

NEGOTIATING THERAPY:

**A STUDY OF THE RELATIONSHIPS BETWEEN PARENTS, CHILDREN AND
THEIR THERAPISTS AFTER CHILD SEXUAL ABUSE**

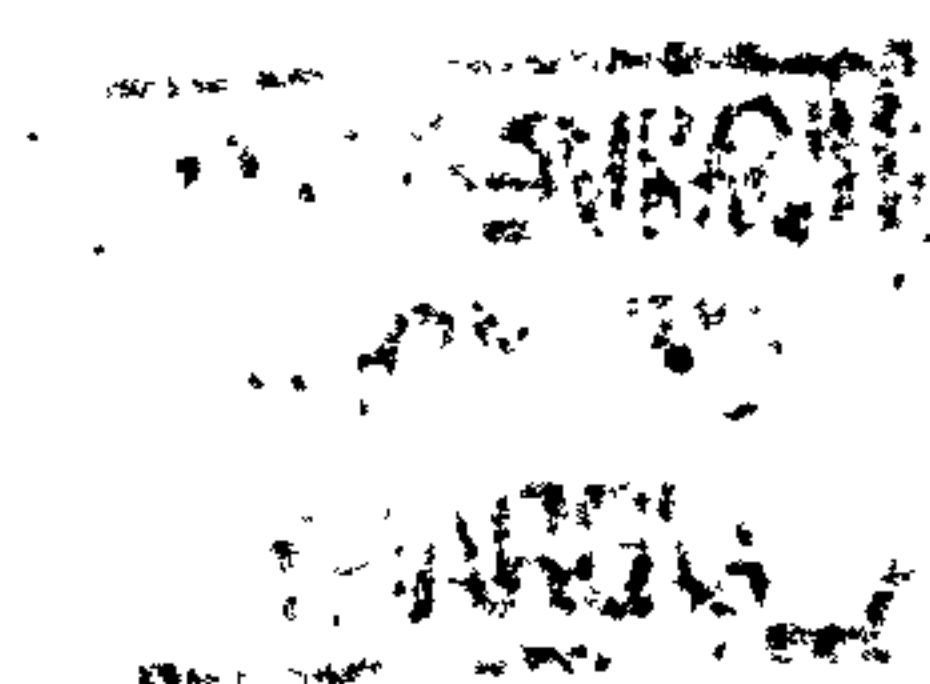
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ABSTRACT

Aims

This study investigates the relationships between the following three groups of people: children and young people who have been sexually abused, the professionals who are engaged in therapeutic work aimed at helping them to recover, and their non-offending parents or carers. A review of the literature demonstrates that the role of parents in relation to therapy with sexually abused children has not been the subject of much attention. Yet there are indications that parents may play a significant role in children's recovery, whilst at the same time they may be deeply affected by finding out about their children's abuse. The study aims to understand the dynamics of the triangular relationships between children, non-offending parents and children's therapists, to seek the most effective ways of maximising parental support for children's recovery and integrating this with professional help and, finally, to explore the possible need to provide 'support' for parents.

Methods

The study uses a qualitative methodology to investigate the work of a team of children's therapists whose practice includes parents in a number of different ways. Firstly, the team's thinking and practice is elucidated through a series of team discussions. Secondly, the views and experiences of parents, children and their therapists are sought in relation to thirteen specific cases.

Conclusions

The study traces a series of factors that may lead workers towards including non-offending parents in therapy sessions with their children, and factors that make this less likely. The study shows how therapists and parents negotiate questions of blame, particularly in the aftermath of child abuse investigations and in situations where there may be difficulties in parent-child relationships. Finally, it shows how one aspect of therapist expertise is 'interactional expertise': the ability to recognise and to incorporate the experience-based expertise of families and to negotiate working partnerships with them.

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DECLARATION

Some of the material in Chapters 3 and 10 of the thesis was previously published as:

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and:

Hill, A. (2006) 'Play therapy with sexually abused children: including parents in therapeutic play', *Child and Family Social Work*, 11: 316-324.

INTRODUCTION

This study investigates the relationships between three groups of people. These are: children and young people who have been sexually abused, the social workers who are engaged in therapeutic work aimed at helping them to recover, and their parents or carers.

In these opening pages I outline the reasons for my interest in this topic and the rationale for the study. I go on to describe the main features of the study and the structure of the thesis. This opening section is only lightly referenced because a full discussion of the topics introduced here is contained in the main body of the thesis that follows.

BACKGROUND AND RATIONALE

My interest in the topic of this study stems from a seven-year period in which I worked as a social worker for the agency that is the setting for this study. I was a member of a team of social workers undertaking therapeutic work with sexually abused children and young people. (In order to maintain the confidentiality of individual participants in the study I do not identify the agency at any stage. However, I cannot easily write about it without giving it a name so, despite the slightly Orwellian overtone, I shall refer to it simply as the Agency).

When I joined the Agency team it was already well established. Therapeutic practice reflected an idea that is central to the psychoanalytic tradition, as we shall see in Chapters 1 and 2; namely that the relationship between the therapist and the client is the main site of change and that other factors are of much less significance. Accordingly, much of the team's effort was focussed on the interaction between the child and the therapist in the therapy room. This had been important because child-centred therapies based on play were still fairly novel when the team was first formed. Much effort had been put into developing the team's skills in the use of play therapy and other 'creative therapies' (Bannister, 2003). Team members saw themselves as being there 'for the child' and relatively little attention was paid to parents. Their role was to agree to the therapy in the first place, to bring the child and then to wait in the waiting room.

To me this seemed at best a missed opportunity to encourage and to build on some of the supportive relationships that I observed between parents and children. Evidence showing that parents are influential in their children's recovery is reviewed in Chapter 2. More

negatively, there is also evidence of a correlation between the serious emotional distress experienced by parents following the sexual abuse of their children and the distress experienced by the children themselves (Newberger *et al.*, 1993). This suggested to me that interventions aimed at reducing parental distress might also be helpful to children.

Some of this thinking was shared by other team members and gradually the team's practice began to change. An early development was the introduction of a peer support group for mothers of sexually abused children (Hill, 2001). This has now been running successfully for over 10 years and several hundred women have attended. Running alongside such support for women was an increasing focus on mother-child relationships. This led to the development of practice in which some mothers remained in the play room with their children for at least some of the time and participated in the therapeutic play. By 2002, when I left the team for my current post, a variety of different approaches were being taken to supporting parents and, in some cases, to involving them directly in play therapy.

However, there is very little about this kind of practice in the literature about therapy following sexual abuse. The play therapy literature continues to focus mainly on the relationship between the child and the therapist as the main site of change, whereas the systemic or family therapy literature has surprisingly little to say about child-centred approaches based on play, or about creative therapies. The exceptions are more recent developments in filial therapy and Theraplay, and I have more to say in Chapter 2 about the use of these therapies following child sexual abuse. Suffice to say that the context for the use of the above therapies is much broader than just child sexual abuse, and that my perception is that the impact on parents of child sexual abuse is both qualitatively and quantitatively different from how parents may be affected in other contexts.

So the rationale for this study is as follows. This Agency team is engaged in a variety of fairly novel therapeutic practices with sexually abused children that include parents in different ways. In general terms I feel very positive about this, having played a part in their development. Yet these approaches are not well represented in the literature and the triangular relationship between parents, children and therapists has not been a focus of much attention. From the professional perspective I wanted to understand what was driving the team to continue to develop practice in this direction; was it based on practice

experience, training, theory or research or a combination of these? I was also very much aware of the surprising lack of general research into children's experiences of therapy (Carroll, 2002). How do children feel about their parents remaining outside in the waiting room? Or, in other cases, how do they feel about parents joining in therapeutic play? Similarly, whilst there is some research into parents' experiences following the sexual abuse of their child, there is nothing that is specifically about their relationship to the child's therapy. What is it like to have your child attend for therapy? How do parents feel about their role in relation to the work of the Agency? What are the best ways for parents, therapists and children to work together? These are the kinds of questions that I hoped to address.

Before giving an overview of the study there are some introductory issues that should be acknowledged or clarified. Firstly I should acknowledge my previous role in the development of the team's practice and how this has influenced the shape of the study. This influence is addressed in Chapter 4 when developing the methodology, and I reflect on the nature and extent of the possible effects when drawing conclusions in Chapter 9. Secondly, there are clarifications relating to my use of language; specifically the terms 'parent', 'child' and 'play therapy'. This study is about the involvement in therapy of non-offending parents. It does not include any known perpetrators of sexual abuse or any therapy that is aimed at family 'reunification' with the perpetrator after incestuous abuse. This is in line with the team's practice. So in this study the term 'parent' always refers to non-offending parents. The term is also intended to include other adult carers such as step-fathers. I have used the word 'children' as the generic term for those with whom the team works; from age 3 to 18 years. This is taken to include young people, although when referring specifically to the older child participants in the study I use the term 'young people'. Finally, I have used the term 'play therapy' as a generic term for the team's direct work with children, although some of the work with older children and young people makes use of other creative therapies and sometimes a more verbal, counselling style of therapy.

OUTLINE OF THE STUDY

Aims

The aims of the study were as follows:

- To understand more about the dynamics of the triangular relationships between children, non-offending parents and children's therapists.
- To seek the most effective ways of maximising parental 'support' for children's recovery.
- To seek the most effective ways of integrating this with professional therapy for the child.
- To explore the efficacy of professional 'support' for parents in the context of seeking to help their children.

The design of the study

In addition to a literature review, the study consists of two phases of data collection and its subsequent analysis. The first phase of the study is concerned exclusively with the professional perspective. It seeks to clarify the team's current patterns of work with children and their parents, to explore the team's thinking and rationale, and to consider future developments. These aims were explored through a series of four focus-group style team meetings with the whole group. During these meetings two different approaches were used to help to structure the discussion, including the use of a series of vignettes. During this phase of the study the discussion was mostly about guiding principles for the work. Although team members drew on examples from their work and the general principles were also discussed in relation to the vignettes, nonetheless the analysis was not fundamentally at the level of individual cases.

The second phase of the study, however, uses a case study approach. During this eighteen-month phase a total of thirteen families took part in the study. These families included seventeen sexually abused children, thirteen mothers, four fathers or step-fathers, one grandmother and twelve non-abused siblings. In relation to each case the aim was to conduct separate, in-depth interviews with the therapist, the parents and the children and to examine the case files. All this was to be carried out for the first time at an early stage of the work and then repeated once the work had been completed. In fact, whilst all the therapists and all the parents were interviewed, it proved particularly difficult to involve children directly in the study and only three of the seventeen were seen. In addition, it was not possible to conduct the second interviews in a minority of cases. Nonetheless some forty-eight interviews were carried out, eighteen with parents, four of which included men, three with children and twenty-seven with therapists. In

addition I carried out an interview with the team manager in which each of the cases was discussed in turn.

As the study progressed, I began to pay increasing attention to the use of language in interviews and the way in which 'negotiations' over therapy are framed. It is fair to say that this has led to a focus on what might be called 'process' issues that I did not foresee at the outset. Whilst it has enabled me to meet the first aim of the study, that of understanding the triangular dynamics, it has nonetheless turned attention away from questions about 'what works' in therapy (the second and third aims) in favour of questions about 'what happens' when parents, children and professionals negotiate their way towards agreement over therapy.

STRUCTURE OF THE THESIS

The thesis consists of four parts. The first is a review of the literature. This review starts, in Chapter 1, with a review of the general literature on child sexual abuse, its causes, effects and 'treatment'. In this chapter I start a practice that continues throughout much of the thesis by separating out literature that discusses child sexual abuse from the perspectives of professionals, parents, and children and considering them in turn. The aim is to look for similarities and differences that will help to develop our understanding of the interactions between the three groups in the context of therapy. In Chapter 2 attention turns to a review of the literature on therapeutic work with sexually abused children, but with a specific emphasis on the nature, extent and outcomes of parental involvement in the work. What patterns of parental involvement are recorded in the literature? What is their theoretical orientation and have they been evaluated? Finally in this first part of the thesis there is a review in Chapter 3 of the literature about 'expertise' and 'partnership' in child protection. These are important topics when considering the relationships between therapists and families. What does the literature have to say about the nature of professional expertise in this context? How do 'lay' people relate to 'experts'? What does the extensive literature about the troubled nature of 'partnerships' between professionals and parents in the context of child protection reveal about the likely dynamics of the relationships between the therapists, parents and children in this study?

The second part of the thesis is concerned with methodology. In a single chapter I give a reflexive account of the development of my thinking about an appropriate methodology for this study, an account of what I actually did in practice, and an account of how my thinking and 'doing' draws on the literature about research methods.

In part three I present the findings of the study. In Chapter 5 this opens with an account of the first phase, exploring the professional perspective in general terms. Chapters 6-8 move on to consider the casework with the thirteen families. Chapter 6 contains an account of the main themes of the interviews with the therapists, Chapter 7 with the mothers, and Chapter 8 with the fathers and the children.

In the final part of the thesis I draw together the conclusions. In Chapter 9 the focus is on the participants' use of language and on the way in which the discourse is framed. In the final chapter I return to the findings of the thematic analysis of Chapters 5-8, placing these alongside the arguments of the Chapter 9 to show how parents, therapists and children negotiate therapy.

PART ONE
LITERATURE REVIEW

CHAPTER 1: PERSPECTIVES ON CHILD SEXUAL ABUSE

INTRODUCTION

During the first half of 1987 paediatricians at Middlesbrough General Hospital diagnosed suspected sexual abuse in a total of 165 children, both girls and boys (Butler-Sloss, 1988a). As Campbell (1988) records, this was a challenge to common stereotypes about abusers, because these were not dangerous lunatics or strangers but 'respectable' men, of all ages and from all classes. And to many the numbers involved seemed incomprehensibly large. In the controversy that followed, two reactions to these diagnoses dominated the media reaction: outright denial, and anger at the doctors whose diagnoses had revealed the nature and extent of the abuse. Not, as Campbell (1988) points out, anger at the abuse itself.

In 1987 I was a newly qualified social worker doing child protection work in a local authority team in Derby. Suddenly, it seemed, sexual abuse was everywhere, and we were acutely aware of how little we knew about it. Indeed, I was one of the professionals who, as Campbell claims, in relation to Cleveland '...thought to themselves, "There but for the grace of god..." (1988: 1). In the following few years I learnt rapidly. One of the main lessons to be learnt from the Cleveland inquiry seemed to be that child sexual abuse is highly contentious and potentially explosive.

There should be no doubt that there is something distinctive about child sexual abuse that leads to ambivalent and often polarised responses. It bridges the gap between public and private space, involves sexuality, power and childhood, the family and the state. As child protection workers themselves, Craig *et al.* (1989) identify four key factors:

- A very high proportion of abusers are male.
- 'Diagnosis' is very dependent on children telling.
- Children are put under huge pressure not to tell.
- Many people find discussion of child sexual abuse painful and will minimise it.

They go on to argue that, although sexual abuse is seen as self-evidently wrong, revealing it results in resistance through denial and minimisation. It 'taps deeply into individual doubts and fears about sexuality and ...challenges the abuse of male power in families' (Craig *et al.*, 1989: 62).

Feminist writers see the latter challenge, and patriarchal reactions to it, as the cause of the controversy. Others use a social constructionist approach to show how professional and media debates about child sexual abuse draw on complex and contested discourses about childhood, the family, sexuality, gender, class and race (for example Parton and Parton, 1989).

In approaching a chapter that will review the literature about child sexual abuse, this insight into the contested, political nature of the topic is crucial. Yet in the introduction I have already referred to a study (Newberger *et al.*, 1993) that comes from a different tradition altogether. The following quotation from the opening of another journal article is typical:

‘The investigation of childhood sexual abuse (CSA) by studying adults is a relatively recent scientific endeavour, having started about 30 years ago’ (Hulme, 2004: 201).

This particular article is concerned with the development of a scientifically valid ‘instrument’ for measuring child sexual abuse. Yet the notion of measuring child sexual abuse as a ‘scientific endeavour’, with all the connotations of objectivity, reason, detachment, and lack of emotional involvement sits in marked contrast to the controversy in Cleveland. It also sits uneasily with the politics of child sexual abuse, where such a clear debt is owed to the women’s movement. As Finkelhor (1984) notes, the upsurge in attention to the sexual abuse of children stems not from a rise in prevalence, nor even just from an increase in reporting, but rather from the impact of the women’s movement in changing our thinking about child sexual abuse and our responses to it. This was certainly the case in Cleveland (Campbell, 1988).

So in reviewing the literature about child sexual abuse there is the challenge of how to make sense of material from several radically different, yet influential sources. These sources include:

- The scientific tradition of enquiry mainly within psychiatry and clinical psychology.

- The women's movement.
- Child protection campaigners (themselves adopting a range of perspectives in relation to children and childhood).
- Policy makers at national and local levels.
- Social constructionism.
- Media representations.

Material from each of these sources is discussed within the chapter, but they do not provide its structure.

Purpose, scope and structure

This chapter is an introductory review of the literature relating to child sexual abuse, its causes, effects and 'treatment'. The review is selective in so far as it is driven by the primary concerns of the thesis. These concerns also provide the structure. There are three main sections, considering sexual abuse from the perspectives of professionals, parents and children. The sequence and decreasing size of the three main sections is not intended to privilege professional perspectives and to sideline children's, but rather it reflects the large imbalance in the volume of literature. The overall purpose is to assess the current state of knowledge, both empirical and theoretical, and in the light of the above discussion, to place that knowledge in an appropriate political, cultural and historical context.

The chapter has a secondary remit that extends a little beyond the literature about child sexual abuse. This reflects the need to relate the discussion of child sexual abuse to the discussion of related topics such as the nature of childhood itself, or the gendered nature of being a 'parent'. Consequently, the literature on childhood and parenthood is also reviewed briefly within the relevant sections.

Methods

I have searched the following databases:

- Social Care Online (formerly eLSC, CareData).
- Cambridge Scientific Abstracts, Applied Social Sciences Index and Abstracts (ASSIA).

- The NSPCC library catalogue.

Social Care Online and ASSIA between them provide international coverage of social care and social science literature and the National Society for the Prevention of Cruelty to Children has a specialist library relating to child maltreatment. Searches were carried out on each database, typically using the following search terms and combinations, albeit that some of them were not recognized by all of the databases:

- Child sexual abuse OR incest AND effects (of abuse).
- Child sexual abuse OR incest AND feminism.
- Child sexual abuse OR incest AND family therapy.
- Child sexual abuse OR incest AND mothers OR fathers OR parents.

This produced a large volume of results, and these were filtered manually according to the specific purposes of the various sections of this chapter. It is noticeable that, since the 1980s when child sexual abuse first rose to prominence in the media, there has been a significant decrease in the volume of literature. Whilst there are new topics, for example links with Post Traumatic Stress Disorder or brain research, nonetheless literature from the 1980s continues to be influential.

Definitions of child sexual abuse

Within the textbooks that reflect an orthodox, scientific approach there is an emphasis on the importance of a precise, agreed definition, and concern over the lack of consensus. For example, within one such edited textbook (Mrazek and Kempe, 1981) there are four consecutive chapters by different authors offering four different definitions. Even worse, as Mrazek laments in her own chapter in the same volume, all such definitions are culture and time bound, 'not based on rigorous scientific enquiry but on values and beliefs..' (1981: 11).

Other authors note the problems over definitions and then go on to develop a definition to suit their own purpose, often drawing on the work of others (for example Glaser and Frosh, 1993). Parton *et al.* (1997) argue that this leads to competing definitions, and that the interesting question is not how sexual abuse should be defined, but rather how those

who are culturally sanctioned to make judgements about sexual abuse (i.e. child protection workers) define it operationally through their practice.

Throughout this thesis I intend to follow the argument of Parton *et al.* (1997) above and examine the use of the term in practice, rather than attempt to impose a definition. However, we should note that the Agency under study follows procedures for inter-agency working in the UK that are set out by the Department of Health and include the following definition:

‘Forcing or enticing a child or young person to take part in sexual activities whether or not the child is aware of what is happening. The activities may involve physical contact, including penetrative (e.g. rape or buggery) and non-penetrative acts. They may include non-contact activities such as involving children in looking at, or in the production of pornographic material, or watching sexual activities, or encouraging children to behave in sexually inappropriate ways’ (Department of Health, 1999: 2.6).

Prevalence

Clearly, estimates of prevalence are related to the definitions used and hence there are the difficulties referred to above, and the additional problem of under-reporting. In preparation for a national UK study of the prevalence of abuse and neglect, Cawson *et al.* (2000) record that previous estimates varied widely from 3% to 36% for females and from 3% to 29% for males, depending on the approach to definition, sampling and data collection. Their own random probability sample of 2869 18-24 year olds led to the following key findings in respect of sexual abuse, based on their definition of abuse:

- 1% of the sample had been sexually abused by parents or carers.
- 3% by other relatives.
- 11% by other known people.
- 4% by strangers or someone they had just met.

This gives a total of 19% of the sample. However, when asked whether they considered themselves to have been sexually abused, only 6% of the sample answered positively. This demonstrates the difficulties of the research definition of consent.

It should be noted that, although the above study contains some methodological difficulties in identifying household composition, nonetheless it seems that only a fairly small minority of the sexual abuse was perpetrated by adults living in the same household. This is an important part of the context for this study, because it points to the existence of a high proportion of non-offending parents, and the likelihood that this includes both men and women.

PROFESSIONAL PERSPECTIVES

Causes of sexual abuse

Victim blaming and mother blaming

Just as the 1980s were a turning point in public awareness of child sexual abuse (Kitzinger, 2004), so they were a turning point in professional thinking about its causes. Before then, psychoanalysts and family therapists had adopted explanations that straightforwardly blamed children and their mothers.

Freud's view that reports of child sexual abuse by adult women represented Oedipal fantasies quickly became a minority viewpoint within psychiatry, even before it was comprehensively challenged (Masson, 1984). From the 1920s to the 1980s, psychiatrists accepted the reality of the abuse, but blamed the victim (Salter, 1988). What is striking about Salter's account of psychoanalytic thinking in this period is the way that explanations for child sexual abuse had a double effect. They blamed the 'seductive' and 'aggressive' child whilst at the same time absolving the offender with claims such as, 'the majority of paedophiles are harmless individuals' (Revitch and Weiss quoted in Salter, 1988: 29). The practice of blaming 'seductive' children, and citing their 'participation' in the abuse as evidence, continued as mainstream practice into the early 1980s and applied as much to extra-familiar abuse as to incest. As Salter argues, this is to confuse cause and effect of abuse, and to miss out the effect of adult power over children.

Running alongside this explanation was a systemic understanding of incest as a product of 'family pathology', where mothers share much of the blame. Reid (1989) provides an account of this literature of 'family dysfunction'. Her account shows that, whilst some authors accuse mothers of actively encouraging the incest, most hold mothers as indirectly responsible, usually by their 'absence'.

‘When a mother withdraws from her family, her children and her husband may turn to one another for support, practical assistance, or comfort and the foundations of an incestuous relationship are laid. In other cases, a man deprived of his conjugal rights may turn to the nearest source of gratification – a dependant child’ (Ciba Foundation quoted in Reid, 1989: 5)

As Hooper (1992) points out, this is just a reworking of the old myth that since men are unable to control their sexuality so women must contain it for them.

In addition, mothers are blamed because of the pervasive idea, rooted in psychoanalytic theory, that mothers ‘know’ unconsciously about the abuse but prefer to keep that knowledge out of their awareness (Salter, 1988). Incest is considered mother’s responsibility even when she does not know that it is occurring. Breckenbridge and Baldry (1997) give a critique of this notion, asking what ‘unconscious knowledge’ could possibly be and how any mother could be held responsible for not acting on it. Nonetheless, my earlier research (Hill, 2001) shows that this idea continues to have a powerful impact on women.

Feminist perspectives

In the above section I have already drawn upon feminist critiques. These began to develop during the 1970s and 80s as a direct result of the work of battered women’s refuges and rape crisis centres (for example Droisen and Driver, 1989). Here workers were meeting women fleeing the violence of male partners in order to protect their sexually abused children, and they were providing counselling to women who revealed sexual abuse in childhood.

At the heart of the feminist analysis, particularly amongst radical feminists, is an understanding of sexual abuse as a manifestation, even a logical extension of the oppression of females that is inherent in patriarchy (Herman, 1981; Nelson, 1987; Rush, 1981; Ward, 1984).

‘Men have economic, legal, political, physical, medical and social power over women, but at the root of all of these is sexual power. Sexual power is exercised

at the most intimate level, the most personal level. Male sexual power over women is expressed in public and in private. It is applied to women individually and collectively. It attempts to determine how women dress, how they walk, how they sit.... Father-Daughter rape is the paradigm par excellence of this social structuring of heterosexual relations' (Ward, 1984: 184).

Child sexual abuse is seen as result of 'normal' not 'deviant' values (Reid, 1989) and much attention is paid to the power of men to conceal, minimise and deny sexual abuse, partly through a network of 'myths' that permeate the culture (Nelson, 1987). As a result there is a decisive rejection of victim blaming and mother blaming, despite evidence that it continues in professional practice (Allan, 2004; Dietz and Craft, 1980).

A whole series of writers have re-examined the evidence for mothers' involvement in child sexual abuse and rejected it (Birns and Myer, 1993; Elbow and Mayfield, 1991; Joyce, 1997; Myer, 1985). The overwhelming evidence from these studies is that most women believe and support their sexually abused children, a position given added weight by a more recent review by Elliott and Carnes (2001).

At this point it should be noted that much of this literature is about twenty years old and that to some extent the debate has moved on. There are now, for example, feminists working within the fields of psychoanalysis and family therapy. Hooper and Humphries (1998) make what, for the purposes of this study, is an important contribution to the debate. Writing from a feminist perspective, they argue that the polarised debate with family systems theorists over the blameworthiness (or otherwise) of mothers has obscured real difficulties in mother-daughter relationships after child sexual abuse. Children's anger towards their mothers may relate to such difficulties. It may not be enough just to explain them away as inevitable frustration with mothers' failure to fulfil the impossible ideal of motherhood. Noting that there is evidence that non-abusive mothers are all too easily equated with non-problematic, and therefore left without help (Farmer and Owen, 1995), Hooper and Humphries (1998) argue that to acknowledge the frequent difficulties in mother-child relationships after abuse is not to return to mother blaming but to recognise the significance of this relationship for children's recovery.

There are also some other weaknesses in the feminist explanation for abuse. As Seymour (1998) argues, a feminist perspective may be seen as a critique of other theories, rather than as a theory in itself. More importantly Seymour argues that, whilst it gives a description of patriarchy and shows how society furnishes males with the opportunity to abuse young females, it does not explain adequately why it is that some males choose to do so. Seymour goes on to develop what she describes as an 'extended feminist perspective' that attempts such an explanation. It is based on an analysis of the construction of 'masculinity' and what Seymour calls 'masculine socialisation' (she acknowledges substantial difficulties with the term) and 'masculine sexual socialisation'. Her claim is that:

'Patriarchy provides males with the social opportunity for abuse. Male socialisation provides the motivation for abuse. Male sexual socialisation provides direction for the expression of the motivation for abuse. Given such socialisation it is hardly surprising that abuse is so widespread' (Seymour, 1998: 425).

Cycles of offending

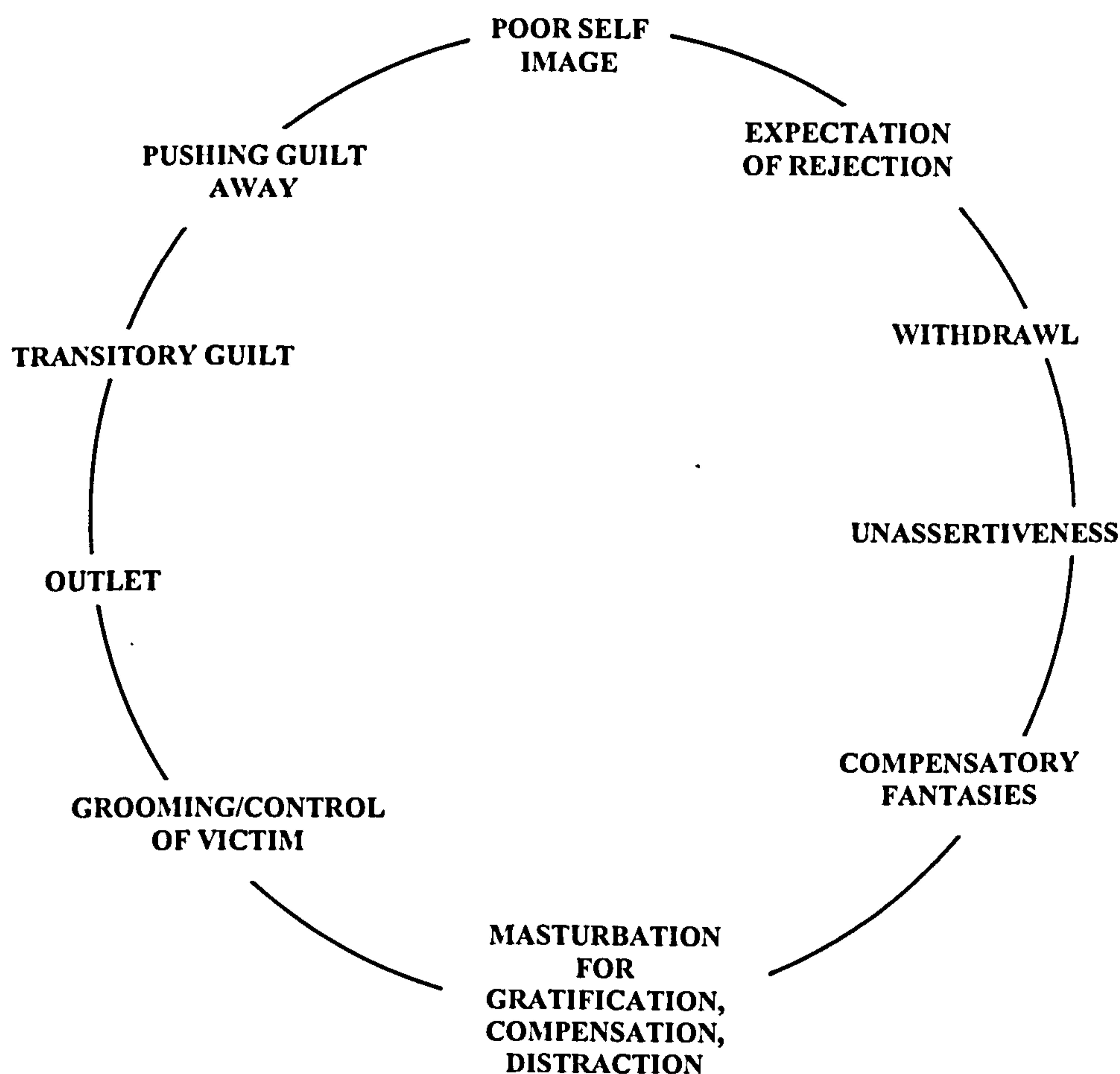
Wolf (1985) developed a model for understanding sex offending against children that draws on earlier cognitive behavioural work on 'addictive cycles'. It goes some way towards explaining how such cycles may develop, but its most significant contribution is in explaining how such cycles are maintained.

Wolf identified 'potentiators', such as witnessing sexual violence or being abused, that seem to have an impact on adult personality. The impact might include poor social adjustment, isolation and difficulties with intimate relationships. This rather sketchy outline of causality leads to the 'poor self image' at the top of the circular representation of Wolf's cycle in Figure 1, on page 17.

From this point on the model successfully describes the stages that perpetrators may go through before offending and how the offence itself leads to reinforcement of a poor self-image and a cyclical pattern of further offending. Poor self-image can lead to a 'victim posture' in which rejection is expected, and perpetrators withdraw emotionally. This can lead to compensatory fantasies of fulfilment, often with a sexual component. This is

often understood as a way of displacing other, more painful feelings. However, such fantasies are a 'cognitive rehearsal' for real abuse and lead to the targeting of a particular child through 'grooming' and, finally, to sexual abuse. Critically, although transitory guilt and embarrassment follow, it is quickly pushed aside using a variety of cognitive distortions and the process starts again.

Figure 1: Wolf's cycle of offending (Wolf, 1985: 368)

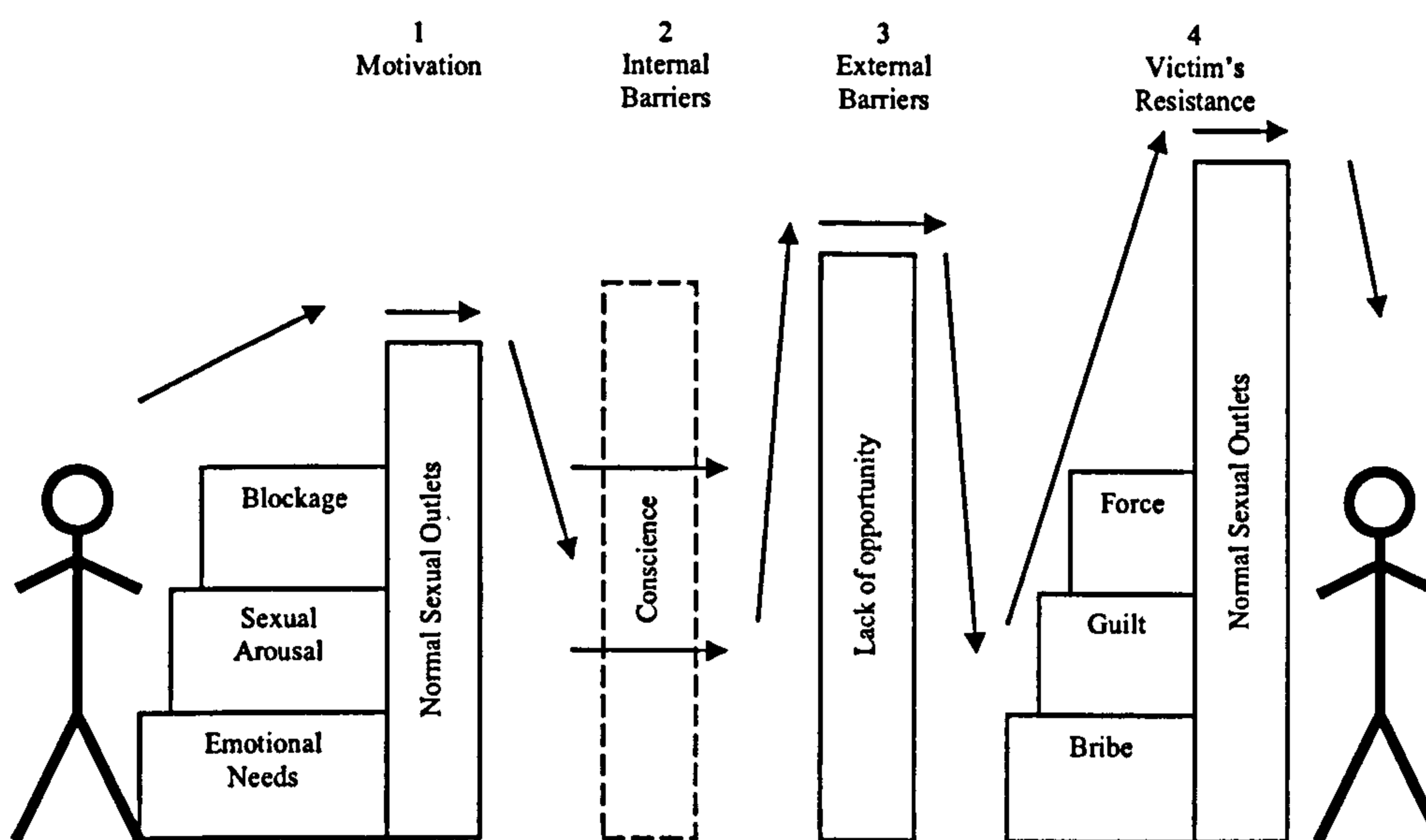


Finkelhor's four preconditions model

Finkelhor (1984) notes the diversity of sexually abusive behaviour. He argues that 'single-factor' theories of sex offending, such as those offered by psychoanalytic theory, family systems theory, learning theory or feminism, above, are insufficient by themselves to explain the full range of sexual abuse. Finkelhor has developed a model that groups factors according to the four preconditions: motivation, internal inhibitions, external

inhibitions and the child's resistance. However, this is fundamentally a descriptive model, a method of cataloguing and conceptualising previously known factors and theoretical ideas, rather than a new causal theory of offending. All four preconditions must be met, in logical sequence, for the abuse to occur. This has been shown diagrammatically as in Figure 2 below.

Figure 2: Finkelhor's four preconditions model (Calder, 2001: 148)



The first precondition, 'motivation to abuse', has the welcome effect of placing the responsibility for the abuse with the perpetrator. However, the detailed work on motivation is complex and some of the ideas are contested. (Here Finkelhor draws on work carried out with an associate (Araji and Finkelhor, 1986)). In particular, the notion of 'blockage' (the lack of sources of alternative sources of sexual gratification) may appear to be a return to 'mother blaming'. The second precondition puts the spotlight on the offender's internal inhibitions and the ways in which these are overcome. The emphasis is on cognitive strategies of justification, and this is an area that is targeted in cognitive behavioural offender treatment programmes. The final two preconditions consider the environment in which the offender is operating. External inhibitors might include the actions of peers, neighbours and the family, as well as the level of supervision that a child receives. Interventions at this level are commonly included in the UK in child protection plans, designed to protect children from known risks. However, such plans need to be carefully considered in the light of what is known about the ability

of offenders to 'groom' victims and their families, sometimes with threats of violence. Finally, this model takes into account the ability of children to resist and the need for the offender to overcome this. Calder (2001) welcomes this addition to the model, whilst acknowledging that even some children who display resistance may be abused by force. This way of thinking has led to interventions with children aimed at increasing their ability to avoid abuse. However, the uncritical use of 'self-protection work' risks passing to children the responsibility for their own protection and, in cases where children are still abused, it may make things worse.

Effects of sexual abuse on children

This section provides a brief overview of the literature that traces the effects that sexual abuse can have on children. A particular focus is on the links with attachment theory, because the potential impact on the parent-child relationship is of fundamental importance to this study.

The variety of possible effects

The most striking conclusion of research into the impact of sexual abuse on children is that there is an enormous variation in possible effects. Thus a study of children referred to a clinic in Boston, MA confirmed that children who had been sexually abused showed more behavioural problems and emotional distress than the general population, but:

'It is equally apparent, however, that not all child-victims of sexual abuse demonstrate the severity of symptoms seen in children undergoing psychiatric treatment for a broad range of problems. Instead, the level of psychological distress observed in these youngsters seems to range from a complete absence of any conventional symptoms of childhood psychopathology to the presence of extreme and pervasive emotional problems' (Gomes-Schwartz *et al.*, 1990).

In the chapters that follow, it will be seen that this range from the virtually symptom-free to quite extreme problems is reflected in the children who are included in this study.

In an attempt to 'map' some of these possible effects, various authors have produced lists of possible behavioural and emotional indicators of abuse. These are helpfully reviewed by Salter (1988). However, there are enormous difficulties in using any such list in an

attempt to 'diagnose' child sexual abuse. This is partly because of the variety of effects already noted (most conceivable behaviours are covered), but more particularly because opposite reactions are on the same list.

'Regressed, withdrawn, depressed behaviour is often found in the same list with aggressive, acting-out behaviour. Fear and avoidance of males are noted along with promiscuity and seductiveness towards males. Nervousness and symptoms of anxiety coexist with pseudomature behaviour' (Salter, 1988: 228).

'Traumagenic dynamics' model

Finkelhor and Browne (1986) have made an influential contribution with a model that organises the observed effects into an explanatory framework. The framework consists of four 'traumagenic dynamics': traumatic sexualisation, stigmatisation, betrayal and powerlessness.

Traumatic sexualisation refers to the process whereby a child's sexuality is shaped by the experience of the abuse in a way that is developmentally inappropriate and interpersonally dysfunctional. Finkelhor and Browne (1986) hypothesise that much will depend on the child's age and stage of development and on the amount of force used and fear invoked. Subsequent research reviewed by Tyler (2002) bears this out, showing that the severity of the abuse, use of force and the victim's relationship to the perpetrator are especially important.

Stigmatisation refers to all the negative connotations about the abuse that are conveyed to the child and become incorporated into the child's self-image. These may come directly from the abuse, but they can also come from attitudes of peers, family and community. One aspect of this is the experience of 'shame', and Feiring and Taska's (2005) research shows that this may be highly significant. Also of note here are the cultural and media images of abuse that are reviewed below under 'parental perspectives'.

Betrayal refers to the experience of having trusted an adult who has abused that trust. Finkelhor and Browne (1986) hypothesise that much will depend on the nature of the pre-existing relationship with the abuser and, significantly from the point of view of this research, on the degree of support from other, non-abusive carers.

Finally, powerlessness refers to the very basic kind of powerlessness that comes with the child's experience of having their body space repeatedly invaded against their will. For each of the four elements of the model Finkelhor and Browne outline the dynamics, list the psychological impact on the child and the possible behavioural manifestations, all in a tabular format (1986: 186-187).

Support from non-offending parents

A consistent research finding is that support from the non-abusing parent is the most important predictor of child psychopathology (Avery *et al.*, 1998; Everson *et al.*, 1989; Woodward and Fortune, 1999). However, there are difficulties in defining the notion of 'support' (Avery *et al.*, 1998) and in measuring its impact. The studies cited above demonstrate correlations between measures of parental support for children (in practice, mothers' support) and the severity of children's emotional and behavioural difficulties. This literature is reviewed more thoroughly in the next chapter where the focus turns to parental support for therapy.

Links with attachment theory

This is not the place for a comprehensive review of attachment theory, but this subsection begins with a brief summary of the basic concepts before exploring the links with child sexual abuse and the themes of this study.

Attachment theory suggests that patterns of attachment formed in infancy can persist powerfully throughout life. They can influence behaviour as an adult, particularly in intimate relationships and in parenting (Howe, 1995; Rutter, 1989). Attachments can be classified as secure or insecure. In his original formulation of these ideas, Bowlby (1997) stated his belief that a warm and continuous intimate relationship with mother was essential for a child's mental health. This Bowlby termed a 'secure attachment'. Associated with such secure attachments are internal representations of the self such as 'I am valued, worthy of love and protection, love and nurturance and I am capable and can develop' (Bacon, 2001: 45).

For the insecure group, internal models of experience in relationships (Heard and Lake, 1997) are more problematic. Researchers have identified three main sub-groups: anxious

(or ambivalent), avoidant (or dismissive) and disorganised (Ainsworth *et al.*, 1978; Main and Solomon, 1986). Anxious attachments are thought to result from inconsistent parental attention and to show themselves in intensified attempts by the child to gain parental attention. Avoidant attachments are thought to occur when parents are regularly rejecting of and emotionally distant from the child. In both cases children become uncertain about their self-worth and they may conclude that there is something unlovable about them (Howe, 1995). Some children who have experienced trauma may have a disorganised pattern of attachment where parents are seen as frightened or frightening and themselves as helpless (Bannister, 2003).

The links with child sexual abuse are potentially complex. It is important to distinguish between patterns of attachment to non-abusive carers that existed *before* the abuse, the impact on those attachments of the abuse itself, and patterns of attachment to sexually abusive caregivers. In the latter case it is clear that this poses different, more complex problems for the child (James, 1994). In the current study there is just one example of a young person who struggled with these issues. But the main focus in this study is on the impact of sexual abuse on pre-existing attachments to non-abusive mothers. Here Bacon (2001) notes that, despite several discussions in the literature of maltreatment and attachment style, there are no clear conclusions and little guidance for clinicians. As she notes, the clearest, albeit indirect evidence of the significance of pre-existing attachment relationships are in the studies cited above that link maternal support with decreased child distress. One interesting study by Rosenthal *et al.* (2003) shows that children who are happy with the support they get from caregivers 'adjust' better after the abuse and that, for young people, support from caregivers predicts better self esteem but more sexual anxiety, whereas support from peers predicts lower self esteem but less sexual anxiety. This may indicate difficulties in communication about sex between adolescent and caregiver. It reopens the debate about the kind of 'support' that is being measured in these studies (Avery *et al.*, 1998).

Since the early development of the theory, Rutter (1981) has shown that Bowlby's narrow focus on mothers was too exclusive. Woodhead (1990) has shown that cultural assumptions about the nature of child rearing may underlie this, and similar ideas. Nonetheless, as we shall see, attachment continues to be a significant theoretical lens

through which therapists in this study see their work. This has particular significance as therapists assess relationships between non-abusive mothers and their children.

Links with Post Traumatic Stress Disorder

A significant development since the early research and theorising of the 1980s has been the increasing awareness of Post Traumatic Stress Disorder (PTSD) and the links with child sexual abuse. Studies have shown that child sexual abuse is associated with PTSD in adult women, and that the severity of PTSD symptoms is associated with the extent of the abuse that involved actual sexual intercourse (Briggs and Joyce, 1997). Similarly, studies of sexually abused children have also shown a link with PTSD (Runyon and Kenny, 2002). In the section on 'parental perspectives' evidence is cited of a link with PTSD for mothers of sexually abused children.

Deblinger *et al.* (1999) provide evidence of the efficacy of cognitive behavioural approaches to treatment of sexually abused children with PTSD. However, it is noticeable that PTSD has not emerged as a significant issue in this research, perhaps because the primary focus on parents and parental involvement has tended to obscure it.

Gender and the effects of child sexual abuse

Studies have consistently shown that men are overwhelmingly the perpetrators of child sexual abuse (Cawson *et al.*, 2000; Gordon, 1990; Wellman, 1993). The same studies and Putnam (2003) show that the proportion of girls who are abused is anything from 2 to 10 times higher than the proportion of boys. However, beyond these basic prevalence figures there is surprisingly little research that attempts to trace the possible differences in the impact of sexual abuse by gender.

Two exceptions to this should be mentioned. One is a study that shows how persistent disordered eating can be an adult female response to child sexual abuse (Root, 1991). The second is a study of college students (Ullman and Filipas, 2005) that again shows a greater prevalence of child sexual abuse in girls, but also an increase in severity and in PTSD. In this study women reported more distress and self-blame after the abuse and a greater reliance on 'trying to forget' than men. They were also more likely to have disclosed the abuse and to have received positive support.

Difficulties with 'disclosure'

Part of the traumagenic dynamic of powerlessness is the element of secrecy that is usually inherent in sexual abuse. Sexual abuse is, in its very nature, the enlisting of a child in a private act, usually known only to those present. The perpetrator is often in a position of power and authority over the child. It follows then that the passing on of information about it is never an insignificant act (Wattam, 1999). This section reviews three types of literature: studies of the factors in children that inhibit telling, studies of factors in the potential 'audience' and finally a more critical look at the notion of 'disclosure' within the child protection system.

Research with adult survivors shows consistently that many never disclosed their abuse, or delayed doing so for years (Finkelhor *et al.*, 1990; Paine and Hansen, 2002). Letters to the National Commission of Inquiry into the Prevention of Child Abuse showed that only about 10% had been able to tell anyone about the abuse directly, though many others felt they had given sufficient signals but that no one had asked them if they needed any help (Wattam and Woodward, 1996). 'Disclosure' in children has been viewed as a stage process, with elements of recantation and denial seen as integral stages (Sorensen and Snow, 1991; Summit, 1983). However, as Paine and Hansen (2002) note, despite a wealth of clinical literature on the factors that inhibit children from telling, there are few qualitative studies that would help to understand the circumstances in which children might tell.

Another consistent finding is that the disclosure process is affected by the context for telling. Alaggia and Kirshenbaum (2005) show how, in intra-familial abuse, family dynamics that include violence, closed communication patterns and isolation can inhibit disclosure. On the other hand, it is widely believed that perceived (maternal) support is an important factor in children's willingness to disclose (Gomes-Schwartz *et al.*, 1990; Summit, 1983). A study by Jensen *et al.* (2005) shows that disclosure becomes less difficult when children perceive that there is an opportunity to talk and a context for doing so, but that 'natural' opportunities for communicating in families about child sexual abuse may be rare and that children may wait in vain for them.

Finally, Wattam (1999) draws on the literature about 'secrecy' to demonstrate how the current organisational procedures of child protection mean that children lose control over

their information as soon as they disclose their abuse to a professional. There is some evidence (see children's perspectives on page 33) that children are aware of this and are more likely to disclose to peers, a process that can lead, indirectly, to referral to professionals. Wattam argues for a more child-orientated system that recognises the dilemmas of telling and the child's need to remain in control of the process.

Approaches to 'therapy'

Chapter 2 contains a review of approaches to therapy with particular reference to the ways in which non-abusing parents and carers are (or are not) involved in the process. The current section is therefore brief and has an introductory purpose, which is to catalogue the main approaches to therapy and to establish any links with the preceding review of theoretical approaches to, and effects of, child sexual abuse.

Cognitive-behavioural approaches

Deblinger and Heflin (1996) give an account of a programme containing three elements; individual work with children, individual work with non-abusing parents and joint parent-child sessions. For both parents and children an important element is 'gradual exposure' to talking about the abuse, combined with learning 'coping skills'. The therapist acts as advocate, educator, role model and coach. This approach is reviewed fully in Chapter 2.

Family therapy approaches

A recent review of family based approaches to therapy concludes that they can be 'highly effective for a minority of families in which intrafamilial sexual abuse has occurred' (Carr, 2000: 67). Whilst the review recommends that family reunification is probably only a treatment goal in a minority of cases it is vague about the circumstances in which this might be realistic, and the implication is that such approaches are only of use in the context of planned reunification.

This might perhaps be understood in the light of the feminist critique of family systems thinking. Nonetheless, as we shall see in Chapter 2, it is perhaps surprising that family therapy seems to continue to focus on incest and to have relatively little to offer in situations where the focus of concern is the child's relationship with non-abusive family members.

Play therapy and the notion of 'recovery'

Carl Rogers (1967) made a significant break with the psychoanalytic tradition with the development of person-centred counselling. Rogers was extremely wary of therapists' attempts to dig into and to make sense of the unconscious. Instead, he emphasised the ability of individuals, given the correct conditions, to achieve their own personal growth. In this scheme the role of the therapist is to provide the conditions, (congruence, empathy and non-possessive warmth), in which individuals can flourish.

These assumptions about individuals' inherent ability to recover, given the correct conditions, can be seen carried over into play therapy with children. Axline writes that the 'curative forces within the child are potent' (1947/1989: 65). Madge Bray, looking back at her early experiences of play work with sexually abused children, writes:

'Deep within each child lay its own answers. I could only act as a catalyst. It was as if we made a journey together. I would come alongside and share part of the child's journey. Only the child would know the direction and it would struggle to find a route..... I learned to say "The child did all the doing – I just made a place where it could happen, and let it be"' (1997: 43-4).

As we will see in Chapter 2, whilst this approach to therapy has much to offer sexually abused children, it may also have some limitations and it may underestimate the significance of parental support.

PARENTAL PERSPECTIVES

Motherhood, fatherhood and childcare

This section reviews the literature on child sexual abuse from the perspective of parents of abused children. But the reactions of mothers and fathers to their children's abuse and their role in children's recovery must be understood within the context of cultural images of 'motherhood' and 'fatherhood' and in relation to the practice of normative parenting, and so this section starts with a brief survey of the relevant literature.

Motherhood

The literature about motherhood is extensive. This brief section aims to summarise some of the themes that are most relevant to mothers of sexually abused children.

For many women, having a child is an important part of building an identity (Richardson, 1993). As part of that identity, women report feelings of being needed, hopes for their children's future and pride in their children's achievements (Boulton, 1983). But research into the experiences of mothers comes from a variety of perspectives and shows a wide range of experiences. Many writers point to the existence of an idealised concept of motherhood (Chesler, 1986; Hooper, 1992; Oakley, 1981a) that may be linked to Bowlby's (1965) work on the importance for the child of consistent maternal love and attention. For these and other feminist writers, such an idealised image of the selfless and endlessly available mother has had a negative impact on women insofar as it leads inevitably to failure, and is another source of mother blaming (Chodrow and Contratto, 1982; Rich, 1977). In practice, Sanford and Donovan (1985) argue that many women find motherhood less rewarding than the idealised image would suggest. More recently, the notion of 'maternal ambivalence' has been developed and explored from the perspective of feminist psychoanalysis (Holloway and Featherstone, 1997). This moves us away from the idea that there is an essential harmony between women and children and towards an understanding of the complexities of women's experience. An insight fundamental to this study is that loss, bereavement and rejection (all linked to women's experience of their children's abuse, as we shall see) threaten the maternal fantasy of being essentially nurturing (Parker, 1997).

Fatherhood

Here, too, there is an extensive literature and this review aims to summarise some of the themes that are most relevant to fathers of sexually abused children.

Clarke and Popay (1998), in reviewing cultural images of fatherhood, note the tendency towards polarisation. On the one hand there is the concerned, involved and providing father and on the other hand there is the 'deadbeat', uninvolved father. There is some evidence that these images may reflect two groups of fathers in the UK, one seeking more contact with family life and the other retreating from it (Moss, 2006). It is possible

that men may move between the two groups at different stages in their lives, but what is lacking is research into what it means to men to be fathers (Clarke and Popay, 1998).

Other writers would argue that the polarisation of images of fathers is not evenly balanced but overwhelmingly negative. Hawkins and Dollahite (1997) document what they describe as the 'deficit paradigm' in scholarly and clinical work on fathering. They argue that it overemphasises men's inadequacies in the role of father. The 'role-inadequacy perspective':

'does not accurately portray the motives and desires of less-than-perfect but caring and committed fathers, which we believe constitute the majority of fathers – and the ones most likely interested in improving fathering' (Hawkins and Dollahite, 1997: 11).

They argue that if social welfare agencies adopt a view of fathers as essentially inadequate then this will be reflected in strategies of family support. This current study includes discussion of workers' views of fathers and their role in children's recovery.

Childcare and social welfare

So far, the discussion of motherhood and fatherhood has not focused specifically on childcare practices. Firstly, it is necessary to note the wide diversity of childcare practice that is related to social class and cultural background (Lamb, 1987). But even with this in mind, Clarke and Popay conclude that 'one of the most consistent findings from existing research is that whatever the employment status of parents, women retain the ultimate responsibility for childcare and emotional labour' (1998: 224). This is also true of their own study, where women felt themselves to be 'full-time responsible' for children even when men were contributing significantly to childcare and housework, and where the men agreed with this assessment. Some women explained that they did not 'trust' their partners to do a good enough job of parenting, and there is research that suggests that men's successful involvement in child care depends on mothers' beliefs and attitudes (Shears and Robinson, 2005). The bottom line seems to be that 'motherhood is mandated and fatherhood discretionary' (Clarke and Popay, 1998: 226). Their hierarchical position in the family and in society allows men to 'opt in' to childcare, whereas women must 'opt out'.

Not surprisingly, there is evidence that these attitudes spill over into service provision in health and social welfare (Edwards, 1998). Fathers are seen to present difficulties when absent physically, emotionally, or both and when present and dangerous. Within child protection, Milner (1993) has argued that social workers often exclude fathers from the terms of the initial inquiry. Mothering is scrutinized, whilst fathering is ignored. Support services are directed and geared towards women as mothers, understandably in view of the fact that they usually have prime responsibility for childcare. However, Edwards (1998) argues that, when men do have contact with welfare agencies, they are 'screened out' partly by the consistent message that children are best care for by women. In this study, the engagement of men with their children's therapy, and with the Agency workers, will be explored.

The impact of child sexual abuse on mothers and on fathers

Mothers

The impact on women of finding out about their children's sexual abuse is compared in the literature to the effects of bereavement (DiSabatino, 1989; Hooper, 1992; Myer, 1985; Print and Dey, 1992). In fact there are many costs (Massat and Lundy, 1998) and multiple losses occurring or threatened as a consequence of child sexual abuse. These may include partner, home, family, and supportive networks (Hooper, 1992). There are powerful emotions, starting with shock and numbness and followed by denial, anger, guilt, resentment, isolation, sorrow, self-pity and finally acceptance (Print and Dey, 1992). Hooper (1992) records how the women in her study felt that this was something that would never entirely go away. A study by psychologists Green *et al.* (1995) reports evidence of delayed PTSD in a small sample of women who were themselves survivors of childhood sexual abuse. The message from these studies is clear. The sexual abuse of their children represents a serious crisis for women that threatens to be overwhelming and that has serious long-term effects on their lives.

In the literature, mothers' perspectives are rarely presented 'directly'. An exception is Ashley's (1990) compilation of writings by American mothers of incest victims. This describes a wide range of experience, but feelings of shock; hurt; betrayal; anger and guilt are common to all. Otherwise, there are four qualitative studies based on interviews

with women that aim to understand and represent their views and experiences. These are reviewed briefly in turn.

Hooper (1992) interviewed fifteen women in England. Having identified the 'losses' referred to above, Hooper notes the danger that a 'loss' model might imply that women's response to men's sexual violence should be one of individual grief rather than a requirement for social change. However, it has the advantages of stressing the significance of the emotional impact and implying a process of change and recovery.

Humphreys (1992) interviewed twenty two women in New South Wales, Australia. Humphreys notes initial reactions of shock and disbelief, even though for many the disbelief was very short lived. She argues that this fits well with a 'loss' model, where denial is a common early response. It should not be regarded as either permanent or pathological, as the mother-blaming literature implies.

Johnson (1992) explores the responses of five American women. She records their sense of guilt and failure in their role as mothers. This same theme comes through strongly in my own interviews with eleven women attending a peer support group in the UK (Hill, 2001). In this case, women made connections with the images of idealised motherhood reviewed earlier.

Trotter (1998) interviewed seven women in the UK. She notes the lack of professional support for mothers of sexually abused children. As we have already seen, this may result from the assumption that non-abusive mothers are 'non-problematic', but there is evidence that the dynamics for women of receiving professional support may be more complex than this. Firstly, most initial contact with professional agencies is in the context of child protection. Hooper (1992) argues that mothers of sexually abused children do not sit comfortably within the mainstream construction of child protection. They are neither perpetrators of abuse nor part of the professional, protective network. So social workers begin by assessing women's 'ability to protect' (Smith, 1995a) and in that context, the responsibility for protecting the child is contested by mother and social worker. The question is 'how much responsibility women are accorded for child protection, and further whether workers attempt to empower them to fulfil their responsibilities or simply blame them for failure' (Hooper, 1992: 162). Hooper goes on to trace a series of social

and organisational pressures that tend towards the latter outcome, although there is more recent evidence of some change in thinking and practice (Calder, 2001). Secondly, there is evidence in three of these studies (Hill, 2001; Hooper, 1992; Humphreys, 1995) that women are acutely aware that judgements are being made about their parenting and that this may make it difficult to receive professional help. My own study shows how, for one woman, feelings of failure as a mother, when subjected to the scrutiny of even a helpful social worker, lead to a 'closing down' and a lack of professional support.

'I could never say to any of the social workers, as much as I liked them, how I really felt. I felt that if they thought that I questioned my own ability as a mother then perhaps I must be guilty somehow... They didn't know how difficult life was, you know, as far as they were concerned, yes it was a difficult time but we were handling it very well' (Hill, 2001: 391).

Fathers

Similar studies of the impact of child sexual abuse on fathers are rare. Both Humphreys (1995) and Trotter (1998) attempted to include fathers in the studies discussed above, but they were successful in interviewing just two and one father respectively. Trotter discusses the possible reasons for this in a later paper (1997). Perhaps the most significant contribution is an account by Stott (1998) that draws generally on her experience as a counsellor in Victoria, Australia, rather than on specific research interviews. Stott notes that some 78% of sexually abused children attending for therapy have a relationship with a non-offending father figure. (This fits well with the UK prevalence study cited above that shows only a small minority of sexual abuse perpetrated by fathers or father figures). In Stott's account, non-offending fathers express anger about the abuse in a similar way to women, but social expectations of men mean that they are likely either to want to act on it, or to feel guilty about not being able to take revenge by murdering the perpetrator. Men also express guilty feelings about failing to protect. Shame may be a significant reaction in men; 'shame that their sons may become homosexual and/or an offender, shame that their daughters are damaged and dirty' (Stott, 1998: 17). These feelings may lead to them remaining silent and isolated. Grief may be difficult for men to express and, as for women, an inhibiting factor may be the need to 'stay strong' for the sake of the child. Fathers consistently report not knowing how to react to their children after the abuse, what to do and what to say, especially about

touching. Many will do nothing in order not to make things worse, but this in itself may send damaging signals to children. Stott argues that support for men may be vital not only for their own sake but in order to support children's recovery.

Parental relationships

Both Stott (1998) and Humphreys (1995) trace the serious impact that sexual abuse can have on non-offending parental relationships. The significance of this appears to be underestimated in the literature, with couple therapy only offered after abuse by mother's partner. Couples with good communication were able to talk through the difficulties, but for parents with relationship difficulties their intense and usually different reactions to the abuse exacerbated the problems. It seems highly likely that this has a negative impact on the child, but this is not an issue that is explored in the literature.

The Agency in this study runs a support group for couples and members of that group participated in the current research.

The influence of media representations

So far this section has considered the impact of child sexual abuse on parents but it has not considered parental understandings of the causes of sexual abuse. The following examines the evidence that cultural and media representations of sexual abuse, and of sex offenders in particular, has had an impact on parental understanding of sexual abuse and on parental responses.

Kitzinger (1999) shows how lurid media descriptions of monstrous 'paedophiles' act firstly to distinguish a minority of evil people from the rest of humanity and secondly to reinforce the concept of stranger danger. The fact that most are male is not altogether obscured, but is brought into question by the constant equation of 'paedophilia' with homosexuality. Kitzinger shows how the concept of the paedophile is constructed, and how it is flawed. It means that the fact that most perpetrators are known to the child is overlooked, and that policies are adopted that would be unacceptable if applied to 'ordinary' men.

Of interest here is the question of whether this affects public understanding of sexual abuse. In a later work, Kitzinger cites evidence from focus groups that demonstrates this. Firstly:

‘Most research participants state that ‘intellectually’ they know that ‘it’s not just men in dirty macs’. ‘It could be anybody’. ‘They don’t wear a badge’. However, many also admit that they would find it very hard to believe allegations made against anyone who was part of their own social circle’ (2004: 129).

Secondly, many people cling to the idea that if they met a child abuser then they would instinctively ‘know’. Kitzinger concludes that public perceptions of child sex offenders largely accord with media representations, but that the direction of influence is not clear. Kitzinger’s focus groups, diverse though they were, did not include any parents of sexually abused children, or at least no one that was identified as such.

CHILDREN’S PERSPECTIVES

Just as the preceding section began with a brief review of the literature on ‘motherhood’ and ‘fatherhood’, so it is necessary to place this account of the literature on children’s perspectives on sexual abuse within the context of a very brief account of the literature on ‘childhood’.

Childhood

Recent sociological work on childhood has argued that childhood should be recognised as a social construction, and that children themselves should be seen as social agents who are active in the reproduction of childhood as they interact with adults and with peers (Corsaro, 2005; James *et al.*, 1998; James and Prout, 1990a; Mayall, 2002). This contrasts with earlier sociological approaches that either ignored children altogether, or saw them as moulded by society through the process of ‘socialisation’, or relied on insights from developmental social psychology to understand their individual development (Corsaro, 2005).

An important strand in this thinking is the focus on children ‘not only as proto-adults, future-beings, but also on children as beings-in-the-present’ (James and Prout, 1990b: 232). This is relevant in the current study. Is therapy aimed at redeeming the child’s

future, where that future is currently threatened by the abuse, or aimed at meeting the child's emotional needs in the here-and-now? What is the relationship between the two aims?

Children's needs

In the previous paragraph I used the phrase 'the child's emotional needs'. Woodhead (1990) notes that children's psychological 'needs' are at the heart of contemporary public concern, and that a concern about children's 'needs' is widely regarded as a progressive and enlightened approach. However, Woodhead argues that, whilst such needs imply an unproblematic understanding of what is universally good for children's development, they may be seen alternatively as a cultural construction, based partly on personal values and cultural ideologies. The current study shows how children's therapists think about children's needs, specifically in the aftermath of sexual abuse.

Children's voices

There are a small but growing number of studies that seek to understand and represent children's voices. These usually make use of qualitative methods (Shaw, 1996) and recent examples include children's views on divorce (Butler *et al.*, 2003), on domestic violence (McGee, 2000) and on social work (Butler and Williamson, 1994). However, such studies are no without their ethical dilemmas (Shaw, 1996) and in relation to the current study these are explored in some detail in Chapter 4. For example, in the context of a study of vulnerable children's views on the services they receive, Aubrey and Dahl (2006) question the uses that may be made by adults of such opinions. Will they be used to increase the autonomy of children or to increase the control over them of service providers?

For the purposes of the current study the following topics seem particularly relevant: children's experiences of sexual abuse, their views about their relationships with their parents and their views about professional help following sexual abuse. There are several studies covering this latter topic and these are reviewed in Chapter 3, page 74, when considering children's views of 'partnerships' with professionals. Studies of children's experiences of sexual abuse and studies seeking their views about parents are reviewed below.

On sexual abuse

There are only a few studies that have attempted to hear from children about their experiences of sexual abuse. Berliner and Conte (1990) interviewed twenty three children in the USA specifically about the context in which they were abused. From the outset the researchers appear to have had a very clear aim. This was to use insights from children into the dynamics of their own victimisation to help devise better prevention strategies. Berliner and Conte use the findings to argue that children should be taught about offender's tactics for justifying sexual contact, and about the powerful deterrent effect on offenders of the threat to tell.

Mudaly and Goddard (2006) carried out a much broader study based on interviews with nine Australian children. The study contains children's views on the causes and effects of abuse, on the decision about telling (often firstly to peers), on the abuser, on their non-offending parents and, finally, on professional interventions. Broadly speaking, the children's insights into the causes and effects of abuse are sophisticated and mirror some of the professional ideas reviewed above; for example, ideas about intergenerational cycles, the dynamics of power and control and the vulnerability of children. However, one limitation of the study is that it was carried out after the children had had extensive therapeutic help and it is likely that cognitive elements of the therapy have influenced their thinking on these issues. Of particular interest to the current study are children's views about non-offending parents. Most felt supported and believed by their mothers, although there is evidence that children were acutely aware of not wanting to upset either parent with talk of the abuse, and for those abused by mother's partner things were more complex and difficult. Some children were worried about an aggressive reaction from their father, and one talked about wanting his father to be more supportive. The study provides further evidence that the level of support from non-abusive parents is a vital factor for children.

On relationships with parents

Mayall (2002) uses interviews with children in the UK to identify the main features of their relationships with their parents and to analyse how these parent-child interactions are a part of the construction of 'childhood'. The findings include:

- Mothers are central, in managing the home and in interaction with children.

- Most young people talked warmly about 'family times', particularly when their father took part.
- Children acknowledged the moral authority of parents, whilst expecting some control over their own activities.
- Children must work on the 'project' of their own life, whilst also contributing to family life.
- Children are highly dependent on parents for material resources, whilst there was more interdependence in family work and care.

Milligan and Dowie (1998) explored children's views about what they need from their fathers. Children talked about the need for a good role model who is supportive and with whom they could spend quality leisure time. There was disapproval of lazy and selfish fathers. The male gender of fathers hardly featured at all in these accounts, nor did any clear desire for expressions of love or any physical contact.

CONCLUSION

This chapter has reviewed the literature about child sexual abuse that is most relevant to this study. From the outset the chapter has drawn attention to the contested nature of the discourse about sexual abuse and to the existence of a variety of very different sources of ideas about it, from the scientific tradition in psychology and psychiatry through feminism to cultural and media representations of 'paedophilia'. As the current study has progressed my attention has been caught and held by the question of how workers, parents and children develop an understanding of child sexual abuse. Which of these sources of ideas is most influential, and is it different for each of them? What impact does this have on their ability to develop a shared understanding of the situation following sexual abuse and to work together therapeutically? This question is taken forward in the final chapter of this literature review, Chapter 3, with a review of the literature on professional expertise. This discusses theory and research into how professionals develop expertise and how it may relate to their use of theory and research in their own discipline.

Returning to the current chapter, much of the literature reviewed is written from what I have called a 'professional perspective'; in other words the authors have a professional interest in child sexual abuse as clinicians, therapists or social workers. As has been

shown, this literature contains ideas about the causes and effects of abuse, based on theory and research. However, I have also included literature that represents parental and children's perspectives, albeit that in many of the studies their views and experiences are mediated through the voices of professional researchers. This literature shows that the impact on mothers, in particular, may be more serious than the 'professional' literature has hitherto recognized. It also points to the possible significance of gender in parental responses. The very limited research with children suggests that fear of further upsetting parents may inhibit children from talking to parents about the abuse.

This way of organizing the chapter reflects the concerns of the thesis as a whole. One of the main aims is to develop an understanding of the complex relationships between professionals, parents and children in the aftermath of child sexual abuse, as they are worked out in practice at the Agency team under study. Hence the next step in the argument is to review the literature on therapy with sexually abused children, with a particular emphasis on parental involvement in children's therapy. What approaches to parental involvement are already used? What is their rationale and to what extent can they be said to be successful? These are the questions to be answered in the next chapter, Chapter 2.

CHAPTER 2: APPROACHES TO PARENTAL INVOLVEMENT IN THERAPY FOR CHILDREN

INTRODUCTION

Having reviewed the general literature on child sexual abuse it is time to narrow down the focus and to explore the literature specifically relating to parental involvement in children's therapy, the main topic of the thesis. This chapter explores the international literature on therapeutic work with sexually abused children. The emphasis throughout the chapter is on understanding the nature, extent and outcomes of non-offending parental involvement in such work. The chapter identifies a number of distinct approaches to therapy that differ widely in the nature and extent of non-offending parental involvement. It is argued that the diversity of approach reflects the variety of underlying theoretical orientation.

Constructing the concept of 'parental involvement'

The way in which this chapter is framed reflects the fact that therapeutic interventions aimed at helping children to recover from the effects of child sexual abuse commonly utilize forms of individual therapy, often based on play (for example Cattanach, 1992; Easton Wickham and West, 2002; Mann and McDermott, 1983). The emphasis here is on the quality of the relationship between the therapist and the child and it is this therapeutic relationship that is privileged. A large proportion of the literature, where it mentions parents at all, is concerned with whether or how parents, who are otherwise peripheral, might be 'linked' to this therapy (the verb used by McGuire and McGuire, 2001). In this way of conceptualising therapy parents become 'involved with' or 'linked to' a professional endeavour that is focused on their child, if only because therapists have to negotiate with parents for access to the child. In fact, the extent to which parental involvement is necessary or desirable is debated in the literature, as we shall see.

However, it is important to note that there are alternative models. Some therapists advocate whole family work (for example Glaser and Frosh, 1993) from the perspective of family play therapy (for example Gil, 1994) or based on a cognitive behavioural approach (for example Deblinger and Heflin, 1996). There is also a strong tradition of group work with sexually abused children that can either replace individual work or be an adjunct to it (for example Kerslake, Kerslake, 1995). These alternative ways of

framing the relationship between parents and children's therapy are also considered in what follows.

The context for parents

The impact of finding out

In the previous chapter it was noted that parents themselves may experience significant levels of distress. A substantial body of research evidence has been developed during the past decade that documents the nature and the seriousness of the impact on non-offending parents of finding out about the sexual abuse of their children. Much of this research is about the impact on mothers (for example Hooper, 1992; Humphreys, 1992) and research into the impact on fathers (for example Stott, 1998) is less extensive, although both Humphreys (1995) and Trotter (1998) have researched separately the experiences of men and women. The main finding is that parents experience significant levels of emotional distress (Davies, 1995; Deblinger *et al.*, 1993; Hooper, 1992; Manion *et al.*, 1996). A review of the literature on the reactions of non-offending parents by Elliott and Carnes (2001) provides evidence of a significant incidence of Post Traumatic Stress Disorder and depression in both men and women following the sexual abuse of their children. In addition to this emotional distress, there may be significant practical losses, financial, vocational and residential (Massat and Lundy, 1998), particularly for women for example (Hooper, 1992). Some other significant gender differences have also been reported. Women have described how they have felt guilt and failure in their role as mothers (Hill, 2001) whilst men have described the difficulties for them of managing the physical and emotional boundaries of a caring relationship with a child who has been abused (Trotter, 1998).

Mothers: blame and support for children

To use the gender-neutral term 'parents' is to risk hiding some important gender issues. Firstly, it should be noted that the literature reviewed in this chapter is concerned almost exclusively with women. As we have seen, an important part of the historical context has been a long-standing, polarized debate about the role of women in sexual abuse between feminist writers and family systems theorists about the responsibility of women (if any) for sexual abuse perpetrated by men (Birns and Myer, 1993; Elbow and Mayfield, 1991; Hooper and Humphreys, 1998; Joyce, 1997; Myer, 1985). Feminist writers have characterized the family systems orthodoxy as mother-blaming. More recently, there has

been a growing understanding of the complexity of the processes by which women 'find out' about their children's abuse, and of the impact on their relationships with their children (Hooper, 1992; Humphreys, 1992). For many women, 'finding out' is both a cognitive and an emotional process. It involves the interpretation of partial, ambiguous or even conflicting information, and it is a long way removed from the simple dualities of knowing or not knowing, believing or not believing, protecting or not protecting (Hooper and Humphreys, 1998). Again, as we have seen, the same authors argue that the polarized nature of the debate may have obscured difficulties in the mother-child relationship.

Elliott and Carnes (2001) have reviewed the literature in an attempt to find out whether non-offending parents believe and support their children. They note the serious methodological problems in making such evaluations, not least because 'belief' and 'support' may not be fixed states but dynamic and fluid processes. They conclude, nonetheless, that the majority of non-offending mothers believe and act to protect their children, whilst some do not. Even when women have ambivalent feelings towards the male abuser, the majority are still able to act protectively. Calder (2001) draws on some of this more recent research in suggesting frameworks for professionals undertaking assessment and support. When considering the potential role of mothers in supporting children's recovery, their own unique experience of 'finding out' and the impact of this on their relationship with their child are likely to be important factors.

Parental distress and the impact on parental 'support' for children

Research suggests that there is a correlation between the levels of distress shown by parents and the levels of distress shown by their abused children (Avery *et al.*, 1998; Lipton, 1997; Newberger *et al.*, 1993). Elliott and Carnes report that there is evidence in both the theoretical and empirical literature to suggest that 'children's emotional and behavioural adjustment following victimization is associated with the reactions and support they receive from parental figures' (2001: 321). They report that empirical studies show a consistent and measurable positive effect on children's recovery given parental support. They describe this as surprising in view of the wide variations in methodology in the studies cited. Indeed, they cite several other studies (Fromuth, 1986; Johnson and Kenkel, 1991; Tremblay *et al.*, 1999) that suggest that parental support may be a more important factor in a child's recovery than any factor associated with the

circumstances of the abuse. Similarly, research by Cohen and Mannarino (1996) suggests that the influence of parental distress is significant enough to outweigh the differences in efficacy of two different approaches to treatment. However, because of the difficulties of defining the concept of 'support' used in these studies, it is difficult to assess the extent to which the support offered by parents addressed the sexual abuse specifically and openly. Since most studies use the term 'parents' it is also unclear as to whether the support was provided by mothers or by fathers and what impact this might have on the child's recovery.

Summary

The introductory argument of the chapter can be summarised as follows. Individual play therapy is a preferred method of intervention with sexually abused children. However, therapeutic work is usually negotiated with at least one parent or carer and there is concern in the play therapy literature about how parents may be 'linked' to the therapy. These non-offending adults are likely to be experiencing high levels of distress as a result of the abuse, and some may not be able to act protectively. These levels of distress are likely to have an impact on the child's distress and, more positively, support from the adult is likely to promote the child's recovery. In this context it is reasonable to assume that the extent to which parents and professionals are able to work together to help children, and the manner in which that is achieved, is likely to have a significant effect on the outcome.

Aims, scope, method and structure

The remainder of this chapter reviews the literature in order to understand the ways in which therapists have understood and responded to parents and to the potential for involving them in the therapeutic work with their children. Five key questions are posed, as follows:

- What models of parental involvement are recorded in the literature?
- What is their basis in theory or location in empirical research into recovery from child sexual abuse, play therapy or participation with parents?
- Are these models sensitive to the impact of gender?
- Is there any indication from the literature as to the context in which these models might be most effective?

- Have these models been evaluated and, if so, what were the results?

Two major divisions run through the literature included in this chapter. Firstly, there are studies that differentiate between the experiences and reactions of mothers and fathers and studies that do not. In practice, both categories of literature are mostly about mothers. The reasons for this will be explored and evidence will be cited to suggest that the literature may not reflect the significance of gender differences when considering the involvement of parents in therapy following child sexual abuse. Secondly, there is literature about intra-familial abuse and literature about extra-familial abuse. This is an important distinction for this review for the following reasons. Intra-familial abuse was the first concern of professionals dealing with child sexual abuse and much of the early literature is concerned with incest. Extra-familial abuse, and parents of children abused outside the family, have received much less attention in the literature and, arguably, even less support. This is ironic in view of the evidence from the prevalence studies reviewed in Chapter 1 that the majority of child sexual abuse falls into this category (Cawson *et al.*, 2000). This finding also implies that child sexual abuse may affect many more non-offending fathers than might be assumed from their relative invisibility in the literature.

The literature reviewed was derived from searches of the databases already listed in Chapter 1, on page 10. Searches were carried out on each database using the following search terms and combinations, albeit that some of the search terms were not recognized by all of the databases:

- Child sexual abuse AND play therapy OR therapy OR behaviour therapy OR cognitive behaviour therapy OR cognitive behavioural therapy.
- Child sexual abuse AND non-offending parents OR non-offending fathers OR non-offending mothers OR non-offending parents OR non-offending fathers OR non-offending mothers OR non-abusive parents OR non-abusive fathers OR non-abusive mothers OR non-abusive parents OR non-abusive fathers OR non-abusive mothers.
- Parents OR carers OR mothers OR fathers AND play therapy OR therapy OR behaviour therapy OR cognitive behaviour therapy OR cognitive behavioural therapy.

The results were filtered manually using the following criteria:

- Related to therapy with children including, but not necessarily exclusively, after child sexual abuse.
- Theoretical or empirical literature.
- Published since 1980 (with the exception of some influential texts that are frequently cited in recent literature).

An initial reading of the literature identified in this way led to the inclusion of some further literature that was cited in the original texts.

In answer to the first question, six different approaches to parental involvement were identified. These are:

- Individual play therapy conducted in liaison with parents.
- Play therapy that includes parents in the therapeutic sessions for at least some of the time.
- Filial therapy.
- Theraplay.
- Cognitive behavioural approaches.
- Family therapy and family play therapy.

The remainder of this chapter is organized according to these approaches. In each case literature relating to the approach is presented and a critique is developed in relation to the four remaining key questions.

THE SIX APPROACHES

Individual play therapy conducted in liaison with parents

This can be described as the mainstream approach in the play therapy literature. Typically, the therapist has an initial meeting with the child's parents and reports back to them at regular intervals during the therapy. However, it is important to note two things. Firstly, that several key texts about play therapy omit any reference to parents. Secondly, that this literature is not restricted to child sexual abuse but is rather about the use of play therapy in response to a broad range of issues.

Virginia Axline has been a key figure in the adaptation and development of non-directive models of therapy for use with children. In her early work Axline (1947/1989) placed little significance on the role of parents in children's therapy. Although parents were seen as an:

‘aggravating factor in the case of a maladjusted child, and while therapy might move ahead faster if the adults were also receiving therapy or counselling, *it is not necessary for the adults to be helped in order to insure successful play therapy results*’ (Axline, 1947/1989: 62, original italics).

As we have already seen, this was justified theoretically on the grounds that the ‘curative forces within the child are potent’ (Axline, 1947/1989: 65). It is these forces that are released through non-directive play therapy and, in Axline's view this process does not require additional support from parents to be effective. More than fifty years later the same view can still be found in the play therapy literature. Landreth claims that ‘children in play therapy can and do change in significantly positive ways without their parents being involved in therapy or parent training’ (2002: 155). However, there has been an important change in emphasis. Landreth stresses that involving parents in therapy is always recommended and may well speed up the process. Accordingly, he devotes some twenty pages in his chapter on involving parents, compared with Axline's four.

Whereas Axline's lack of emphasis on parents has a theoretical rationale, several of the main British and American texts on play therapy offer no explanation for their omission of any significant reference to making links with parents (Carroll, 1998; Cattanach, 1992; Mann and McDermott, 1983; Swainson, 1995). It is impossible to tell from these texts whether this relates to the limitations of space and scope or whether this reflects the practice of these authors.

Other play therapy texts offer only a little more. Bannister (2003) has developed for traumatized children a ‘regenerative model’ that makes use of creative therapies such as art, music, and drama. This may be particularly helpful in the aftermath of child sexual abuse when, as noted below, there are suggestions in the literature that non-directive techniques may have some limitations. But although Bannister (2003) advocates an

assessment process that pays careful attention to the child's past and present attachments she does not advocate practice that includes parents in anything other than a liaison and support role. West (1992) mentions parents briefly in the context of a preliminary meeting with them and the child. She makes no mention of any continuing dialogue with them about the progress of the therapy, though she indicates that contact with them will often be maintained through the family social worker or the professional who referred the child.

In the UK context, Wilson *et al.* (1992) also place a lot of emphasis on the role of the professional referrer. They regard the referrer as a source of information about the child and as a link with the family. For them, and for the rest of the authors reviewed in this section, the key issue is that of confidentiality. How can the therapist maintain a trusting therapeutic relationship with the child in the context of having to liaise with referrer and parents about the work? Wilson *et al.* provide a specimen 'statement concerning therapeutic work' (1992: 75-6) in which the therapist spells out to the professional referrer the approach that the therapist will take. This includes visiting the parents or carers at the beginning of the work with the child, so as to elicit cooperation and to answer questions, and again towards the end of the work so as to assess progress and to make decisions about ending. Other visits would only be arranged if the family were about to withdraw support for the therapy or if they were asking for help with behaviour management. It is made clear that the therapist's primary role is for the child, not the family.

Nonetheless, elsewhere Wilson and Ryan (2001) use a series of case studies to argue that if therapy with children is carried out so that parents are fully involved in what is going on, and if parents are given any necessary and appropriate guidance and help, then parents may benefit as well as their children, even when the emphasis remains on the relationship between child and therapist. Ryan *et al.* (1995) argue that, in the UK context, the relationship between parents and therapists can be understood within the framework of 'partnership'. They argue that an effective partnership brings the kind of stability and security for the child that will allow emotional engagement in the work with the therapist. It is an argument for an improved liaison and not for direct parental involvement in the therapy. Again, a primary concern is to formulate a partnership between the adults that respects the child's right to privacy in her relationship with the therapist.

In the USA, Easton Wickham and West (2002) write specifically about therapy following child sexual abuse. They include a chapter entitled 'Carer Involvement'. This deals with the question of confidentiality and includes a discussion of a typical pattern of visits to carers. In contrast to Wilson *et al.* (1992) they regard carers as a primary source of information about the child and they envisage monthly liaison visits. Perhaps more significantly, Easton Wickham and West (2002) are the first authors in this review to write about the impact on the carers of having a child who is considered to be in need of therapy, including the possible impact on their parenting skills. They suggest some of the feelings that parents may be coping with. These may include:

- Anger, inadequacy or failure at not having protected the child.
- Guilt at not being able to respond to the child in a nurturing fashion.
- Powerlessness at not being able to do anything about it.
- Fear about the long-term effects on the child.
- Sadness and loss.

They argue that parents may need formal therapeutic help from another therapist or less formal support, perhaps from a parents' group (Baghramian and Kershaw, 1989; Brodie and Weighell, 1990; Eaton, 1993; Hildebrand and Forbes, 1987; Masson and Erooga, 1990; Rickford, 1992; Wright and Portnoy, 1990). Crucially, they envisage this work as integrated with their attempts to help the child. 'In general, it will be therapeutic for the child to experience the therapist as a person who respects, supports and nurtures the carer' (Easton Wickham and West, 2002: 70).

McGuire and McGuire (2001) have published in the USA a practical guide entitled *Linking Parents to Play Therapy*. The claim in the foreword is that this book fills a gap in the play therapy literature. Certainly this is by far the most comprehensive and practical account of how play therapists can link parents with the individual play work with their children. McGuire and McGuire (2001) recognize the many conflicting feelings that parents have about bringing their child for therapy. They argue that substantial amounts of attention must be directed towards parents because children gain the maximum benefit when parental consent to therapy is coupled with involvement and support. They are

critical of play therapy training programmes in the USA that fail to teach therapists about how to tie parents in to the therapy.

In summary, it is clear that the literature about play therapy has focused on the relationship between therapist and child and on the content of individual play sessions. Implicit in this approach is the idea that the role of the therapist as a healer of the child is privileged over anything that a parent can offer. It has relatively little to say about linking parents to the work. Amongst those authors who address the issue, the preferred model is to have an initial meeting with parents and then regular reporting back (sometimes via a social worker). In this review this is referred to as individual play therapy in liaison with parents. A primary concern is about how to protect the child's confidentiality.

Only a few authors show an awareness of the impact on parents of feeling the need to bring a child for therapy and only a minority of this literature relates specifically to the aftermath of child sexual abuse. The possible significance of parental gender is not addressed anywhere in the play therapy literature. Even McGuire and McGuire (2001) do not differentiate between mothers and fathers in an otherwise detailed account of the dynamics of play therapists' relationships with parents. Similarly, Easton Wickham and West (2002), writing about therapy after child sexual abuse, use the term 'carers' and do not consider the possibility that child sexual abuse may have a differing impact on mothers and fathers.

Finally, on the question of efficacy and evaluation, there is no record of any attempt to evaluate the effects of liaising with parents in this way. This latter finding may not be surprising in view of the difficulties of researching the effectiveness of therapeutic play per se (Carroll, 2000) and of obtaining children's views (Carroll, 2002).

Play therapy that includes parents in the play sessions for at least some of the time

This section considers the literature that records the practice of play therapists who have extended their individual work with children to include parents, mainly mothers, in the sessions. It has been included as a separate approach because, even though there is only a very small literature, it is specifically about child sexual abuse.

Some therapists have long argued for this approach to child sexual abuse (for example Laing and Kamsler, 1991; Print and Dey, 1992). Their argument is that non-offending parents should be seen as allies and not excluded from the sessions. This derives from a theoretical understanding of the dynamics of child sexual abuse. To exclude parents is to risk reinforcing patterns of secrecy imposed by the abuser and to increase the barriers to parent-child communication that may have been caused by the abuse.

Some of this literature has a feminist theoretical perspective. Whereas Hooper and Humphreys (1998) argue that, for many years, difficulties in the relationships between mothers and children following child sexual abuse may have been obscured in feminist writings because of the need to contest mother blaming, more recently there are Australian accounts of feminist practitioners who have specifically addressed this relationship (Miller and Dwyer, 1997; Roberts, 1993).

The feminist argument for doing so is supported by empirical research with mothers. Humphreys (1995) interviewed mothers and fathers about their support needs following child sexual abuse. A number of the women felt very strongly about being excluded from their children's therapy. They recognized that their children might need some individual time but nonetheless wanted to be a part of some of the sessions. As one woman put it, 'you are concerned, you want to help your child, you need to know what is going on. You are there having to manage for all the rest of the week' (Humphreys, 1995: 17). In this research fathers did not talk about feeling excluded.

The literature reviewed in this section is about including mothers. There does not appear to be any empirical research into the views of fathers about potential inclusion in play therapy, nor any theoretical arguments about the potential advantages or disadvantages of including them. No accounts were found of any evaluation of work that includes parents in this way.

Filial therapy

This is a form of therapy that recognizes the emotional significance of the parent to the child and enables the parent, not the professional, to become the primary therapeutic agent. It takes a non-directive, child-centred approach. It is not concerned only, or even primarily, with child sexual abuse but has a much broader application. The pioneer of the

concept in the USA was Bernard Guerney (1964). One of its most influential current proponents is Garry Landreth. He gives the following definition:

‘a unique approach used by professionals trained in play therapy to train parents to be therapeutic agents with their own children through a format of didactic instruction, demonstration play sessions, required at-home laboratory play sessions, and supervision in a supportive atmosphere. Parents are taught basic child-centred play therapy principles and skills, including reflective listening, recognising and responding to children’s feelings, therapeutic limit setting, building children’s self-esteem, and structuring required weekly play sessions with their children using a special kit of selected toys. Parents learn how to create a non-judgemental, understanding, and accepting environment that enhances the parent-child relationship, thus facilitating personal growth and change for both child and parent’ (Landreth, 2002: 370).

As Landreth makes clear in a recent interview (Watts and Broaddus, 2002) this is a parent education model. Parents are trained in basic non-directive, child-centred play therapy skills with the aim of building the parent-child relationship. Whereas Landreth’s ten-week programme makes extensive use of facilitated peer support groups for parents, VanFleet (1994) describes a similar approach to filial therapy with individual families without any peer interaction.

Filial play therapy has been used for children with a wide range of emotional problems (Landreth, 2002), with parents of children with learning difficulties (Kale and Landreth, 1999), with serious illnesses (Tew, 1997) and with single parents (Bratton and Landreth, 1995). It is unusual amongst therapeutic interventions in that it has been extensively evaluated in practice in the USA, albeit mainly in a series of unpublished doctoral dissertations. Filial therapy has been shown to succeed in training parents to acquire reflective listening skills and the other prerequisites for a non-directive approach (Guerney and Stover, 1971; Lobaugh, 1992). It has also been shown to effect change in children. There are reports of a decrease in problem behaviours (Bratton and Landreth, 1995; Sywulak, 1977), increase in children’s expression of emotion (Glass, 1986), and improvement in children’s feelings of self-confidence (Bratton and Landreth, 1995). Positive changes seem to be long term (Sensue, 1981) and a qualitative study (Cleveland

and Landreth, 1997) demonstrated that children themselves shared this positive view of filial therapy.

Filial therapy has also been used and evaluated with non-offending parents of children who have been sexually abused. Costas and Landreth (1999) carried out an experimental study. This study shows that Landreth's ten-week programme promotes significant increases in parental 'acceptance' of their children and in parental empathy, compared with a control group and as measured by professional observation. It also lowers parental stress levels significantly, as measured by self-report, but only in one limited respect. Parents report reduced stress about their children after filial therapy: they become less worried about them, but they continue to report high levels of personal stress, reporting emotional stress about the abuse, feeling guilty, and worrying about their abilities as parents. Costas and Landreth (1999) report that this continuing parental stress was not found in evaluations of filial therapy in various other contexts. In these other contexts, an improvement in parent-child relationships following filial therapy leads to an overall reduction in self-reported parental stress levels. But there is something about the impact of child sexual abuse on parents that entails that stress persists even as parents worry less about their children. This may not be surprising in view of the research cited earlier showing the serious and long-lasting impact on parents of finding out about sexual abuse.

A second finding from the Costas and Landreth (1999) study is that, despite some 'positive trends', there is neither a statistically significant improvement in the children's reported behaviour, nor in their levels of anxiety, nor in measures of their self-esteem. This is a serious shortcoming. Again, it stands in contrast to the positive evaluations of filial therapy used in other contexts and cited above. The fact that these benefits for children are not replicated when using filial therapy after child sexual abuse may relate to the particular difficulties for sexually abused children of using an exclusively non-directive approach.

Rasmussen and Cunningham (1995) identify a number of these difficulties. Firstly, sexually abused children may lack assertiveness, have low self-esteem and be unlikely to confront problems spontaneously or take the responsibility for change that is a predicate of the non-directive approach. Secondly, sexual abuse conditions children to be highly sensitive to the needs of adults. Such children fear the negative emotions that they

imagine might follow from revealing to their parents feelings about which they are ashamed or embarrassed. They may fear rejection, or they may simply not want to upset their parents. Thirdly, the secrecy that is often imposed on the child by the abuser may need to be challenged. Adults who do not begin to address the abuse issues, verbally or symbolically, may be colluding with the secrecy. Finally, and most importantly, sexually abused children often develop cognitive misattributions that mean that they experience themselves as powerless and unable to affect what happens to them. Rasmussen and Cunningham (1995) acknowledge that the principles of non-directive therapy can be very reassuring to sexually abused children, particularly in the early stages of work. But the above considerations lead them to argue that 'sexually abused children require more than a trusting therapeutic relationship to address the multiple needs related to their trauma' (Rasmussen and Cunningham, 1995: 10). The empirical study by Costas and Landreth (1999) may provide some evidence to support this conclusion, albeit with parents trained as non-directive therapists.

In summary, this is an approach that fully involves parents. Its theoretical base combines a non-directive approach with the understanding that parents can provide the key support for their children if equipped to do so. But the literature suggests some significant limitations of this approach following child sexual abuse. The first relates to the fact that there is strong evidence that parents of sexually abused children suffer significantly themselves. Parents in this position may find it hard to engage in the kind of work that is implied in this approach and, by itself, the emphasis on their relationship with their child may not resolve the other stresses that they are experiencing in relation to the abuse. Secondly, the adoption of a purely non-directive approach (whether it is by therapist or by parent) may present particular difficulties for children recovering from child sexual abuse.

This literature appears to be blind to gender issues, with Landreth (2002), for example, treating 'parents' as a single entity throughout. Costas and Landreth (1999) record the numbers of mothers and fathers included in their study after sexual abuse but they do not discuss any gender issues.

Theraplay

This is another form of therapy that originated in the USA and explicitly involves parents. As with filial therapy, Theraplay is used in a wide range of contexts that are certainly not limited to sexual abuse. In fact it was developed for use with children with autism (Jernberg and Booth, 1999). The Theraplay method involves parents firstly in observing their child through a one-way mirror whilst the child takes part in a short series of play sessions with a therapist. A second therapist 'interprets' for the parent. This 'interpretation' appears to have an explicitly educational purpose, with parents being introduced to ideas about healthy attachment relationships, on which the therapy is based. Secondly, parents and the interpreting therapist join in with another series of play sessions in which the parents is encouraged to take the lead in 'healthy' play with the child.

Theraplay has very clear roots in attachment theory (Koller and Booth, 1997). The 'four dimensions' of the therapy draw on elements of what Jernberg and Booth describe as a 'healthy attachment relationship':

- *Structuring*. Parents are trustworthy and predictable, and they help define and clarify the child's experience.
- *Engaging*. Parents provide excitement, surprise and stimulation in order to maintain a maximal level of alertness and engagement.
- *Nurturing*. Parents are warm, tender, soothing, calming and comforting.
- *Challenging*. Parents encourage the child to move ahead, to strive a bit and to become more independent (Jernberg and Booth, 1999: 17).

In the first edition of their book about Theraplay, published in 1979, Jernberg and Booth argued that Theraplay should not be the treatment of choice for traumatised children, including those who had been sexually abused. This was because they felt that such children needed individual expert help with emotional and cognitive processing of the trauma. However, in the 2nd edition published in 1999, Jernberg and Booth record how their position has changed.

'We see more clearly how trauma can disrupt the parent-child relationship ... We see that traumatised children and their families are often unable to play ...

Theraplay's ability to teach parents and children how to play makes an important contribution to the healing process. By including caretakers in the treatment process, we help them understand their child's anxieties and negative behaviours and learn to interact with the child in a healthier manner' (Jernberg and Booth, 1999: 266).

Their revised argument is that Theraplay can be used to repair attachment relationships damaged by the trauma. It can be used in addition to individual therapy that is aimed at cognitive and emotional processing of the trauma.

As with filial therapy, the literature on Theraplay shows no particular awareness of the impact of child sexual abuse on parents and it is not alert to the potential significance of gender. There is no evidence of the kind of evaluation that is associated with filial therapy.

Cognitive behavioural approaches

Deblinger and Heflin (1996) describe a model used in the USA for cognitive behavioural work with children and their non-offending parents following child sexual abuse. The model includes individual and joint sessions. Individual work with children and with parents comes first and comprises the same three elements in each case: coping skills training, gradual exposure and cognitive and affective processing and, thirdly, education.

Coping skills training aims to provide skills for coping with the emotional distress. Depending on the individual's needs, this may include training in emotional expression, cognitive coping and relaxation techniques. With children, the authors make it clear that 'the therapy process may be best accomplished by entering the child's world' (Deblinger and Heflin, 1996: 28). However, it is clear that, whilst the therapist is prepared to sit on the floor and talk about the child's favourite TV show, this remains fundamentally a talking therapy. Therapist and child together may plan 'assignments', including drawing or writing, but this model does not make any systematic use of play as a means of communication.

Gradual exposure and affective processing is the cornerstone of the cognitive behavioural model. It involves exposing clients to a gradual hierarchy of anxiety-invoking stimuli so

as to 'desensitize' their responses. Deblinger and Heflin (1996) report that for parents this works well. At the beginning of therapy they are very stressed by reminders of their child's abuse and may try to avoid them. After gradual exposure exercises, including information and discussion about sexual abuse, they are more comfortable with abuse-related stimuli and can model successful coping strategies for their children. However, the authors acknowledge that the process is more difficult with children. They report that children are often unwilling to submit to anxiety-provoking stimuli in return for the promise that it will do them good. The authors do not reflect on the potential for disempowering children, or on the obvious parallel with the dynamics of sexual abuse and the potential for reinforcing them. Instead they focus on the more technical problems, such as the fact that children's fears may not be readily apparent and they may not fit into any obvious hierarchy. Nonetheless, Deblinger and Heflin (1996) record that it is possible to encourage children firstly to discuss sexual abuse in general, then the least distressing parts of their own experience and, finally, to move gradually towards the most distressing.

The education section is different for parents and for children. For children it includes information about healthy sexuality, information about child sexual abuse and personal safety skills. For adults the education section is about behaviour management skills, based on social learning theory.

The final stage in the model involves joint sessions with parents and child together. Deblinger and Heflin (1996) argue that this is important because of the way that parents serve as a positive role model for the child with respect to coping. They argue that this is far more powerful than any such influence from a therapist. Joint sessions aim to facilitate open communication about the abuse, about sex education and about safety skills. The aim is for this process to continue at home. Deblinger and Heflin (1996) argue that it is important to prepare both child and parent for these joint sessions, and that children's wishes in relation to these sessions must be respected. They also suggest that it may be helpful to include non-abused siblings in these joint sessions, although they do not suggest individual work with siblings (see Hill, 2003).

McCambridge and Lenaghan (1995) describe an alternative approach used in Ireland. This involves parallel cognitive behavioural groups for adolescent survivors of child

sexual abuse and their mothers. The argument is that the peer group is the most powerful influence on self-concept and identity during adolescence. Peer support groups following child sexual abuse can reduce isolation and help with coping strategies. Similarly, for mothers there is evidence of the significant benefits of peer group support (Hill, 2001). However, McCambridge and Lenaghan's approach does not include any joint sessions with parents and children.

Stauffer and Deblinger (1996) have evaluated a similar model of parallel cognitive behavioural groups for mothers and their young sexually abused children in the USA. They report significant decreases both in parental distress and in children's sexualized behaviours.

In summary, these approaches have a clear theoretical basis in cognitive behavioural work. They include parents either in individual and joint sessions with their child (Deblinger and Heflin, 1996) or in parallel groups with peers (McCambridge and Lenaghan, 1995; Stauffer and Deblinger, 1996). They do not make systematic use of play as a means of communication for children and it is arguable that the use of 'gradual exposure' to anxiety-provoking stimuli is problematic when used with children following child sexual abuse.

Deblinger and Heflin (1996) do not discuss gender issues and they write about parents without gender distinction. The parallel groups included just mothers. McCambridge and Lenaghan (1995) do not give an explanation for this, whereas Stauffer and Deblinger (1996) record that, although invited, very few non-offending fathers attended the group and so they were not included in the study.

Deblinger and Heflin (1996) record that their model can be used most effectively with children aged from three to thirteen years who are displaying symptoms of Post Traumatic Stress Disorder, depression, generalized anxiety or oppositional behaviours. Evaluation of cognitive behavioural approaches that include parents appears to be limited to the study cited above.

Family therapy and family play therapy

It might be expected that, within the field of family therapy, approaches to work with parents and children together following child sexual abuse would be highly developed. In fact this appears not to be the case. Wilson and Ryan (1994) argue that family therapy has only limited use following child sexual abuse for the following reasons. They argue that family therapy uses adult forms of communication, primarily verbal. Play is not well developed in family therapy because of the need to keep adult family members involved. It is unlikely that there will be the time and the privacy needed to address through play the deeper levels of the child's experience. Finally, they argue that children need to retain control over the content and timing of activities used in therapy so as to counter the sexually abusive experience of adult control. This is unlikely to occur in systemic family therapy when the therapist takes a more directive approach.

Gil (1994) expands some of these arguments. She records that the usual practice in family therapy is to treat an individual parent, the parental couple, or sometimes an adolescent and one or both parents. 'It rarely involves young children in conjoint family sessions' (Gil, 1994: v). Gil argues that many family therapists are not trained in work that includes young children. Yet this is despite an early tradition in family therapy that was firmly committed to work with whole families, including young children (for example Ackerman, 1970), and despite the development of 'family play therapy' by influential therapists such as Carl Whitaker (Keith and Whittaker, 1981) and Virginia Satir (Satir, 1972). Zilbach (1986) argues that the use of play in family therapy never gained the momentum that it could have done because adults do not understand that play is children's 'work'. Certainly, as Gil (1994) argues, there has been minimal research into the effectiveness of 'conjoint' family sessions with young children in which play is introduced as a family technique.

Another factor is that family therapy has been associated historically with approaches to intra-familial abuse that have been criticized by feminist writers as being 'mother-blaming'. In addition, there has been concern about the potentially negative impact on abused children of participating in family therapy that includes the offender (Stow, 1994). Carr (2000) describes an approach to such work that takes account of such criticism.

In recent years, feminist family therapists have highlighted difficulties in the relationships between non-offending mothers and children following child sexual abuse (for example, the work of Miller and Dwyer (1997), which has been reviewed above).

CONCLUSIONS

The overall picture appears to be quite disjointed, with a number of disparate approaches based on very different assumptions. The fact that many of the therapeutic approaches identified above are broad in scope and are not used exclusively with sexually abused children adds to the complexity. What follows is an attempt to summarise.

The above review of the mainstream play therapy literature suggests that parents are involved only in quite a peripheral role. This literature is not focussed on sexual abuse but has a much wider scope. Consequently, there is little recognition of the impact of child sexual abuse on parents. Generally, in this literature there is little awareness of the potential benefits for the child of involving parents more fully in the therapy. Filial therapy has developed in response to this latter point, and its ability to 'demystify' the therapeutic process and to empower parents is very positive. But once again filial therapy has a very broad scope. Its use specifically in the aftermath of child sexual abuse may be limited because of its failure to take into account the impact of abuse on parents and its commitment to an exclusively non-directive model of play therapy. Theraplay may have more to offer in this respect insofar as it offers a chance to repair attachment relationships that may have been damaged by the abuse. This is achieved through involving parents in play sessions with the therapist and the child, whilst not excluding parallel work with the child aimed at 'processing' the trauma.

Other approaches also involve parents directly in the work. The cognitive behavioural model developed by Deblinger and Heflin (1996) certainly takes into account the impact of child sexual abuse on parents, on parents' relationships with their children and on parents' ability to support their children. However, it is argued that this model does not capitalize on the benefits of using symbolic play and other creative therapies. Cognitive behavioural approaches understand that children and parents may be reluctant to communicate about child sexual abuse and that a non-directive approach may not be enough. But with the concept of 'gradual exposure' comes the danger that the child will experience a loss of control and that earlier experiences of powerlessness will be

reinforced. Although the cognitive behavioural model takes into account the emotional impact of child sexual abuse on parents, the literature does not explore the different impact on men and women.

On the whole, traditional family therapy models are not well developed for use with non-offending parents, (as opposed to intra-familial abuse), although there are limited examples of the use of play in family therapy and some feminist family therapists have written about their work on mother-child relationships.

Whilst, as we have seen, the literature contains some accounts of parents' views about therapy, the views of children are missing. Certainly, there is no research that has sought to understand children's perspectives on the relationship between their therapist and their parent. How much might children want their parents to become involved? What are the issues for children? In the current study I aimed to include children and young people in such a way as to begin to answer these questions.

However, before moving on to describe the design of the current study there is a final area of literature to review. At the core of the relationship between parents, children and professionals is the idea of professional expertise. Therapists may be thought to have expertise that can be utilised for the benefit of the child and the family. The next chapter begins with a review of the literature on professional expertise, particularly as applied to social work and to therapy. It moves on to review the extensive literature on 'partnership' in the context of child welfare. In this section the dynamics of the relationships between workers and families are examined in the context of worker expertise, power relationships and what has been described as the 'gaze' of child protection.

CHAPTER 3: EXPERTISE, PARTNERSHIP AND CHILD PROTECTION

INTRODUCTION

Having reviewed the existing patterns of parental involvement in children's therapy after sexual abuse, this chapter looks more closely at the nature of the possible relationships between the professional therapists and those they work with. Two questions predominate. Firstly there is the question of expertise. What is the nature of the expertise that professionals bring to therapy, how did they acquire it, how do they use it and how do parents and children relate to it? How does it differ from the 'lay' knowledge that parents or children may have? Secondly there is the question of how parents and professionals work together. 'Partnership' is perhaps an over-used term, but there is an extensive literature about the difficult and complex nature of any 'partnerships' between parents and professionals in the context of childcare, and particularly in the context of child protection.

The first section of the chapter is a selective review of the literature about expertise, focused tightly on social work expertise in particular. The overall scope of the literature about expertise is really very broad indeed, covering a wide variety of professional disciplines, including the conduct of scientific enquiry and questioning the nature of knowledge itself. Most of this is outside the scope of this thesis, but one aspect of this broader literature seems particularly relevant to the current discussion. Insights from the literature related to the sociology of knowledge form the starting point because these highlight two areas that are important in this study: one is a consideration of the power relationships between professional experts and non-experts, and the second is the question of how expert and non-expert knowledge should be taken into account in decision making. The aim is to develop a theoretical framework for understanding social work expertise that can be used to inform the interpretation of the empirical data that is presented in the chapters that follow.

The second section of this chapter reviews the literature on partnership with parents and with children in the context of child protection. This is relevant because all the families in the current study have been the subject of child protection investigations, the therapeutic work is located in an agency that is strongly identified with child protection, and the possibility of renewed child protection concerns was recognised as at least a theoretical possibility in all cases. Again, the aim is to provide a background for

understanding the nature of the relationships between parents, children and professionals that are reflected in the empirical data presented in later chapters.

Finally, in a section headed 'common themes', the implications of this literature are assessed in relation to the aims of the current study.

EXPERTISE

Insights from a sociological perspective

Professional power and its validity

There is a sociological critique of professionalism, stretching right back to the work of Max Weber, that highlights the ability of the professions to become self-regulating and to carve out areas of monopoly expertise (White, 2000). Given the value base of social work, with its emphasis on the 'empowerment' of service users (Adams, 2003), it would not be surprising if social workers had mixed feelings about such a notion of professional expertise, insofar as it confers 'power over' service users. A more recent development of this critique is to identify such expertise as a source of 'social capital' that is used to maintain privileged professional power (Torstendahl, 1990). But social work is a profession that is defined, at least in part, by its value base (Shardlow, 1998) and this includes the 'empowerment' of service users, not merely the exercise of power over them. Social work might therefore be seen as a profession in which there is an urgent need to find new ways of conceptualising professional 'expertise'.

In recent years there have indeed been major shifts in the understanding of expertise. Partly this reflects a shift from modern to postmodern ways of thinking.

'In a modernist conception, legitimate professional expertise is ... defined as that which is generalisable (acontextual), developed by scientific method by researchers, and applied by practitioners to service users' (Fook, 2000: 109).

However, postmodernism presents a far-reaching challenge to the authority of such a modernist conception of expertise (Fook, 2000). This applies equally to scientific expertise where, since the work of Thomas Kuhn (1970) there has been a growing dissatisfaction with such 'technical rationality' (Schön, 1983). Collins and Evans (2002) argue that sociologists of scientific knowledge have shown how it is necessary to draw

on 'extra-scientific factors' in order to understand how any scientific consensus is formed. Scientific method alone is not enough, because science is 'socially constructed' within a specific community of scientists.

The role of non-experts

If, as Collins and Evans (2002) argue, scientific consensus is arrived at by such 'relativist' means, then does this not undermine the privileged position of experts in decision making? Should 'lay' people, or non-experts, not play a role where decision making in science and technology intersects with the public domain: for example in relation to human cloning, or global warming? And should this not be the case particularly in disciplines such as social work where the decisions of experts so closely concern individuals? Collins and Evans argue that there is strong agreement that non-experts have a role to play in decision making in science and technology, but that the difficulty is in finding an intellectually coherent way of defining the *legitimate* contribution that non-experts can make. Their own approach to a solution is reached from two opposite directions simultaneously. The first line of argument is to challenge the idea that all scientists are experts on all questions of science and technology. In other words, they argue that it is only those specialists within the 'core group' of experts who have the relevant expertise. Other scientists may be no more qualified than non-experts. The second line of argument is to begin to challenge the idea that input to decision making should be extended in all circumstances to all 'lay' people. Their argument is that in many situations there are groups of lay people with experience-based expertise, (as distinct from political rights), that their input should be seen as both valuable and legitimate, and that these are the people who scientific experts should work with. They point to the role that Cumbrian sheep farmers could have played alongside UK government experts in managing the aftermath of the radioactive fallout from the Chernobyl explosion. However, such circumstances demand a high degree of 'interactional expertise' on the part of the certified scientific experts if such lay, experienced-based expertise is to be deployed successfully and significant difficulties were highlighted in the above example. This current study has a focus on the interaction between expert therapists and families with experience-based expertise. This is one of the frameworks for thinking about the relationships between therapists and families that will be used later in the study.

However, before moving on to consider such interactions and the literature on 'partnership' in child protection, it is necessary to examine the nature and development of professional expertise in social work rather more closely.

Features of social work expertise

Intuition and 'tacit knowledge'

New thinking on the nature of expertise has been taking place outside social work. In an influential study Klein (1999) investigated the decision making processes of fire fighters, military and medical personnel, often in highly pressurised, 'naturalistic settings'. He observed, for example, nurses treating premature babies with the appropriate antibiotics many hours before blood tests revealed any infection. When the researcher asked the nurses how they knew that the babies were in the very early stages of infection '...“it's intuition” she was told, or else “through experience”' (Klein, 1999: 40). One of Klein's central arguments is that insufficient attention has been paid to this kind of 'intuitive decision making'. As in the example above, a key characteristic is that experts find it difficult to explain their reasoning.

'If experts become aware of solutions as part of their representation of a problem then one would predict that some will be able to consciously describe the means by which they arrived at a correct solution. This does not in fact appear to be the case' (Mayhew, 1999: 201).

Collins describes this as 'tacit knowledge': 'it covers those things we know how to do but are unable to explain to someone else' (2001: 108).

There is considerable interest in the literature in the comparison between this and the kind of rule-driven decision making that can be mimicked by computer modelling. Dreyfus and Dreyfus (1986) have argued that it is not possible to mimic some features of human reasoning, particularly the use of intuition. They have developed a five-stage model for the acquisition of expertise: novice, advanced beginner, competent, proficient and expert. Of particular interest here is that the model suggests progression from an early reliance on rule-bound and consciously analytic behaviour to expert, involved behaviour that relies on an intuitive recognition of similarities with past experience. This fits with Kondrat's claim that 'simple, linear applications of theory to the concrete case

are more frequently the mark not of the expert but the novice professional, one who is either unaware of the complexities or unable to systematically take them into account' (1992: 242). Collins (2001) also argues that there is an element of tacit knowledge that cannot be replicated by a computer, but since this relates to the *development* of tacit knowledge his argument is dealt with below when discussing the production of expertise.

At this point it is time to ask whether these arguments about intuition and tacit knowledge are relevant to social work. Fook *et al.* (1997) studied thirty expert social workers using vignettes and critical incident analysis to identify some of the characteristics of social work expertise. They concluded that their own findings in relation to expert's use of theory were very much in line with the Dreyfus and Dreyfus model, insofar as 'social work theorizing may be more about underlying assumptions, the use of particular concepts, and developing practice wisdom in a seemingly intuitive way, than about using articulated integrated theoretical frameworks' (Fook *et al.*, 1997: 407).

Fook *et al.* (1997) argue that one reason for the predominance of intuition amongst expert social workers is that 'experts may perceive more complexities, and may therefore find pre-conceived formal theory inadequate to address the totality of complex situations' (1997: 408). However, various explanations have been suggested. It could be that experts are unaware of their own thought processes, or that it is too difficult to express the complexity of them (Benbenishty, 2002). It could be that knowledge derived from practice is not conceptualised: that practical knowledge is immanent in practice (Närhi, 2002). It could be that shortage of time and energy leads to 'inferential shortcuts' (Nurius and Gibson, 1990). Or it could be that knowledge that could once be articulated becomes internalised in the expert and no longer accessible (Collins, 1990). Klein argues that intuition is in fact based on sophisticated perception. 'Expertise is learning how to perceive. The knowledge and rules are incidental' (1999: 168).

As a footnote to this section, it should be acknowledged that the social work literature contains evidence of some dissatisfaction with this state of affairs. In particular, O'Sullivan (2005) argues that what he terms 'practice wisdom' in social work requires the ability to make reasoning explicit. He argues that, although identifying the sources of intuitive reasoning may require a high degree of self awareness, nonetheless Schön's (1983) work on 'reflection-in-action' suggests that it is possible to trace them, and

moreover that the need for accountability makes this an imperative. Fook *et al.* (1997) concur with this, whilst noting that the ability to articulate theory and practice may be a separate skill from the ability to practice in an expert manner.

Other types of knowledge

In addition to intuition and tacit knowledge, the literature describing other categories of knowledge is extensive. The following section selects some that is most relevant in the context of the current study. For example, an authoritative knowledge classification system for social work has been produced recently for the Social Care Institute for Excellence (SCIE) by Pawson *et al.* (2003). This identifies the following five sources of knowledge: organisational knowledge, practitioner knowledge, user knowledge, research knowledge and policy community knowledge.

In the context of this study, research and policy community knowledge relating to parental involvement in therapy following child sexual abuse has already been reviewed in Chapters 1 and 2. One of the arguments of the preceding section is that social workers may not make explicit links with these sources of knowledge and hence the predominance of tacit knowledge. This idea is explored in the current study. Also in the context of this study, organisational knowledge might relate to knowledge of the Agency's systems for managing cases by assessment and review, and also to the processes of other organisations, for example those involved in the criminal justice system. When considering practitioner knowledge, Pawson *et al.* (2003) again acknowledge the significance of tacit knowledge; knowledge based on experience of many similar cases. Finally, user knowledge is that derived from first hand experience of social work interventions, in this case designed to help with the aftermath of abuse. A major focus of this study is the interaction of user knowledge and practitioner knowledge.

There are two other relevant knowledge categories not represented in the above scheme. In relation to child protection Drury-Hudson (1999) includes 'personal knowledge' in her scheme. In the context of this study, personal knowledge might be derived from, for example, the experience of being a parent or even, for some workers, the experience of being abused. Närhi (2002) includes the second category: 'value knowledge'. This categorisation draws on the work of Nigel Parton. It takes the view that expert social work practice is not just a question of the technical application of knowledge, from any

source, but rather, as Parton (2000) argues, it is a 'practical-moral' activity based on values and moral constructions. Hence workers' value and moral constructions are of great significance.

The place of creativity and artistry

Fook *et al.* (2000) have adapted the Dreyfus and Dreyfus model of expertise based on their own observations of expert social workers. Fook *et al.* argue that 'expert' workers in the Dreyfus and Dreyfus model are merely 'experienced', rather than truly expert. Their experience allows them to perform tasks using a variety of types of knowledge, some of which is tacit knowledge. On the other hand Fook *et al.* argue that true expertise requires the ability to see situations in new ways and to create new responses. They cite examples of experienced workers whose practice 'did not fit with our notions of 'good' social work' (2000: 178), often because of their tendency to 'individualise' problems or because of their difficulties in working with people socially different from themselves. This led them to suggest an additional stage in the Dreyfus and Dreyfus model to account for the differences between 'experienced' and 'expert' workers. What is needed to attain 'expert' status is the ability to see things differently, to use more creativity or artistry.

This emphasis on seeing things differently reinforces Klein's argument (above) that expert intuition is based on sophisticated perception. In fact there has long been a significant strand of social work literature arguing that social work is artistic in nature and that good practice is linked to creative abilities (Brandon, 1979; Elliott, 1990; England, 1986; Peile, 1993; Weissman, 1990).

The production of expertise

Having considered the nature of expertise in social work it is time to turn to a discussion of its origins. The first thing to note is that 'merely performing a task does not ensure that subsequent performance will be improved' (Ericsson and Smith, 1991: 27). Length of experience is not enough (Mayhew, 1999). This perhaps rather commonplace observation leads to a focus on the specific ways in which experts learn. Based on a review of the literature, Klein has compiled the following list:

- They engage in deliberate practice, so that each opportunity for practice has a goal and evaluation criteria.

- They compile an extensive experience bank.
- They obtain feedback that is accurate, diagnostic, and reasonably timely.
- They enrich their experiences by reviewing prior experiences to derive new insights and lessons from mistakes (1999: 104).

From a sociological perspective it could be argued that this list pays insufficient attention to the 'social' dimension of knowledge development. For that reason this section begins with a consideration of the team context for learning before moving on to consider two items from Klein's list that are most relevant to social work: the process of reviewing experience, often referred to as 'reflection', and the role of 'feedback' from service users

The role of team culture

Collins (2001) has argued persuasively that, of all the features of 'tacit knowledge', the only one that is, in principle, not open to replication by a rule-governed computer is that such knowledge is developed in a social context through interaction amongst practitioners. As he puts it, 'the grounds for our certainties should be looked for in the histories of the social groups in which we are embedded' (Collins, 2001: 111). In social work, where the local unit of organisation is very often the 'team', this means looking at the development of team culture. From a very different perspective, Klein argues that teams have 'the ability to come up with ideas that are beyond the skills of any single team member' (1999: 233). He goes so far as to suggest the concept of a 'team mind'. In his view, such a phenomenon develops as teams acquire basic competencies and a sense of team identity.

A clear example of how a social work team can produce shared knowledge and a common tradition is contained in Närhi's (2002) study of Finnish social workers. Närhi shows how, through team discussion, these workers arrived at a common understanding, in this case about the influence of living conditions on people's welfare. This understanding was derived from different types of knowledge and yet:

'in the process of shared discussion the various types of knowledge became merged into shared knowledge, which usually led to a common conclusion' (Närhi, 2002: 239)

This fits with other evidence that social work decision making is influenced by team culture (O'Sullivan, 1999) and that team culture is an important element in developing social work expertise (Fook *et al.*, 2000).

The process of 'reflection'

The well-known concept of reflectivity (Gould and Taylor, 1996; Argyris and Schön, 1974; Schön, 1983) emerged in response to the perceived gap between formal theory (not often used consciously or directly in practice, as we have seen) and practice (in which tacit knowledge predominates). Professional expertise involves the ability to reflect on practice, in order to develop both theory and practice. Papell lists the essential elements of reflectivity:

- The acknowledgement of a need for a specific epistemology of practice.
- The rejection of linear thinking as the primary mode for professional problem solving and knowledge building.
- The recognition that every professional encounter is unique, and cannot be fully explicated by immanent theory.
- The elevation of art, intuition, creativity and practice wisdom to essential places in professional functioning.
- The perception of the potential for knowledge building through the research processes inherent in reflective practice (Papell, 1996: 12).

However, as Fook *et al.* argue, critical reflectivity is about more than this. 'It is also about uncovering assumptions about power relations, in order to make practice more egalitarian and emancipatory' (2000: 212). Expert practitioners are able to locate themselves in relation to service users, able to take account of their own personal viewpoints. They are able to be reflective, self-knowing and responsible actors rather than detached observers.

The significance of 'feedback'

In this context it is apparent that service users are a vital source of 'feedback' for learning. More radically, Närhi (2002) uses the data from her study to argue that knowledge is produced not only, as we have seen, in discussions amongst practitioner with teams, but also in negotiations with service users. In her case, social workers and service users

negotiate the construction of practical knowledge about the impact of living conditions on welfare. Närhi quotes Fook in arguing that this is an example of professional expertise in the postmodern world, 'grounded and contextual, involving transferable (rather than generalisable) knowledge and the ability to create this through reflective and reflexive processes' (2000: 118).

This claim brings us back to the opening of this section on expertise and the need to find new ways of conceptualising professional expertise in social work that are in line with its emancipatory value base. At the very least, the process of developing expertise in conjunction with service users that Närhi (2002) describes is in line with this aim. Key features are that expertise is negotiated openly and publicly with service users, and that such negotiation is based on communication and trust.

However, in arriving at this formulation Närhi is aware of the continuing influence of the power relationships between social workers and service users. In the context of sexual abuse, given the role of social workers in child protection, this is a serious and important issue. The next section turns to the nature of the possible relationships between social workers and service users following child sexual abuse and examines the potential for working together. In the final section of the chapter themes common to the literature about expertise and that about partnership are identified and discussed in relation to the aims of this study.

PARTNERSHIP

Partnership with parents

The rise of the concept of 'partnership' in child protection

Throughout the 1970s and 1980s, following the publication of the Maria Colwell report (Department of Health and Social Security, 1974), public concern about the protection of children was such that little attention was paid to the rights of parents or the need to engage with them (Corby *et al.*, 1996). Once again, the Cleveland inquiry (Butler-Sloss, 1988a) proved to be a major turning point. The Cleveland report's recommendation that parents and children should be more involved in child protection processes, particularly through attendance at child protection case conferences, was officially adopted in central government guidance ((Department of Health and Social Security, 1988) updated following the Children Act 1989 (Department of Health, 1991)) and implemented by

local authorities in England and Wales as though it was legally binding (Bell, 1996). The guidance is clear:

‘The involvement of children and adults in the child protection conference will not be effective unless they have been involved from the outset in all stages of the child protection process’ (Department of Health, 1991: 43).

The majority of the empirical research on the themes of partnership, participation and empowerment in child protection dates from this period in the early 1990s when parental attendance at case conferences became the norm. Consistent findings are that parents want to attend conferences (Bell, 1996) and that social workers have very positive attitudes towards parental attendance (Macaskill and Ashworth, 1995). Macaskill and Ashworth record workers’ desire ‘to conceptualize the case conference as an open, honest exchange, involving parents in plans and encouraging them to take responsibility for these plans’ (1995: 596) .

This seems to reflect a belief in partnership as a way of resolving the central dilemma of child protection: how to balance the civil liberties of parents with the imperative of protecting children. Thorburn *et al.* (1995b) introduced the idea of a ‘ladder’, where the bottom rung represents the manipulation of parents. The second rung represents placation, followed by informing, consultation, involvement, participation, partnership and finally the delegation of power. This is clearly a hierarchy, with the implication that the delegation of power is the ideal. A similar hierarchy was adopted in influential official guidance in the same year (Department of Health, 1995).

Difficulties with the concept of ‘partnership’

Difficulties with ‘partnership’ in child protection can be usefully divided into the conceptual and the practical. The argument is that partnership is a flawed concept, at least as applied to child protection, and that it is not achieved in practice.

A number of empirical research studies demonstrate the practical limitations of partnership. In their study of a total of 378 family members, Thorburn *et al.* (1995a) found that only 3% could be rated as ‘partners’ in the child protection process, with a further 13% participating to some extent. Most of the 51 families who attended a case

conference in Bell's (1996; 1999a) study felt that they had not had any influence over the outcome. Corby et al. (1996) concluded that parents do not participate meaningfully in conferences but keep their views to themselves because:

- The norms of conference are that they will respond to professionals, not initiate.
- They know that professionals may be sceptical about what they say.
- They don't want information they might volunteer used 'against them'.
- They want to be seen as cooperative and therefore do not argue their own position.

As a consequence the case conference 'is no longer about airing disagreements and conflicts and working through to a decision, but it is more a way of introducing parents to key decisions that have already been taken - less a forum for decision making than a place for asserting the professionals' point of view and, if possible, persuading parents to accept it' (Corby *et al.*, 1996: 487). Parents are aware of this but don't resist for fear of seeming uncooperative. In a similar Australian study, Campbell concludes 'that there has been a heavy reliance on formal procedures to the detriment of direct and helpful engagement between workers and families' (1997: 10).

There seems to be a tone of resignation. Bell (1999b) argues that conflicts are inherent in child protection work and that, whilst alternative models such as family conferencing may be worth investigation, nonetheless there are real limits on partnership in child protection that should be recognised. Corby *et al.* agree. 'Conflict is intrinsic to much child protection work so that the notion of working in partnership is far more restricted and problematic than is recognised in official guidelines and current research' (1996: 488). In addition: 'The emphasis on partnership and empowerment raises false expectation in many parents which can have a negative impact in terms of effectiveness to say nothing of the ethical implications' (1996: 489).

Healey (1998) lists some of the factors that limit participatory practice; relating to service users, professionals and the organisational context. It is suggested that limits exist at the level of individual service users, either because of personal, social or economic deprivation, or because of previous negative involvement with statutory authorities. MacLeod (2001) argues that the concept of partnership may be highly dangerous for children where service users are 'in denial' about abuse that they have perpetrated.

Limits imposed by professionals include their reluctance to relinquish power (Healey, 1998). An organisational context that typically includes high caseloads and limited resources militates against the quality of relationships between workers and service users. A lack of support for workers, particularly in dealing with the emotionally charged nature of the work, adds to the difficulties (Morrison, 1996).

Healey (1998) goes on to identify some of the professional responses to the continuing tension between participation and child protection. One is to accept the constrained possibilities for partnership, as reflected in the conclusions of Bell (1999b) and Corby *et al.* (1996) above, and to try to keep social work intervention to the absolute minimum. Another is to deny the existence of such tensions. Healey (1998) cites studies that show social workers claiming a high degree of partnership working when the reality is very different. Healey argues that workers are in a no-win situation. To claim a participatory ethos when it does not exist is to be open to charges of 'duplicity', yet failure to espouse these values may also result in criticism. 'It is my position that the 'duplicity' often observed by researchers and theorists is a logical outcome of the kinds of standards and ideals which have been grafted on to child protection practice without due consideration for the specific demands associated with such work' (Healey, 1998: 905).

Following on from these empirical studies is the conceptual critique. Firstly, Healey (1998) deals with Thorburn *et al.*'s (1995b) concept of a 'ladder'. Although both Thorburn *et al.* (1995b) and the Department of Health (1995) suggest that climbing the partnership 'ladder' may not be possible, or even desirable in some cases, nonetheless the idea that some forms of partnership are innately superior to others is a powerful one. According to Healey, this privileging of 'delegated power' is problematic because social workers have a statutory duty to safeguard and promote the welfare of children. There is a danger that such privileging will lead to 'a devaluing of and, in some instances, a retreat from this obligation' (1998: 901). Healey argues that the ideals of partnership have been imported uncritically into child protection from other disciplines in which there is no crosscutting imperative analogous to the need to protect children. For example, Thorburn *et al.* (1995b) imported their 'ladder' from the field of social planning.

Secondly, there is the dualistic pairing of partnership and paternalism. Both Calder (1995) and Thorburn *et al.* (1995b) understand paternalism as synonymous with enforcement

and compulsion, and partnership is held up as the polar opposite. Healey (1998) argues that this makes it difficult to acknowledge the complexities of power that are inherent in child protection work. Here, the use of statutory power can be both productive and necessary to protect the vulnerable. In addition, Healey uses a Foucauldian approach to power, not in order to deny inequality, but rather to argue that service users are not merely passive victims of workers' power. She quotes Wise, reflecting on her experience as a statutory social worker and a feminist: 'the myth of compliant and powerless clients is belied by the reality of the complex process of interaction and negotiation that goes on in defining the problem and finding the solution' (1990: 242).

New approaches to the concept of partnership

Partly in response to some of these difficulties with the concept of partnership there have been some changes to official guidance. The current version of *Working Together* accepts the limitations on partnership imposed by the need to protect children.

'Partnership does not mean always agreeing with parents or other adult family members, or always seeking a way forward which is acceptable to them. The aim of child protection processes is to ensure the safety and welfare of a child, and the child's interests should always be paramount. Some parents may feel hurt and angry and refuse to co-operate with professionals. Not all parents will be able to safeguard their children, even with help and support. Especially in child sexual abuse cases, some may be vulnerable to manipulation by a perpetrator of abuse. A minority of parents are actively dangerous to their children, other family members, or professionals, and are unwilling and/or unable to change. Always maintain a clear focus on the child's safety and what is best for the child' (Department of Health, 1999: 84 (7.4)).

More recent guidance on assessment states the position even more succinctly. 'Working with family members is not an end in itself; the objective must always be to safeguard and promote the welfare of the child' (Department of Health, 2000: 13 (1.45)).

Nonetheless, this new guidance hardly does justice to the complexity of some of the debates about partnership and to the possibility of new approaches to the concept. It is also unlikely to result in significant change in practice (Lindley and Richards, 2000).

One possible new approach to the concept of partnership is to consider the role of the 'community' in relation to child protection. This is a significant strand in the current Labour government's thinking, although complex and contested in its own right (Jordan, 1999). Certainly, many of the adult survivors of sexual abuse who wrote to the National Commission of Inquiry into the Prevention of Child Abuse (1996) felt that the 'community' should take collective action to help children experiencing sexual abuse. Jordan (1999) argues that the way forward lies neither in the government's imagined 'working-class utopia' of a past age, nor in state-led communitarianism. Instead, he argues that there is a network of skilled and responsible activists, outside the professional, public services who make a significant contribution through informal, voluntary groups. Gray *et al.* (1997) conducted two surveys in the north of England. As well as confirming the low level of provision of therapeutic services in the statutory social work sector, these surveys show that survivors express a strong preference for the kind of voluntary groups referred to by Jordan above. This is because of the involvement of other survivors of sexual abuse as 'helpers', the feeling of having control over the service for as long as the survivor wants it, and the degree of flexibility offered.

Another possible way forward is to develop the way in which power is conceptualised. As we have seen, Healey (1998) has criticised the dualistic pairing of partnership and paternalism and the assumption that only the former involves the exercise of worker power. In addition, Healey argues that service users are not merely passive victims of workers' power. Specifically, some women may be victims or survivors of domestic or sexual abuse at the same time as they are in a position of power in relation to their abused children (Featherstone and Fawcett, 1994). Workers may have to relate to them differently in these two distinct 'roles'. Secondly, a more sophisticated view of power relations within families challenges the assumption that those who are subject to the exercise statutory power will always experience it as coercive. As Healey argues, the imposition of control over one member of the family may provide a way out of an untenable situation for another. We should acknowledge 'the potentially productive effects of statutory power, particularly in relation to the protection of those family members who are most vulnerable to abuse' (1998: 909). Such a use of power may open up opportunities for working together with non-offending parents in a way that is usually overlooked. This is particularly relevant in the current study because women are only

rarely the perpetrators of sexual abuse, as we have seen in Chapter 1. The consistent and continuing use of the gender-neutral term 'parents' throughout official guidance and in much of the rest of the literature (for example Cloke and Davies, 1995; Department of Health, 1995; 1999) has been a difficulty here. It has obscured the potential for working with such women.

Partnership with children

The starting point – listening to children

In their study of children's experiences of social work and child protection, Butler and Williamson (1994) report that a substantial number of children and young people show a deep lack of trust in adults. This is based on their experiences of not being heard. Concern about the distance between children and adults is a major theme of the Cleveland Inquiry. Its recommendation in respect of children is well known and has been influential.

'There is a danger that in looking to the welfare of the children believed to be victims of sexual abuse the children themselves may be overlooked. *The child is a person and not an object of concern*' (Butler-Sloss, 1988b: 12, my italics).

Since then there has been a rapid expansion of interest in children's rights, mostly centred on policy themes associated broadly with 'citizenship' (Franklin, 2002; Mason and Fattore, 2005; Willow, 2002; Willow *et al.*, 2004). Very little of this development has centred on children's participation in the child protection process or on the opportunities for partnerships with them. However, things are changing and it is clear that under section 53(3) of the Children Act 2004, those undertaking enquiries under section 47 of the Children Act 1989, (often known as child protection investigations), are required 'to ascertain the child's wishes and feelings regarding the action to be taken with respect to him; and to give due consideration (having regard to his age and understanding) to such wishes and feelings of the child as they have been able to ascertain'.

Whilst this new legal requirement may be clear, the difficulties of carrying it out should not be underestimated. As Shemmings (1996) argues, finding out about children's wishes and feelings in the context of child protection means much more than simply asking 'What are your wishes and feelings about...?'. Abused children may have confused and

conflicting ideas. If so, then this is a product of the complex and stressful nature of the situation they are in, not a reflection on their cognitive abilities. Children's responses may vary depending on whom they are talking to, when, and in what context. Kenney (1999) gives the example of a nine year old boy whose mother has schizophrenia. When she is ill he lives with his grandmother but when she recovers he tells his mother that he wishes to return home to live with her. He tells his social worker the same thing but tells his grandmother that he wants to remain with her. At the case conference he says he has not yet decided. Kenney (1999) argues that interpreting a child's wishes and feelings in a situation like this is a highly skilled task. She argues that the worker must pay careful attention to the context in which the child's views were ascertained, the child's relationship to the person they were communicating with, and the child's emotional 'freedom' to communicate. The latter requires a thorough understanding of the potential impact of child abuse.

Consent – competence

In Chapter 1 I have already outlined some of the theoretical discourse about the nature of childhood and how it may differ from adulthood (for example Mayall, 2002). As Munford and Sanders (2004) argue, mainstream developmental and educational research has constructed childhood predominately as either a problem or a developmental project. The consequence is a view of children as vulnerable and incompetent and a culture of not listening to children (Lansdown, 1994).

In England, children's capacity to give informed consent is governed by common law. The current position, following the 1985 case *Gillick v. W. Norfolk and Wisbech A.H.A.*, is that children can give informed consent to medical treatment provided they have sufficient understanding, and that parents cannot override the child's decision (Masson, 2004). However, the question of whether or not the child has sufficient understanding is to be decided on a case-by-case basis. In practice, gauging the ability of children to give informed consent is a complex and skilled task where opinions may vary. There are close parallels with the skills required to ascertain children's wishes and feelings. However, as Langston *et al.* (2004) argue, even very young children can give informed consent and where they are of sufficient understanding 'it may be more ethical to act on their consent than to require the fully informed consent of a parent' (Masson, 2004: 50).

Participation in decision making

As already noted, little of the growing literature on young people's participation is focused on the difficult topic of child protection policy and practice. However, one finding stands out from what there is. In relation to decision-making about their own, individual situations, children need more information about the child protection processes that they are caught up in. 'In investigations of child abuse (which for many children will be their first contact with a social worker) children are often totally unaware of the organisational context of the workers interviewing them. Many children report that they have no idea who it was who first saw them, let alone where they came from or why' (Davies *et al.*, 1996: 101). Both information and explanations are required, and it may be necessary to repeat them for as long as the child seems unclear (Prior *et al.*, 1994).

The case conference is an obvious forum in which children may be able to participate in child protection decisions relating to them. Yet there is something incongruous about children attending such formal and bureaucratic meetings. In the introduction to his study of children's experiences of attending such conferences, Shemmings tells the following story about an eight-year-old boy.

'When he arrived at the meeting everyone noticed that he had a small briefcase with him, the kind that young children put their lunch in when they go to school. As soon as the conference started he opened the case and took out a note-pad ... and a teddy bear: symbolically he had placed on the table the uncertainty of his role in the meeting. And perhaps because he doubted whether adults would be able to clarify his uncertainty, he took a teddy bear *and* a note-pad, just to be on the safe side' (1996: 1).

In fact, current government guidance supports children's attendance, as follows:

'The child, subject to consideration about age and understanding, should be given the opportunity to attend if s/he wishes, and to bring an advocate, friend or supporter. Adults and any children who wish to make representations to the conference may not wish to speak in front of one another' (Department of Health, 1999: 53).

The language here is interesting. Both adults and children can 'make representations'. The highly formal and legalistic language sets the tone for the conduct of such conferences. But of more significance for the current argument is the implication that parents and children are not part of the decision making process, they merely have the right to express their views. As we have seen, this matches the experiences of parents attending conferences. Whilst they were glad they attended, parents did not feel that they had influenced the outcome. Perhaps unsurprisingly, Shemmings' research reaches very similar conclusions in respect of children's experiences. Children were mostly positive about attending, even if they became upset. However, they said that they needed better preparation, particularly for the emotional impact of such meetings and a significant proportion of the older children felt that, although they had been present physically, they had not really participated in the conference (Shemmings, 1996).

Children's experiences of professional responses to sexual abuse

Chapter 1 contains an account of the limited research into children's experiences of sexual abuse. This section turns attention to children's experiences of the professional services intended to protect them. But first it is necessary to note that the variety of children's reactions to abuse mean that it is hard to generalise about the professional response that they might value. For example, MacLeod shows how children ringing ChildLine (a UK national confidential telephone advice line) about physical and sexual abuse have very different ambitions for their abuser.

"I just wish he'd stop."

"I wish I could beat him up."

"I don't want him to go to prison."

"I don't want the family to break up."

"I don't want to see hem again. I wish he would leave and never come back."

"I hate him. I want to kill him."

"I found him lying drunk. I thought about killing him and about killing myself"

(1999: 141-2).

The evidence from ChildLine callers highlights the need to tailor individual responses to the needs of individual children. MacLeod argues that the inflexibility of the statutory

child protection system and children's lack of control over it is a serious problem. By way of contrast, children calling ChildLine do not have to give their name and can put the phone down when they want.

'Children have a different kind of conversation on a helpline, breaking the conventions of loyalty around family life, community and peer group. They are not confined by the 'rules' of social work, counselling or therapeutic practice about how their contact will be organised. They decide whether or not to pursue conversations; so the decisions that are usually taken by adults about the nature, frequency and duration of contact are not the adult's to make' (1999: 149-50).

MacLeod (1999) argues for a more flexible response to child sexual abuse, based on the variety of children's experiences and wishes and on the sheer difficulty for children of engaging with the statutory system.

A similar set of desires is apparent in two other studies. Prior *et al.* (1994) interviewed 81 sexually abused children in London. These children were already 'known' to the child protection system, so the dilemmas about telling or not telling were already resolved. Nonetheless, the children's main emphasis was on the need for professionals to take the time to listen to them and to respond with honesty, integrity and sympathy. This study also highlights children's strong appreciation of the value of therapy, and the fact that it was not available to about a quarter of the sample. Mudaly and Goddard (2006) interviewed nine sexually abused children in Australia. Their experiences of the child protection system is overwhelmingly negative, with the emphasis firstly being on the difficulty for children of getting workers to believe them, and then on children's lack of control over subsequent professional interventions. Once again, this contrasts with a positive view of counselling. Asked what he would say to other children about counselling a twelve year old boy gave a typical response:

'Well, I would tell them, you're a bit scared at the start and that, and then after a few lessons you get to know the people well, and then you'll like it, sort of. But if you keep, like, if you live the attitude like the way it is now, you won't like, anywhere... It's like their decision if they want to get counselling; if they

don't ... well, they're really missing out; it's really good' (Mudaly and Goddard, 2006: 118)

In both studies children also spoke about the criminal justice system and here the criticisms are very harsh indeed. There was a strong sense of injustice, based on traumatic experiences of being cross-examined in the courts and the experience of not being believed.

COMMON THEMES

Two significant themes have been running right through the literature reviewed in this chapter. These themes are influential when it comes to understanding the relationships between the therapists, parents and children in the current study. The first theme is about the significance and validity of professional judgement, and the second is about the significance of two of the sources of knowledge identified by Pawson *et al.* (2003); user and practitioner. The two themes are related insofar as they raise questions about professional power 'over' service users in the context of child protection.

At this point it is necessary to understand the specific context for the current study. All of the families who participated had previously been the subject of enquiries carried out by the local authority, sometime together with the police, under section 47 of the Children Act 1989. These have been commonly known as 'child protection investigations'. In every case the investigation had indicated that the child had been sexually abused but that the child was currently 'safe', often because there was no continuing contact with the perpetrator or because any contact was safely managed. Often this was because of the protective action of the child's mother. So the work of Agency therapists might be described as sitting rather uncomfortably on the borders of child protection. Therapists were working with parents who had been judged by professionals in the child protection system as 'safe' or 'non-abusing'. Nonetheless, these parents had been subject to scrutiny and there was always the possibility of new 'concerns' over aspects of parenting. In other words, as Hooper (1992) observed in her study of mothers of sexually abused children, responsibility for the child's safety and wellbeing was contested, with both parents and professionals staking a claim.

My own position is not that professional responsibility for child protection can be abdicated. For some the notion of professional judgement may have entirely negative connotations, implying the imposition of middle-class values on service users (see Calder, 1995). Yet in child protection, a refusal to engage in such judgements may have negative consequences for children. As Stevenson puts it:

'Who are we, the argument runs, to make an assessment of what is 'good enough' parenting and adequate child development when cultural mores and ethnic variations show such wide variations? It is indisputable that child abuse is a social construction and that such variations exist. But agencies involved in child protection cannot opt out of defining minimum standards and ways of behaving that are acceptable to our society at a given time in our history... When it comes to the crunch... (and it *is* a crunch, not an intellectual foray), these judgement have to be made' (Stevenson, 1996: 15).

I agree with Healey (1998) and her argument for an approach to child protection that acknowledges the necessity for such professional judgement and yet ensures that these judgements are accessible and accountable to service users. Healey argues that this is not the re-imposition of hierarchical structures in which the professional knows best, but neither is it the relinquishment of the appropriate use of power.

This study investigates how parents and therapists negotiate the potential barriers to a working relationship that may result from the exercise of professional judgement. How do the therapists communicate about their continuing responsibilities for child protection? How do parents respond to possible criticism of their parenting? How are any disputes over 'child protection' issues handled? And more broadly, the study also asks about the second theme, the relationship between practitioner knowledge and user knowledge in relation to children's therapy. What kinds of professional expertise do service users value, and what kinds of knowledge do they contribute? Do therapists have the 'interactional expertise' identified by Collin and Evans (2002) to be able to work together with families and to incorporate their experience-based user knowledge? Is there evidence of new knowledge being generated in the interaction, as Närhi (2002) envisages?

Before presenting some of the findings of the study and the conclusions that flow from them, the next section of the thesis describes the methods used to investigate these and similar questions.

PART TWO
METHODOLOGY

CHAPTER 4: PLANNING AND CARRYING OUT THE STUDY

INTRODUCTION

This chapter consists of three interwoven strands of writing. The first is a reflexive account of the development of my thinking about an appropriate methodology for this study, the second is an account of what I actually did in practice, and the third is an account of how my thinking and 'doing' draws on the literature about research methods. This approach to writing mirrors my experience of these three strands as being intimately interconnected.

RESEARCH DESIGN

Initial aims and potential research designs

At the outset the main aim was to test the hypothesis that involving parents more fully in the therapeutic work would lead to better outcomes for children.

Qualitative or quantitative methods?

From an early stage it seemed likely that a significant proportion of the data collected in this study would be qualitative in nature. This was because I was not just interested in *whether* involving parents produced better outcomes for children. In Chapter 2 I have already reviewed studies that support this idea. More importantly, I was interested in understanding in detail *how* this process might work and what factors might help or hinder it in differing sets of circumstances. I suspected that there was sufficient variety in children's family circumstances, the circumstances of the abuse, and their experience of therapy for an analysis of qualitative data to represent the best way to begin to unravel some of the complex dynamics of the relationships between children, parents and therapists and to identify the ways in which involving parents might influence outcomes.

This is to advance a positive case for the use of qualitative methods in this study. At first glance it appears to coincide with what Shaw describes as the mainstream position, namely:

'..that qualitative designs – often identified with case study approaches – are best fitted to answer questions about *processes*. Questions regarding *outcomes* are

better served, or so it is argued, by traditional comparative designs which address the measurement of outcomes' (1999: 122, original italics).

This mainstream position received an early formulation in the work of John Lofland. Lofland *et al.* (2006) argue that there are only three types of inquiry into social phenomena, namely those that are concerned with characteristics, causes or consequences. In Lofland's view attempts to inquire primarily into the characteristics of a social phenomenon are known as qualitative analysis, whereas attempts to inquire primarily into causes or consequences are known as quantitative analysis.

However, as the above quotation hints, Shaw (1999) questions the mainstream view in so far as he argues that it disparages qualitative approaches by suggesting that they are of limited use, often confined to the early, exploratory stages of an enquiry, or to situations in which precision or generalisation across sites is not required. His counter-argument is that qualitative approaches, often including case studies, can provide an understanding of causes and outcomes that may be a better fit with the purpose of many enquiries than conventional, comparative designs (see also Shaw, 2003b; Shaw and Gould, 2001). Miles and Huberman advance a similar argument, leading to the claim that: 'Qualitative analysis, with its close-up look, can identify (causal) *mechanisms*, going beyond sheer association' (1994: 147 original italics). Silverman uses examples of qualitative studies to show that 'the multiple logics of qualitative research emerge from their relationships with the general purposes of research projects' (1997: 25). In each case the key appears to be the question of purpose.

In this case, as I have said, the purpose is to begin to understand the complex dynamics of the relationships between therapists, parents and children and to identify the ways in which involving parents might influence outcomes. This purpose appeared to me from the outset to be well suited to the use of qualitative methods. I was certainly hoping to gain an understanding of process, the traditional focus of qualitative enquiry, but I also wanted to develop an understanding of causal relationships within the dynamics and to understand what influences outcomes. It seemed likely that my approach would include the analysis of individual narratives and the identification of 'themes' within the data, processes that I return to later in this chapter.

A constructivist approach?

This research has involved trying to understand the perspectives of children, parents and therapists. It starts from the constructivist position that each will have 'different experiences and perceptions of the program, all of which deserve attention and all of which are experienced as real', Patton (2002: 98). This is to accept the existence of multiple realities and the subjective creation of knowledge by researcher and researched, a position outlined by Guba and Lincoln (1989) in an early and influential text on evaluation. However, it may be that these differing perceptions do not have an equal chance of being heard 'in the real world of power', and 'this is a problem' as Guba and Lincoln acknowledge (1989: 267). Throughout this research I have been aware of the twin imperatives of social justice and 'empowerment' (Hanley, 2005; Humphries, 1994). Having already noted the lack of service user perspectives on therapy, this research has attempted specifically to highlight the voices of parents and also those of children.

The constructivist approach has also had an important influence on my thinking about the investigation of causation. In this study I have examined the ways in which participants construct accounts of causality. For example, in Chapter 9 I examine how they reason about the causes of difficulties in mother-child relationships. Such an approach has previously been used to study the construction of causal accounts by social work professionals (Bull and Shaw, 1992) but otherwise it appears to be relatively rare in the literature.

The influence of theory

According to Patton:

'Social constructivists' case studies, findings, and reports are explicitly informed by attention to praxis and reflexivity, that is, understanding how one's own experiences and background affect what one understands and how one acts in the world, including acts of inquiry' (2002: 546).

In the introduction to the thesis I have examined my own background and thinking in relation to the study. In Chapters 1 to 3 I have examined relevant literature and given a more formal account of my own theoretical orientation, and possible alternatives to it. In

the chapters that follow I analyse the potential influence of different kinds of theoretical thinking on the accounts that participants construct.

My relationship with 'participants' in the research

I knew that the Agency team in which I had previously been employed might be interested in participating in this study because of their long-standing interest in the topic. This meant that it was inconceivable to me that these professionals would become mere 'subjects' in my study. I thought of them as highly skilled practitioners with a wealth of knowledge about this topic. Neither would they be, as Donald Schön puts it, mere users of the researchers' end product. Instead, the practitioner:

'reveals to the reflective researcher the ways of thinking that he brings to his practice, and draws on reflective research as an aid to his own reflection-in-action... The agenda of reflective research will be generated out of dialogue between reflective researchers and practitioner-researchers' (Schön, 1983: 323-324).

This kind of thinking was partly the inspiration for the first phase of the eventual research design, of which more below.

However, this is not a fully collaborative model of partnership in which practitioners become co-researchers such as, for example, Mailick *et al.* (1995). Whilst practitioners contributed to the data that I collected, they did not play any direct role in obtaining or analysing it. Pragmatically, there was no commitment on the part of the Agency to allow their staff to do this and I did not try to develop an argument for it.

Similarly, I cannot argue that this is fully 'emancipatory' research, at least not in relation to the definition developed at a recent series of seminars organised by the Toronto Group (Hanley, 2005). Here the defining feature of such research is that service users are in control from the outset, identifying and prioritising the research question. This was clearly not going to be the case in my study since I have already located the origins of the research in my own background and thinking. But this does not preclude a meaningful element of service user participation. The Toronto Group distinguishes other approaches more akin to mine, using the label 'involving service users in mainstream research'. As

Heron (1981) argues, it may be useful to think of participative research as lying on a continuum according to the extent to which it is predominantly researcher controlled, in which case this project is towards the 'researcher controlled' end.

But there are dangers for practitioners and service users alike in a research process in which the researcher remains basically in control. In the past I have contributed as a practitioner to research that seemed unsatisfactory to me for at least one of two reasons. Sometimes the researcher ends up taking the credit just for passing practitioner knowledge to a wider audience. Even worse, sometimes the message becomes distorted so that practitioners feel misrepresented in the final research outcome.

An advantage of utilising qualitative methods is that, typically, such methods tend to encourage a more reflexive awareness of the relationship between the researcher and the 'participants'. That is not to argue that quantitative research does not raise ethical dilemmas, or that quantitative researchers are unaware of them. Rather, it is to follow Bulmer's argument that: 'In some respects, the ethical dilemmas facing quantitative researchers are sharper and the freedom of action in research greater, so that the consequent ethical problems that may be encountered are more varied' (2001: 55). And my use of quotation marks around the term 'participants' points to the centrality of the language used to describe those who participate in research: subjects, cohorts, participants, co-researchers, service users, informants, cases, and many more (Williamson and Smyth, 2004).

My approach to ethical issues

In the preceding sections I have already begun to touch upon ethical issues in the overall design of the study and, more broadly, upon issues of morality and social justice. These are not peripheral issues. As Lincoln (1995) argues, ethical standards are fundamental quality criteria against which to judge social science research.

Ethical issues may arise at any phase of a study (Kvale, 1996). In this case they may arise particularly in relation to:

- The overall research design and methodology.
- The research agreement with the social work Agency.

- The principle of informed consent.
- The principle of confidentiality and privacy.
- Research with children.
- The power relationships between children, their parents and their therapists.
- The analysis, reporting and uses of the study.

Rather than write about ethical issues in isolation in a separate section I have chosen to integrate them into the relevant sections of this chapter. My intention is to avoid giving the impression that the consideration of ethics is a distinct, once-only process to be negotiated at the outset of the research, perhaps in relation to gaining institutional consents. Such a process may be necessary, but it is hardly sufficient (Shaw, 2003a). However, my integrated approach may risk losing sight of ethical issues and to guard against this danger I have occasionally used the subheading 'ethics'.

The impact of gender

It should be clear from Chapter 1 that gender is an important issue in any study of child sexual abuse. Morgan (1981) argues that 'taking account of gender' in research is important from the point of view of scholarship, as well as ethically and politically. Morgan (1981) notes that 'taking account of gender' may be harder for male researchers. It should be done in relation to the design of the study, the dynamics of research interviews and in the process of data analysis. I will return to these themes in the relevant sections that follow.

A comparative design?

Although from an early stage I felt that the purpose of my research was well suited to the use of qualitative methods, nonetheless I began with the idea of a comparative design. My early ideas included the possibility of comparing one team that was committed to involving parents in therapeutic work with another 'control' team that, by implication, was not. I wanted to retain an interest in causal processes and outcomes and, at first glance, a comparative design seemed the obvious way to get at them. As argued above, I felt that this could be achieved in this case by using qualitative methods to get at mechanisms rather than statistical associations. But on reflection I came to realise just how deeply my early training in the biological sciences and in statistics, and probably my male gender (Fox Keller, 1990) had influenced me. Instinctively I was looking for a way

to control as many variables as possible and to prove or disprove a hypothesis. In what follows I give an account of how my position changed and where I have ended up.

As I began to work on the details of a comparative design I realised that it had two major practical drawbacks. The first was that it was far from clear how I could 'sell' the idea to the second, 'control' team. It would be clear to them that, in broad terms, I was committed to the appropriate involvement of parents and their perception might well be that I would be using them merely to draw unfavourable comparisons with the first team. It was hard to see what might be the benefit to the second team, and this appeared to be ethically unsound. Secondly, it was not even clear that the first team was working to a model that was sufficiently well defined and distinct from other teams' practice as to fit the comparative methodology.

Difficulties in developing measures of children's recovery

Careful consideration of the results of the Agency's national evaluation (Cotmore *et al.*, 2004), and other reading, led me to conclude that a comparative design faced a still more fundamental problem. The influences on children's recovery are so complex that it would be very difficult to separate out the specific influence of parental involvement.

As we have seen in Chapter 2, despite the variety of different approaches to therapeutic work with children there has been relatively little attention paid to evaluation. A recent overview of experimental studies bears this out by demonstrating the 'sparse evidence of play therapy's effectiveness' (Bratton and Ray, 2000: 81). Carroll (2000) provides a useful account of the field. In relation to research into outcomes Carroll identifies a number of difficulties with what she describes as the 'traditional research approach, derived from a scientific paradigm' (2000: 12). According to Carroll, such approaches imply the quantitative analysis of identified outcome measures so as to assess the efficacy of an approach to therapy. However, as Carroll argues, it may be difficult to:

- Include all the relevant variables (behavioural symptoms, culture, gender, age, and many others).
- Ensure that the same 'treatment' is given to different children, such is the element of spontaneity and specificity within the therapist/child relationship.

- Relate a change in symptoms (e.g. cessation of bed-wetting) to the process of therapy rather than other factors, for example, maturation.
- Relate a continuation in symptoms to a 'failure' of therapy rather than, for example, lack of parental support.

It seems that there are very real methodological problems in trying to measure the overall impact of therapy on any specific child. Thus the task of measuring the particular influence of parents on the therapeutic process seemed almost impossibly difficult.

Modified research aims

As a result I decided to restate the research aims as follows. In circumstances where child sexual abuse has occurred to:

- Understand more about the dynamics of the triangular relationships between children, non-offending parents and children's therapists.
- Seek the most effective ways of maximising parental 'support' for children's recovery.
- Seek the most effective ways of integrating this with professional therapy for the child.
- Explore the efficacy of professional 'support' for parents in the context of seeking to help their children.

The quotation marks around the word 'support' are intended to indicate that this concept is not clearly defined in advance, and that definitions and use of the term by participants are themselves of interest in the study.

The outline research design

In the light of the above, I decided to confine the research to just one Agency team. This follows what Patton describes as 'a common qualitative sampling strategy: studying a relatively small number of special cases that are successful at something and therefore a good source of lessons learned' (2002: 7). I also decided to use a two-phase approach. The first phase would be to work with the team to update and to refine their therapeutic model of involving parents. This would be done in a short series of team meetings that I would attend. My role would be that of a focus group facilitator (Cronin, 2001), helping

the team to explore their existing practice and to identify changes that they might wish to make. The second phase would be to evaluate the model in practice in relation to a series of individual 'cases'.

Research or evaluation?

Having described the second phase as 'evaluation' I must be clear about my understanding of the differences between research and evaluation. There seems to be agreement in the literature that there is indeed a difference between them, but beyond that the consensus breaks down. On the one hand Lincoln and Guba, having defined each activity, argue that: 'The distinctions drawn dramatize the need to view research, evaluation and policy analysis as separate, discrete and mutually exclusive activities' (1986: 560). On the other hand Shaw argues that, whilst there are important differences between the two 'to talk of 'evaluation research'...does make good sense, and involves no confusion of categories' (1999: 11).

Patton provides a particularly helpful American typology based on purpose, as follows:

- *Basic research*: To contribute to fundamental knowledge and theory.
- *Applied research*: To illuminate a societal concern.
- *Formative evaluation*: To improve a program.
- *Summative evaluation*: To determine program effectiveness.
- *Action research*: To solve a specific problem (2002: 213 original italics).

Whilst in the UK the division between applied research and either formative or summative evaluation may not be so distinct (and the terms process/outcome are often preferred to formative/summative) nonetheless Patton's typology helps to clarify the aims of this current research. The first aim:

- To understand more about the dynamics of the triangular relationships between children, non-offending parents and children's therapists

may be seen as an attempt at illumination, and therefore as an example of applied research. The remainder are more concerned with improving practice and might be considered to be in the realm of formative evaluation. It should be noted that the first two

of these latter aims contain assumptions, based on the literature review and on the team's practice experience. These are that maximising parents' 'support' for children's recovery should be an aim of the professionals, and that parental 'support' should be integrated in some way with professional therapy. In both cases the aim is to examine how best this can be achieved. The final aim is less committed in its underlying assumption. Here the notion is that professional 'support' for parents may help children's recovery, but this assumption is not made in a strong form, because the evidence for this is not clear-cut.

These aims and the outline proposal for a two-phase project were first formulated in the context of negotiating consent with the Agency. The aims were weighted three to one towards formative evaluation rather than applied research partly because it seemed likely that this would be a selling point. In reality it seems to me that the first aim is at least as important as the others. It makes sense to me to think of this project as research, with elements of evaluation research.

The influence of case study research

Whilst there seems little doubt that this project could be described as 'case study research' I am reluctant to use this label if it precludes other approaches. This is because other approaches have also been influential (for example, see narrative approaches, page 108). However, Hakim (2000) argues that, because case studies typically use a variety of methods and a variety of evidence, this means that they can often link or overlap with other types of study.

In considering case study research, firstly there is the question of what counts as a case. According to Stake (1995), a case must be an 'entity', something physical rather than an abstract theme. In this research this appears straightforward since the Agency's work with individual children and families is based on a 'casework' model. The language of 'cases' is embedded in the culture of the Agency. However, within social work there is a longstanding and continuing tension between casework models and alternative approaches that work with groups or communities. Within this Agency team, alternative group models of peer support following sexual abuse are available for mothers (Hill, 2001) and for couples. Where parents have attended these groups they were asked to talk about them during their individual interviews. I have also held discussions with each of the peer support groups, as described below.

A second question is whether to consider an individual case or multiple cases. Here the approach has been to compare and contrast different cases in the same setting. The idea is to look for general rules and for exceptions, both in relation to processes and to causes and outcomes. Hakim (2000) observes that confidence in research findings increases both with the number of cases and the number of sites. I was aware that the throughput of 'cases' in this small Agency team was not likely to be very high. I decided to attempt to include all cases in the team over a period of about two years. I also considered adding a second research site, but I soon found that this team's approach to work with parents appeared to be unique within the Agency. Outside the Agency I considered trying to recruit individual play therapists, many of whom are self-employed, and their service users, but the difficulties of finding therapists operating in any similar fashion to the Agency team appeared insuperable.

Finally there is the question of generalisation. There is no doubt that this is often thought to be a weakness of qualitative case study research. As Miller and Crabtree put it: 'Local context and the human story...are the primary goals of qualitative research and not "generalisability" (1994: 348). And in reflecting on her journey to constructivism, Yvonna Lincoln writes 'finally, we began to doubt seriously the possibility of generalization from one site to the next' (1990: 68). Yet, once we accept Eisner's (1991) argument that, in the real world, the transfer of knowledge from one setting to another usually involves some form of modification, and therefore requires judgement on the part of the user, then some form of generalisation seems to be possible. The approach in this study is to try to provide the research audience with the kind of detailed, vicarious experience of therapeutic and family processes that, when combined intuitively with their previous experience, may lead to improvement in practice in similar settings (Stake and Trumbull, 1982).

Obtaining consents from the Agency

My proposal for a two-phase approach was first discussed with the Agency team in February 2004. Although this was a planning meeting it included considerable discussion of the substantive research issues. Thus, with the team's consent, an account of that meeting is included in Chapter 5.

In June 2004 I obtained Agency consent, at a national level, to the two-phase plan that had been agreed with the Agency team. It was agreed that the outcomes would include a report on the project for dissemination within the Agency. It was also agreed that I would seek to publish findings from the work in professional and academic outlets, subject to maintaining the confidentiality of service users and the Agency.

Ethics

The Agency raised concerns about what I might do if I encountered what I considered to be bad or even potentially dangerous practice. One concern was the possibility that my work might result in criticism and bad publicity for the Agency. I responded by giving the assurance that I came to the research with a positive view of the team's work and without any desire to generate negative publicity. I explained that, in the event of my having any serious concerns about bad practice I would raise these with the worker and/or the team manager as appropriate. In the formal agreement with the Agency I undertook to consult at national level about how any such issues might be handled in any published work, without conceding any right of veto.

DATA COLLECTION

Detailed planning and conduct of phase one

With Agency consent obtained I set about detailed planning for both phases of the work. For phase one I arranged to hold a series of four meetings with the team.

There is little doubt that the fact that I am an ex-colleague has had an impact on the dynamics of these meetings, and upon subsequent research interviews with team members. Kanuha (2000) identifies some of the difficulties of 'insider bias'. Firstly, there is the need to separate ones own experiences and subsequent analyses from those of the study participants. Secondly, there is the difficulty of managing shared or taken for granted knowledge, often expressed in 'coded language'. Van Heugten reframes these dilemmas more positively as an encouragement 'to attend to context and process, rather than content and 'fact' finding' (2004: 215).

In order to facilitate the discussion I developed an analytical framework in the form of a grid, as in Table 1 on page 95. The three main areas of service provision that are included in the column headings were selected as being central themes for the research. It was

clear that the table oversimplifies the links and overlaps between the three activities and these were explored in discussion. The topics listed in the three rows were designed to allow the team to develop an inventory of their current approaches, to begin to develop their own critique of those approaches and, at a deeper analytical level, to consider the knowledge and value base that underpins their practice.

Table 1: Grid used in discussion with the team

	Support for parents and carers	Linking parents with therapy	Therapy for the abused child
Current approaches			
Possible areas for development			
Guiding principles			

This grid was drawn on a white board and notes of the discussion were entered directly into the grid as the discussion developed. These entries were sometimes argued over, so that the result was the team's agreed position. The written record of this agreed position has been used as a data source in Chapter 5. The first two meetings with the team were taken up with the completion of this grid.

For the third and fourth meetings I developed a series of four vignettes. These are included as Appendix 1. Vignettes are 'short stories about hypothetical characters in specified circumstances, to whose situation the interviewee is invited to respond' (Finch, 1987: 105). They have three main uses:

1. Interpretation of actions and occurrences that allow situational context to be explored and influential variables to be elucidated.
2. Clarification of individual judgements, often in relation to moral dilemmas.
3. Discussion of sensitive experiences in comparison with the 'normality' of the vignette' (Barter and Renold, 1999).

In this case they have been used to ground the abstract ideas that had been debated in the preceding meetings in the reality of individual family circumstances. The discussion was tape-recorded. Barter and Renold (1999) offer a helpful warning that using such techniques raises the question of the problematic relationship between interviewees beliefs and their actions.

Detailed planning and conduct of phase two

Phase two was to consist of a detailed examination of individual cases. Two factors were apparent from an early stage. Firstly, from the outset I had identified three potentially different perspectives in each case, those of:

- Parents and carers.
- Abused children themselves.
- Therapists.

I was committed to finding ways of collecting relevant data from all three sources. Secondly, my consultative work on the Agency's national evaluation (Cotmore *et al.*, 2004) had made me aware of how the passage of time may have a significant effect on the way in which participants are likely to make sense of their experiences. Because of this I proposed to obtain data at different stages in the progress of the work with the family.

Table 2 on page 97 summarises the sources of phase two data relating to individual cases. The detailed rationale for this design is given below.

Recruiting families

I did not have direct access to families attending the Agency. I was therefore relying on Agency workers to talk to families about the research. I prepared information leaflets, one for adults and one for young people (see Appendix 2), in line with the principle of informed consent (Alderson, 2004; Bulmer, 2001). I hoped that a high proportion of families would agree to take part, but the sample would be self-selecting. The Agency team is located in an area where the proportion of black and ethnic minority people is below the national average and so they were likely to be under-represented in the study. This is recognised as a significant limitation.

Table 2: Data sources for phase two

Source	Type of data	Timing
Parents/carers	Individual and/or joint interviews	Two interviews, the first early in the work and the second once completed
Children and young people	Individual 'interviews', including use of play	One 'interview' after the completion of the work
Therapists	Individual interviews	Two interviews, the first early in the work and the second once completed
Case files	Selective recording of file data using pre-determined criteria	At the end of the work
The team manager	Individual interview	Variable – some cases were complete, others at various stages

However, as Homan argues, as an ethical strategy, informed consent has its limitations.

'The practice of informed consent...shifts from researcher to subject the moral responsibility for delineating the bounds of privacy and for refusing access to researchers: this is especially problematic in view of the relatively powerless role and unpractised negotiation skills of many human subjects and it renders their privacy the more vulnerable' (1991: 55).

In this project there was evidence that workers were acutely aware of the vulnerability of some service users and, where necessary, that they saw themselves as 'advocates' for potential participants. This was most clear in relation to the recruitment of children and young people, where workers took some pride in the refusal of some young people to take part in the research, seeing this as evidence of them becoming more 'empowered'. It also meant that there was a reluctance to talk with families about the research at the very outset of the work when families were often in crisis and perhaps ill-equipped to absorb information and make decisions. So, although leaflets were supplied at the outset, workers did not return to the question of participation in the research until the first review, typically four weeks into the work. This meant that my first interviews with parents and workers were shortly after that, typically about six weeks into the work.

Gaining the views of parents and carers

I interviewed parents or carers at an early stage in the work and tried to do so again once the work was completed. However, in some cases second interviews were not possible, for reasons given later.

In the case of couples I used a combination of joint and/or individual interviews as seemed appropriate, taking into account their own feelings. I felt that I would gain the most data about the impact of gender by including both joint and individual interviews with male and female carers and being able to compare them, but I was prepared to take a pragmatic view of this should this appear to be too much of a burden for them.

Much has been written about the use of interviews in qualitative research. As Warren argues, 'the epistemology of the qualitative interview tends to be more constructionist than positivist.... The purpose is to derive interpretations, not facts or laws, from respondent talk' (2001: 83). Holstein and Gubrium (1995; 2003) describe this as 'active interviewing', participation in the work of making meaning. McCracken (1988) argues that some 'insider' knowledge of the respondent's world put the interviewer at a real advantage. Certainly, much emphasis is placed on understanding the varied and situated perspectives of both interview and respondent (Luff, 1999). These are ideas that I explore fully as I present and discuss the findings. Of particular note at this point is that such interviews do not follow a fixed schedule but tend to 'wander', in Kvale's (1996) phrase, as the interviewer remains flexible and attentive to the variety of meanings that emerge. Nonetheless, I have followed Rubin and Rubin (1995) in using a series of main questions in most interviews, followed by requests for clarification or further information, followed by further, unscripted questions to pursue the implications of answers already given.

Broadly, in first interviews I expected to ask about:

- The circumstances of children's referral to the Agency.
- Parent's impressions of how the abuse has affected the child, themselves, and their relationship with their child.
- Parents' perceptions of the aims of the work.
- Parents' expectations of their own role during the work.

- Parents' views about their own support needs.
- Parents' understanding of how the therapist will handle issues of confidentiality for them and for their child.
- Details of the work plan so far.
- Views and experiences of what it has been like so far to have a child attend the Agency.

In final interviews I planned to ask about:

- How the work plan was actually carried out (the pattern of sessions and parents' roles in relation to those sessions).
- Parents' views about the level of their actual involvement in the work.
- Parents' views about whether their own support needs were met.
- Parents' views about the outcome.

The significance of gender in interviews with parents

In an influential chapter, Oakley (1981b) has suggested that interviewing is a masculine paradigm, in so far as women interviewees may be regarded as 'objects' of study. Since then, feminists have shifted interviewing practice so as to allow the closer development of a relationship between interviewer and respondent. As Oakley puts it, 'no intimacy without reciprocity' (1981b: 49). Stanley (1993) also advocates a degree of interviewer self-disclosure, although others have noted that this is not without its difficulties (Harrison and Lyon, 1993; Reinharz, 1992). Reinharz and Chase note that, for some women, the experience of being invited to speak, coupled with the implication that their words are important, may be 'an epiphany, dramatic as this may sound' (2001: 225). Riessman (1987) draws attention to the impact of this on herself as a female interviewer.

For men interviewing women, Padfield and Procter (1996) have shown, in a comparative study, that after minimising the differences between their genders (female and male respectively) and maximising their commonalities, there was no significant difference in the length of their interviews with women, or in the views women expressed, even on 'difficult' issues such as abortion. However, they found that women who had had an abortion were less likely to volunteer that information to the male interviewer. From the perspective of the women themselves, two factors appeared most important in enabling

women to respond in interviews. One is whether the interviewee perceives herself to be skilled in dealing with men. The second is the ability of the interviewer to put aside inappropriate aspects of 'maleness' (e.g. arrogance, not listening). This is an interesting study with important implications for me. My view is that, after a long career in social work observing female colleagues and interviewing women as mothers, I have learnt to minimise the impact in interviews of my male gender, very much as Padfield and Proctor (1996) describe. Having the 'recommendation' of current therapists and being able to introduce myself as an ex-therapist from the same team has helped to establish trust and rapport with women. But I am aware that for some, perhaps those who perceive themselves as less skilled in dealing with men, there may still be difficulties, and women may not volunteer information as freely as they might to a female interviewer.

When interviewing men there is a different set of issues. Schwalbe and Wolkomir (2001) note that for men who are wedded to attempts to display 'hegemonic masculinity' (Connell, 2005) the interview may be an opportunity to do so, as well as a threat. These dynamics can lead to a struggle for control of the interview, the non-disclosure of emotions, the exaggeration of rationality, autonomy and control and various 'bonding ploys' (Schwalbe and Wolkomir, 2001: 213). For me, as a male interviewer interviewing fathers and carers about their children's sexual abuse, this was difficult territory. Again, I found it necessary to minimise aspects of my male gender, resisting bonding ploys based on 'hegemonic masculinity' and instead seeking to show empathy. I reflect on the impact of these dynamics in Chapter 8.

Gaining the views of children

I planned to interview children and young people myself using child-centred and age-appropriate methods of communication. I wanted to try to understand:

- What it was like for them to come to the Agency.
- What it was like to have their parent or carer either waiting outside, or involved in the sessions, or involved in reviews, as appropriate.

It was important that there should be no confusion for children between my role as researcher and the role of the therapist. Because of this I 'interviewed' children once the work at the Agency had finished.

Gaining the consent of children

In Chapters 1 and 3 I have considered theoretical approaches to the study of childhood and discussed the issues relating to competence and consent. In this study the aim has been to recruit children and young people as fully consenting participants whilst, at the same time, meeting the need to allow parents to exercise parental responsibility. In line with the view that information is the key to informed consent, children were provided with a leaflet (see Appendix 2) that, amongst other things, clearly outlined their 'rights' in straightforward language (Alderson, 2004).

Because I also wanted to gain the consent of parents to their own participation in the study, initial approaches were therefore made to the adults or, in the case of children over about ten years old, to adults and young people together. In most cases of children under ten years old, parents were not enthusiastic about telling children about the research at an early stage. They preferred to give initial consent to involvement in the study for themselves and on their behalf of their children. They preferred to wait until the work was over before talking with me and with their therapist about whether or not to tell the child and/or to seek their child's consent to an interview.

However, it was anticipated that younger children might not always be given a free choice, either because of the protectiveness of some parents or because the enthusiasm of parents and children's desire to please might put them under pressure to participate (Langston *et al.*, 2004). Having a leaflet about the project that was designed for children was a start, but this was not intended to 'bypass' adults. In the end I had to accept that initial approaches to children would be mediated through their parents. But before 'interviewing' children I spent time making an agreement about their participation in the project.

In many ways the complexities of having to first negotiate with parents in order to obtain children's consent to participate in the research project mirrored the process by which therapists gained children's consent to therapy, after discussion with parents.

'Interviewing' children

Having undertaken therapeutic work with children for several years I was used to communicating with children, often through 'play' (Bannister and Huntingdon, 2002). I also had experience of a range of techniques for enabling children to communicate their thoughts and feelings (for example NSPCC *et al.*, 1997). The question was how to adapt such methods for the research context.

I was interested in developing a 'pretend' interview in which the child and I would record interviews with each other as if for a children's TV programme. At some stage I would interview them, as an 'expert' consumer, on what it was like to attend the Agency. However, I was not able to develop these ideas because of the difficulty of recruiting children of the appropriate age to interview. In the event, interviews were carried out with two young people aged 15 years and with a four year old girl. The young people wanted to 'talk' and rejected more creative alternatives. The four year old played and told me about the Agency, but idea of a pretend interview did not seem age appropriate.

The significance of gender in 'interviews' with children

Many of the gender issues previously considered in relation to adults are also relevant here. Frosh *et al.* (2002) have shown that male researchers can relate to boys in 'softer' ways, and that boys can be engaged by a researcher who listens and shows interest in them. In 'interviewing' girls, the difficulty previously noted for adult women, namely a lack of confidence in dealing with men, may be even more of a factor. Pattman and Kehily argue that the need to be 'young-person-centred' is central and that this requires adults to consciously reduce the barriers to 'the child within' (2004: 142).

Gaining the views of therapists

I planned to interview workers twice (as for parents, and for the same reasons). I planned to adopt a very similar approach to the parent interviews. In the initial interviews I planned to ask about:

- Therapists' early impressions of the referral.
- The outcome of their initial assessment.
- The aims of the work.

- The rationale for the case plan, with particular emphasis on the balance of work with the child and any work with parents, and the relationship between the two.
- How therapists plan to manage the dilemmas of confidentiality.
- Their assessment of any needs that parents might have.
- The role of any other agencies who might be involved.

In the final interviews I planned to ask about:

- How the work progressed, again with particular emphasis on the balance of work with the child and any work with parents, and the relationship between the two.
- The therapists' impressions of whether the hoped-for outcomes were achieved.
- Any lessons learned.

I anticipated that some of the therapists might be concerned about the quality of their work being 'judged' by me. This had been addressed briefly at the initial planning meeting with the team. My position was that I was committed to helping the team to develop their practice, from what I regarded as a high base. I tried to act as a 'friendly critic' throughout. It seemed to me that, as the interviews developed, Agency staff became quite comfortable with my role and were able to openly critique their own practice.

Examining the case files

I felt that an examination of the case files would provide me with another way of understanding the therapists' perspective. In particular, it would help to counter the problem that accounts of the aims and achievements of therapy can change over time, and particularly with hindsight. Assuming that case recording was contemporaneous this could provide access to the therapists' thinking during the assessment and case planning process, and their impressions of the work at the time. It would also give access to the thinking in supervision sessions.

However, I was aware of Prior's (2004) argument that documents cannot be read just for their content. It is necessary to understand how and why they are produced and what are the 'rules' surrounding their usage. This was particularly relevant because the Agency would not allow me to copy entire files to analyse at my leisure. (Hayes (2004) notes the

increasing difficulties of gaining access to social work files). I had to find a way to 'codify' and extract salient information. I therefore decided to look at six key documents:

- Initial Case Plan.
- Agreements with parents and children.
- Reviews.
- Closing Summary.
- Supervision Notes.
- Evaluation Forms.

The Agency has a set format for these documents, which is why it is important to understand the conventions surrounding their usage. I searched them for information in relation to:

- Reasons for the referral to the Agency.
- Aims of the work.
- Practical arrangements for the work (methods).
- Reasons given for adopting those methods.
- Outcome.

I recorded words and phrases from each source document relating to each of these areas of interest. I hoped that this would enable me to analyse the construction of the 'case' over time, and in relation to the purpose and readership of the varying documents. The fact that this 'readership' includes parents and children should give insight into the relationship between therapist and family.

Discussion with the team manager

I planned to use an interview with the team manager to address some of the more strategic questions about the team's approach to the work. I intended to focus on exploring the professional decision-making process, particularly in supervision. I wanted not only to discuss each case separately, but also to encourage the team manager to reflect on the similarities and differences between cases and between workers and their approaches.

I left this discussion until late in the research project, when all the cases could be reviewed at once. This interview was tape recorded and transcribed in the same way as the others.

Meeting with the mothers' group and the couples' group

The agency runs a peer support group for mothers of sexually abused children (Hill, 2001) and a similar group for couples. Although only a minority of the parents included in the case studies had attended these groups, the majority of the children of the parents in the groups had attended the agency for therapy. For each support group I tape-recorded a focus group (Cronin, 2001) discussion of the following questions:

- When your child comes for therapy, if you are not part of the play sessions, what do you expect to be told about what goes on? What 'rules' do you think should govern this?
- How do you think you can best work with the therapist to support your child's recovery?
- What support, if any, do you think that you need, or needed, for yourself in order to support your child?
- What is it like, and how does it feel, to have professional help for your child? What are the advantages and difficulties, actual and possible?

I gave each person a copy of the questions on paper, with the invitation to contribute answers in writing if they wished to do so. I also used the same case vignettes that I had previously given to the team, so as to compare parental and professional responses.

Ethics - managing confidentiality

I have used substitute names for all the participants and I have not identified the Agency. All the participants have consented to my seeking to publish accounts of this study subject to this degree of anonymity.

However, managing confidentiality *during* the study was a much more complex and difficult process. When I interviewed parents they knew that I would be talking to their therapist. It seemed likely that this knowledge would influence their account of the service they were receiving. Specifically, if parents thought that I would report negative

comments to therapists then they might be reluctant to make them. When I interviewed therapists they wanted to know how much of their assessment I would subsequently reveal to parents. They might be reluctant to tell me about any negative impressions of parents if they thought that I would not keep the information confidential. Finally, when I interviewed children they knew that I had already been talking to their parents and therapists and I anticipated that what they told me might be influenced by what they thought I would tell their parents and therapists afterwards. Mishna *et al.* (2004) note that there is increasing pressure on researchers to afford children the right to control information revealed to the researcher, and specifically to keep information confidential from their parents.

I noticed that these complex dynamics mirrored the very dynamics that I was trying to study. I was interested in how confidentiality was managed in therapy. Yet here I was faced with a very similar set of questions in the conduct of the research itself.

My approach was to assure participants that I would not pass information from one interview to another. However, I might ask permission to do so in some specific circumstances. At the writing up stage the same issues have been more difficult to resolve. Here I wanted the freedom to reflect openly on all the information in relation to each case. I wanted to be able to write about any difficulties in communication or limits on openness or confidentiality. Yet I knew that a high proportion of the participants would read the findings. In the end, the only way that I can manage this problem is by being very sensitive to it as I write and trying to find an appropriate balance.

DATA ANALYSIS

Transcribing interviews

Audio recordings were made of all the interviews. I subsequently transcribed them using speech recognition software. As I listened to the recording I spoke the words into a computer. (Technical limitations prevented the computer from recognising speakers directly from the tape). This was much quicker than my typing it out. In comparison with professional transcription it was cheaper and probably more accurate. I kept control over the transcription convention and I became more familiar with the data more quickly. Subsequently, I found that this exactly matched the experience of Park and Zeanah (2005).

However, this left the problem of what kind of transcribing convention to use to capture rhythm and punctuation, pauses and misspeaking. Elliot (2005) argues that transcription is the first step in data analysis and that it is important to decide what kind of analysis is planned before making a suitable transcript. Kvale (1996) argues that this is more than just a technical issue and that there is a need for a more reflexive stance in relation to the interpretive nature of transcription. Poland (2001) notes that, because speakers tend to 'run on', the concept of 'sentences' does not fit well with oral accounts. Decisions about how to structure sentences and paragraphs can have a significant impact upon the meaning conveyed by the transcript. My approach has been to try to produce a faithful transcript of the oral record suitable for the types of analysis outlined below, whilst at the same time being reflective about the limitations of accuracy and the element of interpretation. Poland (2001) argues that this is broadly consistent with a critical realist approach and that such considerations underline the indivisibility of methodological and theoretical issues.

I have used the following convention:

- New sentences are used to start what appear to be new statements or new ideas.
- A comma represents a short pause during a sentence.
- Represents a longer pause during a sentence or between sentences.
- Italics are used for words or phrases with strong emphasis.
- Obvious non-verbal elements such as laughing and crying are indicated in brackets.
- 'Overlaps' were only common in the group interviews where they are indicated with a hyphen and the word.
- New paragraph has only been used to denote a change of speaker.

There are a variety of approaches to analysing the transcripts of interviews (Coffey and Atkinson, 1996). The two that have had the most influence on my thinking in relation to this study are what Coffey and Atkinson (1996) describe as the 'coding' of concepts or themes and the analysis of narrative or story.

Coding for thematic analysis

Most thematic analysis is achieved through a process often referred to as 'coding'. Miles and Huberman (1994) provide an illustrated account. Here, codes are simply tags or labels attached to 'chunks' of data. Codes can reflect meanings that are either descriptive of segments of the data or of concepts inferred from it by the researcher. Coffey and Atkinson (1996) argue that codes can be used to simplify and reduce data into manageable segments, or to reassemble, complicate and expand data. They can be created either before the data collection begins, based on the theoretical framework and the research questions, or developed inductively from the data, or a combination of both. In its most 'pure' form, the inductive method reflects the 'grounded' approach originally advocated by Glaser and Strauss (1967). However, Dingwall (1997) joins Miles and Huberman (1994) in arguing for a strong element of the former, theory-based method. He argues that the analysis of semi-structured interviews should only be carried out 'in the light of a well-thought out theoretical question and in the context of other investigator's findings'. Otherwise, he describes it pithily as 'an occasion on which to contemplate the sociological navel, and to find it pierced in contemporary fashion' (Dingwall, 1997: 52).

My approach has been to read the data with an eye to pre-existing themes and questions, but to remain alert to new ones. The pattern of emerging themes in the following chapters reflects this. It has a basis in the themes of the literature review chapters but it also develops new concerns, related to the content of the data.

Analysing narratives

One of the major criticisms of thematic analysis is that it tends to chop up into segments the stories that interviewees tell. There is a danger of losing sight of the totality of the narrative, and of the significance of the fact that it is in narrative form (Coffey and Atkinson, 1996). This is important because of the complex links between story telling, our sense of identity and our understanding of the events we are caught up in. As Linde puts it:

'Life stories express our sense of self: who we are and how we got that way. They are also one very important means by which we communicate this sense of self and negotiate it with others.(they) touch on the widest of social constructions,

since they make suppositions about what can be taken as expected, what the norms are, and what common or special belief systems can be used to establish coherence' (1993: 3).

Focusing on the narrative quality of interviewee's speech has helped my understanding of how participants are conceptualising the issues under study. Elliott (2005) identifies three approaches to narrative analysis: the first reveals a primary interest in the content of the narrative, the second in its form or structure and the third in the performance of the narrative, in its interactional and institutional context. My concern has been primarily with the first of these. However, I have also been interested in the performative or social dimension. Plummer (1995) shows how accounts of 'recovery' from sexual abuse can have an emancipatory function, transforming both individuals and the wider culture, and in what follows I reflect on this process.

Ethics

Ethical issues arise as soon as we encourage service users to tell their stories, simply because, as Clandinin and Connelly argue, such stories are reshaped and relived in the context of relationships with researchers 'that are akin to friendships' (1998: 169). The process of reshaping stories implies change and wherever researchers are implicit in change then there are ethical issues, both in relation to the experience of the service user and in relation to the uses made of the account. Firstly, distinctive stories may make confidentiality harder to maintain. Secondly, if personal narratives are a means to a sense of identity then the experience of reading a researcher's deconstruction and interpretation of that narrative may be deeply unsettling to the participant. An exacerbating factor may be the tendency to see the researcher's account as authoritative (Elliott, 2005).

In this study one story was so distinctive as to be disguised in one significant aspect. Fortunately this element was not central to my research questions. I have been sensitive to the effects on participants of reading my accounts of their stories, but I recognise that there is no complete solution.

CONCLUSION

This chapter has described the development of my research aims and methodology, considered in the light of the relevant literature. I have described a qualitative

methodology based primarily on the analysis of individual cases, seen from the perspectives of children, parents and therapists. Many of the themes about reflexivity, for example in relation to gender, are examined in more detail in the following chapters in relation to the findings.

PART THREE

FINDINGS

CHAPTER 5: DEVELOPING A MODEL

INTRODUCTION

This chapter presents the findings of the first phase of the study. It also includes some initial discussion of the issues raised, although this discussion is developed more fully in later chapters where links are made with other findings. This chapter draws on an initial planning meeting with the team and four further discussions each lasting between one and a half and two hours. Since the planning meeting was prior to the formal consent for the research it was not tape-recorded. With the team's consent I have made use of my own written notes. The first two of the following four meetings were structured around the completion of the following matrix. The use of this was discussed in Chapter 4 (Table 1 on page 95) and it is reproduced here for reference.

Table 1: Grid used in discussion with the team

	Support for parents and carers	Linking parents with therapy	Therapy for the abused child
Current approaches			
Possible areas for development			
Guiding principles			

The completed matrix represented the agreed record of the team's position and I have used it as the data source for the relevant section below. The final two meetings consisted of a tape-recorded discussion of a series of vignettes. The vignettes are included as Appendix 1.

At the outset of the research the team consisted of three female workers who I refer to as Andrea, Becky and Carol, and a female team manager who I refer to as Lynn. All but one of the staff has a social work qualification and they have all undertaken various types of post-qualifying training in therapeutic play work with children. Towards the end of the period of the research a male worker was appointed who I refer to as David. However, this was after the discussions described in this chapter, which is necessarily based exclusively on the perspectives of female professionals.

CONCERNS ABOUT A 'MODEL' FOR PARENTAL INVOLVEMENT

During the early stages of negotiation with the Agency about this study, and before final consent had been given, I met with the team for an initial discussion. During that discussion I raised the possibility of developing a 'practice model' for involving parents more fully in their children's therapy, prior to evaluating that model in practice. The team was very familiar with the idea of having such a model, because there is an Agency requirement that all teams have one to underpin their therapeutic work with children. In fact, the team's model was seen as being in need of updating so my suggestion was timely. However, what was new was the explicit attention paid to involving parents.

Two concerns were raised at this early stage. They became important themes of the professional perspective. The first was concern that the Agency's own policy position would not allow too great an emphasis on parents, or at least not on meeting parent's needs following sexual abuse. This was because the Agency defines its service as being a *service for children*, which fits with its national profile as a children's Agency. The team were clear that this did not preclude working with adults, but only insofar as such work could be justified on the grounds of helping children. Different team members had different opinions about where the boundaries might be, but there was a consensus that any explicit individual 'counselling' for a parent would not be supported by the Agency.

Secondly, the team was concerned that my idea of a 'model' might be too rigid and inflexible. They were very clear that they could not live with the kind of prescriptive model that one member of the group referred to as 'one-size-fits-all'. As the team explained, this was because of the complexity of the differing situations that the team was presented with and the need to use a variety of different approaches. The team felt that the current model for direct work with children, described below, offered such flexibility and should be expanded to include parental involvement in an explicit fashion.

The result was that the 'model' that evolved from the following discussion is indeed a deliberately loose description of a variety of ways of working in a variety of circumstances. The focus of attention for the research is on the ways in which workers 'assess' different types of cases, decide which approaches to adopt and negotiate this with families. In subsequent chapters, the focus will be on understanding the impact that this has on parents and on children.

COMPLETING THE MATRIX

Support for parents and carers

Current approaches

The team identified three main approaches to supporting parents and carers. The first is a long-standing peer support group for mothers of sexually abused children. This group has been in continuous existence for over ten years and in that time several hundred women have attended. It is an open, drop-in group with no fixed agenda, quite different from some of the fixed-life, professionally led groups described in the literature (for example Baghramian and Kershaw, 1989; Brodie and Weighell, 1990; Eaton, 1993; Hildebrand and Forbes, 1987; Masson and Erooga, 1990; Rickford, 1992; Wright and Portnoy, 1990). During 1999 I carried out some evaluative research with members of the group that went some way to explaining its continuing success (Hill, 2001). Women felt that the group:

- Allowed them to voice feelings of guilt and failure *as mothers*.
- Allowed them to be honest about this in a way that was impossible with professionals because of the gaze of 'child protection'.
- Provided an alternative to the perceived difficulties of accepting help from family and friends.
- Provided evidence from other women of children's recovery.
- Provided a source of 'strength', thus indirectly helping their children.
- Gave them the power to decide whether or not to attend, and this was important.

From the point of view of the Agency, the team was clear that any support for parents and carers had to be seen to be of direct benefit to children. It is clear from the evaluation that women claimed some benefit for their children, but it would not be fair to represent this as the main focus of the group. In fact, at the inception of the mothers' support group there had been considerable lobbying of Agency management by the team in order to gain agreement for the group. A key selling point had been the relatively small amount of staff time required to run it. One female worker facilitates the fortnightly two-hour meeting, but a small group of volunteer women are available to make first contact with potential new members and to co-facilitate. Women in my study valued the professional expertise, both as a source of knowledge about child sexual abuse and in managing

occasionally difficult group dynamics, but they were clear that the professional facilitator should be in the background.

The second approach is a peer support group for couples. This has operated in a similar way to the mothers' group, fortnightly on an open-ended, drop-in basis for the past four years. It was inspired by several of the women at the mothers' group who were concerned that their (non-offending) male partners did not have any similar support. Early attempts to set up a parallel fathers' support group with a male facilitator had failed, with fathers failing to attend regularly enough to maintain a coherent group. Women then suggested the idea of a couples' group.

The third approach is the provision of individual advice and support to parents. This included a variety of things, as follows:

- Telling parents about individual support available from other agencies, encouraging them to use them and making referrals as necessary (e.g. Survive, Women's Aid counselling service, GP counselling, parenting support from social services, family therapy at the local Community Adolescent Mental Health Team).
- Attending school meetings to support parents (and giving advice and support to schools on how to help).
- Advising parents and occasional advocacy in situations where there may be continuing risks to children (e.g. applications for contact by the child's abuser).
- Responding to crisis calls from parents during the period of the children's therapy, or while on waiting list.
- Offering telephone support whilst children are on the waiting list (often relatively soon after initial discovery of abuse).

As can be seen above, the expectation is that individual support work for parents will not be the norm once therapeutic work has commenced. Parents are encouraged to seek support from other, adult-orientated agencies. However, the team had created the space for significant individual support for parents in the context of planning for therapeutic work with their children. Team members felt that often this is about 'anchoring' parents who are disorientated, providing information about child sexual abuse and some sense of hope.

Possible areas for development

The team were very happy with the service provided to parents by the mothers' group and the couples' group. However, some of the team felt frustrated by not being able to offer individual therapy to some mothers. They felt that there were situations in which women's overall functioning was being adversely affected by the impact of the abuse, including their parenting and their ability to support their children. The team saw themselves as having specialist skills to offer here because of the direct relationship with the dynamics of sexual abuse. They also felt that the links between parenting and support for children were so strong that an integrated approach was called for, rather than dividing adult and child support between two agencies. The team were clear that this would benefit children and they wanted to see the Agency's remit for the team broadened a little.

Guiding principles

The team were asked to identify the theoretical assumptions, knowledge and value base that had led to this pattern of practice. These were described as 'guiding principles', so as not to steer them in any particular direction. The outcome is summarised below.

The first principle that emerged in the discussion is that parents are likely to have a significant influence on children's recovery. The team pointed out that most children live with a parent or both parents with whom they have significant relationships, and that they only attend the Agency for therapy for an hour or so per week.

A second is that parents need information about what to do in order to help their children. The team felt that parents don't have a 'script' for what to do after child sexual abuse. Unlike other issues and crises, it is not easy to find information. The stigma attached to child sexual abuse means that you can't easily ask other people or find literature. The team believed that, as professionals, they have an important role here in providing information. They noted that the peer support groups had a similar function.

A third is that parents may need emotional support in order to cope with the impact of finding out. The team believed that meeting the needs of parents as secondary victims of the abuse is worthwhile in its own right. But their experience indicated that doing so also helps parents to support their abused children. From the point of view of the children, the team noted that children are always concerned about their parents. If parents are seriously

affected by the abuse then helping parents to recover is something that children both welcome and benefit from. The team felt that, in some cases it is difficult to say who 'got better' first, child or parent, but it is clear that the processes were linked and fed off each other.

Finally, parents may need support in order to help them to cope with the impact of the therapy itself. Where children want to tell parents about the therapy sessions, or are otherwise affected by them, then parents may need support in order to cope with what is coming up.

Linking parents with therapy

Current approaches

Given that the formal Agency model focuses on the direct work with the child, the team was asked to identify ways in which parents were then involved in, or linked to, the child's therapy. They came up with four basic patterns of involvement, although these may form the basis for more complex patterns, as we shall see in later chapters.

In some cases, particularly with nervous, shy or very young children, it was common practice for parents to be in the playroom with the child during the early sessions. This was described as 'settling the child in', and was thought of as a transition phase, a 'stepping stone' on the way to the final goal of individual play work. After a time, it was expected that the parent would leave.

A second pattern involved parents joining in with the play therapy sessions towards the end of individual work with the child. The purpose was to share some of the content of the work with the parents, and to pass back to the parents the responsibility for the child's continuing recovery once the formal therapy had ended.

The third pattern of involvement was more flexible in its timing. Parents might be invited at any stage to join in with some of the sessions if there were thought to be difficulties in the parent-child relationship and that these were blocking the child's progress in therapy. Such work would be aimed at rebuilding the parent-child relationship through the use of play, with therapists 'modelling' interactions with the child.

Finally, there were cases in which parents played no direct part at all in the play sessions. This was usually the case with teenagers, where the team reported that young people have a lot of control over who gets to know about the work, and most prefer to work individually with a therapist. However, this pattern of work was also adopted with some younger children.

In practice, all the parents who had actively participated in play sessions with their child were mothers. Even when there was a male partner, it was the mother alone who participated. Nonetheless, team members continued to use gender-neutral language when talking in general terms about these issues.

In all cases, in the periods where parents were not present in sessions, there was a formal system for liaison with them. Written agreements with parents and children over the aims and conduct of the work lasted typically for six to eight weeks at a time. At the end of that period there would be a review meeting, again typically involving therapist, parents and child, at which information about the progress of the work would be shared and plans made for any extension of it. In between the formal review meetings, the team would have informal telephone contact with parents, sometimes after every weekly play session. This liaison was primarily with mothers, but this time not exclusively so and some fathers were also involved.

Possible areas for development

The team felt that they could work more frequently with parents in the room, but only when this seemed likely to be helpful to the child. They felt that there are cases where it is quite clear from early on that difficulties in the parent-child relationship are a significant factor, perhaps more significant for the child than the direct impact of the abuse. In such cases it might make sense to work with both together, helping parents to enter the child's world through play. Some team members also felt that they could make more use of video to record some of these joint sessions and review them in detail with parents.

Guiding principles

Firstly, in talking about involving parents in the therapeutic process team members wanted to be very clear about their own role. They felt that they had a set of particular

skills in direct, therapeutic work with children that should not be overlooked. These skills are explored more fully in the next section on therapy for the abused child, but it already seemed significant that the team felt that it was necessary to restate, as a 'guiding principle', the centrality of their own role. This should perhaps alert us to the significance of the dynamics of power and expertise between professionals and service users that were discussed in Chapter 3.

Secondly, the team felt that, as a statement of principle, decisions about the extent to which to involve parents should be governed primarily by concern for the child's welfare. In making such decisions team members pointed to a number of theoretical ideas that could be influential in suggesting either more or less parental involvement in the work.

For younger children in particular, the team's concern about separating them from their mothers in order to go off to the playroom with a stranger was informed by attachment theory. This was to understand the importance of attachment relationships in helping children to feel secure in the playroom, particularly in the context of recovery from abuse (Bacon, 2001). As Ryan *et al.* (1995) have argued, children must see evidence of an effective partnership between their therapist and their key attachment figure(s) in order to experience the kind of stability and security that will allow emotional engagement in individual work with the therapist. However, with some children the team found that it proved much more difficult to move on from introductory sessions that included a parent to begin individual work. These were usually situations in which a traumatic experience of sexual abuse had increased the level of separation anxiety felt by both parents and children. Here the team felt that there was an over-riding need for the children to feel more secure in their primary attachment relationships, and attempts to separate them from their parents at this stage would be likely to be counter-productive.

The team's thinking was also influenced by insights from filial therapy. Parents remaining in play sessions often reported not knowing what to say and do, and the idea of play as a medium for children's self-expression and communication was a novel one for some parents. In filial therapy, as we have seen in Chapter 2, parents are trained in the use of non-directive play therapy techniques and act as therapists for their own children. In this context, however, the practice was to include parents in sessions with their children alongside the therapist, not in place of the therapist. This set up an altogether

different dynamic. In particular, parents prepared for the sessions through individual discussions with the therapist. These discussions acknowledged the seriousness of the impact on them as parents and took place in the context of a wider pattern of support, often including peer support. Having the therapist present also allowed parents to observe and to model the therapist's approach.

Another important theoretical idea for the team was that of 'containment'. Team members talked about parents who had difficulty in 'containing' their child's difficult feelings. Parents reported a loss of confidence in responding to children's distress and setting boundaries on their behaviour. Team members described their role in working with parent and child together as 'holding' or 'containing' the emotions of both.

These concepts have their roots in psychoanalytic theory. Containment is a process originally articulated by Wilfrid Bion whereby parents (specifically mothers in the original theoretical work) act as a 'container' for the child's difficult feelings, subsequently allowing the child to take them back in a more tolerable form (Symington and Symington, 1996). Bion went on to argue that in a therapeutic relationship the therapist takes on this 'containing' role (Symington and Symington, 1996), whilst Winnicott (1988) describes the therapist's role as a 'holding' function that is similar to that of a 'good enough' mother. When parents are included in the sessions with their children then the therapist is simultaneously 'holding' or 'containing' the painful feelings of both parent and child. Through a complex process, this experience may allow parents to take back the same role in relation to their own children (Chazan, 2003).

Team members also pointed to the influence on their practice of feminist theory. This leads to what might perhaps be described as a 'default position' in which mothers are seen as allies in the therapy, even though specific child protection concerns might lead workers away from this position. Normally, the team felt that to exclude mothers is to risk reinforcing patterns of secrecy imposed by the abuser and to increase the barriers to mother-child communication that may have been caused by the abuse.

Team members also identified two theoretical ideas that might suggest decreased parental involvement. Firstly, there was a strong belief that children often benefit from having their 'own space' in therapy, just as adults do (Feasey, 2005). Some team members

presented this argument from a psychoanalytic perspective, as a need for 'therapeutic space', whilst another used a children's rights perspective. This raises the question of how much parents should be told about the work. The consensus view seemed to be that children should be offered as much confidentiality as possible in the light of their age and understanding, and commensurate with the need to pay attention to what are often referred to 'child protection issues'. Children should be asked about how much information should be given to parents and their views should be taken seriously. However, there are permanent tensions between a commitment to working in partnership with parents and to maintaining children's confidentiality.

In the team's view, the second reason for decreasing parental involvement would be in situations where the levels of parental distress are extremely high and would be uncontained in a joint session. The team felt that witnessing this could be damaging for children.

Therapy for abused children

Current approaches

The team estimated that about 75% of individual work with children utilises what they described as 'creative therapeutic approaches'. Such approaches draw on visual and dramatic arts, music and sand play to enable children to communicate feelings through symbolic and projective play (Bannister, 2003). The team felt that they employed varying degrees of directedness or non-directedness. This depended not only on the individual training and style of the particular therapist but also in response to individual children's presentations.

Most of the remaining 25% of individual work was said to draw on 'talking therapies' based on person-centred counselling techniques and was usually employed with older young people. However, even in these cases it would be unusual not to use any creative therapies at all.

The team were anxious to stress their individuality. Different team members have different training and skills and some were undertaking further training courses during the period of the research. Current and past training has been in non-directive play therapy, transactional analysis, gestalt therapy, and psychotherapy.

All 'cases' would start with a period of 'assessment'. However, this was understood very much as a 'phase' in the work, also encompassing the building of rapport with the family, rather than a uniform or fixed process. For example, the team does not use a standard set of assessment 'tools' and neither does it use any psychological measures. In fact, the approach to gathering information from children varies from worker to worker. However, there are parameters that are set by the Agency. The overall timetable is fixed, with the need for an initial case plan at the outset. This outlines the arrangements for the assessment period, usually including arrangements for seeing the child. At the conclusion of the 4-6 weeks assessment phase a therapeutic plan is devised.

Possible areas for development

The team felt that the main area for development of their work with children would be the provision of groupwork. In the past the team had run a therapeutic support group for teenaged girls. It was felt that such groups were extremely valuable and could either complement or even replace individual therapy in some cases.

Guiding principles

When asked to think about the underlying principles of their work with children team members turned primarily to various aspects of 'child-centredness'. They talked about the need to understand that these are children and young people first, and that their experience of sexual abuse is secondary. This means that it is necessary to meet with them and engage with them as whole people and not just to work with the abuse. In addition, the team felt that there is a need to work at the child's pace and certainly not to force children on to an agenda about the abuse.

Underlying this was the team's belief that most children will chose to communicate about the abuse 'when they are ready' and that the process of doing so in a safe and 'contained' therapeutic environment will be helpful. A guiding principle is that workers try not to bring into therapy any issues that are not led by the child. This reflects an understanding of the therapeutic process as being driven by curative forces within the child, the theoretical origins of which were discussed in Chapters 1 and 2.

Team members talked about the need to recognise the individuality of children and young people. Their experience was that even when the circumstances of children's abuse might appear to be very similar, nonetheless they might experience things very differently, draw very different conclusions and choose very different methods to communicate their thoughts and feelings about it.

Team members stressed the need to be aware of 'systemic' factors. Whilst they felt that the therapeutic relationship between the child and the therapist was very important, nonetheless it was by no means the only factor in the child's recovery. Many other factors outside the therapy room have a significant impact. The importance of the child's relationship with his or her parent has already been discussed. In addition, factors such as waiting to give evidence in criminal prosecutions, or civil applications for residence or contact, or the child's continuing experience of being bullied were felt to have an impact on the work. The team felt that in such circumstances it was incumbent on them to try to influence these other processes, directly or indirectly, in whatever way they could.

Finally, the team stressed the principle of maintaining the child's confidentiality. This has already been discussed in relation to disclosure of information to parents. In addition, the team's experience was that many did not want their friends to find out and that they did not want to feel 'abnormal' by coming for therapy.

Having discussed the links between parents and their children's therapy in general terms, paying attention to 'guiding principles', the following section turns to the team's view of how those principles might operate in specific, albeit hypothetical, cases.

DISCUSSION OF VIGNETTES

In this section I present some direct quotations from the transcripts of these discussions. In each case the text is preceded by the name of the speaker and the numbered 'turn' in the conversation. The vignettes themselves are included for reference in Appendix 1 on page 261.

Sarah, aged 4

To work directly with Sarah, or 'through supporting Mum'?

The team's initial discussion of the case of Sarah was about the relative merits of either setting up some direct therapeutic work with the child, or supporting her mother, or some combination of the two. It was clear from the language used that, in either case, the workers saw the purpose as being for the child.

Andrea 1: Well I suppose, because of the age of Sarah, there would be, for me, a debate about how much work to do with Sarah and how much to do the work through supporting mum.

Here 'the work' is conceptualised as being centred on the child and support for her mother is an indirect means to that end. In any case, there was general agreement that it would be a good idea to invite her mother to remain in the early sessions to settle the child in. However, Andrea was less clear about whether her invitation would imply that she expected the mother to join the sessions, or whether it was her own free choice. On reflection the team felt that this would probably be left to the mother, on the grounds that she knew the child best.

Becky voiced a possible concern about Sarah's mother joining the sessions from the outset.

Becky 13: I guess for me the flip side of that is whether mum can handle what may be said initially. It may cause more anxiety if mum is in there if the child comes out with something that is sexually explicit, and that kind of might upset mum and that will cause the child to become upset.

How to decide – the role of assessment

This led to a discussion of a practical dilemma. Whether or not to include her mother in early sessions with Sarah felt like a key decision, yet it was being taken before the assessment had really started, largely guided by Sarah's mother. Andrea felt that she

would be guided by what appeared to be least difficult for the child at the start of the first session, rather than by any longer term assessment plan.

The team felt that in Sarah's case it seemed likely that an assessment would suggest that a relatively short piece of individual work might help her to 'work through the traumatic incident' (Carol 23). There was general agreement that this would be best done individually, and that if Sarah's mother had joined the initial sessions then she would later be encouraged to wait outside.

Carol 32: I suppose that I am thinking that, with a four year old, you know I think it quite likely that, if they feel safe, that, you know, if they feel accepted and their feelings are ok, then it is just a matter of time before they play out symbolically what has happened. I feel that those are quite specialist skills in terms of really attuning to the play and sort of feeling confident, as a worker, to go with what the child is bringing, rather than make it ok or get a happy ending to the story. So I would be a bit worried that, if mum was there from the beginning that that might inhibit that process in some way'

However, support for Sarah's mother might be longer term, particularly if she was prepared to join the mothers' support group. If not, then the team felt that Agency policy constraints meant that they would have to be 'more creative' about offering individual support. However, support for Sarah's mother was seen as vital:

Andrea 45: If mum is really struggling emotionally in terms of how to respond to the child and actually a lot of it is around *mum* not being able to cope and manage because of what has happened then ... you know ... whatever we do with the child is not going to move things forward enough because, you know, mum needs to feel stronger and more able to feel that she can parent and is able to respond to what is coming up because of what has happened.

Messages to Sarah's mother

This led finally to a discussion about how to communicate with Sarah's mother about these issues and dilemmas. If Sarah's mother had talked about the stress she was under and asked for support then team members would have no difficulty in being open about

their thinking and planning. But if, on the other hand, Sarah's mother had asked for help for Sarah and showed little insight into the impact that finding out about the abuse had had on her, then things would be more difficult. Nonetheless, team members would seek ways of supporting her:

Andrea 47: I may set up some phone calls and some visits to give some feedback about the sessions and to hear how Sarah is at home. But what we may end up talking about is mum kind of like offloading about how she is feeling or wanting a bit of support and advice about how to meet Sarah's needs at home. So I feel like it's done, but not in such a straightforward, open way.

But the team's experience suggested that most mothers are anxious for individual support and that the usually difficulty is being constrained in what they can offer.

Carol 54: I find it can be quite demanding time-wise. Once a parent finds it useful talking to you then it's like, 45 minute phone calls or visits ... and if you have x number of cases then I find myself choosing the cases where I can offer that and the cases where I can't. If I wanted to offer that on all the cases then there wouldn't be enough hours in the week.

It seemed that children's therapy could be contained within the allocated hour a week, whereas adults made more demands for support at times of their own choosing.

Gary, aged 8

Working with Gary about his relationship with mother and father

The team felt that the difficulties in Gary's relationships with each of his parents would be a main focus of the work. However, in keeping with the principle of working at the child's pace, they would not set that agenda for Gary but wait for him to talk about it. Then the most likely way forward would be to use the regular review meetings with Gary and his parents to work on these relationship difficulties. However, this would only be done with Gary's consent, and if he was reluctant:

Andrea 74: Well.... I suppose I would be encouraging that that might be helpful, but if he said absolutely 'no'.....then we'd be working with that I suppose. Why he would be reluctant... that would be the work.

Testing parental reactions

There was a lot of concern that, whilst the parents acknowledged the impact on them of the abuse, nonetheless they were reluctant to accept help for themselves. Team members felt that, as in the previous vignette, they could find ways around this by 'selling' support to parents as being 'for Gary'. In particular, team members were nervous about how the parents might react in a review session when faced with some of Gary's angry feelings about his mother, and ambivalent feelings about support from his father.

Carol 85: I'd do a piece of work with mum really to assess how mum was with that information and whether she was at a stage where she could meet Gary's needs and then have a joint session with Gary and mum, if and when mum was at the stage where she could give Gary the messages he needed. "I never knew this happened. There's no way I would have made you go and stay if I had known what Tony was doing to you". I mean my fear might be that mum would say something like "Of course I didn't know about it, don't have a go at me about it", or something.

This discussion led to the idea that this would be a three-stage process. First there would be the work with Gary and gaining his consent to involving his parents, as above. Then there would be preparatory work individually with each of the parents and, finally, work with them all together, possibly in the context of a review meeting.

Engaging Gary's father

There was quite a lot of discussion of the particular issues in relation to involving Gary's father in the work. Firstly, there was the view that Gary's relationship with his father was likely to be very significant in Gary's recovery.

Carol 111: The thoughts going through my head about dad is that he is probably feeling quite deskilled in meeting Gary's needs, and so I'd be trying to find a way to listen to dad and help him recognise that he is really important to Gary and that

he has got quite a lot of influence on Gary. I feel that, if I could help dad to meet some of Gary's needs then that would be more effective than me seeing Gary on his own.

In particular, it was felt that Gary needed to be confident that his father believed that the abuse happened and was not his fault.

However, the team anticipated difficulties in engaging with Gary's father.

Carol 97: I think that, logistically, it is more difficult in making that contact with dads if they are working during the day. It means doing an evening visit. I find dads more difficult to get hold of. You have to go out of your way.

Carol's use of language is interesting. It implies that some work is in 'your way' and some out of it. Perhaps father-work fit less readily into the teams' 'way' of working, based on regular office hours. Certainly there was an undercurrent of some irritation here. Workers felt that when they went 'out of their way', the additional effort was not always rewarded. In the past they had worked hard to ensure that fathers could become involved, only to find them choosing not to do so. 'He made me a coffee and then he just went off!' (Becky 114). On reflection the team felt that they had to make it really clear to fathers that they were expected to participate, otherwise they would opt out.

In this vignette there was concern about the likely impact of the abuse on Gary's father.

Becky 99: I think the impact is probably quite dramatic really. Because if it was external to the family then it is just anger that they can have, but when it is somebody in the family and they have had a good relationship up until that point, then they have lost quite a lot of relatives in the family. I think it could be quite a major impact. I'm just wondering who dad has got to talk to really. It would be difficult for mum, his wife, to hear how he might be missing his brother.

The team were hopeful that if the parents were to attend the couples' support group then this might allow them to resolve some of the difficulties in their relationship. They had

seen evidence of situations in which men had been unable to talk with their partners on their own, but had used the supportive group setting to voice difficult feelings.

Jenny, aged 14

Maintaining confidentiality

In this situation the team envisaged undertaking individual therapeutic work with Jenny. Given her age, the team was clear that they would be offering a confidential service to Jenny in her own right.

Lynn (manager) 8: We would want to offer a 14 year old confidentiality, and so what we tell the parents about the sessions will depend a lot on what the child wants. Reporting back to parents about the content of sessions affects the relationship that we have with them, even when the young person wants us to do it and agrees to it. So we tend not to do it without the young person there as well, if we can.

However, the team explained that such work would be set up after visiting the mother, taking a family history, gaining her perspective and making an agreement with her. It would be very unusual to commence work with a young person without first discussing it with their mother. So, in this case, although the subsequent work would be a confidential service negotiated directly with Jenny, nonetheless the initial contact would be mediated through her mother.

The team felt that parents of young people were quite happy with this principle of confidentiality.

Andrea 21: Some parents want their young person to have counselling and they see it as being something independent and they are quite happy for it to be relatively independent. They much more see it as counselling.

Parents do not expect to be involved very much, 'they see their older children as more 'separate' (Becky 19).

However, there may be difficulties when mothers phone up to complain about the young person's behaviour. The following discussion illustrates:

Carol 22: The only thing that I would add is that, in one case, the young person was staying out late at night and getting into trouble with the police and then you've got the parent on the phone saying, "Can you talk to her about it?" And that is pretty difficult.

AH 23: So what do you do?

Carol 24: Er... Well it is really difficult, I think. I guess I was concerned that I did not confront her too much. I did not want to repeat her mother's 'nagging'.

Andrea 25: But there is also an issue about what information the parents are giving you. It might be that the young person is not aware, so it needs to be made open that these calls are being made, the family needs to understand the ground rules.

Lynn (manager) 26: Generally, you would try not to bring into the therapy any issues that were not led by the child. So you might meet with the parents to discuss their concerns about the child's behaviour and you might even arrange a separate session with child and parents to look at it, but you would not just bring it up with the child in the sessions, otherwise you'd just be interrupting the therapy really. However, there might be issues about risk to the young person and then you would have to face up to it.

Difficulties in the mother-daughter relationship?

The team noted that the vignette suggested that Jenny had told a friend about the abuse, and not her mother. This led to a discussion about the possibility of difficulties in the relationship between mother and daughter and what might be the therapist's response. There was agreement that this would form a part of the therapist's initial assessment. If this led to the conclusion that this was a difficulty then the next stage would be to consider the potential for change.

Lynn (manager) 11: You would do an assessment of therapeutic need first, and that is what gives you the chance to identify if a key issue is the relationship with mother. Then, if so, you need to have some assessment of the parent's openness to change. It could be that they will just undermine the therapeutic work. There are some parents who may just damage the process. But the best outcomes are with parents who are supportive and positive and able to hear the messages about what they can do to help.

It might be that this would lead to joint work with Jenny and her mother. There was some concern that such work represented, for the young person, a dramatic change in the style and content of the sessions. Whereas Jenny's own individual sessions would be non-directive in style and led by her, workers felt that joint sessions needed to be carefully planned and structured so as to avoid unhelpful free-for-all arguments. They would feel very different to Jenny and the change would need some careful preparation.

Darren, aged 13

Reassuring Darren's parents

In this case the team envisaged a very similar pattern of individual work with Darren, which would be confidential. The fact that Darren's parents were reporting that he did not communicate much with them was seen as typical of his age, (more so than his gender), and not necessarily indicative of a problematic relationship with his parents. Accordingly, a major task during the early visits to the parents would be to reassure them.

Lynn (manager) 31: I think that, in the initial stages, while doing the assessment, it is about reassuring the parents that their child's behaviour in not wanting to talk to them about it, withdrawing from them emotionally, that this is not about them, but that it is quite a normal reaction to the sexual abuse. They need you to recognise that it is traumatic, that it is upsetting and distressing for them to see the child like this, but that that is why he is coming for therapy. That is how you have to start. You have to say to them, "We know you support him", and you'll begin by doing some work with Darren. It might be that this turns up some difficulties in his relationship with them, but it might not. It might be that he his blaming himself, not them.

The team felt that it might well be that Darren's depression might lift without his ever having talked in detail to his parents about the abuse. However, a lot would depend on the nature of the relationship between the parents and the abuser (a friend of the family) and their reactions to the abuse. Assuming that they supported and believed Darren and had ended the friendship, then the team's view was that they would need encouragement to keep giving him 'messages' of support. These would include the fact that they believed Darren and were angry with the abuser. The encouragement would be needed to keep this one-sided communication going in the face of little response from Darren.

CONCLUSION

The aim of this chapter has been to understand the team's view of the pattern of service provision that existed at the outset of this research study and the rationale that underpins it. This has been achieved through a series of four meetings with the team where we first had an abstract discussion about the team's work and later discussed approaches to hypothetical cases through the use of vignettes. The emphasis has been on the involvement of parents in the therapeutic work. From the team's perspective, this process has helped to expand their existing practice model to include links with parents. From my perspective, it no longer seems quite so clear that what has been described can be usefully thought of as being a specific 'practice model'. This is because of the diversity of different approaches that have been discussed for use in differing situations. The main variables are the child's age, the quality of the relationship between parent(s) and child, and the nature of the impact of the abuse on both parents and child. Whilst the team appears to have been very successful in its resistance to developing a 'one-size-fits-all' model, nonetheless the detailed thinking that they have developed in response to a range of circumstances has been extremely helpful.

Summary of the team's approach

To meet the perceived need to support parents of sexually abused children the team offers peer support groups for mothers and for couples. This is based on an understanding of the seriousness of the impact of the abuse on parents and their need for information and a 'script' to help them to support their children. It also recognises the potentially long-lasting nature of the need through access to an open-ended group. However, the team's feelings about the provision of individual support for parents were more ambivalent. In some circumstances some members felt that they would like to be

able to offer individual counselling to mothers, in particular. But this is not formally within the Agency's remit for the team and the expectation is that parents will be referred to other agencies for such a service. In practice, the team offers informal individual support to parents alongside the direct work with the child, in the context of liaison over the work. The element of support for parents may be more or less explicit in the written agreement, depending on parents' perceptions.

In order to link parents with the therapeutic work there are regular review meetings, usually with both children and parents present. Here the child has a lot of control over what is said to parents. There are some situations in which parents may become actively involved in therapeutic play sessions with their children, particularly the younger ones. The main theoretical framework for this was to think of working on disrupted attachment relationships, although there some alternative frameworks are referred to above. Therapists were interested in expanding their use of play session that included parents but they were more influenced by ideas from filial therapy and Theraplay than by family therapy.

Direct work with children is very child-centred in approach and draws on creative therapies. Much attention is paid to children's rights to confidentiality.

The team manager summed up the team's position as follows:

Lynn 47: Our framework is very much about providing a therapeutic service for abused children. Obviously we gain a lot of knowledge from the parents about the child's history and the history of the family, and parents have a part to play (though not all parents, because some are too negative). For us it is about offering support to parents who do not have any knowledge about child sexual abuse – it is about giving them a script because they do not have any reference points in how to talk to their child, what to expect etc. So I don't have any problem with that, it is part of the job and sometimes it can show up difficult parent-child relationships. But even if the parent comes into the sessions then I still think we are working primarily with the child, though parents should get the advice and guidance that they are asking for. When we are working with parents more directly then this is usually about trying to strengthen attachments. Not that these

attachments are faulty, but maybe the impact of the abuser has had a disruptive effect and that children and parents can be helped, through shared play and more open communication, perhaps modelled by the therapist, to see what is possible.

The nature of this analysis

So far I have tended to present what the team has told me as a straightforward and realist account of practice. However, because the team understood my commitment to developing practice in this area it is reasonable to suspect that this may have influenced their account. In addition, I noticed that the way in which workers contributed to the discussion changed on the one occasion when the team manager was absent from the group. In other words there are indications that how team members account for their work varies in important ways according to the audience. This is an idea that I explore throughout Chapter 9 where, by paying particular attention to language and discourse, I highlight elements of reflexivity, both in relation to my own role and in relation to the reflexive practices of participants.

First, however, I present a thematic analysis of the findings of the second phase of the study. This consists of a series of interviews with workers (Chapter 6), mothers (Chapter 7) and fathers and children (Chapter 8) about parental involvement in therapy in thirteen specific cases.

CHAPTER 6: WORKER'S PERSPECTIVES

INTRODUCTION

This chapter and the two following chapters present the findings of the second phase of the study. This phase is based on case studies of thirteen families. Details of the families who participated in the study are given in Table 3 below, set alongside a note about the circumstances of the children's abuse and the services provided by the Agency. Family members identified with a star (*) are those who were interviewed, either once or twice as indicated by the number of stars. Caleb (case 3) and Barbara, Caitlin and Dana (case 1) are of mixed race. All other participants are of white European origin. All names have been changed.

Table 3: The Families

	Family composition				Details of abuse	Outline of services	Worker	
1	Abigail*	Mum	35		All 3 sexually and physically abused by their father. Also experienced domestic abuse.	Individual play sessions with: Barbara for 9 months Caitlin for 6 weeks Dana for 6 weeks 6 individual sessions for mum – then to GP counsellor.	Andrea Becky	
	Barbara		14	f				
	Caitlin		11	f				
	Dana		8	f				
2	Edith**	Mum	42		Sexual abuse by brother Barry. Both siblings are adopted.	Individual sessions with Felicia for nearly 2 years. Support to parents.	Andrea	
	Aaron*	Dad	47					
	Felicia*		13	f				
	Barry	Sib	16	m				
3	Gabrielle*	Mum	32		Sexual abuse by mother's brother. Previous allegations against father meant he was excluded from the work.	6 individual sessions for Caleb. Individual support for mother who also attended the group.	Becky	
	Graham	Dad						
	(separated)							
	Caleb*		15					m
	Steven	Sib	11					m
Juliet	Sib	9	f					
4	Amanda**	Mum	26		Both boys sexually abused by their 12 year old step brother. Parents were already separated.	4 months individual sessions for Lance. 3 months individual sessions for Malcolm. Mother attended group twice – plus some individual support.	Andrea David	
	Lance		5	m				
	Malcolm		7	m				

	Family composition			Details of abuse	Outline of services	Worker
5	Hannah** Mum	35		Sexually abused by 13 year old neighbour.	9 months individual sessions for Dale. Mother joined in part of sessions after 3 months. Individual support to mother.	Carol
	Dale	9	m			
6	Irene* Mum	41		Sexually abused by 15 year old brother Gareth. He moved to LA accommodation.	Individual sessions with Jackie for 6 months. Some individual support to mum.	Carol
	Frank* Stepdad	38				
	Jackie	6	f			
	Gareth Sib	15	m			
	Harold Sib	17	m			
	Ian Sib	18	m			
7	Karen* Mum	28		Sexually abused by a trusted adult neighbour.	12 months individual sessions for Dale. Mother joined in sessions after 4 months. Individual support to mother.	Carol
	James	6	m			
	Laura Sib	4	f			
8	Tanya* Mum	36		Sexual abuse by a stranger in a park.	5 months individual sessions for Sabrina. Mother joined in sessions after 1 month. Individual support to mother.	Carol
	Sabrina (and grandmother)	7	f			
9	Madeline**Mum	42		Sexual abuse by father on contact visits.	4 months individual sessions for Nadia. Individuals support for mother.	Andrea
	Nadia	9	f			
10	Olivia** Mum	36		Sexual abuse by father of the youngest two on contact visits.	Individual play sessions with children. Pamela for 4 months. Rachel 8 sessions. Individual support for mother.	Carol Becky
	Pamela	15	f			
	Rachel	5	f			
	Keith Sib	7	m			
11	Cathy** Mum	23		Sexual abuse by a 7 year old girl living next door.	Joint sessions with Vanessa and mother for 2 months. Individual support for mother.	Carol
	Oliver* Stepdad	22				
	Vanessa	5	f			
	Matthew Sib	2	m			
12	Bridget* Mum	28		Sexual abuse by step-grandfather.	4 months individual play sessions with Wendy. Individual support for mother.	Becky
	Wendy*	4	f			
13	Ellie Mum	35		Sexual abuse by ex-partner and also extreme domestic abuse.	Joint sessions with Peter and mother for 10 months. Individual support for mother.	Andrea
	Peter	9	m			
	Roy (in care)	16	m			
	Simon	2	m			

This chapter introduces the findings from twenty-two interviews with the three main participating workers, Andrea, Becky and Carol. These workers were interviewed about their involvement in the thirteen cases under study. It was intended to carry out two interviews with each worker about each case, once early in the work and the second after it had finished. However, in two cases the short period of therapy had been completed or was nearly completed at the first interview. In another two cases, two different workers were involved and one of these, David, joined the team towards the end of the study period. Finally, the chapter also draws on a wide-ranging interview with the team manager, Lynn, in which she reviewed all the cases.

The chapter consists of an analysis of the themes of the interviews taken as a whole. Particular attention is paid to the ways in which workers appear to approach decision-making, the kinds of expertise that they draw on and the ways in which they attempt to 'manage' their relationships with children and parents.

When quoting from interview transcripts that relate to work with individual families I have followed the same basic convention as in the previous chapter. However, this time the speaker's name is preceded by the relevant case number (as in Table 3 on page 135) and, when appropriate, a suffix to indicate whether the interview took place early in the work (1) or after it had concluded (2). Hence for example, 4.1 Becky 12 would represent Becky talking with me about case 4 during the early interview, at turn 12 in the conversation.

THEMATIC ANALYSIS

Contact with families before 'allocation'

It was often the case that new referrals would wait perhaps a few weeks, sometimes longer, before a social worker could be allocated. In this interim period the usual practice was to offer some limited support to parents, usually mothers, mostly by way of telephone contact.

Andrea described it as follows:

9.1 Andrea 9: Madeline was ringing up sort of.... in situations that she was finding very difficult, certain things were happening that would make her panic

and get on the phone. So initially my work was in supporting Madeline ... in terms of issues she was struggling with in terms of how to respond to Nadia's behaviour some general parenting stuff actually, but also specific issues connected to sexual abuse and her own ... I suppose her own confusions around what has happened and whether ... her own guilt and all that, sort of, unpacking all that really.

As in this case, there was evidence that this was in response to contacts from mothers in crisis. Nonetheless, it is also indicative of the team's thinking about the centrality of mothers' roles in 'holding it all together' for children, as we shall see in the following sections.

Meeting parents or children first

One of the effects of providing support before allocation was that workers usually met parents before they met children. Workers were aware that this created a particular dynamic, with a variety of potential advantages or difficulties for the child. But it was difficult to predict the impact on any particular child without having met them!

1.1 Andrea 45: So the young person knows we've been ... that their mum has told us things ... and I wonder what impact that has on them. There may well be a positive impact in terms of mum trusting you and all that, but in other cases the child may have lots of other feelings. I think in Barbara's case, and this is only my felt sense of it, I think that she felt quite 'held' by this ... knowing that mum and I were working together.

Direct work by the therapist with the child

In the course of the interviews the workers had plenty to say about the techniques, themes and progress of play sessions carried out by therapists with individual children. This material speaks eloquently about individual children's experiences, their courage and their progress towards recovery, and about the skills and creativity of workers. Nonetheless, the focus of this study is on parental involvement in the process, and consequently I do not intend to discuss the therapist/child therapy sessions in any detail. Suffice to say that there is evidence of a wide range of techniques being employed; from non-verbal, creative therapies to counselling with some older teenagers, and on a

spectrum from quite 'directive' ideas, such as the use of 'worksheets', to the completely non-directive. Underlying all these techniques is a commitment to being 'child-centred' and 'working at the child's pace'.

However, the current study does not exclude the content of therapy sessions altogether. Subsequent sections explore the impact of involving mothers in therapy sessions and, in this context, the meaning of being 'child-centred' and 'working at the child's pace' will be further examined.

Assessing the relationship between parents and children

From the worker perspective, a fundamental factor in shaping parental involvement was the worker's assessment of the relationship between parent and child. This section considers workers' approaches to such assessments.

The interviews show that, in their thinking about mother-child relationships in particular, workers tended to categorise any perceived difficulty as either pre-dating the sexual abuse or arising from it, directly or indirectly. Sometimes both seemed relevant and it was difficult to categorise, as in Barbara's case.

1.1 Andrea 45: The domestic abuse and the sexual abuse are very much interconnected ... and also there is the early stuff with Barbara ... because the domestic abuse is going on from when Abigail was pregnant with Barbara, and so in utero Barbara would have experienced violence towards her ... so this is fourteen years of Barbara feeling very unsafe and also she has some neurological damage and we don't know where that has come from ... how her early attachment stuff ... and she was very poorly as a baby, she was in intensive care and nearly died ... so it's complex.

This is a clear example of an interest in the 'causes' of such difficulties, even if they were hard to be certain about. But workers tended to take a more pragmatic interest in the quality of the *current* relationship and here they were more likely to reach definite conclusions. Thus, in the same case:

1.1 Andrea 46: As I became involved Barbara was feeling much more supported by her mum and there has been a shift in the relationship between them as her mum left her dad and has begun to protect the girls and Barbara is beginning to feel safer.

Where workers identify a pre-existing difficulty

In these cases workers were still primarily identifying a *current* difficulty in the relationship, but one that did not appear to relate to the impact of the abuse on either mother or child. Conclusions were based on workers' confidence in understanding the impact of sexual abuse and were reached by a process of elimination. If the difficulty was not caused by the abuse then it must have been there before. However, workers sometimes showed less confidence in identifying an alternative 'cause'.

8 Lynn (manager) 22: Sabrina was born quite early, she was in the special care baby unit I think, mum has identified that there was a problem with the bonding..... (*Mum is*) very little, she's just like the little girl herself. This is a child who, at the age of four, was playing by herself in a local park and that was how she got sexually abused. So there are a whole series of questions around neglect and the emotional attachment to her mother.

12.1 Becky 19: I'm not 100% sure about Bridget and Wendy. I think Wendy is just not being allowed to speak for herself really. In some respects Bridget's keeping her as a baby, not allowing her to do things for herself. Bridget was quite chatty and she talked all the time but she was all over the place; it seemed like she just needed some attention.

The impact of abuse on relationships between mothers and children

The workers identified a number of different ways in which they felt that the abuse had affected the relationships between mothers and children. Firstly, there were cases in which the trauma of finding out had been such that mothers had been unable, at least temporarily, to really 'hear' their child's distress. So in 15 year old Caleb's case, the therapy:

3.1 Becky 21: ..was all about his mum knowing what really happened. He actually rehearsed that in one of the sessions, what to actually say to her. I asked him if he wanted me to talk to his mum about it and he said, "No, I want to do it". He actually said it out loud to me and once he had done that he felt able to say it to his mum.

In 15 year old Pamela's case, her mother found out very indirectly after Pamela told a friend.

10.1 Carol 4: She wasn't sure whether to believe her initially but then she asked (*her younger sister*) Rachel whether anything had happened to her and Rachel said "yes" directly. And I suppose it's a lot easier when you have a very little girl telling you directly like that. So my initial assessment was that part of the healing for Pamela might be not just individual sessions with me but also some healing of the relationship between her and her mum.

Then there were cases in which workers felt that mothers had reacted in ways that they saw as unhelpful. For example, Carol reported that when Dale told his mother that he was very sad:

5.1 Carol 46: ...she says things like, "I can't take this away, just try and think of happy things". I don't want Dale to have to listen to all that kind of stuff ... I don't feel comfortable with the way she is talking to him.

In a different case, Carol felt that James' mother had overcompensated for the abuse James had suffered by indulging him.

7.1 Carol 2: She wanted to do the best for him, so he got to choose what he had for tea, when and where he went to bed, which I think is understandable, but then when she tried to put that structure and those boundaries back in place, if he didn't get his own way then he would just, you know, start shouting at her, kicking her, punching her, which really left her at a loss as to how to manage that.

In such cases, as we will see, workers had some difficulty in knowing how to approach mothers with these kinds of 'criticisms'. In fact, as the above quote indicates, workers found much of this 'understandable', particularly when mothers were responding to continuing threats from perpetrators. Becky reported that such pressure affected Abigail's mood and thus had an impact on her daughter, Caitlin.

1.2 Becky 4: I think that one of the big things that happened while I was working with Caitlin is that they got an injunction against dad coming anywhere near them. As a result of that the whole family relaxed. One of the problems was that Caitlin easily took up mum's moods. So if mum was feeling anxious then Caitlin would feel anxious.

In cases where the abuser was an older brother who had been living in the same household, the situation was more complex.

2.1 Andrea 6: Well, the impact on Felicia has been that she finds it very difficult to say what she wants. She just wants to keep everybody happy. She is worried about upsetting her mum or her dad. She wants to take care of them. So she is doing a lot of taking care of her mum and even now is aware of the emotional impact on her mum of Barry (*the abuser*) not being there.

Children who are caught in the middle may need particular help with these relationships, as we will see. However, workers were convinced of the centrality of mothers when it comes to giving children appropriate 'messages' after abuse and there were cases in which workers felt that mothers had achieved this very successfully.

4.2 Andrea 3: Amanda's been giving him messages about believing him and supporting him; he clearly knows it's not his fault at all, he clearly knows that what the abuser did was wrong and those are the things that she has given him. When she has struggled to know what to do ... for example, she was unsure whether to tell the boys that he had pleaded guilty or to wait for the sentencing ... she wants to find the right messages to give them and she is looking for advice. I suppose she has a capacity, with the right support, to give the boys what we know are the factors that really help children to recover from sexual abuse experiences.

Note that, even in this case, Andrea felt that Amanda needed 'the right support'. In a later section the way in which workers think about the nature of this support is considered. The important thing to note here is that, when workers made explicit mention of theory then it was attachment theory that they made use of. As Carol puts it:

6.1 Carol 22: I'm not just assessing the impact of abuse on the child on their own but in the context of their attachment with their primary attachment figure. I don't just look at the child; I work with the child and their attachment.

The next section moves on to consider the differing kinds of interventions that flow from such assessments.

Working on the relationship between parents and children

The interviews provided evidence that this was being achieved in two main ways. Sometimes mothers were included in play therapy sessions and sometimes they had individual sessions of their own, albeit with differing degrees of contractual 'formality'. These will be considered in turn.

Advantages and disadvantages of mothers joining the play sessions

Workers pointed out that the question of whether or not to include mother in the play session had to be resolved at the first session, before the worker had got to know the child or family well. This meant that sometimes this was, as Becky put it, an 'instinctive' judgement. Sometimes there were logistical constraints, such as mothers' need to look after another child, and there are examples of workers changing the pattern once the work was under way.

Dealing first with some of the potential difficulties anticipated by workers: they located these at an organisational level, or as relating to the mother or to the child. On the organisational level, the manager was aware of the resource implications.

Lynn 78: If you're going to involve parents in sessions, then it becomes much more than one case, if you know what I mean, in terms of what it's requiring of the therapist.

And workers were aware that, in cases where a prosecution was pending, then a parent's presence in the sessions might lead to evidential difficulties.

Workers concerns about mothers were rather different. Firstly, they knew that involvement might run counter to the common desire to 'hand over' the emotional burden that is noted in the women's perspectives in the next chapter. Secondly, in Jackie's case there were concerns that Irene might not be consistent enough in her support for the work.

6 Lynn (manager) 22: It didn't ever feel like having mum in the sessions was going to be beneficial because we could never say, from one month to the next, whether she was going to be really consistent with Jackie.

And even for mothers who are seen as basically consistent and supportive, for workers there is the question of whether these mothers have the requisite skills to join the play.

11.1 Carol 4: For a child to get into that symbolic play they need a really fine attunement to their feelings and to their play. It requires accuracy. Above all, whoever does it needs to be really okay with the feelings that the child is presenting.

Some mothers were felt to have particular difficulty in allowing children to express what the workers saw as legitimate anger about the abuse.

8 Lynn (manager) 45: Because parents have not been trained to cope with the anger so a lot of parents want it to be all right, or they check the anger and won't allow it to come out.

Workers felt that mothers would need training in both the theory and the practice of non-directive play.

4.1 Andrea 23: It needs another piece of work with mum in terms of how to play nondirectively ... in terms of training mum up to be a bit of a play therapist alongside you.

Workers also anticipated difficulties from the child's perspective if mothers joined the therapy sessions. Firstly, they felt that children need their own 'space'.

1.1 Andrea 32: In a way you could argue that it is very helpful for the child to have their individual space. There have been some things that Barbara has chosen to tell me and it has been okay within the boundaries of confidentiality because it hasn't been about child protection. I think that mum would acknowledge that Barbara has things that she wouldn't want to be expressing if mum was there.

Workers seemed to feel that this was a 'healthy' dynamic when in the context of what they considered a supportive relationship with mother. One advantage for children is that they are freed from having to 'take care of' their mothers and more able to address difficult aspects of the relationship.

13.1 Andrea 9: I think what it does, with mum in the room, it maybe sometimes makes it more difficult for him to express.... and this is a more recent thing..... his rage and anger towards mum.

Some of the difficulties identified above were not fixed but were liable to change as the work progressed. In particular, individual work with mothers was seen as a precursor to their involvement. In Dale's case Carol felt that he would benefit from having his mother in the sessions, but that she needed first to be able to allow and to cope with his expressions of anger and his developmentally regressive play.

5.2 Carol 10: I think in Dale's case I was anxious, for good reason, about involving mum in the sessions. So I did quite a lot of work with mum about nondirective play therapy and the way we work. I think it was very difficult for mum. It seems such a big thing, you know, for mums to come in and to expect them to suddenly kind of act like the play therapist. I just felt very protective of

Dale really. I wanted his mum involved, but on the terms of the nondirective play therapy model.

Similarly, with James:

7.1 Carol 19: My assessment was that, following the abuse James didn't feel like he had a secure attachment with mum because ... I think, from his perspective ... she was unable to contain his angry feelings. She would just burst into tears or start crying whenever he lost his temper and he seemed to be directing his anger towards her. So I really felt that, if she came into the sessions too early, then he wouldn't have felt free to express those angry feelings about what happened to him, because mum would get upset. So, I worked with him on his own. When I felt like he had got what he needed from the therapy, and mum seemed stronger, I thought that at that stage it would be a good idea to have mum in to help her see what he has been through, what the meaning of this has been for him, and how it has impacted on him.

Finally in this section, this leads to a consideration of the advantages of including mothers. Firstly, therapists believed that several of the children actively wanted their mothers to know what they had been through, to understand their feelings more fully.

5.1 Carol 35: His mum is the most significant person to him so you can see why he wants her to be there. It's like he wants her to act as some kind of witness to his feelings, perhaps even validating them. It feels like ... all the work we have done so far is for that to happen.

13.1 Andrea 5: I think, and this is just what I think it has been about, is that he has wanted his mum to hear what his experiences have been.

Another advantage is that it makes it possible to work therapeutically with feelings 'live' as they happen, drawing on skills from family therapy. A good example is Carol's spontaneous decision to include James' mother, following a tantrum in the waiting room.

7.1 Carol 16: James refused to come in the play room. So I brought mum in as well, simply because I couldn't leave them in the waiting room. And then he started shouting and kicking mum, which was a really good opportunity to work with ... and mum was crying... and I said that it wasn't ok for him to kick his mum and so at that point he lay on the ground thumping the floor and kicking his legs. So when there was a quiet patch I said "You know it is really strange because (*the abuser*) did all those horrible things to you but you've never been angry with him, you're just angry with mum".

Following this, James made and then smashed up clay models of his abuser. Later, when invited to make a model of his mum he gave it to her, telling her he loved her and was not angry any more.

In some cases, particularly where there had been attachment problems before the abuse, Carol felt she was not working so much with mother as co-therapist, but rather as an additional 'child'.

8.2 Carol 10: Sabrina was playing with the dolls and mum was totally engrossed, like a little child, playing in the sandpit. Mum was saying to Sabrina, "Sabrina, look what I've made in the sand!" Just like she was a little kid! My instantaneous reaction was ... you're the parent ... you should be paying attention to Sabrina and not playing like a child yourself! I felt quite angry with mum. I just more or less blanked her out and played with Sabrina. But when I looked at that in supervision afterwards I decided I would pay attention to the child in Tanya and recognise her as a needy sort of person as well as Sabrina. And as soon as I had that frame of reference everything seemed to fall into place. I approached it as though I had two kids in the play room together. And mum just absolutely blossomed. And Sabrina began to feel safe and to feel that mum was really attuned to her so then Sabrina moved into symbolic play, which I thought was a really big achievement. We were moving on to another level of play.

This led away from a primary focus on the abuse and Sabrina's sexualised behaviour. But 'it just felt like the attachment issue was the most important thing. The other work

wouldn't make sense until you've sorted out the attachment' (8 Carol 2.20). Once again, assessment of attachment seemed to be the key in workers' thinking.

6.1 Carol 22: If there is a secure attachment then I'll involve the parent as much as possible in the work. And if my assessment is that there is an insecure attachment, then that's when I might be holding back a bit, giving the child more time on their own. But also I'm very protective of the child, very protective of the child's therapeutic space. I don't want the parent to intrude on that if it might stop the therapeutic process.

It was apparent that workers were weighing up these perceived advantages and disadvantages in relation to the specifics of involving mothers in individual cases and trying to strike the right balance. However, the overall context was always positive towards mothers, even when there were perceived difficulties in their relationships with their children.

5.1 Carol 46: Part of it is providing containment. Daniel Stern says that when mothers have problems in their relationships with their babies then what we need to do is not to criticise the mother but allow the mother to have trust in herself, trust in her own natural intuitive mothering abilities. And the way you do that is to provide that containment, to contain her anxieties, to enable her to build up her trust in herself and to enable her to build up her strengths.

Support to parents

This section examines workers' accounts of the support that they provide for parents, in the context of trying to effect changes in the parent-child relationship that will help parents to support their abused children. However, it should be acknowledged that the distinction that the workers made between providing support to parents for themselves, in their own right, and providing support for them with the intention of improving their support for their children's recovery was not altogether consistent. As we shall see in Chapter 9, it could be argued that this is less to do with muddled thinking than with the context in which the workers are explaining it. Different audiences make different demands. In presenting their thinking to parents, to me, or to Agency managers, workers have different objectives in mind.

In those cases where workers were confident about the quality of the attachment relationship and about mothers' parenting skills then things were at their most straightforward. In such cases 'support' consists of two strands: helping mothers to deal with their own emotions, and providing information and advice about 'managing' their sexually abused child.

4.1 Andrea 5: My role is to support her with issues around parenting as a result of the boys' sexual abuse, as well as to give her some support for herself, so she can be there for the boys, giving them what they need in relation to the sexual abuse, as well as supporting her with her feelings ... because if those can be contained and held, then it can stop her from saying things to the boys that might not be helpful. Most parents don't have that experience of abuse. So part of my role has been helping her deal with those specific issues that she is having to deal with as a parent of two small children who have been sexually abused, and thinking through what is helpful to say to the boys, giving her some little 'scripts' around things that come up ... because she wouldn't have that knowledge base really ... and to help her think through around timing of when to tell them.

Sometimes this definition of 'support' included an element of education about the process of therapy, particular the use of non-verbal play techniques with younger children.

10.1 Becky 11: But I think that mum's concern is that Rachel doesn't talk about it. What I have explained to mum, and I think she felt a lot more relieved afterwards, is that five-year-olds don't have the vocabulary to talk about it. So the expression will come out in her painting. I think when mum heard that message, that she isn't going to come up to her and talk about it, that she felt a lot more relieved. I think the reassuring messages to mum have been at least as important as the work with the child.

In such cases this is partly about building mothers' confidence, not only in the therapy, but in their own parenting, as Carol suggested in the previous section above.

4.2 David 4: There were times when I picked up, I suppose just intuitively, that she was feeling very ... that her sense of her identity as a parent has been greatly impacted by the experience. I was at great pains to pick out anything that I noticed about Malcolm that reflected her expertise.

Sometimes, out of sympathy for the child, mothers had relaxed boundaries, for example, over bedtimes, and 'support' to them included help with rethinking this and, if necessary, guidance with some simple behaviour management techniques. In Abigail's case this included guidance about how to encourage Barbara's autonomy, particularly in decision-making.

1.1 Andrea 41: I gave feedback about how mum could support Barbara to make decisions, feeding back the thematic issues emerging from the sessions and what Barbara's needs might be as a result ... and mum was very receptive to hearing that.

In other cases, things were more complex. Andrea felt that Madeline found it difficult to understand which aspects of her ex-partner's behaviour were abusive and why. This was affecting her ability to support her daughter in dealing with the same issues.

9.1 Andrea 29: So actually a lot of the work is around supporting Madeline in understanding what has happened and acknowledging what is abusive behaviour, and around what needs to be in place in terms of protection and contact. In a way it's not our role, but it ties in, in terms of boundary setting generally. That is my rationale for continuing to work with Madeline. I think that if mum is able to be clearer about what messages she's giving to Nadia then I think that will help Nadia. I think it would help Nadia to have a clear message about the fact that what her dad did was not normal behaviour between an adult and child and no way could be an accident. I think the fact that mum has been a bit confused about that is partly her background and to do with how she was parented and not really having boundaries set for her. I don't think she's got a lot to draw on in terms of her experience of boundaries and her current lack of support, because she moved away from her support network.

Reflecting on this in the second interview, once the work had ended, Andrea said that she saw a parallel process going on.

9.2 Andrea 2: Both Madeline and Nadia were ‘in denial’ about the significance of what had happened to Nadia. It felt as though there was a parallel process going on between where Nadia was and where mum was. Once mum was clearer then that enabled Nadia to be protected and it enabled Nadia to move on as well.

This experience of having some individual sessions of their own had the unexpected benefit of helping mothers to understand the value, to the children, of such sessions.

1.1 Andrea 31: It made a space for her, but it was also helpful because she respected the therapeutic space for the child – having experienced it herself.

However, workers also saw some negative aspects of ‘supporting’ mothers in the above ways. One theme running through the interviews is the fear of ‘getting dragged into acting like a social worker’, as Becky put it. The team was concerned about providing services to parents that might otherwise be provided by the local social services department.

3.1 Becky 8: I didn’t set out to spend more time individually with mum than with Caleb. It happened by accident really because of her needs – and because of Caleb’s needs as well. So what happened was mum jumped on the bandwagon of thinking that she is there to support me ... so I would often get phone calls from Gabrielle just telling me either about Caleb’s behaviour or the other children’s behaviour, so I was just like a social worker. I very much tried to get SSD involved and to try to get rid of that role for me so I could concentrate on Caleb and what had happened to him but I found myself being dragged into acting like a social worker, very much so.

Becky’s use of the phrase ‘being dragged in’ clearly shows that she feels that such support to Caleb’s mother is not her role. The key for her seems to be that Caleb’s mother was reporting difficult behaviour such as petty crime by children who had not been abused and that this was felt to be outside the Agency’s remit. This is in a context in

which the team reported 'defensive practice' by local authority social workers who appeared anxious to limit the services that they provided. In Sabrina's case, where parenting was thought to be 'chaotic', Lynn felt that the lack of additional support from the local authority was limiting the therapy.

8 Lynn (manager) 35: Children can't be doing recovery work whilst this sort of chaos is going on. So we referred to social services, requesting more family support with a parenting focus for Tanya and Sabrina. Then we could focus on Sabrina and her needs in the therapy sessions. But until we get some infrastructure in there in terms of supporting Tanya, then what we get at the moment is being rung up every five minutes about the next crisis.

As the definition of 'support' is expanded, it seems that it quickly exceeds what the team feel that they can provide, or indeed what they feel that they ought to provide. In these circumstances the team felt that inter-agency collaboration was the answer. However, the team felt that it was very difficult to obtain family support services from the local authority to complement their own work.

Managing the confidentiality of children's sessions – 'feedback' to parents

When parents were not physically present in play sessions then there were arrangements for keeping them informed. Workers referred to this as 'feedback'. There were two basic mechanisms; informal telephone or face-to-face feedback after individual sessions (either all sessions or selected sessions) and the more formal 'reviews' where worker child and parent met together every six to eight weeks. However, even within this common framework it was striking that there was wide variation in the patterns of information-sharing, depending on the circumstances of the case, and that this was a significant area of worker power and discretion.

The first thing to note is that workers brought a therapeutic standpoint to the conduct of review meetings. Reviews were often used to work therapeutically on emotions and on parent/child relationships. During a review, Pamela's mother looked at some of Pamela's paintings and started to cry.

10.1 Carol 4: So I kind of like slowed it down and said to mum, “Why are you crying, how do you feel?” And mum said that she was really proud of Pamela, and really sorry about what had happened. And then Pamela started to cry and they had a cuddle and they looked lovely together. And I took loads of photographs with our digital camera and I gave them to them as a way of recording their relationship.

With younger children, reviews could be used to reinforce therapeutic messages that the therapist wanted the mother to give to her child, and to show the child that mother and therapist were united and working together. This primary concern with therapeutic goals, rather than children’s rights to confidentiality, reflects the overall tone of workers’ thinking about ‘feedback’. Indeed, in some cases the whole idea of obtaining meaningful ‘consent’ from children to disclosure of information seemed impossibly difficult.

1.1 Andrea 17: It is difficult with Barbara because she would probably agree with anything I said. So to actually get her real agreement about what is going to be shared I think is very difficult. And that has been a big part of my work, trying to facilitate her to make *any* decisions for herself (*laughs*)!

However, in other cases consent to disclosure was a significant factor, and young people controlled the flow of information about session content.

3.1 Becky 48: I felt it was between Caleb and I, and I felt that he was old enough to be able to decide what was shared with mum and what wasn’t. So what I would say to mum was very general - like he turned up, or he didn’t turn up - and it really was as general as that. I was able to tell her whether he had been here, not much about the content of the session, but maybe a little bit about his mood.

Between these two extremes there were examples of workers taking rather more complex positions. Andrea described a case in which she felt it would be in Felicia’s interests to disclose something to her mother.

2.1 Andrea 16: But it is not a child protection issue, or about safety, so even though I think it would be better if that was communicated to her mum, I have to

be respectful, and work at Felicia's pace, because at the same time I don't want to undo the very thing that I am working on, which is trying to get her to say what it is she wants! I could destroy the whole process if I wasn't respectful of that.

Once again, it is the wider therapeutic goal that takes precedence. When asked to distinguish between child protection concerns that must be disclosed and things that might merely be in the child's best interests to disclose, Andrea gave the following example.

2.1 Andrea 16: Felicia was having nightmares after one of the contacts with Barry (*her older brother and the abuser*) in which he was attacking her. I felt that it was really important that this was shared with Edith and Aaron (*her parents*) because this is connected to her safety during contact, and I was quite directive and Felicia agreed. However, another issue was her saying that she couldn't sleep in her bedroom because that was, essentially, where the abuse happened. But she didn't want me to share that with her parents because she felt that her dad was really busy and that he wouldn't have time to do anything.....it was about her taking care of them basically.....and I hoped that would change.

But in Nadia's case, the same worker, Andrea, disclosed some of Nadia's feelings to her mother at a review, despite Nadia's resistance because:

9.1 Andrea 45: I felt that Nadia needed to know that mum knows, and that mum can support her with that, and acknowledge that it's very hard.

So it seems that workers are making very fine judgements based on the nature of their relationships with mother and child and their perceptions of the child's best interests.

Sometimes, particularly where there were underlying concerns about attachment relationships, workers were worried about possible negative consequences of disclosing information to parents. Early in the work with Dale, Carol was reluctant to tell his mother, Hannah, about the content of session and was concerned about her reading the file notes.

5.1 Carol 16: I think I was concerned at the time just to protect his space. I was worried that Hannah might be wanting to read things about the sessions so that she could follow them up with him and talk at home .. and that that might interfere with the process.

Carol expressed similar concerns about telling Jackie's parents about some of the themes in her play. Carol felt that these included play about an inconsistent and sometimes nasty mother-figure and that being open with her mother about this could make things worse for Jackie.

The decision not to disclose this detailed information was taken despite the fact that Jackie wanted this to happen.

6.2 Carol 8: I think Jackie knew that she was getting something really special from the sessions, and she really liked them, but she wanted to be able to share that with her mum and dad. Those seem to be her wishes and feelings, but then I am making an assessment of how able she is to give informed consent. I just felt that it wouldn't have been safe to share some of the details with her mum and dad because I felt that there could be repercussions from that.

With younger children it was very common for them to want to tell their mothers all about the sessions, particularly in cases where workers felt that there were secure attachments. In these situations workers welcomed such spontaneous feedback and sought to maximise its therapeutic benefit.

4.2 Andrea 9: In one session Lance had done a picture of his protectors, including his mum, overcoming the baddies and he wanted her to have it. So in a way he'd given his permission for the feedback. I laminated it and they kept the picture. It was a very tender moment where he was explaining to his Mum how much he loved her.

The overall picture in relation to 'feedback' seemed to be that workers were concerned to manage it in such a way as to keep children safe and to promote the overall therapeutic goals. Sometimes these goals included work on the parent-child relationship, whether

this was made explicit to parents or not, and the feedback was managed with these therapeutic goals in mind. Workers seemed to be exercising considerable discretion over these decisions.

When parents disagree with the therapist

In Dale's case we have already seen how his mother, Hannah, was keen to read his file notes in order to find out more about the therapy, because the worker, Carol, was not forthcoming with information. This arose because of Hannah's conviction that 'just playing' was not helpful and that a more 'straightforward' approach was needed.

5 Lynn (manager) 19: I think his mum could see that Dale was progressing but at times she wanted a more radical approach. Sometimes she wants to be in the sessions to say, "Let's nail it on the head, let's speak about it". But when she tried that in relation to his behaviour at home it didn't work with Dale at all. In the main I think she saw how beneficial Carol's approach was, but I think there were times when she doubted the play therapy approach and it being so nondirective at times. She didn't have that confidence that he was on a journey, that there was a process going on and that you might interrupt that by suddenly saying, "Just sit down there Dale because we want to talk about this, this and this".

Carol described the process whereby she was able to allow Hannah to express her doubts, whilst simultaneously protecting Dale's therapeutic space and helping Hannah to understand the process of therapy, before finally including her in the sessions, as we saw earlier. In this case the disagreement was resolved over time by the combination of a skilful use of professional status and expertise in insisting on the non-directive approach, and the use of the interpersonal skills needed to allow Hannah to feel 'heard' and to develop her understanding.

In James' case there was a specific disagreement between Carol and James' mother, Karen, over the fact that Karen had told James that his abuser had gone to prison for the offence when, in reality, he had been acquitted and had moved out of the area.

7 Lynn (manager) 51: I suppose that what we thought, right from the outset was that it was very clear that the child needed to be told the truth. However, this was

a very, very seriously disturbed little boy who had obviously been horrendously traumatised. I suppose that we started from the position of thinking that lying to him is problematic, though we could understand why Karen had done it. But children don't cope very well with finding out, and he will find out. So in supervision we concluded that James couldn't cope with being told at that time and it was not the most important thing. But for Carol it was about, "Am I perpetuating this lie?" Anyway, in the end it came from James, who did indeed find out ... but at least Karen had reached the point where she didn't deny it. Because it had been on the agenda and what Carol had agreed with her was that we would keep looking at it, when to tell him.

Once again, a difficult decision was considered in supervision, but this time, whilst the worker was not happy with how the current position had been reached, nonetheless she temporarily accepted that Karen's position was in James' short-term interests, whilst working on a longer term strategy for dealing with him either finding out or being told.

These two cases show that parents do not necessarily share the professional perspective on how to help their children, and that the professionals are then faced with difficult decisions about how to respond. The dilemmas are about the extent to which professional judgement about what is best for the child should be compromised in the face of parental objections, about how to utilise any authority that derives from professional knowledge in the face of parental scepticism, and how to manage personal relationships with parents in the context of disagreements.

Managing 'child protection issues'

For a few children there were what the team referred to as 'ongoing child protection issues'. In other words, even during the period of the therapy there was the possibility of further abuse. In some cases families were still being threatened by the absent perpetrator and in other cases, involving abuse by an older brother, there was continuing contact between the siblings. Workers talked about having a dual role to play. They found themselves advising parents about how to keep the child safe and also, where necessary, challenging what they saw as inadequate child protection planning within the multi-agency child protection system.

1.1 Andrea 6: At the beginning of the work with Barbara there was still threats from dad, in real life, so there was stuff to do in supporting Abigail with that and feeding back how Barbara was feeling.

9.2 Andrea 6: He was released from prison during the course of my work and that was a significant time. They had to think about what might happen in terms of contact. There were issues to do with letter writing, a Christmas cards, and those sorts of issues. I had to help mum think through what might be the purpose and whether it would be helpful or not to Nadia.

In each of the cases involving abuse by an older brother who was living in the same household workers had serious concerns about the multi-agency response.

2.1 Andrea 20: I came in on the case when those decisions had already been made and there was a plan for contact every six weeks. Straight away I had questions about what had the decision making process been and why contact now? But those decisions had already been taken. But that continues to be a role that I seem to be playing, in terms of questioning the system around how appropriate is this contact.

6 Lynn (manger) 34: But my view is that it was a complete sham of a case from the beginning, allowing Gareth (*older brother and abuser*) to go back there when he clearly presented such a massive risk to Jackie. And to give the parents their due, it's only because they said that he needs to leave, because he's being so abusive, that he did leave. So when I said to social services, "What's the outcome of the risk assessment?" "Well", said the social worker, "it's sort of ongoing". So Gareth is being rehabilitated and the risk assessment is ongoing! It's like the social worker didn't even understand the question. There were things like, "Well the Family Centre have taught her how to scream!" It was just like; hello, wake up! This is a six-year-old that we are talking about and you can't be serious, can you, that you're expecting this child to defend herself? And then you ask what the protection plan is and mum and step dad are both working in the evenings and an older sister was supervising and protecting! What kind of a child protection plan is that?

Workers felt that they were in a difficult position when asked to work with a child who they felt was not adequately protected. They felt that the multi-agency system was not responding adequately to sibling abuse and that they had a role to play within the system in advocating for the abused child. This was particularly true when only the perpetrator, not the abused child, had an allocated local authority social worker. In each of the above cases workers felt that their intervention had led to adequate protection for the child and the therapy had continued. But the manager, Lynn, was philosophical about the limits of what could be achieved.

6 Lynn 24: Our service is about offering support and therapy to abused children, but there are bits of the system that we haven't been able to effect, I suppose.

In Felicia's cases, taking action early in the therapy to limit her contact with her brother was apparently against her own wishes, although these seemed to change later on.

2.1 Andrea 20: One of the things I did quite early on in the work, which was a risky thing to do in terms of my therapeutic relationship with Felicia ... I stated quite a strong view about what I thought about contact. And she was not in favour. But I made the decision that that was what I needed to do to keep her safe. And in actual fact it has not impacted on our therapeutic relationship at all – I think that is quite interesting – maybe there was a part of her that was quite relieved that somebody took a stand.

This is another illustration of the complexity of trying to respect children's 'wishes and feelings' when they have split loyalties and complex emotions.

Deciding to end

The therapists' accounts suggest that most decisions to end the work were made either by mothers or by the therapists themselves. Children rarely initiated endings. Only Caleb, aged 16, voted with his feet and stopped coming after a while, without explanation.

Decisions led by mothers

When mothers felt that children had recovered and the therapist agreed, then things were straightforward.

4.2 Andrea 7: His mum feels he's back to his old self really. We offered a final six sessions and his mum reduced it to four. In a way she has instigated the ending rather than us. We have been responsive to mum and what she feels she can manage. I trust her that if she feels they were not managing then she would ask for more. There isn't anything that I'm seeing in Lance's session that's making me question her decision to end it.

However, if the therapist felt that this was premature then there was some negotiating to be done. In Barbara's case, Andrea felt that being a part of this process was beneficial for her, and the work was, indeed, extended.

1.1 Andrea 45: Mum wanted us to work towards a planned ending and it was difficult for Barbara to say what she really wanted – for the work to go on longer. But I felt that there was some helpful things about that – that there was some modelling of the fact that it was ok for us to have a difference of view but we can come to some agreement – whereas Barbara has not experienced that before.

However, not all such negotiations were successful and some mothers exercised their right to no longer bring the child.

6.2 Carol 18: What mum was saying was that she thought that Jackie was ready to finish because she was better now. She thought the therapeutic work had been really helpful and that Jackie was ready to finish but I thought that was premature. My feeling was that mum was finding it hard work to bring Jackie to the sessions.

Decisions led by therapists

In such cases workers were very aware of the need to prepare both parents and children for endings. There was evidence of considerable work being undertaken so as to ensure positive endings or all concerned. The work with Felicia provides a good example.

2.3 Andrea 8: Because of her background, anytime Felicia said goodbye to anybody it was a major thing. So I knew it was going to be potentially quite difficult to end the work. We had a very slow, phased ending from October to March. In a way that was a piece of work in itself, making sure that she felt that someone wasn't going to just drop her and not care about her any more. She was reluctant at first to be thinking about it, but as we got closer towards ending there was a bit of her there was ready to end.

Outcomes

In each of the final interviews the therapists were asked to reflect on the outcomes of their work. In addition to their own perceptions, workers were able to draw on completed evaluation forms obtained from children and parents, albeit that the overall completion rate was only about 50%.

Difficulty distinguishing effects of therapy from maturation

It was immediately apparent that therapists were aware of the difficulty of distinguishing the effects of therapy from simple maturation. Nonetheless, as in Barbara's case, when a main theme of the work had been about developing her independence as a teenager, maturational change may indeed be related to the therapy.

1.2 Andrea 15: There was a huge shift in Barbara compared with when she first came. She left as a teenager whereas at the beginning it felt like having a baby in the room. At the end she was starting to become quite a rebellious teenager over normal sort of things. She was starting to have fun and it was lovely to see some spontaneity develop. Mum was able to see the changes in her; she had made progress at school. There was clear progress in the external world as well. Mum accessed support for herself through a counsellor and so she moved on as well.

By and large, however, workers were looking for other ways of thinking about outcomes and measuring progress. Two main approaches were apparent.

Relating progress to obvious, 'external', changes

As in the quotation above, workers often made reference to academic progress as a sign of returning concentration levels and a more general return to 'normality'. Indeed, for

Caitlin, the very fact that she was able to return to school was cited as evidence of success, because she had been terrified of her father's threat to abduct her. In Felicia's case, the fact that she felt strong enough to refuse to be interviewed in this research was cited by Andrea as a measure of success, because Felicia had been formerly so compliant and anxious to please adults. (She later changed her mind, apparently not wanting to be left out!)

Workers rarely made claims about changes in children's inner, psychological well-being, unless such changes had been an explicit aim of the work.

Relating progress to goals achieved

The commonest way of thinking about outcomes was for workers to refer back to the goals that had been agreed at the beginning. Sometimes these had clearly been achieved.

5.2 Carol 8: It had reached the point where he had met the aims that we had set at the beginning of the work. These were; not to blame himself for the abuse and to feel that he was an okay person, to boost his self-confidence and to be aware of his own power. This emerged a lot, his aggressive feelings, and punishing the bunny rabbit that was symbolic for the abuser. So the piece of work also seemed to be with mum; her accepting this play theme and accepting Dale's anger, because mum has found that difficult.

Andrea talked about how she had successfully helped Madeline to rethink her approach to protecting Nadia. And Carol talked about successfully helping Cathy to establish boundaries and a routine for Vanessa's care. Sometime, however, goals were only partially achieved and workers reflected some frustration.

8.2 Carol 12: The quality of the relationship between Sabrina and her mum, in terms of their ability to play, and mum's attunement to Sabrina's feelings has improved. The problem is that Sabrina has had more angry outbursts, and mum just needs so much help with very basic skills of parenting.

CONCLUSION

This chapter shows that therapists are making complex assessments not only about children's therapeutic needs, but also about parents. In the context of the research interviews it also shows therapists explaining and justifying their approach to involving, or not involving, individual parents. Explanations always start with workers' assessments of the parents.

Assessments of parents include judgements about the quality of their parenting, the nature of their relationship with their child, and the impact on parents of finding out about the abuse. It is clear that workers were thinking about different 'categories' of cases, and that a fundamental division is between cases where there were thought to be significant difficulties in the parent-child relationship before the abuse occurred and cases where there were not. The significance of this category distinction is in the way that it appears to frame workers' relationships with parents. If the problems follow from the abuse, then parents may be seen as secondary victims. They may still need some help and support because of impact on them, but they can be seen as potential partners in helping the child to recover. On the other hand, if there had been significant difficulties prior to the abuse, then workers may feel that they are also dealing with the negative consequences of this. Here the balance of the intervention may shift. If parents are understood as being locked into the overall pattern of difficulties and lacking insight into this, then the therapists' intervention may be aimed at both parent and child, individually or together, and there is less sense of a partnership with the parents to help the child.

But even in cases where there were no 'pre-existing difficulties' and more of a sense of partnership, parents were not in the same position as therapists in trying to help their child. The team manager, Lynn, identified two different barriers; a lack of knowledge about abuse, and the emotional impact on the parent.

8 Lynn 62: So as a therapist it makes life difficult because it's not a straightforward partnership relationship between you and the parent. I guess most of the time there might be an imbalance of knowledge but that the therapist might try to overcome that by sharing some with the parents. But in this case, even if the parent gains that knowledge and expertise she wouldn't be able to take are on an equal role because of all the difficult feelings she was carrying herself.

Chapter 9 contains a more detailed analysis of the effect of these barriers on worker-parent partnerships. It also considers in more detail the influence of language and discourse on the processes by which professionals categorise families, and the strategies that they use to justify their approaches. The chapter also considers the impact that this has on parents and on children, and the ways in which they respond to it.

CHAPTER 7: MOTHERS' PERSPECTIVES

INTRODUCTION

This chapter introduces the findings from eighteen interviews with twelve women whose children attended the Agency for therapeutic help. It was intended to carry out two interviews with the mother in each case, once early in the work and the second after it had finished. In six of the twelve cases the second interview did not take place. One woman declined a second interview because the first had been too upsetting for her, a second family moved out of the area, and in the other four cases the short period of therapy had been completed or nearly completed at the first interview. (The thirteenth and final family in Table 3 on page 135 agreed to participate in the study on the basis that only the worker, Andrea, would be interviewed.)

As in the previous chapter, the main themes are presented from the interviews taken as a whole. As before, the themes are organised according to an outline chronology of contact with the Agency; from finding out about the Agency to the conclusion of the work. Later, in Chapter 9, more attention is paid to the nature of my gender and relationship with the interviewees and the possible influence of this, and to the narrative structure of the individual interviews, including the way in which discourse is framed and language is used.

THEMATIC ANALYSIS

How it all started

Immediate impact on mothers

For ethical reasons, the Agency only provided me with contact details for each family who had agreed to participate. This meant that I began each interview without any background knowledge about the family, and that women began the interviews by saying something about the circumstances of their children's abuse and how they found out about it. Whilst this material is not central to the current study, nonetheless I have included some of it, insofar as it relates to earlier research and provides the context in which negotiations over therapy are taking place.

The first thing to note is the seriousness of the impact on the women themselves. One woman lost her job, another family network split in half over the issue. Many reported feeling guilty about what had happened. The emotional impact was enormous:

11.1 Cathy 10: I was just crying every day through it. Every day it was on my mind and Vanessa's behaviour was getting more naughtier and naughtier.

7.1 Karen 74: For the first four days after I found out I was sat in that chair shaking and being sick.

3.1 Gabrielle 17: It was very hard work. And just everyday life was difficult. It just seemed to take over my whole life from the moment I woke up till I went to bed. I just couldn't forget it.

This sometimes affected women's perceptions of events:

1.1 Abigail 2: The referral if I remember rightly came at a totally crazy time. There is things that I find hard to remember times, dates, who you know because so much happened, but as far as I can remember I'm sure it was the police that referred the children to the Agency. Yes, I'm pretty sure.

It meant that this was a difficult time to be negotiating with professionals about therapy for children:

1.1 Abigail 68: ...there was a stage, when I first came here (*to the Agency*), there's quite a lot of things went straight over the top of my head. But I'm not saying that they (*Agency staff*) did anything wrong. Even now I am very forgetful. But because of the abuse I lost my ability to spell, just little things like that, I was sending people texts that they couldn't read.

11.1 Cathy 10: I think possibly because, at the beginning my head wasn't with it, if you know what I mean, so any advice or anything I'd have been given I don't think I would've taken on board the same. Because it's like, well it isn't a

depression because I wasn't depressed, but your head's so mixed up with so many things.

Not knowing about the abuse

One of the emotions expressed was incredulity at not knowing about the abuse.

1.1 Abigail 38: I just couldn't believe it. I couldn't believe that I could live in a household and not know.

This applied even when the abuser was outside the household although, by way of explanation, Olivia stressed her lack of experience of sexual abuse.

10.1 Olivia 55: Looking back, it were so weird, because when you don't know nothing about it you don't know what's going on and then afterwards, when you know what's gone on and you look back and you can tell.... But you don't at the time. I've not had anything to do with anything like this ever in my life, not even friends saying that things had happened to them, there were nothing.

Believing the child's account

None of the women in this study had any difficulty in believing their child's account of abuse. Often this was because they felt that the child would otherwise have no knowledge of such acts.

5.1 Hannah 7: I knew straight away that Dale wasn't lying. He had no idea, he still has no idea of any kind of sexual acts at all and he described it completely. So I knew immediately from the words he was using to try to describe what had happened, I knew exactly that it had happened.

Child protection investigations and legal proceedings

Women talked at length about their experiences of investigations and of court cases, both civil and criminal. Women in this study did not feel 'suspected' of being involved in the abuse, although some were uncomfortable about having their parenting scrutinised. But they were critical of the lack of help from social workers engaged in 'investigation'.

4.1 Amanda 12: Social services, they closed their file on me because they said that ... because I coped well and I didn't go loopy ... I asked for help but they said I would have to go on a waiting list and it would be such a long time that by the time I came to the top of the list there wouldn't be any point ... so they just closed the file on me and I haven't seen them since.

Court cases, on the other hand, were always experienced as very stressful, whether civil or criminal. Women perceived the processes as fundamentally unjust and damaging for children. They were concerned about unfairness to children deemed too young to give evidence, and about therapy sometimes being denied to children who will be witnesses. One woman who had also been living with domestic abuse reported how the abuser used the court process to continue to threaten her and her children.

Non-offending fathers' reactions – concern about

Of the four women with male partners (one of whom was separated) three were very concerned about their likely reactions. One did not tell him for twenty-four hours:

2.1 Edith 3: ...because I didn't want the kind of reaction that you might expect a man to react ... because men deal with things differently. They either take no notice and don't react at all, or they get very angry, there's no middle ground. They are not good with emotions.

5.1 Hannah 59: ...if his dad knows then there will be hell to pay. He'll come up here and bring somebody with him and (*the abuser*) will be dead. Dale will be watching his dad go to prison and I don't want that.

In reality, whilst expressing anger, neither of these men tried to assault the abuser. These issues are considered from a fathers' perspective in Chapter 8.

The impact on the family

Initial impact of abuse on child

In their first interviews, women described a wide range of ways in which they felt that their children had been affected by the abuse. Firstly, some of these are presented in the women's own words.

2.1 Edith 11: She was totally disturbed, obviously. She wasn't sleeping and all the things that go with any trauma.

4.1 Amanda 8: ...because Lance was not doing very well at all, he was wetting the bed and he was having nightmares, he wasn't coping very well at all, he was getting very angry, very aggressive, he was kicking and biting and punching Malcolm.

5.1 Hannah 9: He talks about it every day and every night, how much he hates him, how much he wants to kill him. Recently, he says about himself, I should be put to sleep forever and then it won't hurt anymore.

7.1 Karen 8: Yes, he went through a lot of emotions did James. He started taking it out on me, hitting me. The first day the social worker came he got a baseball bat to me. He went through a stage where he was breaking down and crying and sobbing. He punched himself on his nose and the next morning there was blood all over. He is biting himself. The other day I saw him banging his head on the doorframe and it had a nail in it and he was scratching his arms on it. Things like that.

8.1 Tanya 6: And then she was like, playing the tushy game, where she was licking somebody else's tushy and somebody else was licking her tushy. It just sort of got out of hand. She was doing her pee and her poo behind her bed. Her behaviour just got gradually worse and worse and worse.

10.1 Olivia 32: Nightmares. Pamela has a scar on her face. I saw her do that one night when she was asleep. She has scarred all her face, but the nightmares were really, really bad.

This list includes many of the elements recorded in the literature review: difficulty in sleeping, nightmares, anger, depression and sexualised behaviour. In one case Karen acknowledges that her son, James, appears to be angry with her. This is the first

indication of difficulties in a mother-child relationship as seen from a mother's perspective.

Initial impact of abuse on child-mother relationship

Women were aware of the tendency for their children to wish to 'protect' them from difficult feelings.

1.1 Abigail 9: I thought she'd never say anything. I thought: she is only going to say something when she comes here (*to the Agency*). I thought: she is trying to keep a lid on it to save me the pain and agony with it.

They were even more aware of the need to control their own emotions.

10.1 Olivia 42: ...especially when you're trying to move forward and prove to them that they're safe and not to be scared ... for me to look scared, or be crying, or if anything that happened made me go to pieces in front of them ... then I think that would have brought more fear for them.

4.1 Amanda 23: ...you are trying not to show them any emotion, you're trying to be as strong as you possibly can, and the only time you can show your emotion is when they've gone to school, or maybe when they've gone to bed ... because you don't want to upset them any more than they are.

But only two of the women spoke directly about the impact on their relationship with their child.

5.1 Hannah 37: Dale and I have always been really close. We still are. But I think that he went through a period of, not mistrusting me, I mean he obviously went through a period of blaming me, I went through a period of blaming me, we went through all that but, I think he might have started to worry that I couldn't protect him ... and it did put a bit of a barrier between us.

Mothers' group discussion 26: She thought that why she couldn't speak to me was because she thought that I wouldn't love her any more, and I wouldn't want

her. But when she told me, we both cried together, and I gave her hugs and said, “You did the right thing”.

Whilst the above quotations show that a few of the women were aware that the abuse had affected their relationship with their child, nonetheless the overall impression from the interviews is that the women placed much less emphasis on this than did the therapists.

Expectations of the Agency

Reasons for seeking help from the Agency

Many of the women turned first to family or to close female friends for help in the initial crisis of finding out about the abuse. However, despite reporting a positive early response, the women found there to be serious limitations with this kind of informal help. There were concerns about talking about something so personal and as potentially stigmatising as sexual abuse, certainly about continuing to do so once the initial crisis was over. And women felt that informal supporters became less sympathetic over time, expecting them to ‘move on’. There was also the belief that informal support was limited by the fact that these people had not had the personal experience of abuse that might give them a kind of expertise and enable them to understand.

The specific driver for several women was the feeling that their children needed help and that they themselves were not able to provide it. They felt that they did not know what to say or what to do, and they felt that relevant expert advice was not available to them informally from friends and family. However, none of the women had had any prior knowledge about the Agency. Most had been told about it by the police or social services staff that carried out the child protection investigation and had agreed to being referred. Others had discovered the Agency for themselves but were dismayed at the effort involved and the lack of general advertising of the service.

5.1 Hannah 19: Dale wouldn’t talk to me .. and he was saying he wanted to go to sleep forever. I didn’t know what to do. I said to the police lady, “Is there someone I can talk to?” Now I was getting desperate and they rang (*the Agency*) for me.

The above quotation illustrates the other significant aspect of the dynamic of seeking help from the Agency, that it reflects a sense of desperation. Indeed it is possible to read the desperation almost as a justification for accepting professional help, in a cultural context in which this might be seen as an admission of failure.

Interestingly, despite the time gap of almost forty years, Mayer and Timms' (1970) influential book *The Client Speaks* contains an account of how clients reached the Family Welfare Association that has the same elements: similar limitations of informal networks, the difficulty of finding professional help, the role of referrers and observations on the significance of being desperate. 'It is only desperation that makes it possible to assume the role of client with self-respect' (Mayer and Timms, 1970: 53).

Aims of work

Where women found it difficult to talk with their child about the abuse, then often they were looking for a 'neutral' space for the child to talk.

3.1 Gabrielle 27: (*The aim is*) ... being able to talk about the experiences he had had. I mean he hadn't told me anything about what had actually happened. He never told me the details and all that time talking to Becky really helps him to offload.

In other cases they were looking for 'back up' and for reassurance from someone with expertise.

4.1 Amanda 24: I just wanted them to make sure that the kids are okay.

Expectations of mothers' role in therapy

At the outset, none of the women expected to play any significant part in relation to the child's therapy. The only expectation was that the therapist would tell them how the therapy was going. Women saw the therapy as being the therapist's responsibility. In fact, for some women there was a real sense of relief at handing over responsibility to someone else.

10.1 Olivia 70: Quite honestly phew (*puffs out her cheeks, breathes out heavily, sits back in her chair and mimes relaxation*). That's how I felt.

Nonetheless, this handing over of responsibility only occurred once women had 'checked out' the workers and were confident about the workers' approach. This echoes the findings of Fisher *et al.* (1986) in their study of the use of local authority 'care' for children. They found that, contrary to expectations, parents were not very concerned about losing their 'rights' over their children but much more concerned to find workers who could carry out aspects of parenting that they themselves were struggling with, typically those aspects to do with controlling children's behaviour.

However, as is clear below, this did not prevent some from feeling excluded.

Mothers' role during or after therapy

In later interviews there was evidence that women did in fact play a more active role, with some actually joining in the play sessions (see below). But where women considered using similar play techniques at home they were concerned about their own perceived lack of skills.

5.2 Hannah 33: One night I got a cushion out and I said to him: pretend about (*the abuser*) and hit it. And he did. But I don't feel confident that I would do things right.

But women were aware that, once the play sessions ended, then the responsibility would pass back to them. For most, this was uncomfortable and was eased by a promise of continuing support from the Agency.

4.1 Amanda 62: What Andrea (*the worker*) has already said is that, even when the sessions finish with the children ... that she will still keep in contact with me and will meet with me once a month if I want. She has made me feel better in that way that it's not going to just be stopped dead and then that's it.

Fathers' involvement in therapy

As we will see in Chapter 8, fathers played little part in relation to children's therapy. One woman whose husband might have been involved explained it as follows:

2.1 Edith 77: He hasn't been able to. He did come to one session where Andrea (*the worker*) asked if he would like to come to meet her. In fact, we spent about two hours here just to talking and crying with Andrea. There may be things going on in his head that he doesn't want to talk about. But he hasn't really been able to come, what with work and that.

Edith clearly recognises the emotional impact on her husband, his ambivalence about 'talking' and she cites work as the cause of his lack of involvement. The question of whether this was a 'real' explanation was not addressed. However, this was a first interview and later he became more involved and talked to me about his feelings about this process. This is explored in Chapter 8.

Finding out about the content of therapist/child play sessions

Five of the twelve women actually took part in at least some of the play therapy sessions with their child and the therapist. Their experiences are discussed below. However, in almost all of the twelve cases there were sessions that included just the therapist and the child. This section presents the women's views and experiences of the arrangements for 'feedback' about those sessions.

There were three main channels of communication. Women found out about the sessions directly from their children, from conversations with the therapist (some planned in advance, others more informal) and at pre-planned review meetings usually involving mother, child and therapist.

Who is in control of feedback?

As noted above, although women expected to leave the therapy to the therapist, nonetheless they expected to be informed about progress. Most talked about the need for their child to have a confidential relationship with the therapist, and yet they wanted to know about the sessions. Abigail described how she asked her children, but did not 'pressure' them.

1.1 Abigail 51: We'd come out and I'd ask them what they had been doing today. Whatever I got back from them I never pressurised them into telling me any more. They told me whatever they wanted to tell me.

Edith felt that the therapists were in a difficult position.

2.1 Edith 29: I think they've got a very fine line to tread in keeping confidentiality of the child so the child trusts them ... but they've also got to be able to talk to the parents so the parents doesn't feel like they are being undermined and things are being done behind their back ... or things might come out in a couple of weeks time and you haven't got a clue why. So it's a case of working together, and not working together. (*Laughs*). It's a clever balancing act and it comes down to not just simply workers that's trained and done other courses and maybe have some experience, it's a personality thing it's being open and not judgemental.

Her analysis of the solution is interesting insofar as she stresses that the workers' open and non-judgemental 'personality' is a key factor in managing the 'clever balancing act'. Yet in Chapter 6 we saw that workers were grappling with the difficulty of deciding just how open and honest they could actually be.

Women were also aware that the review meetings might be difficult for children.

2.1 Edith 76: I think she's scared. I think she is obviously a little bit apprehensive that Andrea (*the worker*) is going to say something that she maybe doesn't want me to hear or that something is going to get said and I'm going to react to it. So I always think that she's a little bit wary about the meetings.

From the mothers' perspective, there were several examples of women who seemed to want to hold together in contradiction their respect for children's confidentiality and their own need to know. Sometimes this resulted in what seemed to be confusion. Olivia claims not to know what happens, and yet the therapist tells her about it.

10.1 Olivia 26: I'm not sure. I don't really know. ... obviously, the therapy is inside that room ... I don't really ... well I do know what's going on, because Becky talks to me and tells me about it and shows me the pictures.

The women's accounts seem to point to a distinction between second hand 'knowing about' and first hand knowledge. The former is filtered through the therapist in a way that may feel unsatisfactory.

7.1 Karen 28: She (*the therapist*) said to me that she'll only tell me things that I need to know. Whatever they talk about she doesn't tell me, she'll just tell me how it goes. But I don't know why it should be kept from me though really. I just thought that she should tell me everything really. But that's the way it is, isn't it. That's how it works and I'm all right with it.

All the women agreed with the policy of the Agency that states that, on occasions, children's confidentiality may be breached if necessary in order to protect them. Important information may be shared with parents or child protection professionals. Yet even here some mothers claimed that workers should be able to respect children's wishes. One seemed to feel that the key to the dilemma lies in the malleability of children.

2.1 Edith 35: There's always a way round a child. They can come out with something and you can say, "I think your mum should know", and, "Would you like to tell her, or would you like me to tell her?" She'll say, "No I don't want to tell her". And you say, "Well can you tell me the reasons why you don't want her to know?" And you work on those reasons, trying to find out what her insecurities are. Once you've got a lid on the insecurities and you've showed her that those insecurities aren't actually a problem then you can go back to those questions again and ask, "Shall I talk to your mum?" So you can work around it but still hold confidentiality. Because you've got to remember that they are children. It's all very well having the Children's Act and having children's rights but we still have to ... these things have to be broken sometimes in order to protect children.

The emotional impact of the material

For many of the women, hearing the details of what had been happening in the therapy sessions was very difficult.

1.1 Abigail 45: Well they did come home with certain things that they had done. And it really shocked me actually, the things that came out creatively.

Once again, women were aware of their reactions and understood that it might influence children and therapists' decisions about what to 'feedback'.

Feeling left out

About half of the women said that they did not like being excluded from the play sessions. However, most also accepted that this was necessary for their child's recovery.

4.1 Amanda 28: At first it was a bit weird. I wanted to be in with there with them. I wanted to know how they were feeling. I just wanted to be with them to make sure they were okay and to make sure that they knew that they could talk to the counsellors. But now I'm sort of use to it and I just go and make the coffee and get their juice.

4.1 Amanda 58: It doesn't really feel like a partnership arrangement. It feels like they take the kids away and they do what they have to do and bring them back. Sometimes it feels a bit weird to let go of them, and not to know what's happening. It's only if it's something that is affecting their safety, or something important that I'll get to know, but otherwise I don't. But I know that I've got to sort of think: well, in a way it's me letting go of the kids. In a way, I know that's why their behaviour is improved and I have seen a difference in them ... so it is working, whatever's happening. But because I can't sort of see what's happening, it's the curiosity, maybe, I don't know ... but not knowing what's happening within those four walls... But, because I've seen how much of a difference it's made to the children, I think: well, if I don't need to know, then I don't need to know. If the children aren't going to come home and talk to me about it, if they don't want to talk to me about it then that's fair enough because they have got somebody.

On an even more positive note, Gabrielle concluded that it was precisely because of the commitment to a confidential child-therapist relationship that her son slowly began to open up to her as well as to the therapist.

3.1 Gabrielle 37: Becky (*the worker*) told me that anything he wanted to talk about was confidential ... if he didn't want to discuss anything with me then that was up to him. I was okay with that, because if he wasn't talking to me and he had no one else to talk to then he would just have bottled it up. I was quite happy for him to talk to somebody on the outside. But after some of the counselling sessions he opened up an awful lot. Without the counselling sessions, I don't think I'd have been able to talk to him and I don't think Caleb would have opened up to me as much as he did.

Joining in the sessions

All the women who joined their children in play sessions described this as a very positive experience. Some were not very clear about why they had been invited to join in, but those that were related it to the wishes of the child.

5.1 Hannah 25: And he kept asking, "Can mum come in with us, can mum come in with us?" And Carol (*the worker*) had said to me, "It's not a good idea at the moment. I would really like to keep on as we are with a view to you joining the sessions in the future."

Hannah was nervous about the idea but reassured by the promise of some preparation.

5.1 Hannah 25: .. to have a session where I am worrying about saying the right or wrong thing and being careful ... I think I would just find it too stressful anyway. But that is something that Carol and I have to talk about and she's going to lead me into it. Sort of teach me how to come into it as opposed to just coming and joining in sort of thing.

Another source of concern was the potential for embarrassment.

5.1 Hannah 25: It's really weird but you know when you with your own child at home you are relaxed and you're playing whatever games you play, you don't even think about it, but you know, when you in that situation you're so embarrassed... all I could think was: this is ridiculous!

11.1 Cathy 10: I was worried about what it would be like. Like being embarrassed, having somebody else there while you're playing with your bairn and that. But once you get to know them the worker then it's all right.

Both these women were grateful to the worker for acknowledging that she too was concerned about potential embarrassment as she 'played' in front of mothers. This openness seemed to be a factor in putting women at ease.

Perceived benefits

Hannah felt that her joining in the sessions was an important way of ensuring continuity with home, now and once the therapy ended.

5.2 Hannah 19: I think I was prepared to put up with the uncomfortable side of things just to make sure that he realised that the Agency, although it was going to finish, that I was part of it, that it is part of home and that it is all part of the same thing.

Others saw more direct benefits for themselves.

8.1 Tanya 34: I think I'm getting more from me being there and just.... just talking to her and playing with her. I feel a whole lot better than I did when I was just sitting in the waiting room. I just felt good because I'm sort of helping her too ... me and her are sort of helping each other. That's good.

Women also saw their children using the opportunity to communicate with them therapeutically through play. James had behaved violently towards his mother. Yet:

7.1 Karen 50: ...when I went back in they had made clay models ... there was one of me and one of the abuser. He smashed the one of the abuser and I was

watching and it was clear that he loves me to pieces. It was good ... and he has been all right with me since then.

Nonetheless, women felt that the 'rules' of the playroom were special and some made it clear to their children that the therapeutic 'licence' did not extend to home.

5.2 Hannah 19: I could say, "This is something for the playroom and I don't mind you doing it when you're there, but when you come home...." So it made him realise that I was there for support and I was interested, and I was involved, but that we still had an ordinary life to lead and it stopped at the door sort of thing. Not the problems, not the talking but the... I mean he understood anyway that I wasn't going to have him coming home and throwing things around the house like they do in the playroom if that's what they feel they need to do.

Ideas about the expertise of therapists

Views about women's relationships to therapist expertise varied with the experience of the support offered. When this had been received at an early stage then women tended to defer to professional expertise.

1.1 Abigail 44: I just wanted them to take the kids and just sort them out.

9.1 Madeline 50: ... I see Andrea as the skilful professional who knows ... whereas I have no idea how to do that side of things.

12.1 Bridget 23: the play work I couldn't have done with her. On that level, I couldn't have done that with her. I suppose if I was trained and qualified than I could, but I couldn't do that.

Where support had been delayed, and Olivia felt that she had done most of the work with her children before the Agency became involved, then things were different.

10.1 Olivia 50: I suppose not having the knowledge and not knowing anything ... it meant that I needed reassurance from them. I'm just trying to think really.

Because I don't really know what they've given that's different. It's like they've checked my work.

For a member of the mothers' group who had had a bad experience of help from another agency altogether there was the feeling that her part had been vital.

Mothers' group discussion 23: He was seven or eight at the time and he was saying to me, "I want to talk about it." Sometimes I was crying myself to sleep. I just wanted it all to go away and not have to deal with it. But you have no choice. So I thought my part in his recovery was very important. I think you're the linchpin in your child's recovery.

Gaining insights and information from therapists

Many of the women valued the insights into their children's thoughts, feelings and behaviour that they felt that they had gained from talking with the therapists. An example is Abigail realising that her daughter was taking adult responsibility for protecting her from the distressing facts.

1.1 Abigail 30: I think if I'd been out there on my own dealing with this I don't know if I'd have seen that her playing the adult... And the court case, I don't think I'd have worked that one out for myself either. It came out in the session, through the worker, just how beneficial that court case had been for Caitlin.

Hannah felt that she benefited from insights into her son's anger, and how he could express it safely.

5.2 Hannah 21: And it also helped me understand the anger side, because I hadn't seen that. At the end of the day I felt more confident that he was getting it out of his system in the sessions. Whereas before we started seeing Carol he was just frustrated, we were going round and round in circles and nothing was getting any better. But when I saw that he was allowed to do certain things ... and the way she worked with him to encourage him to express himself differently from just sitting on a settee and cuddling up and talking... There are other ways to do things... And I think it really helped him.

Many other mothers, to whom it was also a new idea, shared this understanding of how play and use of creative techniques, rather than talk, could help children to express thoughts and feelings.

8.1 Tanya 42: At first I thought: why is she going there to play? I thought it was weird. But then Carol explained that kids can do stuff when they're playing ... and I sort of went, oh, right. But I do I see a wee bit of a difference in her.

5.1 Hannah 21: At the beginning, I didn't think it would help because I knew he wouldn't talk to her. I kept saying to Carol, "Do you not broach the subject, do you not bring it up, and don't you get them to talk about it?" And she explained that there are different therapeutic ways and one of them is through play, to do it through play with them and act things out and things like that. Well I have never come across that before and, like I say, it was just a huge relief.

7.1 Karen 44: You see ... it's mad how it works. Because in the sessions they built a prison, well James did, out of cardboard and they did these clay models. They built the abuser out of clay and put him in the middle. It was weird what happened was that James got some soap to wash his hands when he finished playing. He got the soap and he was just covering the abuser in it and the whole prison and he was just covering the soap all over the prison for about 20 minutes. And Carol (*the worker*) asked me what I think to that? I said "I don't know". Carol said that it was like he was covering the abuser. I said that to me it was like James was cleaning him. He was obsessed with soap. So it comes out in the play, it's good. It's better than sat talking and asking. Now when I'm watching him play I am always thinking ... whereas before I didn't have a clue about children doing things through play.

All the women actively sought out advice and reassurance, based on their perception that the therapists had relevant expertise.

5.1 Hannah 23: Well, I'm getting a lot of advice about what to do, and I talk it over with Carol. She built my confidence back up. At the end of the day she often

says, you're doing the right thing, that is the right thing to do and I'm thinking, oh thank goodness for that.

4.1 Amanda 20: Well I just used to ask all the time whether I was doing the right thing. I didn't know what I was supposed to be doing. I didn't know if I was supposed to ask them to talk about it or if I wasn't supposed to get them to talk about it ... when they were naughty whether to discipline them in the same way or be more gentle with them because of what they've been through ... and all that kind of thing.... it was all a bit.

Challenges and concerns

There were also some difficulties in women's relationship to professional expertise. Firstly, faith in such expertise was by no means automatic. Sexual abuse represents an enormous betrayal of trust, and many women had also had previous negative experience of professionals, so women were clear that trust had to be earned.

Mothers' group discussion 30: You build up a relationship over time really. Because at the time you going through such an emotional upheaval that you don't trust anyone. And there are definitely some real difficulties with some professionals. You need honesty ... you need to be sure that they will be open with you.

Secondly, there were disagreements about some issues. For example, Hannah was doubtful about whether Dale should be encouraged to express his anger.

5.2 Hannah 3: I was worried that he was going to just change too much ... that he would stay being angry all the time ... though I must admit, he's not. However, as soon as anybody does anything or says anything he gets extremely mad ... but he was never like that before the sessions. There are times when I think it's a bad thing. It's not always appropriate to be angry, it's not always appropriate to say whatever you feel, and he has to learn that too.

And Karen agreed to differ with her therapist over whether or not James should be told that his abuser did not go to prison.

7.1 Karen 20: Well we get on really well and I think she's lovely and she's really absolutely brilliant. Yes, she's brilliant ... but she does think that he needs to be told and I don't.

But where trust had been established some women were actually quite open to being challenged by therapists because it was experienced as being constructive.

1.1 Abigail 32: Andrea (*the worker*) said that it is really important that Barbara starts to make some of her own decisions. That feels okay because I have realised that what they're saying is right ... and if I'm in the wrong then I can take that ... and they do it in a certain way. They don't do it in a way that makes you feel: I must be the worst mother ever ... they don't make you feel like that ... they are just trying to help.

However, for some women, a lack of confidence in their own parenting ability made this a difficult experience.

9.1 Madeline 78: I am being judged as a parent as well ... how I handle things. That's what I also have going on for me. Will I be looked at as a failing parent? Because I didn't have a lot of confidence ... because it takes it away. I've heard people say, "Why didn't I know?" or, "Why didn't she say?"

Experiences of support for mothers – its relationship to work with the child

Support for mothers from Agency workers

Women's experiences of being supported by Agency workers varied widely, as did their understanding of such support in relation to the overall aims of the Agency. None had had any formal sessions with an explicit therapeutic purpose, but many had had regular informal telephone and face-to-face conversations with the child's worker. Hannah found this a source of advice and encouragement to her as a parent. She also felt that it related directly to the therapist, Carol's work with her son Dale.

5.1 Hannah 42: I talked to Carol, and Carol has helped me. She has helped me enormously because ... one, she has given me the confidence that I am doing the

right things and that I have been saying the right things and she has been able to throw ideas around with me, perhaps try and do this or perhaps try and do that, whatever it has been and I have found that invaluable. Not only the work she is doing with Dale, as I say, but the work that she is doing with me. She wasn't going to sit there and be really judgemental and say, "You're an awful parent". So if I had any worries like that, I could talk to her. If I had any feelings like that, I could talk to her, which was brilliant ... and it all related, because everything I was talking about was related to Dale and helping her with him and her assessments of him anyway.

Where children had been waiting for allocation of a worker then many women had received support in the interim period. Amanda felt that this had been very helpful, but was concerned that she felt it had been withdrawn once the children's therapy had started.

4.1 Amanda 38: When I had Becky to speak to ... when I could go and see Becky and she would come and see me ... then I felt happier because I had somebody to talk to about things ... just one person. I didn't have to keep meeting somebody else and tell them what happened. But then like, I don't know why, Becky said that because she had put me to the mothers' group, things like that, obviously she's got a big workload and she can't because it's only the initial assessment, sort of thing, that she gets involved with but I think if there was somebody, like an adult counsellor for the mums that you could book in to see or whatever ... not just the mothers' group ... then that would be really good. It would be linked to the work with the children because I think that sometimes you do need somebody to say, "Yes, you are doing the right thing" or, "You should do this". I guess your confidence is knocked when your child has been abused. I don't think it would worry the kids if I had a worker as well. It wouldn't have to be somebody separate. Possibly other kids, or older kids, or things like that. In different circumstances, maybe, because they might think, well that's my person. But I don't think it would upset my kids.

Amanda was clear that she felt that she would have welcomed individual counselling from the worker who was seeing her children, but she was inhibited from asking for this by her perception that the Agency was for children. Karen was even clearer about this.

Despite acknowledging the quality of the telephone support from Carol she felt that she had not received support for herself.

7.1 Karen 57: You don't get support through the (*Agency*) do you? I think there's a support group where I could go but I can't travel to (*it*). It's a Tuesday evening and I can't do it. The doctor referred me to a nurse and so on but..... The (*Agency*) is more for the children isn't it? I mean Carol has been there on the phone. She has been really good. I couldn't have wished to have anybody better. But to me it is for the children, isn't it? So there has been no support for me at all.

In part, this depends on definitions of 'support'. Karen seemed to have in mind some sessions that would be just for her. Others felt supported without this.

10.1 Olivia 109: From my experience, they've helped me without having any sessions with me or anything. They've just encouraged me that we're doing all right.

Amanda had also found it helpful to have contact with another mother.

4.1 Amanda 37: Becky introduced me to another mother whose son had been abused and he was now a lot older. She had been to the (*Agency*) for a few years now. She came and she spoke to me and it was nice because it was weird that we both felt the same way about so much of it even though her story was a completely different story to mine ... it still brings the same feelings out.

Experiences of mothers' group

All the women had been told about the mothers' support group. Once again there was a variety of experiences of this as a source of support. Three of the women had chosen not to attend, either fearing that it would upset them or feeling that the circumstances of their child's abuse were too different from others for it to be helpful. Amanda attended just once before reaching the same conclusion. But those who attended the group found it extremely helpful. The advantages cited were:

- The ability of other mothers to understand – contrasting with the difficulty of talking about sexual abuse to friends.
- The opportunity to express emotion in a safe environment.
- The open-ended nature of the support.

Support for mothers from other agencies

Only a minority of the women had actively sought additional help from other agencies. These women talked about the difficulty of gaining any such support, particularly from social services. As we have already seen, Amanda complained that social services had closed their file on her after the investigation ‘because I coped well and I didn't go loopy’ and ‘it would be such a long time that by the time I came to the top of the list there wouldn't be any point’ 4.1 Amanda 12.

One woman had felt the need for individual counselling and had obtained this through Women's Aid. She felt that this was appropriate since it focused on issues that were not directly related to her child's abuse.

Support from the Agency as advocates

In a few cases it was clear that women were grateful for assistance in dealing with other agencies, such as the police.

1.1 Abigail 9: They were great because they became that middle person and they contacted them for me.

From the women's perspective this appeared to be unproblematic, in contrast with the professional perspective discussed earlier.

Endings and outcomes

Negotiating endings

In the second interviews women were able to look back at the way in which the work had ended. Some spontaneously gave their assessment of the benefits, as discussed below, but most had to be prompted to think about how the decision to end had come about. Olivia said that she felt it had been left up to her teenage daughter to decide when to end,

but that the younger daughter had simply accepted the therapist's decision. It was striking that none of the women saw the timing of the ending as a difficult or a contested issue.

Positive outcomes of therapy

The women talked about a range of perceived benefits of therapy. Most were described in terms of regaining a sense of 'normality'. Abigail felt that her daughter had become a 'normal' child again.

1.1 Abigail 22: Through the work here with Caitlin she has now become not just a child, but a child with attitude: a normal child.

However, Irene felt that the process of regaining confidence was double-edged.

6.2 Irene 61: It's improved her, she's more bubbly, she's more gobby. It can be a bad thing, it can be annoying from a parent's point of view, but at the end of the day you know that nobody can get one up on her now.

This increasing confidence also showed at school, where she had made rapid progress.

Gabrielle reported that Caleb had opened up to her and that there had been a positive impact on their relationship.

3.2 Gabrielle 37: Without the counselling sessions, I don't think I'd have been able to talk to him and I don't think Caleb would have opened up to me as much as he did.

Olivia felt that the ending of the therapy put extra pressure back on her.

10.2 Olivia 18: I think I have probably found it harder since the sessions stopped than the girls have. It's like I was being very strong and very together and then when it's all been over I felt like I've let myself relax, let the barrier down. So I think it has affected me more than the girls.

As we saw earlier (page 173), Amanda talked of being offered continuing support after the end of the work with the children, so as to ease this transition.

Personal gains from being involved in the research

Olivia reflected on the usefulness of the research interviews in helping her in her dealings with Agency workers.

10.2 Olivia 32: Speaking to you has been very helpful. It has made me think carefully about what was going on. Instead of just going along with it I have actually thought about what would help and what wouldn't help.

CONCLUSION

Women's descriptions of finding out about the abuse, the impact on their children and themselves, their experience of police, social services and the courts has much in common with previous research. Referral to the Agency was often at a time of crisis, with a sense of 'desperation' being the driver. Women were anxious to access what they perceived as expert help for their children.

After referral to the Agency none of the women expected to play a significant role in the child's therapy. However, they expected to be told something about its progress and most recognised the dilemmas involved in maintaining confidentiality for children whilst at the same time reporting back to parents. Some women appeared to believe that workers had the interpersonal skills to resolve these dilemmas successfully, whilst others felt 'left out'. There is a sense in which the women trusted the workers to carry out a skilled extension of their own parenting role in supporting their child, one that they were temporarily unable to fulfil because of lack of expertise in relation to sexual abuse or because the abuse had made the relationship with their child difficult. To that extent women were happy to hand over responsibility to workers once they were confident in the worker's approach.

All the women valued the professional expertise of workers. This was not only in relation to their skills in direct work with the child but also as a source of knowledge and advice for themselves about how to manage their children's behaviour after child sexual abuse.

There is evidence that women were actively seeking concrete advice about how to react to their children in specific circumstances.

Both of these factors have implications for the kind of partnerships that were established. Were the workers willing to take the kind of expert role that women expected: to undertake individual work with the child and to advise the mother? The previous chapter showed that workers placed much emphasis on the significance of mother-child relationships. Workers were skilled and consistent in their efforts to maximise maternal support for children. In many cases there were active attempts to recruit mothers into the therapeutic process of helping children. However, in cases where workers felt that mothers had limited insight into difficulties in their relationships with their children there was less of a sense of a partnership between the adults, but mothers were still drawn into the work as therapists tried to help with this.

Significantly, only a minority of the women identified difficulties in their relationship with their child. In such cases women understood the difficulties as being related to the abuse and were able to accept being included in therapy sessions when asked to do so. Amongst those who joined in with play sessions there was a strong feeling that this was very helpful for a variety of reasons. However, some were aware that their parenting was under scrutiny and this was a source of tension.

These sorts of tensions between mothers and workers are brought into sharper focus in the conclusion of the thesis in Chapters 9 and 10. Here the central theme of the thesis is further developed as I show how therapists and mothers 'negotiate' these difficult issues in relation to therapy and reach working relationships. But so far we have not considered the perspectives of fathers or of children. These are also significant elements in the negotiation of therapy, and it is to these missing voices that we turn next.

CHAPTER 8: MISSING VOICES

INTRODUCTION

So far this study has followed the pattern seen in the literature of paying most attention to professional accounts of theory and practice and then to the experiences of mothers of sexually abused children. It is noticeable that the literature contains very little about children's experiences of therapy, and little about the experiences of fathers of sexually abused children. From the outset I wanted to ensure that these 'missing voices' were included in this study. It was anticipated that this would present some difficulties, for reasons that are considered below, and the result has been that the data is indeed somewhat limited both in volume and in scope. However, there are findings that are interesting and that may have implications for practice. This chapter presents them and begins to assess their potential significance.

FATHERS' PERSPECTIVES

The data

Of the thirteen families in the study, only three included a resident father or a male partner; these were Aaron, Frank and Oliver. However, in each of these families the man agreed to be interviewed together with the child's mother. In one case there was an interview at the beginning and again at the end of the child's therapy; the others were carried out once it had been completed. This gives a total of four interviews involving men.

Comparison with mothers' perspectives

Earlier chapters have already shown how the gender-neutral term 'parents' is preferred in most of the relevant literature and is mostly used by the therapists. It has been suggested that this had tended to obscure some of the gender differences between men and women's experiences and reactions when their children are sexually abused. However, before exploring the evidence in this study for some of those gender differences, it is important to acknowledge that there is also evidence of significant commonality.

When talking about the impact of the abuse on their children and about the progress of therapy both men and women gave similar accounts, emphasising the same features and

often giving similar explanations. This was true of both the individual interviews and the joint interviews but it was most striking in the joint interviews. The following passage is typical. Aaron and Edith are providing what amounts to a joint description of Felicia, a shared understanding of her, in which their contributions are seamlessly tied together.

2.2 AH 8: What stage had she reached by the end? What you think changed over those two years?

2.2 Aaron 9: Well again, going back to initially really she was suffering sleepless nights, she had bits of flashback, there were certain key areas, key dates and things when you would go away for weekends... or like an anniversary .. anything that pops up ... and from that she would have sort of...

2.2 Edith 10: ..it was like a bereavement....

2.2 Aaron 11: ... she'd go quiet. She go in herself. Or sometimes she would go the opposite way and be non-stop talking, a little bit hyper. You know it was.... it was strange. She wasn't really talking. She wouldn't sit down, she wouldn't openly discuss anything. You could see something was wrong by her expressions, and by her mannerisms, by her general demeanour really.. so you would ask questions but she wouldn't give anything away. She would say, "I haven't slept". She would have bags under her eyes after several days and you would say, "Are you sleeping all right?" And she would say, "Yes". So you would start to pick up on little things and I think gradually, over a year, that was getting less and less. Certainly over this last...

2.2 Edith 12: ...six months or so..

2.2 Aaron 13: ...since the summer ... total change really.

2.2 Edith 14: She's more of her old self. She is coping better isn't she?

2.2 Aaron 15: Things like ... a TV programme where the word rape.

2.2 Edith 16: .. or even somebody kissing.

2.2 Aaron 17: ...she would hide her face or jump up quick and leave the room. Things on the telly where there were brothers and sisters arguing and fighting, voices raised and things like that. Or anything intimate, not even sexually intimate, then she'd be out of the room. But that is gradually disappearing.

2.2 Edith 18: It is now on the low end of the scale.

The same thing was true of both male and female accounts of the dilemmas relating to children's confidentiality. Both partners saw the issues in very much the same way.

6.1 Frank 54: Carol (*the worker*) doesn't actually say a lot about what goes on in the playroom.

6.1 Irene 55: All she does is tell us, "She's starting to react through her play now".

6.1 Frank 56: She doesn't tell us what she is actually doing. It's like, one time I went into the playroom and Jackie started sticking stars onto a piece of paper. I said to her, "Draw us a picture of so-and-so". Carol said, "No, just let her get on with it, you can't tell her what to do, you just have to let her get on with it". I didn't realise at the time that you are not actually told what they do with them at the Agency.

6.1 AH 57: So does it feel as though you actually need more information?

6.1 Irene 58: I trust Carol. If she thinks we need to know, then she'll tell us. If we don't need to know, then I suppose she wouldn't. But the point is that Jackie trusts her.

6.1 Frank 59: Personally, I think Carol knows what she's doing and we just let her get on with it. Because we are seeing the results from it aren't we?

The overall impression is that these couples have arrived at a shared understanding of many of the issues that are of relevance in this study. These include the impact of the abuse on the child and, in broad terms, the relationship between the parents and the therapeutic process. However, within this overall context of a shared viewpoint there is evidence of some significant gender differences, and it is these that will be considered next.

Impact of abuse on men

Anger

Anger appears to be another response that is common to both men and to women. As we saw in Chapter 1, there is no doubt that many, indeed perhaps most, mothers of sexually abused children are extremely angry about what has happened. So in writing a section about men's anger I am not intending to deny that women feel angry, but rather to examine the gender differences in the ways in which that anger is perceived and the significance that is attached to it.

In Chapter 7 we saw how some of the women were extremely worried about their partner's likely reaction. This was true in Aaron's case, where Edith was so concerned about him assaulting their son, Barry, the perpetrator, that she warned the school in advance.

2.1 Edith 5: I was very concerned about how Aaron would react. The first thing he did was grab his car keys and head for the front door. I asked him where he was going and he said he was going to school to get Aaron. I told him that he wouldn't get anywhere near Aaron and so he came back and he said, "What do we do?"

Aaron confirmed that he had wanted to do 'thump' Barry.

2.2 Aaron 12: Well... I mean personally, when it first happened I found it very difficult..... the police are aware, social services are aware me, personally, I would have felt a lot happier on the day it happened if I had got hold of Barry and given him a good thumping.

Similar concerns were widely shared by members of the mothers' support group. It seems that the difference is a heightened fear of the possibility of men acting on their anger and actually assaulting the abuser. This was particularly the case where men had a history of previous assaults.

Cutting off feelings for the abuser

Two of the three men interviewed in this study were in families where the abuser was an older brother. In Aaron's case, he and Edith had adopted Felicia and Barry, who are full siblings, and in Frank's case he was Jackie's step-father. These situations set up complex and painful family dynamics in which both adults had mixed feelings towards the abuser. It was striking that both the men involved talked about the stereotypically masculine response of 'stepping back' or distancing themselves emotionally.

2.2 Aaron 16: I mean I wasn't (*so upset*) because I sort of took a step back from Barry. You've done the crime, serve the time ... tough. Because I am like that, really. I'm quite.... hard in that respect. But Edith found it harder because the relationship had built up through the years and Barry being the age he was.

6.1 Frank 24: Yes, totally he denies doing it. But because of everything that has gone on here we do believe that it happened. But at the same time you can't turn your back on him. Though I have, I'm not so close that I was. Obviously it's different for Irene, being his mum, but I tend to be more distant from him since it all sort of blown up.

It is possible that my gender as a male interviewer has had an effect here, with these men exaggerating autonomy and control over emotion in this context. However, since there are other examples of these men talking about how they have learned since then to begin to express emotion, this seems unlikely to be a major factor.

Impact on the couple relationship

In Aaron and Edith's case, their differences in attitudes towards Barry appear to have led to some difficulties in their relationship. They alluded to these difficulties in their joint interview once the work had ended, whilst being careful to place them firmly in the past. Edith said that Aaron had 'opted out' and Aaron acknowledged that he had found it

difficult at first to communicate his feelings to anyone. During the early interview, Felicia's therapist, Andrea, considered this to be highly significant for Felicia.

2.1 Andrea 16: They are really struggling. I think Edith is much more ambivalent and Aaron is much more clear. He is there totally for Felicia. He is very angry with Barry and thinks he should have been sent to prison. So there is conflict and there has been at least one incident of violence between them and I think part of Aaron (*seeing a psychologist*) is around how he manages his communication. But obviously Felicia is aware of the conflict in her parents' relationship and that violent incident, because mum left home for a period of time, which all plays into her wanting to not upset anyone.

With the benefit of hindsight, in her second individual interview Edith explained Aaron's behaviour in terms of what she considered to be typical male roles.

2.2 Edith 67: It sounds horrible but it's because he's male. We have a particular role as males and females, and as a father he is a protector. He finds it very hard that he hasn't been able to protect his daughter, and he can't kill his son! Perhaps even twenty years ago Aaron could have taken his son outside into the garden and give him a good kicking. Not that it would change the way he is, it wouldn't have stopped him abusing again, but do you know what I mean?

Involvement in the work

In two of the three cases, men reported that the therapists' normal pattern of working office hours limited their involvement in the work, as Edith suggested in the previous chapter. They were often at work themselves during this period. However, there is some evidence that influences on the degree of men's involvement with children's therapy are more complex than this.

Andrea, Felicia's worker, was convinced that it was in Felicia's interests for Aaron to be involved in the review meetings with Edith, Felicia and herself. She realised that when the invitation was framed as a choice, for example, "You are welcome to join us if you wish", then Aaron would choose not to participate. Because of this:

2.3 Andrea 6: I more actively wrote to him saying more or less that I expected him to be there, rather than leaving it open. I was more proactive. And I think maybe there were issues that he wanted to talk about as well, mainly to do with the contact with Barry.

This fits with Edith's account of his tendency to 'opt out' if possible. Aaron's subsequent attendance at reviews in the later stages of the work demonstrates that he had some flexibility over his working hours if he chose to exercise it.

The actual level of these fathers' involvement varied greatly. As we have seen, Aaron became more involved as the work went on, attending reviews and driving Felicia to the sessions. Oliver was quite involved from the outset. He attended the initial meetings with his partner, Cathy, and he signed the initial agreement with the Agency alongside her. Oliver seemed to expect to be involved and to welcome his involvement. On the other hand, Frank was not involved after the parents' initial visit to the Agency and he seemed to feel quite excluded. He felt that the worker had been there for his step-daughter, Jackie, and not to talk to him. This was difficult to explain because the worker, Carol, felt that he offered good support to Frank. From her perspective, the difficulty was in meeting him.

6.1 Carol 18: Mum said that at first she wasn't sure whether or not to believe Jackie, but that Frank believed her right from the word go. I haven't had much contact with Frank, because he hasn't been that when I've visited. Jackie has painted some really lovely pictures for her dad. So it feels as though he's really been there for her and she has a very positive picture of him. He may have been more supportive than mum, which is not to say that mum doesn't care.

Support for men

Advice and information

All three men said that they wanted advice and information about the effects of abuse and how to help their children. In this respect the general picture is very much the same as for women. Nonetheless, the men had an additional, gender-specific concern about the effect on the physical boundaries of their relationships with their children, particularly girls. For example, Frank said that he didn't know about whether this had changed the 'rules' about his daughter's personal privacy. Was it still okay to bath her? What should he say or not

say to her in order to help? Frank said he would like to be able to observe the therapist, Carol, working with Jackie in the play room so as to learn from her. He suggested that sessions could be recorded on video tape. Aaron suggested that it would be useful to have a bookshelf in the waiting area with books about the experiences of other families.

Personal and emotional support

Whilst happy to accept advice and information, these three men were far less open to the idea of receiving and emotional support from workers, despite acknowledging the difficulties that they had experienced. Aaron said that he could not have talked to Andrea by himself, even if such individual counselling had been offered.

2.2 Aaron 34: No, probably not. I was going through some depression at the time. It took me really all that first 12 months to get into opening up and to start talking about anything. Even now, you've probably noticed if you've done interviews like this before, I'm all right so long as it is talking about the factual things ... as soon as you start talking about feelings and how you feel then it's still sort of twinges on the edges. But I do find it a little bit easier. It's not about talking to a woman. I think if I was more able to discuss feelings then gender wouldn't matter.

Once again, I wonder about the influence of my own gender on this. Does the fact that I am a man make Aaron emphasise his reluctance to talk to any helper? Certainly not according to his account. He goes out of his way to deny the influence of gender. For him it is not about gender but about his own inability to talk about his feelings, albeit that this is changing.

Groups

None of these three couples had attended the couples' group, although they had all been invited. This appeared to be a joint decision in each case, with Edith and Aaron believing that the fact that it was sexual abuse by a sibling meant that they would feel very different from other couples. Aaron was much more open to the idea of having a group for men who are carers of sexually abused children. He argued that:

2.2 Aaron 43: It should be a pub or a club. Go down the social club, take the backroom, go to the bar, sit down with a pint and you'll get them all talking.

Difficulties and limitations of the data

The relative lack of data from men is a product of the low proportion of families in which there was a non-offending male carer. Of course, this is related to the fact that in four of the thirteen families it was the resident male partner who sexually abused the child and subsequently left or was removed from the family, but it also reflects a fairly high proportion of single mothers. However, the fact that all three of the eligible men were enthusiastic about participating in the study appears to be indicative of a desire to be involved and to be heard. The difficulty is that, with relatively small numbers and a variety of views expressed, it is hard to draw firm conclusions from this data.

CHILDREN'S PERSPECTIVES

The data

Of the seventeen children and young people included in the study, only three have been interviewed; Felicia and Caleb, both aged 15, and Wendy, aged 4. For the reasons given in Chapter 4, the research interviews took place once the work was ended and I saw each child once. At the end of this section the difficulties of obtaining this data are discussed, along with its limitations.

The interviews with the two teenagers were similar to the interviews that I carried out with adults. They were based on verbal communication and used a semi-structured format. The young people themselves chose this format in preference to any more creative means of self-expression. Caleb was interviewed on his own, whereas Felicia chose to have her mother and father present. With younger children I had planned to use some additional non-verbal communication tools, based on play, as described in Chapter 4. However, these were intended for 7 to 11 year olds, rather than for Wendy, who was aged 4. Wendy was interviewed in her own house, where she chose to play with her own toys whilst talking to me.

In each case the child or young person had been involved in individual sessions with a therapist, and a series of review meetings with parents.

Being referred to the Agency

None of these children referred themselves to the Agency; it was their mother's idea. This meant that there was a process of explaining and 'selling' to them the idea of therapy, firstly by mothers and later by the therapist.

2.2 AH 8: Whose idea do you think it was that you should start going there?

2.2 Felicia 9: My mum.

2.2 AH 10: What did you think about that when she first said it?

2.2 Felicia 11: I wasn't really sure about it but when I started going it felt all right.

This was related to how the children understood the purpose of the work.

Reasons for going to the Agency

Caleb was clear that it was to try to help him to deal with his anger and bad behaviour, that he recognised the need for this, and that the help would come through 'talking'.

3.2 AH 4: Why did you start going to (*the Agency*), what were you hoping to get out of it?

3.2 Caleb 5: Just to talk and to try to sort the problems out.

3.2 AH 6: What problems do you think there were at that stage?

3.2 Caleb 7: Anger. Not doing what I was told and stuff like that.

3.2 AH 8: Your mum obviously wanted you to go (*to the Agency*)

3.2 Caleb 9: Yes

3.2 AH 10: What did you expect to get out of it?

3.2 Caleb 11: Talking.

However, Felicia appeared to find it too difficult to name the purpose of the work.

2.2 AH 14: Why did you keep going? What did you want to get out of it?

2.2 Felicia 15: To... I don't really know.

It is possible that Felicia really did not know what she wanted from the sessions, or that she had some ideas but not the language skills to express them. But it seemed to me to be much more likely that she found it too difficult to talk about the effects that the sexual abuse had had on her. She was being asked to remember and to say how bad she had felt early in the therapy. And she was being asked to do this by an adult male interviewer, who she did not know, in front of her parents.

Four year old Wendy understood that the reason for going to the Agency was 'to play'. She told me that she really enjoyed playing.

12.2 AH 6: What did you like best?

12.2 Wendy 7: Just playing ... playing with the tent. But I didn't get time for my picnic though.... I don't play with half my toys, and I've got thousands!

Experience of sessions

When asked to think about what had helped them, both Felicia and Caleb pointed to the opportunity to 'talk'.

3.2 AH 20: Did you do any writing or drawing?

3.2 Caleb 21: Yes, but I usually just talked.

3.2 AH 22: You preferred to talk?

3.2 Caleb 23: Yes.

3.2 AH 24: What did you like best?

3.2 Caleb 25: Just talking

3.2 AH 26: What do you think helped you most?

3.2 Caleb 27: Talking.

3.2 AH 28: So how did Becky (*the worker*) help you to talk?

3.2 Caleb 29: Well it helped, because I could talk about any subject, I could talk about the subject that I want to talk about. Sometimes she asked me questions.

For Caleb it was important that he could chose what he wanted to talk about, even though he was sometimes asked questions.

Confidentiality

For Caleb the importance of being 'in control' was most apparent when we talked about his understanding of the extent to which the sessions remained confidential.

3.2 AH 32: So, how did you feel about your mum knowing anything about what you and Becky were talking about?

3.2 Caleb 33: I didn't really like it. But she had to ask me before she told my mum ... she had to ask me. So if I said, yes, then she told her a tiny bit, but if I said no then she wouldn't. But mostly I said, yes.

3.2 AH 34: So you had control over what Becky told your mum?

3.2 Caleb 35: Yes.

3.2 AH 36: And was that written into an agreement?

3.2 Caleb 37: Yes.

3.2 AH 38: How did you feel about that ... did you want to be in control of this?

3.2 Caleb 39: Yes. I thought that if she told my mum then she would get all upset.

3.2 AH 40: So you were concerned about your mum getting upset?

3.2 Caleb 41: Yes. It is better to talk to a stranger who you don't know and who doesn't know who your friends are. If I talk to my parents then my mum knows who my friends are and she would probably talk to them ... so it is better talking to a stranger.

3.2 AH 42: Looking back at it, do you think that your mum could have been more involved in the work you did at (*the Agency*)?

3.2 Caleb 43: No, not really.

3.2 AH 44: Because she could have come in to sessions. You could have talked together with Becky.

3.2 Caleb 45: I didn't want that. When we go to a school meeting I don't get a chance to talk ... my mum's always talking, and my dad. So I'd never get a chance to talk... whereas if I go on my own then at least I get a chance to talk.

It is absolutely clear that Caleb wanted an independent relationship with his therapist, a confidential space away from his parents where he could 'talk'. One of his reasons for this is his belief that his mother would not respect his confidence. This fits with another of the reasons for not using informal networks that was identified by Mayer and Timms (1970). Nonetheless, Caleb acknowledged that he mostly said 'yes' to his mum being told about the sessions. He was less clear about the reasons for this, although he stressed that Becky wasn't allowed to say much. Becky's account is that she said 'not much about the content of the session but maybe a little bit about his mood' (3.2 Becky 48).

I asked Caleb whether there was anything at all that a worker should always tell a parent, even against the wishes of the young person. Caleb said he didn't know. I then gave an example.

3.2 AH 87: What if you told your worker that you were so unhappy you planned to hurt yourself?

3.2 Caleb 88: Oh, yes, I'd expect her to say about that.

3.2 AH 89: So there are some things you would expect her to say? How do you think the worker should tell the difference between things they should tell parents, even if the kid doesn't want it, and things they can keep quiet?

3.2 Caleb 90: I don't know. But I liked being asked, being in charge.

At the time, I thought that Caleb was telling me that he thought that the worker *should* tell his mum about this, but the transcript is more ambiguous. In turn 88 Caleb says this is what he would *expect* to happen, not necessarily that he approves of it.

Felicia confirmed that her therapist did indeed tell her parents things that she did not want them to know about. We have already seen that from Andrea, the therapist's point of view, this was to ensure her physical and emotional protection in the context of continuing contact with her brother Barry, her abuser.

2.2 AH 16: Your mum and dad were just saying that they had regular meetings with you and with Andrea. What were those about?

2.2 Felicia 17: Just to talk about the things that me and Andrea had talked about.

2.2 AH 18: So were you happy to tell your mum and dad about the things you'd been doing or were there bits of it that you didn't want to tell them about?

2.2 Felicia 19: Bits that I didn't want to tell them about.

2.2 AH 20: So how did you decide which bits to tell them?

2.2 Aaron 21: Did you discuss it with Andrea first?

2.2 Felicia 22: Yes I discussed it with Andrea before we went to the review.

2.2 Aaron 23: There were some things that you didn't want us to know. But Andrea thought it was best.

2.2 AH 24: Do you think she was right to tell your mum and dad?

2.2 Felicia 25: Yes.

2.2 Aaron 26: A lot of that was about things like meetings with Barry weren't they?

2.2 Felicia 27: Yes.

2.2 AH 28: What would have happened if you had gone, "No, no I don't want to tell mum!" Would Andrea have taken any notice?

2.2 Felicia 29: No.

2.2 Aaron 30: Well I think she might have.

2.2 Felicia 31: Yes.

2.2 Edith 32: But Andrea hasn't made you say or do anything that you didn't want to.

2.2 Felicia 33: No.

The above extract is interesting in that it shows how little freedom of expression Felicia actually had, and how little she felt that she had. Felicia was sure that Andrea would

overrule her on some things and she said so. But her parents were not happy with this idea and they insisted that Andrea would have taken notice of her, and that she had not made Felicia say anything that she had not wanted to. Felicia duly agreed. Quite why the parents took this position is not clear to me. After all, they had already agreed that there were some things that Andrea had felt best to tell them, against Felicia's wishes. But Felicia's one word replies might well indicate her fear of giving the 'wrong' answer. Certainly, one of the goals of the therapeutic work had been to encourage her to express her own opinions more freely. The above exchange, brief though it is, might well be illustrative of the family dynamics that have discouraged her from doing so. It is certainly yet another illustration of the difficulties of eliciting and understanding children's perspectives.

Ending and looking back

Felicia came to the Agency once a week for nearly two years. From the therapist's perspective, as we have seen, ending the work was a vital part of the process. Andrea was well aware that Felicia was unlikely to initiate an ending, so that ending with Felicia's genuine consent was difficult. The Agency asks for written comments from service users on an evaluation form once the work is completed. On the evaluation form Felicia has written:

2 Felicia (evaluation form): I have enjoyed it and it has been helpful. It is a bit upsetting that I have to stop coming.

In the interview with me Felicia was more positive about the decision to end. This seemed to stem from a conviction that she had changed for the better.

2.2 Felicia 57: When I first started to go I didn't really like it but I got used to it and I started to like it. I didn't used to like saying things to people because it might upset them but I'm not like that any more. It helped me a lot.

For Caleb it was more clear cut. He took the decision to end the work and simply stopped coming. His worker, Becky, was not consulted. From Caleb's perspective this appeared to be exactly how he wanted it. Once again, being in charge of the decision seemed to be very important to him.

3.2 AH 95: How did you know when it was time to stop going to *(the Agency)*?

3.2 Caleb 96: I was ready to do something else. I was getting a bit bored because there was nothing to talk to her about.

3.2 AH 97: So did you feel much better, or just a bit?

3.2 Caleb 98: A lot better.

Difficulties and limitations of the data

I regret that I was not able to interview a larger proportion of the children in the families in the study. However, I accept that there were real ethical difficulties, and that therapists and parents were right to be concerned about them. In many cases the conclusion seemed to be that the risks to the child outweighed any potential benefits. The risks that were foreseen included being reminded of the early traumatic period and re-experiencing difficult emotions. Anticipated benefits included being able to reflect on progress made. My difficulty was that, because I did not know any of the children, this judgement was in the hands of others. Whilst I was confident that the techniques that I planned to use would minimise the risks to children, nonetheless it was clear that therapists and children were cautious about this. Some older children were asked to make their own choices, but many of the younger children were not approached directly.

The result is that I have not been able to obtain as complete a picture of children's perspectives as I had intended. There are some useful insights from the two young people, and from the youngest child. But the middle age range, from 5 to 11 years, is not represented. This is unfortunate because it could be argued this is where the dilemmas about parental involvement are at their most acute and where children's voices are infrequently heard.

CONCLUSION

These findings in relation to men are very much in line with the studies reviewed in Chapter 1. They suggest that men may have more difficulty than women in dealing with their anger or, at least, that there is more concern about the potential for men to act

violently in response to the abuse. There is evidence from the men's accounts that they have chosen to 'cut off' emotionally from the abuser in a way that is stereotypically masculine, although this is in a context in which the abuser is their son or step-son. The study breaks new ground in asking about men's involvement in their children's therapy. There is some indication that men are willing to become involved, but that there is a tendency for them to 'opt out' when given the option and particularly when the expectations of them are not clear. Workers were more successful in involving fathers when they were direct about expecting them to be present. In the aftermath of sexual abuse these men wanted advice about how to manage their relationships with their abused children, particularly in relation to giving and receiving physical affection and in relation to intimate physical care. The men indicated that finding out about the abuse had had a serious emotional impact on them but they were doubtful about the prospect of accepting emotional support from professionals at the Agency. One felt that group support might be useful if the group took place in an informal, man-friendly context such as a social club.

The findings in relation to children show that the referral process is indirect, with mothers encouraging their children to attend the Agency. The children had widely varying understandings of their reasons for attending. However, both teenagers valued 'talking' and Wendy loved 'playing' and all three were very clear that they felt better as a result of doing so. This is very much in line with Carroll's (2002) study of children's views about therapy, where the emphasis is on the centrality of children's experience of play as both means and end. For one of the teenagers in particular there was a strong indication that he valued having a great deal of control over the therapeutic process, including what he chose to talk about in sessions, what information was shared with his mother and when the therapy ended.

These themes from the perspectives of fathers and children are now considered alongside those of mothers and therapists in the concluding part of the thesis.

PART FOUR
CONCLUSIONS

CHAPTER 9: TALKING ABOUT THERAPY

INTRODUCTION

So far I have presented the main themes from my initial discussions with the team, and from my interviews with team and family members about individual cases. This thematic analysis was carried out following a detailed 'coding' process, as described in Chapter 4. The outcome in Chapters 5 to 8 is a summary of what appear to be the main issues in respect of parental involvement in children's therapy from the perspectives of each of the three main groups of players: professionals, parents and children. Throughout this phase of the analysis I have mostly treated the data as a straightforward account of what those participating in the research have thought, felt and done. My role has been to present an honest account of what participants have told me and quotations from interviews have been used to demonstrate this.

This concluding part of the thesis takes the analysis further. In the course of two concluding chapters I show firstly how attention to the use of language can help to show how professionals, parents and children seek to present their positions to one another and, secondly, how these practices enable them to negotiate the complexities of therapy. In these chapters quotations from interviews are used to illustrate my arguments.

In this current chapter the first step is to highlight elements of reflexivity, both in relation to my own role in the research project and in relation to the reflexive practices of research participants. For example, team members were well aware that I was broadly in favour of maximising parental involvement in children's therapy. Did this influence their accounts of their own actions and, if so, how? But a second and arguably more important step is to focus more directly on an analysis of language and discourse. What are the contextual factors that have influenced these particular accounts? What clues are there as to the ways in which participants in interviews have created their own understandings of the issues, managed disputes or reached agreements with others? In this chapter the focus is on the persuasive verbal practices that professionals use to create four different 'case types'. Sometimes these versions of the world collide with those of parents and other professionals and must then be defended. I hope to show how, through a delicate process of negotiation, workers, parents and children are able to reach some sort of understanding about how therapy can proceed. Of particular interest is to understand the shape and the

parameters of that negotiation because, it is argued, this represents the crux of the professional intervention and it is here that the real 'work' takes place.

Some theoretical formulations from discourse analysis

In this chapter the aim is to draw attention to the ways in which the major themes of the previous three chapters come together *in practice* as workers, parents and children interact in the mundane business of interviews, phone calls, meetings and therapy sessions. At this point it is necessary to introduce some key theoretical ideas from discourse theory and research. These will be reviewed briefly before moving on to a consideration of the extent to which they may help to understand how parents and professionals negotiate therapy.

Hall *et al.* (2006) argue that professional processes are constructed in everyday activity and that they depend on communication.

'It is suggested that any claims to truth by social workers, clients or other professionals have to be acted out in professional settings for them to matter. Facts, opinions or assessments have to be worked up in talk or in writing. The professional and the client will gather pieces of information and comment to support their version of events and to persuade others of its veracity. Such performances in meetings, interviews or in writing will require a wide range of persuasive and interactional devices' (Hall *et al.*, 2006: 15).

Accountability

A major 'driver' for the use of such devices is the need for professionals to be seen to be accountable, to justify their practice. Whilst the notion of accountability includes overarching professional responsibilities enshrined, for example, in law, nonetheless discourse analysts point to the ways in which individual professionals, in their everyday conversations and texts, are required to justify their actions in different ways to a variety of audiences. Rhetorical devices are used routinely to persuade others (Billig, 1987). In the current context these audiences might include parents and children in informal meetings and conversations, and also other professionals in case conferences and, occasionally, formal presentations to courts. But such justificatory devices are not confined to professionals. As we shall see, there are examples of parents feeling the need

to account for their parenting practices in relation to perceived criticism, and some limited evidence that children show a parallel awareness of their audience.

In the context of child welfare, to focus on justificatory practices in the face of potential or actual criticism is to move into the realm of moral judgements about the character both of parents and professionals. Are the various actors behaving in ways that are judged by others to be good or bad, caring or neglecting, responsible or irresponsible, safe or dangerous? Issues of blame and responsibility are never far away (Parton *et al.*, 1997). In what follows I will reassess the data in this study in order to consider how the various parties approach issues of blame and responsibility. It is argued that the approaches that they take are indeed central to the successful negotiation of therapy.

Categorisation

Running alongside the need for accountability is the need for professionals to make assessments of what type of case this is and what is going on here. Such assessments form the basis for professional interventions and therefore, as we have seen, they must be actively justified. But the process of 'assessing' is seen by discourse theorists as intimately connected with the processes of 'categorisation'. Categorisation is seen as 'a set of processes which result in facts, opinions or circumstances being established as one type or category, rather than another; for example, this is a case of 'failure-to-thrive', not delayed development' (Hall *et al.*, 2006: 15). However, the processes of categorisation are as much about constructing and defining the categories themselves as they are about selecting appropriate categories for individual cases. And if there is more than one possible category scheme then the processes of categorisation, like accountability, will have a rhetorical aspect that involves persuading others and making arguments (Billig, 1987).

So the category of 'good mother', for example, is built on ideals of motherhood that may be strongly contested and which have a significant moral flavour. Thus, as we have seen, being categorised as a 'bad mother' is something that women are extremely concerned about. In practice, workers tend to use sub-categories such as 'a good mother, but lacking specific parenting skills to cope with the abuse'. In the section that follows I attempt to describe a detailed scheme of categories and sub-categories for mothers, fathers and

children as represented in the data, to show how these categories are constructed in negotiation with families, and to show how they are used.

There is a considerable amount of work on how the institutional or organisational context effects the processes of categorisation, although as Hall *et al.* (2006) note, little of this has been applied to social work. To summarise their account:

- Encounters within institutions are bounded by attention to organisational rules, mandates and procedures. (Goffman's concept of 'frame analysis' underlies much of this work.)
- Individuals may well show awareness of these 'frames', so that the interaction has a reflexive quality.
- Organisational priorities and structures influence (and are influenced by) the establishment of case categories by professionals.
- Being categorised as one case type or another can mean specific routes through the organisation, implying a specific pattern of professional activity and/or service provision (for example in child welfare, whether it is a 'child protection' or a 'family support' case).
- Organisational case categories may not be as fixed as they first appear. In everyday use they are dynamic and adaptable, responding to particular circumstances.

Many of these features of can be seen in relation to the organisational practices of the Agency. There is a tension here between the 'structure' imposed by the Agency and the freedom of action of individual workers (I avoid the usual term 'agency' of workers only in order to avoid confusion). The interaction between the organisational 'frame' and the practice of therapy is a complex one where, as we shall see, there is evidence of significant unease amongst the therapists. Are they in broad agreement with the Agency 'frame'? How does it affect the categories that they construct and utilise, and how much does their practice influence Agency priorities and structures?

Expertise and partnership with parents

In this chapter it is argued that these twin themes of accountability and categorisation, derived from discourse theory and research, have significant links with the themes of

Chapter 3, namely expertise and partnership with parents. Professional expertise is demonstrated, for example, through the use of 'theory language'. This may be seen as a rhetorical device aimed at justifying practice and demonstrating accountability. There are examples of this in many of the interview quotations in Chapter 7, such as:

1.1 Andrea 45: I think that she felt quite 'held' by this ... knowing that mum and I were working together.

8 Lynn 77: Mum has identified that there was a problem with the bonding.

8.2 Carol 10: Sabrina began to feel safe and to feel that mum was really attuned to her so then Sabrina moved into symbolic play.

When seeking to agree a plan for therapy, therapists may make different tactical uses of their expertise, either downplaying it by using less theory language when the primary need may be to engage and empower parents, or emphasising it in an attempt to persuade or to boost confidence in the therapeutic process. Similarly, the construction of categories such as 'supportive mother' creates the conditions for specific kinds of partnerships. This interplay between verbal practices, perceptions of expertise and the possibilities for partnership are explored throughout the chapter.

PROFESSIONAL TALK ABOUT 'CASES'

This section discusses significant features of the way that professionals talked to me about their work, both in the general team discussions in the first phase of the research and then individually in relation to their individual cases. It begins with some points about the context in which professionals were talking: reflection about the significance of the fact that they were talking to me, rather than to anyone else, and points about the Agency context. It then moves on to a wider consideration of the language used in relation to mother, fathers, children and the relationships between family members.

The context of professional talk

The Agency context and the impact of being almost an 'insider'

In approaching the first phase of the research I was aware that my previous membership of the team had given me a set of initial views about what the team does and why, as well

as some ideas about the potential for the development of practice. Indeed, it was these latter ideas in particular that had formed part of the motivation for the research, as recorded in the introduction. Of equal importance was how the team understood my motivation. They knew that I was broadly in favour of increasing parental involvement so that there was a tendency for workers to emphasise cases where this had been possible and had worked well, whilst being apologetic about cases where it had not been possible or had not worked well. To counter this I made it clear that I was interested in all kinds of cases and was seeking to learn from the totality of their experience.

Later I became aware that the team experienced another kind of anxiety about the research. I realised that they were extremely anxious not to be misrepresented by me to the Agency's national managers. Concern centred on the team's perception of the Agency's policy of providing services to children, not adults. My research topic implied that specific work with parents might be of value, and the team had some considerable sympathy with this, yet this was not officially sanctioned by the Agency. This put them in a difficult position. Firstly, they were concerned that I did not suggest that they had already exceeded the official brief in their work with parents. This is difficult because the evidence from the research suggests that the team's perception of the 'official brief' may not be entirely clear. Secondly, they were concerned that any suggestions for change that might emerge from this research should be presented to the Agency sensitively and in a way that did not antagonise.

Thus when Lynn summarised the team's position in the passage already quoted in Chapter 5, she is anxious to present it as in line with Agency policy.

Lynn 47: For us it is about offering support to parents who do not have any knowledge about child sexual abuse.... So I don't have any problem with that, it is part of the job and sometimes it can show up difficult parent-child relationships. But even if the parent comes into the sessions then I still think we are working primarily with the child, though parents should get the advice and guidance that they are asking for.

Her use of the phrase, 'So I don't have any problem with that', suggests that others (perhaps her own managers?) might. 'The job' here implies services to children. So Lynn

is here giving her own authoritative interpretation of the Agency policy: 'the job' of helping children includes supporting parents where they lack knowledge of child sexual abuse. More interestingly, Lynn's account of having parents in the sessions also claims that the primary work is still with the child. This contrasts with team members' own rationale for having parents in the sessions that, as we saw in Chapter 6, was primarily about working on the mother-child relationship.

8.2 Carol 20: ...it just felt like the attachment issue was the most important thing. The other work wouldn't make sense until you've sorted out the attachment.

It appears that when it comes to accounting for the team's practice, one important audience is the senior management. At the end of the whole team discussions described in Chapter 5 it is the team manager who assumes responsibility for attempting a summary statement of the team's position and is aware of the need for it to fit with Agency policy. As nearly an insider and as an ex-colleague I was certainly expected to understand the delicacy of these issues and I felt trusted to handle them carefully.

The effects of hierarchy

We have seen how the team manager took some responsibility for the presentation of the team's position. In fact the unplanned absence through illness of the team manager at one of the initial team discussions showed other effects of hierarchy on the nature of the data I obtained. When looking at the transcripts of the discussion, the difference between the meetings is visually quite striking. Whereas in other meetings team members had contributed mainly short statements, in quite well formed English, in the absence of the team manager their contributions became much longer and they appear to be less clearly expressed.

Earlier, in Chapter 5 on page 130 there is an example of an exchange that was typical in the presence of the team manager. There are three short contributions from team members, followed by a longer one from the manager. The nature of them is also typical and seems significant. A team member raise difficulties, another suggests a way forward and then the manager sounds quite authoritative in suggesting the solution. In the absence of the team manager debates were not rounded off in quite this way. It appeared that team members were much more prepared to speak 'off the cuff', perhaps without having fully

thought through the position. There was also evidence that they were prepared to be more subversive. In Chapter 5, in the absence of the team manager they talked about strategies for providing individual support to parents under the guise of 'feedback' about the child's therapy sessions. It appears that the need for accountability to Agency policy and standards in a hierarchical organisation has influenced the way in which these professionals talked about their work.

Professional talk about mothers

This section presents a detailed account of a category scheme in action. It begins by looking at how workers assess the support needs of mothers and then their relationships with their abused children.

'Support' for mothers

In Chapter 5 I identified some 'guiding principles' for providing support to parents that emerged from the team discussions. These were:

- Parents are likely to have a significant influence on children's recovery.
- Parents need information about what to do in order to help their children.
- Parents may need emotional support in order to cope with the impact of finding out.
- Parents may need support in order to help them to cope with the impact of the therapy itself.

In Chapter 6 we saw how individual workers approached the issue of support for mothers in individual cases. The argument here is that, in relation to the cases under study, workers are constructing a category system based on ideas about what might be the parameters of a mother's 'normal' reaction to child sexual abuse. (Note, not a 'normal' mother's reaction – there is evidence to show that workers are accepting of a wide range of mothering styles and practices. This is about what might 'normally' be expected as a reaction to child sexual abuse, given a diversity of mothering practices).

A 'normal' reaction would include bullet points two and three above: not knowing what to do or say to help the child and being seriously emotionally affected themselves. So, speaking of Amanda in case 4, Andrea says

4.1 Andrea 5: Mum is very supportive of the boys. In one sense the boys were doing very well and it was more around continuing to support mum with the messages to carry on giving them, because she has been doing a fantastic job in being able to do that really.

4.1 AH 6: But she sounded quite lacking in confidence when she spoke to me.

4.1 Andrea 7: I think in terms of some of the specific issues about how to respond, and I think at the moment we're in a period of crisis, this week. There are a whole lot of other things to be dealing with now and she hasn't been quite sure how to deal with them. And what would she be drawing on to deal with those things? Most parents wouldn't have that experience. So part of my role has been helping her deal with those specific issues.

Andrea first of all gives her assessment of Amanda as 'very supportive' of the boys and 'doing a fantastic job'. Then, in response to a counter-suggestion from me, Andrea concedes that Amanda has sometimes needed help with some of the complex issues thrown up by the abuse. In this case the current issue was what to tell the boys about the progress of the criminal prosecution. However, this difficulty is normalised with the rhetorical question, 'What would she be drawing on to deal with those things?' The overall effect is to construct the category of 'supportive mother' and sub-category 'in need of limited, normal and justifiable expert help'.

From the worker's perspective, establishing this first case type with the relevant audiences is relatively easy. Firstly, the overall positive view of her parenting is likely to be welcomed by the mother. As we have seen, help with the sexual abuse issues is carefully constructed in such a way as not to imply criticism. It draws on the perceived expertise of the worker in relation to sexual abuse and, if such expertise is accepted by the mother, then it opens the way to a partnership based on the child's interests. After the audio tape had been switched off, Andrea described this to me as 'a nice piece of work', reflecting perhaps not only the positive outcome but also the way in which her expertise was valued. Secondly, the argument can be made that it fits within the Agency remit discussed above.

However, one effect of this categorisation is to imply that the main focus of the therapy could be with the children. There is no problem in Amanda's relationship with them; she just needs some advice about how to respond to them on specific, difficult issues. As a consequence, Amanda remained outside in the waiting room during sessions, partly to look after her other child. The way in which this was negotiated was not entirely satisfactory from her point of view, as we shall see when examining the mothers' accounts below.

Other categories and sub-categories also exist. Firstly there is a category of mothers who workers assess as providing less emotional support than their abused children need. This category and its sub-divisions are explored in the next section that focuses on mother-child relationships. The other group to consider here are mothers who workers assess as basically 'supportive' towards their children but whose own need for individual support extends beyond what workers consider 'normal' following child sexual abuse.

Consider what Andrea had to say about Madeline in Chapter 6. Andrea felt that Madeline had particular difficulties in understanding how and why her ex-partner's actions, progressing from French kissing to digital penetration, had been abusive.

9.1 Andrea 2: I think Madeleine was unsure of what was within the normal range of adult to child behaviour in terms of Madeline's experiences of being parented herself, her own experience and confidence in parenting.

9.1 Andrea 29: So actually a lot of the work is around supporting Madeline in understanding what has happened and acknowledging what is abusive behaviour, and around what needs to be in place in terms of protection and contact. In a way it's not our role, but it ties in, in terms of boundary setting generally.

There is an implication that Andrea expects most women to recognise sexually abusive behaviour easily. Certainly, this is the only case in the study where workers suggest such a difficulty. Andrea explains it in terms of Madeline's childhood experiences. It seems to be 'abnormal' and it suggests the need for work with Madeline in order to keep Nadia safe in the context of requests from the perpetrator for contact. However, Andrea believes

this to be 'not our role', presumably because the local authority has the primary responsibility for child protection. So here is the category of 'supportive mother' again, but this time with a new sub-category of 'additional, unusual needs that may not fit the Agency remit'.

From the worker's perspective, establishing this second case type with the mother may be slightly harder. Andrea told me 'Madeline was very concerned that I was going to see her as a bad parent, she verbalised that to me and I had to give her a lot of reassurance' (9.1 Andrea 49). It may be difficult for the worker to be open about her perception of the problem without alienating the mother. This may lead to what Stenson (1993) describes as 'indirection', a lack of clarity that has been found to be characteristic of some social work interviews. However, rather than being evidence of a lack of skill, I wish to follow Stenson in arguing that this deliberate lack of clarity may be necessary. Workers may need to sustain an element of ambiguity about the problem and not to name it whilst trust is built and a 'helping' relationship established.

Establishing this second case type within the Agency is also difficult insofar as it may be 'not our role'. In this case there was no significant attempt to engage another agency. However, in a case arguably of the same type we have seen in Chapter 6 how Becky tried hard to involve the social services because she felt 'dragged in' to help with a range of family problems that were beyond her remit. Cases of this type involved constant negotiation between worker, team manager and other agencies over who should provide what support.

Difficult mother-child relationships

As we have seen in Chapter 6, workers sometimes felt that there were difficulties in the mother-child relationship. Within this category they distinguished two sub-categories; firstly, difficulties that were a direct result of the abuse and, secondly, difficulties that existed before the abuse but were often exacerbated by it.

Where the difficulties were a result of the abuse the following possible dynamics have already been noted:

- Mother's distress means that the child does not experience her feelings as 'heard' or recognised by her mother.
- Mother's distress means that her emotional state directly affects the child.
- Mother's distress means that the child 'protects' her mother in a variety of ways that are not helpful to the child.
- Mother's guilt means that she loses control over behavioural boundaries.
- Mother's confusion means that she is unable to give the child what the workers feel are necessary, helpful 'messages' about the abuse (e.g. it wasn't your fault).

Once again, underlying this construction is a concept of what might 'normally' be expected following sexual abuse, based on workers' experience and on their understanding of theory. This is a list of reactions that are 'only to be expected'. The centrality of 'normality' to this construction means that the third case type 'mother-child difficulties arising from the sexual abuse' has similar operational dynamics to the first case type 'supportive mother in need of limited expert help' above, where 'normality' is also central. It can be also be negotiated with the mother without implying criticism of her parenting. These are the kind of difficulties that any parent might have in these circumstances. So Carol talks about James' mother, Karen, in the following terms:

7.1 Carol 21: My assessment at the beginning was that the abuse had effected his attachment with his mum and, I don't know what sort of attachment issues, if any, were there before the abuse, but I think following the abuse he didn't feel like he had a secure attachment with mum because, I think from his perspective, she was unable to contain his angry feelings. She was understandably distressed and she would just burst into tears or start crying whenever he lost his temper and he seemed to be directing his anger towards her.

Note the use of the word 'understandably' in relation to mother's distress, and the prominent use of theoretical ideas about 'attachment' and 'containment'.

This contrasts with cases in which workers came to the view that the difficulties in the mother-child relationship were not just a result of the abuse. In other words there was 'something else going on'. As noted in Chapter 6, workers showed a distinct reticence in

their assessment of what that 'something else' might be. However, in relation to one case the team manager was clear.

Lynn 92: Well when you meet Tanya, the mum, you can see, she's very little, she's just like the little girl herself. Also, she goes right off the deep end about things, they really overreact, her and Grandma. Grandma, from what we had been told, seemed very punitive and controlling. Tanya seems as though she would be very indulgent most of the time but then completely over the top. They expect to this child to go up to bed and watch a DVD have a drink and then watch more TV and then go to sleep. She is only eight or nine and no one even says goodnight to her! She was referred to us for work about her sexual boundaries, whether she was beginning to be socially inappropriate, but at the lower end of the scale. It then emerged that there was a kind of cluelessness really from mother and it seems that we needed to do some work about the relationship between these two, how they are together.

Here, for the first time we see direct criticism of a mother (she is immature, 'just like the little girl herself') and of her parenting ('a kind of cluelessness'). But note that this was the manager talking to me, not the caseworker, whose message was similar but whose language was rather more circumspect. This may reflect the fact that this fourth case type is perhaps the most difficult to establish face-to-face with the mother and that careful, circumspect language is the order of the day. As noted above, there is the danger of alienating mother through being too direct, and the opposite danger of too much 'indirection'. In considering mothers' accounts below, we will build a picture of how this negotiation proceeds from mothers' perspectives.

Professional talk about fathers and male carers

Once again there was clear evidence of workers using a system of categories. The most fundamental division was between fathers who were seen as a threat to the child and/or her mother and fathers who regarded as 'safe'. That may not be surprising in view of the strong focus of the Agency on child protection and the background and child protection experience of these social workers.

Fathers were categorised as a threat if they were the perpetrator of the sexual abuse. None of these men continued to live in the same household as the child and there was no attempt on the part of Agency workers to encourage contact. Rather there were cases in which the worker advocated for no contact, or restricted, 'safe' contact. Although it may not be obvious from this study, because it has not highlighted the themes of children's therapy, these perpetrators were nonetheless central to the therapeutic work, much of which revolved around coming to terms with 'him' and what he had done.

Fathers could also be categorised as a threat if they had abused other children. In one case, this emerged after the parents (who were then separated) began attending the couples' group together.

3.1 Becky 17: ...after the first group I went to see Gabrielle (*the mother*) on her own and she told me that Caleb's dad had been accused of sexually abusing his sixteen year old step daughter, many moons ago. So we felt that it was not appropriate for him to come to the group because it is for non abusing parents and he now became an abuser, not of the children we were working with, but an abuser all the same.

Note that it is explicitly acknowledged that this allegation was 'many moons ago'. Yet 'he *now* became an abuser'. So the current shift to *becoming* an abuser is clearly a result of a category change, not a result of him committing abuse. The effect of this re-categorisation is dramatic and he is barred from the group. In fact he is advised to seek help from another agency as a perpetrator.

Only three families in this study contained what the workers felt were 'safe' fathers or carers. There is evidence in the child welfare literature of social workers drawing a distinction between 'useful' and 'useless' fathers (Scourfield, 2001). In this study there is limited evidence of a similar distinction, but more orientated around worker activity. Workers distinguished between those fathers it was worth investing time in, because of a perceived payoff for the child, and those it was not. As we have seen in Chapter 5, this category is constructed against a background feeling that working with fathers is 'going out of your way'. So fathers could fall into the latter category of 'not worth investing time in' even if they were felt to have something to offer the child, simply because

engaging with them did not seem feasible. As we saw in Chapter 5, workers complained of investing time in fathers only to find them 'opting out'. And in Frank's case, although the worker felt that he had been 'more supportive than mum', nonetheless he had not been present when Carol had visited and this was taken as evidence of him opting out.

Professional talk about children

In many ways the category systems that the workers employed when talking about children were simply a mirror of the parental categories. Thus there were categories 'child with supportive mother' and the rest. This is partly because the study has emphasised the issues related to working with parents.

However, one distinctive feature of professional talk about children was the attention paid to age or, more specifically, to the degree of independence from parents. So, as we saw in Chapter 5, at age fourteen years the team would want to 'offer confidentiality' to the young person and only 'feedback' information to parents with the young person's permission and, ideally, in their presence. However, in several of the cases in this study workers argued that they were justified in using their authority either to persuade young people to tell their parents critical information, or simply to reveal it. The justification was based on the workers' perception of the child's 'best interests'. The consequence is that, whilst there might appear to be two distinct categories here, 'independent young people who receive a confidential service' and 'younger, more dependent children who do not', in fact the categories are much more fluid. Young children may be given considerable autonomy about what to tell parents when the issues are not thought by workers to be important for parents to know. And, as we have seen, older young people may find themselves 'leaned on' if the issue is felt to be serious. Workers appear to be exercising considerable discretion here.

MOTHERS' ACCOUNTS

Whereas my interviews with the therapists set up a dynamic in which the workers provided explanations and justifications for their approaches to cases, my interviews with mothers had a very different set of dynamics. This section begins with a reflexive account of some of those dynamics and the effects that they had on the overall shape and character of the women's accounts. Following that I draw attention to the way in which

individual women responded to the workers' attempts to categorise them and the effect that this had on negotiations about the nature of the therapy.

Giving narrative accounts

Having approached each of the first interviews without any background knowledge, it was necessary for the women to tell me something about the circumstances of their child's abuse, the nature of the impact on the child and on themselves as parents, and the circumstances of the referral to the Agency. It was clear from the information provided to the women, verbally and in writing that this would be by way of an introduction to the main focus of the research interview, which was about their relationship to their child's therapy. In practice it was noticeable that these two stages of the interview were quite different. It appeared that the women found it much easier to tell the 'story' of finding out about the abuse and referral to the Agency than they did to give an account of how they related to the child's therapy.

This difference showed itself in several ways. Women's introductory accounts of the circumstances of their child's abuse very often proceeded with little in the way of prompts or questions from me. Typically these accounts are lengthy and free flowing and they highlight the emotional impact, with some of that emotion being experienced again in the telling. Whilst each story is different, there are nonetheless some striking similarities between them. In each case the abuse comes 'out of the blue', the effect is emotionally devastating, there is 'officialdom' to be dealt with (in the shape of an investigation and/or legal proceedings) and referral to the Agency is usually seen as a significant turning point on the road to recovery. They can easily be seen as discrete narratives of the type originally described by Labov (1982) and consisting of orientation (what it was like before the abuse happened), complication (finding out about the abuse and dealing with the authorities), evaluation (what the impact was like) and resolution (being referred to the Agency). By way of contrast, accounts of mother's relationships to the child's therapy were much more difficult to obtain. They tended to emerge in response to quite specific questions from me; they were less free flowing, less obviously emotional and women appeared to be spending more time thinking about their responses. There was a much greater variety of responses and more difficulty in identifying common ground.

In his account of the telling of sexual stories, Plummer (1995) identifies three main 'modernist' sexual story types: rape stories, coming out stories and recovery stories. Plummer's emphasis is not just on the content of such stories but rather on the changing nature of their construction and usage in the context of social, cultural and political change. His argument is that contemporary rape stories have become a feature of everyday life, and that themes of women's resistance and survival are bound up with accounts of finding a new identity. Similarly, Plummer argues that recovery stories, although less overtly political, are equally ubiquitous, particularly in the USA. Such tales tend to identify a new problem, (the 'last taboo') and give a personal account of recovery from some form of dysfunction or addiction.

Elements of these common genres are clearly identifiable in the women's accounts. They are not first hand rape stories, since the abuse was of their children, and yet many of the themes of anger and resistance to male violence are present alongside anger at 'official' responses.

4.1 Amanda 4: *(In the police interview)* ...he started coming out with more details and he actually said that he had anally raped him. I was so shocked when I heard that. I wanted to kill *(the abuser)*..... He was charged over eight times for four rapes and four other offences. They said that they did that because they knew that the defence would try to drop some charges. But I said that if he didn't plead guilty to rape them I would go to court because I didn't want him getting away with what he had done..... *(Social services)* came in and they spoke to the children. They interviewed the children and as soon as they got the information they wanted, that was it, they weren't interested after that.

But there are also themes from 'recovery' stories, with women feeling that the abuse of their children marks them out as somehow different and giving an account of a personal journey towards some sort of hope.

Mothers' group discussion 71: If you would tell people what you are contending with then they wouldn't understand. They think it's a problem, like not doing your ironing... just a minor thing and you'll get over it. They don't think it's this gut wrenching, heartbreaking thing that never ever goes away. You think about it

every single day of your life and you probably will do forever. If it wasn't for the mothers' group then I don't know where we'd all be.

It seems that women had access to 'templates' for the telling of their introductory stories about the abuse, its immediate impact and the referral to the Agency. When asked to move on to talk about their relationship to Agency therapists and the work with their children, then it felt as though they were moving into less well-charted waters and I found myself doing more of the talking.

It is possible that this difference between the two types of narrative style was exacerbated by the effect of talking to a male interviewer. As we have seen, research by Padfield and Procter (1996) suggests that one of the residual effects of men interviewing women is that women may be less likely to spontaneously volunteer information. It could be argued that, in the absence of a clear 'template' for telling about their relationships with the professionals, women were being asked to volunteer information. It could be that a female interviewer might have found women more ready to volunteer spontaneous thoughts and experiences about their relationship to their children's therapy.

Talking about relationships to workers and to the child's therapy

In a chapter discussing parents' accounts of social work in child welfare and child protection, Hall *et al.* (2006) show how some mothers may challenge negative worker categorisations, such as 'not coping'. They also show the difficulty of doing so and the relative powerlessness of parents under scrutiny. This section reviews the case examples of the four case types given above, from the perspective of the mothers' accounts.

In Amanda's case, an example of the first case type, she was seen by her worker as a 'supportive mother' who was in need of a 'normal' amount of advice and support. Consequently there was no obvious negative categorisation for her to challenge. Amanda accepted the proposal that Andrea worked with the child whilst Amanda remained in the waiting room. However, this does not mean that Amanda was entirely happy with the situation, as she began to tell me in response to specific questions. As we saw in Chapter 7, she felt excluded, saying that it did not feel like a partnership, 'they take the kids away and they do what they have to do and bring them back', and that she was not asked to contribute anything. With one of the children this felt justified, because Amanda agreed

with the worker that Lance would not open up about his feelings in her presence for fear of upsetting her. With the other it was less satisfactory, but Amanda did not feel able to question it. So although the negotiation over the arrangements for therapy was successful insofar as it led to an agreed pattern of work, nonetheless Amanda had some negative feelings about it. This was exacerbated by her feeling that, after the initial period before allocation of a worker to the boys, she had not had access to the same level of personal support.

Turning to the second case type, in Madeline's case the worker had felt the need to work individually with her to help her to recognise and understand her ex-partner's behaviour as being abusive. This was seen as an unusual need, but in the context of a supportive maternal relationship. The worker suggested that seeing Madeline constituted 'a lot of the work'. It is striking then that, on the face of it, Madeline's account shows little evidence of this 'work' at all, even in the interview that took place after the work had ended. In the first interview the emphasis was on how strange it was not to know what Nadia was saying to Andrea in the sessions, and how scared she was that Andrea might 'find out about all the skeletons' and 'take my daughter away from me'. In the second interview Madeline appeared to me to be far more guarded and she did not have a lot to say. She said that:

9.2 Madeline 5: ...the support from Andrea has been really very good and I feel a lot more confident now and I don't need to carry on seeing her.

One possible interpretation of this relies on Stenson's (1993) concept of 'indirection'. As we have seen, it would have been difficult for Andrea to be very open about her assessment at first, for fear of antagonising Madeline. So, as the work progressed and Madeline's thinking about sexual abuse was, presumably, gently challenged, then Madeline would have begun to gain some insight into Andrea's aims, even though these were not clearly stated. Once successfully 'educated', or 'persuaded' to change her thinking then, looking back in discussion with me it may not have been easy or comfortable to acknowledge the transition, particularly if the nature of the change had not been openly acknowledged to Andrea.

This is an example of a complex negotiation which, arguably, was successful in agreeing a pattern of work with both mother and child only because the workers' aims may never have been made fully explicit.

In contrast, the third case type concerns a situation in which some difficulties in the mother-child relationship are thought by the worker to be a 'normal' result of the sexual abuse. In her interview with me, Karen also appears to understand the problems as resulting from the abuse.

7.1 AH 51: So the work that Carol has done has had an impact on the relationship between you and James?

7.1 Karen 52: Oh yes. He blamed me. I worked, and I would have blamed my mum. She is the closest to you and you do blame her.

7.1 AH 53: So it must have been difficult for you to know how to handle that?

7.1 Karen 54: Yes, I just gave in. Like with my little girl, I've just given in with her as well. I had so much going on, and now she's terrible as well, she is very naughty. And I just give in. I don't know how to deal with it.

Note that Karen, in turn, normalises the way in which her son, James, blames her. In Karen's view it is 'normal' to blame your mother, particularly if she goes out to work. Karen's account of 'giving in' to both children is also very similar to that of the worker. It appears that there was little difficulty in agreeing the aims of the work, and that this extended to Karen actually joining in with the sessions, as we saw in earlier chapters. Here Karen reports what Carol told her:

7.1 Karen 32: It seems to be going really well now. Carol rang me and she said that it is going really well because he is building that bond up with me, getting involved.

Karen adopts the worker's theory language of 'bonding' to understand what is happening between them in these joint play sessions. However, this case had one major element of

disagreement between Karen and her worker. Karen had told James that his abuser had been sent to prison after trial, when in fact he had been acquitted and had left the area. Carol felt that he should be told the truth before someone else told him. Karen felt this would upset him too much. This also became a topic for negotiation, with Carol deciding that she should not and could not simply overrule Karen and tell James, and Karen gradually becoming persuaded to tell him a few weeks later. In this respect, as more generally, there is clear evidence of Karen appreciating Carol's expertise and being increasingly led by it.

Finally, the fourth case type is where workers felt that difficulties in the mother-child relationship were not just as result of the abuse. Here there was implied criticism of Tanya's apparent immaturity and her parenting, at least from the team manager. However, Tanya's account does not reflect this at all. She speaks very positively of the worker, Carol, and of her experience of joining in with the play sessions.

8.1 Tanya 20: I'm a bit..... Carol has been brilliant. And now I'm joining in with them. She asked me what size Sabrina was when she was born and I said, about that size (*gesturing: small*). And she was eight weeks early. I was just sort of telling her. I told her that I used to have a doll called 'Tiny Tears', and she's getting that for her Christmas this year. So it's good, it is, it's good, because I'm joining in and it's good. I don't know. I just felt good because I'm sort of helping her too, me and her are sort of helping each other.

Tanya seems to feel ok about Carol's interest in Sabrina's prematurity, insofar as it may provide an explanation for their difficulties that does not blame her. Tanya seems to feel some surprise at how easy it was to talk to Carol about this difficult time, 'I was just sort of telling her'. And the improvement in the relationship with Sabrina is reflected in the fact that Tanya is planning to buy Sabrina a Christmas present.

So how was this achieved? It appears that Tanya already felt that she had some difficulties with Sabrina. Carol chose not to present Tanya with a negative assessment of her as a parent, but instead at least implied that the difficulties were related to Sabrina's prematurity, thus side-stepping the question of blame. This meant that they were able to agree on a plan to include Tanya in the sessions to work on 'the bonding'.

These four case types each show workers and mothers negotiating successfully over the aims and conduct of therapy. At the heart of these negotiations are issues of trust, power, expertise and the apportioning of blame.

FATHERS' ACCOUNTS

All three of the men who contributed to the research were interviewed jointly with the child's mother. Two of the men shared the conversation with their partner in a balanced manner, leading to a sense that the couple had a shared understanding of the situation (see Chapter 8). The third contributed rather less. As with the individual women's interviews, men joined in with a spontaneous and free-flowing narrative account of the abuse, its aftermath and referral to the Agency. Again, accounts of how they related to the process of therapy were less 'worked out' and preceded in response to questions from me.

It is fair to say that none of the three had a great deal of involvement in the therapy. Aaron was most involved, having had an initial meeting with the therapist and having attending some review meetings later in the work. Consequently the interviews tended to focus on the reasons for this low level of involvement. This created a dynamic in which the men may have felt on the defensive, particularly when, as in Aaron's case, there was implied criticism from his partner. Aaron certainly used justificatory language throughout the interview. For example, when asked to what extent he was involved in the process of reviewing Felicia's therapy, Aaron relied, "As work permitted" (2.2 Aaron 25), thus providing a justification for an implied low level of involvement rather than the possible alternative 'not very much'.

Broadly, two main justificatory strategies emerged. The first was the claim that there were limited opportunities to get involved, either because of work (Aaron) or because of feeling excluded from the process (Frank). Frank felt that the worker was there for Jackie, his step-daughter, and not for him. As we saw in Chapter 8, he wanted more advice about what to say and do but he felt unable to ask. The second strategy was to point to the difficulties, for men, of handling these difficult emotions. Frank and Aaron, in telling the initial abuse narrative, gave an account of how their first response had been to 'cut off' emotionally as a way of coping. As Aaron put it, 'They always say that the male finds it

difficult to talk about feelings' (2.2 Aaron 80). As noted earlier, this second strategy may have been encouraged by having a male interviewer.

The overall impression is of men who felt as though they were peripheral to the therapy and who had mixed feelings about that position. Partly it was very comfortable because it allowed them to continue to cut off from difficult feelings, and partly it was uncomfortable because of both external and internal pressures to become more involved.

CHILDREN'S ACCOUNTS

The children's accounts differ in structure from the adults' accounts as a result of the nature of my agreement with the participant children. Children were assured that they would not be asked to talk about the circumstances of the abuse itself, because the research was about their experience of attending the Agency and any role that their parents might have played in relation to their therapy. This meant the children's interviews lacked the introductory, narrative phase that was present in the parent's interviews when they told the story of the abuse and its immediate aftermath. As with the parental interviews, accounts of the therapy itself were elicited mainly in response to questions and they are not generally free-flowing. However, being interviewed after the therapy had ended meant that children had the opportunity to look back and make sense of it as a whole. At the end of her interview, this is how Felicia summed it up:

2.2 Felicia 57: When I first started to go I didn't really like it but I got used to it and I started to like it. I didn't used to like saying things to people because it might upset them but I'm not like that any more.

Although extremely brief, this has some of the narrative elements described by Labov (1982). There is no real orientation, but this has been provided throughout the interview, so that the story starts with complicating action (getting to like it) and emphasises evaluation and resolution (I'm not like that any more).

These children's accounts do not show any real evidence of the kinds of verbal strategies that adults use to justify their positions and to persuade others. There is little evidence that blame is a central issue, at least not the adult dynamic of seeking to avoid blame. Instead there is often evidence of children blaming themselves for the abuse, and of

concern about this as a therapeutic issue. However, the lack of persuasive or justificatory strategies does not mean to say that children are unaware of their audience. Instead, I would argue that there is a parallel concern for what might be termed, 'avoiding trouble'. This takes several forms. Firstly, children were concerned not to be seen to have transgressed any adult rules. Caleb had a written agreement with his therapist about dates and times for sessions. So Caleb was reluctant firstly to admit that there were times when he had failed to turn up for his therapy sessions and he stopped in mid-sentence as he decided not to tell me the reasons.

3.1 AH 17: So what was it actually like, doing these sessions with Becky?

3.1 Caleb 18: Ok

3.1 AH 19: Did you look forward to it, or not want to go, or what?

3.1 Caleb 20: Sometimes I didn't want to go ... but other times it was ok

3.1 AH 21: When you didn't want to go, why was that?

3.1 Caleb 22: I was a bit.....

This links to the second form of 'avoiding trouble' by not criticising adults, or by not offering opinions in case they are construed as criticism. It is possible that Caleb was withholding criticism of his therapist, but it may be that he felt that the difficulty was elsewhere. Thirdly, children talked openly about not wanting to upset their parents. For Caleb this meant keeping the sessions confidential from this mother. For Felicia it meant saying very little at all at first.

It seems that both adults and children are aware of their audience. Just as the interviews show adults are concerned with justifying their position and persuading others, so there is some limited evidence to suggest that children are concerned about not causing trouble through misdemeanour, criticising adults or expressing difficult emotions. These different concerns reflect the relative power positions of adults and children. The children's concern for avoiding trouble underlines the difficulties that they face when

'negotiating' with adults over the arrangements for therapy, and the difficulties of researching their views.

CONCLUSION

This chapter has focussed attention on the use of language in the interviews that I conducted. It has examined how professionals talk about mothers, fathers and children in the context of therapy and how mothers, fathers and children talk about their experiences of therapy and therapists. However, since completing the analysis and during the oral examination of the thesis, it was pointed out to me that there is a key literature within family therapy that deals with 'talk' within therapeutic processes, some of which is specifically about questions of 'cause' and 'responsibility'.

This literature was not included in the earlier literature review chapters simply because, during the early stages of the study when those reviews were carried out, I had not anticipated that I would be writing a chapter about language and discourse. As outlined in the introduction, the balance between the aims of the study has shifted as the study has progressed. However, some of the analysis in this chapter has much in common with ideas of 'neutrality' and 'multipartiality' in the family therapy tradition, insofar as it shows how therapists avoid 'blaming' stances even as they look for explanations. Further, more recent literature shows how families and therapists must engage with the moral context for negotiating blame and responsibility (for example Stancombe and White, 2005). This literature is particularly relevant and will inform any future work that I may undertake in this area.

In this chapter it is argued that professionals categorise cases according to judgments about maternal supportiveness and the causes of any perceived difficulties in mother-child relationships. Some of the influences on the construction of these categories have been traced, in particular the organisational context. Categorisation according to case types may suggest different patterns of therapeutic intervention but, it is argued, the shape of the actual intervention is influenced also by parents' and children's responses to the workers' assessments. An assessment that suggests that serious difficulties in parenting were present even before the abuse occurred is unlikely to lead to an intervention targeting those difficulties unless this is understood and agreed by the parent. This leads to the argument that negotiation is at the heart of the work. However, the

above summary makes it sound as though the starting point for negotiation is the outcome of the worker's assessment and whether or not it is shared by the family. In fact, as we saw in Chapter 5, workers understand assessment as a phase in the work, also encompassing the building of rapport with the family, rather than a uniform or fixed process. As Andrea put it, 'I suppose it's like I test the water' (Andrea 9.1.35). So the negotiation starts right from the first contact with Agency and also encompasses the assessment phase itself.

A significant limitation of this study will now be apparent. My arguments about the significance of a negotiated approach to therapy are based on individual interviews with the parties involved. I do not have direct access to any of the interactions between family members and therapists. The significance of this is one of the topics to be discussed in the concluding chapter that follows.

CHAPTER 10: NEGOTIATING THERAPY

INTRODUCTION

In this, the final chapter of the thesis, I draw together the findings of the thematic analysis presented in Chapters 5-8 and the conclusions of the previous chapter about the relevance of language and discourse. However, before doing so I wish to reflect a little on the relationship between the two.

To some extent it has felt as though the thematic analysis has focussed on issues such as how workers manage 'feedback' to parents about a child's individual therapy, or how parents experience participation in therapy sessions. These might be thought of as the substantive issues. In writing about these themes I have been pursuing the first, most general aim of the study, namely to understand more about the dynamics of the triangular relationships between children, non-offending parents and therapists. But questions about effectiveness are apparent at the same time. For example, workers have explained the rationale for their approach to giving 'feedback' in terms of 'what works', and what pitfalls they are seeking to avoid. In this way the thematic analysis has given some clues in answer to the remaining aims of the study; namely, to seek the most effective ways of maximising parents support for children's recovery and integrating it with professional therapy, and to explore the efficacy of professional support for parents themselves.

The attention paid to language and discourse, on the other hand, has felt as though it has moved the focus towards what might be called 'process' issues. It has turned attention away from questions about 'what works' in therapy in favour of questions about 'what happens' when parents, children and professionals negotiate their way towards agreement over therapy. I would argue that this has made a major contribution to understanding the dynamics of the triangular relationships between children, non-offending parents and children's therapists, fulfilling the first aim of the study.

This final chapter draws on both types of analysis and attempts to integrate the two. Firstly, with regard to the 'substantive issues', I have used the thematic analysis presented in Chapters 5-8 to summarise the main factors that lead therapists, parents and children either towards therapeutic work that include parents directly in sessions, or towards individual therapy for the child. These factors provide clues about 'what works', certainly in the opinion of therapists, insofar as they provide an insight into the reasoning

that is being used. Factors that lead towards individual therapy with children and liaison with parents are considered first, along with some of the factors that limit this approach. This leads to a summary of the factors that lead towards therapy that includes parents directly in the sessions, and a similar account of the limitations of this approach. In contrast to many of the preceding chapters, the perspectives of professionals, parents and children are woven throughout the text and do not provide the structure for the chapter.

Finally, in the concluding section of the thesis, I return to the concept of 'negotiation' that was being developed in the previous chapter. This is because, although the possible reasons for adopting a specific pattern of therapy are presented as discrete factors, it is rarely the case that one factor alone is decisive in determining the pattern of therapy. More often than not, a variety of indications and counter-indications are apparent to some or all of the parties. There are many options. So the question remains; how are these weighed up and an outcome arrived at? My argument is that this occurs through a process of negotiation between professionals and families that incorporates the professional notion of 'assessment', with its roots in professional judgement and expertise, but that it also incorporates elements of user-expertise.

WORKING INDIVIDUALLY WITH CHILDREN – LIAISON WITH PARENTS

Reasons for doing so

Therapists' understanding of the child's need for 'therapeutic space'

As we have already seen, therapists were drawing on a tradition of practice that places much emphasis on the centrality of the therapeutic relationship. This is envisaged as being a safe 'space', in which the therapist is able to provide 'containment' for the expression of difficult feelings. The specific skills of the therapist are the key to the child's progress, insofar as they provide the necessary conditions for the child to undertake their own therapeutic 'journey' (Axline, 1947/1989; Bray, 1997).

Whilst this appeared to be a starting point for much of the professional thinking, there appeared to be some cases in which this was an over-riding consideration and others in which additional factors led to a different pattern of therapy. Of interest here is to try to identify some of the characteristics of cases in which the therapists' perception that the child needs 'therapeutic space' was the primary reason for working individually with the child. One important factor was the age of the child. For young people such as Felicia (13

years), Caleb (15 years) and Barbara (13 years) there seemed to be a presumption that this was more appropriate at their stage of development. As we saw from the teenage vignettes that the team considered in Chapter 5, a confidential individual service is very much the 'default position' in the team's practice with this age group. A second factor is any perceived difficulty in communicating with the child. In Barbara's case, in particular, the team manager felt that the skills of the therapist were extremely important in facilitating non-verbal communication in the context of her learning disability.

1 Lynn (manager) 12: It felt as though Barbara was really on a very deep journey really, working at quite a deep level, but very very slowly ...though sometimes when we thought it was slow it was really because of the communication from Barbara, which was quite outside what you get from most young people ... at an extreme. I think many therapists would have given up at a much earlier stage, thinking that she wasn't ready to work, or "I can't really do anything here", but Andrea, with quite a lot of patience and perseverance, demonstrating to her that she was there and that she was listening, was able to get through at some level... But if you had been less patient and demanded verbal communication then you wouldn't have got it.

These were skills that parents were thought not to have, as is shown by the way in which the team manager talked about Barbara's mother.

1 Lynn 12: Mum was very involved at a sort of support level, reviewing the work and in bringing issues. I mean she often rang for advice ... so she was a very involved parent, but there was a sense from the worker that she didn't actually need her and that what she needed was space for Barbara to do the work.

A shared view of parents as too emotionally 'involved'

From the parent's perspective there was the recognition that sometimes they were too emotionally involved to be able to help their child. Edith put it like this:

2.1 Edith 19: Although I could talk to her, she could ask the questions and I could answer them, because I'm *involved* and I have my own bitter feelings, I've got my own anger, I've got my own sadnesses. This means that, try as you might

it is very difficult not to put your impressions, your feelings on to somebody, especially if they are distressed. You don't want to say things to people that they don't need to hear. It's not good for them to hear it.

2.1 AH 20: What kind of things might you have said that you didn't want Felicia to hear?

2.1 Edith 21: About killing him, calling him a bastard, all those sorts of things that you might use as an adult. These are not the sort of things that a child should have to handle.

Sometimes this dynamic was reversed, with the parent aware that their child would want to protect them from angry or difficult feelings. As Bridget put it:

12.1 Bridget 12: I think Wendy works better when I'm not around. She's more cooperative and communicative. If I'm there she tends to not say as much.

12.1 AH 13: I wonder why that is?

12.1 Bridget 14: Because she doesn't want me to hear it. She knows it upsets me, she's quite a clever child really.

It is interesting that this dynamic was understood and agreed upon by all three groups; parents, therapists and children. Edith's worker, Andrea, shared Edith's view above:

12.2 Andrea 16: I think that if Edith was in the sessions Felicia would not be able to really.... I am trying to help her thinking about what she wants/doesn't want and I think if Edith was there it would be more difficult to do that because she would be taking care of Felicia.

And Caleb, aged 15, voiced the same thought in relation to his mother.

3.2 Caleb 40: Yes. I thought that if (*my worker*) told my mum then she would get all upset.

The level of agreement on this point seems to be strong. It might even provide a partial explanation for the overall lack of parental involvement that was noted in the literature. If all three groups share a widespread belief that parents are too emotionally involved to help their children then it may not be surprising that therapists take this role on their behalf.

Parents' belief that they don't know how to help

Closely allied to the problems of emotional involvement is the feeling of many parents that they do not know how to help. This was noted in Chapter 7 and is illustrated by Gabrielle's reflection on the reasons why she and Caleb were referred to the Agency.

3.2 Gabrielle 15: Caleb obviously needed support, because everybody needed support from me, and I couldn't give him individual support and I didn't know how to help him. Well now, looking back, I know that the best way to help Caleb was to listen to him. But I couldn't do that at the time because I didn't understand my own feelings.

Again, as noted in Chapter 7, for some parents there was a sense of relief at finding some expert help.

1.1 Abigail 43: At the time, I just wanted them to take the kids and just sort them out. I had come to the end of my tether really. I didn't know how to deal with it.

Parents' belief that their child will listen to someone else

Some of the parents of older children held the belief that their children were far more likely to take notice of someone other than themselves. Edith clearly saw the worker, Andrea, as an influence on her daughter, Felicia.

2.2 AH 22: So I can see now that you were thinking that coming here would give Felicia somewhere neutral, somewhere detached from you.

2.2 Edith 23: And something else; saying things that if I said them she would say, "That's my mother saying that", whereas with Andrea saying it she will take it. That's parent-child for you!

Interestingly, this idea is not reflected anywhere in either the therapist interviews or in the interviews with the young people themselves. This would appear to be because the therapeutic approaches that are used do not attempt to offer advice to young people and still less to 'persuade' them. Therapists do not see themselves in the role that Edith has in mind. Although I did not specifically ask about this, nonetheless I strongly suspect that the therapists' beliefs about their own lack of 'influence' over young people would be quite similar to the parents! Certainly there is nothing in the, albeit limited, data from young people to support the idea that therapists influence young people in this way.

I am reminded once again of Mayer and Timms' (1970) finding that clients were looking for concrete advice or action and were often dissatisfied with talking therapies. In this case the lack of advice and guidance to children contrasts with the way in which workers felt able to give advice to parents about how to manage their children's behaviour after abuse. As we saw in Chapter 5, therapists felt the need to provide what they called 'scripts' for what to say. In this case parents were receiving the advice they sought in relation to parenting issues and they seemed to assume, wrongly, that therapists were offering similar advice and guidance to children in therapy sessions.

Parents' need for independent expert assessment

Parents had often formed their own tentative conclusions about how their children had been affected by the abuse. However, they lacked confidence about the accuracy of those conclusions, either because of their emotional involvement or their perceived lack of expertise, as noted above. So allowing a therapist to see the child individually and to make an independent assessment was often very reassuring for parents.

Olivia felt that Rachel had not been seriously affected and was coping well, but she was worried that she might have missed some counter indication. So she found it reassuring to wait outside the therapy room and to receive positive feedback as Rachel came out.

10.1 Olivia 82: I've always sat and waited for her, when (*the worker*) Becky's brought her out and they've brought the pictures she's done and Becky will say, "She's got lovely flowers, she's got you all there, and she's happy in herself". That's what I needed.

Young people wanting the chance to talk, in confidence

As we saw in Chapter 8, Caleb was very clear that he wanted individual sessions with his therapist. He gave two reasons for not wanting his mother present in the sessions. Firstly, he did not feel that his mother would keep things confidential. Secondly, he felt that she would do all the talking.

3.2 Caleb 41: It is better to talk to a stranger who you don't know and who doesn't know who your friends are. If I talk to my parents then my mum knows who my friends are and she would probably talk to them .. so it is better talking to a stranger.

3.2 Caleb 45: I didn't want that. When we go to a school meeting I don't get a chance to talk ... my mum's always talking, and my dad. So I'd never get a chance to talk ...whereas if I go on my on then at least I get a chance to talk.

Worker's belief that it may not be 'safe' to include mother

Finally, as we saw in Chapter 6, there was one case in which the therapist, Carol, was concerned that the child's play included themes about a nasty and inconsistent mother-figure. Involving mother in this play was felt to be entirely inappropriate, unless further assessment led to an intervention strategy that included work on the mother-child relationship. At an interview early in the work Carol said:

6.1 Carol 12: I'm reluctant to feed too much of the detail back to mum, or to involve mum in sessions at this stage in the work. I feel like I would like to see some sort of completion, maybe, in the work with Jackie, and then perhaps involve mum in the work later on.

Limitations of individual work with children

One of the main limitations of individual work is that, by excluding parents from the therapy, the potential advantages of including them are lost. These potential advantages are fully explored below. This section is therefore confined to a consideration of some of the other limitations of individual work that are indicated by the data.

Confidential 'therapeutic space' may be limited by the need to inform parents

I have included a full discussion of the arrangements for 'feedback' to parents, seen from the perspectives of therapists, parents and children in Chapters 6-8 respectively. This sub-section summarises some of that material.

Firstly, even after consultation with the child, therapists are able to exercise considerable discretion about what information about the sessions they pass on to parents. Parents have mixed feelings about this. Whilst most acknowledge the children's need for some privacy, nonetheless many were frustrated by what they felt was a lack of information. As a minimum, therapists routinely undertook to tell parents about 'child protection issues', but there appeared to be a lack of clarity, at least amongst parents, about what might be so serious that the therapist would override the child's wishes and disclose it to them. The two interviews with young people are in strong contrast with one another. Caleb (15 years) appears to have considerable control over the feedback to his mother and is very pleased with this. Felicia (13 years) appears to think that her worker would have overridden her wishes.

The conclusion appears to be that worker judgement about what 'feedback' to give, and how to manage the process, is central in determining the size and nature of the therapeutic space that is offered.

Parents may feel excluded

This comes through clearly in the data presented in Chapter 7. About half of the mothers who were not included in the play sessions talked about feeling left out, whilst at the same time they acknowledged the children's need for some privacy. It could be argued that these feelings of exclusion only begin to limit the therapy if they have a negative impact on the working relationships between therapist, parent and child. This is difficult to assess directly from the interview transcripts. Nonetheless, Amanda, (who is quoted in Chapter 7 as saying that it did not feel like a partnership because of the lack of information), did not attend the final series of individual support sessions that were offered to her. It seems quite possible that these negative feelings are an explanation. However, Amanda appears to be the exception and, in most cases therapists appear to feel that they can 'contain' these feelings in the context of individual support to mothers.

Conclusion

This section has listed some of the reasons for working individually with children and some of the limitations. It has treated them as discrete factors, whereas in individual cases it would appear to be the interplay of these factors, in negotiation between therapists, parents and children that determines the pattern of the therapy. They may be considered to be the pieces of the jigsaw, but the shape of the final picture is determined by how they are put together. Nonetheless, when a professional commitment to giving children a 'therapeutic space' is combined with the shared perception of parents being too emotionally involved and with parents' willingness to hand over responsibility to suitably qualified workers (see Chapter 7 page 173 and the reference to Fisher *et al.* (1986)) then there is a powerful dynamic in favour of individual work, the dominant pattern reflected in the literature.

The final section of the thesis returns to the process of negotiation between parents, children and workers over forms of therapy. However, before doing so, the following section provides an account of the reasons for including parents in therapeutic play and the potential limitations.

INCLUDING PARENTS IN THERAPEUTIC PLAY

Reasons for doing so

Helping children to feel secure – an attachment perspective

As we saw in Chapters 5 and 6, the therapists used an attachment perspective as an explicit theoretical base for some of their work. Clearly, from such a perspective the process of 'settling children in' to individual therapy, as described in Chapter 5, is very important. In the initial team discussions, team members described how they often found that children were reluctant to leave their parent(s) in the waiting room in order to go off to the playroom with a stranger. In response to this the team began to involve parents, usually mothers, in the introductory play sessions. This was to begin to understand the importance of attachment relationships in helping children to feel secure in the playroom, particularly in the context of recovery from sexual abuse (Bacon, 2001). For some children, individual work remained the first choice, for some of the reasons given above. In some cases this was achieved but, as Ryan *et al.* (1995) have argued, children must see evidence of an effective partnership between their therapist and their key attachment

figure(s) in order to experience the kind of stability and security that will allow emotional engagement in individual work with the therapist. This is why good liaison with parents remains an important feature of the work, including dealing with any feelings of exclusion, as we have seen.

However, with other children it proved much more difficult to move towards individual work. These were usually situations in which a traumatic experience of sexual abuse had increased the level of separation anxiety (Bowlby, 1998) felt by both parents and children. Here there was an over-riding need for the children to feel more secure in their primary attachment relationships, and attempts to separate them from their parents at this stage would be likely to be counter-productive. The therapist, Andrea, describes working with Peter, aged 9, who had been severely traumatised.

13.1 Andrea 3: Peter wouldn't separate from his mum. It is quite difficult to describe the level of his anxiety, and how he is, because it really is quite extreme end. He just wouldn't have come into the play room. In this case it was quite clear that there was no way, I mean he was telling me, that there's no way, I'm not coming into that room unless my mum can come too.

In such cases mothers remained in the therapy room so as to provide a sense of security for their children.

Modelling play therapy to parents – filial therapy and Theraplay

As we have seen, parents were frequently unsure how to help their children following sexual abuse. They reported not knowing what to say or do, and the idea of play as a medium for children's self-expression and communication was a novel one for some parents. It is clear from the therapist interviews that one of the reasons that they included some mothers in sessions was to try to model play therapy, as a way of helping mothers to help their children.

Partly, therapist were drawing on the concept of filial therapy (Landreth, 2002). As we have seen, in filial therapy parents are trained in the use of non-directive play therapy techniques and act as therapists for their own children. Parents are trained in basic non-directive, child-centred play therapy skills with the aim of building the parent-child

relationship. However, in filial therapy the professional role is to train parents as therapists and not, as in the practice in this study, to work directly with children alongside their parents. Secondly, filial therapy is not concerned only, or even primarily, with child sexual abuse but has a much broader application.

The practice described here was to include parents in sessions with their children alongside the therapist, not in place of the therapist. This is perhaps closer to the practice of Theraplay (Jernberg and Booth, 1999), as considered in Chapter 2. Theraplay draws on attachment theory and aims to promote secure attachments. The evidence from therapists in this study is that they were drawing on insights from Theraplay for the same purpose. Parents were prepared for the sessions through individual discussions with the therapist. These discussions acknowledged the seriousness of the impact on them as parents and took place in the context of a wider pattern of support, often including peer support. Having the therapist also present allowed parents to observe and to model the therapist's approach.

Rebuilding confidence in parenting – therapeutic perspectives on 'containment'

Sometimes parents' experience of being unsure about how to help their children following the sexual abuse extended well beyond the play room. As we saw in Chapter 7, they reported a loss of confidence in key areas of parenting; responding to children's distress and setting boundaries on their behaviour. Parents reported not knowing what to do or say in response when children expressed difficult feelings about the abuse. They appeared to be 'making allowances' for challenging behaviour that might be a reaction to the abuse, partly out of sympathy for the child. Later they often had difficulty in deciding how much of the behaviour was really related to the abuse. This can be a serious problem because, as Smith (1995b) argues, it is important for sexually abused children to see authority exercised effectively, without bullying or abuse, in order to learn the difference between assertiveness and aggression.

From a psychotherapeutic perspective these can be seen as difficulties with 'containment'. As we have seen in Chapter 6, this is another significant theoretical influence on therapists' thinking. When parents are included in the sessions with their children then the therapist is simultaneously 'holding' or 'containing' the painful feelings of both parent and child. Through a complex process, this experience may allow parents

to take back the same role in relation to their own children (Chazan, 2003). Given the extreme trauma that Peter had experienced, and the challenging nature of some of his behaviour, Andrea, his worker, felt that this was a central dynamic of the therapy sessions, in which Peter's mother participated.

13.1 Andrea 5: And I suppose the other advantage is that I have been role modelling to mum around how to set boundaries and limits and contain Peter and keep everybody safe in the room. The major therapeutic task is around containing him in the space.

In addition to this therapeutic process, the provision of information about the possible effects of child sexual abuse and having access to the accounts of other parents and children (for example Peake, 1997) also appeared to be helpful. Reading this kind of material appeared to 'normalise' the experience, leading to the conclusion that the current situation was not primarily caused by personal failure and to an expectation of recovery based on the experiences of others.

Working on parent-child relationships – feminist and family systems theory

As we have seen, sometimes the therapists' perception was that parents' ability to help the child was limited by difficulties in the parent-child relationship. In such cases having both adult and child present in the sessions offered a chance to work on the relationship.

However, this is sensitive and gendered ground. In Chapter 1 I have reviewed feminist writing that has characterised the family systems orthodoxy as 'mother blaming' where the implication is that mother-child difficulties were a causal factor in abuse perpetrated by men. More recently, Hooper and Humphries (1998) have argued that the polarised nature of the debate may have obscured difficulties in mother-child relationships, some of which may have caused by the abuser as a part of the abusive dynamic. Children may direct a lot of their anger at their mothers, no matter how unfairly, and as we have seen, mothers may have difficulty in containing their children's feelings.

Some therapists have long argued for including mothers in the work (for example Laing and Kamsler, 1991; Print and Dey, 1992). Their argument is that mothers should be seen as allies and not excluded from the sessions. This derives from a feminist understanding

of the dynamics of child sexual abuse. To exclude mothers is to risk reinforcing patterns of secrecy imposed by the abuser and to increase the barriers to mother-child communication that may have been caused by the abuse.

But even where such difficulties may exist, in the aftermath of sexual abuse mothers are particularly sensitive to implied negative judgements about their parenting (Hill, 2001). Negotiating with mothers about the aims of such work is a delicate and highly skilled task, as we saw in the previous chapter. Nonetheless, from the therapeutic perspective, an effective way of promoting change in that relationship is by working on the issues 'live' as they present themselves in the therapy, as we saw with James in Chapter 6, on page 147.

Limitations

Children may need privacy

It might be argued that including parents in the therapy sessions does not respect the need for children and young people to have privacy and confidentiality within their therapy. This argument could be advanced either, as in the previous section, from a psychoanalytic perspective, as a need for 'therapeutic space', or alternatively from a children's rights perspective. Certainly, confidentiality is seen as a fundamental part of the context for therapeutic work with adults (Feasey, 2005).

Two arguments should be taken into account here, one theoretical and the other pragmatic. Firstly, feminist writers have long questioned basic assumptions about the value of independence, as opposed to interdependence. Through empirical studies, Gilligan (1982) identified two contrasting models of human development: the detached approach that values independence, avoids intimacy and is typically adopted by men, and the attached approach that values intimacy, avoids isolation and is typically adopted by women. With Gilligan's analysis in mind, Alderson (1994) challenges the assumption that children's integrity is necessarily threatened when their experiences and decisions are not strictly autonomous, but are shared and influenced by their parents. She cites evidence that suggests, for example, that although children do not want to take fully autonomous decisions about medical treatment they still experience 'shared decisions' as 'very much their own' (Alderson, 1994: 52). Secondly, the pragmatic argument is that children in western society do not usually have independent access to services.

Therapists negotiate with parents or carers about the arrangements for the work, often before meeting the child.

These arguments may be seen as a counterbalance to the arguments in the previous section in favour of an independent, confidential service for children. The study contains examples of cases of each type; that is of cases in which an individual, confidential service was considered the highest priority and cases in which parental involvement was seen as the key. The question of how this was decided in individual cases is one to which we will return in the final section.

Parents may be too distressed

As we have seen in Chapter 7, parents may be deeply affected by the abuse. It may be that the experience of being a part of the therapy session and seeing the child express painful feelings about the abuse adds to the difficulties for parents, even if it is helpful for some children. Once again, the example of Peter is interesting. Here Andrea, his worker, describes the need to 'debrief' Peter's mother after each of the sessions, as a way of helping her to cope with this emotion.

13.1 Andrea 15: I think it has been very difficult for mum. The emotional content of the sessions has been quite harrowing, some of it, and how you respond to that as a parent? What reaction do you have to that, how you deal with that, how might you respond? So I have seen her outside of the sessions for a debrief after the sessions, but it hasn't always been enough on its own. Occasionally she has cancelled sessions, or not turned up and I think that is because she has not been able to face it.

Parents may need preparation

The women who participated in the play therapy expressed some nervousness about joining in the sessions. They saw the therapist as the expert and they were anxious not to do anything that would undermine the value of the session. Neither had much insight into the use of play as a medium for children's self-expression. This meant that the therapist spent time with the women, outlining the basic approach and clarifying what was expected of them. It is not argued that this is a major limitation, but that it is a significant extra task within the therapeutic process.

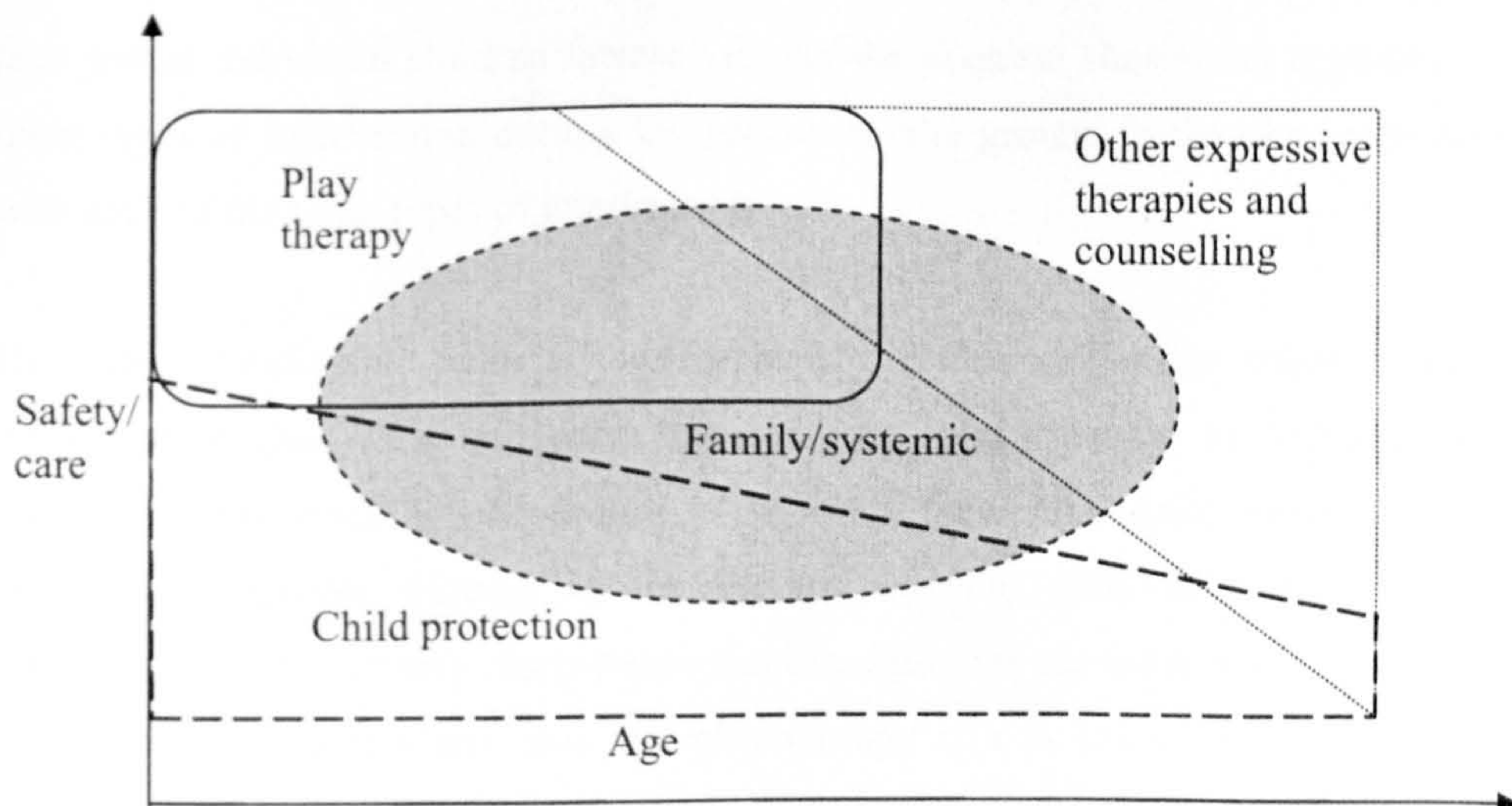
CONCLUSION

In the first half of this final chapter I have used evidence from the findings of the study, Chapters 5-8, to make a general list of the various arguments for and against the two fundamental approaches to therapy that were apparent in the cases under study: namely, parents included in therapy sessions or not. However, in conclusion I need to return to the fundamental issue of how these arguments are weighed up in relation to individual cases. Why is any particular approach adopted in any particular case? How are the pieces put together to make the final picture?

Conceptualising work with parents in the context of children's age and safety

One way of thinking about the question is illustrated in Figure 3 below. This is a two dimensional plot of children's age (increasing left to right) against a notional professional assessment of children's level of safety and/or the quality of their care (increasing upwards). Four types of intervention following sexual abuse are plotted, based on the literature review in Chapters 1 and 2 and according to how they appear to have been used in the cases under study.

Figure 3: Types of intervention by children's age and safety



Firstly there is the rectangle representing 'individual play therapy'. This appears to have been used in the 'safe' cases for younger children. The study did not include any cases in which there was serious concern about children's care or safety, because the team took the view that therapeutic work would be inappropriate in such circumstances. Hence the lower, wedge-shaped, second group of 'child protection' interventions are not much represented in the study. (There may be a small amount of overlap in the few cases with residual child protection concerns). Thirdly, individual work with older young people tended to rely less on play and more on other forms of self expression, verbal and artistic. I have labelled these, 'other expressive therapies and counselling' and they form the triangle in the upper right section. There is some evidence to suggest that it was more acceptable to work individually with older children who were lower down the safety/care axis, particularly when this was their expressed wish. It is also partly perhaps in recognition of the limited prospects for change and the lack of alternatives. I would argue that Caleb (aged 15) fitted this category. The quality of care from his mother may not have been the highest but he wanted individual therapy and did not want his mother to be involved.

It is the positioning of the final type of intervention that is of particular interest. This is labelled 'family/systemic' and is shaded and oval in shape. It is intended to include all those interventions that are aimed at children's relationships with their families rather than just at individual children themselves. As the diagram shows, my argument is that these types of intervention occupy the vacant middle ground in the plot, with overlaps with each of the other types of intervention.

How does this diagram relate to the themes of this chapter? In this scheme, individual work with a child falls into either the category 'play therapy' or 'other expressive therapies and counselling', depending on the age of the child and the choice of approach. Work that includes parents in the therapy sessions falls into the category of 'family/systemic', *but only that portion that overlaps with the other two*. These cases are still high on the safety/care axis and play therapy is a possible alternative. However, whilst this diagram may act as a conceptual device for cataloguing cases, it does not shed any further insight into why, if a case falls into the overlapping section where either might be appropriate, an individual or a family approach is selected.

For that we need to return to the category types that were identified in the previous chapter. These can also be fitted into this scheme. For example, the category of 'supportive mother' indicates that the case is high on the vertical axis, but does not hint at what approach might be taken. For that we need to consider the sub-category. As we saw in Chapter 9, it seems that a key factor in deciding on whether or not to involve mothers directly in the therapy is the judgement about whether their reaction to the abuse is 'normal' or whether it indicates any underlying difficulty in the mother-child relationship. The former is more likely to lead to individual work and the latter to 'family' work that might include mothers in the sessions.

However, even now the diagram in Figure 3 on page 250 is limited in two ways. Firstly, it pays attention to just two main factors, age and safety, whereas as we have seen above, other factors such as perceived difficulties in the mother-child relationship are of vital importance. It is difficult to represent multi-dimensional models on paper. Secondly, it contains the tacit assumption that *therapists* are responsible for deciding on the approach to therapy, after a process of categorisation. In fact, although therapists may make proposals, this is an oversimplification. Parents and children have a vital role in shaping the therapy, by negotiation with the therapist.

Negotiating therapy

It is a fundamental argument of this thesis that initial agreements about the shape of therapy are reached through a process of negotiation between therapists, parents and children. The focus of the negotiation then switches to the conduct of the therapy, with issues about feedback from sessions and perceptions of children's progress coming to the fore. This section reassesses the findings of the thesis so far and seeks to develop a picture of the processes of negotiation that occur throughout the life of the therapy.

Starting points

It may seem an obvious point, but at their first meeting, family members and Agency therapists start from very different places. As we saw in Chapter 1, families' understandings of child sexual abuse may be influenced by media representations. Parents may view the therapists as 'experts' and they may be very willing not only to seek advice and guidance for themselves but also to hand over responsibility for the helping and supporting the child. As we have seen, this is driven by a sense of 'not

knowing what to do'. None of the parents in the study expected to be actively involved in therapy sessions. They appeared to start with a view of therapy as undertaken by a skilled therapist working individually with their child. All the parents expected to be kept informed about the progress of the work although most felt that it ought, in some way, to be kept private. The latter feeling was strongest in relation to older children. However, there was a lack of clarity about how the apparently contradictory imperatives of 'feedback' and 'privacy' could be reconciled. It is also important to understand that when parents first contacted the Agency they were often in emotional crisis. As we saw in Chapter 7, this means that this is not an easy time to be negotiating agreements with therapists.

Therapists, on the other hand, have experience of working with sexual abuse and a considered theoretical and organisational framework for therapy. This has been explored fully in Chapter 5. Therapist expertise is based on various kinds of knowledge; theoretical, tacit and organisational. Therapists appeared to understand and to value the expertise and knowledge that families had in relation to their own history and functioning and to the impact of the abuse. They always attempted to incorporate such knowledge into their assessments. There is also evidence in Chapter 6 that workers seek routinely to give parents confidence in their own expertise. Although therapists appeared to start with the assumption that individual work with the child was the 'normal' model nonetheless, as we saw in Chapter 5, therapists saw advantages in including parents, usually mothers, in the therapeutic work in a range of different circumstances.

The evidence from the children in the study, obtained directly in a few cases and indirectly from parents and therapists in others, indicates that children had very few ideas about what to expect from therapy. Nonetheless there was considerable variation, correlated with age, between those who wanted their mothers present in the therapy and those who did not, whilst many did not express any strong preference.

Key issues for negotiation

Therapists described the beginning of this negotiation as an 'assessment'. As we have seen, there was considerable resistance amongst the team to the idea of assessment as a uniform or fixed process. The team did not use any standard assessment tools. Instead this was envisaged as a phase in the work that included the building of rapport with the

family. Because of the primary interest in parental involvement, this study has not focussed on the worker's assessment of the impact of the abuse on the child, although this is an important element of their assessment. Instead, interviews with workers focused on the role that parents played in relation to the therapy. The accounts that workers gave to me suggest that, during the assessment phase and in their interactions with families, workers are constructing and using a flexible category system of case 'types'. The key category divisions are between:

- Cases where most difficulties in parent-child relationships are related to the abuse and cases where there are significant other difficulties as well
- Cases where mothers are seen as supportive of the child and cases in which this support may be lacking

The outcome of this categorisation is likely to influence decisions about the type and level of parental involvement, as we have seen. Insofar as they necessarily reflect therapists' assessments of the causes of difficulties these categories are linked to issues of blame and responsibility. It appears that workers are weighing up whether parents are part of the problem or part of the solution, or in some complex way a little of both. The outcome of this judgement affects the nature of the working relationship with parents and the shape of parental involvement in the work.

This is not to suggest that therapists are acting in a manner that blames parents, or that they are judgemental (although they do, quite properly, make judgements). Quite the reverse is true; there is plenty of evidence of workers seeking to support women, to see the positives and to raise confidence in their parenting.

This is significant because, as we have seen, women in this position have an acute sensitivity to professional blame. And workers are not the sole arbiters when it comes to determining the pattern of therapy that is adopted. Interventions must be negotiated with parents and with children. The women's accounts show how they have their own concerns, some of which coincide with those of the therapists whilst others cut across them. For example, as we have seen, women do not have automatic faith in professionals as therapists. Women are therefore making their own assessments of the honesty and

trustworthiness of the professionals. Women are concerned primarily for their children and getting some expert help for them appears to be the main issue.

Fathers appear to have a rather different agenda, although only a small number were interviewed and it is difficult to draw strong conclusions. One felt a lack of clarity at first about what role he 'should' play in relation to his child's therapy. When given a choice, for example, "You are welcome to join us if you wish", then he would choose not to participate. He wanted to be involved, but he was not sure how to go about it or what the reaction of female workers might be. In the absence of positive encouragement, the evidence seems to be that men opted out of the negotiation altogether. Although in this case this enabled him to cut off from some of the difficult emotions, this father was uncomfortable with this outcome because of continuing internal and external pressures to become more involved. However, workers had become increasingly aware of this and there was evidence of substantial efforts to involve fathers and to be clear about expectations. In this case this resulted in significant involvement later in the work.

The issues for children are less clear, because of the limited amount of data obtained directly from them. What is clear is that children are in a relatively powerless position in relation to these negotiations over the shape and conduct of therapy. This is despite evidence of a real commitment to child-centred and anti-oppressive practice on the part of the therapists and my conclusions here should not be seen as reflecting badly on the therapists. Rather this reflects the reality of children's experiences after abuse. Children are often in severe emotional distress following the abuse and, arguably, their choices are limited. In their interviews workers talked about the ways in which children often seek to avoid upsetting parents by not expressing difficult emotions, and workers showed concern about the difficulty for children in voicing any dissatisfaction with the process of therapy. Perhaps the main strategy for children could best be summed up by 'avoiding trouble'.

The process

The process of negotiation over arrangements for therapy brings together the perspectives of the three groups; parents, professionals and children. My argument is that the professional perspective is based, in part, on careful listening to what parents and children have to say. Whilst parents and children may feel that they lack expertise, it

seems that workers value the experienced-based expertise of parents and children and, moreover, that they have the 'interactional expertise' (Collins and Evans, 2002) to incorporate it into their practice. However, in the context of therapy following child abuse, negotiating the incorporation of parental expertise may not be straightforward precisely because of the need to negotiate issues of blame.

As noted in the previous chapter, the process of negotiation is easiest when the worker's assessment is that the child's mother is supportive and that any difficulties that she may be experiencing are understandable in the context of the sexual abuse. In these circumstances the chances of the woman detecting (incorrectly) any hint of blame in the therapist's account is much reduced. The difficulties can be clearly understood to be the fault of the abuser. If these difficulties are in the mother-child relationship then it may be relatively straightforward to negotiate mothers' participation in the therapy sessions, with the goals being openly stated. Otherwise the outcome may be individual therapy for the child with close liaison with the mother.

As we have seen, things become more complex when the worker's perception is that there are some difficulties that cannot be construed as arising from the abuse. Here there is an increased likelihood that mothers might feel blamed in some way, and this was an outcome that workers were anxious to avoid. There is evidence that workers were not fully open about such assessments, certainly not in the early stages, and that they were making use of 'indirection' (Stenson, 1993) in interviews so as not to confront the issue in a way that might damage the developing relationship with the mother. This is not to suggest any kind of duplicity. Indeed I would follow Stenson, who argues that it is essential in social work to develop the ability to delay direct discussion of professional assessments that may be difficult for parents until such time as a trusting and positive relationship has been established so that difficult feelings can be contained. In one case in which parenting deficits were addressed openly, the therapist's implied explanation related to the child's prematurity at birth, in a way that helped to resolve the question of blame. This is a clear example of how causal explanations may be utilised by workers to further their therapeutic aims (see Bull and Shaw, 1992).

In another case there was an example of an open disagreement between mother and worker about whether or not to tell a child the truth about his abuser's acquittal in a

criminal trial. This example shows a negotiation, in which the mother holds considerable power by virtue of the implied threat to end the therapy. The outcome was a compromise in which the worker accepted mother's argument that now was not a good time to tell the child, but the mother accepted the need to tell him at a later stage. This case is a good example of mother and worker managing a specific disagreement, effectively by agreeing to disagree, in order to allow the primary objective of therapy for the child to be achieved.

As noted in the conclusion to the previous chapter, the evidence from the interviews that I undertook with individuals led me to take an increasing interest in the process that I have called 'negotiation'. However, the design of the study did not include any attempt to gain access to direct evidence of the interaction between parents, children and therapists. As recorded in Chapter 4, I considered the possibility of asking for access to videotapes of therapy sessions, whether or not parents were included, but decided against this on the grounds that it would be too intrusive given that the team did not have a culture of videotaping sessions. The end result is that what I have been able to say about the process of the triangular negotiation has been constructed from the accounts of the individual parties.

Outcomes

Overall, workers and parents reported a high degree of satisfaction with the outcomes of the negotiations over therapy and of the therapy itself. Parents spoke very highly of workers, highlighting the quality of the relationships that they had been able to build with their children, their skills in play-based therapy and the progress that children had made as a result. Most mothers were also very satisfied with the level of support that they themselves had received from workers, and/or from the mothers' group, although a few felt that they had needed more than had been offered.

In most cases there appeared to be surprisingly little difficulty in identifying when to end the work, and usually this was done by agreement. There is a real sense in workers', parents' and children's accounts of it being somehow obvious that things got better and that it was time to end. As we have seen, workers referred back to the aims of the work and talked about the extent to which they had been achieved. Parents talked about children returning 'to normal' and children talked of 'feeling better'. This applied equally

in cases where parents had participated in the therapy sessions and where they had not. It seems that parents had little difficulty in recognising when their child's behaviour was no longer showing signs of being affected by the abuse.

Final reflections on 'partnership' and professional expertise

One of the outcomes of this research has been a greater understanding of how the professional perspective in social work, with its language of 'assessment', 'theory' and 'therapeutic intervention', is only one part of the story. Interviewing parents and children for this research has increased my awareness of just how active they are in shaping the course, in this case, of the therapeutic undertaking. It seems that this is not just a case of responding to the therapists' views, arrived at after a professional assessment; although there are examples of parents accepting, resisting or rejecting these. Rather, parents and children are actively involved in the process of developing, with the therapist, a shared understanding of what has happened, what the effect of the abuse has been, and what should be done to help. This process, which I have described as the negotiation of therapy, is achieved by talking. From a narrative perspective it could be seen as the joint construction of a credible account. It involves the efforts of both the family and the therapist, although the balance may shift throughout the process. The family may be most active in describing the circumstances and impact of the abuse, although, as in my research interviews, the role of the interviewer in shaping the account remains influential. On the other hand, the therapist may be most active in describing potential therapeutic approaches.

One of the clues that alerted me to the significance of this process was the way in which workers talked about their practice in relation to assessment. In their account, as we saw in Chapter 5 and above, assessment cannot be divorced from the process of relationship-forming. Workers rejected the idea that they applied standardised, objective assessment tools to families. Instead, they talked with families and, through a process of reflection, reached a view about what was happening and what might be done to help.

There are links here with the literature reviewed in Chapter 3 about the development of professional expertise. Certainly there is evidence of therapists rejecting the role of detached observers and instead acting as reflective, self-knowing and responsible actors, aware of power relations (Fook, 2000). Expertise within the team has been developed in

dialogue with families, not merely by observing them (Närhi, 2002). I have argued that this reflects the 'interactional expertise' of workers (Collins and Evans, 2002): their ability to interact with the experience-based expertise of families. However, workers' interactional expertise is seen primarily at the level of casework. Arguably there is room for the collective expertise of parents and children to interact with that of workers at a more general level, perhaps in a meeting between the team and the mothers' or couples' support group. This would allow parents with experience-based expertise to contribute to the kind of discussions reported on in Chapter 5. However, it would require workers to develop their 'interactional expertise' to a new level.

Returning to the level of individual cases, in many of them there was evidence of a genuine partnership between the professionals and the family. However, the most difficult issue was the always the question of blame and culpability, and this was a cause of much tension. As we saw in Chapter 3, generally in the context of child protection there may be limited opportunities for working in partnership with parents. But the Agency's therapeutic work takes place in the aftermath of a child protection investigation and offers the opportunity to engage with non-offending parents. Even so, there is evidence that mothers in the study were particularly sensitive to having their parenting judged by social workers, because many already felt that the abuse meant that they had failed in some way as mothers. Therapists too were acutely aware of this and so, when workers reached the view that mothers needed some help with parenting, or to improve their relationship with their child, they were very careful indeed about how this was communicated. Sometimes the difficulties were construed as having been caused by the abuser, or otherwise as not being the mother's 'fault'. In other cases workers were very skilled at not accidentally implying criticism and so no such criticism appeared to have been heard by the women involved.

What this shows is that workers are highly skilled at forming and maintaining working relationships with families, even when there are areas of potential tension or even disagreement. They seem to have an ability to 'contain' irreconcilable tensions in a way that is acceptable to everyone, but without necessarily resolving them. A key example of this concerns the central triangular dynamic between parents, children and workers. As we have seen, parents who are not involved in therapy sessions accept children's need for

privacy and yet expect 'feedback'. So how is this achieved? Edith explained it in a passage quoted earlier:

2.1 Edith 29: Andrea (*the worker*) always rings me if there is something she feels she needs to ask me or if Felicia has said something in the session that she's not sure about, she'll get Felicia's permission if she can tell me. It's their being open in that way, because if they weren't open in that way then you'd feel very threatened, very excluded from it. I think they've got a very fine line to tread in keeping confidentiality of the child so the child trusts them ... but they've also got to be able to talk to the parents so the parents doesn't feel like they are being undermined and things are being done behind their back ... or things might come out in a couple of weeks time and you haven't got a clue why. So it's a case of working together, and not working together. (*Laughs*). It's a clever balancing act and it comes down to not just simply workers that's trained and done other courses and maybe have some experience, it's a personality thing it's being open and not judgemental.

Edith points not to training but to personality. For her it is not about formal knowledge but about how workers present themselves. Women need to feel that they can trust their worker and that they are not being judged.

It has been an unexpected conclusion of this study that one of the key factors in these complex negotiations over therapy is the ability of workers to display 'interactional expertise'. In the context of therapy, this means the ability to recognise, to value and to incorporate the experienced-based expertise of families, whilst not undervaluing professional expertise and not losing sight of professional responsibilities for child protection. As we have seen, in cases where there is some professional concern about parenting this may lead to complex balancing acts in which acceptable accounts of the causation of mother-child difficulties, or the use of 'indirection' may be employed to maintain a working partnership with parents. Pre-requisites for the development of such interactional expertise are the possession of subtle inter-personal skills based on good communication and the ability to be reflexive and self-aware.

APPENDIX ONE

VIGNETTES

Sarah, aged 4

Sarah has been referred by social services following an inconclusive police/SSD investigation into the suspicion that her father sexually abused her on agreed contact visits. Sarah's mother has stopped the contact and the police and SSD are not planning any further action. The referring social worker believes that it is very likely that Sarah was abused, and that her mother will prevent further contact with her father. The strongest evidence came from things that Sarah said to her mum about her dad. Mum found these confused and difficult to understand and reported them to the SSD as suspicious, though she was unsure whether they definitely indicated sexual abuse. Sarah has not said any more. There have also been examples of unusual sexualised behaviour.

The referral came about because Sarah is not sleeping well: she is reluctant to go to bed and she wakes up with nightmares. Sarah is frightened to go outside and, in particular she becomes highly distressed if made to travel in a car. It is thought that the suspected abuse took place in a car, possibly on a journey. Sarah is now very nervous with strangers, especially men, and wants her mother with her at all times.

Angela, Sarah's mother, separated from Sarah's father, her partner of 6 years, about 6 months ago. She suspected him of having a relationship with another woman. Nonetheless, Angela was still trying to come to terms with the idea that he might have abused his daughter. She feels that this reflects badly on her as a judge of character, and she is still not entirely sure how to interpret what she heard, and Sarah's behaviour. Angela has a son age 16 and a daughter aged 13 from a previous marriage. The two teenagers got on very badly with Sarah's dad and they were pleased to see him go.

Gary, aged 8

Gary is the second child of Tony and Diane. He was sexually abused by a 17 year old male cousin of his, at the nearby cousin's house, over a two year period. The cousin in question is Tony's nephew. He was convicted in court, having denied the offences, with Gary giving evidence.

You have been working with Gary for some time. He has been expressing a lot of anger about the abuse. He says that he told his mum ages ago that he no longer wanted to visit his cousin's house, (without telling her about the abuse), but she insisted, particularly during school holidays when there was no other child care. He sounds angry with her. Gary is also concerned that his dad might be angry with him, because this has resulted in an argument between Tony and his brother and the two are no longer talking to each other. Dad's brother had accepted his son's denial and believes Gary to have invented the allegation. Gary does not appear to be entirely confident about his dad's position.

Both parents tell you that the abuse has had a really serious impact on them, with the court case taking over their lives for a while. The break with Tony's family has been traumatic. They have always said that they want any help you can provide to be given to Gary, and not to them, since Gary is their priority. Tony, in particular, has said that he is not confident in talking to Gary about sex, or about the abuse, and would not know what to say. He appears nervous about engaging with professionals. Diane is more open, talking about the way they both seem depressed and hinting that it has had a negative impact on their relationship.

Jenny, aged 14

Jenny has been sexually abused by her mother's partner. Mother separated from him soon after finding out. The abuse came to light after Jenny told a friend. Jenny is beginning to use the therapy to talk about the abusive relationship, and about her mother's reaction to finding out.

Darren, aged 13

Darren has been sexually abused by a friend of the family. He has become very withdrawn and both parents say that he won't talk to them about it. They are extremely worried about him and feel guilty about their apparent inability to help him. In therapeutic sessions Darren appears depressed a lot of the time, but he is beginning to express some anger.

APPENDIX TWO

INFORMATION LEAFLETS (see note on page 265)

For adults

Front

Contact Details

If you are prepared to consider taking part in this research study then please complete the following form.

This form does not commit you to taking part. The researcher, Andrew Hill, will contact you to give you further information and answer any questions you may have.

Parents' Names.....

Child(ren)'s Name(s).....

Address.....

Tel.....

Andrew Hill
Lecturer in Social Work
Department of Social Policy and Social Work
University of York
Heslington, York
YO10 5DD

tel: 01904 321268
email: ah33@york.ac.uk

The Researcher

The researcher is Andrew Hill, a Lecturer in Social Work at the University of York. Andrew has many years' direct experience of undertaking therapeutic work with children and he has worked in the Agency team in XXXXXX. More recently he has written about the impact of child sexual abuse on whole families. He has acted as a consultant to the Agency at national level during an evaluation of therapeutic services.

Clearly, this research concerns very painful and sensitive topics. The Agency and the researcher are committed to respecting the views and confidences of the families who agree to become involved in the project, and to being sensitive to their feelings. The identities of individuals would be known only to the researcher. The location of the Agency team would be disguised in any public documents.

THE UNIVERSITY of York

Children, Parents And Professionals: Working Together For Recovery After Child Sexual Abuse

A unique research project at XXXXXX seeking answers to questions such as:

- What can parents do to help their children to recover from sexual abuse?
- What might parents themselves need in order to help their children?
- How can parents best support the work of professional therapists, and how can therapists best support parents?
- What do children themselves want in the way of help from parents and professionals?

Back

Background

The Agency in XXXXXX tries to help children and young people in ways that fully include their parents. Experience shows that parents can have a powerful, supportive influence on children's recovery. But most of the expertise in therapy is about the therapist and the child. Very little is known about how parents might help the process. Many parents, especially mothers, say that finding out about the abuse has a devastating impact on them. They sometimes feel excluded from professional work with their child. So how can such parents help the work of therapists, and how therapists can support parents?

The findings will be important for professionals who undertake therapeutic work with children. We will produce a report for the Agency and seek publication of the findings in professional and academic journals.

THE UNIVERSITY of York

Aims

- to gain a better understanding of the relationship between professional therapy for children and support from their parents
- to seek the most effective ways of maximising parental support for children's recovery
- to seek the most effective ways of integrating this with professional help
- to explore the usefulness of professional support for parents in the context of seeking to help their children

How You Can Help

We are seeking parents, children and young people who are willing to talk about their experiences of therapy, perhaps soon after it starts and then again at the end. We are also seeking your agreement for the researcher to talk to your Agency worker to gain her impressions of the work, and to read your case file.

Safeguards

Clearly, this research concerns very painful and sensitive topics. The Agency and the researcher are committed to respecting the views and confidences of the families who agree to become involved in the project, and to being sensitive to their feelings. The identities of individuals would be known only to the researcher. The location of the Agency team would be disguised in any public documents.

What To Do Next

This leaflet cannot answer all the questions that you may have about the project. If you are prepared to consider becoming involved then please complete the form overleaf and give it to your Agency worker.

For children

Front

Contact Details

If you think you might want to take part then please fill in the form below.

This form does not mean you definitely want to take part. It just means that the researcher, Andrew Hill, will contact you and your parent(s) to give you further information and answer any questions you may have.

Name

Address

.....

Tel.....

Andrew Hill
Lecturer in Social Work
Department of Social Policy and Social Work
University of York
Heslington, York
YO10 5DD

tel: 01904 321268
email: ah37@york.ac.uk

The Researcher

The researcher is Andrew Hill, who works at the University of York. In the past Andrew was a worker at the Agency team in XXXX and he is used to playing and talking with children who are recovering from abuse.

It may be that some of the things you might talk to Andrew about could be difficult or upsetting. Andrew will do his best to be sensitive to your wishes and feelings. You can talk to your Agency workers if you have any worries about this. Above all, although we want to learn from your experiences, we will **not** tell anyone else who you are. Andrew will be the only person to know this. He will not even say in which town the research was carried out.

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Children, Parents And Agency Workers: Helping Children And Young People To Recover From Sexual Abuse

We are trying to find the best ways for parents and Agency workers to work together to help children. Can you help us find answers to questions such as:

- How do you think your parent, parents or carers are involved in your work at the Agency?
- Are there any other ways they could get involved that would be helpful?
- What is it like for you when your worker talks to your parents about the work with you?

Back

Background

The Agency in XXXXX tries to help children and young people by involving their parents in the work. We think that having the support of parents may help children to recover. However, we don't know what children and young people think about their parents being involved in their work at the Agency.

We want to find out by talking to children and to their parents. We are calling this a "research project".

We think that the results of this research project will help everyone who works with children who have been abused. When it is finished we will write about it so that they can find out more.

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Aims

- to find out what it is like for children and young people when their parents are involved in the work
- to find out what is the best thing that parents can do to help children to recover
- to work out how everyone can work together to help children

How You Can Help

We want to find children, young people and their parents who are willing to talk to the researcher, Andrew Hill, about what it is like to come to the Agency. You would probably meet with him twice, once soon after your work starts and then again at the end. We would also like you to agree to let Andrew talk to your Agency worker, and to let Andrew read your Agency file.

Keeping It Safe

It may be that some of the things you might talk to Andrew about could be difficult or upsetting. Andrew will do his best to be sensitive to your wishes and feelings. You can talk to your Agency workers if you have any worries about this. Above all, although we want to learn from your experiences, we will **not** tell anyone else who you are. Andrew will be the only person to know this. He will not even say in which town the research was carried out.

What To Do Next

You probably have more questions about the project. If you are prepared to consider becoming involved and want to talk to Andrew about it then please complete the form over the page and give it to your Agency worker.

The above are scaled-down, photographic reproductions. The originals were A4 in size and designed to be folded in three vertically. In these reproductions the name and location of the Agency team has been deleted.

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