtois, 2004; Covington, 2003, 2012; Read et al., 2006). Ultimately, survivors reveal a need for professionals to keep the dialogue open regarding CSA in the context of the service they are attending (Breckenridge et al., 2008; Martsolf et al., 2010; Nelson & Hampson, 2008; Schacter et al., 2008, Scott et al., 2014). Professionals must therefore manage their own discomfort while containing that of their clients. This safe and acknowledged space assists clients to develop positive coping strategies to regulate emotions and manage the effects of CSA. This is consistent with workforce expectations in the Let’s get real framework mentioned in Chapter Three: “to mitigate the physical, social and emotional effects of trauma and abuse on people’s lives” (MOH, 2008a, p. 9).

Participants’ discussions about the nature of CSA therapy and its timing with substance abuse therapy varied. However, there appeared to be a general consensus that clients needed to attain some level of safety and stability, before discussing CSA events in detail. This is reminiscent of a staged model of sexual abuse and trauma treatment as discussed in Chapters Two and Three. The first stage is focused on achieving safety and stability, through psychoeducation and skills building to recognise and manage the effects of abuse and trauma (Courtois, 2004; Dass-Brailsford, 2007; Haskell, 2003; Herman, 1997). While some believed that processing and integrating trauma at some level was important, others noted that not all clients may need, or desire to progress from the first stage. This latter view is consistent with Courtois (2004), who makes a similar point stating “Some clients never move beyond or complete Stage 1…. Some clients may have no need to move into the latter two stages” (p. 419).

In this study, stage one work was being carried out formally in a DBT programme for just ten clients with a diagnosis of borderline personality disorder, who had substance abuse problems. Borderline personality disorder is often associated with a history of childhood abuse, neglect, and trauma coupled with poor attachments and problems with affect regulation (Briere & Scott, 2014; Miller, 2002). Te Pou has endorsed the use of talking therapies in mental health and addiction, and notes that DBT is a promising though costly intervention involving specialist training and longer-term treatment (Te Pou, 2009a, 2009b, 2009c, 2010). Clients generally attend a one year programme of individual and group therapy which “seeks to improve
interpersonal, self-regulation and distress tolerance skills by integrating behavioural strategies with mindfulness practices” (Te Pou, 2010, p. 54).

Several participants felt that abstinence from substances was an essential condition of stability, whereas others felt that CSA therapy and substance abuse therapy could be dealt with concurrently. In the latter view, there appeared to be a general expectation that such integrated treatment would occur elsewhere. While there did not appear to be any overt organisational commitment to routinely addressing the impact of a past history of CSA upon current problems, some participants discussed the role of psychoeducation, and interventions such as timelines and genograms, to help clients perceive the links. This work appeared to be carried out in an ad hoc and often implicit fashion, almost functioning under the radar of business as usual. In the field of substance abuse and mental health, psychoeducation is often utilised regarding medication issues, alcohol and other drugs, self-care, and coping skills (Lukens & McFarlane, 2004; Walsh, 2010). Clearly, there is potential for psycho-educational interventions to assist clients to understand and manage the impact of abuse, and its traumatic effects on mental health and substance abuse problems, which fits with stage one trauma work. However, this requires a significant paradigm shift within mental health and addiction services to locate abuse and trauma as core business, rather than a peripheral issue to be referred elsewhere, if and when it comes up.

Participants with an understanding of trauma saw the benefits of psychoeducation, in reframing clients’ trauma responses and substance abuse as understandable, normal reactions to overwhelming events. As discussed in Chapter Three, several manualised forms of treatment for trauma, substance abuse, and mental health problems have been developed, which can be administered in group settings or in individual work. This small minority of practitioners already had the knowledge and skills to facilitate such stage one groups. This work can assist clients to counter prevailing individualising and medicalising discourses, and the accompanying stigma and sense of abnormality (Bloom, 2013; Bloom & Farragher, 2010, 2013; Covington, 2003, 2008, 2012; SAMHSA, 2014b). Many argue that mental health and addiction professionals are well placed to carry out the work of making links between trauma, mental health, and substance abuse through such integrated first stage treatment (Briere & Lanktree, 2013, 2014; Covington, 2003; Fallot & Harris, 2002; Ford & Russo, 2006; Haskell, 2003; Knight, 2015, Miller & Guidry, 2001; Najavits, 2002; SAMHSA, 2014a, 2014b; Veysey & Clark, 2004).
All participants demonstrated awareness that clients’ problems with managing the impact of CSA may be inextricably linked with triggers to substance abuse and poor mental health. While they sometimes spoke of more overt trauma triggers such as intrusive memories and intense emotions, only a few discussed more subtle emotional and physical manifestations and alterations in consciousness. The latter may not be obviously associated with the past, and are therefore easily attributed to present events (Briere & Lanktree, 2014; Courtois, 2004). This requires practitioners to have an adequate understanding of trauma, so they can assess for the more subtle presentations of traumatic stress, and assist clients to identify and manage these implicit invasions of the past upon current functioning. Participants’ comments regarding the merits of psycho-educative interventions therefore suggest the need for some type of assessment of clients’ trauma symptoms. While the literature suggests that formal screening tools may be more effective at picking up PTSD, a full psycho-social assessment may also ascertain post-traumatic stress and complex trauma not meeting the threshold for a PTSD diagnosis (Courtois, 2004).

**Fusion of organisational and individual barriers: The role of social defences**

The reported paucity of organisational support for routine CSA inquiry and response in this study is reminiscent of other findings within mental health and addictions services (Agar et al., 2002; Ashmore, 2013; Breckenridge et al., 2010, 2012; Day et al., 2003; McLindon & Harms, 2011; Nelson & Phillips, 2001; Posner et al., 2008; Young et al., 2001). The main organisational barriers cited by participants in this study were a lack of training and support, a predominant medical model, and services operating as “silos”, corresponding with Breckenridge et al.’s (2010) study. Despite a mandatory risk assessment and an abundance of literature highlighting a history of CSA as a risk factor for suicide and self-harm (Beautrais et al., 2005; Bruffaerts et al., 2010; Cutajar et al., 2010a; Martin et al., 2004; MOH, 2003, 2006, 2008c; Molnar, et al., 2001; Plunkett et al., 2001; Read et al., 2001), there was no expectation for CSA inquiry to occur. The organisational culture, as described by participants, appeared to emphasise strictly demarcated boundaries between services, and located CSA as a specialist, expert domain. This reflects the NSF’s position discussed in Chapter Three, which states that mental health and addiction services are not funded to provide services solely related to sexual abuse (2015a). This black or white, all or nothing mentality within governmental and

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96 The service specification for mental health and addiction services was first published in 2009 with a small number of minor amendments up to 2015. However, there has been no alteration regarding the position statement mentioned.
organisational culture is likely to filter down to individual levels. At the same time, dichotomous thinking and silo mentalities may be reinforced by anxiety at all levels of the organisation.

Participants’ discomfort was reflected in verbalised, embodied, and emotional reactions to discussing CSA and perpetrators. They described being affected on a visceral level whether they had knowledge and experience in working with CSA or not, and whether they had personal experience of CSA or not. With regard to CSA inquiry and response, emotional discomfort emerged as a key feature in all of participants’ accounts, but for many different reasons. All participants noted taboos around sex and CSA, which elicited discomfort in broaching the topic with clients. Their knowledge of the difficulties of disclosure led to a fear of offending clients and being intrusive. This in turn supported a preference to build a relationship before asking, and for some provided a rationale for the belief that clients would tell when ready. Many felt anxious about inquiring and responding because of their lack of training, and the lack of organisational support. Several participants appeared concerned that any discussion of a client’s history of CSA moved into the realm of therapy, and therefore beyond their work remit. Others were fearful that CSA inquiry could destabilise vulnerable clients. Both lack of training and fear of destabilising clients, even with training, were linked to notions of doing more harm than good, and opening up a can of worms.

No social worker specifically voiced a concern about VT as a potential outcome of CSA inquiry and response, as cited in another study (Eilenberg et al., 1996). However, it was clear that all were aware of the negative emotional impact in engaging with the topic. The potential for VT was therefore an implicit but pervasive thread in participants’ accounts. Some had made decisions not to work in the field of CSA, and one felt it was helpful to take a break from the field. In addition, two social workers discussed the need for professionals to have worked through their own histories of CSA to some extent in order to minimise countertransference. As discussed in Chapter Two, unrecognised countertransference can increase the risk of VT. The cost to self in addressing trauma such as CSA, even at the level of basic inquiry and response, cannot be under-estimated. Studies of AOD clinicians and social workers who work with trauma have found significant rates of STS or VT (Bride, 2007; Bride et al., 2009). Part of being trauma-informed requires ongoing organisational support to address and prevent VT through supervision, peer support, and training (Berger & Quiros, 2014; Read et al., 2007). Participants’ concerns regarding the welfare of clients were perhaps more overt, but the emotional cost to the personal and professional self was a constant under-current.
Figure 3, which I devised as part of my analysis of the findings, summarises the multifaceted and inter-related influences on CSA inquiry and response.

All of participants’ concerns and fears about asking could be somewhat contained by organisational cultures which did not expect staff to routinely inquire about CSA, or incorporate CSA into treatment plans. Drawing on psychodynamic literature, Diamond, Allcorn, and Stein (2004) suggest that the silo metaphor functions to defend against anxiety at individual and organisational levels. Psychological defences emerge as a means to deny, minimise, avoid, or evacuate negative emotions. These defences involve “taken for granted, frequently routine, rationalised, and unconscious dynamics of organisations” (Diamond & Allcorn, 2009, p. 3). Teasing out intertwined individual and collective defences is no easy matter. In both this study and Breckenridge et al.’s (2010, 2012) study, workers held various positions in relation to their organisational culture’s approach to trauma, from resistance to acceptance, and as barriers to inquiry or justifications not to inquire. Fallot and Harris (2009) discuss the role of “trauma champions” to spearhead and sustain change yet ultimately organisational commitment at workforce and government levels is also needed, so that trauma champions do not become trauma martyrs.
The case for routine inquiry

The lack of routine inquiry found in this study may seem surprising, given that there were certainly national expectations for the mental health workforce to address trauma histories at assessment and treatment stages. However, NZ social policy at the time of the interviews provided minimal focus on the impact of trauma and abuse on mental health and addiction problems. Unlike the Department of Health in the UK, where it has been policy to inquire about all forms of abuse in assessments since 2003, there was no government policy regarding routine inquiry at the time of the interviews, nor has there been any national policy since. Yet policy alone does not appear to create significant changes in practice. In the UK, between 2003 and 2008, rates of inquiry about CSA and other forms of abuse remained low, and many mental health trusts had not incorporated CSA into assessment forms (Scott et al., 2014).

While not a popular position among participants, many authors argue that routine inquiry and response regarding CSA, and other forms of abuse, is justified, given the significant associations between childhood abuse and mental health/addiction problems (Bloom, 2013; Day et al., 2003; Lab et al., 2000; Mansfield et al., 2016; McLindon & Harms, 2011; Nelson & Hampson, 2008; Read et al., 2006. 2007; Xiao et al., 2016). These views are now gaining a greater foothold in NZ mental health policy and workforce expectations through the trauma-informed groundswell across the world (MOH, 2012a, 2015c). Participants, if still working within a DHB, are now likely to be required to routinely assess for abuse and trauma within assessments. Yet without training and support there may well be continued resistance to routine inquiry. Sampson and Read (2016) have undertaken a chart review of 250 files within four community mental health centres in the ADHB, to ascertain whether staff have increased rates of asking about abuse and neglect since a similar audit of the same centres in 1997 (Agar & Read, 2002). While they found rates of identification of CSA increased from 20%–32%, they also found that 35% of client files (n =250), showed no evidence of any inquiry into abuse and neglect. Clearly, there is still some way to go in ensuring routine inquiry and response.

Most participants had received minimal training regarding CSA in their social work education and many felt ill-equipped to inquire and respond. The findings suggest the need for professional training if services were to successfully implement such practice. This study reveals that training needs to address workers’ resistance and concerns about CSA inquiry and response by acknowledging, as this discussion has, the difficulties, complexities, and benefits of such practice. Changing practice may elicit resistance and anxiety in managers and staff for
all the reasons that have been mentioned, but also because organisational change is anxiety-
provoking (Bovey & Hede, 2001; Diamond & Allcorn, 2009), particularly so, for organisations
experiencing chronic stress (Bloom, 2011). Training, supervision, peer, and organisational
support must therefore provide sufficient emotional safety and containment to address anxiety
and other negative affect. Otherwise, emotional discomfort at all levels may sabotage attempts
at organisational change (Diamond & Allcorn, 2009).

Addressing CSA within social work education

The next part of this chapter addresses the education implications of the findings,
taking into account both educator and social worker perspectives. A number of parallel
processes emerged in addressing CSA in social work practice and education. These issues are
discussed in the rest of this chapter and summarised below:

a) Assisting clients and students to make links between CSA and a range of
other mental/emotional, physical and relational problems

b) The benefits of psycho-education to understand, normalise and manage the
impact of direct or indirect trauma

c) Destigmatising CSA by normalising its prevalence for clients and student
survivors

d) Containing yet not shutting down students’ or clients’ disclosures

e) The risk of poor responses to clients’ or students disclosures

f) Pacing students’ and clients’ exposure to traumatic material

g) Client, students, social workers and educators may all be survivors of CSA

h) Emotional costs of addressing CSA for social workers, students and
educators: the risks of countertransference, indirect trauma and re-
traumatisation

i) Organisational barriers to addressing CSA

j) Fear of opening up a can of worms for clients or students

k) Concerns about destabilising clients or students

l) Concerns about intruding into private, sensitive areas for clients or students

m) Easier to address CSA when relationship has been built with client or
student
The topic of CSA: Space, place, and attention

The majority of social workers and all educators believed CSA to be a relevant issue for social work education, informed by their knowledge of its prevalence in community and clinical populations, and its widespread impact. Most believed the topic of CSA deserved a place in the undergraduate curriculum. Their views are consistent with a growing body of literature indicating the need for training in this area within social work education (Campbell & Carson, 1996; Cunningham, 2003; Day et al., 2003; Jones, 2002; Kenny & Abreu, 2015; Knight, 2015; Leech & Trotter, 2006; McKenzie-Mohr, 2004; Miller, 1999; Palmer et al., 2001). One social worker and one educator felt that CSA education may be more appropriate at master’s level, however only a small proportion of NZ social workers go on to postgraduate study (Beddoe, 2014; Pearman, 2011). Without some training at undergraduate level, the majority of social workers entering practice may be ill-equipped theoretically and emotionally to address CSA.

For some educators, the widespread and potentially long-term impact of CSA justified incorporating the topic into many areas of learning, to assist students to make the connections with other issues. Kenny and Abreu (2015) endorse the need to embed training in CSA within various social work papers. This might include “social welfare policies and services courses” and papers that address mental health and substance abuse problems (p. 579). Students are likely to benefit from connecting the dots between CSA and physical, developmental, mental/emotional, and social problems across the lifespan, as discussed in Chapters Two and Three. This encourages students to hold the possibility that CSA may be a relevant issue in a variety of practice areas. Awareness and consciousness raising regarding CSA emerged as an issue in relation to practice and education, and the experience of participating in the research. Assisting students to make links mirrored social workers’ perspectives about helping clients to appreciate links between CSA and current problems.

Despite the importance of making links with other related areas, educators also believed the topic required some structured lectures attending to specific dynamics and issues. Several also commented that “a little knowledge is dangerous”, and social workers noted the importance of recognising one’s limitations and not doing harm. These comments suggest that students could benefit from some dialogue about the practice limits of a basic working knowledge of CSA, without undermining capability to empathically address the issue using social work skills. For most educators, CSA was a core issue in social work and therefore required basic knowledge within a generalist programme, while at the other end of the spectrum...
of knowledge it was also a specialist field. The debate in the focus group regarding perceived
differences and similarities between responding to bullying and CSA highlighted the nuances in
perceptions regarding core and specialist knowledge. In contrast, polarising the issue of CSA as
a specialist and expert domain ran the risk of creating a “pariah” subject, leading to its
marginalisation in practice and education.

Suggestions regarding content of CSA training corresponded significantly with other
authors’ recommendations (Grady & Abramson, 2011; Kenny & Abreu, 2015; Myers, 2008).
However, certain areas were under-recognised or not discussed by educators in this study.
These included blaming the victim and/or non-offending mother, trauma and complex trauma,
traumagenic dynamics, and the ACE study. The latter could highlight the inter-relationships
between CSA and other issues, and the intergenerational impacts of trauma (Chapman et al.,
2004; Dube et al., 2003, 2005; Felitti et al., 1998; Larkin, Felitti, & Anda, 2014). As discussed
in Chapter Three, the ACE study has been used in trauma-informed training for mental health
professionals in NZ (Midland DHB, 2014). Only four social workers and one educator
discussed the need to teach about trauma as part of CSA training, and this was likely to have
been influenced by their own knowledge of trauma. The educator was already teaching about
trauma and VT within one lecture. NZ educators Marlowe and Adamson (2011) state that “the
concept of trauma is one that pervades a number of core teaching foci: human social
development; child protection; loss and grief; community work; mental health; and reflective
practices” (p. 624). While trauma may implicitly pervade many areas of social work education,
the degree to which it is explicitly addressed and taught will depend on educators’ knowledge
and experience. Understanding “trauma’s neurobiological toll” (Zilberstein, 2014, p. 292) on
children and adults helps situate problems with affect regulation, mental health, substance
abuse, relationships, and parenting in context.

Similarly, only one educator suggested that CSA inquiry and response should be
taught, the same educator who suggested teaching about trauma. In addition, four social
workers made some reference to teaching about CSA inquiry and response. The lack of
academic attention to CSA inquiry and the traumatic impact of CSA, were mirrored to some
extent in social work practice. As discussed in Chapter Three, many authors recommend
teaching social work students how to take a trauma history (Breckenridge & James, 2010;
Bussey, 2008; Kenny & Abreu, 2015; Shannon et al., 2014). Teaching how to respond to a
disclosure of CSA and to inquire in the first place is, in a sense, where the “rubber meets the
road”, where theory and practice intersect, and where the reflective use of self is most crucial.
The findings with social workers coupled with the literature suggest that such training may
elicit significant discomfort among students and perhaps some educators, and without training, these emotional barriers may be perpetuated in practice.

The growing emphasis on trauma-informed service delivery and assessments within NZ mental health policy and workforce expectations have implications for education providers (MOH, 2008a, 2010, 2012a, 2015b, 2015c; Te Pou, 2009d, 2009e, 2009f). Equipping social work students with the skills and confidence to inquire and respond effectively may ultimately support a paradigm shift in organisational cultures. Conversely, failing to address CSA in social work education at the level of core knowledge suggested by educators, ultimately creates a vicious circle. Not only does it reduce the number of social workers who feel able to address the issue in practice, but also the number of educators who feel capable to teach about the topic.

As discussed in Chapter Three, urgent calls have been made for social work education in the UK to better prepare social workers for the challenges of identifying and working with sexual abuse in children (Martin et al., 2015). In this study, requests from CYFS for a greater educational focus on child protection provide further support for the need for CSA training at undergraduate level, rather than being relegated to a workforce training issue. NZ policy regarding vulnerable children has also emphasised the need for trauma-informed service delivery (MSD, 2015b, 2015c, 2016a, 2016b). A “trauma-informed practice framework” is expected as part of the new operating model for the Ministry of Vulnerable Children, Oranga Tamariki (MSD, 2016a, p. 4), with social workers “explicitly recognising and seeking to remediate the trauma that this group of children and young people may have suffered” (MSD, 2016b). This has significant implications for social work education, given that “social workers will need new knowledge, competencies and skill as the system moves towards trauma-informed and evidence-based practice” (MSD, 2015c, p. 15). In this new era of joint accountability for vulnerable children across multiple agencies and government departments, the responsibility to be trauma-informed ultimately applies to all social workers. The new model of NZ child protection social work is not only trauma-informed, but takes an investment approach, recognising the social and financial costs to society of unresolved trauma across the lifespan (Heckman, 2006; MSD, 2015c). This new paradigm also recognises the folly of an over-reliance on routinized practice and risk-averse approaches:

In our Interim Report, the Panel noted the need for a shift from rules, compliance and timeframe-driven practice to professional judgement based on an evidence-based understanding of the impact of trauma on children and young people, the science of child development and attachment, and best
practice approaches in building resilience in children and young people. (MSD, 2015c, p. 65)

**CSA perpetrators**

At least half of participants from both samples believed social work education needed to teach about perpetrators, as well as victims. This perspective was informed by observations that CSA generally occurred in a relationship between victim and perpetrator, that an understanding of CSA perpetration could play a role in prevention, and that victim dynamics were often influenced by perpetrator dynamics. In addition, some educators believed that knowledge of both fields and collaboration between professionals created a more in-depth understanding. However, it was clear that not all educators had knowledge to teach in this field. With the exception of one educator who had previously worked with sex offenders, social work educators were less confident and knowledgeable about sexual abuse perpetrators. In addition, several educators displayed and/or verbalised discomfort about this client group, as did social workers. Consequently, lack of knowledge and emotional discomfort constituted significant barriers to teaching about perpetrators, despite the acknowledged benefits. These findings suggest that educators would need emotional support and academic and/or professional consultation, in order to implement training in this area.

Given the prevalence of CSA in community and clinical populations, coupled with significant numbers of children and youth who sexually abuse others, social workers are likely to encounter CSA perpetrators in a variety of practice settings (Grady & Abramson, 2011; Lancaster, 1997; Myers, 2008; Young & LoMonaco, 2008). Consequently, these authors have argued that social work curricula need to include teaching about sexual abuse perpetrators, as discussed in Chapter Three (Grady & Abramson, 2011; Hirst & Cox, 1996; Lancaster, 1997; Lowe & Bohon, 2008; Myers, 2008). The educator with the most knowledge regarding perpetrators argued that fully appreciating the complexities of CSA requires an understanding of both perpetrator and victim dynamics. As Salter (1995) has observed, victims find it difficult to “shake free of an internalised perpetrator” (p. 3). She notes that this “internal perpetrator-based critic … may or may not be sadistic, depending on the dynamics of the abuse, but is frequently hostile and blaming of the victim” (Salter, 1995, p. 271). Having this knowledge assists social workers in understanding some survivors’ self-sabotaging and risky behaviours, which often thwart engagement. In addition, Lancaster (1997) has pointed out that social work knowledge regarding perpetrators’ modus operandi is vital in order for social workers to “recognise potentially abusive situations and work in a preventative way” (p. 91).
Both social workers and social work educators commented on the unhelpful stereotypical image of the sexual abuse perpetrator as a dirty old man, a stranger, or a monster. These distorted perceptions were believed to prevent detection and increase stigmatisation, reducing the likelihood of perpetrators gaining or seeking support. Both sample groups felt that these stereotypes needed to be addressed in CSA training. Several educators believed it was important to teach about the psycho-social backgrounds of perpetrators and developmental antecedents to their offending. Similarly, Grady and Abramson (2011) suggest teaching about “causal factors associated with the types of offenses committed” as well as “effective treatments for reducing sexual crimes, and policies that enhance or derail rehabilitation” (p. 442).

While both samples expressed compassion, clearly there was an emotional cost to engaging with the topic of CSA perpetration. Both social workers and educators verbalised aversion to working with this client group, apart from one participant in each sample who had previously worked in the field. They attempted to separate and condemn the acts as opposed to the person, however participants in both data sets still felt repulsed on emotional and visceral levels by perpetrators, consistent with Myers’ (2008) comment that “this demonic image is viscerally held” (p. 208). One educator highlighted the importance of giving students permission to express negative emotional reactions, and to be prepared to work with the “energy” that came up. Students may otherwise attempt to contain their feelings of disgust, fear, and anger through a desire to be perceived as non-discriminatory (Myers, 2008). On the other hand, emotional responses to perpetrators may be particularly intense for students who have CSA histories (Myers, 2008), and one educator in this study spoke of a student’s disclosure of CSA in class, coupled with an extreme display of anger towards perpetrators. Managing and facilitating such intense emotions in a group setting, whether expressed or inhibited, naturally poses considerable challenges for educators, who are not immune from feeling such emotions themselves. Among both sample groups, participants’ facial expressions, tone of voice, changes in breathing, and cathartic laughter provided non-verbal indications of emotional discomfort regarding perpetrators, along with their verbalised discomfort.

Preparation for students

Anecdotes from educators suggested that students who had not suffered any abuse were perhaps more vulnerable to experiencing general disequilibrium and shattered assumptions about the world and others (Agllias, 2012; Janoff-Bulman, 1992). It was certainly recognised
that students with trauma histories were at risk of being triggered by class material, particularly if they had not resolved these issues to some degree. Strategies to prepare students included normalising the prevalence of CSA, acknowledging and normalising the emotional impact, recognising that a significant proportion of students came with abuse histories, providing information about lectures in advance, and giving information about support services on campus and off-campus. These are consistent with the literature (Barter, 1997; Cunningham, 2004; Jones, 2002; Miller, 1999). However, only one educator mentioned theoretical frameworks to assist students to be aware of and manage their emotional reactions, such as transference, countertransference, trauma, and VT. Teaching students about transference and countertransference enhances self-awareness regarding practice and the risks of VT (Pearlman & Saatvitkne, 1995; Ruch, 2010; Urdang, 2010). Learning about VT highlights and normalises the inevitable effects of being exposed to painful and sensitive material, and provides strategies to enhance self-awareness and self-care (Breckenridge & James, 2010; Bussey, 2008; Cunningham, 2004; Gilin & Kaufman, 2015). Balancing this teaching with vicarious resilience helps students appreciate the benefits and personal growth that can occur from working with others’ pain (Breckenridge & James, 2010). One social worker pointed to vicarious resilience in feeling bolstered by female prisoners’ willingness and strength to approach and work through their own pain.

Process issues for CSA education

Just as social workers had voiced concerns about opening up a can of worms with clients, two educators referred to the can of worms metaphor in relation to students. For all educators, this metaphor was implicitly present in relation to complex group dynamics, as well as students’ emotional reactions, necessarily requiring skills and confidence to facilitate and manage. Since students could have intense emotional responses to CSA in the absence of a personal history, the can of worms metaphor ultimately applied to all students. As discussed in Chapter Three, classroom safety has been paradoxically linked to the capacity for risk-taking and the ability to experience and express uncomfortable and conflicted emotions (Barrett, 2010; Boler, 1999). Explicit strategies and ground rules that acknowledge the dynamic nature of safety and its dialectical relation with discomfort may therefore be needed to prevent students suppressing feelings through fears of being judged incompetent (Myers, 2008). As Cunningham (2004) has noted, educators can manage risk in the classroom, but risk cannot be eliminated, nor should it be. Discourses privileging rational thought over emotion may need deconstructing
and challenging so that students feel permitted to express inner experiences (Barlow & Hall, 2007).

Related to students’ emotional expression was educators’ emotional expression and their awareness of students’ reactions. Educators’ ideas and practice about modelling comfort and openness regarding sensitive material is recommended in the literature (McCammon, 1995). Yet one educator noted the danger of educators being inured to the topic. This might lead to failing to appreciate the potential emotional upheaval for students or showing too little emotion. If educators fail to display any emotion, students may also feel emotionally inhibited. As discussed in Chapter Three, the literature suggests a delicate dialectic between modelling comfort, while also modelling appropriate and authentic displays of emotion (Carello & Butler, 2015; Courtois & Gold, 2009; Cunningham, 2004).

Educators described noticing how the content was being received by students, such as a shutting down or “blocking” reaction, or emotional arousal. These emotional reactions parallel the traumatic symptoms of numbing, avoidance, and hyperarousal, although no educator referred to these terms. As discussed in Chapters Two and Three, the impact of vicarious trauma and direct trauma are remarkably similar. Trauma theory not only has theoretical value, but is also an adjunct to facilitating process issues when teaching about CSA. One of these educators also acknowledged that addressing process issues was difficult and sometimes avoided, but easier when a relationship with students had been built. This mirrored some social workers’ perceptions that asking about CSA was easier once a relationship was established with a client.

Some educators believed that gender and culture were important considerations when teaching about CSA. Several authors have emphasised attendance to language and course material that equally addresses male survivors (Miller, 1999) and female perpetrators (Denov, 2003; Hetherton & Beardsall, 1988) to counteract stereotypes. Two educators suggested separate gender groups for Pacifica and Maori students, with a view to bringing groups together to dialogue at a later stage. This later re-grouping resonates with Mila-Schaff and Hudson’s (2009) notion of the “negotiated space” (p. 37). Characterised as “the watering hole, the marae atea, the debating chamber, the kava”, the negotiated space “is where intercultural negotiation and dialogue is given permission to take place” (p. 37). However, other educators commented that this may be impractical for programmes which have very few Pacifica or Maori students. Two educators also emphasised the importance of language in relation to CSA education for Pacifica students, who may require more subtle metaphorical approaches. Several Pacific
authors have discussed the use of metaphor, linguistic formalities, and body language to promote engagement rather than defensiveness and shame, when working with Pacific families to address abuse (Autagavaia, 2001; Crummer, Samuel, Papai-Vao, & George, 1998; Mafele’o, 2004; Mata’i’a, 2006; Mulitalo-Lauta, 2000). Teaching Pacifica students about CSA may therefore require a similar attention to language.

Students’ CSA histories and their disclosures

One educator believed the prevalence of CSA among social work students was much higher than among the general population, while others believed it was similar. Even if the prevalence is similar to community populations, given that females make up around 75% of students (Christie, 2006; Perry & Cree, 2003), this indicates that perhaps one in five students may have experienced CSA. Another educator commented that students with abuse histories often identified their past as a motivation to embark on social work training, consistent with other research (Buchbinder, 2007; Christie & Weeks, 1998; Humphrey, 2007; Sellers & Hunter, 2005). The reality that a proportion of clients, students, social workers, and educators were survivors of CSA, and at different stages of their own journey of recovery, was another parallel process in this research.

The degree to which students’ CSA histories came to the attention of educators and the manner in which they were divulged varied considerably. Implicit and explicit disclosures could occur in admission interviews, private conversations, classroom settings, or written assignments. Just as social workers had perceived clients’ CSA histories to be outside their work remit, educators also perceived students’ abuse histories to be a private matter, and only relevant to academic concerns if an obvious problem arose. Concerns about intruding into private spaces therefore appeared to be an issue for educators as they had been for social workers.

Within this study, only two programmes appeared to hold admission interviews. Some participants believed lack of contact with students prior to them turning up for class was a missed opportunity for initial preparation and information. In addition, having little or no information about students’ histories inhibited some educators from using more experiential forms of learning. Half the educators did not appear to have received a disclosure of CSA from a student, while others had received multiple disclosures. Educators’ varying levels of receptivity and comfort with receiving disclosures perhaps also impacted their knowledge of student survivors. For example, one practice to inform students there was no requirement to
disclose personal issues may have inhibited students from disclosing. Conversely, normalising and validating the reality of students’ traumatic histories and using experiential methods of learning, as some educators endorsed, may have encouraged disclosure. Social workers pointed to a metaphorical space for disclosure similar to Heidegger’s concept of the clearing. This was created by the recipients’ comfort and receptivity and the quality of relationship they had with the victim/survivor. As several social workers pointed out, survivors are often highly attuned to non-verbal signs of discomfort and anxiety which may have a silencing effect. This has implications for survivor students who may potentially experience implicit silencing messages from educators (Smith, 2014).

Educators’ beliefs that disclosures of CSA were generally more appropriate in private settings, and probably more likely to occur through journals, or private conversations with lecturers or supervisors, is consistent with Miller’s (1999) observations. In this study, the potential risks or benefits of disclosure of a history of CSA in the classroom were mainly contingent on the degree to which the student had resolved the issue, but there were also concerns about the risks of being judged by students and faculty. Others have also voiced concerns that the classroom is an unprotected and inappropriate environment for disclosure of sensitive material, potentially causing disruption academically and emotionally (Cunningham, 2003; Miller, 1999). There were no suggestions or examples of pedagogical practice from educators about preparing students for the possibility of disclosures in the classroom and discussing the implications, as suggested by other authors (Agllias, 2012; Jones, 2002). Such a discussion could assist students’ reflection and experiential learning regarding the dilemmas of disclosure, and develop some mutual ground rules and boundaries for the classroom to mitigate the risks. Without consideration of confidentiality, there is the risk that disclosures may continue to be discussed on and off campus, which was a concern regarding one classroom disclosure.

Given that the classroom is a microcosm of society, McCammon (1995) has suggested that public disclosure has therapeutic and socio-political value, such as providing testimony to the reality and depth of trauma, breaking silence, transforming shame, guilt and passivity, and placing the event in a political and social context. However, as social workers in this study pointed out, the benefits of disclosure are largely dependent on the response. There are risks to the disclosing student from others’ inappropriate and often anxious responses, including disbelief, unsupportive attitudes, and anger (McCammon, 1995). These mirror the risks clients encounter in disclosure to family, friends, and professionals, as social workers discussed. Alternatively other students may become emotionally overwhelmed and/or triggered by the
disclosing student (McCammon, 1995), and this mirrors the risks of counter-transference and VT for social workers and educators. Responding to a students’ disclosure in class or in private is reminiscent of the balancing act in containing yet not shutting down clients’ disclosures. Knowing how to respond appropriately to a disclosure of CSA therefore seems an important early consideration for educators and students, when addressing abuse and trauma.

**Pastoral and gatekeeping responsibilities**

The research suggests that teaching about sensitive issues such as CSA generates gatekeeping and pastoral responsibilities, and that these responsibilities are not always clearly defined. This can be problematic given that tensions can arise between the two issues. While students were expected to critically and reflectively engage with their life experiences, programmes varied in their attention to experiential learning and opportunities to process affect. In addition, students’ reflective use of self could be limited by expectations for professionalism and objectivity, suggesting that there were also conflicts between the requirements for reflexivity and gatekeeping. As I discussed in Chapter Four, academic organisational cultures tend to privilege the intellect over emotion. Within social work education, this unspoken rule potentially creates barriers to emotional intelligence. In a culture where intellect is privileged and gatekeeping is poorly defined, students’ emotional reactions and/or personal unresolved issues may be suppressed.

Legitimate academic spaces for students to explore personal issues did occur in some programmes. Just as timelines could assist clients to appreciate the links between the past and present, some educators discussed the use of timelines, genograms, and life story essays to enhance students’ reflective use of self. These methods did tend to generate disclosures of abuse. Several also suggested role play, another experiential learning strategy, used with considerable success in CSA inquiry and response training (Cavanagh et al., 2004; Read et al., 2006; Scott et al., 2014). Creating and facilitating the space for reflective, student-centred learning requires significant reflective capacity (Mishna & Bogo, 2007) and calls into question “the degree to which pastoral care ” is part of the social work educator role (Adamson, 2006, p. 53). All educators demonstrated reflective capacity, but expressed varying levels of comfort in facilitating and managing process issues. This was perhaps influenced by perceptions about their roles and relationships with students, and skills in this area.

Several educators believed counselling needed to be normalised and framed as a healthy and responsible decision which could enhance practice (Strozier & Stacey, 2001;
Sudberry, 2002). However, one surmised that expectations to address the impact of one’s past experiences on practice was perhaps more overt in counselling programmes. Sudberry (2002) also acknowledges this view but challenges it, given the significant overlaps between the professions and the clients they serve. Counselling programmes appear to have overcome the rational/emotional dichotomy by normalising the impact of practitioners’ relational past on effective practice. Didham et al. (2011) argue that developing the self-awareness needed for effective social work practice equally requires students to “examine their own family of origin and previous life experiences” (p. 525). As discussed in Chapter Three, NZQA social work unit standards regarding abuse and trauma explicitly encourage self-awareness and analysis of the impact of personal abuse histories upon practice, yet these standards are not being utilised. Social work could learn from its sister profession in developing a similar academic culture; however the discussion in the focus group suggested that social work and counselling are more likely to be perceived as discrete professions in NZ than other countries.

Multiple views were expressed among both sample groups regarding the resolution of CSA suggesting many roads and many levels, from various stages and models of formal therapy to informal support. Survivors’ capacity, willingness, and readiness to gain some level of support regarding CSA were all considered important factors, along with some awareness of its negative impact upon current functioning. While there seemed to be a general acknowledgement that the process was more cyclical than linear in nature, social workers disagreed about whether healing involved meaning-making. Educators and social workers in individual interviews and within the focus group believed that students should be assisted to identify unresolved issues, and work through them, ideally before placement, or at least before qualifying. Although all educators endorsed counselling as a potential resource for students, many argued that the resolution of trauma did not necessarily require formal counselling. They also raised concerns about “problematizing” students with trauma histories, and discussed students’ readiness and motivation to work on their own issues. While there may be many paths to resolving personal issues impacting practice, the key issue is to assist students to identify the impact of such issues in the first place. Harvey (1996) identified seven useful criteria for the resolution of trauma which could be discussed with students. These may even be debated, given the variety of opinions expressed in this study. Yet they provide some starting point for considering issues for survivor students and clients:

1. Physiological or bodily symptoms have been brought within manageable limits.
2. Ability to bear feeling associated with traumatic memories.
3. Authority over memories has been established: the person can elect to remember or not.
4. Memory of the traumatic event is a coherent narrative linked with feeling.
5. Damaged self-esteem has been restored.
6. Important relationships have been re-established.
7. A coherent system of meaning and belief has been reconstructed that encompasses the trauma.

Being attuned to more subtle indicators of difficulties, and providing forums and pedagogical strategies that encouraged emotional expression and examination of personal histories, potentially increased pastoral and gatekeeping responsibilities. These findings highlight the inter-relationships between such responsibilities, which need not be seen in opposition to each other, but rather as mutually dependent. Bridging the personal-professional divide requires clarity for educators and students regarding the programme’s gatekeeping policies and expectations, and provision of pastoral support. Urwin et al. (2006) suggest that standards of conduct for students should be made explicit, while reframing gatekeeping as support, rather than punishment, throughout the entirety of the curriculum. Ideally, there needs to be a greater acknowledgement that both issues are centred on the welfare of students and clients. The findings suggest the importance of educators continually holding both aspects in mind, so that the welfare of the student is not privileged over that of the students’ clients, or vice versa.

**Trauma-informed care**

Clearly, trauma-informed care is an important consideration for social work education, just as it is for social work practice. Just as clients require safety and containment in addressing their trauma histories, so do students require safety and containment in learning about CSA and trauma, whether or not they have personal experience. Just as clients can benefit from psycho-education to understand, manage, and normalise trauma symptoms, so can students benefit from psycho-education to manage and normalise their responses to learning about CSA, and to develop self-care plans. In this discussion, I have drawn on theory, empirical literature, and policy consistent with trauma-informed care to consider the implications of my findings for social work practice and education. While some theoretical elements are recognised facets of trauma-informed care, such as attachment theory, the neurobiology of trauma, countertransference, and VT (Harris & Fallot, 2001; Layne et al., 2011, 2014, Miller & Guidry,
2001) others are perhaps less recognised, such as social defences (Bloom & Farragher, 2013) and Goffman’s (1959) work on stigma.

The subtle yet compelling power of dominant discourses to influence victims’ interpretation of CSA and self, and societal and professional interpretations of the victim and CSA, are also important considerations within trauma-informed practice and education. The normal/abnormal dialectic emerging from these findings does not appear explicitly within the literature related to relational dialectics theory, or the literature regarding CSA. However, this dialectic is informed by relational dialectics theory (Baxter & Montgomery, 1996), developmental and attachment theory, Finkelhor and Browne’s (1987) traumagenic dynamics, Goffman’s (1959, 1963) work on stigma and impression management, and empirical findings regarding the normalising and desensitising practices of perpetrators (Craven et al., 2006; Young, 1997) and victims’ interpretations of their abuse (Hlavka, 2014; Lab & Moore, 2005; Morrow & Smith, 1995).

Conclusion

A compelling rationale for addressing CSA in social work practice and education emerged in this research. Participants discussed the high prevalence of CSA among clients with mental health and addiction problems; the significant prevalence in the community; the multiple intra-psychic, interpersonal, and socio-cultural barriers to disclosure; and the wide-ranging impacts of CSA across the lifespan. Within mental health and addiction services, these aspects could influence clients’ capacity to build a therapeutic relationship and engage in treatment. Yet social workers were resistant to the idea of routine inquiry. The findings suggest that emotional discomfort, lack of training, lack of organisational support, concerns for the client, and perhaps concern for self are all implicated. However, recovery ultimately requires discovery of the underlying antecedents to mental health and substance abuse problems. Only then can clients be assisted to address the impact of trauma, prevent re-victimisation, and break negative inter-generational patterns. Ultimately, this is an empowering, destigmatising, and potentially consciousness-raising intervention, promoting social justice and consistent with social work’s mission.

The research suggests that a significant paradigm shift is needed in mental health and addiction services, social work education, and other relevant spheres of social work, which acknowledges CSA and other forms of abuse and trauma as core business. Otherwise, they are
likely to remain peripheral issues. This is reflected in the lack of reference to abuse and trauma in the NZ social work practice standards, as discussed in Chapter Three. It is possible that social defences are operating to reduce anxiety, by perpetuating organisational cultures which marginalise CSA as a practice or educational concern. Discourses such as “services as silos” and the “generalist and congested nature of social work programmes” had the effect of relegating CSA to the periphery of practice or education. Yet there were examples in practice and education of transcending organisational barriers to some extent. Having significant practice experience and knowledge conferred a greater degree of comfort and confidence to approach the topic of CSA with clients or students, to respond to disclosures, and to manage process issues. Social workers or educators did not deny the reality of CSA or its impact, but CSA was often denied a routine and central place in practice and education, seemingly condoned by organisational practices and culture. As Cohen (2001) has demonstrated there are many subtle forms of denial operating at individual and institutional levels which can ultimately reinforce each other:

People, organizations, governments or whole societies are presented with information that is too disturbing, threatening or anomalous to be fully absorbed or openly acknowledged. The information is therefore somehow repressed, disavowed, pushed aside or reinterpreted. Or else the information ‘registers’ well enough, but its implications - cognitive, emotional or moral - are evaded, neutralized or rationalized away. (p. 1)

The metaphor of services operating as silos constitutes a significant barrier to the increasing number of recommendations for multi-disciplinary collaboration within NZ mental health and child protection policy (MOH, 2005, 2008, 2012a, 2015c; MSD, 2015b, 2015c, 2016a). The good news is that there is no need to re-invent the wheel in order to implement trauma-informed practice within organisations. A number of excellent toolkits are available for organisations seeking to create change (Bateman, Kezelman, & Henderson, 2013; Fallot & Harris, 2009; Klinic Community Health Centre, 2013; Nova Scotia Health Authority, 2015; SAMHSA, 2014b). However, they do require a significant commitment of time, resources and funding for reviews of systems and policies and training of all staff.

Participants from both samples endorsed a basic level of training in CSA at undergraduate level, which some programmes were already providing. Given the emotional costs of addressing CSA, the findings suggest that CSA should be taught within a trauma-informed framework that addresses the risks of VT. This would narrow the gaps between client and student by highlighting the similarities between direct and indirect forms of trauma. As Miller (1999) has observed “teaching that goes beyond content and skills development to
acknowledge process and parallels to the material under study can powerfully and safely engage students in a process of learning” (p. 73). The notion of intruding into private areas was a key concern in social work practice and education. However, I argue in this thesis that there is a robust rationale for addressing the personal histories of clients and students. This rationale can be made explicit through information about services/education, assessment/admission processes, and engagement in treatment/education. Merely asking clients about CSA is not sufficient. Clearly, it is important to know how to ask, and to follow up with assessments of trauma symptoms and current safety for the client and their children. By providing psychoeducation, tools, strategies, and support, the potential for the past to impact current functioning is recognised and normalised, equipping survivors with knowledge to make informed decisions.

Recommendations

1. Routine assessment for abuse and trauma is recommended within DHBs providing mental health and addiction services (MOH, 2012a). The findings of this research suggest that trauma-informed training, similar to the one day training undertaken in Midland and Auckland DHBs, is needed to support staff to overcome discomfort and anxiety related to asking about CSA and responding to it.

2. Mental health and addiction services are well placed to provide stage one trauma work within individual and group work. Staff who are knowledgeable about trauma could identify suitable programmes, modify them if necessary, and facilitate them. Appreciating the impact of past trauma upon present functioning is an empowering psycho-educative intervention for clients, helping them to make sense of and gain mastery over triggers. This is likely to enhance therapeutic engagement and treatment outcomes.

3. Under-graduate social work programmes need to include a basic level of training regarding CSA, as discussed by participants and suggested in the literature. Policies and workforce expectations regarding working with mental health and addiction problems and vulnerable children highlight the need for social work education to address trauma and abuse. Trauma-informed education would have the dual purpose of equipping students with knowledge and skills to support clients, as well as enhancing their self-care and reflexivity.
4. Based on participants’ suggestions and the literature, under-graduate social work programmes should ideally include the following topics related to CSA, other abuse and trauma: definition, prevalence, biopsychosocial and developmental impacts, attachment implications, perpetrator issues and dynamics, neurobiology of trauma, trauma-informed care, traumagenic dynamics, triggers and re-traumatisation, VT and vicarious resilience, self-care, ACE study, attitudes and stereotypes, gender and cultural issues, blaming the victim and/or non-offending caregiver, disclosure difficulties, other forms of abuse, asking and responding, barriers to asking, reporting and legislative requirements, consumer perspectives. Given that much of this training has been delivered in one day for mental health professionals, it is feasible to produce basic training for social work students within 15 hours of lectures.97

**Directions for future research**

The research findings suggest a number of potential avenues for further inquiry. Given the small sample of social work educators, further examination of the current level of social work education with regard to CSA, other abuse, and trauma could be usefully explored through a survey of all social work programmes in NZ. Similarly, a larger scale inquiry of social workers’ knowledge of CSA and trauma and current practice in this area, along with their previous educational experiences and current educational needs could be conducted through ANZASW. This could include social workers in a variety of social work settings. The issues emerging with regard to students’ trauma histories, tensions between gatekeeping and expectations for reflexivity, and variations in content and delivery of CSA and trauma training, suggest that qualitative research with students about these matters would represent another fruitful line of inquiry.

Given the increased expectations within policy and workforce documents for mental health and addiction services to be trauma-informed, it is timely to implement a survey of DHBs in NZ to ascertain how and to what degree they have implemented changes. This survey could draw upon some of the organisational self-assessment tools and toolkits that have been developed for mental health organisations seeking to implement trauma-informed service delivery (Klinic Community Health Centre, 2013; Mental Health Coordinating Council, 2016).

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97 This might translate to 15 credits or 150 hours of total study, including workshops delivered by external agencies, tutorials, assignments, supervised practical placements, and study time.
Another useful area of research within mental health and addiction services would be with survivors of CSA. There is certainly scope for qualitative research which explores their views about the impact of CSA upon their mental health and addiction problems, and their experiences of professionals’ practices in relation to CSA inquiry and response, and addressing CSA and traumatic impacts in treatment plans. Lastly, if mental health and addiction services were to implement integrated treatment for mental health, substance abuse, and trauma issues, such as Seeking Safety (Najavits, 2002), there is a need for randomised controlled, and preferably, longitudinal trials to empirically establish the utility of such programmes.

**Revisiting the weaving metaphor**

The similarities between symptoms of trauma and vicarious trauma highlight the reality that empathy will at times elicit parallel feelings and cognitions in social workers, educators, and students, as those experienced by clients. This thesis argues that part of the framework, or loom, of social work practice and education needs to be trauma-informed and emotionally intelligent. This equips practitioners to:

a) be open to the possibility that clients may have experienced adverse childhood events such as CSA.

b) understand the developmental, relational, emotional, physical, and neurobiological impacts of CSA and other forms of abuse, and use this knowledge in relationship-building, assessment processes, empowering, and destigmatising interventions.

c) be confident and competent in routinely inquiring about abuse and assessing for trauma symptoms.

d) acknowledge and manage the inevitable emotional costs which emerge from addressing CSA and other forms of abuse in social work practice and education.

e) use their trauma-informed understanding to critically analyse the dominant medical model within mental health and prevailing risk discourses within child protection.

This loom contains multiple woven threads such as supervision, peer support networks, training, multi-disciplinary working, and collaboration with survivors, providing a firm safety net to “hold” all concerned (Winnicott, 1965). Recognising the need for “help for the helper” (Rothschild & Rand, 2006) also points to the needs of non-offending caregivers, often mothers, when children and adolescents disclose CSA, an issue under-recognised in this research and in practice (Alaggia, 2002; Breckenridge & Davidson, 2002; Tarczon, 2012; van Toledo & Seymour, 2013). Without this trauma-informed knowledge and the organisational support to
validate this knowledge, CSA may be marginalised as a social work practice and educational concern.

The weaving metaphor is also symbolic of the need to consider the warp and weft of micro and macro processes in addressing CSA, and the dialectic of knowing and not knowing at individual and societal levels. Participants’ experiences, perspectives, and observations indicated that anxiety could manifest in knowing and not knowing about CSA for survivors, students, and professionals. Furthermore, they often highlighted societal responsibility for the sexual abuse of children, and revealed the reality that perpetrators are part of our society, they are one of us. Societal attitudes and discourses often sustain not knowing about CSA. They can feed perpetrators’ delusions, support their illusions of normality, and contribute to their elusiveness; they also silence and obscure victims. As participants pointed out, public discourse about CSA, which could support victims to speak out, is largely absent. While government inquiries in Australia and the UK are now investigating the extent of institutional forms of CSA, the institution of the family98 as a site of CSA remains in the shadows of public consciousness.

I have argued in this thesis that the cost of not knowing about CSA for survivors, professionals, and society is greater than the cost of knowing. At individual and collective levels, the cost of not knowing is reflected in the negative impact of survivors’ unidentified traumatic stress and emotional regulation difficulties upon their physical and mental/emotional health (Herman, 1992, 1997). We all pay the costs of the pernicious relational and intergenerational effects of unresolved trauma (Bloom & Reichert, 1998). The reality is that CSA constitutes a public health issue, and requires a public health model of prevention (Mercy, 1999). Ultimately, we all need to be willing to know about CSA, and to stand against its many forms and the discourses that support or obscure it, so that victims can feel able to come forward, and feel confident that they will be heard.

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98 By family, I mean the many permutations of family in modern society, which do not necessarily involve biological ties.
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Appendices

Appendix A: Information sheet for social workers

Constructions of child sexual abuse among social workers in an alcohol and drug counselling service and university social work educators

INFORMATION SHEET FOR SOCIAL WORK PARTICIPANTS

Thank you for showing an interest in this project. I am a social work student at the University of Otago and am undertaking this research as part of the requirements for the Masters in Social Welfare.

Please read this information sheet carefully before deciding whether or not to participate. If you decide to participate I thank you. If you decide not to take part there will be no disadvantage to you of any kind and I thank you for considering my request.

What is the Aim of the Project?

This project is being undertaken as part of the requirements for the Masters in Social Welfare at the University of Otago.

The research seeks to explore social workers’ and social work educators’ subjective and contextual understandings of child sexual abuse and the implications for social work practice and social work education.

I hope that the small-scale study may generate a larger scale inquiry of social workers’ knowledge of CSA, their previous educational experiences and current educational needs.

What Type of Participants are being sought?

Approximately twelve qualified social workers with a diploma or degree in social work are being sought to participate. Both male and female participants over 20 years of age are sought with a range of age, ethnicity and job description within the service.

What will Participants be Asked to Do?

Should you agree to take part in this project, you will be asked to:
- complete and post/email back a form regarding demographics
- participate in two semi-structured interviews of one hour’s duration each which will be audio-recorded and conducted at your workplace
- complete and submit to me a reflective journal after the completion of both interviews

Separate in-depth interviews will be undertaken with social work educators within the eight universities of NZ. A sub-sample of six social workers and two social work educators will be asked to participate later this year in a focus group of one hour’s duration, facilitated by me. This group will be audio-recorded and video-recorded and will be conducted at one of the offices of the service. The focus group will offer the opportunity for both groups to begin the
process of dialogue regarding their constructions of CSA and the implications for social work practice and education.

The research has been designed to promote participants’ professional and personal development through the use of a reflective journal and a collaborative approach to exploring the meaning of child sexual abuse. The reflective journal is designed to provide a reflective learning opportunity to support you in processing your cognitive and affective responses to engaging with the subject of CSA, as well as reflecting upon the sources for your understanding. The degree of reflexivity and the degree to which you wish to share your reflections with me are entirely at your discretion.

The proposed research, which requires you to keep a reflective journal, may therefore meet some of the requirements for continuing education under DAPAANZ. Approval for credits under DAPAANZ for the reflective practice journal will be made by DAPAANZ and will not depend on my input.

It is recognised that the process of engaging with a difficult and potentially emotive subject such as CSA could precipitate some level of tension and/or distress. You are welcome to contact me should any issues or concerns arise over the course of the research. You will also have the opportunity to temporarily or completely stop the interview process should distress occur and if need be, withdraw from the research. You are also welcome to bring a support person to interviews.

As professionals you may already be quite aware of the counselling services available but I have included a brief list below for your reference:
- Auckland Sexual Abuse Help   www.sexualabushelp.org.nz
- Auckland Therapy   www.aucklandtherapy.co.nz
- Counselling Services Centre   www.csccounselling.org.nz
- New Zealand Association of Counsellors (NZAC)   www.nzac.org.nz
- Rape Prevention Education- List of national providers   www.rapecrisis.org

Can Participants Change their Mind and Withdraw from the Project?

You may withdraw from participation in the project at any time and without any disadvantage to yourself of any kind. You have the right to choose both the nature of, and the degree of information that you wish to supply to me and to refrain from answering any question without any consequences.

If the reflective journal is intended to be submitted to DAPAANZ as credits towards the continuing education requirements of registration with DAPAANZ and is not completed to a sufficient degree, these credits may not be awarded to you. This decision is entirely at the discretion of DAPAANZ and does not involve my input.

What Data or Information will be Collected and What Use will be Made of it?

Your perspectives and understanding of CSA will be gained through the use of in-depth, semi-structured, face to face interviews which will be audio-recorded. Questions will be drawn from issues arising from the academic literature, the media and from popular culture, as well as seeking to understand the policy/education/practice issues as well as personal/familial influences that contribute to an understanding of the subject. Each interview will also include one vignette for you to comment upon.

This project involves an open-questioning technique. The general line of questioning includes:
- prior CSA training
- self-assessment about what is known and not known about CSA
- participants’ meanings of various terms related to CSA
- perspectives on CSA debates
- how CSA is addressed within the agency and in clinical caseloads
- how social workers determine and view the severity and impact of CSA
- cognitive and affective responses to CSA
- values, beliefs and family norms in relation to sexuality
- sources for understanding CSA

The precise nature of the questions which will be asked have not been determined in advance, but will depend on the way in which the interview develops. Consequently, although the University of Otago Human Ethics Committee is aware of the general areas to be explored in the interview, the Committee has not been able to review the precise questions to be used.

In the event that the line of questioning does develop in such a way that you feel hesitant or uncomfortable you are reminded of your right to decline to answer any particular question(s) and also that you may withdraw from the project at any stage without any disadvantage to yourself of any kind.

Data elicited in interviews will be received and held by me and any person employed by me to assist in transcribing the audio-recorded interviews. I intend to transcribe the majority, if not all, of the interviews, however, any transcribers employed will be requested to sign a confidentiality agreement ensuring that they undertake to keep data stored securely and to refrain from discussing the data with anyone else. Data may also be shared in more general terms with my supervisor and also in peer group reviews but only non-identifying information will be discussed.

You will be offered the opportunity to receive a digital copy of the transcribed interviews, and to provide feedback regarding any perceived inaccuracies.

I intend to analyse the data by segmenting the text from the transcripts into conceptual categories and initially identifying themes and sub-themes. The categories will be derived from pattern recognition, making comparisons and contrasts and by continual reference back to the research questions and the literature.

A sub-sample of six social work participants and two social work educators who participate in the focus group will also have the opportunity to comment upon the themes that I have identified as arising from individual interviews with social workers and social work educators.

Electronic data will be stored on my laptop and backed up onto an external hard drive stored in a locked room along with hard copies of transcripts, reflective journals, and notebooks for memo-writing.

At the end of the project any personal information will be destroyed immediately except that, as required by the University’s research policy, any raw data on which the results of the project depend will be retained in secure storage for five years, after which it will be destroyed.

Reasonable precautions will be taken to protect and destroy data gathered by email. However, the security of electronically transmitted information cannot be guaranteed. Caution is advised in the electronic transmission of sensitive material.
The results of the project may be published and will be available in the University of Otago Library (Dunedin, New Zealand) but every attempt will be made to preserve your anonymity. Direct quotations will be used, but only those which avoid your identification and you will be given an opportunity to choose a pseudonym to be known by in the research.

You will have the opportunity to debrief with me at the end of your interviews by Skype video conferencing. This can be a helpful process for participants in that it provides an opportunity to feed back your perspectives of my role as researcher and the research experience, and to clarify any further issues or concerns.

You are most welcome to request a copy of the results of the project should you wish.

**What if Participants have any Questions?**

If you have any questions about the project, either now or in the future, please feel free to contact either:-

Sally Beale  
Student researcher  
027 2086466  
email: beasa638@otago.ac.nz

Dr Anita Gibbs  
Supervisor  
Department of Sociology, Gender and Social Work  
(03) 479 5677  
email: anita.gibbs@stonebow.otago.ac.nz

This study has been reviewed and approved by the University of Otago Human Ethics Committee. If you have any concerns about the ethical conduct of the research you may contact the Committee through the Human Ethics Committee Administrator (ph 03 479 8256). Any issues you raise will be treated in confidence and investigated and you will be informed of the outcome.
Appendix B: Consent for social workers

Constructions of child sexual abuse among social workers in an alcohol and drug counselling service and university social work educators

CONSENT FORM FOR SOCIAL WORK PARTICIPANTS

I have read the Information Sheet concerning this project and understand what it is about. All my questions have been answered to my satisfaction. I understand that I am free to request further information at any stage.

I know that:-

1. My participation in the project is entirely voluntary;

2. I am free to withdraw from the project at any time without any disadvantage;

3. Personal identifying information about me, such as demographics, will be destroyed at the conclusion of the project but any raw data on which the results of the project depend will be retained in secure storage for five years, after which they will be destroyed;

4. This project involves an open-questioning technique. The general line of questioning includes:
   - how CSA is addressed within the agency and in clinical caseloads
   - how social workers determine and view the severity and impact of CSA
   - prior CSA training
   - self-assessment about what is known and not known about CSA
   - participants’ meanings of various terms related to CSA
   - perspectives on CSA debates
   - cognitive and affective responses to CSA
   - values, beliefs and family norms in relation to sexuality
   - sources for understanding CSA

I understand that the precise nature of the questions which will be asked have not been determined in advance, but will depend on the way in which the interview develops. In the event that the line of questioning develops in such a way that I feel hesitant or uncomfortable I may decline to answer any particular question(s) and/or may withdraw from the project without any disadvantage of any kind.

5. I understand that the process of engaging with a difficult and potentially emotive subject such as CSA could cause me some level of tension and/or distress and that I can temporarily or completely stop the interview process should distress occur and if need be, withdraw from the research. I also understand that I can contact the researcher should any issues or concerns arise over the course of the research.

6. I understand that I am able to bring a support person to the interview and if I do so, my support person will be informed of their responsibility to maintain confidentiality.

7. The results of the project may be published and will be available in the University of Otago Library (Dunedin, New Zealand) but every attempt will be made to preserve my anonymity. I am also aware that
I am able to choose a pseudonym for the purposes of the research.

I agree to take part in this project.

.............................................................................    ..................
(Signature of participant)      (Date)

This study has been reviewed and approved by the University of Otago Human Ethics Committee. If you have any concerns about the ethical conduct of the research you may contact the Committee through the Human Ethics Committee Administrator (ph 03 479 8256). Any issues you raise will be treated in confidence and investigated and you will be informed of the outcome.
Appendix C: Demographics form for social workers

Constructions of child sexual abuse among social workers in an alcohol and drug counselling service and university social work educators

DEMOGRAPHICS FORM FOR
SOCIAL WORK PARTICIPANTS

Please complete the following details:

1. Name:

2. Pseudonym for research:

3. Contact phone number or email:

4. a) Ethnicity:
   b) Iwi affiliation:

5. Age:

6. a) Position:
   b) Number of years worked in position:

7. a) Social work qualification:
   b) Year gained:
   c) Academic institution:

Please return this form to me either by email or using the stamped addressed envelope provided with the hard copy. I thank you for your time and look forward to meeting you.

Sally Beale
Student researcher

027 2086466

email: beasa638@otago.ac.nz
Appendix D: Information sheet for social work educators

Constructions of child sexual abuse among social workers in an alcohol and drug counselling service and university social work educators

INFORMATION SHEET FOR SOCIAL WORK EDUCATOR PARTICIPANTS

Thank you for showing an interest in this project. I am a social work student at the University of Otago and am undertaking this research as part of the requirements for the Masters in Social Welfare.

Please read this information sheet carefully before deciding whether or not to participate. If you decide to participate I thank you. If you decide not to take part there will be no disadvantage to you of any kind and I thank you for considering my request.

What is the Aim of the Project?

This project is being undertaken as part of the requirements for the Masters in Social Welfare at the University of Otago.

The research seeks to explore social workers’ and social work educators’ subjective and contextual understandings of child sexual abuse and the implications for social work practice and social work education.

I hope that the small-scale study may generate a larger scale inquiry of social workers’ knowledge of CSA, their previous educational experiences and current educational needs.

What Type of Participants are being sought?

A key educator within the social work department of each of the eight universities of NZ is sought, therefore totalling eight participants. Both male and female participants are sought with a range of age and ethnicity.

What will Participants be Asked to Do?

Should you agree to take part in this project, you will be asked to:
- complete and post or email back a form regarding demographics
- participate in one semi-structured interview of one hour’s duration which will be audio-recorded and conducted by Skype video conferencing

Separate in-depth interviews will be initially undertaken in Auckland with qualified social workers at addiction and mental health services prior to the interviews with social work educators. A sub-sample of six social workers and four social work educators will be asked to participate later this year in a focus group of one hour’s duration, facilitated by me. This group will be audio-recorded and video-recorded and will be conducted at one of the offices of the service. The focus group will offer the opportunity for both groups to begin the process of dialogue regarding their constructions of CSA and the implications for social work practice and education.
It is recognised that the process of engaging with a difficult and potentially emotive subject such as CSA could precipitate some level of tension and/or distress. You are welcome to contact me should any issues or concerns arise over the course of the research. You will also have the opportunity to temporarily or completely stop the interview process should distress occur and if need be, withdraw from the research.

As professionals you may already be quite aware of the counselling services available but I have included a brief list below for your reference:

Auckland Sexual Abuse Help   www.sexualabusehelp.org.nz
Auckland Therapy   www.aucklandtherapy.co.nz
Counselling Services Centre   www.cscounselling.org.nz
New Zealand Association of Counsellors (NZAC)   www.nzac.org.nz
Rape Prevention Education- List of national providers   www.rapecrisis.org
Sexual Abuse Centre   www.sexualabuse.co.nz

**Can Participants Change their Mind and Withdraw from the Project?**

You may withdraw from participation in the project at any time and without any disadvantage to yourself of any kind. You have the right to choose both the nature of, and the degree of information that you wish to supply to me and to refrain from answering any question without any consequences.

**What Data or Information will be Collected and What Use will be Made of it?**

Your perspectives and understanding of CSA and the implications for social work practice and education will be gained through the use of in-depth, semi-structured interviews conducted by Skype video conferencing which will be audio-recorded. Questions will be drawn from issues arising from the academic literature, the media and from popular culture, as well as seeking to understand the policy/education/practice issues as well as personal/familial influences that contribute to an understanding of the subject. You will also be asked to comment upon themes arising from the interviews with social workers.

This project involves an open-ended questioning technique. The general line of questioning includes:

- self-assessment about what is known and not known about CSA
- participants’ meanings of various terms related to CSA
- perspectives on CSA debates
- cognitive and affective responses to CSA
- sources for understanding CSA
- how CSA is addressed within the social work curriculum and to what degree
- how relevant and applicable is CSA education across all social work disciplines
- an evaluation of the sufficiency and efficacy of the current level of CSA education

The precise nature of the questions which will be asked have not been determined in advance, but will depend on the way in which the interview develops. Consequently, although the University of Otago Human Ethics Committee is aware of the general areas to be explored in the interview, the Committee has not been able to review the precise questions to be used.

In the event that the line of questioning does develop in such a way that you feel hesitant or uncomfortable you are reminded of your right to decline to answer any particular question(s)
and also that you may withdraw from the project at any stage without any disadvantage to yourself of any kind.

Data elicited in interviews will be received and held by me and any person employed by me to assist in transcribing the audio-recorded interviews. I intend to transcribe the majority, if not all, of the interviews, however, any transcribers employed will be requested to sign a confidentiality agreement ensuring that they undertake to keep data stored securely and to refrain from discussing the data with anyone else. Data may also be shared in more general terms with my supervisor and also in peer group reviews but only non-identifying information will be discussed.

You will be offered the opportunity to receive a digital copy of the transcribed interviews, and to provide feedback regarding any perceived inaccuracies.

I intend to analyse the data by segmenting the text from the transcripts into conceptual categories and initially identifying themes and sub-themes. The categories will be derived from pattern recognition, making comparisons and contrasts and by continual reference back to the research questions and the literature.

A sub-sample of four social work educator participants and six social work participants who participate in the focus group will also have the opportunity to comment upon the themes that I have identified as arising from individual interviews with social workers and social work educators.

Electronic data will be stored on my laptop and backed up onto an external hard drive stored in a locked room along with hard copies of transcripts, reflective journals, and notebooks for memo-writing.

At the end of the project any personal information will be destroyed immediately except that, as required by the University's research policy, any raw data on which the results of the project depend will be retained in secure storage for five years, after which it will be destroyed.

Reasonable precautions will be taken to protect and destroy data gathered by email. However, the security of electronically transmitted information cannot be guaranteed. Caution is advised in the electronic transmission of sensitive material.

The results of the project may be published and will be available in the University of Otago Library (Dunedin, New Zealand) but your anonymity will take priority over the publishing of data. Direct quotations will be used, but only those which avoid your identification and that of the institution you work within, and you will be asked to choose a pseudonym to be known by in the research.

You will have the opportunity to debrief with me at the end of your interviews by Skype video conferencing. This can be a helpful process for participants in that it provides an opportunity to feed back your perspectives of my role as researcher and the research experience, and to clarify any further issues or concerns.

You are most welcome to request a copy of the results of the project should you wish.

**What if Participants have any Questions?**

If you have any questions about the project, either now or in the future, please feel free to contact either:-
Sally Beale
Student researcher
027 2086466
email: beasa638@otago.ac.nz

Dr Anita Gibbs
Supervisor
Department of Sociology, Gender and Social Work
(03) 479 5677
email: anita.gibbs@stonebow.otago.ac.nz

This study has been reviewed and approved by the University of Otago Human Ethics Committee. If you have any concerns about the ethical conduct of the research you may contact the Committee through the Human Ethics Committee Administrator (ph 03 479 8256). Any issues you raise will be treated in confidence and investigated and you will be informed of the outcome.
Appendix E: Consent form for social work educators

Constructions of child sexual abuse among social workers in an alcohol and drug counselling service and university social work educators

CONSENT FORM FOR SOCIAL WORK EDUCATOR PARTICIPANTS

I have read the Information Sheet concerning this project and understand what it is about. All my questions have been answered to my satisfaction. I understand that I am free to request further information at any stage.

I know that:-

1. My participation in the project is entirely voluntary;

2. I am free to withdraw from the project at any time without any disadvantage;

3. Personal identifying information about me, such as demographics, will be destroyed at the conclusion of the project but any raw data on which the results of the project depend will be retained in secure storage for five years, after which they will be destroyed;

4. This project involves an open-questioning technique. The general line of questioning includes:
   - self-assessment about what is known and not known about CSA
   - participants’ meanings of various terms related to CSA
   - perspectives on CSA debates
   - cognitive and affective responses to CSA
   - sources for understanding CSA
   - how CSA is addressed within the social work curriculum and to what degree
   - how relevant and applicable is CSA education across all social work disciplines
   - an evaluation of the sufficiency and efficacy of the current level of CSA education

I understand that the precise nature of the questions which will be asked have not been determined in advance, but will depend on the way in which the interview develops. In the event that the line of questioning develops in such a way that I feel hesitant or uncomfortable I may decline to answer any particular question(s) and/or may withdraw from the project without any disadvantage of any kind.

5. I understand that the process of engaging with a difficult and potentially emotive subject such as CSA could cause me some level of tension and/or distress and that I can temporarily or completely stop the interview process should distress occur and if need be, withdraw from the research. I also understand that I can contact the researcher should any issues or concerns arise over the course of the research.

6. The results of the project may be published and will be available in the University of Otago Library (Dunedin, New Zealand) but my anonymity will be preserved by the exclusion of data that would identify me or the academic institution that I work within.

7. I agree to use a pseudonym for the purposes of the research.
I agree to take part in this project.

.......................................................... ........................................
(Signature of participant) (Date)

This study has been reviewed and approved by the University of Otago Human Ethics Committee. If you have any concerns about the ethical conduct of the research you may contact the Committee through the Human Ethics Committee Administrator (ph 03 479 8256). Any issues you raise will be treated in confidence and investigated and you will be informed of the outcome.
Appendix F: Demographics form for social work educators

Constructions of child sexual abuse among social workers in an alcohol and drug counselling service and university social work educators

DEMOGRAPHICS FORM FOR SOCIAL WORK EDUCATOR PARTICIPANTS

Please complete the following details:

1. Name:

2. Pseudonym for research:

3. Contact phone number or email:

4. a) Ethnicity:
   b) Iwi affiliation:

5. Age:

6. a) Position:
   b) Number of years worked in position:
   c) Social work programme/s offered:
   d) Papers taught:

7. a) Social work qualifications:
   b) Year gained:
   c) Academic institution:

Please return this form to me either by email or using the stamped addressed envelope provided with the hard copy. I thank you for your time and look forward to meeting you.

Sally Beale
Student researcher
027 2086466
email: beasa638@otago.ac.nz
Appendix G: First Interview guide for social workers

Interview Guide for Interview One: Social workers

1. TRAINING CSA
under-grad? post-grad?
work-related? courses? conferences?
self-study?

2. KNOWLEDGE CSA
self-assessment?
sources of knowledge?
what areas competent? what gaps?
how relevant to position?

3. DEFINITION CSA
how do you define CSA?

4. PREVALENCE CSA
NZ society?
mental health system? A and D?
gender?
sources for views?

5. TERMS: “VICTIM” & “SURVIVOR”
usefulness? differences?
gender differences?

6. CSA (SYMPTOMS/BEHAVIOUR)
physical, emotional, mental, social? what proportion show symptoms?
behaviour with abuser?
understanding of trauma, PTSD, dissociation?
sources for views?

7. CSA DISCLOSURE
factors affecting credibility-age, context? retractions? suggestibility? false allegations?
recovered memories/false memories?
ritual/satanic abuse?
what do you know about forensic interviewing of children?

8. CSA INQUIRY
always ask? at what point?
how ask?
comfort? competence?
gender issues?
cultural issues?
response?
how many clients with CSA history?
treatment for victims? timing A and D vs CSA?

9. EMOTIONS
feelings?
body reactions?
thoughts? checking OK?
Appendix H: Second interview guide for social workers

Interview Guide for Interview Two: Social workers

1. REFLECTION
use of reflective journal?
what has come up in last 2 months?
feelings? thoughts?
new sources?
new understandings?

2. SEXUALITY
sex education in families?
are children sexualised? role of media, culture, internet?
gender differences in expression of sexuality? socialisation?

3. SEXUAL OFFENDER
what comes to mind when thinking of a sexual offender against children - gender, age, relationship to victim? what feelings, body feelings?
how do they present? would there be any signs to alert you?
what proportion adolescents? what proportion female?
what differences intra-familial/extra-familial offenders?
how define paedophile? what images and feelings come up?
 sources of knowledge?

4. AETIOLOGY SEXUAL OFFENDING
factors? influences? motivation? what theories draw on?
cycle of sexual abuse? other abuse? gender issues?
role of pornography?
 sources of understanding?

5. SEXUAL OFFENDING
processes leading up to offending? role of fantasy?
strategies used to offend?
strategies to silence and maintain offending?
how would you describe the relationship between victim and offender?

6. CSA PROSECUTION/CONVICTION
what proportion?
process for victims?
what are main offences?
what are average sentences?

7. TREATMENT SEXUAL OFFENDERS
what do you know about treatment?
factors impacting treatment?
treatment efficacy? rehabilitation successful?
community support?

8. IMPACT OF CSA ON CLIENTS
what impact? are clients always aware of the impact?
relationship between CSA history and client’s A & D/mental health problems?
gender differences? cultural differences?
how important is meaning making for integration and healing?
Appendix I: Guidelines for completing reflective journals for social workers

Constructions of child sexual abuse among social workers in an alcohol and drug counselling service and university social work educators

Guidelines for the use of a reflective journal

Reflexivity is considered an essential component of good social work practice and research indicates social workers value the opportunity to engage in reflective learning opportunities in the workplace. It is hoped that your experience of keeping a reflective journal will promote both professional and personal development.

The reflective journal is an opportunity to:

- to reflect upon how your understanding of child sexual abuse has been influenced by your professional experiences, the workplace, education, research, social policy, the media, culture, and your own socialisation, gender and ethnicity.

- to reflect not just upon what child sexual abuse means to you on a cognitive level but to also reflect on your emotional response to examining the subject of child sexual abuse, and how that may influence your cognitive processes.

- to consider the perspectives of both victims and offenders and how these perspectives intersect.

- to reflect upon relevant practice issues that arise.

- to consider over the course of keeping the reflective journal whether there have been any shifts in your understanding and perspectives of child sexual abuse.

- to reflect on two vignettes which will be given to you at the first interview.

The degree of reflexivity and the degree to which you wish to share your reflections with me are entirely at your discretion. It is anticipated that you might record your reflections once a week, but you may wish to make entries more or less frequently.

If you are registered with DAPAANZ you are able to gain 75 credits towards your registration. DAPAANZ requires you to make 2-3 entries per year, to reflect on practice issues and ideas that relate to practice, to do some reading regarding the subject, and to use supervision. DAPAANZ would expect that you would submit 2-3 pages when your registration is due for renewal.

Please feel free to contact me if you require further clarification.

Sally Beale
Student researcher
027 2086466
e-mail: beasa638@otago.ac.nz
Appendix J: Vignettes for social workers

Constructions of child sexual abuse among social workers in an alcohol and drug counselling service and university social work educators

Vignettes and related questions

Vignette 1

Marie is a 25 year old Pakeha woman who you initially assessed. She has been attending a substance abuse group you are co-facilitating to support her in addressing her binge drinking, benzodiazepine addiction and marijuana use and has made good progress. Marie was also diagnosed with borderline personality disorder 3 years previously. She confides in you that she has recently remembered that she was sexually abused by her father starting at age 9. She tells you that she confronted her father, who is a well-respected specialist in the field of dermatology. He responded with shock and complete denial. What is your response?

Vignette questions

What is your view on the debate between recovered memories and false memories?

Does the client’s substance abuse and mental health diagnosis impact in any way on the credibility of the allegation?

Does the father’s professional status impact in any way on the credibility of the allegation?

What factors might have led the client to forget her alleged sexual abuse by her father?

Vignette 2

Wiremu is a 15 year old Māori male youth who has been heavily consuming marijuana, binge drinking and glue sniffing since the age of 12. Early in the initial assessment, he told you that he lost his virginity at age 12 to a Pakeha woman in her mid-thirties, who he mowed lawns for. They continued having sex for over a year. Wiremu described the experience as his sexual initiation and maintained that he benefited from it. He told you that he had never told anyone. At the end of the session, Wiremu laughed and said he had made it all up about having sex with the Pakeha woman, and he had only fantasised about it. What is your response?

Vignette questions

What is your view about retractions of sexual abuse?

If the victim doesn’t frame the event as sexual abuse, is it sexual abuse?

In your view, is sexual abuse by a female perpetrator as harmful as sexual abuse by a male perpetrator?
Appendix K: Interview guide for social work educators

Interview guide for social work educators

1. KNOWLEDGE CSA
   self-assessment?
   own training?
   work-related? supervision? courses? conferences? self-study?
   other sources? media?

2. DEFINITION AND PREVALENCE CSA
   how do you define CSA?
   prevalence NZ society? gender? mental health? A and D?
   sources for views?

3. SOCIAL WORK CURRICULUM
   how is CSA addressed? what is taught?
   covered within other subjects? eg trauma, mental health, families, family violence, human
   development?
   Demographics of students?

4. RELEVANCE OF CSA TO SOCIAL WORK
   how relevant is an understanding of CSA to all social work fields?
   is CSA a core issue or a specialist issue?

5. ASSESSMENT OF CURRENT CSA EDUCATION
   does the current programme adequately address CSA? if not, is there space for further training?
   what are the essential issues of CSA to cover in a social work programme?
   teach CSA as part of another paper or separate paper on trauma and abuse?

6. PROCESS ISSUES FOR CSA EDUCATION
   how easy or difficult is it to address CSA?
   how is the course material delivered? any parts of the programme taught experientially?
   how many students might have a personal history of CSA? how would students be supported?
   how to support students to fully engage with sensitive and difficult subject? gender, cultural
   issues?
Appendix L: Focus group handout

Constructions of child sexual abuse among social workers and social work educators

FOCUS GROUP OUTLINE FOR PARTICIPANTS

Focus group purpose

- To explore views about the content and process of social work education in the field of child sexual abuse (CSA).
- To consider the ways in which culture, gender, age, power, personal abuse histories, and group dynamics may impact on CSA education.

Topics for consideration

1. CSA - Core issue, specialist issue, a continuum?

2. Preparation and support for students

3. What’s taught/ what should be taught/ what can be taught?

4. Use of self/ emotional intelligence/ reflective practice

5. Delivery of CSA material
APPLICATION TO THE UNIVERSITY OF OTAGO HUMAN ETHICS COMMITTEE FOR ETHICAL APPROVAL OF A RESEARCH OR TEACHING PROPOSAL INVOLVING HUMAN PARTICIPANTS

PLEASE read carefully the important notes on the last page of this form. Provide a response to each question; failure to do so may delay the consideration of your application.

1. University of Otago staff member responsible for project:
   (surname) (first name) (title)
   Gibbs    Anita      Dr

2. Department:

   Department of Sociology, Gender and Social Work

3. Contact details of staff member responsible:

   (03) 479 5677  anita.gibbs@stonebow.otago.ac.nz

4. Title of project:

   Constructions of child sexual abuse among social workers in an alcohol and drug counselling service and university social work educators.

5. Brief description in lay terms of the purpose of the project:

   The socially constructed nature of child sexual abuse (CSA) is reflected in the multiple professional and societal interpretations of what constitutes and causes CSA, and the extent to which it is a problem (Doan, 2005; Mildred, 2003, Scott, 1995; Southwell, 2003). From a professional perspective, competing definitions of child sexual abuse...
necessarily impact on research, practice, policy and education (Haaken & Lamb, 2000; Haugaard, 2000). Yet there is a paucity of research which seeks to qualitatively explore social workers’ understanding of child sexual abuse and to discover with participants the influences upon their meanings which encompasses both personal and structural processes.

The proposed qualitative study seeks to explore social workers’ subjective understandings of child sexual abuse (CSA) and the social context from which they have arisen. The implications for social work practice and social work education will also be explored with social workers and key educators within the social work departments of the eight universities of NZ.

The research will utilise a constructivist paradigm which recognises the relational and contextual nature of knowledge construction resulting in diverse perspectives. A constructivist framework also acknowledges that the influence of power and political factors may lead to certain discourses being privileged over others. It has been noted that social constructionism encompasses a diverse and sometimes conflicting range of perspectives (Cromby & Nightingale, 1999). In terms of the realist/relativist debate within social constructionism the researcher considers herself more closely aligned to the realist end of the continuum (Houston, 2001; Nightingale & Cromby, 2002).

The project will undertake two levels of inquiry:

a) What meaning does child sexual abuse have for social workers and what influences their constructions of meaning?

b) What implications do social workers’ constructions of child sexual abuse have for social work education and social work practice?

### 6. Indicate type of project and names of other investigators and students:

<table>
<thead>
<tr>
<th>Type</th>
<th>Names</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff Research</td>
<td></td>
</tr>
<tr>
<td>Student Research</td>
<td>Sally Beale</td>
</tr>
</tbody>
</table>
7. Is this a repeated class teaching activity?
   Yes  
   No  

   If applying to continue a previously approved repeated class teaching activity, please provide Reference Number:

8. Intended start date of project:
   20th March 2010

   Projected end date of project:
   December 2012 - January 2013

9. Funding of project.
   Is the project to be funded:
   (a) Internally  
       University of Otago Postgraduate Scholarship
   (b) Externally  

   Please specify who is funding the project:
   (If externally funded, will there be any commercial use made of the data and will potential participants be made aware of the external funding before they agree to participate? If not, please explain)

Not applicable

10. Aim and description of project: (Clearly specify aims)
The aims of the research are as follows:

- to explore potentially diverse interpretations of child sexual abuse among social workers in an alcohol and drug counselling service and among social work educators within the eight universities of NZ.

- to encourage social workers to reflect upon how their understandings of child sexual abuse have been influenced by their professional experiences, the workplace, education, research, social policy, the media, culture, and their own socialisation, gender and ethnicity.

- to encourage social workers to reflect not just upon what child sexual abuse means to them on a cognitive level but to also reflect on the affect that is produced in the process of examining the subject of child sexual abuse.

- to explore with key educators within the university social work departments how and to what degree child sexual abuse is addressed within the social work curriculum.

- to explore with key educators within the university social work departments the relevance and applicability of child sexual abuse education across all social work disciplines.

- to explore with key educators within the university social work departments the sufficiency and efficacy of the current level of child sexual abuse education in the light of emerging themes arising from the interviews with social workers.

- to encourage and facilitate discussion between social workers and social work educators regarding their constructions of child sexual abuse and its implications for social work education and practice.
11. **Researcher or instructor experience and qualifications in this research area:**

Supervisor: Anita Gibbs – Associate Professor Anita Gibbs is a qualified social worker of over 20 years, has a range of practice experience and has been researching social work related topics since 1989. She has also supervised MSW and other social work postgraduate students at Otago since 1999.

Researcher: Sally Beale - The researcher is a qualified social worker with experience in mental health working for the Richmond Fellowship in the UK and working in NZ as an alcohol and drugs counsellor. The researcher observed within these work settings the disproportionate representation of a history of sexual abuse among clients with mental health problems and/or alcohol and drug problems, an issue clearly recorded within a review of 40 studies (Read, Goodman, Morrison, Ross & Aderhold, 2004).

The researcher also observed within her work settings how a history of sexual abuse may constitute a causative factor in clients’ mental and emotional problems (Ainscough & Toon, 1996; Kendler, Bulik, Silberg, Hettema, Myers, & Prescott 2000; Fergusson, Horwood & Lynskey, 1996) although many clients did not initially make the link between their history of sexual abuse and their current problems (McGregor, 2003). Many clients had never disclosed their sexual abuse and even though a substantial proportion had already entered the mental health system, sexual abuse inquiry was not always part of the assessment process (Read, McGregor, Coggan & Thomas, 2006).

The researcher not only worked with female clients who were sexually abused by males, but female clients who were sexually abused by females and male clients who were sexually abused by both genders.

12. **Participants**

*Participants means any person whose behaviour, actions, condition, state of health the researcher proposes to study; or whose personal information the researcher proposes to collect or use*

Two sets of participants will be interviewed for the project:
1. Social workers in an alcohol and drug counselling service.

2. Key educators within the social work departments from the eight universities of NZ.

12(a) **Population from which participants are drawn:** *(in particular, please specify whether any of the following might participate: minors, prisoners, hospital patients, or anyone whose capacity to give informed consent is compromised in any way)*

A purposeful sample of qualified social workers will be drawn from the various departments of an alcohol and drugs service.

Additionally, a key educator within the social work department from the eight universities of NZ will be asked to participate.

12(b) **Specify inclusion and exclusion criteria:**

The following information applies to both social workers and social work educators:

**Inclusion criteria:**

- over 20 years of age *(a range of ages)*
- male and female
- all ethnicities
- holding a diploma or degree in social work

**Exclusion criteria:**

- Under 20 years. Although it is unlikely that qualified social workers will be under 20 years of age, it is considered that the level of reflexivity required of participants would be better suited to a more mature population.
- unqualified social workers
12(c) **Number of participants:** *(where a sample size calculation is appropriate i.e., for quantitative research, it should be provided)*

For the first sample of social workers, 12-14 participants are required. For the second sample of key educators within the social work departments, 8 participants are required.

12(d) **Age range of participants:**

Over 20 years.

12(e) **Method of recruitment:**

The researcher approached the clinical advisor of the alcohol and drugs service last year to discuss the research project and the feasibility of conducting the study within the service. The clinical advisor has indicated verbal and written approval of the proposed research, and a letter endorsing support is attached to this application.

Once ethics approval has been obtained, the enclosed information sheets and consent forms will be sent to all prospective participants. Currently there are 24 qualified social workers employed at the service working in a range of departments such as the in-patient detox unit, a youth counselling service, a pregnancy and parental service, a methadone service, dual diagnosis, and a number of different geographic alcohol and drug (A and D) counselling services.

Social workers who are registered with the Drug and Alcohol Practitioners Association of Aoteoroa New Zealand (DAPAANZ) are required to complete further training and/or complete a reflective practice journal as part of their commitment to continuing education and in order to maintain registration.

The proposed research, which requires participants to keep a reflective journal, may therefore meet some of the requirements for continuing education under DAPAANZ. Approval for credits under DAPAANZ for the reflective practice journal will be made by the participant’s supervisor and will not depend on input
from the researcher. The information sheet makes it clear that although participants are free to withdraw their participation from the project at any time, their withdrawal may have consequences for their DAPAANZ continuing education credits depending on their level of completion of the reflective journal.

With regard to recruitment of key educators within the social work departments of the universities of NZ, appropriate persons will be identified within each university. The researcher intends to begin contact by telephone to informally discuss the, and follow up with the sending of information sheets and consent forms to prospective participants within each department.

12(f) Please specify any payment or reward to be offered:

A small gift basket of natural skin products made by the researcher will be given to each participant at the end of the interview process. Participants will not be informed about the gift prior to undertaking the research.

13. Methods and Procedures:

The first stage of the research will involve drawing a purposive sample of 12-14 social workers from qualified social workers employed at the alcohol and drugs service aiming for maximum variation in age, ethnicity, experience and job description as well as a balance of gender. The rationale for obtaining maximum variation in the sample is based on the research which has indicated cultural and gender differences in professionals’ constructions of CSA (Christopherson, 1998; Ward, Connolly, McCormack & Hudson, 1996).

Once consent forms have been returned participants will be asked to complete a written form regarding demographics with a stamped, addressed envelope to return to the researcher prior to interviews being conducted.

Prospective social work participants will be asked to keep a reflective journal to record and reflect upon their cognitive and affective responses to encountering the subject of child sexual abuse within their practice, daily life and from the interview process. Meaning making regarding child sexual abuse is thought to require affective processing which is necessary for proper cognitive
accommodation. From the perspectives of both professionals and clients, overwhelming emotion engendered by difficult and painful issues such as CSA may undermine the capacity to reflect (D’Cruz, Gillingham, & Melendez, 2007; Leech & Trotter 2006; Meyers, 2008; Simon, Feiring, Kobielski & McElroy, 2010).

Reflexivity is considered an essential component of good social work practice (Bagshaw, 2006; Butler, Ford, & Tregaskis, 2007; Heydt & Sherman, 2005; Taylor, 1998) and social workers value the opportunity to engage in reflective learning opportunities in the workplace (Beddoe, 2009).

The interview guides will be initially piloted with a sample of two MSW students and one social work educator so that any areas that require modification can be identified. The benefit of a semi-structured interview using open-ended questions is the ability to produce a richness and depth of data unable to be captured by standardised instruments. Its flexibility allows for unanticipated responses, a greater degree of participant control over the process and is most suited for the discussion of sensitive topics (Rubin and Rubin, 1995).

Johnson (2002) also notes that in-depth interviewing is particularly appropriate where “the knowledge sought is often taken for granted and not readily articulated”, where “the research question involves highly conflicted emotions” and where “individuals or groups involved in the same line of activity have complicated, multiple perspectives on some phenomenon” (p. 105).

Social work participants will be interviewed for one hour on two separate occasions at the workplace. In-depth semi-structured interviews with interview probes will be utilised which will be audio-recorded and transcribed.

The interviews will be underpinned by social constructionist theory seeking to uncover the perspectives and constructions that social workers have with regard to child sexual abuse and the contexts from which they have arisen (Burr, 2003). Questions will be drawn from issues arising from the academic literature, the media and from popular culture, as well as seeking to understand the policy/education/practice issues as well as personal/familial influences that contribute to an understanding of the subject. Each interview will also include one vignette for participants to comment upon.

General themes which will be traversed in the interview guide are:
- how CSA is addressed within the agency and in clinical caseloads
- how social workers determine and view the severity and impact of CSA
- prior CSA training
- self-assessment about what is known and not known about CSA
- participants’ meanings of various terms such as CSA, victim, survivor, perpetrator, paedophile
- perspectives on CSA debates such as recovered memories, false allegations, retractions, prevalence
- cognitive and affective responses to CSA
- values, beliefs and family norms in relation to sexuality
- sources for understanding CSA

The second stage of the research will involve single semi-structured interviews with the key educators within the social work departments of the universities of NZ. The interviews will be one hour’s duration and will be conducted by Skype video conferencing and audio-recorded. As with social work participants, the interview guide for key educators will explore their constructions of meaning regarding child sexual abuse but will also discuss:

- how CSA is addressed within the social work curriculum
- to what degree is CSA addressed
- how relevant and applicable is CSA education across all social work disciplines
- an evaluation of the sufficiency and efficacy of the current level of CSA education

The third stage of the research will involve a focus group of a sub-sample of six of the original social work participants and a sub-sample of two of the original key educators. The focus group will be of one hour’s duration, will be facilitated by the researcher and will be conducted at one of the service’s
departments. The group will be audio-recorded and video-recorded in order to accurately record both content and process of group interaction.

The interview guide for the focus group will be based on themes arising from the individual interviews and cannot be fully anticipated in advance. This will provide a form of member checking where participants are able to comment on the researchers’ presentation of themes. It is argued that participants can only comment on their own transcripts and that it is unrealistic to attempt to achieve validity through members’ feedback regarding emerging themes because of the issue of multiple perspectives. However the researcher perceives the opportunity for participants to comment upon her interpretations as a valuable process which promotes collaboration and acknowledges the potential that meaning construction may alter over the course of the research and continue to be debated among participants. Participants will be encouraged to discuss what implications social workers’ constructions of meaning regarding child sexual abuse have for social work practice and social work education.

A potential limitation of focus groups is that some participants may be inhibited by the group interaction, so it will be important for the researcher to recruit participants who feel confident in a group setting and to utilise group work skills to facilitate equal participation.

Thematic analysis will be used to analyse the data. Themes and sub-themes will be initially identified by segmenting text from the transcripts into conceptual categories. The codes will be derived from pattern recognition, making comparisons and contrasts and by continual reference back to the research questions and the literature.

Memo-writing will also be utilised as a further analytical and reflective tool (Birks, Chapman & Francis, 2008). The researcher will remain alert to potential disconfirming evidence emerging from the data and the opportunity to conduct negative case analysis (Padgett, 2008).

Data analysis will attend to both manifest and latent content, the descriptive and interpretive, and the parts and the whole, enabling synthesis to occur from the process of analysis. All analytic decisions will be justified and made transparent within the research process by a clear audit trail. Potential researcher bias will be addressed by the researcher’s use of a reflective journal and regular peer
debriefing. The researcher plans to set up a peer debriefing group through MSW students at the University of Otago. The researcher intends to follow Dever’s (1999) suggestion to seek out sceptical peer review whereby peer-reviewers in a sense play devil’s advocate asking challenging questions about methodology and interpretations.

Ezzy (2002) challenges the idea that preconceptions and hypotheses in qualitative research can be suppressed. Instead he suggests that preconceptions are not the problem but it is the way in which they interact with the research by potentially constraining new understandings that is the problem. An awareness of the often simultaneous process of induction and deduction and a high degree of self-awareness are in his view key to maintaining integrity and efficacy in data analysis. The researcher has purposefully included methodology which promotes reflexivity for both participant and researcher in order to promote effective data collection and analysis.

Methodological triangulation will be achieved by the use of multiple in-depth interviews, reflective journals, and a focus group. Data source triangulation will be achieved by the interviewing of social workers and key educators within university social work departments.

In maintaining the ethical principles of beneficence and non-maleficence the researcher has anticipated the potential harm and benefits to participants which might arise from the interview process. The researcher will consistently prioritise the welfare of participants over the research process and work to build an open and effective research relationship with participants. The issue of potential harm to participants highlights the need to seek ongoing consent. If a participant became distressed during an interview the researcher would give the participant the opportunity to stop the interview. This may be a temporary measure, in order to support the participant to regain composure, but if necessary, may result in the participant withdrawing from the research. Participants will have access to a list of counselling providers and will be encouraged to contact the researcher at any time should queries or concerns arise.

It is also noted that qualitative interviews can provide benefits to participants such as providing a sense of purpose, increasing self-awareness, facilitating catharsis and promoting empowerment (Hutchinson, Wilson & Wilson, 1994). It is anticipated that the participant’s use of reflective journals will also promote professional and personal development.
14. Compliance with The Privacy Act 1993 and the Health Information Privacy Code 1994 imposes strict requirements concerning the collection, use and disclosure of personal information. These questions allow the Committee to assess compliance.

14(a) Are you collecting personal information directly from the individual concerned?

YES

If you are collecting the information indirectly, please explain why:

14(b) If you are collecting personal information directly from the individual concerned, specify the steps taken to make participants aware of the following points:

- the fact that you are collecting the information:

  Social work participants will be informed that information will be collected from them by the following means:

  - completion of a form regarding their demographics
  - completing and submitting a reflective journal
  - the digital audio recording of two semi-structured interviews of one hour’s duration each

  Social work educators will be informed that information will be collected from them by the following means:

  - completing a form regarding their demographics
  - the digital audio-recording of a one hour Skype video conferencing interview

A sub-sample of six social workers and two social work educators will be informed that information will be collected from them by the following means:
- the digital audio and video recording of a one hour focus group.

- the purpose for which you are collecting the information and the uses you propose to make of it:

Both sets of participants will be given the following information regarding the purpose for collecting the information:

- The project is being undertaken as part of the requirements for the Masters in Social Welfare at the University of Otago.

- The research seeks to explore social workers’ and social work educators’ subjective and contextual understandings of child sexual abuse and the implications for social work practice and social work education.

- The researcher anticipates that the small-scale study may generate a larger-scale inquiry of social workers’ knowledge of CSA, their previous educational experiences and current educational needs.

Both sets of participants will be given the following information regarding the researcher’s proposed and/or anticipated uses for the research:

The results of the research will be available at the University of Otago Library, Dunedin, NZ and may be published, however every attempt will be made to preserve the anonymity of participants. Direct quotations will be used but only those which avoid identifying the participant and all participants will be given an opportunity to choose a pseudonym to be known by in the research.

- who will receive the information:

Both sets of participants will be given the following information regarding who will receive the information:

- data elicited in interviews will be received by the researcher and any person employed by the researcher to assist in transcribing the electronically recorded interviews. Transcribers employed by the researcher will be requested to sign a confidentiality agreement ensuring that they undertake to keep data stored securely and to refrain from discussing the data with anyone else.

- data may also be shared in more general terms by the researcher with her supervisor and also in peer group reviews.
Social work participants will additionally be given the following information:

- data from reflective journals will be received by both the researcher and each participant’s supervisor.

- the consequences, if any, of not supplying the information:

Social work participants and social work educator participants will be given the following information regarding the consequences of not supplying the information:

- Participants have the right to choose both the nature of, and the degree of information they wish to supply to the researcher and to refrain from answering any question without any consequences.

- Participants have the right to withdraw from the research at any point without any consequences.

Additionally, social work participants will be informed:

- If the reflective journal is intended to be submitted to participants’ supervisors as credits towards the continuing education requirements of registration with DAPAANZ and is not completed to a sufficient degree, these credits may not be awarded to the participant. This decision is entirely at the discretion of the participant’s supervisor and does not involve the researcher.

- the individual's rights of access to and correction of personal information:

Both sets of participants will be given the following information regarding participants’ rights of access to and correction of personal information:

Participants will be offered the opportunity to receive a digital copy of the transcribed interviews, and will be encouraged to provide feedback to the researcher regarding any perceived inaccuracies.

14(c) If you are not making participants aware of any of the points in (b), please explain why:

Not applicable
14(d)  Does the research or teaching project involve any form of deception?

NO

If yes, please explain all debriefing procedures:

Although there is no deception to participants within the proposed research the researcher concurs with (Sieber, 2004) that debriefing benefits the participant in the following ways:

- it gives the participant an opportunity to feed back to the researcher their perspectives of the researcher and the research experience, to clarify any further issues and to raise any concerns.

- it gives the researcher the opportunity to thank the participant, and more fully explain the research.

The researcher intends to offer debriefing to all participants by Skype at the conclusion of the interviews and to be available by email or mobile phone to respond to any concerns or stress arising from participation in the research. The researcher applies to the ethics committee for special consideration of her circumstances as a remote services student residing in Northland. The researcher runs a small home-based business as a naturopath and is currently not working as a social worker, so has no other contact details to provide to participants.

14(e) Please outline your storage and security procedures to guard against unauthorised access, use or disclosure and how long you propose to keep personal information

All raw data held by the researcher during the research process will be securely stored at the researcher’s home premises given that she is a remote services student. Electronic data will be stored on the researcher’s laptop and backed up onto an external hard drive stored in
a locked room along with hard copies of transcripts, reflective journals, and notebooks for memo-writing etc. All necessary measures to promote security will be taken such as ensuring that the researcher’s laptop remains either in a locked room or within the care of the researcher at all times. The researcher takes her commitment to ensure the privacy and confidentiality of her participants very seriously.

The research project is funded until 31st January 2013 and at the end of the research project the researcher will submit all data to the University of Otago for archiving. Specific identifying information regarding participants such as demographics will be destroyed by the researcher at this time.

14(f) Please explain how you will ensure that the personal information you collect is accurate, up to date, complete, relevant and not misleading:

All personal information will be collected directly from participants. Demographics will be collected by requesting the participants to complete a written form prior to the interviews, and the details will be briefly checked with each participant at the start of each interview.

In order to ensure that the personal information collected from interviews is accurate the researcher will be audio-recording interviews and intends to personally transcribe the majority, if not all the interviews herself. If any transcripts are prepared by anyone other than the researcher, such transcripts will be compared to the audio-recordings to ensure that they are accurate. A digital copy of the transcripts will be offered to all participants and they will be encouraged to feed back any perceived inaccuracies. The researcher will embark on all interviews trusting that the information provided by each participant is accurate.

Ensuring that the personal information is complete and relevant requires good interviewing skills, a well thought out interview guide and a thorough search of the literature and consequent adequate grounding in
the issue at hand. The researcher has spent and continues to spend considerable time reading the literature and planning the interview guide, and intends to pilot the interviews in order to assist in determining their adequacy in ensuring completeness and relevance. The researcher acknowledges that she is a novice and relies on the wisdom of other researchers via academic texts, articles, and her supervisor, as well as the opportunity to engage in peer review.

To ensure that the personal information is not misleading the researcher intends to attend to ground rules or “house-keeping” at the beginning of each interview session to remind participants that they can seek clarification over any question and that the researcher may also seek clarification over any answer. With regard to social work participants the researcher will also have an opportunity to seek clarification regarding any matter arising in the transcripts of the first interview with participants at the second interview. Social work educators will be asked in the consent form whether they will be prepared to be contacted for clarification over any matter arising from their interview, although it is anticipated that such areas would be addressed in the interview.

The issue of potentially misleading personal information also relates to data interpretation and the researcher therefore considers it important to attend to the context of the information, to continually be aware of bias, and to maintain an empathic stance towards participants whether face to face with participants or with their data.

14(g) Who will have access to personal information, under what conditions, and subject to what safeguards against unauthorised disclosure?

Only the researcher will have direct access to personal information, but the information may be discussed indirectly through supervision and peer groups. Only non-identifying information will be discussed.

Transcribing will be carried out as soon as possible after interviews and will be carried out by the researcher. In the event that transcripts are
produced by anyone other than the researcher any such person will be required to sign a confidentiality agreement ensuring their own security provisions for the data and an undertaking not to disclose any information to unauthorised persons.

Participants will be given the opportunity to receive a digital transcript of their interviews, and they will also be offered a digital copy of the research findings.

14(h) Do you intend to publish any personal information and in what form do you intend to do this?

The researcher hopes to disseminate research findings among the university social work departments, the two organisations that validate social work degree programmes, NZQA and CUAP, and the NZ Universities’ Academic Audit Unit. It is also hoped that the research findings may lead to publication within an appropriate peer-reviewed journal.

As mentioned at 14 b) every attempt will be made to preserve the anonymity of participants. Direct quotations will be used but only those which avoid identifying the participant and all participants will be given an opportunity to choose a pseudonym to be known by in the research.

14(i) Do you propose to collect information on ethnicity?

A copy of the researcher’s application for Research Consultation with Māori is attached. It is noted that the small sample sizes of the proposed research will limit the ability to make substantive comparisons or generalisations with regard to ethnicity, but it is hoped that the research will be of direct interest to Māori.

The researcher considers it important to seek consultation with appropriate organisations regarding culturally sensitive interviews for all ethnic groups represented by participants.
Moewaka Barnes, McCreanor, Edwards, and Borell (2009) define tikanga as “wise action and thought” which “draws on theory and practices validated by Māori” (p. 452). Tika (truth), pono (honesty) and aroha (love) are proposed as matapuna (principles) to provide an ethical framework for research involving Māori. These principles resonate with the researcher as they also represent the core values of her daughter’s school which runs a bilingual unit and has close links with the local marae.

The researcher’s focus on reflexivity is designed to promote rigour in all facets of the research including cultural competence. Symonette (2009) emphasises the need for a high degree of self-awareness and “empathic perspective taking” which involves both “cognitive and affective frame-shifting” resulting in an ethnorelative rather than ethnocentric stance (p. 285-286). As Symonette (2009) notes: “None of us is born multicultural, so we each must consciously and conscientiously put ourselves in decentring situations that fire up our awareness of our own sociocultural prisms: lenses, filters, and frames” (p. 288).

15. Potential problems: Explain whether there will be harm or discomfort to participants, medical or legal problems, or problems of community relations or controversy, or whether any conflicts of interest might arise

In terms of the ethical consideration of beneficence the research has been designed to promote professional and personal development through the use of a reflective journal and a collaborative approach to exploring the meaning of CSA. It is recognised however, that the process of engaging with a difficult and potentially emotive subject such as CSA could precipitate some level of tension and/or distress in some participants. The researcher has therefore carefully considered the ethical imperative of non-maleficence as it potentially relates to the participants.

The way in which the researcher intends to protect participants from experiencing psychological harm from participating in the research is through the following methods:
- It is the researcher’s view that informed consent is an ongoing dynamic process rather than an event. Although clear and comprehensive information will be provided to participants through the information sheet and consent form, the researcher will be available to respond to any queries or concerns that arise throughout the research process.

- Information about appropriate counselling services will be provided within the information sheet and social work participants will have access to their clinical supervisors over the course of the research.

- The reflective journal is designed to provide a reflective learning opportunity for social workers and to support social work participants in processing their cognitive and affective responses to engaging with the subject of CSA. The degree of reflexivity and the degree to which participants wish to share their reflections with the researcher are entirely at the participant’s discretion.

- Social work participants will not be directly asked if they have a personal history of child sexual abuse. However if participants disclose such information they will be asked if they are willing to explore how their experience has mediated their understanding of child sexual abuse.

- Debriefing will be offered to all participants at the conclusion of interviews.

- Interviews will be designed to focus on more concrete and practical aspects at the ends of interviews as a way of desensitising participants from the sensitive and potentially emotive aspects of the research.

- The researcher has chosen to sample a population of social work professionals and academics who presumably have good personal and professional support systems in place, consistently engage with challenging and sensitive issues and are not considered to represent a vulnerable population.
16. Informed consent

*Please attach the information sheet and the consent form to this application. The information sheet and consent form must be separate.*

At a minimum the Information Sheet must describe in lay terms:

- the nature and purpose of the research;
- the procedure and how long it will take;
- any risk or discomfort involved;
- who will have access and under what conditions to any personal information;
- the eventual disposal of data collected;
- the name and contact details of the staff member responsible for the project and an invitation to contact that person over any matter associated with the project;
- details of remuneration offered for participation and compensation payable in the event of harm;
- Exclusion criteria for the project if applicable including Health Concerns. *(If exclusion include a clear statement to the effect that: “People who meet one or more of the exclusion criteria set out above may not participate in this project, because in the opinion of the researchers and the University of Otago Human Ethics Committee, it involves unacceptable risk to them.”)*

and any other relevant matters

The Information Sheet must conclude with the statement: "The University of Otago Human Ethics Committee has reviewed and approved this project."

The Consent Form must make it clear that a participant:

- understands the nature of the proposal;
- has had all questions satisfactorily answered;
- is aware of what will become of the data (including video or audio tapes and data held electronically) at the conclusion of the project;
• knows that he or she is free to withdraw from the project at any time without disadvantage;

• is aware of risks, remuneration and compensation;

• is aware that the data may be published;

• is aware that a third party (i.e. transcriber) may have access to the data;

• is aware that every effort will be made to preserve the anonymity of the participant unless the participant gives an express waiver, which must be in addition to and separate from this consent form.

(Applicants should use the pro forma Information Sheet and Consent Form provided by the University of Otago Human Ethics Committee, with appropriate adaptation, unless a case is made and approved that these formats would be inappropriate for the specific project;
Research or teaching involving children or young persons require written consent from both the child or young person AND the parent/guardian unless an adequate justification is provided).

17. Fast-Track procedure  (In exceptional and unexpected circumstances, and where the research needs to commence before the next monthly meeting of the University of Otago Human Ethics Committee, a researcher may request that the application be considered under the fast-track provisions).

Do you request fast-track consideration? (See Important Notes to Applicants attached)

NO

(Please note that this involves the application being sent around members of the Committee by correspondence and can be expected to take 10 to 14 days)

If yes, please state specific reasons:-

18. Other committees

If any other ethics committee has considered or will consider the proposal which is the subject of this application, please give details:

Not applicable
19. **Applicant's Signature:** .................................................................

**Date:** ..............................

Please ensure that the person signing the application is the applicant (the staff member responsible for the research) rather than the student researcher.

20. **Departmental approval:** I have read this application and believe it to be scientifically and ethically sound. I approve the research design. The Research proposed in this application is compatible with the University of Otago policies and I give my consent for the application to be forwarded to the University of Otago Human Ethics Committee with my recommendation that it be approved.

    **Signature** of **Head** of **Department:** .................................

    **Date:** ..............................

*(In cases where the Head of Department is also the principal researcher then the appropriate Dean or Pro-Vice-Chancellor must sign)*
Dr A Gibbs  
Department of Sociology, Gender and Social Work

21 March 2011

Dear Dr Gibbs

I am writing to let you know that, at its recent meeting, the Ethics Committee considered your proposal entitled "Constructions of child sexual abuse among social workers in an alcohol and drug counselling service and university social work educators".

As a result of that consideration, the current status of your proposal is:- Approved

For your future reference, the Ethics Committee's reference code for this project is:- 11/051.

Approval is for up to three years. If this project has not been completed within three years from the date of this letter, re-approval must be requested. If the nature, consent, location, procedures or personnel of your approved application change, please advise me in writing.

Yours sincerely,

[Signature]

Mr Gary Witte  
Manager, Academic Committees  
Tel: 479 8256  
Email: gary.witte@otago.ac.nz

c.c. Professor H R Campbell  Head  Department of Sociology, Gender and Social Work
Dear Assoc. Prof. Gibbs,

I am again writing to you concerning your proposal entitled "Constructions of child sexual abuse among social workers in an alcohol and drug counselling service and university social work educators", Ethics Committee reference number 11/051.

Thank you for your email of 18 December 2014, advising that Sally Beale's research has been upgraded to PhD level. We confirm that ethical approval is extended for another three years until 18 December 2017.

Your proposal continues to be fully approved by the Human Ethics Committee. If the nature, consent, location, procedures or personnel of your approved application change, please advise me in writing. I hope all goes well for you with your upcoming research.

Yours sincerely,

Mr Gary Witte
Manager, Academic Committees
Tel: 479 8256
Email: gary.witte@otago.ac.nz

cc. Professor H R Campbell  Head  Department of Sociology, Gender and Social Work