"It Affects You For a Lifetime"! Perspectives on Child Sexual Abuse in Jamaica

A Qualitative Study

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Jamaica NONE in three

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Message from the Commonwealth Secretariat

It is a scourge on our global society that even today, one in three women and girls experience physical or sexual violence in their lifetime. Gender-based violence (GBV) is a crisis that extends beyond national and socio-cultural boundaries, across the globe, and across our Commonwealth member countries alike. It affects people of all ages, genders, ethnicities, and economic backgrounds. It is an urgent, world-wide human rights issue.

Recognising this, national governments, international bodies such as the United Nations (UN) and non-governmental organisations (NGOs), have developed strategies to end violence against women and girls (VAWG). Appropriate national and international laws are a crucial component in safeguarding women's and girls' rights. But alone, they are not enough. From the moment they are born, millions of girls are subjected to multiple forms of violence including rape, female genital mutilation (FGM), sexual exploitation and child marriage. Survivors may experience trauma, drop out of school, suffer from mental health problems, all of which also have significant social and economic costs.

In spite of the progress made over recent decades, the statistics still tell a shocking and unacceptable story, as do the harrowing individual experiences of the survivors of GBV interviewed by the None in Three Research Centre for this report.

Child sexual abuse (CSA) is a major form of GBV in Jamaica. The Planning Institute of Jamaica reported that 255 children were victims of rape in 2016[1]. Growing CSA trends in the Caribbean include the over sexualisation of children, and its normalisation[2]. The None in Three Jamaica team is seeking to prevent this form of child abuse through their research.

Media attention in countries across the globe raises consciousness of the issue in waves, from the Me Too movement, to the reported 'hidden' pandemic behind the 2020 lockdown due to Covid-19 – a surge in domestic abuse. This is not a new phenomenon, but the growing awareness is a catalyst for action to which we must respond. All countries, all societies need to work to eradicate this pandemic that affects one in three women in their lifetime.

The Commonwealth Secretariat is working alongside partner organisations on measures that will help our 54 member countries to stem the rising tide of GBV, especially school related GBV. Educating to actively promote a gender equal, respectful, non-violent culture with gender aware pedagogy or approaches is key. As a member of the Global Working Group to End School-Related Violence, the Secretariat aims to help practitioners and policy makers in the education sector, apply a gender lens when developing violence prevention, response approaches and safeguarding. Schools related gender-based violence (SRGBV) affects millions of children and young people, especially girls.

The Ni3 Centre's approach, which we in the Commonwealth subscribe to, is one of prevention through high-quality, gender sensitive education. By engaging young people as adolescents, when attitudes and opinions are forming, we stand the best chance of influencing them for good. The potential for adolescents and young people to act as agents of change and achieve the social transformation necessary to end GBV is tremendous. None in Three's approach includes developing and testing immersive, pro-social computer games, themed around issues of GBV, to help young players build empathy with victims, and to prevent future violence.

We welcome this research and the accompanying three reports (from None in Three in India, Uganda and the UK) and the contribution that the innovative approach could make to our work. By listening to the lived experiences of both victims and perpetrators of GBV in four study countries, the global research centre has built up a solid evidence base for each of its culturally appropriate, educational video games. It will therefore provide a new resource to help end GBV including school related GBV.

Through renewed commitment and concerted action, we can end domestic and gender-based violence.

Layne Robinson
Head, Social Policy Development
Commonwealth Secretariat

1 *Unicef, 2018, Situation Analysis of Jamaican Children, read online*
2 *Jones & Trotman Jemmott, 2016, Twenty-one lessons: preventing domestic violence in the Caribbean read online*

Foreword

The problem of Child Sexual Abuse (CSA) in Jamaica is intractable. Many reports and scholarly papers have created a body of work that has highlighted the cultural underpinnings of the practice and the ways in which victims are permanently traumatised. This prior work has led to the establishment of institutions to remove children from abusive situations and laws to deal with perpetrators. Yet, as this research report reveals, the problem still exists and is in need of greater national attention. Aptly titled, “It affects you for a lifetime!" Perspectives on Child Sexual Abuse in Jamaica, this research report adds unique insights to the existing store of knowledge. The team has done an excellent job in the research and writing of this important and useful report.

This document presents the findings and conclusions of qualitative research done among Jamaican survivors of CSA in the context of a global project titled None in Three (Ni3). Its investigative techniques are scientifically sound. The voices of the victims are presented with authenticity as they bear witness to the inestimable damage done to their lives while they were vulnerable, young and helpless. The findings are presented with singular granularity that makes compelling reading. This report is certain to stimulate dialogue and the search for further solutions for this severe national problem that affects male and female with devastating personal and societal consequences.

We confirm through this important research work that CSA in Jamaica is composed of contact and non-contact abuse. Survivors experience physical, verbal and emotional damage. The average age of onset is nine (9) years old. Touching, penetration, pornographic performances are part of the spectrum enforced on children due to financial dependence, shame and fear of repercussions.

The drivers of CSA in Jamaica are multi-layered and multifactorial. These include myths, culture, lack of parental supervision, child shifting, poor educational preparation and limited awareness of children’s rights.

Survivors report maladaptive and destructive behaviours that last a lifetime. They speak of the consequences of poor emotional and psychological support. General emotional distress leads to anger, hostility, homicidal thoughts and suicidal ideation. Poor interpersonal relationships, lowered academic performance and becoming dysfunctional at work are all part of the deleterious impact of CSA. Many victims do not come forward because of an inadequate justice system that often shames the victim, scars familial relationships and damages social positioning.

From the evidence unearthed, so much is left to be done to mitigate against the problem of CSA and quell the hurt and trauma that it causes. There needs to be a system of therapeutic justice and psychological support to enable salutary and positive healing effects. The report suggests several policy, practice and societal changes that could lead to remedy. The solutions require comprehensive and multi-disciplinary approaches.

Finally, this report, “It affects you for a lifetime...” leaves me with the haunting images of helpless children suffering and shuddering in silence, in fear of recrimination from family and society, as they endure the maltreatment of a lifetime. Alone and vulnerable, like lambs to the slaughter.

Ellen Campbell Grizzle CD., PhD., R. Ph
Member, International Advisory Group, Ni3
Associate Professor, University of Technology, Jamaica

Acknowledgements

We would like to say thanks to the University of Technology, Jamaica, the local home of our research centre, for providing the environment to enable us to be involved in such an important effort to help stem child sexual abuse in Jamaica. Special thanks are extended to the participants of our in-depth and focus group interviews, who have entrusted us with sensitive yet vital information that will be used to educate, enlighten and effect social as well as policy change in our country. We also extend appreciation to our counterparts from the other country teams in India, Uganda and the UK who exchanged ideas at various points along the way during the research process. Additionally, this study would not have been possible without the kind support of our many valued stakeholders which include:

Centre for Investigation of Sexual Offences and Child Abuse (CISOCA)
Child Protection & Family Services Agency (CPFSA)
Children First
Choose Life International
Dispute Resolution Foundation
Eve for Life
Girl Guides' Association
Institute of Gender & Development Studies- University of the West Indies
Jamaicans for Justice
Men of God against Violence and Abuse (MoGAVA)
Ministry of Education, Youth and Information
Ministry of Foreign Affairs and Foreign Trade
Ministry of Health
Ministry of Justice
Ministry of National Security
National Council on Drug Abuse
Soroptimist International Club of Jamaica
The National Parenting Support Commission
UNICEF Jamaica
Woman Incorporated (Crisis Centre)
Women's Centre of Jamaica Foundation
Women's Media Watch
Women's Resource & Outreach Centre
Young Women Christian Association (YWCA)

Contents

Abbreviations

CAPRI	The Caribbean Policy Research Institute
CISOCA	Centre of Investigation of Sexual Offences and Child Abuse
CPFSA	Child Protection and Family Services Agency
CSA	Child sexual abuse
GBV	Gender-based violence
OCR	The Office of the Children's Registry
UNHCR	UN High Commissioner for Refugees
WHO	World Health Organization

Executive Summary

UNICEF[3] estimates that at least **120 million adolescent girls** under the age of 20, or about **one in ten, experience child sexual abuse worldwide**. The figures for Jamaica are also staggering, as the Child Protection and Family Services Agency (CPFSA)[4] reported just under **2,500 cases** between January and October 2018, in a population of **2.7 million**. The figures for boys are unknown as fear of stigma or reprisals lead to underreporting by boys.

The aim of these studies was to gain an understanding of child sexual abuse through the eyes of adult male and female survivors in Jamaica.

3 *UNICEF. (2014). Nearly one in four adolescent girls experience physical violence, read online*
4 *The Gleaner. (2018). Horrific! - 20% Spike in child abuse cases reported to cpfsa so far this year, read online*

Method

Two sets of qualitative studies were conducted.

One was in-depth interviews with female survivors of child sexual abuse ages 17 and older.

Each interview took place in a secure and safe environment with an interviewer.

A total of ***15 females*** participated in the study.

With their permission, the interviews were audio recorded and were later transcribed verbatim. These transcripts were later analysed by four local Jamaican researchers, to see the themes that emerged.

A study was also conducted with male survivors of child sexual abuse.

Two focus group interviews were conducted. The first with male survivors aged 16-25 years.'

The other focus group interview took place among male professionals who work with ***male survivors*** of child sexual abuse. All male participants gave permission for their interviews to be recorded using audio-recorders. These were later transcribed and analysed by a team of four local Jamaican researchers.

All participants chose a pseudonym (false name), by which they were called throughout the interview. Their names and identities were kept confidential. Before conducting any of the interviews, ethical approval was gained from the University of Huddersfield's School of Human and Health Sciences Research Ethics Panel and the University of Technology, Jamaica, Ethics Committee.

KEY FINDINGS

EXPERIENCES OF ABUSE

Findings from our research indicate that child sexual abuse, which was perpetrated by individuals known to the victim such as family members or family friends, involved physical as well as verbal/emotional abuse. ***The age of onset of abuse ranged from 4 years to 15 years of age. The average age was 9 years old.*** CSA which involves physically touching the child's sexual regions or forcing the child to touch the perpetrator's sexual regions is referred to as contact sexual abuse, while noncontact abuse involves verbal harassment or forcing a child to engage in pornographic images or films. The experience of survivors included both contact and noncontact sexual abuse.

This research also reveals that ***child sexual abuse happens as a result of multiple factors including: negative cultural perceptions and myths which normalise CSA; low socio-economic status; negative parental factors; child shifting (i.e. the practice of sending children to stay with friends and relatives for extended periods of time); and prior victimisation.*** Among the low socio-economic factors were issues concerned with financial difficulties and residing in disadvantaged communities, in substandard living arrangements which increased vulnerability to abuse. Lack of adequate supervision and poor parent-child relationship were identified as some of the negative parental factors which contributed to sexual abuse.

EFFECTS OF ABUSE

CSA is associated with adverse outcomes, which are not just experienced over the short term immediately following the abuse, but can persist throughout the survivors' lives. Female survivors reported challenges with psychological functioning, interpersonal relationships, academic and occupational functioning, and inappropriate behaviours. They experienced significant emotional distress resulting in a range of emotions, as well as suicidal thoughts, self-harm behaviours and poor self-esteem. In addition, CSA was associated with challenges with intimate relationships, sexual functioning, and parenting. Female survivors also reported that subsequent to the abuse, they struggled in various aspects of their academic and occupational lives. Further, perhaps in an attempt to cope, some survivors engaged in externalising behaviour such as the use of substances, stealing, and gambling.

DISCLOSURE

After the abuse occurred, it was revealed that ***survivors experienced mixed emotions including anger, disappointment, despair, shame, and confusion. This resulted in disclosure being delayed in many instances. Some respondents reported that they did not want to tell anyone about the abuse*** for various reasons. These included:

- fear of disbelief by others;
- fear of what might happen to their family especially when they relied on the perpetrator financially;
- blaming and shaming by others especially family and community members;
- feeling the need to protect the perpetrator due to power and status as well as relationship with the family.

Other reasons given included the long process cases take in court, in some instances up to three years. This was worsened by the fact that they would have to face the perpetrator in court for several appearances during this period, which the survivors found to be traumatic. Some explained that even when formal reports were made, they decided either not to identify the perpetrator as such, or to drop charges before the court cases were finished.

For those who decided to tell someone about it, this was found to be easier when there was someone who took the time to be supportive, to listen and intervene. Having someone who had gone through similar experiences was encouragement to share or reveal their own experiences as well. In other instances, the disclosure was not planned; it came out either because they had medical conditions that caused them to go to the doctor or because others observed changes in their behaviour and investigated or probed as to the reason for these changes. In a few cases, the first time that disclosure was being made was in the interview for this study. All persons who required intervention were signposted to psychiatrists or psychologists who had previously agreed to provide such services pro bono to such individuals.

COPING AND RESILIENCE

The strategies used for coping by survivors are not static but can change over time. Both positive and negative coping strategies were employed. Writing about the abuse was an important coping strategy used by several participants. Some utilised various escape strategies to avoid the effects of the abuse. These included substance use, singing, doing puzzles, playing games or hanging out with friends.

PERSPECTIVES ON MALE SEXUAL ABUSE

CSA can also be severely traumatising for male survivors. Focus group discussions with practitioners who work with male victims of CSA reported that boys/men show a range of adverse outcomes, some of which are similar to those reported for female survivors, but in some cases expressed differently. In our focus groups, male survivors described experiences such as:

- aggressive behaviours;
- hyper-sexuality;
- out-of-control behaviours;
- hyperactivity;
- problems with authority;
- poor social interactions;
- use of indecent language;
- poor academic outcomes; and
- smoking.

In addition, findings from the focus group discussion with male practitioners revealed that non-disclosure of sexual abuse among boys was a result of flawed perceptions or beliefs. Such misconceptions led to sexual abuse being viewed as a 'rite of passage'.

Other factors which contributed to non-disclosure among boys included lack of knowledge that they were victimised, fear of negative reactions to disclosure, and pressure from family to conceal the abuse.

Conclusion and Recommendations

Overall, the evidence is compelling that CSA is a severe problem within Jamaican society. CSA continues to be perpetuated due to social and cultural factors that help to limit disclosure and normalise CSA within communities and society at large. The result is that survivors are left feeling isolated and can suffer adverse consequences of abuse; most times, not receiving the help they need to cope with the abuse. On their own, they may develop maladaptive coping mechanisms to "heal" themselves, but this is not inevitable: some survivors demonstrated that resilience and recovery may also be possible. Nonetheless, it is apparent that there are many gaps to be filled in addressing CSA in Jamaica. It is also quite clear that a multifaceted approach needs to be taken to tackle CSA, with the aim of reducing the number of incidents and providing necessary support to victims.

The following recommendations are made in light of the findings of this research.

Raising awareness and improving knowledge about CSA using school-based interventions

To help children and their carers to understand the many factors associated with CSA, there needs to be a drive to increase public (including children's) awareness about the signs of CSA and sexual grooming. Providing developmentally appropriate information to children about CSA is pivotal to facilitating disclosures. Teachers also benefit, as they too can be informed about signs of CSA and how to act on helping children with disclosure and reporting. Further, there is some evidence that parental involvement can result in knowledge and attitudinal gains and increase support for their children. School-based programs should:

- Have evaluation of effectiveness built in
- Incorporate modelling, discussion and skills rehearsal
- Be at least four to five sessions long
- Have the capacity to be delivered by a range of personnel
- Involve active parental input

Educating the public about CSA - promoting CSA prevention is everyone's responsibility

Enormous effort must be made to educate the public to change negative attitudes about CSA. One way of doing this, is through the use of social marketing campaigns aimed at increasing the awareness of members of society so they understand that CSA is wrong and ought not to be tolerated. This may include the use of music, dub poetry, traditional and social media, or other channels that are culturally relevant and appealing locally. Mass media have great potential in positively building awareness of and changing attitudes about CSA.

Empowering parents and other family members to facilitate disclosure and support for children

Family members must actively engage in the prevention of CSA by breaking the silence and taking a zero-tolerance approach to CSA. Additionally, parents, guardians and other family members need to be empowered, through education, with information about how to appropriately prevent CSA and respond when a child discloses sexual abuse. Conducting educational social group work sessions on child sexual abuse with the family members is a starting point in preventing and responding to CSA. This prevention strategy focuses on educating family members about sexual abuse, with the objective of strengthening families on the topic. The objectives of these educational work sessions should include:

- defining child sexual abuse
- discussing measures to be taken when the child is sexually abused
- describing factors that put children at risk of being sexually abused
- discussing the rights of children in respect to care and protection
- describing the impact of child sexual abuse
- discussing the importance of communication within the family system
- discussing the importance of providing care and protection to children and the role of professionals

Conclusion and Recommendations

Sensitisation training for frontline staff who are a part of the judicial process

Frontline staff in the judicial system need to be adequately trained in how to appropriately respond to persons who are victims of CSA. The roles of police officers and prosecutors are important in CSA cases and their actions can affect the outcome of investigations and legal consequences associated with CSA. In addition, the police, especially the special unit for handling CSA cases, should establish proper protocols and guidelines in conducting investigations into CSA, interviewing child victims and suspects. Further, due to the recognition that poor interviewing can result in emotional distress, alienation of children, and inaccurate assessments of allegations, police officers and other professionals within the Centre for the Investigation of Sexual Offences and Child Abuse (CISOCA) should receive specialised training in child forensic interviewing.

Prosecution and rehabilitation of perpetrators

As was found in our research, most victims of CSA did not receive justice, due to their cases being inadequately investigated when disclosure was made to police officers. Therefore, greater enforcement of the law is required, in order to prevent new and/or prolonged cases of child victimisation. Jamaica already has the legislative framework established to tackle sexual abuse and violence and therefore, full enforcement of existing laws is paramount to dealing with perpetrators and officers must be objective and proactive in their investigations of abuse. The law and its consequences for sexual abuse must be well publicised until the very thought of it becomes a deterrent to anyone engaging or thinking of engaging in such acts.

In order to effectively respond to CSA, remedial/rehabilitative programmes for perpetrators must be implemented following prosecution. Rehabilitation programmes for perpetrators of CSA are needed to reduce the likelihood of perpetrators becoming repeat offenders. Perpetrators of child sexual abuse have often been victims themselves and victimisation issues should be raised in offence-focused treatment programs to resolve early trauma.

Establishing child friendly courtrooms

For child sexual abuse victims, going through the court system can be stressful and lead to significant distress. The following measures may help to ease survivors' level of distress as they interface with the justice system.

- Video recording of evidence in chief and the use of Closed circuit television (CCTV) to conduct a remote cross-examination (however, both of these 'special measures' reduce the likelihood of the case ending in a conviction) should be used as an alternative method of sharing victims' testimony, thus sparing the victims the potentially re-traumatising effects of having to face the perpetrator. Testifying in front of the accused is the most difficult part of the court proceedings for some children and protecting children from being in contact with the accused during the court proceedings may help to reduce their stress and anxiety.
- Support should be given to child victims and their families to ease distress and provide realistic expectations of court proceedings. For instance, courtroom visits prior to actual court dates are recommended for children in order to help with desensitisation. Family members should be involved as well, as they too may be anxious, and this may inadvertently be transmitted to the child.
- CSA is difficult to prove and prosecute. This is due to the fact that the child victim is usually the only witness, which makes their testimony exceedingly important however, because of the overwhelming nature of the courtroom and the court case, children sometimes freeze or become anxious in the middle of testimony. Having a child-centred court that adopts a sensitive position to cases of CSA is paramount. It is critical that lawyers, judges and other court officials receive adequate training in how to recognise when a child is anxious and upset or becomes dissociated.

Improving efficiency and delivery of services within Child Protection Agencies

More child-care personnel are needed to work within Child Protection Agencies (Child Protection and Family Services Agency, Centre for the Investigation of Sexual Offences and Child Abuse, Office of the Children's Advocate) to assist with educating the general public, investigations, and processing of reported cases of CSA; thus improving response to CSA and reducing the waiting period. Greater empathy, as well as other psychological support and training, is needed among child-care professionals, to foster an environment of trust. Child service agencies should then be equipped with non-financial resources such as self-instructional materials or resource libraries. Adequate training in the form of workshops or conferences for agents may also prove useful in improving delivery of services to victims of child sexual abuse.

Medical and mental health services

In cases where current or on-going abuse is reported to the police medical examinations of CSA victims can provide important physical evidence in child sexual abuse cases, as well as detect when sexual abuse has occurred. Therefore, medical professionals including paediatricians and family doctors must be aware of the medical indicators of and conditions related to sexual contact and alert the authorities when they suspect cases of CSA. It is also important that at least some of these professionals are trained in child forensic medical examinations. Recognising that this recommendation will generate some concerns, consideration should be given to routine and standardised screenings for CSA being built into the healthcare system since evidence suggests that a brief screening tool where practitioners ask the child one or two questions can be used to identify children who have experienced sexual trauma.

Experiencing CSA can be detrimental to the health and well-being of survivors and their families. This can also be exacerbated by unsupportive interactions with medical personnel and the criminal justice system. There needs to be increased effort made to prevent survivors from enduring the mental health sequelae that can be associated with CSA. Routinely, once a child who has experienced CSA presents at an agency/organisation, they should be referred to support from professionals trained in this area to help them process the experience in a way that does not lead them to manifest expressions of mental distress. Mental health services should be available to survivors of CSA at various stages, from the point of disclosure, while going through the legal process, and even for some time after. In addition, it is critical that mental health practitioners are skilled in using evidenced-based treatment for CSA.

1

Introduction

“GBV presents one of the greatest impediments to women’s well-being and their right to equal citizenship”

(Robinson 2008)

Gender-based violence (GBV) is considered a major public health problem and violation of the fundamental human rights of women across societies (World Bank, 2019). It encompasses threats of violence or coercion perpetrated against any individual and is typically based on gender norms and socially driven power inequalities between men and women. GBV can be physical, emotional, psychological or sexual in nature, and affects both genders (UN High Commissioner for Refugees (UNHCR) Emergency Handbook, 2015). However, while boys and men are also affected, GBV disproportionately affects more women and girls (UNHCR, 2012).

None in Three Research Project

"There is one universal truth, applicable to all countries, cultures and communities: violence against women is never acceptable, never excusable, never tolerable." (United Nations, 2008)

The global None in Three Research Centre was established in 2017 to address various forms of gender-based violence around the world. According to the World Health Organization, one in three women and girls worldwide experience some form of gender-based violence in their lifetime (World Health Organization, 2013). For us at the None in Three Research Centre, the only acceptable statistic is "None in Three". Set up in partnership with institutions from India, Uganda, Jamaica and the UK, the Centre is dedicated to creating scientific evidence aimed at changing "attitudes and practices which perpetuate violence against women and children through new research, appropriate public information, and educational programmes" (UN/CEDAW GR No. 19). As part of its inquiry into GBV, the None in Three Centre has conducted both quantitative and qualitative research. Findings will inform the development of serious computer games to be used as interventions to engage children in a process which seeks to increase awareness of gender-based violence, the role of gender inequality, to develop non-adversarial conflict resolution skills, and increase empathy. The project is funded by the Global Challenges Research Fund (GCRF) through UK Research and Innovation (UKRI).

Each country is focused on a specific form of GBV. In Jamaica, the focus is on adult-perpetrated child sexual abuse (CSA). The None in Three Research Centre, Jamaica, is housed at the University of Technology, Jamaica. The research in Jamaica has sought to examine the prevalence and impact of violence exposure among school-aged children and the lived experiences of adult survivors of CSA. The focus of this report is a qualitative analysis of the adult survivors' experience of CSA, including the nature of the abuse, barriers to disclosure, risk and protective factors, consequences of CSA, and the strategies used to cope.

Child Sexual Abuse

CSA is any sexual encounter that occurs between a child (under the age of 16 years) and an older person (as children cannot legally consent to sexual acts). This abuse may involve contact, like touching or penetration. It also includes non-contact cases, such as viewing sexually explicit activities, exposing children to inappropriate sexual material/media or child pornography (Jones & Jemmott, 2013).

In 2017, a UNICEF report estimated that approximately 15 million adolescent girls aged 15-19 years experienced CSA worldwide. Boys are also at risk, although a global estimate is unavailable. Locally, girls accounted for 97.3 per cent of the 1,094 child abuse reports received by the Centre for the Investigation of Sexual Offences and Child Abuse, Jamaica (Caribbean Policy Research Institute, 2018). For the period Jan-Oct 2018, the Child Protection Family Services Agency investigated 2,327 cases of sexual abuse. Some 463 cases were from the Kingston and St. Andrew region (Robinson, 2018). But these are only reported cases. It is difficult to account for the true prevalence of CSA due to the hidden nature of sexual abuse cases.

Nonetheless, local estimates suggest that there are thousands of children and adult survivors who are living with a range of short and long-term consequences associated with CSA. However, specific research within the Jamaican context is lacking. Although recent studies have provided some insights into the Caribbean context (Jones & Jemmott, 2013), it is important to examine contextual factors within specific countries. While some experiences of CSA may be similar across countries, differences in socio-cultural contexts may contribute to nuances in the experience of CSA or influence outcomes for survivors. As such, any attempt at intervention must be evidence-based and have a culturally specific approach.

Signs of Child Sexual Abuse

It is important to know signs of possible CSA in order to know how to intervene appropriately. There are two main sets of signs that adults, especially parents, guardians, teachers and guidance counsellors should be aware of: physical and emotional. Physical signs of CSA include stomach pains, enuresis, encopresis, adverse reactions to milk or yogurt (due to resemblance to semen) or soreness in the genital area (Jensen, 2005). Emotional signs include fear, anxiety, sadness, aggression or withdrawal without an obvious cause, mood swings and reluctance to be in the presence of the perpetrator. Additionally, behavioural signs may manifest themselves in the form of sexualised behaviour while playing with dolls, sexual experimentation, excessive masturbation, or drawing sexual acts (David Finkelhor, 1994; Jensen, 2005).

Rationale

Statistics from national agencies in Jamaica show that CSA is a persistent problem in Jamaican society. For instance, data from the National Children's Registry (2017) shows a steady increase in reports over nine years, between 2007 and 2015, with slight declines in 2016 and 2017. Across the years, the average number of reported male cases of CSA were 215, female cases were 2250, and the overall average was 1,340 (see Figure 1). It is important to note that these figures are likely to represent a substantial under-estimate of the true prevalence of CSA, given the barriers victims and survivors experience in reporting CSA to the authorities. As our analysis will go on to show, the situation is likely to be especially complex with regards to the experience of boys and young men.

The rationale for focusing on adult survivors of CSA was to obtain a retrospective understanding of their experience within the Jamaican context and the impact it has had on them. Information gleaned from survivors' experiences has been used to formulate actionable recommendations which we hope will help to galvanise social change towards prevention and improving supportive systems.

Study Aims

The overarching aim of the research in Jamaica is to inform a culturally relevant intervention to address CSA. Specific aims of the qualitative component of the research were to:

- Develop an in-depth understanding of the issue of CSA within the Jamaican context.
- Explore the process of disclosure for CSA survivors.
- Examine the effect of CSA on the lives of survivors.
- Investigate the strategies used by survivors to cope with their experience of CSA.
- Make recommendations that may help to inform policy changes or improvements.
- Use the findings from our research to develop an authentic, interactive computer game aimed at changing attitudes and behaviours of young people.

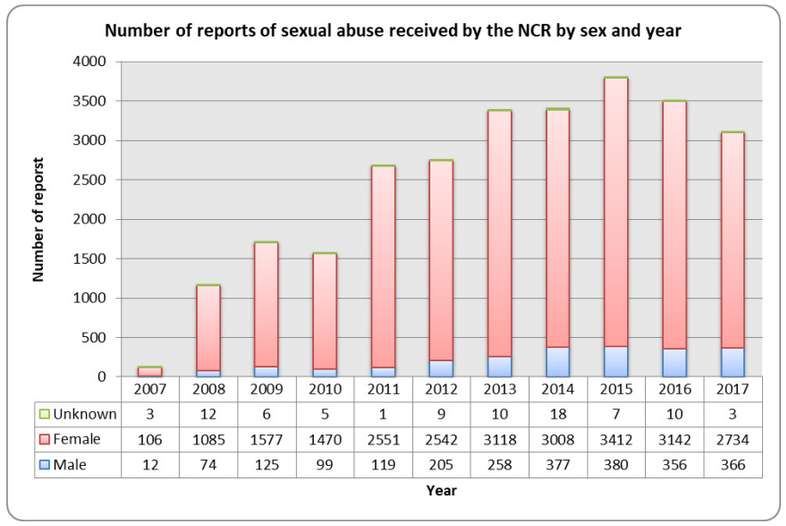
Country Profile

Jamaica is the largest island in the English-speaking Caribbean, with a population of approximately 2.7 million (Statistical Institute of Jamaica, 2011). It is about 146 miles in length, with widths varying from 22 to 51 miles and covers an area of 4,411 square miles (See Figure 2). Kingston is the capital and most populous city (Jamaica Tourist Board, n.d.). The island has a Human Development Index (HDI) of 0.726 and is classified as an upper middle-income economy, ranked 96 amongst all other countries (United Nation Development Programme, 2019). However, despite its ranking, Jamaica continues to struggle with low growth, high public debt, and high levels of crime and violence (The World Bank, 2019).

Jamaican Laws and Agencies related to Child Sexual Abuse

CSA is prohibited by law in Jamaica and it is mandatory for persons who become aware of cases of CSA against a child under the age of 16 years to report the abuse to the relevant authorities. Legislative reforms and institutional strengthening have been implemented over the years to address the care and protection of children. These include but are not limited to the Child Care and Protection Act (2004), the Child Pornography Prevention Act (2009), and the Sexual Offences Act (2009). Established

Figure 2: Maps of Jamaica showing political boundaries and location globally



	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Unknown	3	12	6	5	1	9	10	18	7	10	3
Female	106	1085	1577	1470	2551	2542	3118	3008	3412	3142	2734
Male	12	74	125	99	119	205	258	377	380	356	366

Figure 1:

Number of reports of sexual abuse received by the National Children's Registry by sex and year

agencies with specific mandate for investigating and providing support for CSA cases include the Child Protection and Family Services Agency (CPFSA), the Office of the Children's Advocate (OCA), the Centre for the Investigation of Sexual Offences and Child Abuse (CISOCA), and the Victim Support Unit (VSU) (Caribbean Policy Research Institute, 2018).

Despite these efforts by the State, a 2018 UNICEF commissioned report states that while there have been attempts to increase resources and efforts to safeguard the rights of children in Jamaica there are "structural and systemic inadequacies," that the State needs to rectify. In addressing violence against children in general in Jamaica, the authors of the report aptly summarise the challenge of legislative enforcement.

> ***"Jamaica already has many of the variables—laws, policies, institutions—needed to reduce violence against children, but without the institutional capacity to coordinate and implement, and without increased resources towards improving this capacity, the government's commitment will be questioned, and there is little potential for improvement and change." (CAPRI 2018, pp. 8)***

Our research with the None in Three Research Centre aims to try and address these limitations in protecting children from CSA in two ways. First, by contributing to the knowledge base on experiences of CSA survivorship, especially barriers and facilitators to reporting. Second, we will implement and evaluate an early, grassroots, serious gaming intervention in schools to support young people in identifying and reporting CSA.

2

Research Design

2.1 Study Design

The research design was a cross-sectional qualitative study. Data were collected over a period of six months (October 2018 – April 2019) using in-depth individual interviews and focus group discussions. The two main overarching aims were to understand child sexual abuse (CSA) from the perspectives of adult female and male survivors in Jamaica and to investigate the long-term psychosocial consequences of CSA on them. Data were collected through focus group interviews with a) adult male survivors of CSA and b) male professionals who worked with survivors of CSA. In-depth interviews were conducted with adult female survivors of CSA.

2.2 Sampling and Sample size

Research participants: women

The goal of this qualitative study was to recruit 40 female participants. However, the final sample consisted of 15 female survivors of CSA. The participants' ages ranged from 28–48 years at the time of the interviews. The stated age at the time of the abuse was between 4 –15 years.

Research participants: young males

A sample of five young men was recruited for a focus group interview. The participants' ages ranged from 16–25 years at the time of the interview. The stated age at the time of the abuse was between 4 –15 years.

Research participants: male professionals

A group of five male professionals who have worked with male survivors of CSA were recruited by invitation to participate in a focus group.

Selection of study participants

This research used purposive sampling techniques in order to identify women and young men who had survived CSA and professionals who had worked with persons who had survived CSA.

2.3 Inclusion Criteria

Research participants: women

Women were included if they:

- Were 16 years and over.
- Self-identified as a survivor of child sexual abuse.
- Had at least one experience of child sexual abuse in their lifetime.

Research participants: male survivors

Men were included if they were between 16-25 years and had experienced CSA.

Research participants: professionals

Participants were included if they were professionals who had as part of their professional practice worked with men or youth who had experienced CSA. They were invited from a number of professions within social work, medicine, and law.

2.4 Data collection methods

In-depth interviews with women

The qualitative research comprised semi-structured interviews with women. The advantage of using semi-structured interviews is that it allows for flexibility in the flow of the interview and in generating additional responses that may not have been otherwise derived based on initial predetermined questions (Creswell & Creswell, 2018). The interview schedule consisted of five sections with a series of questions relevant to each section. Participants were asked to respond to general questions about themselves relevant to the research, questions about their experience of CSA, their coping strategies and the process of reporting or disclosing the abuse. The interview schedule acted as a guide for the researcher; however, participants were probed based on the need for additional information or clarification.

2.5 Recruitment

Recruitment for female participants was accomplished by: (a) distribution of posters and flyers describing the study at women's care agencies and universities; (b) television interviews of members of the research team; (c) and word-of-mouth. Participants were both agency- or self-referred.

2.6 Setting

Interview locations were chosen by the participants and for the most part were in an office setting. Some of the interviews with the women were done via telephone based on location of participants. Participant anonymity was protected with the use of pseudonyms. They were given a participant information sheet to read and their verbal consent was recorded using their chosen pseudonym.

On average interviews were 60 minutes long. The interviews were digitally recorded with permission from the participants using two digital recorders. The interviews were then transcribed verbatim using Express Scribe - NCH software. Subsequently, all transcripts were imported into NVivo 12 software for coding and analysis.

2.7 Focus group interviews with men

Focus groups were conducted with young men, as well as with professionals who worked with survivors of child sexual abuse. Focus group interviews are typically conducted with a group of persons under the guidance of a skilled moderator (Leung & Savithiri, 2009). Participants were asked to talk about their attitudes, perceptions and experiences toward CSA. A set of open-ended questions was posed to the participants who were encouraged to respond freely and openly, while the moderator steered the discussions within the focus of the research objectives. Focus groups typically consist of 7-10 participants (Leung & Savithiri, 2009), and our focus groups were comprised of five male survivors of CSA and five professionals who work with CSA survivors.

2.8 Recruitment

Focus group with professionals

Participants for the focus group with professionals were purposively recruited through relevant agencies tasked with the care and protection of children as well as via snowballing.

2.8.2 Focus group with young male survivors

Young men were recruited via a snowballing technique in which one individual was contacted who met the criteria for the group. He was able to contact other young men who were also willing to participate in the focus group discussion.

2.9 Setting

Young males

This focus group was conducted in a safe non-threatening environment which encouraged participants to openly and willingly share their experiences. The discussions were facilitated by a male moderator and lasted for approximately one hour.

Professionals

The focus group was conducted in a private office setting where two moderators facilitated the discussion. Some participants who were unable to attend in person joined via the telephone. The duration of the interview was approximately 60 minutes. With the permission of the participants this interview was recorded using two digital voice recorders.

2.10 Instrument

Young males

The interview schedule for the focus group consisted of 13 questions regarding their thoughts, feelings and experiences of CSA, as well as recommendations they would make for prevention and support for boys who may experience CSA. The interview started with a case study eliciting participants' responses to scenarios in which an underage male was abused by his female teacher. This was later changed to a female victim and her male teacher to contrast the participants' responses.

Professionals

An interview schedule was used as a guide to facilitate discussions surrounding participants' views on the nature and prevalence of CSA among boys, and the typical profile of perpetrators. Additionally, they were asked to evaluate the adequacy of support systems and interventions available for male victims. Participants were also asked to provide recommendations for improvement in the justice system and greater accessibility to services.

2.11 Data Management

All transcriptions and field notes were entered into a single Jamaica NVivo database for analysis. All data were kept confidential in password secured computers. A back-up of data sets was routinely undertaken and saved on external storage. The external back-up drives were stored in secured cabinets. Only members of the research team could access the data.

2.12 Analysis and Quality Control

The researchers conducted thematic analysis (Braun & Clarke, 2006) on the transcripts using NVivo v.12. Additionally, in keeping with good research practice and in order to maintain quality control, several steps were followed. Transcripts were first read by four researchers who are trained in thematic analysis, in order to get an overall familiarity and understanding of the material. Each researcher was subsequently randomly assigned a set of transcripts to be coded. Line-by-line coding was carried out independently by the researchers. This process was partly inductive, as coding categories were initially informed by a priori categories (i.e. based on pre-prepared themes identified in the literature review, topics from the interview schedule) and adapted according to emerging themes.

Researchers cross-checked each other's coding for quality assurance purposes. With researchers using the coding scheme established in NVivo, similar classifications were produced by each researcher reviewing the codes. Major themes and sub-themes were extracted, refined and re-named. Where discrepancies were identified between researchers, further discussions were had until consensus was obtained on the final themes and sub-themes.

2.13 Ethical Considerations

Ethical approval for the project was granted by the University of Huddersfield's School of Human and Health Sciences Research Ethics Panel and the University of Technology, Jamaica Ethics Committee. Confidentiality and anonymity were maintained throughout the process as outlined under Data Collection Methods and Recruitment, on pages 28 and 29, above.

Given the sensitive nature of the topic and the potential for adverse emotional reactions, a National Response Team (NRT) of qualified volunteers was established to provide support/ interventions for research participants. This team comprised practitioners in fields from various helping professions. Where necessary, participants were referred to members of the team for intervention.

The following chapters explain in detail our findings based on several themes that emerged from our analyses of the transcripts from the interviews conducted. By way of introduction to those chapters, we present a word cloud which is a visual representation of the most frequently occurring words across all transcripts for all female participants. The larger the words, the more often they were spoken by the participants. Mother, right and school were among the most commonly used words.

Figure 3: Most frequently used words by young women

3

Experiences of Abuse

Child sexual abuse is divided into two categories: contact and non-contact sexual abuse.

Children oftentimes are exposed to multiple types of abuse.

The majority of perpetrators are known to the victims. These include family members and friends of the family.

3.1 Types of Sexual Abuse

Sexual activities involving a child are generally categorised as contact and noncontact sexual abuse. Kotzé & Brits (2019) makes mention of a third category being contact sexual abuse without sexual intercourse. According to Murray, Nguyen, & Cohen (2014), the sexual abuse of children involves many types of sexually abusive acts including sexual assault, rape, incest, and commercial sexual exploitation.

3.1.1 Contact sexual abuse

All survivors indicated their sexual abuse involved some type of physical contact. According to Finkelhor (1994) contact sexual abuse is touching of the sexual regions of the child's body (genitals or anus) or touching the breasts of pubescent females, or the child touching the sexual parts of the perpetrator's body. Survivors recalled they experienced inappropriate touching of their breasts, bottoms and/or vaginas, received forced kisses and/or hugs, were forced to touch the genitals of perpetrators, experienced penile and/or digital penetration and received or were forced to provide oral sex.

Finkelhor (1994) also posits that contact sexual abuse is of two types: penetration, which includes penile, digital, and object penetration of the vagina, mouth, or anus. Non-penetration, which includes fondling of sexual parts of the child's body, sexual kissing, or the child touching sexual areas of a perpetrator's body. Survivors reported their experience involved both non-penetration and penetration sexual abuse. In some instances, their initial experience was fondling which eventually led to penetration, while others reported penetration only. Finkelhor's finding is in keeping with our research as participants experienced both types of contact sexual abuse as evidenced below:

> ***"I notice that they would always be touching me, touching me on my privates.... he had his hand in my bosom feeling up (fondling) my little busts"- [Ashley, 29]***

> ***"I think I was around twelve, thirteen, think I was just going through puberty. So, my breast where up and he came, he came into the toilet (bathroom) and he touch me on my breast"- [Marie, 47]***

> ***"He took me in the bathroom and he told mi (me) to perform oral sex on him"- [Grace, 25]***

> ***"And a (I) start feel the hardness of his penis against mi (me). And then just spin mi round (spun me around), just spin mi round (spun me around) and enter mi (me) from way back (entered me from behind)"- [Hope A, 35]***

3.1.2 Noncontact sexual abuse

According to Finkelhor (1994), noncontact sexual abuse includes exhibitionism, voyeurism, and the involvement of the child in the making of pornography. Additionally, sometimes verbal sexual propositions or harassment are included as well. Prior to experiencing sexual contact, some survivors indicated they encountered inappropriate comments and actions directed towards them or were forced to observe inappropriate behaviours or images:

> ***"I remember there was a (an) ad on the TV, it was the cable TV and like the ad would seh sumn bout (said something about) making you go all the night and his question to me was if I think I can go all night" – [Ashley, 29]***

> ***"So what he'd do is give me one a dem (one of those) sex magazines, and he would just a- d-like, I mean I'm a child so I don't know th, so, but he'd say to me, yuh (you) like this style or yuh (you) like this style, showing me the different positions (sexual positions) and y'know?"- [Hope A, 35]***

> ***"he use to have sex with another little girl and I had to sit and watch this thing that he was doing"- [Superstar, 26]***

3.1.3 Physical & verbal abuse

Many survivors indicated that along with being sexually abused, they were physically abused by the perpetrator. This is in contrast to the World Health Organization (2003) which suggests that with the sexual abuse of children, physical violence is rarely involved. Harriott & Jones (2016) posit that Jamaican children and youths are disproportionately affected by crime and violence, adding that they experience and are witnesses to a range of violent acts.

> ***"I can remember even receiving slap from him in my face, when I refuse to open my legs he will (would) burn me with cigarette"- [Rihanna, 28]***

> ***"and then he came and he handle me like really aggressive ripped off all of me (my) clothes...him (he) just ripped off all of me (my) clothes and force himself inside of me"- [Star, 42]***

A few survivors expressed that along with being physically abused, they were also verbally abused. This finding supports Murray et al., 2014 who suggest that child sexual abuse occurs alongside other forms of abuse:

> ***"However, ummm, he would seh to me seh I'm not a, mi nah go amount to nuttn, mi nah go come to nuttn, ummm, man ago tek advantage a mi, mi a whore, mi a bitch...."- [Raven, 20]***

English Translation

> ***"However, ummm, he would say to me that I will not amount to anything, men will take advantage of me, I am a whore, I am a bitch..."-[Raven, 20]***

3.2 Perpetrators of Sexual Abuse

Sexual abuse may be carried out by men and women, strangers, trusted friends or family, and people of all sexual orientations, socioeconomic classes, and cultural backgrounds (Murray et al., 2014). Indeed, Finkelhor & Shattuck (2012) contend that the perpetrators of child sexual abuse are often known individuals. This is in keeping with our study in which 13 out of 15 survivors were abused by persons known to them; commonly family members and neighbours:

> ***"I was sexual abused by my uncle which is my father's brother"- [Rihanna, 28]***

> ***"Ahmm, the second time, I have actually experience something close to sex was from my father [hmmm] aaahhh he molested me" [Cody, 17]***

> ***"...so she had this friend that ahmmm, she kept us as babies.....we would stay at her house until our mother come and take (took) us. She had other children there which were her children, older boys, older girls and they had their children there also..... I remember seeing him yuh nuh (you know) calling and touching the other little girls and it didn't dawned (dawn) on me that he would do it to me also" [Marie, 47]***

Two survivors, however, mentioned being abused by strangers:

> ***"He was a stranger that came into my life. Ahm so he saw the vulnerability and took disadvantage (advantage) of it"- [Goodie, 27]***

A common experience shared among most survivors was being abused by multiple perpetrators. These offenders included family members, acquaintances, neighbours, and strangers:

> ***"Well ahm, it happens (happened) when a (I) was, it happened when I was 12 years old..... a (I) was in the room lying down and that's when my cousin and three of his friends came in on me. And they sexually molest me"- [Kelly, 29]***

> ***"I was pinned down in the bed and that was the first time I ahhh my uncles.... actually, my first uncle had sex with me.....and ahmmm two other uncles joined in"- [Hope B]***

> ***"I open my eye and I saw my step father over me....I got pulled from a car, from a taxi and this man rape (raped) me" -[Star, 42]***

4

Risk Factors for Child Sexual Abuse

Factors such as negative cultural perceptions as well as myths, poor parent-child relationships, lack of adequate supervision, and low socio-economic status contribute to child sexual abuse.

Child shifting and prior victimisation have also been identified as risk factors of child sexual abuse.

Numerous studies conducted indicate that sexual abuse during childhood happens as a result of multiple factors. Theories such as the routine activities theory (which was further developed to include environmental factors), the ecological model, the transactional influences theory and the ecological, transactional and developmental model have sought to predict and explain some of the risk factors of child sexual victimisation (Assink et al., 2019). Despite this Jones & Jemmott (2013) note that while some factors may increase the risk, unfortunately children from all socio-economic backgrounds experience sexual victimisation. Assink et al., (2019) posit however, that for effective assessment and intervention, knowledge on risk factors is crucial. As such, this research sought to highlight some of the contributing factors (fig.3) associated with child sexual abuse within the Jamaican context.

4.1 Cultural Factors

4.1.1 Cultural norms

According to Smith, McLean Cooke, & Morrison (2019), cultural and social norms promote or inhibit the occurrence of sexual violence against women. The experiences of female survivors we interviewed suggested that negative cultural beliefs influenced their perceptions, such that some believed the abuse was normal. These survivors were of the view that child sexual abuse was a common phenomenon within their communities and appeared to be accepted among residents:

> ***"It felt like it was a norm. Like you just tell somebody and nothing happens. Yuh nuh (you know) you just tell just so you can say dat (that,) hey dis (this) happened to me, what are you going to do? But den (then) nothing is done, and it makes you feel as though, like what happened to you wasn't a big deal. Like just get over it. Yuh nuh (you know) and it felt like that was the norm even in our society, dat (that) when something bad happens to you as a female you know, just get over it"-[Grace, 25]***

> ***"in our community you know this wasn't happening to me alone, this was the norm"- [Star, 42]***

This normalisation led them to believe that nothing would come of reporting their sexual abuse and/or that persons would undermine the significance of the abuse; which in many instances resulted in non-disclosure. Indeed, a report from Amnesty International (2006) suggests that patriarchal attitudes such as male aggression and male sexual entitlement are so entrenched in the Jamaican culture that rape of women by men is often trivialised and viewed as "men being men" or "just a little sex". One survivor highlighted this experience:

> ***"it was just done and if a parent make noise, you would hear them say is just little sex wah you a go on so fa, a just little sex"-[Star, 42]***

English Translation

> ***"it was just done and if a parent tried to speak out against it, they would say it's just sex, why are you acting like that"- [Star, 42]***

Social norms may also dictate how persons respond to abuse. Jones & Jemmott (2013) reveal that failing to act to protect a child contributes to the sexual harming of children. Some survivors believed not enough was done by parents, family members or community members to report their abuse or seek justice on their behalf. Instead, their abuse was concealed or denied:

> ***"My grandmother was on the bed beside me and up to... now she denies it, she denies it... she was very upset at me... she called me a liar"- [Hope B]***

> ***"she never said anything... I didn't get any justice from my mother. She didn't say to me that he was wrong for doing it"- [Marie, 47]***

In contrast to this, however, one survivor's father ensured that his daughter's perpetrators were brought to justice despite her fears of going through the judicial process:

> ***"Soh (so) it was terrifying fah (for) me. An becass (and because) my father wanted justice. He always drag me through it an seh (and said), come on wi (we) need fi (to) do dis (this)"- [Kelly, 29]***

4.1.2 Cultural myths

For one survivor, mention was made of being used as a cure for HIV; this is a term referred to as 'virgin cleansing'. According to Leclerc-Madlala (2002) virgin cleansing is the belief that a man can be 'cleansed' of HIV/AIDS through intercourse with a virgin, but the girl herself would not be infected in the process.

> ***"But in the midst of all of dat, dat, dat (that, that, that) particular individual was HIV positive. Yes, and I was technically being used as a cure, back then. Yes, because yuh know deh seh (you know they say) when you have sex wid (with) a virgin ahm, HIV, it can be cure. It can cure HIV yeah, soh a (so I) I was use as a cure, as a substitute for a cure at that time"-[Goodie, 27]***

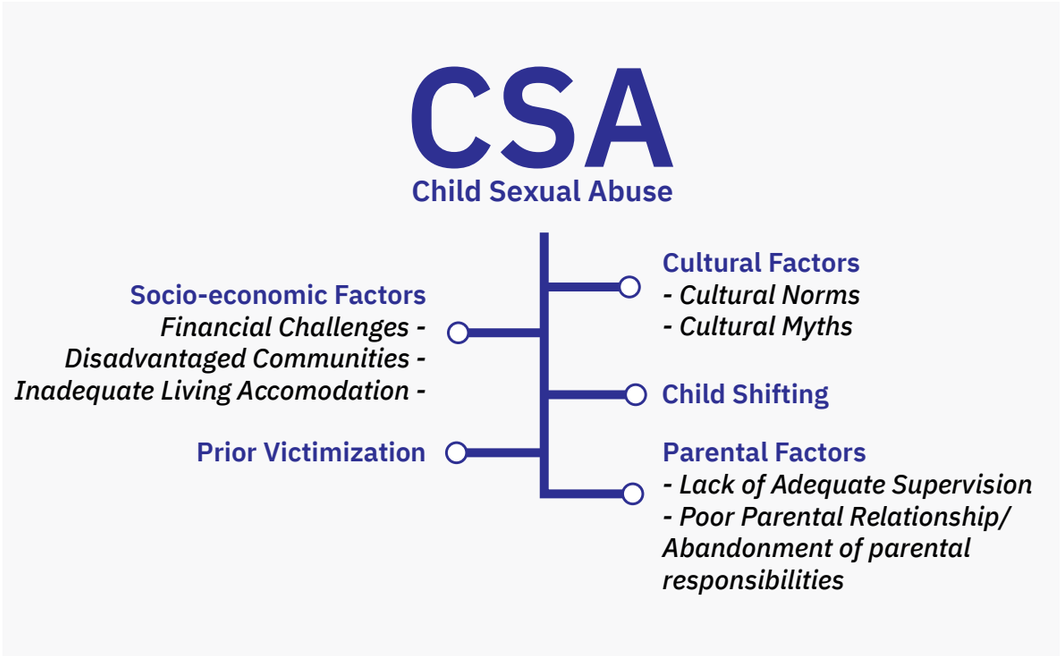


Figure 4: Factors contributing to child sexual abuse

4.2 Socio-Economic Factors

Smith et al. (2019) postulate that in contrast to the financially disadvantaged, affluent families have social privileges and options that are not available to the poor. These include having better supervision, residing in protected communities and having access to resources. According to Barrow (2008), poverty limits communities and families to providing only the basics such as food and shelter, and prevents them from thinking about wider aspects of child development. It is therefore presumed that provided the victims were from a more financially stable household, their abuse could have been mitigated. That is not to say that children from more affluent families do not experience sexual abuse, as Smith et al. (2019) also reveal that sexual violence permeates economic and geographic boundaries. Though our sample did not include any survivors from affluent communities, the survivors we interviewed highlighted how their socio-economic conditions placed them at increased risk for CSA.

4.2.1 Financial challenges

Survivors highlighted that due to the financial difficulties within their families, they experienced being exploited by individuals who were aware and took advantage of this vulnerability. Early research by Finkelhor, Moore, Hamby, & Straus (1997) reported a similar finding and revealed that families with lower income were at increased risk for sexual victimisation, in comparison to other families.

> ***"my mom use (used) to use me to get stuff, and from a tender age but they wouldn't, wouldn't let it go, as fast as they would like. So, she would force me on to men and people to get money"- [Cody, 17]***

> ***"Alright, so the how, how it happened? So I, my parents broke up, yes and I was in between... a half of a home and nowhere... Yes, and I wanted to go to school... and then... here comes dis (this) man where... he would provide me with stuff, you know? Provide mi (me) with school and, stuff to go school, lunch money, all of those stuff and in in exchange right? Sexual advances were made".- [Goodie, 27]***

Some survivors noted that occasionally they had to seek financial assistance from other family members, community members, and in one case, an individual within the justice system. These persons exploited the vulnerabilities of the survivors by demanding sexual favours in return:

> ***"He was supposed to send me back to school in September, for me to come back I had to sleep with him. I told him no on several occasions and he was persistent..... and I was so desperate to go back so I just gave up and just lay down and let him do what he wanted to do"- [Cody, 17]***

> ***"So, I was there and then it started to happen he use to give me money and mi have fi do this yuh nuh (and I had to do this, you know) until I, I overheard...because I couldn't deal with it though, because I didn't have anywhere to go, cause I didn't have any money per se however, it was one time when I refused on giving him sex and I overheard him telling his wife that I had to leave"- [Superstar, 26]***

Financial stability on the other hand does not exempt persons from exposure to abuse. One survivor highlighted this when she mentioned that her biological father ensured her financial needs were met. This is in contrast to the many other survivors who mentioned they experienced financial challenges.

> ***"when it comes on to like go to school and so forth my dad will send my money..... and he [uncle] will (would) always say don't tell your grandmother, don't you ever. I was like okay. So at that time I didn't figure (think) that would reach me because I expect for him to protect me, not to hurt me"- [Rihanna, 28]***

4.2.2 Disadvantaged communities

Notably, some survivors were from volatile and/or economically disadvantaged communities. A similar finding was obtained by (Sedlak et al., 2010; Black et al., 2001) who identify poverty and residing in communities with high levels of violence as risk factors for CSA. In Jamaica, a quarter of children live in poverty and this is more evident among female headed households, which worsens children's vulnerability (Caribbean Policy Research Institute, 2018). In highlighting this, two participants noted that;

> ***"I...we were very poor, very very poor. I am from a very poor family and I use to (often) visit my relatives who are also very poor, so when we visit, we all would be sleeping in the same bed and that kind of thing. And so, I remember that particular night, I was in my grandmother's bed, and I literally felt the shadow of something come over me and I mean, I didn't understand a lot of what was happening at that time...right, but ahmmm, I tried to cry out but I was prevented from crying out. I was pinned down in the bed and that was the first time I ahhh my uncles.... actually, my first uncle had sex with me. Ahmmm, it continued every night.... every holiday..."- [Hope B]***

> ***"I would visit my dad like twice during that period while my mother was away, but then when she came back I begged her to take me and she said no because dons were sending for young girls to have sex with them. We from a very violent community"- [Hope A, 35]***

4.2.3 Inadequate living accommodation

Smith et al. (2019) postulate that a major contributing factor to Jamaica's high incidence of sexual violence and abuse is the living conditions of families in deprived communities. Some survivors expressed having to share a single bedroom unit with family members. It was when these survivors shared inadequate living accommodation that they experienced sexual abuse. Smith et al. (2019) note that it is within such living conditions, that is, the close proximity to an adult male, that the likelihood of CSA is intensified. Some survivors experienced being victimised by their uncles, stepfathers or cousins with whom they had to share a living space:

> ***"I think it was on a weekend, I went to bed one night and my uncle came in...it was a one bedroom, so three beds was (were) in one room".-[Rihanna, 28]***

> ***"we use to sleep on the floor, it was one bed one room.... I remember one night, you know, I was sleeping and I felt my underwear being pulled off me... and I open my eye and I saw my step father over me pulling off me (my) panty" –[Star, 42]***

4.3 Parental Factors

According to Rudolph, Zimmer-Gembeck, Shanley, & Hawkins (2018) family features and parenting practices associated with an increased risk of CSA include parental absence, poor parent–child relationship, low maternal attachment, lack of communication and lack of supervision/monitoring.

4.3.1 Lack of adequate supervision

In the Caribbean, women have traditionally borne greater responsibility for children's care and protection and, as a result, children are affected by women's unequal economic power and the resulting lack of access to material and financial resources (Caribbean Policy Research Institute, 2018). This means women have to juggle their time between work and caregiving. For most survivors, their mother was the primary caregiver. In their recollections, survivors whose mothers worked were either left unsupervised, left in the neighbours' care, sent to reside with extended family members or left in grandmother's care, especially during holiday periods. When survivors weren't adequately supervised they were at greater risk of sexual abuse:

> ***"We went- I went, he took me there for the summer holiday and at one point me (my) aunt had leave the home, for two days. Leaving, leaving de (the) younger siblings and with my eldest cousins. So one night a (I) was dere (there) and the younger siblings, they went down to another uncle of theirs down the road. A (I) wasn't feeling so well so a (I) didn't go so a (I) was in the room lying down and that's when my cousin and three of his friends came in on me. And they sexually molest me, that night"- [Kelly, 29]***
>
> ***"Right, so ahmm my mother was a single mother, and she works so on, she works every day and I, I and she did domestic work, so sometimes especially on a Saturday I was alone. So afterwards she would go and get the grocery so she had this friend that ahmmm, she kept, she kept us as babies. So, until our childhood she would be the person, when we would come from school we would stay at her house until our mother come and take us. She had other children there which were her children, older boys, older girls and they had their children there also..... he pull me by the shirt and dragged me into the bathroom that was outside and I had my first experience encounter with him"- [Marie, 47]***

Although there were instances where survivors appeared to have been adequately supervised, they still encountered abuse. According to the World Health Organization (2003), one feature that characterises child sexual abuse is that the perpetrator is typically a known and trusted individual. Of note, is that most survivors were left in the care of trusted individuals when they were sexually abused. In some such cases, the abuse was committed by the trusted individual themselves, while for others it was relatives or friends of that trusted individual:

> ***"However, when I was 5 years old, ummm, I was sexually molested by my step-father. Ummm it was, my mom is not much of an educated person so she does the normal dom- domestic helper jobs so she goes in and lives in for 2 weeks then goes out and goes back in you know the live in jobs that ?. Right so, I had to stay with my step-father" –[Raven, 20]***

In some cases, bringing persons into the home environment to visit or reside exposed children to perpetrators of abuse. For example, some survivors indicated that abuse occurred when extended family members or friends visited:

> ***"she said that my aunt was staying with us, my uncle [uncle in law] came home, he was drunk and he took me in the bathroom and he told mi (me) to perform oral sex on him"- [Grace, 25]***
>
> ***"So, I don't remember how I end up like, you know it's a family friend so he said come sit in my lap and whatever... about that and then, you know, next thing I know his hand... cause (because) I developed breasts early, even just the buds you know? ... he push (pushed) his hand through my dress and start to play, fondle with"- [Savannah]***

4.3.2 Poor parental relationship/abandonment of parental responsibilities

Many survivors expressed that they did not share a close relationship or an emotional bond with their mothers and/or fathers. This was in part due to instabilities within their families. Some survivors reported that financial challenges, physical abuse, negligence, illness or death resulted in a parent being absent; as such they were unable to develop an emotional bond. However, even with the presence of a sole parent, which in many cases was the mother, some still reported not sharing a close relationship. This lack of emotional connection led the survivors to not disclose their abuse. When the abuse was discovered however, whether through a doctor's visit, made public by a neighbour or disclosed by the victims themselves, they were met with blame and/ or disbelief which resulted in non-disclosure of subsequent abuse. This was also evident in cases where the victim's primary caregiver at the time of the abuse was another family member.

> ***"Well, my mother wasn't a person who, my mother wasn't a person who I could talk to, she wasn't that open, receptive I would say, to any sort of conversation especially that....I can't tell my mother dis (this) because she might just blame me, I just kept it to myself, I kept it to myself...I just wanted her to be my mother per se, to have a conversation with me"- [Super star, 26]***
>
> ***"Uhhh dad is actually, hmm, not there. Not here. I don't know da, so dad is missing in the picture, I never had a father figure...You know, like you have some girls that their mom is their best friend? Nah (no), not for me..... Ahhh, relationship with mom got sour when things in my life got sour"- [Raven, 20]***
>
> ***"all my mother said to me was this, she just looked at me like I was some scum..... and it was just painful to have to go through that so I said, I promise myself that if anything should happen like that I would just keep my mouth shut"- [Star, 42]***

One survivor even perceived that if her negligent parent had been more involved, this might have prevented the abuse.

> ***"Uhm but, all a dis (this) happened because ahm my dad just did not want to take up the responsibility of being a father"- [Goodie, 27]***

4.3.3 Child shifting

Barrow (2008) highlights that a recognised practice within the Caribbean culture is child shifting. This involves moving a child from his/ her parents to another part of the family or to friends. Some survivors indicated that during childhood they were sent to reside with family for extended periods or visited family members and friends for holidays. They perceived that as a result, they were exposed to sexual abuse:

> ***"So he decided dat (that) he was going to sen mi dere (send me there) for the summa (summer) holiday. We went- I went- he took me there for the summer holiday and at one point me aunt had leave (left) the home, for 2 days. Leaving, leaving de (the) younger siblings and with my eldest cousins. So one night a (I) was dere (there) and the younger siblings they went down to another uncle of theirs down the road. A (I) wasn't feeling so well so a (I) didn't go so a (I) was in the room lying down and that's when my cousin and three of his friends came in on me. And they sexually molest me, that night" – [Kelly, 29]***
>
> ***"and after that now, going to the country, a use to spend holidays in the country that's my father relatives ahmm my father's mother yeah. My grandmother and my uncle, two uncle they lived at the house so my younger uncle he resembles me and so persons would think he is my father and I remember one holiday he molested me and it became a regular thing, until nobody asked me if I wanted to go back to the country, it just, it's just a norm fi go a (it's just the norm to go to the) country every holiday" [Superstar, 26]***

4.4 Prior Victimisation

A finding shared by Assink et al. (2019) is that a history of sexual victimisation was strongly associated with child sexual abuse. Some of the survivors we interviewed indicated they were abused multiple times by different individuals. In such instances, this was so because others were made aware of the victimisation and instead of offering assistance, they also perpetrated abuse:

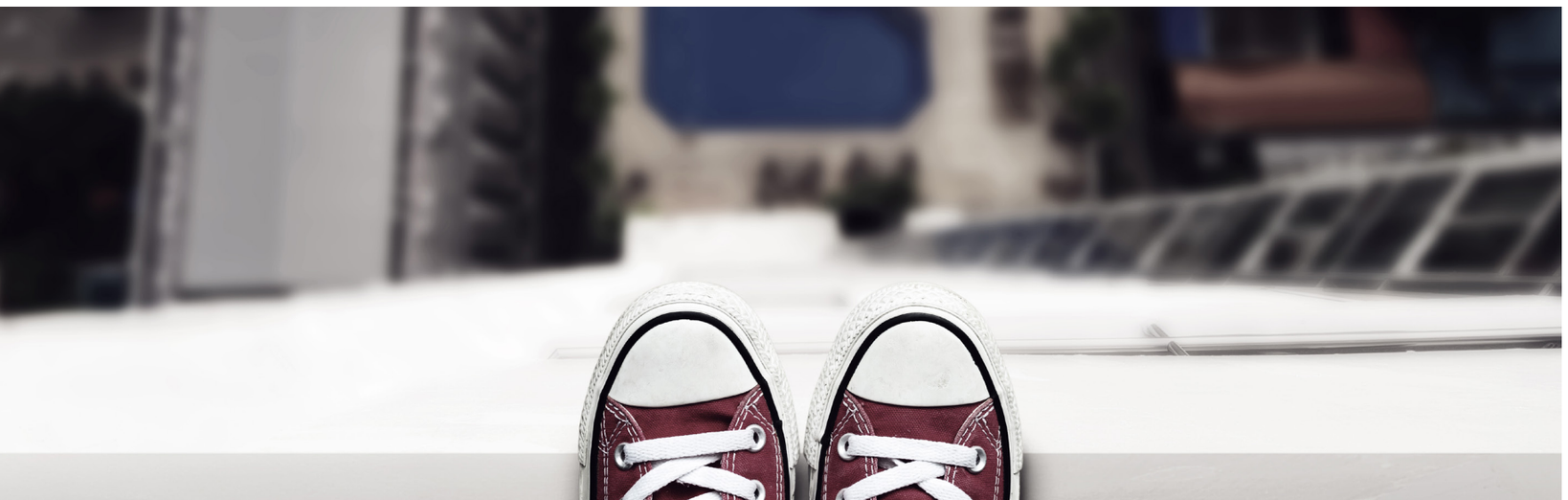
> ***"and so from there ahhmm he had other brothers.... who... knew about it, they heard about it and I guess this was an opening, like a (an) opening and so... all the brothers... had had their time" [Hope A, 35]***

Because of the recurring experience of sexual victimisation, this led one survivor to perceive that she was a target for CSA:

> ***"A (I) dont know if have this sign that says you're welcome to have sex and do whatever you want with me"- [Hope A, 35]***

5

Effects of Abuse



CSA is detrimental to the emotional and psychological well-being of survivors. The research showed that female survivors suffered great emotional distress resulting in a kaleidoscope of emotions, as well as suicidal thoughts, self-harm behaviours and poor self-esteem.

Due to poor psychological functioning, survivors also had challenges adjusting in their academic and occupational lives.

A number of survivors reported challenges in forming emotional connections in intimate relations and sexual functioning. Women survivors also expressed challenges with parenting their children.

Some survivors of CSA exhibited maladaptive externalising behaviours including substance use, stealing and gambling.

This section summarises the findings on the consequences of child sexual abuse (CSA) for survivors. There is large body of literature that has documented the short and long-term effects of CSA on survivors. Existing research shows that the impact of CSA is wide ranging and persists throughout the lives of survivors (Molnar et al., 2001). The findings of the current study are commensurate with the literature and suggest that being a CSA victim is associated with poor psychological/emotional functioning, problems with interpersonal relationships, reduced academic and occupational functioning, substance misuse and other externalising behaviours. These ideas are summarised in Figure 5. The lifelong effects of CSA on the well-being of survivors are summed up by two of the participants:

> ***"it affects you for a lifetime, it affects you... it affects you in getting into a relationship... in trusting people, a whole lot of summen (things)" - [Superstar, 26]***

> ***"I tell you...my lady in every aspect you don't live a normal life after (you've) gone through something like that...you do not live...cry often...you hate yourself a lot" - [Star, 42]***

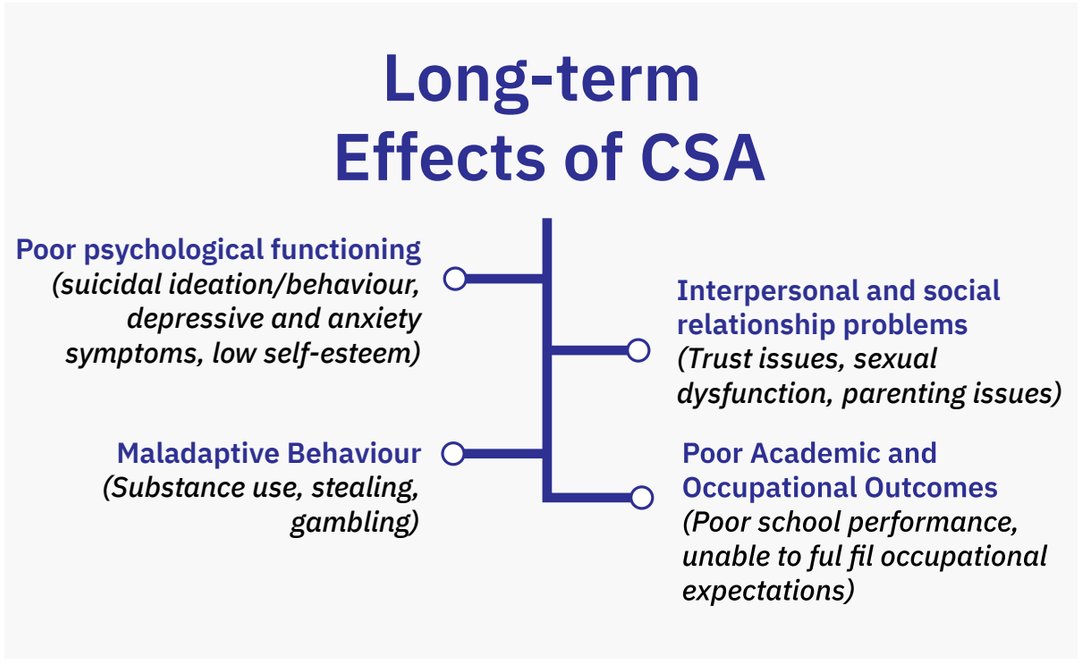


Figure 5: Summary of the main consequences of CSA

5.1 Poor Emotional/Psychological Functioning

5.1.1 General emotional distress

The female survivors of CSA that were interviewed reported being traumatised by their experience of CSA and indicated that they had experienced and continue to experience significant emotional distress. Indeed, the World Health Organization (2013) reports that survivors of CSA are at an increased risk for depression and anxiety symptoms compared to women who have not experienced abuse. In this study, the female survivors reported that they experienced depressive symptoms including low mood evidenced by bursts of crying, feelings of worthlessness, hopelessness, numbness, as well as anxiety symptoms such as panic attacks. These symptoms are associated with significant emotional distress and affect the quality of life of the survivors.

> ***"a (I) was just complain that a (I) can't sleep... at nights. Cause a (I) could not sleep. I had to be drinking cough syrup to goh (go) to ma (my) bed. A (I) was suffering from panic attacks. A (I) ended up at Take of Me Hospital because I could not sleep. I was just constantly crying cause I overthink a lot, so I was keep going back to that situation trying to play out, what can I do, how can come out a dis (of this) situation [Uhm] how can I start over, [Uhm] you know?..." - [Grace, 25]***

Shortly after the abuse and for some time after, survivors can also experience a range of other emotions (Dorahy & Clearwater, 2012; Feiring & Taska, 2005). In the current study, several socio-emotional experiences were reported among the survivors including shame, embarrassment, confusion, fear, and guilt.

> ***"So [ummhh] I really felt ashamed, felt bad. This is not something that you want to be talked about but I use to write.... Uhuhum. I wouldn't talk to anybody about it. Like a sey (I said) it's a shameful experience" - [Hope A, 35]***

5.1.2 Anger/hostility and homicidal thoughts

An emotion that was common among most of the women survivors was an intense feeling of anger, particularly directed towards the men who abused them, but also males in general. Some women reported that they "hated" men and their feelings of abhorrence would manifest in aggression towards males. For some, the intensity of the anger led to thoughts of retribution. That is, some of the women stated that they had thoughts of wanting to harm or kill the men who abused them in an effort to get justice for themselves. One of the survivors interviewed expressed the intensity of the feelings of anger towards men:

> ***"But ahhmm after a while I realise that I became really angry. I was having, some murderous thoughts cause a (I) would think about how am going to get back to all a (of) these men fah (for) what they had done to me. Soh (so) I strategised in my head this is how I'm going to kill this one this is how I'm going to kill that one and to the point where I would get like a knife or soh a (so I) would stab up the teddy bear, stab up the bed y'know (you know)? Just to relieve maself (myself)" - [Hope A, 35]***

5.1.3 Suicidal ideation/behaviour and self harm

Research internationally and within the Caribbean has shown that survivors of CSA are at an increased risk of suicide (Jones & Jemmott, 2013; Ystgaard et al., 2004). The experience of CSA brings about intense feelings of distress (Rosenthal et al., 2005). Therefore, it is not surprising that most of the female survivors

we interviewed reported a history of suicidal thoughts (ideation) and/or suicide attempts. Ten out of the 15 women stated that they either thought about suicide many times after the abuse or attempted suicide, and for some, multiple times. Suicidal thoughts appeared to be precipitated by depressive symptoms including feeling purposeless and hopeless. For some of the survivors, the emotional distress was so palpable that they felt life had no value or meaning and they struggled to find a reason to continue living. The struggle of getting through each day after the abuse and to sustain a sense of purpose throughout adult life is verbalised by one of the survivors:

> ***I was still struggling, as I said, I still wanted to die. I still wanted I didn't have a desire to live and even though my children were there and I was doing all of that, it's for them I, I had to to ahhhh let me, I guess force myself to make it through each day. I had to yuh nuh (you know) give myself a pep talk every day that you have to do this if not you for them and that would take me through the day ahmmm tomorrow I had to do it again. It was very difficult for me to live through a day..." - [Hope A, 35]***

Internalising the abuse may also result in participating in self-injurious behaviour such as cutting, burning, and scarring of the skin or body. Previous studies have reported an association between CSA and expressions of self-harm (Jones & Trotman Jemmott, 2013; Polusny & Follette, 1995). This was also discovered in the current study. A few of the women survivors (3/15) described inflicting self-harm through cutting, as a way to cope with the pain experienced subsequent to the abuse or as a means of finding release. One survivor described her attempts to "feel" by engaging in self-injurious behaviours.

> ***"...I would just be marking on my skin. You know that thing they call 'cutting'? [hmm hmph] I remember writing on my hand vividly 'crazy bitch'. I, I used the pen and I used the white out [hmm hmph] and then I use (used) the pen to dig it out so I would literally have the scars umm and then the thing that hit me the most, was- I don't even know what I was thinking when I did it but I lit fire on the stove, I know what I was thinking now. I remember I was- I could not get in touch with my emotions and that was- That couldn't be right. That was off for me [hmm hmph]. How can I not be in touch with my emotions? Apart from the feeling of worthlessness which is not feeling. How can I not be feeling? How can I not be connecting? How can my heart be frozen kinda (kind of) thing? [hmm hmph] Like your heart not supposed to do that. [hmm hmph] That was what was going on in my head so I lit the fire on the stove and I put my hand in it but I wasn't feeling anything [hmm hmph] I cried. It's fire. Regardless of what was happening, how can fire not burn? [hmm hmph] That nah guh dung well (That's not going well) with me [hmm hmph] and so I realised that, I'm not ok [hmm hmph]" - [Ashley, 29]***

5.1.4 Negative perception of self

The experience of CSA appeared to erode the survivors' positive sense of self. Many of the women had a distorted view of themselves. Particularly, they reported experiences of self-blame, self-hate and low self-esteem. The cognition, associated with the perceived responsibility for the abuse, appeared to emerge from their own internal ideas of their inability to prevent the abuse as well as how others responded to their experience. A positive association between CSA and poor self-functioning is found in other research (Jones and Trotman Jemmott, 2009; Stern, Lynch, Oates, O'Toole, & Cooney, 1995).

Some women blamed themselves for the abuse, thinking that they somehow placed themselves in the position to be abused or thought that they had done something to bring the abuse upon themselves.

> ***"I start blame myself for everything. Every behaviour I, I just blame myself, that I put myself in that position, so I been abuse (d) as a child and so this is what happened to me and mi bad and all them summen deh (and I am bad and all of those something)" - [Superstar, 26]***

Many of the women engaged in self-loathing. They had abhorrent ideas of self and considered themselves to be of little worth and value. At least two of the women mentioned that they did not feel worthy of love as one survivor [Hope B] stated - *"I could not accept the fact that some-one could love me".* Generally, it was evident that many of the women had low self-esteem. The debilitating ideas of self are reported by one survivor:

> ***"...I hated myself I looked in the mirror and I saw me and I just hated me I would curse me I would call myself weak and worthless and nothing and I just didn't like me...I just didn't like me at all" - [Star, 42]***

5.2 Poor Interpersonal Relationships

There were several interpersonal difficulties reported by the women survivors. Having a history of CSA seem to affect the development of healthy interpersonal and social relations as well as survivors' approach to parenting. It is evident in the survivors' narratives that these challenges mainly emanated from issues surrounding (lack of) trust and emotional safety.

5.2.1 Social and romantic relationships

Many of the women reported having trust issues in their relationships with men but also with people in general. For some, the world was not a safe place and they had little confidence in the people in it. This damaged sense of trust made it difficult to form meaningful bonds with others which resulted in some of the women being withdrawn or experiencing feelings of isolation. For instance, some survivors indicated that it was difficult to connect with others.

> ***"I don't put my trust in people" - [Cody, 17]***
>
> ***"...I never trusted people and that's why I said to you even marriage for me was, is a miracle because I never trusted anyone, yuh nuh (you know) and I never made friends, high school and I never made friends. I , I , I.. there was nobody that I bonded with...., I could identify that this my best friend, ahm ahm nothing like that." - [Hope B]***

Experience of CSA was also linked to later complexities of intimacy in adult romantic relations. Previous research has shown that forming healthy and satisfying intimate relationships can be affected by unresolved and enduring emotional issues from past abuse (Fairweather & Kinder, 2013) and this was also reported by a few of the women in the current study. For instance, some of the survivors noted difficulties forming emotional attachments because they felt incapable of loving, felt they were not worthy of love, or insisted on remaining distant because of the fear of being hurt (again) by men.

> ***"...a (I) didn't a (I) didn't use to let persons close to ... As soon as I realise that you were getting too close, I would step away. So it wasn't, it wasn't, it wasn't easy for someone to be close to me. It was like a (I) was incapable of loving someone [Uhm].A (I) didn't a (I) didn't really have feelings about per- about all ahm relationships, feelings and so forth and when, when I met my husband honestly, ahm, that was manifesting a lot..." - [Kelly, 29]***

One fundamental aspect of CSA is the feeling of helplessness or powerlessness (Jones and Trotman Jemmott, 2009). Survivors may seek to compensate for this sense of emotional helplessness later in their adult relationships. In this study, at least two survivors indicated that they developed a need to have control in their relationships, which involved directing the terms of relationships and sexual relations. This need to have control may be one way for women to counteract earlier feelings of helplessness which characterised their abuse.

> ***"... the thing is, whichever crowd I would be a part of I would be the one in charge. I would be the one laying down the rules and ahmmm it gave me a sense of control, because the think is, I would never allow myself to or knowingly allowing myself to be vulnerable, so I had to be the one making the rules and I guess that is why even in the, ahmmm the promiscuous relationships I decide on when or if I am to see you, I decide when you go, I decide on when you come. So I, felt I had control of my life, [yes] it's not a matter of being accepted in a crowd but I, I really never, I don't never, I have never felt accepted, but I had to have some level of control. So important, I mean that was the most important [yeah] thing to me [hmmm] and coming into adulthood and entering into relationships they didn't last for long because, it was my way or the highway..." - [Hope B]***

Despite some survivors' attempts to maintain some control in their interpersonal relationships, there were somewhat contrasting reports representing situations in which the women experienced other forms of abuse (emotional and physical) in their relationships with men. In those reported cases, the abusive situations may be associated with low self-esteem or other situational factors such as becoming pregnant. It is noted in the literature that survivors of sexual abuse either experience other forms of abuse concurrently with sexual violence or may be at risk for these other forms of abuse subsequent to sexual violations (Higgins & McCabe, 2001)

> ***"...when I found out I was pregnant my father decided I could not stay at the house. So, I was on the street for a while and I... eventually went and stayed with the father of my child and that was painful, because there was no physical abuse at the time, but [hmmmm] there was a lot of emotional abuse, there was no connect what so ever, [yeah] and I felt like a slave [hmmm] you know , I had to do all of these wifely things [hmmmm] and I was eighteen years old." [Hope B]***

5.2.2 Sexual maladjustment/dysfunction/ sexuality

CSA has been associated with later challenges to sexual well-being and functioning (Fergusson, McLeod, & Horwood, 2013; Kristensen & Lau, 2011). Approximately a third of the women in the present study reported issues with sexual functioning including sex with multiple partners, lack of ability to enjoy sex, and problems with setting sexual boundaries. Some of the women also indicated that they engaged in same sex relations after experiencing sexual abuse by male perpetrators. Sexual abuse can affect the sexual preferences of survivors. For men, research has shown that where sexual abuse is perpetrated by an older male, male survivors may interpret this is an indication of being gay (Gartner, 1999). On the other hand, females who are abused by male perpetrators may develop an aversion towards men (Marvasti & Dripchak, 2004), and find comfort in same sex relations.

There were a few women who described themselves as being "promiscuous" after the abuse. Having sex with multiple partners was seemingly tied to the women's sense of self-worth or numbness (not caring). This is captured in the following quote from one of the women:

> ***"I was very, very promiscuous. I think from I was may be about thirteen fourteen ...., I was having sex with anybody ..., it didn't matter, it didn't matter it's not like, and it's not like I, I didn't have to like you; didn't have to have any feelings towards you, I just needed that moment of gratification and once it was done I would hate you" - [Hope B]***

Again, in contrast to some of the women who spoke of their need to retain control of their sexual relations, other survivors struggled with feeling in control. For instance, one of the woman survivors noted a challenge in maintaining appropriate boundaries with partners. She describes her experience of dating, not feeling ready to engage sexually but acquiescing, and later engaging in self-blame.

> ***"I remember there's this ex I had from high school. I started seeing him again and then he got the opportunity to have sex with me [hmm hmph]. I never really wanted to but it was forced but mi (I) just lef (left) it as it is because mi (I) think [mi careless in it?] I went to where he was [hmm] kinda (kind of) thing so like there were a lot of this that I did after or I allowed and so I just blamed myself for them so I had a lot of self-blame thing going on." - [Ashley, 29]***

Additionally, some women survivors found sexual relations with their partners to be emotionally and physically challenging. Specifically, sexual intimacy after abuse brought on intense feelings of anxiety, reoccurrence of shame, and general inability to find enjoyment in sexual relations with partners as the following quote illustrates:

> ***"Because by this I'm married, my husband cannot enjoy me fully. I think he can but I have to let go somewhat. But ahhmm it... bothers my marriage where sex wise... it just wasn't fun... there was just no fun in sex and I shouldn't get married when a (I) didn't enjoy it....? He wants to enjoy it but I am not letting go to allow him to." - [Hope A, 35]***

Some survivors of CSA grapple with their understanding of their sexuality and sexual identity after the abuse, including confusion about their sense of maleness and femaleness (Roller et al., 2009). In the current study, several of the women engaged in same-sex relations and reported that dating women gave them a sense of comfort and safeness that could not be found with the gender associated with their abuse. However, at least one young lady who reported dating females admitted that being with women left her unsatisfied and conflicted as she felt this was not her natural orientation.

> ***"so... I thought that being with women would have satisfied... my, you would say, my underlining issue, [Uhm]... but it didn't, and... it felt wrong. A (I) would be, a (I) was always conflicted by the fact dat a (that I) was dating females [Uhm] and a (I) said okay 'why am I doing this?" - [Grace, 25]***

5.2.3 Parenting

The relationship between CSA and parenting competence in adulthood has been given much attention in the literature. There is some evidence to suggest that a history of CSA is associated with various parenting concerns including quality of relationships with children and risks for various forms of intergenerational abuse (Sanjeevi et al., 2018). In the current study, many of the survivors had children and a common theme among them was their approach to parenting. Approximately half of the women interviewed talked about their responsibility as parents to prevent their own children from experiencing sexual abuse. The women described themselves as protective and vigilant. Perhaps realising from their own experiences that the perpetrator of abuse could be anyone and the circumstances that increase the risks of abuse, the women endeavoured to monitor the movements of their children and were cautious and restrictive with persons they entrusted with their children.

> ***"(I) don't get a chance to goh (go) certain places that a (I) would want because a (I) don't leave ma (my) child with any and any one [uhm]. A (I) don't trust persons a lot, like even my mom, a (I) don't leave my son with my mother [uhm] . Aa (I-I) don't leave ma wid ma maddah (my with my mother) any at all." - [Chloe, 24]***

It is evident from previous sections of this report that one risk factor that contributed to CSA among the survivors was poor parenting. These women survivors appeared to understand the importance of their role in fostering healthy parent-child relationships to minimise the potential for abuse of their children.

> ***"...it's my responsibility to ensure what I wen(t) through you will never have to go through it and, I felt that my mother should have done that." - [Hope B]***

Some of the women, who themselves had poor relationships with their mothers, endeavoured to encourage trusting relationships with their own children, with the hope that the children would feel comfortable sharing or disclosing any inappropriate sexual advance made towards them. The women indicated that they would emphasise to their children the importance of disclosure. One woman spoke of her efforts to protect her child by educating her about sex related activities.

> ***"... what I do with my eldest child now, we have that mother to child mother to daughter bond, very, very close. So, I can say every single detail, anything happening, she tells me, she is not afraid, so I don't, I don't, even though you must try as parents, however I still understand that when it comes to you children to trust you, you have to set that foundation from an early age and an early stage, so, yuh nuh (you know) nothing happen she run to me and say mommy so and so and so [hmmm, hmmm] or whatever, (so, you know anything happens, she will come to me and say mommy so and so or whatever). A talk to her about good touch, bad touch because even so when she is not around me ahmmm... When she is not around me, ahmmm I trust that she can call me at any given time to say mommy this is happening- [Superstar, 26]***

In addition, whilst not common among the females in this study, one woman admitted that while she lived in fear of her children being sexually abused and tried to protect them, she realised that she would maltreat her children at times because of the residual anger from her past sexual abuse. Dilillo et al., (2000) indicate that a history of CSA can predict the risk of physical abuse as a parent, and this relationship is mediated by maternal anger. Also, of note is that one survivor shared her fear of having children because she was terrified that her child would have a similar experience.

> ***"I don't wish any of this on anybody like, I'm scared to have kids." - [Raven, 20]***

5.3 Poor Academic and Occupational Functioning

As a result of the severe impact CSA has on emotional and psychological functioning of survivors, it was highly likely that their ability to function in academic and occupational settings would also be affected. Previous research has linked CSA to an increased risk for poor educational attainment and reduced life chances, though social, family, and contextual factors may influence these outcomes (Barrett, Kamiya, & O'Sullivan, 2014; Boden, Horwood, & Fergusson, 2007). Ten of the 15 women interviewed for the current study revealed some challenges in occupational and academic functioning after the abuse. Specifically, some of the survivors struggled to function at school which led to immediate effects subsequent to the abuse such as a decline in their academic performance, truancy and, for some, dropping out of school completely.

> ***"... so I will just be at school every day so, but mentally mi no deh deh (but mentally I was not there), it's like mi deh some way else (it's like I was somewhere else) but mi know seh the teacher deh and the board up a deh board a teach summen [but I know the teacher is at the board and teaching] but to tell yuh the truth me don't get it and then it showed [but to tell you the truth, I didn't get it, and it showed], it showed in my test paper, in my test and so on..." - [Superstar, 26]***

Whilst many of the survivors indicated that they struggled academically after the abuse, others managed to complete their secondary level schooling and a few were able to pursue tertiary level education. An important factor for these young women was perhaps the intervention and support of others, such as the insistence of their parents.

> ***"A (I) stop going to school an (and) everything. Until at one point my dad an (and) I had a talk an (and) he was like. 'hey, shit happens' [Uhm] 'and it's not like we can turn back the time to prevent it from happen. Im tell mi seh im know it hurt becass it hurt im to (he told me that he knows it hurt because it hurt him too) [Uhm]. But it's time fah (for) me to get maself togedda an (myself together and) start going back to school, becass a (because I) had a bright future ahead of mi (me) [Uhm]. And he keeps pushing and pushing and pushing until a decide seh (I decided that) okay I was going to go back to school." - [Kelly, 29]***

Despite positive academic engagements for a few of the women, many of them struggled with self-doubt and felt that they were not able to live up to their own occupational expectations. For instance, a few survivors revealed that they did not have enough self-confidence to pursue goals or make "something better" of themselves. In fact, some survivors admitted that they were not even able to conceive a meaningful occupational future for themselves and struggled to understand their purpose in society.

> ***"I went back home and back home is in a very poor destitute community and I had finished high school before I got pregnant but I didn't have a career, yuh (you) see and so I went back home and I was a legit a bum. So, I would sit on the corner with the guys, I would smoke the weed (marijuana), I would drink the alcohol. I would talk all kind of crap and I would do that over every day and that was basically my life [yeah] and by the time I was twenty–one, I had two kids [hmmm] and I was still in that cycle. I had no goal, no future, no vision, no nothing" - [Hope B]***

Nonetheless, a few of the women noted that their children were the catalyst for giving them renewed purpose in life. It seems some of the women came to the realisation that the life of their children would be adversely affected if they did not change the trajectory of their own lives.

> ***"After I finished high school a (I) just basically was just living like a zombie. A (I) didn't care about anything, a (I) didn't care what happen to me, (I) didn't care what happened to anyone. Soh a (so I) was a (I) was living. Just for living sake. I didn't have a purpose that I want to look forward to. Until I found out dat (that) I was pregnant with my son. And after I had my son dat (that) December. I dat (that) give me a sense of say okay I have to be here for him. If not for me den (then) for him. Soh (so) I started pulling maself togedda (myself together), a (I) started researching and so forth, starting to learn how, to it was like a (I) was a (I) was learning how to walk again. So I started getting my act together." - [Kelly, 29]***

5.4 Maladaptive Behaviours

Research suggests that CSA is associated with increased risks of substance misuse (Draucker & Mazurczyk, 2013; Polusny & Follette, 1995) and other externalising behaviours (Maniglio, 2013). Externalising behaviour may serve as way of coping with the distress brought on by the abuse or may be a signal for help (Fisher et al., 2017). Similar findings were noted in this study. Five of the survivors indicated that they engaged in some drug use or other forms of maladaptive behaviours such as stealing and gambling. For at least four of the women, the enduring effects of the abuse resulted in misuse of substances such as alcohol, cigarettes and marijuana. One survivor sums up the extent of her maladaptive behaviours and misuse of substances whilst still in secondary school:

> ***"So, I started smoking marijuana and I started taking it to school, and I would sell it at school and yuh nuh (you know) and there was has I said, I was in a group at school with mostly boys. I would use the money, the money generated from the sales to purchase the alcohol and to gamble yuh nuh, yuh nuh (you know, you know). I was always doing the wrong things all the time yuh nuh (you know). I was caught up in the wrong crowd..." [Hope B]***

Another survivor indicated that while she did not turn to drugs, she "acted out" by stealing. She also reported almost being expelled from school and running away from home. The survivor describes her actions as a way of crying out for help and trying to escape her circumstance of abuse.

> ***"I still, I still was being abuse [crying] over and over again [okay]. So, I just started to do random stuff, cause I just, I didn't have to steal but a (I) steal and, and persons, it was as if I was crying out, but nobody could really hear me. I was acting out nobody could really see that, nobody paid attention to all those signs." - [Superstar, 26]***

6

Disclosure

Disclosure of CSA is a process. It is usually delayed.

After sexual abuse occurs, many children choose not to tell anyone due to certain barriers to disclosure including fear, financial dependence on the perpetrator and challenges faced in the justice system.

Social support and having an opportunity to tell are among the greatest facilitators of disclosure.

6.1 Definition of Disclosure

There is great variation in the definition of the term disclosure in the context of CSA. It may be used to describe any of the following: telling someone about the abuse for the first time, telling a friend or peer, making a statement to authorities such as the police or others in the justice system or those in the child welfare system, divulging parts of the story, as well as recounting the experience from memory perhaps for purposes of an interview for research for example. For purposes of this section, all of the above encompass disclosure – we view disclosure as an ongoing process involving psychological, social, emotional, and behavioural components, rather than a one-off event.

6.2 Theoretical Background

It has been estimated that somewhere between 30-80% of persons who experience CSA do not disclose the abuse or there is a delay of disclosure until adulthood (Goodman-Brown et al., 2003; Smith et al., 2000). It is also noteworthy that some children will intentionally tell others about the abuse while others do so indirectly if at all. This is in keeping with the findings from our study, where 12 out of 15 persons indicated that they delayed disclosure. One respondent puts it this way:

> ***'it was not until like probably in my teens... like in ma (my) teen a (I) would tell ma (my) mother. Ah (I) told ma mom and they were surprised' (Grace, 25)***

In a somewhat dated but seminal publication, Summit (1983) proposed a model known as Child Sexual Abuse Accommodation Syndrome which is relevant to the current study. He suggested disclosure was a process and explained why children choose to disclose or not. The syndrome is composed of five categories: (1) secrecy, (2) helplessness, (3) entrapment and accommodation, (4) delayed, unconvincing disclosure, and (5) retraction (Summit, 1983). He proffered that it is not that children are vindictive and calculating and hurl baseless accusations at adults about sexual abuse, rather in most instances children are fearful, tentative and confused about the nature of the sexual abuse and the outcome of disclosure. In fact, victims oftentimes not only regret having disclosed in cases where they are disbelieved by adults but become more embittered toward those who rejected their pleas for help than the one who initiated the sexual encounters.

Summit went further to suggest that a child who is molested by a father or male guardian and then who is rejected by the mother is psychologically orphaned and virtually defenceless against multiple harmful consequences. Conversely, when a mother or female guardian believes the child and intervenes, she serves as an advocate and protector against the recurrence of abuse. This in turn empowers the child, resulting in a better prognosis for recovery with less severe and long-term harmful effects (Summit, 1983).

Goodman-Brown et al (2003) further developed Summit's work to include self-blame, fears of the consequence of telling, or others' reactions in their model as key factors influencing delays in disclosure. They opined that developmental factors, particularly cognitive limitations, may inhibit disclosure in young children as younger children may not fully understand that abuse is wrong and inappropriate.

Disclosure is pivotal for a child to access the necessary intervention after CSA has occurred. The fact that there is a delay or reluctance to disclose CSA at all implies that children who experience CSA may not get the support or intervention necessary to cope, which could lead to long term physical and mental health problems such as anxiety, depression, post-traumatic stress disorder and substance use disorders. In addition, the lack of disclosure may lead to further victimisation and put others at risk of abuse. In the remainder of this chapter, we examine CSA survivors' reasons and experiences for (non) disclosure, with a view to understanding what needs to be in place for children to safely disclose CSA.

6.3 Types of Disclosure

Children disclose in various ways. Some make full disclosure, giving details about their abusive experience shortly after it occurs. Others may reveal bits of information over time, not necessarily in chronological order and sometimes to several people (Ciarlante, 2007). Perhaps the two most common typologies of disclosure are purposeful and accidental disclosure as described in the seminal work by Mian et al. 1986. Purposeful disclosure refers to "an intentional and deliberate revelation of the abuse with clear intent of revealing its existence" while accidental disclosure is "a statement made without forethought or intent to reveal the abusive relationship". Accidental disclosure may occur when a physical symptom is detected or when a child displays some behavioural or emotional symptom (Shackel, 2009). One of the respondents recounted that this is what happened in her case:

> ***"Well... I... I didn't open up to her, it is the doctors [aahahahah] and so when ahmmm they examine me and so on [that's how they found out] calling the police that's when she found out. I didn't open up and sey (say) boy that was what was happening and so on I didn't tell her" (Superstar, 26)***

Similarly, another respondent had this to say about the accidental nature of disclosure:

> ***"...Well yes, my mom, my mom, my mom ahm, fou- well she-she found out about it and it cause one whole bag of something, police and everything involved in it." (Goodie, 27)***

Disclosure may also be categorised as prompted or elicited in which the disclosure is assisted by other people and precipitant disclosure which occurs when an event prompts or triggers a memory of the abuse (Campis et al., 1993; Hershkowitz et al., 2007).

6.4 Barriers

6.4.1 Fear of disbelief by others

Several studies point to the fact that a key factor in their propensity to disclose is a child's fear of disbelief by others. This precludes disclosure. (Goodman-Brown et al., 2003; Kogan, 2004; Tener & Murphy, 2014). This is closely tied to the actual reaction of others. Children are very sensitive to others' initial reaction to their disclosure. The following excerpts show the initial reaction of others after the child chose to tell them about the abuse. For Marie, she was molested by a neighbour's son. Being the child of a single mother, she was left in the care of another single mother next door while her mother went to work. She outlines what happened after the incident occurred:

> ***"This was the same day because, I saw the blood. I didn't know, I thought it was something bad had happen I went next door and I told my mother other friend [hmm] and she said that I musten (must not) go over there. I must stay there, while I was there his mother came and started to look for me and the lady didn't tell her why... I... was by her house and it started a big confrontation between the two ladies, with the lady that is keeping me and the lady that I made the complain to [yes]. When my mother came in the evening and my mother friend told my mother the truth, told my mother what happen [hmm]. My mother went back over there collect my little sister she never said anything....[she never said anything to you] no, my mother never said anything to me, to Ms R, that's the lady that made the complaint [hmm] she never said anything to the lady***

that kept me and my smaller sister, she just collected the bag and left. Up to this day I felt, also up to dis (this) day, I, I didn't get any justice from my mother. She didn't say to me that he was wrong for doing it, or, or some girls woud dah seh their mother woud dah sey a you cause it (or some girls would say their mother said, you're the one who caused it). She never explain, explain anything, anything to me all that I told, "I must never... ever... go back there."...", I am thinking that my mother cause, cause they were three good friends yuh nuh (you know) they were three mothers, single mothers and I am wondering if my mother blame me why Ms Tate and the other lady not talking. ..." "I don't think they ever spoke again. And that burden came down on me because, mi wonder if a me mash up the friendship (I wondered if I am the cause of their relationship being torn apart had I not let her son do this to me" (Marie, 47)

After being molested, Raven was so traumatised that she had a severe reaction. Her mother's decision was to cover it up.

> ***"I fainted on the spot, woke up in the hospital and my mom was there and mi mada look pan mi and she seh to seh, "Raven, tell the doctor seh yuh drop and lick yuh head and cut yuh foot, (I) said you know what happened and she looked at me and said, "nuttn nuh happen to you, you too lie." (My mother looked at me and said, "Raven, tell the doctor that you fell and hit your head and cut your foot," I said you know what happened and she looked at me and said, nothing happened to you, you're a liar." (Raven, 20)***

In the case of Savannah, she cried out for help while the abuse was occurring, but no one came to her rescue:

> ***"I'd be calling for help but nobody came... I think after crying out... a saying mommy! And she not answering and to my mind, I am here, and she is just outside the door and she not hearing me?..." (Savannah)***

All of the accounts above, illustrate the point that these children were abandoned having told adults who were supposed to care and protect them and see to their safety. These initial reactions lead to further confusion and guilt on their part not only for what happened, but also that they felt guilty for disclosing because of the negative response from the trusted adults.

6.4.2 Intrafamilial or extrafamilial

Perpetrators tend to look for individuals who are easily and readily accessible and most perpetrators are known to victims. Indeed, a child is three times more likely to be molested by a trusted adult than by a stranger (Summit, 1983). Fear of negative consequences for the perpetrator who may be a family member as well as the relationship between the victim and the perpetrator and family dynamics all combine to hinder a child to disclose the abuse (Collin-Vézina et al., 2015; Lemaigre et al., 2017).

6.4.3 Age

Children who were very young at the time of the abuse and who experienced more frequent abuse took longer to disclose. Older children were more likely to feel that they were responsible for the sexual encounters. Children took longer to disclose the more closely related they were to the offender.

6.4.4 The justice system

In the event that a CSA case is reported to the police, and there is sufficient evidence to warrant a prosecution, the case may proceed to court. However, there is a risk that cases may be lost at the investigation stage, and will not automatically proceed to court.

It is important to understand the basic neurobiological responses to trauma and stress and to see the link with having child witnesses providing open testimony in court. Van der Kolk (2006 and 2014) found that there is increased activity in areas of the brain that support emotions and a simultaneous decrease in regions that govern speech and communication. When a witness is exposed to traumatic triggers, it decreases their ability to communicate effectively. There are several potential triggers that exist in the courtroom. These include the sight of the perpetrator, direct questioning about the abuse, and even the presence of the judge, jury, police and others, many of whom are strangers. Just the mere fact that the child is in court may trigger this neurobiological response.

> ***"An even fi goh inna (and even to go into) courthouse... an seh (and say) they find the perpetrator and you are in a courthouse with the perpetrator an affi goh back ova all a dat! (and have to go back over all of that)" (Chloe, 24)***

This becomes heightened for those children who may be exposed to repeated abuse. Thoman (2014) argues that traumatic experiences in the child's early environment can cause chronic dysregulation that may impede communication and information processing. In addition, research shows that anxious child witnesses have poorer recall and information processing, answer questions less accurately, have a greater level of difficulty concentrating and provide less complete and accurate descriptions of events (Thoman, 2014).

There has been widespread concern over the past three decades, especially in North America and Europe, about children's ability to cope with a legal system that was designed by adults for adults. It is believed that young children may not have the ability to comprehend the nature of the crime, the implications of the importance of their testimonies, or be simply too afraid or anxious to testify. In addition, court cases may drag on for years and can take a toll on anyone, let alone children. This is compounded by the fact that the child witness has to recount many times the unpleasant circumstances of the abuse. This is eloquently stated below:

> ***"A lot a (of) times sometimes the reason why person doh (don't) worry ahm report that they have been abused is because all a (of) the things weh (what) come afterwards. Because you report it. Is eedah yuh goh (either you go) to the police station they don't tek (take) it serious (seriously) And each time yuh affi a (you have to) continue a talk ova (over) everything weh (what) happen to yuh (you), yuh (your) experience and everything. An yuh (and you) talking to people who maybe have not experience sexually abuse before. And they may not understand or feel your pain or know weh yuh agoh (that you are going) through". (Chloe, 24)***
>
> ***..."if they do tek (take) it serious and it goes to the court is a long drawn out thing, fi (for) all a five, six years". (Chloe, 24)***
>
> ***"it's not easy. It's not easy because I have, I have a lot a (of) friends... who have tried doing it, going to the court an (and) all and they stopped. They just give up on the justice system [okay yea. So?]. Because of the time it takes". (Chloe, 24)***

Courthouses can be scary places for children and even for adults. Another significant barrier to disclosure is the fact that survivors must face the perpetrator again. This inevitably leads to re-living the trauma over and over again. The following quote best illustrates this:

> ***"An even fi goh inna (and even to go into) courthouse [uhm]... an seh (and say) they find the perpetrator and you are in a courthouse with the perpetrator an affi goh back ova (and have to go back over) all a dat (all of that)" (Chloe, 24)***

If an adult who is perceived in the community as respectable and reasonable is accused of sexual assault by an uncertain, emotionally distraught child, some adults who hear the accusation will fault the child. As shown in Figure 6, this is likely to be an important barrier to CSA survivors' access to justice. None of our respondents immediately sought to disclose to the police or other authorities, instead, their first experience of disclosure was to a trusted adult known to the child.

> ***"I'm thinking, if me fi go tell somebody seh this ya Pastor yah weh everybody look up to a do this dem ago tell you like, dem ago tell mi seh mi straight up lie.***
>
> ***"Yeah highly respected and so I'm like, who is going to believe me"? (Grace, 25)***

English translation:

> ***"I'm thinking that if I tell somebody that this Pastor who everyone looks up to is doing this, they're going to tell me that I'm lying". (Grace, 25)***

6.5 Facilitators

Support from others with similar experiences

'The following excerpt details circumstances that led one woman to decide to talk about her experience for the first time because she realised that she was in the presence of other adult females who were also survivors of CSA and who themselves had disclosed. Therefore, she felt that she was not alone and gained the impetus to share her experiences:

> ***"I realised that almost everyone in the room wrote their own name. They were sexually abused and like I just couldn't believe it and a (I) breakdown and a (I) started crying. And they came and they started asking what was wrong, and a (I) disclosed. And a (I) told them that I was afraid that I was the only one here [uhm], other than the presenter [uhm] who has been sexually abused soh a (so I) didn't write (my) name. But afterwards now an a si (and I saw) how the other persons are brave and they write their names that they are sexual abused, a (I) just couldn't hold it anymore" (Chloe, 24)***

> ***"And hearing their stories and getting to exchange stories and that's how I deal with mine. Because you know that you are not alone, it, it not unique to you. It could, it could have happen to anyone" (Chloe, 24)***

An opportunity to tell

Having an opportunity to tell someone about the abuse has been found to be a significant factor in facilitating disclosure. It is critical that a person has not only the time, but the place where they feel that it is appropriate to disclose to a confidante, their experience of CSA. Additionally, the setting has to be deemed to be safe. The situation may also present itself where the topic of CSA is being explored either through conversation or external sources such as through the media (television, radio etc). Some respondents also described that opportunities to disclose arose when someone they trusted showed concern for them, be it a family member, teacher, neighbour or some other adult. In the case of Grace, below, her Pastor realised that something was wrong and decided to ask his wife who had a similar experience, to intervene.

> ***"And pastor would call mi (me) and would say you need to come to work an a seh (and I'd say) a (I) don't want to come to work. A (I) just don't want to come to work. And he said, okay a (I) need you to speak to my wife. An den (and then) she took my number, she got my number rather, and she messaged me. An dat (and that) night a (I) was crying and she said, 'can I call you?' [Uhm] and I said yes, you can call mi (me)... and she was talking to me about her experiences [Yah]. And she was telling me about Jesus giving me the peace that I, that I need if would just accept Him and be saved. I... will not be in the state where am constantly think all a (of) the hurt, the rejection the pain, He will take that away... it was a very extended conversation where she was just talking to me and just tell me about her experiences and all a dat (of that). And... a (I) said well, cause at that time a (I) met her already [Uhm], at church when a (I) saw her. Soh a (I said) okay, fine, ahm... A (I) was so fed up. A (I) was so fed up a (I) decided dat (that) something had to be done." (Grace, 25)***

In the case of Hope B, the trusted person was her husband to whom she had first disclosed. He in turn encouraged her to disclose to her mother, because he'd seen how it was affecting her after so many years.

> ***"... then he (my husband) stood up one day and say, 'no, you're not going to do this to yourself any more. You're going to confront these people and you are going to let them know what it is, is happening and if you want me to be there with you I will be there with you. I, I, whatever it take [hmmm] he said, we are going to do this'. And it was at that point, [hmmm] I think I was about maybe thiry-four years old there about and he said call yuh (your) mother call her, [hmmm] and I called, and I said to her that I need to talk to her. And she came at the house and he said 'you want me to come with you?' and I said no. I felt I needed to do this on my own [yes] he was right outside the door waiting (chuckle) yuh nuh (you know) waiting to come in. In the event I needed him and, hmmm I spoke to my mom at that point and hmmm told her how I felt about everything, I told her how I felt about her [hmmm] because I hated her [her hmmm] and I told her why" (Hope B)***

Star had mixed reactions to her disclosure. She found an opportunity to tell her grandmother, whom she trusted. Her grandmother believed her and her grandmother then disclosed to Star's mother. The reaction from Star's mother was that of denial and blame. However, the support of her grandmother was reassuring.

> ***"I went up there and I explain to them and I explain to my grandmother and me (I) tell her and she say she a come talk to my mother and when she come and talk to my mother she say me (my) mother say she don't want me back there and thing and me no have nowhere fe (to) go and she ago make me stay so she talk to me and she ask me fe (to) tell her the truth and me (I) tell her everything and she say she believe me because a so man stay" (Star, 42)***

English translation

> ***"I went up there and I explained to them and I explained to my grandmother. She said she would speak to my mother about the situation. My mother told her that she didn't want me back at her place and I didn't have anywhere else to go, so my grandmother allowed me to stay with her. She then asked me to tell her the truth about what happened and I told her everything. She said she believed me because that's the way men are" (Star, 42)***

Research also suggests that disclosure is more likely to be made following a prompt rather than being initiated by a child (Kogan, 2004). This

is particularly true if the prompt comes from a trusted adult. Close relationships may therefore play an important role in facilitating children to disclose CSA (Priebe & Svedin, 2008).

6.6 To whom is disclosure made?

When disclosure was finally made, there were a wide range of persons to whom survivors of CSA disclosed. These included family members, friends, schoolteachers, medical doctors, counsellors, psychologists, pastors. These persons primarily were persons whom the survivors either trusted and or expected would provide further assistance and protect them from future harm. The persons to whom the disclosure was made initially were very close female family members or close friends. These were either to a mother, grandmother, or aunt. Depending on how those persons responded, no further disclosure may have taken place. If the persons to whom disclosure was made believed them and they decided to make a report, then disclosure would also have to be made at various other levels, as shown in Figure 6.

In a number of instances, these trusted persons either did nothing about the disclosure, blamed or shunned the survivors. Usually when this happened, persons withdrew and their trust in others was eroded. This may be coupled with feelings of confusion, as the survivors may ask themselves if it was their fault, did it really happen at all and what they could have done differently.

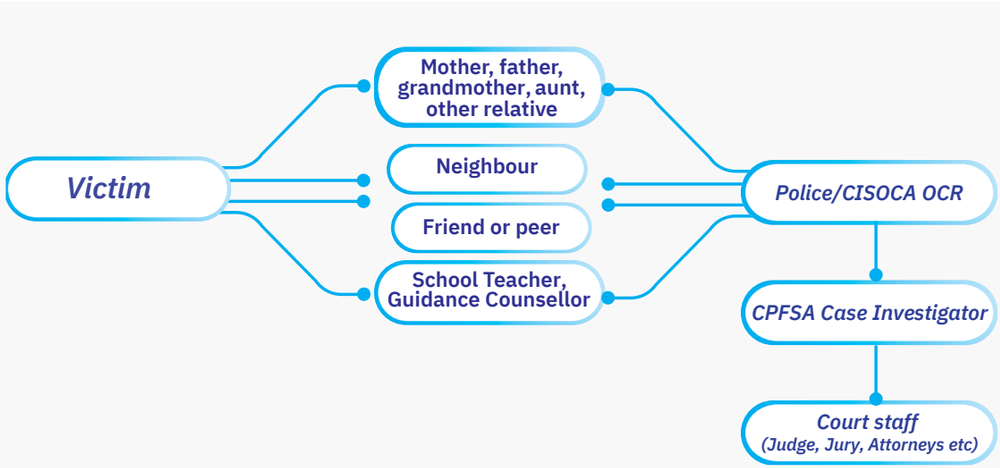


Figure 6: Chain of Persons to whom disclosure is made

Disclosure, when believed, has the benefit of being cathartic for survivors.

A few of the respondents expressed that they found it cathartic when they disclosed to someone who showed concern. The excerpts below illustrate the point:

> ***".. Is like talking to other persons and sharing, I realise she (that) when you talk about yuh (your) abuse with persons who has, especially have experience similar or the same thing... Like other persons you {uhm] it helps to have that support" (Chloe, 24)***

> ***"Well, most a di (of the) times when I discusseds my problems with other persons, I, I was given sound advice. Yes. Sound advice as to what to do because I only discussed my problems with persons like ahm Healthcare providers or Counsellors". (Goodie)***

7

Coping and Resilience

Coping and resilience are not static but rather evolve over time.

Some coping strategies used by children are different compared to those used by adult survivors.

Both positive (writing, reading, becoming mentors, hanging out with friends or listening to music) and negative coping strategies (substance use, suicidal behaviour, risky sexual behaviours) were used by survivors to cope with the sexual abuse.

7.1 Definition of terms and theoretical background

Coping

As discussed in chapter 5, child sexual abuse can have several debilitating effects on children – emotionally, socially, cognitively and otherwise that may last into adulthood (Afifi & MacMillan, 2011; Johnson, 2004; MacMillan et al., 2001). Another important consideration is how children cope with these experiences. Coping includes thoughts, emotions and behavioural responses employed when one faces stressful or threatening situations (Walsh et al., 2010; Folkman & Lazarus, 1980). Coping is not static but rather coping strategies may change over time (Horowitz, 1986).

It has been observed that one set of coping strategies are seen in the immediate aftermath of CSA and another set in the long-term. In the short term the main coping strategies include psychological escapes, physical resistance and distancing. In the long-term these evolve and may include rumination, normalising of abuse and acquiring a sense of psychological control.

Closely tied with the distinctions is the consideration that coping strategies employed during childhood appear to be unique compared with those employed when these victims become adults. During childhood some of the main strategies employed are attempts to stop the abuse, avoidance, psychological escapes and compensation. On the other hand, during adulthood in order to cope, survivors may employ strategies such as breaking away from the past, engaging in self-discovery and/or cognitive coping. It is important to note that some people do not learn effective coping strategies and may be more vulnerable to distress (Aldwin in Littleton et al., 2007).

7.2 Resilience

There is no consensus on the definition of the term resilience. Some commentators conceptualise it as a personal trait as opposed to a dynamic process. Others view it as two-dimensional and take into consideration the life circumstances of the victims as well as evidence of positive adaptation (Domhardt et al., 2015). Walsh and colleagues consider resilience in maltreated children to be present when they show a normal range of competence across several domains including behavioural competence (how they act toward others), emotional competence (referring to mental health), social competence (peer relations) and academic achievement (school performance) (Walsh et al., 2010). Some people subscribe to the view that this positive adaptation must occur in several areas of life (Domhardt et al., 2015) while others suggest that it is sufficient to display positive adaptation in only one domain. Others consider the absence of psychopathological symptoms as indicative of what is referred to as relative resilience (Domhardt et al., 2015). Nevertheless, high levels of resilience may be protective against the negative effects of child abuse (Brewer-Smyth & Koenig, 2014). For purposes of this report, we have decided to adopt the view that while resilience is not unidimensional, persons can display resilience in one domain and not in others. Based on interviews conducted, our study yielded a number of coping strategies and evidence of resilience as discussed below.

7.3 Expressive and Cognitive Processing

Writing as Therapy

Nine out of the 15 women interviewed reported engaging in writing or journaling as a way of coping with their experience. Expressive writing can serve many emotive and cognitive purposes including, catharsis, finding clarity and understanding, and self-discovery (Meston et al., 2013). Meston and colleagues also found that women with a history of CSA who suffer symptoms of depression, post-traumatic stress disorder (PTSD), and sexual dysfunction, experienced reduced symptoms when they participated in expressive writing. However, while expressive writing or experimental disclosure produces both physical and psychological benefits (Baikie & Wilhelm, 2005; Frattaroli, 2006), the mechanism by which these benefits occur seems to be complex (Baikie & Wilhelm, 2005). Nevertheless, many of the women survivors in our study described writing as a process that enabled "healing" as a way to ease the psychological pain associated with the abuse.

> ***"So I started to write every single thing that happened to me and all a (of) those stuff... So writing was one of my healing process(es)... I started to write at age twelve but at some point I stopped... Then I started again because I realise(d) that ahmmm writing... it helped me a lot." (Rihanna, 28)***

One survivor specifically indicated that writing helped her to cope with depression and suicidal thoughts. Similar findings have been noted among college students who experienced reduced anxiety, depression, and suicidal ideas after writing about childhood physical or sexual abuse (Aldridge Antal & Range, 2005):

> ***"...and I got into depression and I didn't even know that it was depression that I was going through and I wanted to kill myself... Going back to when I was a teenager how I cope(d), I use(d) to just write my feelings down." (Star, 42)***

Journaling or writing provided some survivors the opportunity to safely express details about their experience that they would have found difficult to express to someone else. One participant describes her writing as speaking to a friend at a time when she could tell no one, while for another, writing gave her a place to speak about things that she felt embarrassed about:

> ***"Yes it did help because not... being able to tell anyone... but being able to write it... it would've feel (felt) like is just you have a little friend there where you just writing it to and that's how I felt, at that time." (Chloe, 24)***

> ***"So I really felt ashamed, felt bad. This is not something that you want to be talked about but I use(d) to write. I use(d) to write a lot. So I would write from what I remember, from living in the country and such." (Hope A, 35)***

For one participant, writing helped with self-discovery and was a method for therapeutic catharsis. In one sense, she was trying to understand her experience of the abuse and in another sense, she used writing as a way to express her feelings directly to her perpetrator. In clinical settings, the latter may be considered a kind of empty chair technique, where the survivor is able to express previously constricted thoughts to the perpetrator, without confronting him face-to-face (Paivio et al., 2010).

> ***"In all a dis and trying to find myself and trying to figure out what was really happening, I decided that 'look, mi tired now. This nah work'... and whatever. So I found myself writing Pastor a 7- 8 page worded paper, back and front and I'm like: 'what did I find to write so like?' I was probably very detailed why it was that long. But I wrote him a very detailed letter telling him off and telling him all that I've been through" (Ashley, 29)***

English Translation:

> ***"In all of this situation and trying to find myself and trying to figure out what was really happening, I decided that 'look, I'm tired now. This is not working'... and whatever. So I found myself writing Pastor a paper 7- 8 pages long, written on both sides and I asked myself: 'What did I find to write so much about?' I was probably very detailed why it was that long. But I wrote him a very detailed letter telling him off and telling him all that I've been through...." (Ashley, 29)***

Ashley also had the opportunity to retrospectively reflect on how writing was one way in which she was able to get through her experience. She recalled recently finding one of her journals and being able to connect with the emotions that she had recorded many years before:

> ***"...I went home recently, ... and I found a book and I was reading the book and like I didn't know I was such a good writer...but when I read it, I could literally connect with the kinda pain I was having, like 'who is th-' like I literally said: 'who was this girl?' 'What exactly was I feeling to be writing like this?' And so I realised that I've been through hell emotionally, mentally like: 'wah dat?' Yeah that hit mi to read a writing of my own..." (Ashley, 29)***

At least three of the women survivors became authors. They saw writing as not just a means of catharsis but were also motivated to openly reveal their stories about their abuse in order to help other young women. The women deduced that through their books, they would be able to reach many more people by sharing their experiences and how they were able to surmount the challenges they faced. Hope B expresses it this way:

> ***"I just authored and published my first book... So that is basically about my experience and how I found healing and ahmm.... you know basically to help others too, to realise that it's not the end of the world. Yes, it's painful, and it is difficult to deal with. But at the end of the day there is life after abuse." (Hope B)***

> ***"And I believe that God himself instructed me to go ahead and write this book, put this book out there because this is a means to reach people, you never even meet yeah... yuh nuh , people overseas, wherever. I will never be able to meet them and sit down and talk to them like this. But when they pick up my book and they will read and see yuh nuh , how I got over the different stages, and how I manage to heal. And I believe it will be a very helpful tool in their healing as well." (Hope B)***

7.4 Psychological Escapism

Oaksford & Frude (2003) refer to psychological escapes as "coping strategies that enabled survivors to mentally evade their abusive situation" (p. 55). In their study, the authors identified several ways in which psychological escapes might manifest, including wishful thinking, engaging in activities to "block" thoughts of the abuse, attempting to bury memories of the abuse, denial, emotional apathy, and the use of substances. In our study, women survivors reported engaging in several escapist strategies to help keep their experiences of abuse off their minds. These included the use of substances, reading, dissociation, playing puzzles or card games, and meditating.

7.4.1 Substance use

One of the most common forms of psychological escape that our participants used was substance abuse, which was reported by six of the 15 women. The use of drugs is seen as a way of numbing or dulling the emotions or memory of abuse (Morrow & Smith, 1995). Some of the women engaged in the use of substances only immediately following the abuse, while others continued to do so as adults. The survivors reported using alcohol, cigarettes, and marijuana. For a few of the women, the use of substances occurred in the context of, or was accompanied by, partying.

> ***"Yeah, so ahm... eventually a started ahm, when a started college a started smoking, started drinking and cigarettes and marijuana. Soh a was doing them both and a was drinking and a would goh to parties a lot. Soh yuh know, being just dis party person, just going over and over an den ahm... when it all kind a wined down and the liquor yuh nuh wear off or when the marijuana ahm, wear off and you lay, when I lay down I would just start crying and den I was very like I said emotional." (Grace, 25)***

As can be derived from the quote above, these types of behaviours may offer temporary relief from overwhelming thoughts and emotions attached to the abuse. However, they are typically associated with negative outcomes over the long term as they can prevent necessary processing and subsequent resolution of the trauma (Merrill et al., 2001; Wright et al., 2007).

It is also noted that the use of substances may have been influenced by certain environmental or familial circumstances. For instance, one survivor had a family culture of marijuana use which made the drug easily accessible to her. Along with using marijuana herself, she also made a business selling it while in high school and used the money generated to acquire alcohol and feed her gambling habit.

> ***"...not to go into too much detail [okay] about my family but their, but their culture my family culture, ahmmm, somewhat expose me to marijuana [okay], and so it was always available to me, and that was, that was where everything started. So, I started smoking marijuana and I started taking it to school [hmmm], and I would sell it at school and yuh nuh (you know) and there was has I said, I was in a group at school with mostly boys [yes]. I would use the money, the money generated from the sales to purchase the alcohol and to gamble..." (Hope B)***

Another survivor turned to drinking and smoking because, according to her, she had no one around her to offer support and she felt helpless. She relied on the drugs to prevent her from resorting to more harmful actions.

> ***"I started drinking and ...smoking a lot [uhm] because a (I) didn't have a care, no one to seh (say) don't do this or don't do that or yuh gonna harm yuhself (you going to harm yourself)" (Chloe, 24)***

7.4.2 Other Distractions

The next most prevalent escapist strategy reported was reading. Four of the women indicated that reading was one way in which they were able to temporarily divert their thoughts away from the experience of CSA. For at least one participant, reading was a way to educate herself and settle her mind, not just in direct relation to her CSA experience but also because she was HIV positive.

> ***"Well the most challenging time was ahm accepting my status. Yes, but I am the kind of person like this. As I said, I read all so I was educated and I try to inform myself as much as possible. Soh by reading and reading I realise that okay, summh mi can live with just***

> ***like diabetes. Soh mi nuh badda mek it badda mi, as how most people mek it badda dem. Mi jus focus on being healthy, and just have a normal life. ...-Adherence is very important." (Goodie, 27)***

One participant indicated that along with reading she would engage in other forms of distractions such as singing, doing puzzles or playing card games:

> ***"...but during my the coping with I would read [ahahahah], I would do ahmmm, what you call that thing puzzle [ahahahah] I would get the puzzle book, I would sing [okay, okay], I would just, I would keep, I would just... I didn't have any friends. (Superstar, 26)***
> ***"...I just kept to myself, I would just play... any game. A would, I would buy the cards pack and I would play the card pack by myself. It woulda like a me alone deh sharing and all these things yuh nuh. But just fi kinna have a .... steady mind setta. Just to get mi mind off a it. A of what is being happening and so on. Yeah. But just to kind of have a...steady mind setting. Just to get my mind off it." (Superstar, 26)***

Another participant found comfort in meditating by the sea in an attempt to relax and escape irrepressible thoughts related to her abuse experience.

> ***"so when it's really overwhelming, will (would) go on the beach... and relaxed... meditate and all of those stuff" (Rihanna, 28)***

Most of the participants who used psychological escapes, did so in isolation. However, one participant described spending time with friends and the use of humour to help distract her from memories of the abuse:

> ***"A just laugh it off sometimes, or I would sit down, or I would walk find my friends or just talk rubbish or sometime reasoning and.... all sort .... that's basically what a do. Sometimes it seems to not bother me but then, I would always say no it don't bother me but when I really think about it, it does. I just don't say it. But, ahmmm I am just glad I don't bring it out towards people." (Cody, 17)***

English Translation:

> ***"I would just laugh it off sometimes, or I would sit down, or I would walk to find my friends or would just talk rubbish or sometimes reason to myself and.... all sort of things .... that's basically what I do. Sometimes it seems to not bother me but then, I would always say no it doesn't bother me but when I really think about it, it does. I just don't say it. But, ahmmm I am just glad I don't bring it out towards people." (Cody, 17)***

Dissociation has been considered as an avoidant technique or a problem-solving technique in the literature, but it is arguably an important strategy used to cope with trauma (Phanichrat & Townshend, 2010). One survivor spoke of her attempt to consciously distract herself or in some way disconnect from what was happening while being sexually assaulted.

> ***"I guess that's it ahmm, [aahhh] that's what they call coping stress mechanism [okay] but .... ahmmm mi (I) just zone out so, whenever it happens it's like me, it's like it's two of me. I can't separate myself fi not feel the pain, so mi just put mi, mi me think about summen wey. I remember sometimes I would cry [aaahhhhah] when me when he would have sex with me and imagine yuh nuh [aahhhhahah] some other different things... (Superstar, 26)***

Translation:

> ***"I guess that's ahmmm what they call coping stress mechanism [okay] but .... ahmmm I just zoned out so, whenever it happens, it feels like there is two of me. I couldn't separate myself from not feeling the pain, so I just thought about something else. I remember sometimes I would cry when he would have sex with me and imagine you know about different things..." (Superstar, 26)***

Emotional apathy was also expressed by one survivor. She spoke of finding herself in a state of mind in which she was generally indifferent about life:

> ***"Yes to be honest yes, I, at one point mi start get... mi start have dis 'mi noh business' thing about mi. ...But it never lasted for long time... It didn't last for a long time." (Goodie, 27)***

English Translation:

> ***"Yes to be honest yes, I, at one point I started to get... I started to have this 'I don't care' thing about me. ...But it didn't last for a long time... It didn't last for a long time." (Goodie, 27)***

7.5 Self-harm

Some of the women interviewed admitted that they engaged in suicidal behaviour or other "pain-relieving" behaviours including self-harming (cutting), suicidal attempts, and obtaining tattoos. It is noted that tattoos while not generally associated with self-harm, was referred to in this way as a pain reliever for one participant. These behaviours are not unusual for survivors of CSA. Research shows a strong association exists between childhood abuse and future suicidal ideation and attempts (Enns et al., 2006). Also, child sexual abuse is associated with later incidents of deliberate self-harm (Romans et al., 1996; B. A. Van der Kolk et al., 1991). Injurious and non-injurious self-harm behaviours reflect the ways in which survivors struggle to manage their thoughts and emotions related to abuse. For instance, these behaviours may be an attempt to divert or suppress painful feelings, regain control over one's body, or a way of outwardly enacting feelings of worthlessness, shame, or self-hate (Noll et al., 2003; Phanichrat & Townshend, 2010).

Child sexual abuse is debilitating psychologically. Emotions and thoughts may become overwhelming for survivors, leading to suicidal ideation and, in some cases, suicide attempts. Three of the participants in our study spoke of at least one attempted suicide. One described her reason for the suicide attempt:

> ***"I would not find peace...I did not know what peace felt like because at one point I decide(d) that I am going to...I tried to kill myself when I was a teenager. I tried to kill myself" (Star, 42)***

Cutting was also practiced by one of the survivors. She describes performing this activity as a way of inflicting her own pain on herself, but at the same time receiving pleasure from it.

> ***"An a would cut ma-self. A cut ma-self and ahm a would just continue doing it, doing it over and over and over again. And it was just something a would doh. Just sit down in the dark and just listen music and cut up myself, over and over and over again." (Grace, 25)***

In a similar way, the participant described the pleasure she also received from the more socially acceptable practice of getting tattoos.

> ***"Right, soh ahm... it felt like a was, when was inflicting pain on myself, it made me feel good. When I was inflicting pain on myself. Yeah, yeah a know. It seem strange but ahm, it would be similar to me getting a tattoo.***

> ***A started getting tattoos and... it was... the pleasure of feeling dat pain... dat made mi constantly get tattoos. Soh it was similar to me cutting myself. The pleasure of feeling pain, ahm... made me continue cutting ma-self." (Grace, 25)***

7.6 Risky Sexual Behaviours

Risky sexual behaviours is a coping technique that increases the risk of sexually transmitted diseases and reinforces low self-esteem among CSA survivors (O'Leary & Gould, 2010). Hyper-sexual behaviours may result from confusion and misattributions about the survivor's role in the abuse which may lead to distorted ideas of sex and sexual relationships (Hughes et al., 2015). For at least one of the women, sex was a means of coping with the abuse. She acknowledged her confusion about her experience and resorted to sex as her means of coping.

> ***"Yes, soh it was just like one whole confusion. I was confused. Mi noh know wah fi do [Right]. Yeah soh, I basically I use to cope with sex." (Goodie, 27)***

English Translation:

> ***"Yes, so it was just like one whole confusion. I was confused. I didn't know what to do [Right]. Yeah so, I basically I used to cope with sex." (Goodie, 27)***

7.7 Social Support

Seeking and receiving social support have been found to be protective for trauma survivors. It helps to protect their mood and thinking as it may help to reduce shame and stigma that is likely to be felt by survivors, thus helping them cope. Having social support also benefits the survivor by affirming their worth and value. It also may play a role in establishing a sense of safety (Bryant-Davis et al., 2011). Knowing that someone is willing to listen and that someone cares helps persons to cope with the intense feelings of confusion, guilt, shame, anger and sadness among others that may arise after CSA occurs. As eloquently described by three of the survivors, social support also helped to provide a form of motivation by providing a reason for living:

> ***"that how a (I) even met ahm my mentor. And she had the same experience... Soh (so) we share similarities so when a (I) have her around, you know she would motivate me at that time when a (I) was going through that she would motivate me and say that she was living the same way, probably, she would describe it a little, a lot worst, but you know ahm... we shared a lot of similarities. Soh (so) when you have somebody you can look to, who, who has been through it... and they're out of it and yuh si dat (you see that) they are accomplishing the goals that they have always wanted to it mek yuh (make you) feel that 'hey you can get over dis (this)" [Uhm], you know, it is possible if you have help and she was a help fah (for) me". (Grace, 25)***

> ***"And I started to attend support group my sister saw that I was going according to her she say ' she think I must be getting mad'. So she carry me cause I was not getting any medical treatment [treatment] at the time [yeah, yes]. She took me back to the support group... and I started the support group and counselling [okay] at that time [hmmm]..... I think all growth started from then". (Marie, 47)***

> ***"So I started going into Facebook groups ahm dat (that) was motivational groups and so forth. So I start going into dose (those) groups and support groups and so forth [Okay]. So after after going the social media supports group. I started going to support group from from the health center [Okay]. So after doing dose (those) supports groups and persons that are also positive was here an (and) everything, everything just started forming tegedda (together), to say okay I can do this [Okay] And I am I am going to do this and was determined to do it." (Kelly, 29)***

7.8 Providing Support

It is interesting to note that not only did persons seek support, but when they became adults, some of them also became mentors and life coaches or motivational speakers themselves, providing support to others. The choice of occupation/career of the participants was primarily in the helping professions. Research shows that there is a significant relationship between experiencing childhood trauma and tending to gravitate to those professions, namely, social work, psychology, nursing, counselling, the clergy etc. (Reilly & D'Amico, 2010). Oftentimes, the chronic emotional pain that is felt by survivors of CSA translates into a sense of duty and a desire to 'make things right' by committing to serving others who may have similar experiences (Reilly & D'Amico, 2010). Findings from our study were in keeping with this as 12 out of 15 of the survivors were either working in or being trained to go into one such profession. The experiences in the excerpts below underscore the personal satisfaction gained from helping others.

> ***"I became a peer counsellor [ok] that did me justice because I was- I found that valuable, I was helping others. There were so many children with so many issues [hmm hmph] and they had no problem talking to me and I'm like ok this is cool I feel good to know that when they are finished talking to me they are ok or they are feeling better". (Ashley, 29)***

> ***"So I, I transit into a mentor mom pretty fast. I, I was only at Please Myself for a few months bef- ahm before they choose me to be a mentor [Oh]. And from den (then) I'm just helping my mentees, a (I) understand what they are going through becass (because) I have been there [Yes] So I am just a strong rock for them right now [Right]... Yes. Ahm, I'm doing the job that I love [Uhm]. Actually, my aim is to be the best mentor" (Kelly, 29)***

> ***"And that is why I, I, I give myself to people [hmm] now because .....if one woman could have made such a big impact in my life, I think I can do the same for somebody else. So, I [hmmm] lend myself to people... That's where I am at right now I, I tell people I am not afraid to give someone my number call me , if you need someone to talk call me and my husband and I, we have this relationship, knows I am on the phone eleven o'clock and I say honey, I am talking to this person and I will talk to you on the phone [hmmm]. I will encourage you, whatever it is I need to do. I will try to do because I believe that community is important in helping people to get over the hurdle [yeah] of dealing with the effects of sexual abuse" (Hope B)***

7.9 Religion and spirituality

There is growing evidence that religious involvement can be associated with good physical and psychological health for persons who practice a faith (Brewer-Smyth & Koenig, 2014). Attending a religious service at least once per week is associated with lower physiological effects of stress on the body (Brewer-Smyth & Koenig, 2014). Religion and spirituality may also promote resilience through various forms of social support (Brewer-Smyth & Koenig, 2014). Forgiveness of self and others (a particularly contentious notion in child sexual abuse

literature) may indicate better subjective health and decreased hostility for some (Brewer-Smyth & Koenig, 2014). Faith-based groups can help persons redirect their attention from the traumatic experiences to positive thoughts and emotions thus promoting resilience – known as mind renewal (Brewer-Smyth & Koenig, 2014). More than half (nine out of 15) of the participants in our study reported that their religious beliefs and practices were found to be useful methods in coping with the abuse, especially in the medium to long-term.

> ***"... mostly going to church, that would have been the coping mechanism." (Savannah)***

> ***"I believe that the church because if it wasn't for my spiritual upliftment or enlightenment, I would not find peace." (Star, 42)***

Below we see that in the case of Hope B, there is ambivalence as on the one hand she acknowledged that she had some connection with God, she had the support of her husband who prayed for her, and she also had various forms of support, yet she still did not have a desire to live.

> ***"I had a real encounter with God. I had a real encounter, I was actually on my way to a dance one night and I had an encounter, real encounter with God ... I had some kind of support [aahhh] ahmmm emotionally, spiritually, [yeah] because he (my husband) would pray, oh my God he would pray and financial to some extent. So yuh nuh and things just started to look better in my eyes [yes]. So I, I became a little bit more hopeful and ahmmm I was still struggling [hmmm], as I said I still wanted to die." (Hope B)***

For Hope A we also see evidence of a complex and contradictory relationship with God. She cries out to her God yet at the same time questions whether she really has an understanding of who this God is. Ultimately however, it was in the finding of faith that she was able to talk about her experiences and attributed her ability to participate in the interview to the "deliverance" she experienced.

> ***"I would cry to God [ummhh]. Ah (I) never understand who this God is but a (I) would cry to him cause a (I) use to goh (go) to church yuh know? ... I believe I am able to sit here and talk to you like this... because of my experience or my encounter with Jesus rather... Ahhmm I gave my life to Christ and through giving my life to Christ I met a man of God, he is a pastor and told me about deliverance not knowing my situation but he was just preaching about it and some stuff that I have been through and he mentioned about the whole sexual perversion and what happens." (Hope A, 35)***

Forgiveness

The following excerpts illustrate how one specific aspect of religion – forgiveness – can help or hinder coping. On the one hand, both Hope A and Hope B were able to forgive. Hope B was able to forgive her mother, even though she did not believe her after disclosing to her on more than one occasion about the abuse by her mother's brothers. Hope A was also able to forgive the perpetrators and 'get over it' as she says.

> ***"I don't blame her anymore at all. I have forgiven her (my mother) completely and ... really been trying to work on a relationship with her..." (Hope B)***

> ***"So going forward I can advise somebody else on what to do cause forgiveness plays a very important role as well soh (so) in order fah (for) you to get healing you realise that you have to forgive yuh' know?... Sometimes the person may not want to but a (I) mean it is your hurt so whether they want to or not yuh' know you need to get over it". (Hope A, 35)***

For at least one participant however, the Christian emphasis on forgiveness was not protective, but instead caused feelings of guilt as there was a dissonance between how she was feeling and her Christian beliefs. The literature speaks to this possibility as well, where religious coping may actually exacerbate distress (Bryant-Davis et al., 2011).

> ***"And I just can't forgive this man and it's the weakest [?] point I [?] to forgive him but I can't. It was so bad. I want, tried to kill him. I, sometimes I, ha, sometimes I wish I could kill him but it's not right for me being a Christian [?] to think about these [?] That spirituality has gone downwards [?] because of my situation and it's awful. I don't wish any of this on anybody like, I'm scared to have kids". (Raven, 20)***

Closely tied with their religious beliefs is the fact that having social support from persons especially in their religious circles proved to be beneficial and enabled survivors to better cope with the abuse.

> ***"I would always have that teacher talking with me or praying with me and stuff so I had that. Umm that did me justice I believe umm so I'm grateful for those little things [hmm hmph] and then umm becoming a Christian". (Ashley, 29)***

> ***"My husband is very supportive and a few people from church who is always checking on me calling me yuh nuh (you know)? Sometimes all we need is community because I felt as if people really cared yuh nuh (you know)? And at that time I could say alright if I am feeling this way I can call so and so and yuh nuh (you know) I can reach out to this person and so on [and I can trust them] and I can yes...." (Hope B)***

> ***"I had people in my life who would pray and encourage me and there was this one particular woman she was, I met her through my grandmother" (Hope B)***

7.10 Emotional

The expression of emotions is another method of coping with trauma that has been well documented. In one well-known psychological theory, coping strategies can be broadly divided into two types: emotion-focused and problem-focused. Although problem-based coping is generally associated with improved health outcomes (eg. Penley et al. 2002), emotion-based coping may be particularly important in situations where there is no obvious solution to a problem – as is the case in living with experience of CSA. The theme of experiencing and expressing emotions was evident as transcripts were analysed. Various emotions were felt and expressed, many of them were negative emotions but some had beneficial results.

Sadness, weeping and crying

The shedding of tears is a reaction to pain and anger. While crying is common in both humans and animals, weeping is demonstrated only in humans (Bellieni, 2017). It is therefore important to distinguish between the two concepts. Crying refers to uttering of a shrill loud sound, while weeping is an expression of grief by shedding tears (Bellieni, 2017). There are several useful functions that weeping serves. First, it is a request for help, or a signal sent to others and easily detected that causes others to provide help to those in distress. It is also found to be self-soothing as it helps to reduce feelings of pain or anger and it gives us a sense of wellbeing. It is also deemed to be allostatic as it helps to stabilise mood (Bellieni, 2017). Weeping was used as a means of coping especially in the immediate aftermath of abuse by many of the respondents (10/15). For some,

even during the interview they broke down in tears just recounting their experiences. Three of the participants described it like this:

> ***"So, the only thing a (I) could do a (I) could curl up in my bed and cry [Uhm]. A (I) use to cry a lot". (Kelly, 29)***

> ***"When I lay down I would just start crying and den (then) I was very like I said emotional. I guess you would call me emotional at that time yea, and would listen to some really depressing songs, an ah (and I) was like thinking about the situation over and over again like why this had to happen to mi (me)". (Grace, 25)***

> ***"I remember sometimes I would cry when me when he would have sex with me and imagine yuh nuh (you know) some other different things ". (Superstar, 26)***

Another participant, Star, notes that she used to cry a lot but now is able to talk about the experiences without being as emotional:

> ***"there were times when I couldn't talk about these things without crying I would come like a...a wash me wash me face". (It would seem like I was washing my face) (Star, 42)"***

Loss of bladder control

A significantly greater proportion of survivors of abuse have had bladder control problems than those who have never been abused (Davila et al., 2003). Hope B was so traumatised that she lost bladder control after being molested by her uncles on multiple occasions. Although she tried to disclose to her mother and grandmother who lived in the same house, they shunned her and she was re-victimised. This may have been a means of psychological control, as well as her way of crying out for help, but instead, she was further victimised as her peers made fun of her at school and she retaliated. Here is her account of what happened:

> ***"I remember when I was in grade three at the primary level I use to wet myself at school. And yuh nuh (you know) I would be teased at school. I would be so embarrassed and then I would get into fights. So, I would always be fighting, I would fight in every single school that I went to. I was angry [yes], and .... I was very withdrawn, ... [hmm] very very withdrawn. So, I believe that these were some of the ways that I dealt with it". (Hope B)***

Anger

Anger is one of those negative emotions that frequently arise due to early victimisation (Estévez et al., 2016). There is a tendency for persons who are maltreated to become more violent than those who are not maltreated and this is seen as a method of coping especially among children who may not be able to properly verbalise their feelings. Additionally, aggression to peers and aggression in adulthood are among other forms of how anger may be expressed externally. (Estévez et al., 2016). Other studies have shown that CSA and displaced aggression are related. More specifically, a significant and positive association was found between CSA and displaced aggression (Estévez et al., 2016). Each of the quotations from four respondents all point to anger as a dominant emotion expressed after experiencing CSA. These feelings of anger were at times intense with evidence of displaced aggression and aggression towards others. This is how they described these emotions:

> ***"I cannot handle my situation the way I'm suppose(d) to do it and I see people handling their situation in a calm and peaceful manner... I was angry and I was beating the wall" (Star, 42)***

> ***"I became really angry. I was having, some murderous thoughts cause a (I) would think about how I'm going to get back to all a (of) these men fah (for) what they had done to me. Soh (so) I strategised in my head this is how I'm going to kill this one this is how I'm going to kill that one and to the point where I would get like a knife or soh a (so I) would stab up the teddy bear, stab up the bed y' know? Just to relieve maself (myself). Yea, and it felt good to me." (Hope A, 35)***

> ***"So, I would always be fighting, I would fight in every single school that I went to. I was angry, yes" (Hope B)***

> ***"I would be very aggressive towards them sometimes yuh nuh (you know)? So, sometimes a (I) would be very aggressive toward them, and would be like you would say 'feisty towards them', like I would say "why are you talking to mi (me)"? "Stop talking to me, you talk too much", you know, I would be very uhm aggressive towards them". (Grace, 25)***

Mixed feelings

It is also noteworthy that some persons experienced mixed emotions – both positive and negative. The expression of these emotions also appeared to help them to cope with the abuse.

> ***"it's painful and it is difficult to deal [hmmm] with but at the end of the day there is life after abuse". (Hope B)***

> ***"It's been a painful journey. I have learnt a lot of lessons and I can now stand and say that I am grateful, for the journey. It might sound crazy, but I am grateful for the journey, because, I think that it has helped me to be the woman I am today." (Hope B)***

> ***"I just needed that moment of gratification and once it was done I would hate you yeah". (Hope B)***

> ***"I started getting tattoos and... it was... the pleasure of feeling dat (that) pain... dat (that) made mi (me) constantly get tattoos. [Uhm] Soh (so) it was similar to me cutting myself. The pleasure of feeling pain [Uhm], ahm... made me continue cutting ma-self" (Grace, 25)***

> ***"I use(d) to say what do I have to smile about...I felt guilty even smiling even laughing...that (was) never normal... I felt guilty when I laugh(ed)...it wasn't really a laugh it was just because I don't want my face to look so depressed so I just smile but now when I laugh I really do laugh and I really do smile and I accept me now and I appreciate me now when I couldn't do that before 2016 I couldn't do that...I didn't know how to do that". (Star, 42)***

7.11 Conclusion

Based on the foregoing, the survivors of CSA in this study utilised various coping strategies and exhibit various levels of resilience at different points in time. Many of those who were interviewed displayed current levels of positive adaptation as they demonstrated social, behavioural and emotional competence and academic achievement, by way of having successful careers, mainly in the helping professions, having families of their own and writing books chronicling their experiences of CSA. There was also evidence of psychological escapes, self-discovery, cognitive coping and having a sense of psychological control. Among our sample of women who self-identified as survivors of CSA there was no hint of normalising CSA, however the same might not be true for

other people who have experienced CSA but who do not conceptualise their experiences as abuse, as will be seen in our discussion of the study with male interviewees later in this report. It is possible that many others have lower levels of resilience and coping and that could not possibly be captured in research such as this because they are not yet at a point where they are able or willing to share their experiences.

It is our considered view that healing from child sexual abuse is debatable. We ask the question 'does one really heal from child sexual abuse and other forms of maltreatment?' If one should agree that the term 'heal' refers to being free from the injury and becoming well again, then it is questionable whether this is even possible with survivors of CSA. However, what we can say, based on our findings, is that many survivors of CSA can and do find ways to live well with their emotional and psychological injuries. Seeking social support and empathy, working in helping professions, engaging in spiritual practices, and self-expression through writing or other creative endeavours were all identified by our participants as helpful ways to cope in the aftermath of CSA. The approaches to coping employed by our participants offer valuable insights for health and care practitioners in terms of tools and strategies with which to support survivors of CSA.

We have concluded that while high levels of resilience and productive coping techniques may buffer the negative effects of childhood abuse, survivors may employ productive coping strategies and display resilience which may enable them to function relatively well. Many survivors find ways to hide their emotional wounds, bury the memories and work around them. Nevertheless, the psychological damage and scars remain and persist into adulthood. As one participant put it 'it (the effects of the abuse) lasts for a lifetime'.

It is also important to note that our observations about coping are based on a very small sample size. Although our in-depth data provided detailed insights about the process of coping, we may have missed other problems and possibilities in coping with CSA that are experienced by survivors in Jamaica, and our sample cannot be said to be representative of the population of persons who may be survivors of CSA. As such further research needs to be done in this area. In the meantime, it is critical that measures be put in place to prevent CSA and other forms of violence from happening in the first place.

The following chapter details the findings from focus group interviews conducted among young males who had experienced CSA. It is important to note that these young men did not consider themselves victims or survivors as they did not perceive the experiences to be abuse, but rather early sexual initiation which for them was a bragging right. The word cloud below illustrates the most frequently used words by the respondents. The size of the word reflects the greater usage of the word. The minimum number of letters in the words was 5 letters. 'Multiple', 'money' and 'experience' are among the most commonly used words.

Figure 7: Most frequently used words by young men

8

Boys Hurt Too

In Jamaica, CSA among boys is not perceived as abuse when perpetrated by women.

Due to a lack of sensitisation, CSA is misinterpreted. CSA is also concealed for fear of negative reactions.

Boys are also negatively affected by CSA.

Deficiencies in the justice system prevent disclosure and re-traumatise survivors; thereby preventing justice.

Although there has been a plethora of research on CSA, often the focus is on girls and female adult victims (Spataro et al., 2001). We have discussed in previous sections of this report the challenges associated with disclosure and under-reporting of CSA among female survivors. Global and local estimates for CSA among girls and women were noted, however, concrete estimates of prevalence among boys or male survivors are less forthcoming (Homma et al., 2012). Suggestions have been made to account for the lower reported prevalence rates, such as CSA may occur less in males than in females or, sexual abuse in boys is concealed to a greater extent than in girls, hence less frequently reported, particularly given the heightened stigma associated with male sexual abuse. Most notably, boys tend to experience feelings of shame, guilt, and fear associated with internalised or culturally prescribed gender expectations (Homma et al., 2012). While the figures are said to be far lower than those for girls, there is still cause for significant concern as there are severe and chronic long-term consequences associated with CSA among male survivors (Kia-Keating, Sorsoli, & Grossman, 2010; Simon, Feiring, & Kobielski McElroy, 2010)

Perhaps not surprisingly, in the current research we encountered challenges in recruiting male survivors of CSA. This may be attributed to many factors, but a significant factor was the stigma and connotations that are associated with male sexual abuse. However, we sought to obtain the perspectives of male survivors through focus group interviews with (1) a group of young men willing to talk about their early sexual experiences and (2) a focus group with male practitioners who work with male survivors of child abuse. Three major themes were extracted from the discussions from the two focus groups.

8.1 Factors that Contribute to Under-reporting/Non-disclosure of Child Sexual Abuse Among Boys

In Jamaica, since the creation of the OCR (Office of the Children's Registry), there has been increased reporting of male victimisation. This was revealed in the focus group interview among male professionals:

> ***"...more persons are sensitive to the issues, umm, I think more cases are being reported but I think its underreported, nonetheless". – [Male professional]***

There are also media and NGO reports of sexual victimisation of male children in institutional care (Harriott & Jones, 2016). However, Gagnier & Collin-Vezina (2016) add that disclosure is often very difficult for boys and most wait until adulthood to disclose, if at all.

Misconception

There is a general consensus that within the Jamaican culture, if an older female engages in sexual intercourse with a male child it is not child sexual abuse. Cromer & Goldsmith (2010) share a similar finding, as their Google search to identify purported CSA myths also includes "if the perpetrator is female, then it cannot be sexual abuse" and "boys can't be sexually abused." The professionals/practitioners in the focus groups were aware of these beliefs about the sexual abuse of boys by women.

> ***"let's take it from the female perspective and I know, you know, umm especially with those cases that I've come across with the female, there seems to be, in our Jamaican context that it's not recognised as a, a sexual abuse... as a matter of fact some men feel it's good for them from a heterosexual perspective" [Tony, male professional]***

> ***"So, for example, for a boy by the age of twelve years old he's expected in some communities, he's expected to be engaging in sex because now you're a man" [Martin, male professional]***

Within Jamaican culture, this type of behaviour is encouraged because it is believed to prevent homosexual tendencies (against which there are huge social taboos); a finding revealed in our research among men with early sexual experiences.

> ***"If me have one son mi would a want my son fi experience eeh at a young age cause, mi want him goh the right part mi noh want him goh the way, like. Like dis (this) American cultural, dem like bisexual mi noh waan Bisexual, mi want him straight, yeah" [Franklyn, 19]***

English Translation

> ***"If I have a son, I would want my son to experience it at a young age because I want him to follow the right path. I don't want him to adapt the American lifestyle, of some who are bisexual. I don't want him to be bisexual, I want him heterosexual". [Franklyn, 19]***

Research has shown, in cases involving female perpetrators, that young boys, particularly at the adolescent stage, are less likely to perceive a sexual experience by an older female as abuse (Spataro et al., 2001). The sexual abuse of boys by women is perceived as a "rite of passage" and a means for bragging within Jamaican culture. According to Peluso & Putnam (1996), some boys may try to frame incidents of abuse as rites of passage, or getting lucky, based on how they were socialised. This finding corroborates our research among both men with early sexual encounters and professionals/practitioners who work with male victims of CSA:

> ***"Well at the time a think it positive y'nuh cyaa sometimes yuh a laugh afta yuh fren an a se wi have sex an yuh nah have eeh soh eeh kinna feel good fi know seh yuh a dweet" [Franklyn, 19]***

English Translation

> ***"Well at the time I thought it was a positive thing, you know. Sometimes you laughed at your friend and say we are having sex and you are not. So it felt good to know you were doing it" [Franklyn, 19]***
>
> ***"we have spoken about ahh the, the, the cultural views of the situation ahh where a boys umm is abused by a female it's almost seen as a rite of passage" [Ren, male]***

Lack of sensitisation/education

Based on our research, professionals indicated that due to a lack of sensitisation about child sexual abuse, especially among boys, they are less likely to report such incidents:

> ***"sadly we have not maybe socialise our boys to the level to recognise sexual abuse" [Tony, male professional]***
>
> ***"when this, these things happen to boys they keep it in they don't really go to or you know, we haven't taught them that, Ok, you need to report this" [Tony, male professional]***
>
> ***"So, what I want to highlight specifically is that a lot of our boys, they don't consider themselves victims because of the benefits that they are getting and also, because of the, the society's expectation of what it is to be a man. Umm, they're not, they don't consider themselves victims or those around them don't consider themselves victims, they are actually public heroes" [Martin, male professional]***

In highlighting the benefits of prevention programmes, MacMillan et al. (1994) note that such programmes improve children's knowledge and prompt some to disclose past abuse.

Negative response/reactions

"Victims' fear and interpretation of the situation as something other than sexual abuse (i.e. personal factors) contributes to the secrecy of abuse" (Hohendorff et al., 2017) .

This finding supports the view among the professionals interviewed, who agreed that boys do not disclose their abuse for personal reasons such as fear of being labelled as a homosexual.

> ***"He might think that he'll be in trouble and then this older umm male umm would try again and again and after few times they start labelling them as homosexuals" [Dr Peter, male professional]***

Early research by Browne & Finkelhor (1985) highlights that exposure to sexual abuse in childhood and adolescence involves the traumagenic dynamic of stigmatisation. This finding remains consistent to date, as Samms & Cholewa (2014) posit that survivors and witnesses of child sexual abuse do not disclose out of shame and fear of the stigma attached to being sexually abused, or fear of further abuse and harm. From this research, one practitioner emphasised:

> ***"A lot of boys keep these kind of things silent because of the stigma associated with it" [Tony, male professional]***

Family secrets

Paine & Hansen (2002) note that, in some cases, the child's fears are reinforced when the child discloses the abuse to family members and/ or others and is pressured by them to maintain the secret. This is consistent with our findings as it was noted among professionals that further disclosure is sometimes prevented due to the family's concealment of the abuse:

> ***"it could be the family factor of which there is a disturbance with reporting; 1) is umm what happens in the family should remain in the family" [Dr Peter, male professional]***

8.3 Consequences and Effects of Abuse for Boys and Men

As with female survivors, boys who have experienced CSA also suffer long term negative effects (Homma et al., 2012). However, as noted in previous sections, the consequences of CSA among males may be dependent on the perceptions of sexual abuse as being negative or positive and how CSA is defined. One qualitative difference between male and female sexual abuse is the issue of sexual identity. Most cases of CSA in boys and girls are perpetrated by men. However, less commonly reported is abuse of boys by female perpetrators. Social constructions of gender identity would suggest that boys and girls may have different views of CSA when a female perpetrator is involved. However, where the abuser is a male perpetrator, research shows that boys are affected by the perceived stigma of homosexual connotations (Spataro et al., 2001).

For instance, the focus group discussions suggest that when males report early sexual experiences with older women, they tended to perceive this as a consensual positive encounter that provided opportunities to strengthen their masculinity and it was perceived as a natural part of boys' sexual maturity or growth. The point was also made that in heterosexual interactions, boys tend not to view the situation as abuse, or see themselves as victims. Nevertheless, the young men interviewed for this study admitted that experiencing CSA could affect boys psychologically, particularly if the child is "too young" or has not reached sexual maturity – defined as when a boy is able to ejaculate. Some of the young men stated that their own early sexual encounters resulted in confusion.

> ***"Cyaa mi (cause I) did young mi (I) confused, yuh understand (you understand)? An a bigga smaddy (bigger somebody)." - [Young man in male focus group]***

English Translation

> ***"because I was young and confused. Do you understand? And it was an older individual". [Young man in male focus group]***

Other consequences that were noted as of concern to the boys were getting a girl pregnant and exposure to sexually transmitted diseases or infections.

> ***"Cyaa anoh (cause it's not) really eeh (the) sex but a di (is the) consequence weh (that) him agoh (going to) face cyaa (cause) suppose like eeh (the) girl get pregnant a eeh faddah agoh (is the father going to be) responsible y'nuh (you know)" - [Young man in male focus group]***

English Translation

> ***"cause it's not really engaging in sex but it's the consequences that he will face. Because if he gets a girl pregnant, the father will be held responsible" [Young man in male focus group]***

CSA can be severely traumatising for male survivors. A history of CSA has been shown to adversely affect psychological functioning and result in many externalising behaviours (Kia-Keating et al., 2010; Simon et al., 2010). Whilst those in the focus group involving young men, who admitted to earlier sexual experiences, did not admit to many of the negative consequences, the professionals interviewed, who work with child survivors, noted additional ways in which young boys are adversely affected. In their experience, the male survivors exhibited several symptoms including aggression, hyper-sexuality, out-of-control behaviours, hyperactivity, problems with authority, poor interpersonal relationships, use of indecent language, poor academic outcomes, and smoking.

> ***"...sometimes aggression to the female, they are very aggressive...Yes, they will be more aggressive like they will deal with them just like their, their male counterparts. Kick them, you know, and also be very sexually umm very, very highly sexual over tone, inappropriate sexual touching umm and those kind of things will be done. Umm I'd, I'd have cases where some boys have been, police had come to me due to some of those kind of cases. Umm, usually you have serious, not a father figure is not in the home umm and the mother can't control, can't control the child. Umm, another thing is that they usually, one of the things I recognised about a lot of them, especially the, the boys when they are younger, they are abused sexually, they can't keep still, they usually suffer with like ADHD [or/and] those kind of things, behavioral problems in the classroom, the teacher usually can't control them, stuff like that. Some of those things that are to [manifest it?] with them umm some of those things. I know they usually have serious umm sometimes authoritative problems." - [Tony, male professional]***

> ***"...they tend to develop poor interpersonal skills with their peers and they usually gravitate to things that are, what we consider, inappropriate behaviors such as smoking and inappropriate touching, umm very lewd language, descriptive languages umm, compared to what ordinary people do when it comes to sex." - [Tony, male professional]***

> ***"And I've seen where that has caused significant problems, significant stress, so the behavioral issues start to pop up, the poor academic performance, dropping out of school, maladaptive behavior, smoking and all these things and umm persons had to step in to assist umm because parents didn't know what to do anymore, they couldn't control the child..." - [Martin, male professional]***

One professional explained that when affected at an early age, some survivors may also experience loss of memory associated with the incident. Other research has shown that repression of memories in an attempt to "block out" the experience of abuse is common among survivors of CSA (Alaggia & Millington, 2008).

> ***"...one of the things that we have seen is that sometimes when boys are impacted at early age there is just total loss of memory of the expe-, of the trauma that they have gone through." - [George, male professional]***

Similarly, research has shown that males with a history of CSA are at a higher risk for suicidal ideation (Alaggia & Millington, 2008). One practitioner in our study noted that in his experience, male survivors were affected by severe mental health issues, which at times may lead to suicidal ideation.

> ***"the impact that ahh, this is having on individuals may become suicidal and may end up in the mental health, ah public mental health facilities..." - [George, male professional]***

Yet another important observation indicated by the professionals was that some boys who are abused, later become abusers themselves, as noted in the following excerpt:

> ***"Yeah, I was saying many times these, the abused become the abuser and I heard that may [reflect?] by my [...?] so the abused becomes the abuser and that usually happens with, umm primarily with peers but even in the adulthood though many of those who have been abused and do not get help, ahh actually end up being abused (an abuser?) or [...?] in, in the long run." - [George, male professional]***

Indeed, some research suggests an abused/abuser hypothesis of child sexual abuse, with stronger evidence for male survivors (Kolvin et al., 2012). That is, male perpetrators of abuse often report a history of child sexual victimisation. However, these predictions are not always supported, as some literature suggests that male survivors of CSA are no more likely to become abusers themselves (Salter et al., 2003), or at least, the link may not be direct or inevitable (Lambie et al., 2002). One explanation for this apparent discrepancy may be that, as is the case with other forms of abuse, some survivors may pledge never to put another person through their experience (Mathews & Collin-Vézina, 2016), while others may experience such distorted emotions, such as misplaced anger or hostility, that they go on to perpetrate abuse. Other explanations have turned a focus on resiliency as a moderating factor in the victim-offender cycle (Lambie et al., 2002).

8.4 Deficiencies Within the Justice System

Research has shown that there are several factors within the criminal justice system that adversely affect survivors of child sexual abuse. These include emotional response to police investigations, lengthy court process and testifying in court (Connon et al., 2011). In many cases, these challenges make prosecution of child sexual abuse cases difficult and survivors prematurely end their pursuit of justice (Block & Williams, 2019). In the accounts of the professionals interviewed who encounter the various layers of the justice system in their role as childcare practitioners, there seemed to be consensus that the criminal justice system in Jamaica has inadequately served the needs of child sexual abuse survivors.

The focus group discussion with childcare professionals suggested that one of the factors that contributed to under-reporting and general help seeking intentions was the systemic challenges within the justice system and how CSA matters were handled. Participants suggested that first contact professionals such as the police, even those at the special unit in charge of child abuse cases, are not sensitive to cases of CSA, particularly with boys. For instance, one practitioner noted his experience reporting a male case of CSA and receiving a less than favourable response from the police.

> ***"First of all, police need to be very unbiased in how they view victims. Never forget a case that I reported [then?] I, when I said what I said the tone changed when I reported who did what, the tone just suddenly changed and I was like huh?" - [Moses, male professional]***
>
> ***"Yes. You know, even when there was a case of female abusing younger male, the response was not as quick in how they would have dealt with if it was the other way around and, and so that at the, at- CISOCA, they, they really need to be unbiased." - [Moses, male professional]***

Practitioners also emphasised the challenges with going through the court system. According to these professionals, the length of time for cases to be processed and concluded in the courts was not only a deterrent to seeking justice but also re-traumatised the survivors.

> ***"...my only concern sometimes for the victims of these children is that when it reach to court, the boys how they are put on, because how the system is set up it sometimes it's very drawn out, I know of a particular case that took five years. Yeah five years and the boy is a big, well, well not big man but he's about twenty something now, but he was around ah thirteen or fourteen when he was ah sexually abused." [Tony, male professional]***

The perception among professionals regarding non-disclosure of sexual abuse cases also involved what transpires within the systems responsible for dealing with such cases. Their view was that due to the delays and rigors within the justice system, a child might be less likely to disclose abuse. When and if disclosure happens, the child might also refuse to have the matter dealt with by the courts or discontinue attending court proceedings;

> ***"Even when the child is taken to court, ahh it becomes a difficulty because one side of the system who is supposed to do the preparation does not, does not do, does not do its job properly and so you may have a report being made and you will have a child going to court one time then the case reports are not prepared, then they will put off for another date and then the time you come and think all is well until one year later, police call to say, "Oh well, prepare this child for court tomorrow," and then that just lends itself to trauma right there and then you know, so, so you, you do find that these are the gaps that take place umm, which will now when the child recognises that, "So I have to go back over this all over again? No" and, and dealing with that is, can be, can be quite traumatic for them" [Moses, male professional]***
>
> ***"how the system is set up it sometimes it's very drawn out" [Tony, male professional]***

Another concern was how court proceedings that involved CSA survivors were carried out. The court conditions were described as being "unfriendly" for a number of reasons as articulated by one professional:

> ***"And also, umm court system is actually umm not child friendly, umm they are meant to sit in front of the perpetrator and there are some really hostile umm defense lawyers who grill them umm and, and make them breakdown in the witness box..." [Dr. Peter, male professional]***

According to Goodman (1984), children who experience traumatic events may suffer from posttraumatic stress disorders. Despite the courts having an obligation to protect children, many legal requirements may further negatively impact the child's mental health. Previous research also shows that when children are interviewed within the courtroom environment they tend to have greater memory problems and demonstrate significantly greater heart rate variability or anxiety as opposed to children interviewed in a private room (Nathanson & Saywitz, 2003). Consequently, Connon et al. (2011) have suggested that there is value in providing a more child friendly court room environment and practices to aid in the justice process for CSA survivors. One of the professionals in our study expressed his experience with the courts and recommendations he has proposed.

> ***"... umm court system is actually umm not child friendly, umm they are meant to sit in front of the perpetrator and there are some really hostile umm defense lawyers [thank you] who grill them umm and, and make them breakdown in the witness box umm and in spite of [I writing?] to many judges that this child has Post Traumatic Stress if at all, they should try to umm collect evidence via video umm and if that is not an option they should be [put?] in a private room" [Dr. Peter, male professional]***

9

Conclusion

Our findings revealed the complexity of the impacts of CSA upon both male and female survivors in Jamaica. Survivors experienced multiple forms of abuse - sexual, physical and emotional. In fact, in more than one instance sexual abuse was coupled with physical violence. The perpetrators are oftentimes known to the victims, being either close family members, neighbours or friends of the family. In contrast with the assumption that these persons should be protecting the minors, in many instances they turn out to be the ones meting out the abuse.

The effects on victims have been shown to be severe and long-term; in many instances, lasting throughout the survivors' lifetime. Many experienced poor psychological functioning. For example, most of the female survivors had either thought of or attempted suicide after the abuse occurred. They also explained that they felt as though life had no value or meaning and struggled to find a reason for living. Some of them described having intense feelings of anger directed not only toward the men who abused them, but toward men in general. Some reported having a mixture of emotions including negative perceptions of themselves and hating themselves after the abuse took place. In fact, most survivors recounted experiencing difficulties in both intimate and social relationships even in adulthood, which may be linked to what they describe as their negative views of the world and their lack of trust of others in general.

Child sexual abuse in Jamaica seems to be culturally entrenched in some sub-cultures. Indeed, CSA was normalised and culturally accepted especially among some adults. Participants recalled that at times when disclosure was made even to parents and guardians, especially females, the response of many was that it was neither unusual nor surprising. Also, there are cultural myths that appeared to be drivers of the abuse, as some men believed that to have sexual relations with a female virgin would be the cure for any sexually transmitted infections that they may have. On the contrary, this is how some victims contracted STIs themselves including HIV.

Among the risk factors for CSA in Jamaica, the type of parenting within survivors' homes was identified as a challenge. In many instances, there were single parent/female headed households. This may have led to inadequate supervision of children especially after school when they get home and during the holidays, as the single parent had to work to provide for their families. This was so despite it being illegal to leave minors unattended. The problem is further compounded by the fact that oftentimes because of the financial disadvantages that some families faced this led to financial dependence on men. In many instances survivors and their families were from poor or disadvantaged backgrounds. This financial disadvantage was abused. Evidence suggested that the power differential between perpetrator and survivor was also abused.

Another risk factor that emerged was the cycle of abuse. In some instances, it was revealed that CSA was intergenerational. This may help to explain one reason for the normalisation of CSA to occur and for it to be perpetuated between generations. Paradoxically, it is noteworthy that while both male and female survivors were very protective of their daughters, the men tended to condone harmful sexual behaviour among their sons, seeing it as a rite of passage. Indeed, none of male victims viewed the behaviours as abusive, but merely as early sexual initiation and a bragging right.

Several barriers to disclosure were identified. On the micro level there was the fear of what may happen to the perpetrator and indeed the family of the survivor. This was especially so, when the family depended on the perpetrator for financial assistance. On an intermediate level, community members would oftentimes revictimise the child by blaming them for the abuse or for reporting it to the authorities. At a macro level, as well as the cultural factors discussed above, the justice system was found to be unfriendly to victims of abuse in many ways as the children would have to face the abusers in court. These court cases were drawn out for years in many instances. A few of the adult participants were disclosing for the first time during the interviews conducted for this study that they were abused.

Despite this, participants displayed varied resilience and coping strategies. For some, they exhibited what may be categorised as adaptive coping techniques, as they would journal or later become authors chronicling their experiences of CSA. Some also were able to surmount their challenges through educational attainments and later moving on to having successful careers becoming professionals in healthcare, education and other sectors of society. There were still others who became mentors for girls who are survivors of CSA. On the other hand, others employed maladaptive coping strategies which included suicidal ideation, suicidal attempts, self–harm, and substance misuse. What was even more common was a mixture of both adaptive and maladaptive coping exhibited by any one individual at various points in time.

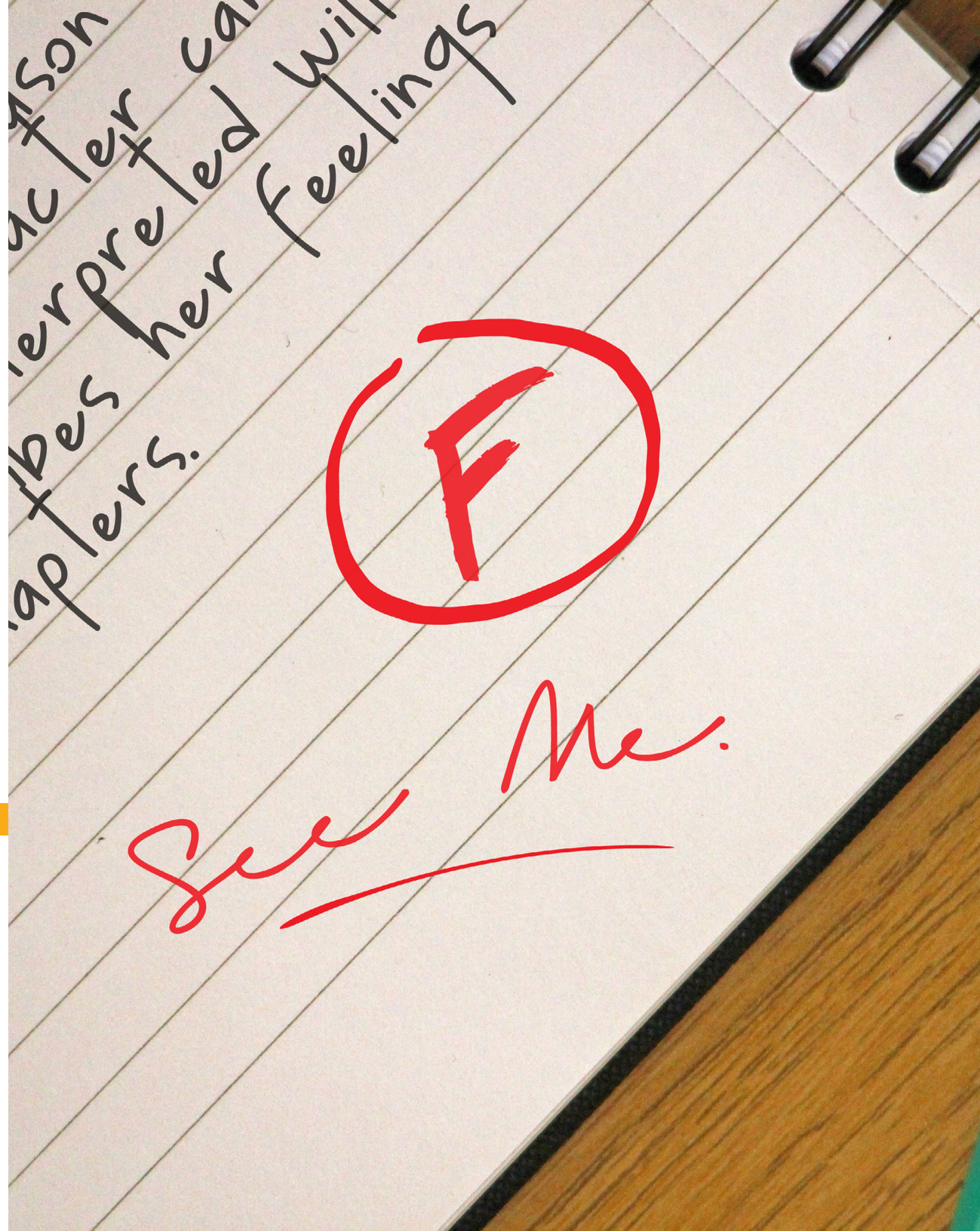
Based on the foregoing, we found CSA in Jamaica to be multifaceted and undergirded by culturally entrenched beliefs and values. This has implications for policy and practice. Jamaica is not short of legislation related to CSA and the protection of children and the government is also a signatory to the UN Convention on the Rights of the Child that provides for the protection of children. Yet in many cases laws are not enforced and international conventions are not complied with. The UN Sustainable Development Goal number 5 speaks to achieving gender equality and empowering women and girls; the primary driver of the work of the None in Three Centre. Additionally, Jamaica's Vision 2030 goal number two speaks to the Jamaican society being "Secure, Cohesive and Just". The UN SDGs and Vision 2030 are interconnected and designed to reinforce each other.

There is a need to increase awareness of the nature of CSA, as well as its effects on individuals, families and the wider society. It is critical that each individual breaks the silence when they know or suspect CSA to be taking place, as well as challenging cultural beliefs that enable it. CSA is preventable. Therefore, prevention strategies must be devised to address this problem. It is against this background that the recommendations in the following chapter are being made in order to stymie the alarming rates of CSA in Jamaica with a view to eradicating the problem and reducing the incidence to none in three; the only acceptable statistic (The None in Three Research Centre).

It is critical that each individual breaks the silence when they know or suspect CSA to be taking place, as well as challenging cultural beliefs that enable it.

10

Recommendations



This section provides recommendations that draw on the findings outlined in this report as well as justifications supported by existing literature. The recommendations proposed incorporate the idea that the challenge of CSA is due, in part, to multiple factors at the individual, institutional, and societal levels which influence its perpetration, concealment and continuance in low and middle income countries and developed nations (Mathews & Collin-Vézina, 2019). As such, in order for the problem of CSA to be addressed in Jamaica, a multifaceted approach is required to adequately address the matter at all levels. Indeed, the World Health Organization, (2002) has called for a public health approach to reducing the rates of CSA. This involves promoting more proactive approaches to preventing CSA while making necessary interventions readily available for victims (Knack et al. 2019).

Table 1

Summary of recommendations

Recommendation Category	*Specific Tasks*	*Implementing Unit*
Education and Empowerment	Raising awareness and improving knowledge about CSA using school-based interventions	Ministry of Education, Youth and Information (MOEYI) through schools as part of the Health and Family Life Family Education (HFLE) curricula
	Educating the public about CSA - promoting CSA prevention as everyone's responsibility	MOEYI collaboration with other Ministries/Entities including Ministry of Culture, Gender, Entertainment and Sports (MCGES) and NGO's, e.g. UNICEF, Churches, Community Club and Social Groups
	Empowering Parents and other Family members to Facilitate Disclosure and Support for Children who have been Sexually Abused	Relevant arms of Ministries. E.g. National Parenting Support Commission (NPSC) under MOEYI; Victim Services Division, under Ministry of Justice (MOJ), Churches, Community Club and Social Groups
Improving the Criminal Justice System	Sensitisation Training for frontline staff who are a part of the Judicial Process	Relevant arms of MOJ and Ministry of National Security (MONS)
	Prosecution and Rehabilitation of Perpetrators	Relevant arms of MOJ and Ministry of National Security (MONS)
	Establishing child friendly courtrooms	Relevant arms of the MOJ, MONS, General Legal Council
Child Protection Agencies	Improving efficiency and delivery of services within Child Protection Agencies	Centre for Investigation of Sexual Offences and Child Abuse (CISOCA) under MONS; Child Protection and Family Services Agency (CPFSA), under MOEYI; Office of the Children's Advocate (OCA)
Medical and Mental Health Services	Improving Medical Care for CSA victims	Ministry of Health and Wellness (MOHW)

10.1 Education and Empowerment

> ***"So if we sensitise our children about these things like a [I] said put programmes in place ahhmm set up workshops for them.....we can find out a lot of what is happening in the homes or in the schools... Cause like a [I] said it happened at school to me too y'know. So get programmes out there to sensitise our children. How to tell them how to act, y'know who they can call, who they can relate these things to"- Hope A***

Raising awareness and improving knowledge about CSA using school-based interventions

It was evident from findings in our study that CSA occurs under various circumstances and perpetrators can be anyone, even someone typically viewed as trustworthy. To help children understand the many factors associated with CSA, there needs to be a drive to increase the awareness of children about the signs of CSA and sexual grooming. Providing developmentally appropriate information to children about CSA is pivotal to facilitating disclosures. It has been found that school-based interventions about unwanted sexual experiences supported victims to disclose.

Research suggests that the use of school-based programmes have advantages that help with the prevention of CSA. For instance, in a review of the effectiveness of school-based programmes by Topping & Barron (2009) the authors indicated that these programmes can be built into the school's curriculum and are able to reach many children of all demographics. Teachers also benefit, as they too can be informed about signs of CSA and how to act on helping children with disclosure and reporting. Further, there is some evidence that parental involvement can result in knowledge and attitudinal gains and increase support for their children. A particular disadvantage noted by Topping and Barron is that usually school-based programmes are brief and this can affect the effectiveness of such programmes. The researchers provided specific recommendations for school-based programmes. The programmes should:

- Have evaluation of effectiveness built in
- Incorporate modelling, discussion and skills rehearsal
- Be at least four to five sessions long
- Have the capacity to be delivered by a range of personnel
- Involve active parental input

Educating the public about CSA - promoting CSA prevention is everyone's responsibility

The findings from our study suggest that cultural factors and social norms are important drivers of CSA. This means that enormous effort must be made to educate the public in an effort to change negative attitudes about CSA. One way of doing this, is through the use of social marketing campaigns aimed at increasing the awareness of members of society so they understand that CSA is wrong and ought not to be tolerated. This may include the use of music, dub poetry, traditional and social media, or other channels that are culturally relevant and appealing locally. An advantage of media and other culturally based campaigns is that they can be broadly disseminated to a large audience at relatively minimal cost (Marcus et al., 1998). Mass media have great potential in positively building awareness of and changing attitudes about CSA. However, there are important factors that should

be considered that can affect their effectiveness. For instance, ensuring that key messages are based on sound evidence (Marcus et al. 1998) and the method of dissemination is culturally relevant.

Educating and empowering parents and other family members to better respond to and facilitate disclosures, to provide support for children who have been sexually abused, and to protect them from further abuse.

> ***"Parents need to be educated. I think ahm the parents ahm are not educated (on) certain things, certain parents, they are parents but they are not parents in a sense where the their child can come to dem an (them and) share anything, You need to have that bond wid yuh wid yuh (with your with your) child where your child feels free to come to you and let yuh (you) know that they going dere soh (to point A), dem noh affi hide an goh dere (them don't have to hide and go)".- Chloe***

Family members must actively engage in the prevention of CSA by breaking the silence and taking a zero-tolerance approach to CSA. Additionally, parents and guardians as well as other members of the family need to be empowered through education with information about how to appropriately prevent CSA and also respond when a child discloses sexual abuse. As revealed in our research, when parents and/or other family members become aware that a child is being sexually abused and do not respond by taking appropriate actions to mitigate it, this results in continuation of abuse and may also hinder further disclosure.

Conducting educational social group work sessions on child sexual abuse with the family members is identified by Masilo (2018) as a starting point in preventing and responding to CSA. This prevention strategy focuses on educating family members about sexual abuse, with the objective of strengthening families on the topic. The objectives of these educational work sessions, as identified by Masilo (2018) include:

- defining child sexual abuse
- describing the types and signs of child sexual abuse
- discussing measures to be taken when the child is sexually abused
- describing factors that put children at risk of being sexually abused
- discussing the rights of children in respect to care and protection
- describing the impact of child sexual abuse
- discussing the importance of communication within the family system
- discussing the importance of providing care and protection to children; and
- making group members aware of the social work intervention in relation to cases of child sexual abuse

10.2 Improving the Criminal Justice System:

> ***"First of all, police need to be very unbiased in how they view victims. Never forget a case that I reported I, when I said what I said the tone changed when I reported who did what, the tone just suddenly changed and I was like huh??".....Yes You know, even when there was a case of female abusing younger male, the response was not as quick in how they would have dealt with if it was the other way around and, and so that at the, at- CISOCA, they, they really need to be unbiased.." [Moses, Professional]***

Sensitisation training for frontline staff who are a part of the judicial process

Frontline staff in the judicial system need to be adequately trained in how to respond appropriately to persons who are victims of CSA. The roles of police officers and prosecutors are important in CSA cases and their actions can affect the outcome of investigations and legal consequences associated with CSA. In addition, the police, especially the special unit for handling CSA cases, should establish proper protocols and guidelines in conducting investigations into CSA, interviewing child victims and suspects. The police response may determine whether or not the victim and their family further engage in the process of justice, which therefore determines whether the perpetrator is held accountable. Our research noted some of the challenges with police officers. Particularly, findings from the focus group study with professionals demonstrated that police officers may not be sensitive to cases of CSA, which leaves survivors feeling judged or stigmatised.

Beckett & Warrington (2015) in a report of the experiences of adolescent victims of child sexual exploitation (CSE) with the criminal justice system pointed out that quality of initial contact with frontline professionals including the police can enable or inhibit the process of justice for young victims. They found that some of the adolescents in their study, perceived that the police officers they engaged with were judgmental, blamed them or did not believe them, and were generally unprofessional. Beckett and Warrington suggest that specialist training and ongoing professional development of frontline staff is an important area of focus to better serve the needs of victims. Further, due to the recognition that poor interviewing can result in emotional distress, alienation of children, and inaccurate assessments of allegations, there has been advocacy to involve trained child forensic interviewers in CSA cases (Quas et al., 2005).

It may be useful therefore, for police officers and other professionals within the Centre for the Investigation of Sexual Offences and Child Abuse (CISOCA) and other selected officers in the general police population to receive specialised training in child forensic interviewing.

Prosecution and Rehabilitation of Perpetrators

> ***"Justice, okay I would want them to go to prison. Ahm a (I) mean the judge she may- he or she would probably come up with a different time span, but a (I) would, a (I) would want dem (them) to spend a good time in prison, an- in- an- an being in prison not only dat, a (that, I) would want dem (them) to be in some programme that would help to be like reform them or something". -Grace***

When a child is sexually abused, the ideal set of events regarding law enforcement according to the US Department of Justice (2001) is an investigation to determine if a violation of criminal law occurred, identifying and apprehending the offender, and filing appropriate criminal charges. Unfortunately, in many cases of CSA this ideal scenario of events is not achieved. As was found in our research, most victims of CSA did not receive justice, neither were their cases properly investigated when disclosure was made to police officers. Therefore, greater enforcement of the law is required, in order to prevent new and/or prolonged cases of child victimisation. Miller (2014) agrees by stating that Jamaica already has the legislative framework established to tackle sexual abuse and violence and therefore, full enforcement of existing laws is paramount to dealing with perpetrators. The US Department of Justice (2001) posits that the response of law enforcement to child abuse needs to be consistent. In response to this, officers must be objective and proactive in their investigations of abuse. Questions concerning who, what, where,

when, how, and why must be answered. Miller (2014) adds that the law and its consequences for sexual abuse must be well publicised until the very thought of it becomes a deterrent to anyone engaging or thinking of engaging in such an act.

In order to effectively respond to CSA, remedial/rehabilitative programmes for perpetrators must be implemented following prosecution. Rehabilitation programmes for perpetrators of CSA are needed to reduce the likelihood of perpetrators becoming repeat offenders. Findings from Craissati et al. (2002) suggest that perpetrators of child sexual abuse are often victims themselves and recommend that victimisation issues should be raised in offence-focused treatment programmes to resolve early trauma.

Establishing Child Friendly Courtrooms

> ***"Alright for me one ahmmm if you're going to take a statement from a child, do not have the child and the person that commit the act in the same room even to record what the child says, because to be honest going to court and ahmmm live a daily life routine talking about your story over and over again it is very hard" -Rihanna***

For child sexual abuse victims, going through the court system in an attempt to hold their perpetrator accountable can be stressful and lead to significant distress. Research has shown that there are specific aspects of the criminal justice system which are not child friendly such as waiting times for the matter to begin in court, delays and lengthy proceedings, aggressive defence lawyers, and having to provide testimony in open court (Myers, 1994: Jones et al., 2005: Quas et al., 2005). In an Irish study, Connon et al. (2011) found that children's experiences with the criminal justice system were mostly negative and were associated with poor psychological adjustment in the long term. Some evidence from our study also suggests that the criminal justice system in Jamaica is less than favourable to child and adolescent survivors of CSA. In England and Wales and Australia (see Lee et al. 2019) a number of 'special measures' have introduced to help children and vulnerable witnesses give their evidence in court and to reduce the level of retraumatisation caused by the court process. These include; pretrial court visits, the use of intermediaries (professionals who ensure that the questions posed to the child are comprehensible and age appropriate), de-formalising the court room (e.g. the removal of wigs and gowns ordinarily worn by the judiciary), permitting the child to be accompanied by an appropriate adult onto the stand, allowing the child to sit near the judge, the use of screens to prevent the child feeling intimidated by the accused, the recording of the formal statement given to the police to permit the recording to be played in court as 'evidence in chief' and the use of closed circuit television to allow the child to undergo cross-examination away from the main court room). While not all of these have been individually evaluated for their impact on cases and children's well-being, they certainly appear to be offer a more humane approach to the justice process for child witnesses. Consequently, the following measures might be considered for the Jamaican context:

- Closed circuit television should be used as an alternative method for hearing victims' testimonies and played simultaneously in the courtroom thus sparing the victims from having to face the perpetrator and thereby be re-traumatised. Myers (1994) suggests that testifying in front of the accused is the most difficult part of the court proceedings for some children. Connon et al. (2011) point out that protecting children from being in contact with the accused during the time of the court proceedings may help to reduce their stress and anxiety. In other jurisdictions, children have been allowed to testify in the judge's chambers while the rest of the court members watch on a television monitor inside the courtroom (Myers, 1994).
- Children experience high levels of fear and anxiety during court proceedings (Jones, et al., 2005). Therefore, any support that can be given to child victims and their families to ease the distress and provide realistic expectations of court proceedings should be implemented. Family members should be involved as well, as they too may be anxious, and this may inadvertently be transmitted to the child. In some jurisdictions, victim support and advocacy programmes are provided in the court systems. These programmes aim help child victims and their families with a variety of activities, including preparations and expectations for court, counselling (providing that this does not involve talking about the circumstances of abuse, but rather tackles issues such as managing symptoms of PTSD or anxiety, otherwise this would jeopardise the admissibility of the evidence in the trial – see Jenkins et al., 2015), personal advocacy and other court related services (Jones et al., 2005). Given the challenges with the court processes noted by the professionals and female participants in our study, a similar service may prove beneficial in the Jamaican context.
- CSA is difficult to prove and prosecute. This is due to the fact that the child victim is usually the only witness, which makes their testimony exceedingly important (Myers, 1994). However, because of the overwhelming nature of the courtroom and the court case, children sometimes may freeze or become anxious in the middle of testimony. Having a child-centred court that adopts a sensitive position to cases of CSA is paramount. This should include all members within the courts. It is critical that lawyers, judges and other court officials receive adequate training in how to recognise when a child is anxious and upset or becomes dissociated. Child witnesses should also be allowed to take frequent breaks to allow them to regain their composure and resume if they are able to or to end the session early if necessary. According to Myers (1994), judges have command over their courtrooms and are in the position of authority to limit intimidation and harassment of child witnesses, especially during cross-examination.

10.3 Child Protection Agencies:

> ***"I mean I know work is being done ahm... on the agency part on, the agency's part and I am sure there are counsellors out there I believe, a (I) believe that they need to be a lot more practical in terms of going into the communities you know, going to the community kinna (kind of) would say set up shop. You know they kind of set up shop and ahm interact with people you know. Have dem (them) come out you know, you put up your posta (poster) an (and) talk to them one on one. You will find dat (that) child will come out and speak [Uhm] up when they know that they have people that come out you know... trying to help basically reach out to them, to say dat (that) ahm people are here you know. People are here dat (that) actually cares, that wants to see ahm to see justice [Uhm], that wants to, to, to help your case and we don't-we, we, we are not just sitting down and hearing your story and letting it pass by".- Grace***

Improving efficiency and delivery of services within Child Protection Agencies

More child-care personnel are needed to work within Child Protection Agencies (Child Protection and Family Services Agency, Centre for the Investigation of Sexual Offences and Child Abuse, Office of the Children's Advocate) to assist with educating the general public, investigations, and processing of reported cases of CSA; thus improving response to CSA and reducing the waiting period.

Based on our findings, child protection agencies were identified as not doing enough to educate or engage the public, specifically communities, about CSA. According to Miller (2014), in Jamaica, the child protection agencies are severely understaffed and are heavily burdened with administrative duties and tasks. As a result, the approach taken by these agencies in

response to CSA is reactive instead of proactive. In response to this, financial provisions from the government should be made to assist child protection agencies with recruiting and maintaining additional staff to offset the workload. A proactive response facilitated through sufficient financial support from the government will help to challenge sexual abuse.

Although the duty of the child service agent is primarily to investigate suspected cases of abuse, Karageorge & Kendall (2008) indicate that there are times when the child-care provider must speak with the child to gather more information. Therefore, greater empathy as well as other psychological support and training is needed among child-care professionals to foster an environment of trust. Child service agencies should then be equipped with non-financial resources such as self-instructional materials or resource libraries. Adequate training in the form of workshops or conferences for agents may also prove useful in improving delivery of services to victims of child sexual abuse. Karageorge & Kendall (2008) agree by stating that ongoing training programmes are needed to ensure that all staff continue to learn about young children, as well as to develop and refine their caregiving skills.

10.4 Medical and Mental Health Services

> ***"An wen mi goh, wen mi goh a hospital di, di) procedure was, a neva experience any form a aggression. Yeah a neva experience any aggression, but I felt di eyes di, di, di it wasn't spoken aloud but di, di, di ahm Major an di way persons looked at me at the time . I felt yuh nuh? A kinna felt a way". - Goodie***

English Translation

> ***"And when I went to the hospital, the procedure was, I never experienced any form of aggression. Yeah, I never experienced any aggression, but I felt the eyes, it wasn't spoken aloud, but the way people looked at me at the time, I felt, you know, kind of embarrassed". -Goodie***

10.4.1 Improving medical care for CSA victims

In cases where current or on-going abuse is reported to the police medical examinations of CSA victims can provide important physical evidence in child sexual abuse cases, as well as detect when sexual abuse has occurred.

As indicated in our study, doctors are among the list of persons to whom survivors are likely to disclose their abuse. Medical professionals are also among the frontline staff who come into immediate contact with a child who is sexually abused. Therefore, medical professionals including paediatricians and family doctors must be aware of the medical indicators of and conditions related to sexual contact and alert the authorities when they suspect cases of CSA. It is also important that at least some of these professionals are trained in child forensic medical examinations, such that when a suspected case of CSA is referred to them, they are able to differentiate between signs of sexual abuse and other conditions (Jones et al., 2005). Undergoing medical examinations can be stressful and unpleasant for children. Therefore, it is also important that professionals in the medical field are adequately trained in how to appropriately respond to persons who are victims of CSA. For example, there is some evidence to suggest that children tend to have a more positive experience when medical practitioners are emotionally supportive and take the time to explain medical procedures (Jones, et al., 2005).

There has been some argument for routine and standardised screenings for CSA to be built into the healthcare system (Hanson & Wallis, 2018). However, healthcare professionals including doctors, nurses, and mental health practitioners may be reluctant to screen children for CSA because of a number of concerns. These include the belief that such screening is not necessary if CSA is not the presenting problem, uncertainty about how to respond to disclosure, and the belief this type of screening is out of the scope of their practice (Hanson & Wallis, 2018). While comprehensive screening may be daunting for some practitioners, Hanson & Adams (2016) suggest that a brief screening tool can be used to identify children who have experienced sexual trauma. For instance, Cohen et al. (2008) have proposed a single routine question that can be asked in primary care practices: "since the last time I saw you, has anything really scary or upsetting happened to you or your family?"

Even without the use of formal screening tools, there are other signs related to CSA that practitioners should be aware of and pay attention to when providing primary healthcare to children. These may include obvious signs of distress, refusal to be examined, and being anxious about separating from their caregiver (Hanson and Wallis, 2018). Important information may also be provided by caregivers at the time of office visits including the child experiencing physical symptoms (e.g. enuresis, loss or bladder control, stomach aches, fatigue); emotional symptoms (e.g. sadness, irritability, angry outbursts); changes in behaviour (e.g. nightmares, not wanting to sleep alone, withdrawal); and other changes including use of sexual language and inappropriate sexual behaviours (Hanson and Wallis, 2018). These types of reports do require additional investigations by healthcare providers such that appropriate referrals can be made and the child can get the help they need.

Improving mental health services for CSA survivors

> ***"Yes, it was very helpful. Because as I said I, I, I was always a motivated child... and I knew the circumstances in which I was, I was in at the moment. Soh (so), I used the counselling as a, a way to seh (say) it's not the end of the road, I can survive all of this. Because there was this one particular lady shi (she) always seh (said), 'look how yuh are nice (you are a nice individual),' an (and) so forth. 'Yuh nuh seh all a dis you know seh yuh (you know that all of this you) can overcome all a dis (of this)'. An a (and I) did a few sessions with her and yuh nuh (you know), the counselling went well". - Goodie***

Experiencing CSA can be detrimental to the health and well-being of survivors and their families. This can also be exacerbated by unsupportive interactions with medical personnel and the criminal justice system. This report has provided some evidence to support these observations and suggests that the availability of support to enhance the psychological well-being of survivors is necessary across the life-span and that such support may need to extend beyond offers of counselling.' Whereas in some cultures peer-support has been found effective, only a few participants in this study referred to having conversations with other survivors, however they did talk of the cathartic effect that came of writing about their experiences and feelings. As indicated by one participant, Goodie, counselling can be helpful. However, based on the findings documented in this report, only a few of the female participants indicated that they received any form of counselling to help with recurring symptomatology associated with CSA. For the participants that received counselling, there were mixed feelings about the usefulness of this intervention. There may be several reasons why accessing mental health services is a challenge for survivors. These may include stigma or other attitudinal factors, inadequate knowledge about available services, insufficient trauma-focused trained professionals, and cultural factors associated with seeking mental health services (Sivagurunathan et al., 2019).

Despite these factors, there needs to be increased effort made to prevent survivors from enduring the mental health sequelae that can be associated with CSA. Routinely, once a child who has experienced CSA presents at an agency/organisation, they should be referred to support from professionals trained in this area to help them process the experience in a way that does not lead them to manifest expressions of mental distress. Mental health services should be available to survivors of CSA at various stages, from the point of disclosure, while going through the legal process, and even for some time after. In addition, it is critical that mental health practitioners are skilled in using evidenced-based treatment for CSA (Hanson & Wallis, 2018) and understand the restrictions on the type of therapeutic interventions that are permissible pre-trial (Jenkins et al., 2015).

11

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Researchers' Briefing Pack

CONTENTS

1. QUALITATIVE RESEARCH DESIGN

Qualitative methodology is sensitive to unique personal experiences, perceptions, beliefs and meanings of individuals and is considered therefore to be the most appropriate approach for exploring the needs of victims and perpetrators of child sexual exploitation. This aspect of the None in Three project is led by Dr Graham R Gibbs and Karyl Powell-Booth and carried out by a team of highly skilled Jamaica researchers http://www.noneinthree.org/jamaica/

The research design is a cross-sectional qualitative study - data are collected at one time-point using semi-structured interviews and focus groups with purposively selected participants. Criteria for selection are determined by the research questions we seek to answer and the analytic approach used will be template analysis informed by grounded theory and situational analysis.

Conceptual Framework
The conceptual framework underpinning the design is informed by four factors:

1. Extensive expertise of the social, legal, policy and cultural context (the research leaders have researched and published extensively on the topic of qualitative research, child sexual exploitation in the region and have provided consultancy, training and programme development support to the Jamaica government, international development agencies, professionals and civil society organisations.
2. Excellent local knowledge – key researchers are nationals of the country in which the study is conducted and have appropriate linguistic skills; cultural, geographical, political and demographic knowledge and are in touch with contemporary realities and the impact of current social stressors on populations
3. Theories on causation of child sexual exploitation
4. A narrative literature review of issues affecting the victims of child sexual exploitation, the impact of child sexual exploitation on children and young people, intimate partner violence, gender bias and factors that contribute to abuse behaviours.

Quality

It is important to ensure that qualitative research is credible and does not stray into the anecdotal. We will therefore adopt the quality framework proposed by De Witt and Ploeg (2006) which calls for 'balanced integration, openness, concreteness, resonance and actualisation' (p.224). This will be given effect in several ways:

1. Authentication of claims made through the use of NVivo software to manage the data
2. Close supervision of the research process
3. Consistent application of the guidance contained in this document to all research activities
4. Ensuring the data generated are dependable and that findings are derived directly and only from the data
5. Differentiation between the voices of the research participant and the researcher
6. Documentation and audit trail of procedures adopted
7. Meticulous data management procedures

Sampling

This research uses convenience, purposive, non-probability sampling techniques in order to identify particular groups of people whose circumstances are relevant to the social phenomena being studied. This approach is particularly important given the sensitivity of the issue being explored and the potential to increase risk to participants who are recruited through other means.

The qualitative research for None in Three comprises semi-structured interviews with women and focus groups with men and youth. Interview and Focus Group Guides are included in the Appendix.

1.1 Interviews with women

In addition to face-to-face interviews, women should be offered the option of telephone interview or Skype interview (without video). IMPORTANT- If a woman chooses this option, researchers should never leave messages on women's cell phones/mobiles or initiate email contact unless the woman gives assurance that this is safe for her. These 'innocent' behaviours can be a source of great risk to a woman who is being abused.

The aim is to interview 40 women survivors of child sexual exploitation in each country. The decision about which groups of women to include should be based on the circumstances and proposed focus of the computer game in your country as well as the literature review.
Research questions

The primary research questions will be derived from your literature review but could include which those that follow. These will inform the prompt questions in the interview guide in the appendix.

1. How do women define child sexual exploitation (or other form of child sexual exploitation)?
2. What are the factors that contribute to the risk of violence against them?
3. What particular factors, unique to the circumstances of specific groups of women, produce additional risks or challenges for women affected by child sexual exploitation?
4. What are women's views about the reasons for increased risks?
5. What are the effects upon them?
6. What are the effects on their families?
7. Do professionals and agencies working with women who face child sexual exploitation, know of the additional risks and challenges presented by these particular circumstances?
8. What strengths, resilience and strategies do women in these particular circumstances draw on in managing/reducing/preventing or escaping risk of violence?
9. Who helps them?
10. What help do they need?
11. What can escalate and de-escalate child sexual exploitation rates in Jamaica?

Recruitment

We should aim to recruit forty women in total. Basic demographic data will be obtained from the women but there is no requirement to ensure representativeness for this aspect of the research. Sampling and recruitment is purposive based on the objectives of the research. Access to these women will be primarily through stakeholder agencies, government departments and snowballing. In relation to group iv, access is likely to present significant challenges. Creative methods (e.g. approaching night clubs or advertising should be considered).

Criteria for inclusion:

- Is a female aged 16 years or above (this is the legal age of sexual consent (for those for whom this is the focus) and will enable you to capture the experiences of adolescents)
- Self-identifies as a victim or survivor of child sexual exploitation
- Has an experience/s of child sexual exploitation that is current, recent (in the last 12 months) or historic (older than 12 months)

1.2 Focus groups

We are aiming to conduct four focus groups with men and youth (aged 16-25 years) in each country as follows:

i. Group 1 - men (of any age) who are at least mid-way through or have completed a violence reduction programme .

ii. Group 2 – youth (young men 16-25 years) who are known to have perpetrated violence or have been identified as being at risk of violent offending (contacted via the Probation service or juvenile detention facilities)

iii. Group 3 - men (25 years +) who have been exposed to violence (e.g. in childhood or as victims) but who are not violent themselves

iv. Group 4 - youth (young men 16-25 years) who have been exposed to violence (e.g. in childhood or as victims) but who are not violent themselves

Research questions

The primary research questions the focus groups aim to address will be guided by your literature review, your country circumstances and the proposed focus of the computer game but could include the following: (they also feature in the focus group guide in the appendix):

1. How do men define child sexual abuse (or other form of child sexual exploitation)?
2. What are their thoughts about its prevalence, causes and effects?
3. How has living with child sexual exploitation affected them?
4. How has living with child sexual exploitation affected their families?
5. What situations/circumstances contribute to men being violent (e.g., social, cultural, economic)?
6. What is the impact of these situations on men?
7. What strengths, resilience and other strategies do men in these particular circumstances draw on in managing/ reducing/preventing or escaping risk of sexual abuse?
8. What can escalate and de-escalate rates of child sexual exploitation/abuse in Jamaica?
9. Who helps men?
10. What help do they need?

Criteria for inclusion:

i. Group 1 - men (of any age) who are at least mid-way through or have completed a violence reduction programme [THESE PROGRAMMES IN YOUR COUNTRY CAN BE NAMED].
i. Group 2- comprises young men 16-25 years who have been identified as having involvement or risk of involvement in offences of a violent nature
ii. Group 3- comprises men 25 years or older who have experienced violence themselves but are against violence in interpersonal relationships.
iii. Group 4- comprises young men, 16-25 years who have experienced violence themselves but are against violence in interpersonal relationships.

Recruitment

Groups 1 and 2 should be recruited via relevant organisations. Groups 3 and 4 should be reflective of diversity in terms of socio economic status, age, urban/rural habitat, occupation (we will not be seeking representation of sexual orientation in this aspect of the research, given the risks involved in 'outing'). Each group should have a maximum of 10 members. Ways of achieving diversity are by recruiting participants from generic settings such as sports clubs, churches, mosques, temple, social gatherings, community colleges, social media, rather than through employment routes.

Data analysis

All interviews and focus groups should be digitally recorded and transcribed by the researchers. Thematic analysis will be carried out based initially on a-priori (pre-prepared) themes using NVivo software in order to identify and report patterns across groups of participants and across all countries. Pre-prepared themes will be drawn from those identified in the literature review, topics from the interview schedule and the case data collected. These themes will be drawn up by Dr. Graham R Gibbs (the Work package 2 lead) in consultation with each country director and country qualitative lead. The analysis will follow the general procedures as described by Braun and Clarke in the adapted table below. (Braun, V. and Clarke, V. (2006) Using thematic analysis in psychology. Qualitative research in psychology, 3(2), 77-101.)

Data management

i. If possible, all interviews and focus group discussions should be digitally recorded.
ii. If this is not possible, field notes should be taken and written up as soon as possible to allow the aforementioned analysis by the senior researchers in your country.
iii. Used digital recorder memory cards should be kept in locked storage.
iv. Recordings should be transcribed at the soonest opportunity, with a 'master' copy available to draw on if needed.
v. Any identifying information in the transcripts should be anonymised
vi. All transcriptions and field notes should be entered into a single, Jamaica NVivo database for analysis.

Phase	Description of the Process
Familiarisation	Transcribe data, read and re-read the transcript, noting down initial ideas. Write a short summary of each interview (focus group) identifying key themes.
Generate initial codes	Code interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code. Use the pre-defined codes/ themes for this initially, but where possible or necessary create new codes too.
Search for themes	Collate the codes into potential themes, gathering all data relevant to each potential theme
Review themes	Check if the themes work in relation to the coded extracts (level 1) and the entire data set (level 2), generating a thematic 'map' of the analysis
Define and name themes	Conduct ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme
Produce the report	A further opportunity for analysis. Select compelling quotations to illustrate findings, relate back to the research questions and literature, produce the report of findings

vii. All electronic data should be password protected (e.g. with a password protected personal computer).
viii. Digital files (transcriptions etc.) should be stored in the Jamaica secure storage area. This should be password protected and regularly backed up ideally to a geographically separate site.
ix. A systematic approach to version control during data analysis should be adopted and the NVivo database should be stored in the Jamaica secure storage area.
x. Retain and store securely all signed, fully informed consent forms.
xi. Any hard data (handwritten field notes etc.) obtained should be kept in locked storage.
xii. All digital files (transcriptions, NVivo database etc.) should also be archived in the None in Three Centre secure storage area to which researchers in all countries will have access. This will ensure that data are backed up (for verification, archiving and audit purposes).
xiii. Hard data sets should be copied and sent to the None in Three Centre Project Administrator by courier or scanned and deposited in the None in Three Centre secure storage area

2. ETHICAL PRINCIPLES

2.1 The conduct of the research will be based on clear ethical standards which will assure confidentiality, privacy, anonymity and informed consent. All research assistants will receive training in the research methodologies to be employed in the project. This training will also address ethical issues and stress the need to maintain strictest respect for confidentiality
2.2 Ethical adequacy of the research will also be assured through ensuring that the research outcomes are geared towards policy reform and that the participants are not exposed to detriment or harm
2.3 The project will be carried out in accordance with the University of Huddersfield's Research Ethics Guidance as outlined in the website extract below and with the University of Technology, Jamaica ethics guidance:

RESEARCH: Honesty and Misconduct

Introduction
...Research misconduct is often easier to recognise than to define but two broad categories can be distinguished. The first involves fabrication or falsification of research results; the second arises where there is plagiarism, misquoting or misappropriation of the work of others. It also includes, for example, the unethical use of material provided in a privileged way for review or assessment.

Research misconduct involving plagiarism, piracy or falsifying results is a form of dishonesty which is viewed by the University as a serious offence...

8.2 Good practice, ethics and plagiarism in research
(i) Principles of good practice
In the conduct of all research, the University expects the following general principles to be understood and observed.

Honesty
At the heart of all research, regardless of discipline, is the need for researchers to be honest in respect of their own actions in research and in their responses to the actions of others. This applies to the whole range of work, including experimental design, generating and analysing data, publishing results and acknowledging the direct and indirect contributions of colleagues, collaborators and others. All researchers must refrain from plagiarism, piracy or the fabrication of results. In the case of employees, committing any of these actions is regarded as a serious disciplinary offence.

Openness
While recognising the need for researchers to protect intellectual property rights (IPR), confidentiality agreements etc., the University expects researchers to be as open as possible in discussing their work with others and with the public. Once results have been published and where appropriate, the University expects researchers to make available relevant data and materials to others, on request.

Guidance from professional bodies
Where available, the University expects researchers to observe the standards of good practice set out in guidelines published by relevant societies and professional bodies.
(ii) Leadership and co-operation in research groups
The University is committed to ensure that a climate is created which allows research to be conducted in accordance with good practice. Within a research group, responsibility lies with the group leader who should create a research environment of mutual co-operation. They must also ensure that appropriate direction of research and supervision of researchers are provided.
(iii) A critical approach to research results
Researchers should always be prepared to question the outcome of their research. While acknowledging the pressures - of time and resources - under which researchers often have to work, the University expects research results to be checked before being made public.
(iv) Documenting results and storing primary data
Throughout their work, the University requires researchers to keep clear and accurate records of the procedures followed and of the results obtained, including interim results. This is necessary not only as a means of demonstrating proper research practice but also in case questions are subsequently asked about either the conduct of the research or the results obtained. For similar reasons, data generated in the course of research must be kept securely in paper or electronic form, as appropriate. The University expects data to be securely held for a period of five years after the completion of a research project.
(v) Publishing results
It is expected that research results are published in an appropriate form, usually papers in refereed journals. This has long been widely accepted as the best system for research results to be reviewed - through the refereeing process - and made available to the community for verification or replication... The University expects anyone listed as an author on a paper to accept personal responsibility for ensuring that they are familiar with the contents of the paper and that they can identify their contributions to it. The practice of honorary authorship is unacceptable.
(vi) Acknowledging the role of collaborators and other participants
In all aspects of research, the contributions of formal collaborators and all others who directly assist or indirectly support the research must be properly acknowledged. This applies to any circumstances in which statements about the research are made, including provision of information about the nature and process of the research and in publishing the outcome. Failure to acknowledge the contribution of others is regarded as unprofessional conduct. Conversely, collaborators and other contributors carry their share of the responsibility for the research and its outcome.

2.4 The proposal will be subject to approval by the University of Huddersfield Ethics Committee and by the University of Technology, Jamaica ethics procedure. Specific ethical guidelines to be applied will be as follows:

i. The aims and objectives of the research will be clearly explained to all participants and stakeholders
ii. All interview respondents will remain anonymous – actual names and other means of individual identification will not be used and each person will be allocated an ID number
iii. Focus group participants will be advised of the need to protect confidentiality and that individual experiences of abuse should not be disclosed within the group setting
iv. Focus group participants wishing to share personal experiences about abuse will be given the opportunity to do so in private and referred for counselling/other support as appropriate
v. Data will be kept confidential in a secured and locked location. Each Research Assistant will be asked to sign an undertaking to this effect and that, when each stage of field work is complete, the data sets will be transferred to the operational office for the project where they will be kept in locked storage and backed up in secure electronic storage.
vi. The data will only be seen by members of the research team
vii. The project will not provide financial inducements to participants although travel costs and any other expenses incurred by participants will be met
viii. Due to the sensitive subject of the research, and the possibility that during interviews, topics may be brought up that cause psychological distress or trauma (child abuse or . violence), National Response Teams will be identified comprising statutory specialists (social workers, police, therapists other government personnel) and trusted organisations (shelters, homes, health clinics, NGO's, appropriate support groups, women's empowerment organisations, etc) and individual specialists (social workers, counsellors, government staff etc.). These teams will be briefed about the research and will be asked to provide support/ interventions for research participants who have experienced abuse or are at risk
ix. Where focus groups are held with young people in institutions, participants will be asked to self-select for inclusion in the study based on a briefing from the researchers. Where appropriate the consent of parents/ guardians will also be sought. In addition to the general consent form, participants will be asked to confirm that no coercion or inducements were involved in their decision to participate
x. Informed Consent - all participants in the project (e.g., interviewees, survey informants, practitioners, agency representatives) will be asked to sign a consent form and will be informed:

- Of the nature of the research (goals and objectives, etc.)
- Of the research methodology to be used
- Of any risks or benefits
- Of their right not to participate, not to answer any questions, and/or to terminate participation at any time without prejudice
- Of their right to anonymity and confidentiality
- That in the interests of safeguarding children, any information revealed in the course of the project that indicates risk of abuse will be passed to the relevant authorities in line with country safeguarding protocols

3. INFORMED CONSENT

The project will allow for any of the following methods of obtaining informed consent:

3.1 Informed consent form: an informed consent form will be provided for use by the researchers. This will detail the principles outlined above and require the participants' signature.
3.2 In instances in which written communication is not appropriate (for example with people with visual impairments or with people with literacy challenges) researchers will read the information contained in the consent form and ask the participant to sign.
3.3 Participants who do not wish to sign can have their consent recorded by the researcher

4. ETHICS AND CHILDREN'S RIGHTS

4.1 Owing to the sensitive nature of the study and the potential for actual cases of sexual abuse to be disclosed, commitment to confidentiality must be balanced by the primary need to safeguard participants' welfare first and foremost. Additionally, professional judgement and discretion must be exercised in consideration of their welfare needs, beyond the implementation of the study.
4.2 These issues will be addressed in the training for Research Assistants
4.3 Guidelines regarding confidentiality, information sharing and duty of care to participants will be made available to all members of the research team.
4.4 The project will not involve interviews with children and young people under the age of 16 years. However, it is possible that in the course of the study, information regarding children at risk of abuse will be revealed. Furthermore, it is likely that some young people may wish to discuss experiences of past abuse. It is therefore important to identify the ways in which the project in each country will seek to safeguard children, to uphold children's rights and to support young people through any traumatic disclosures.
4.5 Safeguarding Children and Young People - At all times the safeguarding of the well-being of children will be paramount. Given the context of research confidentiality which requires that names of individuals are not obtained, individual follow-up will require the consent of the person concerned. Participants with knowledge about children at risk will be empowered and supported in disclosing the information to professionals within the National Response Teams who have statutory child protection responsibility.
4.6 Where appropriate, young people participating in the project will be advised to share information with relevant authorities and helping agencies, in the interest of their own safety.
4.7 Information about how to access the help of the National Response Teams will be provided to all participants
4.8 The researchers will ensure that young people are not harmed through participation in the research by providing a safe research environment for focus groups, through training for researchers on how to respond appropriately to distress and disclosures of trauma and abuse and by organising de-briefing sessions.
4.9 Youth-appropriate information will be produced detailing the aims of the research, how long the focus group sessions or completion of survey questionnaire will take, where they will take place and contact details for the research team. This information sheet will also include a statement explaining participant's rights as follows - We respect your rights:

- To take time to decide whether to help us
- To refuse to take part
- To refuse to answer questions
- To withdraw from this project at any time
- We will keep notes and digital recordings from the groups in a safe lockable place
- When we talk about the research or write reports, we will change people's names so that they remain anonymous.

4.10 The reporting of any allegations regarding actual sexual abuse shall be in accordance with the child protection policy and legislative framework of the specific country in which the research is taking place and will be assessed not only in terms of the immediate support needs for the survivor but also, the perpetrator's potential risk to others.

4.11 Concerns in respect of potential or identified risk to children will be passed to the respective country child protection agencies who will determine what action should be taken.

5. RISK ANALYSIS AND MANAGEMENT PLAN

Brief description of activity:
research field work – interviews and focus groups

Location: Jamaica,
Assessment by: Graham R Gibbs and Christine Fray-Aiken, Country Director (CD)
Assessment date: March 2018
People at risk: Research Assistants (RA)

Hazards identified	Risks to health and safety	Measures to manage the risk effectively	Action	
			Who	When
Travel and working in remote areas	Isolation Fear Increased possibility of personal harm or injury	Must carry authorisation, ID and cell phone at all times	RA	During fieldwork
		Within-country travel must be with regard to personal safety. Only the following forms of transport permitted: own transport, friends, relatives, authorised car rental companies or authorised taxi's	RA	Ongoing monitoring and vigilance required
	Increased risk of theft of personal goods	Must notify the CD they are reporting to of their whereabouts at all times during fieldwork	RA CD	
		Must only go to locations pre-agreed with CD and to agencies where authorisation has been obtained	RA	
		Must be mindful of and take responsibility for assessing risk for personal safety within any given situation. I.e. if allocated an area considered unsafe, alternatives must be secured	RA	
		Must conduct interviews, survey and focus groups in daylight hours	RA	
		Must not carry valuables during fieldwork	RA	
		CD to follow up all stages of fieldwork through daily email/phone contact	CD	
Invitations into people's homes	Reduces opportunity for staying safe, may present unknown risks or compromise RA	Must not enter private homes	RA	
Female RAs working with young men	Increased risk of sexist, or abusive or inappropriate behaviour	Guidance and training to be provided	WP2 leader/ co-PIs	
		Focus group, interviews and surveys must be held in appropriate (public) settings	RA	
		Where there are any obvious signs of alcohol or drug use among participants, then the research process should be ended immediately	RA	
		Abusive language or behaviour must lead to the immediate termination of research process	RA	
Participants request ongoing contact	Inappropriate crossing of professional boundaries	Should not divulge personal contact details	RA	
Researching sensitive topics	Distress or disclosure of abuse from participants	Training	WP2 leader/ co-PIs	
		Establishment of National Response Teams	CD	
		Should not engage in counselling or giving advice but must refer to the National Response Teams (NRTs)	RA	
		If the RA is distressed in carrying out the study they should debrief with the PI at the soonest opportunity, make use of peer support and may also access counselling through the NRTs	RA CD	
Over exposure to computer work (data entry & analysis, lit searches)	Eye strain, neck/headache Wrist strain	Repeated breaks – self monitoring	RA	

Risk Assessment review to be carried out by Dr. Christine Fray-Aiken and Karyl Powell-Booth before the commencement of the fieldwork

6. GENERAL GUIDANCE FOR CONDUCTING INTERVIEWS AND FOCUS GROUPS

This section gives general guidance on how to conduct interviews and focus groups.

Selecting participants
Approach potential participants in any appropriate manner (e.g. in person, by telephone or email, fliers, posters). Briefly describe the research, including aims, expected outcomes and research methods (interview, focus group). Ask if they are interested and have any questions. Give them an Information Sheet and provide researcher contact details.

Hard-to-access individuals, or those consulted because of particular experiences may have to be contacted through others, called gatekeepers, such as managers of agencies. In such cases, explain the research to the 'gatekeepers', to reassure them and so they know who you are trying to access and why.

Focus groups should comprise between 4 – 10 people. Use at least two digital recorders and if possible have at least two researchers present.

Who selects? Participants should be self-referring although agencies may also refer. Selection should aim to ensure diversity (e.g. socio economic status, education, employment status, age, urban-rural) and participants must meet the minimum criteria.

External ethical approval. Some organisations or agencies may have formal ethical approval procedures for you to follow. In such cases check how long these procedures take and build in time to follow them. Ensure that you get written confirmation of approval once it is given.

Preparation
Check practical arrangements with participants one or more weeks before interviews or focus groups take place. These arrangements should include dates, times and locations of interviews. They should also identify any particular participant needs (including mobility, dietary and audio-visual needs) and how these can be catered for.

Provide more detailed information about the interview to participants, including the aim of the research, the role they can play and assurances about confidentiality and how to withdraw. Give them an opportunity to ask questions.

Easily accessible locations and times where participants feel at ease can help the discussion in interviews and focus groups. If necessary, discuss with participants where would be appropriate for them.

Appropriate locations. Focus group locations should be quiet and private, and should be visited by researchers before the consultation. Check what facilities it has (such as flipchart and pens, enough tables and chairs cups for drinks, tea or coffee-making facilities and whether there are nearby toilets). Any recording equipment should be tested to ensure there is no background noise that will interfere with transcribing. Consider whether the participants will feel at ease in the proposed location – places they already know may be better, or alternatively they may prefer a neutral space.

Food? Food can help people relax, which is important in focus groups where participants don't know each other. It is also important to provide food, drinks and breaks in extended interviews or those that take place during mealtimes. In both cases, ensure that food is appropriate for participants and that there is sufficient cutlery and crockery available.

The interview
Arrive early, to prepare the space and to be there to greet participants when they arrive.
Bring:

- Consent forms
- Information sheets
- Flipchart and pens (if using)
- Notebook for researchers
- Audio Recorders, with a spare if possible
- Spare batteries (for recording equipment)
- Spare, blank memory cards (for recording equipment)
- Details of support groups and helplines
- Water or water jugs
- Water glasses/cups
- Food, plates and cutlery (if providing food)
- Tea, coffee, milk, sugar and cups (if providing hot drinks)

Arrange the interview space and any waiting area. Have a chair for each person, laid out in a circle or round a table, so that everyone can see everyone else. Water should be easily available before and during the consultation, particularly to stop people's throats going dry. Toilets should be easily accessible. Food or other drinks (if provided) should be available before or after the interview, to avoid it distracting participants or muffling their voices.

Check any recording equipment (audio or visual), including how background noise is affecting it on the day. Before starting the recording of a session, the researcher should dictate and audio record details of the session (date, time, place, respondent identifier, focus group etc.) on all the memory cards being used.

Welcome all participants (and anyone accompanying them) warmly and try to make them feel relaxed.

Explain housekeeping arrangements, such as where the toilets are, and answer any questions people they have.

Introductions. Researchers should introduce themselves and their roles in the project, then ask participants to introduce themselves (if a focus group) - by pseudonym if they wish Researchers explain purpose of the None in Three project, including the focus on resilience and strengths of persons affected by child sexual exploitation.

Give out information sheet

Explain participants' rights in relation to the interview, notably that they do not have to take part in the research, that they can refuse to answer any questions if they wish, that they can decide to withdraw from the research if they wish and that none of the above decisions would have any negative consequences.

Provide time for questions.

Give consent forms to participants to sign. Collect signed copies and retain.

Using recording equipment- Check it can pick up everyone's voice well enough for transcription. Ask everyone to speak briefly ("hello, my name is..." is enough) and then play back the recording. This is particularly important in a focus group where there are many voices coming from different directions. Ask participants to turn off mobile phones.

Taking notes- Ensure there is sufficient space for writing and explain that will be taking notes during the focus group. If conducting an interview – notes should be taken immediately afterwards.

Explain role of researcher, which is to ask questions and listen to participant's answers. As researcher, you may try to clarify or reflect on what is said, or ask follow-up questions not on the original interview schedule, to develop the

discussion or ensure you understand the point the participant was making.

Begin with easy questions that participants are happy answering, moving onto more detailed or difficult issues later.

How to ask questions. Active efforts must be made to minimise any possible distress caused by the research. Child sexual exploitation is a sensitive and stigmatised issue, and women are often blamed for the violence they experience. All questions about violence and its consequences should be asked in a supportive and non-judgemental manner. In addition, care needs to be taken to ensure that the language of the questionnaire cannot be interpreted as being judgemental, blaming or stigmatising

Focus groups
Explain ground rules for focus groups, which should include:

- Respect, particularly being polite, not talking over another person and giving everyone a chance to participate;
- Confidentiality (not repeating content of the meeting to anyone else);
- Anonymity (not giving examples in ways that reveal personal or confidential information to other group members)

Explain role of researcher, which is to ask questions but not participate in the discussion. However, researchers may try to clarify or reflect on what people have said to develop the discussion or ensure they understand the point the participant was making. The researcher will also intervene if the discussion is being dominated by some participants or to move the discussion on.

Interactive sessions. Some participants answer better when being more interactive. One way of doing this is to ask people to write down or draw answers to questions on Post-it notes, with one response on each (they can use as many notes as they like). All the Post-it notes are then placed on a chart, with identical/similar answers from different people placed together. This can be useful for stimulating discussion about lots of issues covered by one question and for seeing which issues are important for many people. It can also allow quieter focus group participants to participate equally with those who dominate conversations. However, this format can take up lots of time and result in long discussions, so researchers may need to halt discussions to enable other questions to be asked.

Endings

Finish on time. Some participants will have other commitments and you may only have the venue for a fixed period of time.

Provide expenses, if applicable. Make sure you get originals or copies of any receipts/tickets people are claiming. If paying in cash, note down how much is being given out.

Provide support information (National Response Team information) for participants who may want it. This information, which could include telephone helpline numbers or details of organisations, should be easily accessible somewhere that people can take it without having to ask.

Provide researcher contact information in case participants want to clarify anything later or are uneasy about what they said in the consultation.

Wait behind in case any participants want to discuss anything with you in private. Do not look as if you want to leave or begin packing up until the participants have all left.

Label recording memory cards. E.g. put them in labelled envelopes.

7. UNIVERSITY ETHICS APPROVAL

Ethical approval has been obtained from the University of Huddersfield, School of Human and Health Sciences Research Ethics Panel and must also be obtained from the UTech ethics panel before commencement of the research.

8. GOVERNMENT/AGENCY APPROVALS

In addition to approval from the University of Huddersfield, School of Human and Health Sciences Ethics Panel, written permissions must be obtained from all relevant government departments and agencies in the research countries, where such permissions are appropriate.

Profiles

Professor Adele Jones, PhD

Professor of Social Work at the University of Huddersfield, Adele specialises in international children's rights andprevention of violence against women and children. She has authorednumerous publications on a range of topics around child abuse and gender inequality andled more than 26 international research projects, culminating in the creation and leadership of theglobal Ni3 Research Centre.

http://www.noneinthree.org/meet-the-centre-team/adele-jones/

DrGraham Gibbs,PhD

An expert in qualitative research methodsbased at the University of Huddersfield,Grahamhas led and supported a range of social science research projects, with a focus on computer assisted learning. Graham has written two bookson qualitative data analysis and supported researchers withNVivo data analysis in international projects including Ni3.

http://www.noneinthree.org/meet-the-centre-team/graham-gibbs/

Dr Tim Gomersall, PhD

Senior Lecturer in Psychology at the University of Huddersfield, Tim's research interests include: the psychology of illness self-management; gender, sexuality and health; and health technology evaluation. He has authored and co-authored several publications around psychology and health, and has provided expertise to the Ni3 team in using a metasynthetic approach to reviewing existing literature.

http://www.noneinthree.org/meet-the-centre-team/timothy-gomersall/

Christine Fray, PhD

Christine is an Associate Professor at the University of Technology, Jamaica and Country Director of the None in Three Research Centre, Jamaica. She is a Registered Nutritionist and a Licensed Master Sports Nutritionist. Her areas of research are Nutrition Economics, Chronic Non-CommunicableDiseasesand Gender-Based Violence.

http://www.noneinthree.org/meet-the-centre-team/christine-fray/

Roxanne Harvey, BSc

Roxanne is a Research Assistant with None in Three Research Centre, Jamaica. She holds a Bachelor's degree in Child and Adolescent Development with a minor in Disabilities Studies from the University of Technology, Jamaica. Roxanne's research experience focused on bullying among high school studentsin Jamaica.

http://www.noneinthree.org/jamaica/meet-the-team/roxanne-harvey-2/

Craig McNally, MSc

Craig is an Associate Clinical Psychologist and counsellor at theUniversity of Technology, Jamaica. A member of the Jamaica Psychological Society,he also hasexperience facilitating life skills development training with youths in under-served communities. His research interests include various aspects of mental health, education and diversity issues

Kenisha Nelson, PhD

Kenisha is a lecturer at the Universityof Technology, Jamaica and Research Assistant at the None in Three Research Centre, Jamaica. She has a PhD in Psychology with emphasis in Occupational Health Psychology. Kenisha's research interests include stress and well-being, gender-based violence, and help-seeking behaviours for mental health problems.

http://www.noneinthree.org/jamaica/meet-the-team/kenisha-nelson/

Karyl Powell-Booth, MSc

Karyl is an Associate Clinical Psychologist and is the Research Fellow at the None inThree Research Centre, Jamaica. She is also alecturerat the University of Technology, Jamaica. Karyl is currently pursuing a Ph.D.in Psychological Medicine. Her research interests include youth self-injurious behaviour and gender-based violence.

http://www.noneinthree.org/jamaica/meet-the-team/karyl-powell-booth/

Karl Whyte, PhD

Karl is a lecturer at the University of Technology,Jamaicawith several years of clinical and teaching experience in Psychology. He holds a PhDin Health Psychology.He is also a registered member of the Jamaican Psychological Society and an international affiliate of the American Psychological Association.

www.noneinthree.org/jamaica