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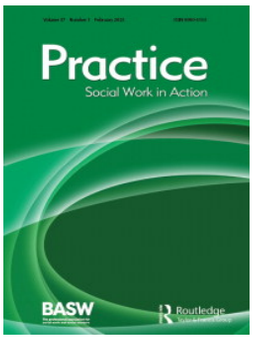

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Child Sexual Abuse: A Social Work Perspective and Retrospective Case File Analysis

Stephanie Kewley, Victoria Blinkhorn and Libby Thomas

When responding to concerns of child sexual abuse (CSA), social workers must provide child-centered approaches that are developmentally appropriate and tackle the complex needs of the child(ren) and the wider needs of family members. Meeting the needs of the whole family, not only safeguards and prevents future harm, but helps address trauma, and promotes strength within the child and family unit. Using a concurrent triangulated mixed method design; nine semi-structured interviews with social workers and a multi-level retrospective case analysis of 41 CSA cases were undertaken. Using descriptive statistics and thematic analysis we developed three themes: (1) CSA cases are highly complex in which family challenges and intergenerational abuse are frequently observed; (2) Barriers exist when attempting to access or engage external services in cases of CSA; and (3) The emotional labour experienced by SWs engaging in CSA work means that training and support is vital. We hope to inform social work policy in CSA cases and call for improved data recording practices; improved social work knowledge and confidence; greater understanding by funders of the needs and service gaps for children and families; and better provision of support and supervision for social workers.

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Introduction

By ratifying the United Nations Convention on the Rights of the Child (UNCRC 1989), the UK government acknowledged that children have the right to be protected from violence and to enjoy the best possible health. This includes access to healthcare services to maintain their well-being (Articles 19 and 24). However, it is estimated that around 500,000 children are sexually abused every year across England and Wales (Karsna and Bromley 2023). This

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highlights the critical need for health, social care, and criminal justice professionals to identify and respond to children at risk. Addressing concerns about child sexual abuse (CSA) is crucial for protecting children from further harm and ensuring they (and their families) receive appropriate healthcare and support, while also enabling effective responses from the relevant services.

When concerns regarding child welfare are raised, across England and Wales, there is a duty on local authorities, integrated care boards, and the police, to work together to protect and promote the well-being of children and make arrangements to identify and support those at risk (Children Act and C.41 1989; Children Act, C.31 2004; Working Together to Safeguard Children, 2023) Yet, responding to CSA is complex, it requires consideration of multiple factors, because, CSA exists within interacting socio-ecological layers (Bronfenbrenner 1977). These factors together influence the attitudes, behaviours, and characteristics of (a) the child; (b) the immediate family; (c) the wider community/school/social support; and (d) societal attitudes towards CSA. Thus, when considering CSA concerns, those with safeguarding responsibilities must be alert to these multiple layers of influence and risk.

Evidence suggests that some personal characteristics increase the vulnerability of particular children (Finkelhor 1980). Girls are more likely to experience CSA by family members, whereas boys are more likely to be sexually abused by people in authority. Children living in care are four times more likely to experience CSA, and while the majority of people convicted for sexually abusing children are adult males (Karsna and Bromley 2023), survivor reports indicate a greater number of women are involved in sexually abusing children, compared to official criminal justice reports. In the Crime Survey for England and Wales (Office for National Statistics 2020) 92% of perpetrators of CSA were said to be male, but, male survivors reported a greater likelihood of sexual abuse by a female.

In their more recent survey in 2023, the Office for National Statistics found children in England and Wales to be disproportionality more likely to be victims of a sexual offence compared to adult victims of sexual abuse. In 2022 children were victims in 40% of all sexual offences, yet only made up 20% of the population. Other factors strongly linked to CSA victimisation, include prior victimisation (of the child and their parents); the presence of other forms of child abuse within the family (non-sexual); parental issues including domestic abuse, substance abuse, psychiatric/mental ill health; being a non-nuclear family; and being a socially isolated family (Assink et al. 2019). Thus, if we are to help identify, respond to, and prevent CSA, family systems and structures along with adverse childhood experiences, across all actors within the immediate and wider family network must be understood (McKillop 2019).

Identifying and intervening in cases where there are known risks and concerns of CSA as early as possible, and in a trauma-informed way, should protect the child(ren) from current and continued harm, while also supporting

effective responses to CSA (Levenson 2020). Social workers are vital in this process. Following a referral to social care services, social workers (SW) should determine what action is needed by assessing the child(ren) and family. A child-centred approach underpins this work, to ensure the needs of the child and family are met (Working Together to Safeguard Children 2023). But, for example, where CSA is intrafamilial, the complexity is often heightened. The abuse has been carried out by an (often trusted) family member, such as an adult caregiver, or another child in the family, such as a sibling (Yates et al. 2024). The discovery of abuse within the family environment significantly disrupts the family unit; responses are often negative, the victim is not believed and there might even be physical retaliation (Elliott et al. 2022). With undoubtedly heightened emotions, family members require appropriate and sensitive responses.

To do this, SWs must collaborate with multiple agencies. They must gather information, analyse need, understand the complex nature of risk/harm, determine if the child is a child in need, or needs significant protection, and provide support to the child and family to improve developmental and health outcomes and prevent future harm. While the Framework for the Assessment of Children in Need and their Families (2000) provides a structure for assessors to consider the (a) developmental needs of the child, (b) parental capacity of the caregivers, and (c) the family and environment in which the child resides, SWs report a lack of confidence and knowledge when working with cases of CSA (Kwhali et al. 2016). Indeed, a complex decision-making process (Taylor 2012), climate of fear, demanding workloads, lack of managerial support (Ravalier et al. 2021), and the pressure of reaching informed, evidence-based decisions (Vyvey et al. 2014) are important factors at play for SWs working with CSA. Yet, if social workers reach an incorrect, or misjudged decision, the consequences can be fatal (Murphy 2022).

Social care services must provide child-centred responses that are developmentally appropriate, tackling the complex needs of the child(ren) as well as the wider needs of family members (Warrington et al. 2023). This is because meeting the needs of the whole family (McTavish et al. 2021), not only safeguards and prevents future harm, but helps address trauma, and promote strengths within the child and family unit (Schreier, Pogue, and Hansen 2017; Serin 2018). However, we do not yet have a comprehensive (national) picture of the needs of children referred to social care services, particularly where there are CSA concerns. No publicly available data outlines actions taken by social workers following child protection assessments and the recording of data continues (across England and Wales at least) to vary considerably across local authorities (Karsna and Bromley 2023). Calls from the recent Independent Inquiry into Child Sexual Abuse (IICSA) (Jay et al. 2022) and the National Review by the Child Safeguarding Practice Panel Review (2024) seek further urgent examination of these complex issues. For local authorities, in the absence of a robust and trusted national data set, local monitoring of cases is required.

This project, therefore, aims to carry out a retrospective case file analysis of CSA cases across one local authority and examine SW experiences when working with children and families in which CSA concerns are present.

Method

This project forms part of an ongoing collaboration between the research team and Cheshire and Merseyside Social Work Teaching Partnership which aims to increase the confidence and competence of SWs when responding to cases of CSA.

Design

A concurrent triangulated mixed-method research design was adopted. Retrospective case file analysis (the most common research method in child protection research due to its non-intrusive approach (Witte 2020) and semi-structured interviews were used to garner reflexive and experiential responses (Braun and Clarke 2022) of participants' experiences working with these cases. While a deductive approach was used in the retrospective case file analysis (i.e. we agreed on key variables ahead of data collection); the themes from the qualitative interviews were developed inductively.

Sample and Recruitment

Case Files

To determine case files and which variables should be collected, a meeting between the research team and two auditors at the local authority took place. It was agreed, that internal staff (auditors) would access the data needed from local authority electronic case management records. Data would be extracted into an Excel spreadsheet and fully anonymised before sharing with the research team. It was agreed all CSA records dating back two years would form the case file sample. Retrieving cases prior to two years might reflect out-of-date practice.

Qualitative Interviews

A sample of nine practitioners employed by the Local Authority with varying experiences and roles took part in a semi-structured interview. Participants' gender and ages were not relevant to this study so were not collected. Participants' job role is detailed in Table 1 to avoid identification, job titles are generic, and names are random pseudonyms.

Table 1. Participant and job role.

Participant	Role
Jessy	Team manager
Aubrey	Education safeguarding officer
Shannon	Social worker
Florence	Team manager
Lesley	Social worker
Alisia	Service manager
Jordan	Social worker
Helena	Social worker
Emlyn	Probation officer

The Local Authority gatekeeper reached out to potential participants *via* email across the authority, inviting volunteers to participate. An information sheet summarising the project along with the first and third authors' contact details was sent to potential participants. Recruited participant contact details were provided to the third author who arranged interviews at a mutually convenient time. Consent to take part in the project was secured both verbally and *via* electronic consent.

Data Collection

Case Files

An Excel spreadsheet and guidance notes were developed (in collaboration with auditors) to support the data extraction process (full variable list provided as Supplementary File). Auditors populated information for each variable against each family member within the case. For example, if the family consisted of one child who had caused harm and one child who was harmed, along with a third sibling, one caregiver, and an extended family member, then five rows required populating. Variables included demographic information, details of current and historic sexual abuse, domestic violence, drug/alcohol use, mental/physical health, and parenting ability as well as questions around what risk assessments/outcomes were recorded, if police or other agencies were involved, and had the needs of the child and family been met.

A pilot test of two cases was trialled by two auditors and amendments were made to the spreadsheet and guidance. Then ten auditors extracted case information onto the master password-protected spreadsheet. This was then shared with researchers for analysis (authors one and two). A second extraction exercise was required as meaningful analysis was not possible as significant data was found to be missing across several cases. In the second extraction, two auditors re-visited case files to resolve missing data. Once complete author two spent time preparing the file for analysis, including

making sense of the varying levels of analysis needed, dealing with missing data, and quantifying some of the free-text responses.

Qualitative Interviews

Interviews were conducted *via* MS Teams, during working hours and at the convenience of both the interviewer (author 3) and participant. Using an interview schedule, questions were asked about training, experiences of working with CSA cases, working with other agencies, and levels of support provided when working with families in which CSA concerns are present. Interviews lasted between 30 min to one hour and were recorded using the MS Teams function. Participants were thanked and de-briefed after the interview. The audio recording was transcribed by a transcription service approved by Liverpool John Moores University into Word, and ready for analysis.

Data Analysis

The retrospective case file analysis of families ($N = 41$) included frequency and descriptive-based statistics. This allowed for a broad presentation of the demographic information, along with other key factors, which were involved in the cases.

Interview data was analysed using Thematic Analysis (Braun and Clarke 2022) by the third author under the supervision of author one. Using the fully transcribed interviews, initial codes were developed, helping to identify patterns across the sample and unique areas of interest. Once coding was completed a process of theme development began, supported by supervision and active reflection from the third author who maintained a reflective log/diary of their process. The researcher was careful to capture example extracts to detail each sub/theme. The third author wrote up a description for each theme making sense of their interpretation across the whole sample.

The first author carried out this same process but with the retrospective qualitative case file data. When combined with interview analysis the three authors provided discussion and feedback to agree on the final presented interpretation.

Ethical Approval

We mitigated potential ethical concerns, in particular, when discussing SWs experiences of working with CSA cases. We fully briefed participants ahead of the interview *via* the gatekeeper, as detailed in the information sheet, and at the start of each interview. As we were not concerned with collecting any details of specific cases, we asked participants to anonymise, use pseudonyms,

and maintain confidentiality when discussing cases. We were also mindful of the well-being of the participants, reflecting on the practice and experiences of children and families in which CSA was a concern can be psychologically demanding. We, therefore, allowed for breaks when needed, reminded participants that they did not need to answer all questions, and provided a debrief at the end of the session. Liverpool John Moores University Research Ethics Committee approved this project (REC No: 23/PSY/018).

Findings

This analysis provides a unique insight into CSA cases at the individual level (i.e. the person harmed or the person who caused harm) but also at the family level. We first provide an overview of the children and families in which CSA concerns are present across the local authority as recorded in official case files. Following this we describe the three themes developed following the Thematic Analysis of nine practitioner interviews, we triangulate some of these findings from the retrospective case file analysis.

An Overview of N = 41 Cases in Which CSA Concerns Are Present

Across the 41 cases, significant pieces of data were absent from the case files. For example, six had no information available regarding the person who caused harm and 26 had no information regarding the child who had been harmed. In some cases, this was due to the person living outside of the local authority, but not in all cases. Despite this, our sample consists of 36 people who caused sexual harm and 16 children who were harmed. Over half of the cases were intrafamilial (Table 2) and ongoing (Table 3).

The majority of those recorded as causing harm were adult males, many of whom had no health problems, and over half ($n = 19$; 53%) living with the family when the sexual abuse took place. The children harmed were on average aged 10 at the point of assessment, 63% were female ($n = 10$) and 37% male ($n = 6$) while most lived in the family home, 37% of these children ($n = 11$) were cared for children and sexually abused in their foster placement or children's home. Table 4 provides the demographic information for both the people who had caused the harm and the children who were harmed. There were 17

Table 2. Descriptive information regarding the type of child sexual abuse.

Type of sexual abuse	Number of cases (%)
Intrafamilial	21 (51.2)
Extrafamilial	13 (31.7)
Unknown	7 (17.1)

Table 3. Descriptive information regarding the current status of the cases.

Status	Number of cases (%)
Active/ongoing	21 (51.2)
Closed	17 (14.5)
Unknown	3 (7.3)

Table 4. Demographic information for people who caused the harm and the children who were harmed.

Demographic	People who caused harm ($n = 36$)	Children who were harmed ($n = 16$)
Age	9-55 ($M = 19.9$, $SD = 10.6$)	1-18 ($M = 10.3$, $SD = 4.8$)
Sex	34 males	6 males
	2 females	10 females
Disability	25 none	13 none
	8 learning	3 learning
	2 behavioural	
	1 unclassified	
Mental disorder	27 none	14 none
	7 neurodevelopmental	2 neurodevelopmental
	2 depression	
Living arrangements	19 living with family	11 living with family
	9 lived elsewhere	5 cared for children
	7 cared for children	
	1 temporary family arrangement	

children (in total) who were cared for by the local authority. However, due to scant information available in our retrospective case file analysis, we are unable to establish with certainty the specific risks and needs of these most vulnerable children. We are unclear if this is a result of poor case file recording or an inability of auditors to access relevant data given the multi-agency involvement of these cases.

The type and frequency of abuse children experienced was variable ranging from being raped to being made to touch someone else. Where the information was recorded, half of the cases ($n = 4$) were noted as being one incident (see Table 5).

Considering the type and frequency of abuse by those who caused harm (Table 6) it is unclear in 64% of these cases ($n = 23$) if previous sexual offences had been committed (in 19% or $n = 7$ cases there was no recorded history) but in 11% ($n = 4$), previous sexual allegations and one conviction for distributing child abuse material was noted. In cases where the frequency of abuse was recorded, 10 cases were documented as one incident, and a further 13 cases

Table 5. Type and frequencies of abuse related to children who were harmed ($n = 16$).

Type of sexual abuse	• Sexual touching of any part of a child's body = 7 • Forcing a child to take part in sexual activities = 2 • Using a body part or object to rape or penetrate a child = 2 • Making a child undress or touch someone else = 1 • Missing information = 4
Frequency of sexual abuse	• One incident = 4 • Up to 5 incidents = 2 • Between 5 and 10 = 1 • 10+ incidents = 1 • Frequency unknown = 1 • Missing information = 5
Domestic abuse	• Historic concerns = 3 • Missing information = 13

occurred between up to five and over ten times. In over half the cases some form of poor self-management was found ($n = 18$), in a third of these cases ($n = 12$) this included the person's own sexual trauma experience, and over a quarter had a history of domestic abuse ($n = 10$).

Finally, we turn to the adults within these families who did not sexually abuse the children. Little data was available for caregivers and other adults in these families, however, across the 41 cases we were able to collect information on 58 adults (40% male $n = 23$; 60% female $n = 35$). The mean age was 42 ($SD = 9.2$). Although little information on their health was provided in 14% ($n = 8$) we found either physical or mental health difficulties (e.g. depression/bipolar disorder). For 19 adults, it was recorded that they presented with negative, resistant, or hostile views towards authority and 40% ($n = 23$) had general/self-regulation challenges, in terms of having a chaotic lifestyle, sexual abuse history, and substance misuse problems. In over half of the cases ($n = 31$) domestic abuse concerns were noted, and half had ongoing concerns around parenting ability and child abuse and neglect.

Practitioner Interviews

Theme One: CSA Cases Are Highly Complex in Which Family Challenges and Intergenerational Abuse Are Frequently Observed

There is significant complexity and variation within and across the sample, other challenges co-exist and not one case of CSA is the same: All SWs during the nine interviews described a breadth and variety of cases, these were all unique and each required varying responses, and approaches and as Florence notes, this was often because families have 'really complex dynamics'. When

Table 6. Type and frequencies of abuse related to people who caused harm ($n = 36$).

Type of sexual abuse	• Sexual touching of any part of a child's body = 13 • Forcing a child to take part in sexual activities = 6 • Using a body part or object to rape or penetrate a child = 5 • Showing pornography = 1 • Forcing a child to make, view or share child abuse images or videos = 3 • Exposure = 1 • Missing information = 8
Frequency of sexual abuse	• One incident = 10 • Up to 5 incidents = 10 • Between 5 and 10 = 2 • 10+ incidents = 1 • Frequency unknown = 9 • Missing information = 4
Domestic abuse	• Historic concerns = 10 • Current concerns = 1 • Missing information = 25
History of criminal convictions	• Conviction of drug offence = 2 • Rape allegation = 1 • Report of sexual abuse = 1 • Child exploitation allegations = 1 • Conviction for distributing child abuse material = 1 • None = 7 • Missing information = 23
Self-management	• Un-treated/supported own trauma experience = 12 • Limited cognitive function = 4 • Current drug misuse = 1 • History of drug use = 1 • Poor coping or low levels of resilience = 1 • None = 14 • Missing information = 3
Attitudinal factors	• Distorted attitudes towards child sexual abuse = 6 • Lack of knowledge/awareness of signs and indicators of child sexual abuse = 6 • Religious beliefs that support child sexual abuse = 1 • Negative views or resistant to co-operate with authorities = 3 • Beliefs that allow, support, or condone children to have access to inappropriate/illegal sexual material = 2 • Misogynistic and objectifying views of women and children = 1 • None = 18

families blend, the complexity and number of family members needing assessment/intervention simply increases and when CSA is present, the complexity intensifies. For example, the consequences for biological parents in

Table 7. Themes and sub-themes developed from the stakeholder interviews and triangulated with retrospective case file analysis.

Theme	Sub-theme
CSA cases are highly complex in which family challenges and intergenerational abuse are frequently observed	• There is significant complexity and variation within and across the sample, other challenges co-exist and not one case of CSA is the same • The intergenerational nature of CSA revealed significant unmet needs of caregivers
Barriers exist when attempting to access or engage external services in cases of CSA	• To access CAMHS "you need a letter from God" • The criminal justice agenda is conviction led and lengthy investigation result in delayed support causing a harmful ripple effect • Education provider responses to HSB are experienced as oppressive and risk-averse
The emotional labour experienced by SWs engaging in CSA work means that training and support is vital	• Varying levels of confidence • "You don't want to bring that home with you" the impact of child protection work • The impact of hybrid working on peer support and the need for enhanced clinical supervision in CSA cases • The Harmful Sexual Behaviour Panel is a safe supportive space, a real asset to CSA practice but to enhance practice further, more training is needed

cases of harmful sexual behaviour (HSB) between siblings are challenging enough but:

> 'if you've got … a blended family where the perpetrator might have a different dad to the victim, that can then very often kind of impact on that dynamic further, because … the mum very often than not, or the dad, is in a position where they're having to almost choose between the two siblings because the other partner will be so annoyed and outraged or upset by what the child has done so it just adds further into the dynamics for the family and of being able to support them'. (Florence)

Complexity is increased sometimes because of external environmental factors, disguised compliance, and/or the presence of other types of abuse, these factors can mask the signs and indicators of CSA and prevent a timely response, for example:

> 'There was neglect in the house. It was really unclean. The oldest girl was having some issues. She [the mother] told us the baby's dad wasn't living in the house. We had no evidence to suggest he was and then we had lockdown

> and she phoned me nearly every day, 'Oh, just checking in with you, we're doing okay, everything's great'…. all the while this male had been living in the house and he had been sexually abusing the older daughter … it came about because he'd injured her. I think she had a bite mark on her that he'd done and then she was able to disclose it'. (Jessy)

Likewise, cases with a high profile in the community, or those that had press or social media interest because of criminal justice involvement compounded the impact on the child and family, as well as the efforts of the SW attempting to support the family. Helena described one family whose son (who had a learning disability) had been removed from school following an HSB allegation. This resulted in the family being isolated in the community and while 'under investigation … windows got smashed on the house, the car, there was a lot of retaliation in the local community'. The impact of this on the children and the family intensified what was already a challenging case for both Helena and the many professionals involved.

Complexity was equally reported in individual factors, for example, parents themselves often have needs that make them vulnerable, and place children at some degree of risk, either because parents do not have the capacity to parent safely, or they are victims of abuse and trauma. Florence described in one case a 'Dad had learning difficulties and mum had left the family home- … there was always concerns that there was sibling intra-familial abuse' and in another case 'mum had obviously, been sexually abused as a child, but she was having sexual thoughts about her baby … she wanted some help … ' Of course, individual factors impact children too, often these are because of difficulties one or more of the parents face, which heighten the complexity and the response needed. Alisia spoke about several diverse cases:

> 'I've had children that have masturbated with faeces because of the high level of neglect and mum was a sex worker and they were exposed to stuff and then went on to sexually abuse their sibling which was a girl. I've had animal stuff, doing stuff to cats and dogs'.

Shannon detailed a similar case in which:

> 'There was a lot of sexualized behaviour from mum, and she used to show him [the child] stuff on the phone like pornography or videos of her having sex with males and that and he started to display them types of behaviours as well'.

In addition to individual factors, domestic abuse featured across many SWs caseloads. When sharing experiences SW reported these cases are our 'bread and butter, sadly' (Lesley) and that CSA 'stem[s] from predominantly domestic abuse' (Alisia) and is intrinsically linked to intergenerational CSA:

> 'One of them is, I'm aware of is part of a swinger's group, the parents. So again, it's that influence of what their boundaries are exposed and their sexual experiences themselves, but usually it's, you know, it's layered, you

> know, like mum's had it from brother and then they don't speak to that brother and then granddad knew about that. That's a common theme. Definitely. And domestic abuse'.

Coupled with 'neglect, domestic abuse has been my main themes that have been in the child's background that I've worked with' (Alisia). One of the challenges SW faces given the multiple issues of 'neglect and poor levels of supervision … and [CSA] might not necessarily get picked up on as quickly, because there's all the other factors at play, which actually present quite similarly at times' (Florence). Jessy recalled several cases in which there was 'long-standing neglect', and issues of CSA were missed because the focus was on the neglect. The concern would often 'start off with something like domestic abuse and then we find out there's alcohol, sexual harmful behaviour, there's criminality … ' (Helena).

Across our retrospective case file analysis, we found this complexity, coexistence, and concurrence of CSA alongside several family problems/challenges. Domestic abuse issues were present in 11 individuals who had caused harm, and 3 who had been harmed. Of the caregivers for whom we had case information, over half of the cases ($n = 31$) had reports of domestic abuse concerns along with issues of parenting ability and child abuse and neglect. In one case, a history of domestic abuse was recorded, along with both adults and children misusing alcohol and drugs, there was a history of physical and/or emotional neglect/maltreatment, caregivers being separated, and one suffering from depression (Case #9). In another case, two children in the family had disabilities, and poor school attendance, the female caregiver was disengaged with most services and the family's home conditions were described as 'poor' (Case #15). In cases where the child who caused harm was central, we observed higher levels of need for both the child and the family. For example, in Case #39, not only did the child have learning difficulties and a neurodevelopmental disorder, but they also had their own history of trauma and experience of sexual victimisation. In addition, there was evidence of a chaotic family lifestyle, poor parenting practices, and distorted attitudes and beliefs across the family that facilitated access to inappropriate/illegal sexual material/activity.

The Intergenerational Nature of CSA Revealed Significant Unmet Needs of Caregivers. In our SW interviews, participants reported many cases where 'both parents had experienced sexual abuse in their own childhoods' frequently 'the perpetrator, are often traumatised or potentially a victim themselves' and there is usually 'a history of sexual abuse within the family network' (Florence), indeed, there were 'high numbers where it's generational' (Lesley). Lesley had considerable experience with families in which CSA was intergenerational and the parents of children who had harmed or were harming others, had themselves lived experience of child sexual abuse. In one case 'the mum had been through the same situation when she was a child … she herself went into care at a young age'.

When thinking about trying to put support in place for parents who themselves face significant difficulties, SW reported this to be a challenge. In one 'very entrenched family' Lesley described a mother who was going to have her unborn child removed at birth, she described the need for support and help but because she was so 'damaged … she's just not got the capacity to make that change' Lesley felt she would not work with the help offered, not because she was resistant to offers of help, but she could not embrace the help:

> 'Because what happened to her …. I don't think that Mum has ever had the ability to think for herself. I think when she was younger, she was abused. She went into care. I think she was the victim of a sexual assault. She then come out and she'd most probably been controlled and coerced by this partner that she's had from the year dot, that he was most probably doing God knows what to her, as well as the children. And I think her father …. was kind of controlling the whole family … I think she might have been a prostitute'.

Intergenerational abuse that is known within families but not discussed across the generations was experienced by Alisia in the cases she worked with. She reported 'totally massive age differences in grandparents, parents, between partners …. abuse, sexual stuff in the family that's been undisclosed, that's been known about, but nothing's dealt with'.

While the lack of response to CSA for children who grow up and themselves become parents was recognised by SW as a problem, it was unclear what support or signposting they were able to provide for these parents when responding to the legacy of this unresolved trauma. In our analysis of the recording of case files auditors' details of historical CSA were often sketchy and unclear. There was not a complete account of family members' needs, but of the caregivers we had information on, we found high numbers who had their own lived experience of abuse. We found 53 had a history of domestic abuse and 12% had also been sexually abused as a child. Many survivors of CSA who are themselves caregivers of children who have been abused may need their own support and help concerning their own traumatic experiences. We cannot be certain what support was provided for caregivers in our retrospective case file analysis because the information included was so scant.

Theme Two: Barriers Exist When Attempting to Access or Engage External Services in Cases of CSA

To Access CAMHS 'You Need a Letter from God'. Known or diagnosed mental disorders were identified in 11 children across our retrospective case file analysis. For some, mental ill health was identified as a factor related to the potential onset of harmful behaviours but also a consequence of the discovery or subsequent investigation that followed an allegation of CSA. In one example the mental health of one young person deteriorated following allegations of

HSB to such a degree that he required the support of local Child and Adolescent Mental Health Services (CAMHS).

Yet, accessing child mental health services remains an ongoing challenge and frustration noted by participants who reported that 'unless there's an actual diagnosed mental health problem and its actually impacting right now, they [CAMHS] won't support' (Helena). While Helena recognised 'they're really overwhelmed. I know they're inundated themselves' she still 'struggle[s] with them in general'. Others too recognised the wider systemic problem with the system. Florence noted how 'the scaffolding's not in place'. There are some services available, for example following an assault, the Rape and Sexual Abuse Support Centre provides invaluable support for victims, but 'it's not specialist tailored support for children who've perpetrated sexual harmful behaviours cos there's actually a trauma there for them' (Florence). When attempting to refer to CAMHS, SW described having to almost persuade CAMHS colleagues to accept the referral for a child who they believe needs help 'there's a gap in services getting into CAMHS, like you need a letter from God' (Florence). Lesley was quick to not 'paint them [CAMHS] as the black sheep but' her frustration and feeling isolated when trying to support children was clear:

> 'CAMHS are very quick to say things are environmental and push it back on to social care … there seems to be a lack of facilities for teenagers suffering with emotional wellbeing, presenting with these complex issues … whilst we may be able to identify abuse we're not therapeutic workers, we need our partner agencies who are therapeutically trained to be able to support these victims or, or possible victims of sexual abuse. And I just think resources for CAMHS and tier four beds that we would like these children to access, isn't there'.

The Criminal Justice Agenda is Conviction Led and Lengthy Investigations Result in Delayed Support Causing a Harmful Ripple Effect. Where an allegation of CSA is made (particularly intrafamilial), the disruption and fallout for the whole family unit is immense. When an allegation is against a child, determining the appropriate response requires considerable sensitivity to ensure the child who was harmed is protected, but equally, that the child who caused harm is supported and duly held accountable. Participants in our sample discussed the notion that sexual behaviours in children range from developmentally appropriate to problematic and harmful, and as such, striking the right balance when responding to allegations is critical. Aubrey was frustrated by policy that requires some professionals to immediately involve the police when any allegation is made. As she describes:

> 'Schools will be managing inappropriate behaviour, you know, the two kids in PE who run up behind a boy and pull his pants down and his underpants come down. Is it harmful? Yeah, there's an element of harm … they need to know it's not appropriate, it needs to be addressed and dealt with. But do we need to get the police in because it's potentially an assault?'

Where police involvement is proceeded with, Aubrey highlights how she has experienced bail conditions to be so limiting, even with child protection strategies in place, that they compromise the child's access to education. She said, 'the child's not allowed to associate with any other child under the age of 16' but 'there's a contradiction between the police bail conditions concerning risk, and also providing that child's right to education'. Alisa felt this was due to a lack of knowledge about the spectrum of sexual behaviours in children, particularly by the police. Her experience was that some specialist police are trained in sexual exploitation but more general CSA 'they're not properly trained in this area … in the world of harmful sexual behaviour, it's your regular police that are called on … there's more work to be done there'.

Where police investigations are undertaken, these can take many months to process, often without satisfactory conclusion and the ability of SWs to provide appropriate support to children and families can be compromised. Keeping children safe is of course the priority and as Lesley notes in situations where abuse is in the family environment, one child may need to move out of the family home when allegations are made about a sibling. But 'the difficulty we have is that … the police have no timescales'. While it is appropriate for the safety of children that some children are removed from the family home, it is the secondary harm caused by the time taken to process cases through the criminal justice system that is of concern to our participants. In one case a brother had alleged to have harmed his sister and so he had to 'leave the family home but it went on for years and years' (Lesley).

In some cases, SW reported instances where the police perceived providing treatment to a child who has caused harm during an investigation might interfere with their investigation. They will often say 'you can't do an intervention with them whilst we conduct our investigation' (Florence). Florence provides an example of a 'young boy who there'd been an incident with his younger sister when he had been about 12 and there'd been some sexual touching of his cousin. It transpired there been some sexual touching of his younger sister' the police became involved and they were not 'able to do an AIMS assessment, we weren't able to do any intervention' but by the time the police process 'concluded and we were able to do something it was almost like two and a half years, nobody had been able to have a proper intervention or conversation with this young person'. Florence describes this example as quite an awful one because by the time they were able to 'offer an intervention … he'd shut down and we'd kind of missed our opportunity for him' she described being professionally 'stuck' that barriers from the 'police and the investigation' prevented her from supporting the child who had harmed, she recognised that he too was 'traumatised or potentially a victim' himself.

In these instances, the child and family are placed under significant distress. Helena recalls an HSB case in which a boy was alleged to have sexually harmed a girl at school. The safety plan and restrictions set by the police

meant the mother could not allow her siblings (the boy and his sister) to be left together/alone, despite there being:

> 'no risk to the sister we felt from him' but 'we weren't allowing him and her to be alone. So, we were saying to mum 'you have to always be there with them' … she had a job … it just impacted on so many different layers of their life and it went on for two years … it's only just this year gone to court and closed. So, it's been 2 years of their life … its affected friendship groups, peers, school, everything just everything for the family as a whole, not just for him … and obviously not just for the female who made the allegation. It's, it's, it's been that whole ripple effect'.

Our retrospective case file analysis included 21 cases that were under police investigation, a further 17 had been closed with no further action. The 'no further action' conclusion reached by police or court acquittals, was noted by participants to be a real challenge. As Jessy highlights, in cases 'not prosecutable, then that's the police done … you're left with a child who has experienced abuse, and you still need to support them'. This can leave families blaming the victim, or no longer believing them. Jessy describes a family she is working with at the moment, the child 'claimed her uncle had sexually abused her, and it went to court and the whole family now is struggling … because it didn't go any further'. The consequences of not being believed, particularly, by family members can sometimes be as damaging as the abuse itself. Jessy empathises with the victim she worked with, after seeing how brutal the court process had been. Some children are not believed by professionals, and she wonders how people recover:

> 'you wouldn't put yourself through it … we find with a lot of the sexual exploitation cases where, you know, they might have, you know, gone through the police system, but nothing's happened and then they get charged with somebody else's, and it's like … it happened to me as well, you know … nobody listened, the police don't take that seriously'.

Or in some cases, SW are left with the child who had caused harm but was now not taking any responsibility for their behaviour because the threshold for prosecution had not been met. For Jordan this impacted her confidence to deal with one 17-year-old who had:

> 'Been NFA'd [no further action] for a rape … from his perspective, he feels completely innocent … So even now as a relatively experienced social worker, I probably don't feel that confident in having those conversations with that young person. From his perspective, he's 17 having a conversation with me about what is difficult enough as it is, and then the added complexity, from his perspective, it's been not guilty by the police, so he's done nothing wrong. Even though it's not guilty what happened was still harmful'.

Education Provider Responses to HSB Are Experienced as Oppressive and Risk-Averse. While Aubrey (an education safeguarding officer) feels the provision

within schools around sex education, is 'not fit for purpose' and that 'the Ofsted rapid review said you know the education they get in schools is too little too late and not fit for purpose', she has seen an improvement in schools' responses to HSB cases over the years. She reports how:

> '15 years ago, the school was like "get rid, get rid we can't manage the risk' and it was a real uphill battle to say to schools 'actually take the sex bit out, it's a behaviour and you manage behaviours of children on a daily basis. In fact, out of all the professions, you're probably experts in managing children's behaviour."'

However, other SWs in our interviews expressed frustration at educators' 'risk averse response' in which children who caused harm will 'be stopped from coming into school, they'll be stopped coming into class' (Florence). The reaction from parents who 'say to a school, I don't want that paedophile in class with my daughter, and the child was five years of age' (Alisia) places pressure on school leaders to respond punitively, which is simply very often counterproductive. In one example the child who was alleged to have caused harm experienced an oppressive response where he 'felt victimised and he hadn't been found guilty' (Helena).

Participants recognised these reactions are grounded in 'fear and uncertainty … about how they manage and how they support' (Florence) but when practitioners in schools lack awareness of HSB, this creates 'blockades' and prevents positive non-judgmental work with children and families. The consequence of this misplaced fear creates a disproportionate response to children who have harmed, and the notion of 'risk' dominates decision-making. Responses must be proportional to the assessed risk but as Florence shares, this is often not the case:

> 'So you'll hear people saying things like well, can they come into class, do we need to follow them to the toilet and it's like alright, let's, let's look at the proportionality of what they've actually done and how they've actually offended and you know, they're not going to be attacking people in the toilet cubicles do you know what I mean'.

The Emotional Labour Experienced by SWs Engaging in CSA Work Means That Training and Support is Vital

Varying Levels of Confidence. Like all professional practice, skills, experiences, and levels of confidence fluctuate, our sample reflected this variation in confidence levels. Most reported good levels of confidence due to their years of experience and variety of roles across the service. Their confidence had developed over time, through exposure to lots of different cases 'I've had quite a mix' (Florence) and having a 'good network, whether that's in the police or specialist services' (Lesley). SW generally felt very

much supported in this space, so if there was a concern around a case Helena felt:

> 'very confident that I'd be able to say, do you know what I need some training. Do you know what I need to be pointed in the direction of who to speak to, but I'm quite confident in saying that that's what I need, I need this support, cause it's something you just can't, it's one of them things that I mean, you can't wing anything in this job and do you know what I mean'.

Having colleagues from multi-agencies sitting on a panel who 'are very knowledgeable, extremely skilled and experienced, and are also people that professionally I trust implicitly' boosted Aubrey's confidence levels with HSB cases. Indeed, Shannon will regularly reach out to more experienced colleagues 'for advice and, we can get consultations if we need them'. At times confidence levels waned, for more personal reasons, Jordan, lacked confidence speaking with 'teenagers about their own behaviours …I don't feel confident in doing interventions' she was happy 'speaking to parents about their children displaying behaviours' but recognised a gap in confidence when working with teenagers. Reflecting as to why this might be, was something she would take to supervision, but she was more than confident with 'safety planning and holding other professionals to account'. A sense was felt across all SW that working 'within an interagency model means it's not always just on us' (Jessy).

'You Don't Want to Bring That Home with You' the Impact of Child Protection Work. The effort required to manage one's own emotions and apply practical strategies and tactics to cope when working with CSA cases was recognised as being part of the job. Jordan said she thinks 'there's probably a certain expectation of, that's what you deal with in the job. Which is probably not right but is the reality'. Aubrey recalls a time when the work of supporting others was 'really impacting, I knew at that point, that I needed help and support…. thoughts of these children were not going away' the response from management was not particularly helpful, but Aubrey pressed for support because what she was feeling was 'bizarre'; although she was 'not suicidal' her struggles were significant. Once she began some therapeutic work with a professional, she was able to take 'a deep breath' and work through the issues.

These experiences are not uncommon, for Shannon working with CSA cases can be 'like secondary trauma all the time… you've got your own personal experiences and sometimes it can trigger things that you've been through'. Florence noted, that some cases are more difficult than others and 'they can bring quite a lot of vicarious trauma…. there is an impact when you're dealing with somebody else's trauma all the time'. Participants were mindful of the impact on themselves and their families. Jessy described not wanting 'to bring that home with you. You don't want to impact your partner because, like, my partner doesn't work in this environment'.

Most participants reported healthy coping strategies to manage these emotions. Aubrey reports being able to compartmentalise experiences by having a mental cutoff 'on the motorway on the drive home' because 'I have three children of my own', she is also able to 'let off steam or, or say, to somebody I heard this really awful thing today'. But, for others the pressure is too great, and Alisia made 'the decision to leave because I couldn't do that day in day out'.

The Impact of Hybrid Working on Peer Support and the Need for Enhanced Clinical Supervision in CSA Cases. Informal support from colleagues is important, it improves confidence, and feelings of well-being and helps deliver better outcomes for children and families. A good example of this comes from Helena who described how she has:

> 'peers that I'm close to or work colleagues that I'm close to, sorry that I see in work and out of work, so they're friends. I've got colleagues that are just colleagues in work, but there's absolutely nobody that I wouldn't approach and just say, do you know what, I'm actually really struggling and can I just, can I just bat this off you and can we just have a chat'.

However, some participants expressed that because of the autonomous nature of their work, informal peer support is dependent upon relationships and friendships made at work. If bonds are strong 'you can have those conversations. If you haven't, then it's probably more difficult' (Jordan). Compounding this for some participants who joined the local authority during the first Covid outbreak, was hybrid working. They were disadvantaged, as friendship bonds were weaker than those who joined pre-Covid. Jordan started at the local authority 'during COVID, and it was difficult … you haven't developed those relationships that you're able to develop when you're in the office'. Indeed, with changing working patterns and a greater use of hybrid working, a reduction in peer support was noted, staff are 'more isolated now in how they work because we're working from home a lot … not coming into the office as regularly, that's where they get the support from' (Jessy). Helena pointed out 'if you're really upset, there's nothing worse than blubbering on the Teams meeting and your managers the other end, it's awful'.

It was encouraging to note that in addition to peer support, 'senior management are present … they just know by your body language if you're having a tough day' (Shannon). It is of course also individual professionals' responsibility to actively engage and seek out supervision and support. Lesly notes that she has:

> 'been taught that as a social worker you have to be an autonomous practitioner, you know, you have to take responsibility. I'm not going to put out these signs that say I'm really struggling because I've got a crap case. So, I think a lot of the time whilst there are little processes in place like supervision and peer support and group supervision, things like that, you

> know, it's my responsibility also to raise it if it's becoming too much of a burden'. (Lesley)

Effective clinical supervision addressing SW professional development should be delivered by a supervisor who has the skills and attributes to facilitate a constructive supervisory relationship and take place in an environment that is conducive to effective supervision. Participants in our sample felt that while:

> 'we're very good at supervision … we'll go through cases … but we don't have access to clinical supervision which is something we've said we really do need. There're those times you just need that support. People are more isolated now in how they work because we're working from home a lot. So, they've not got as much, they've got the peer support there, but they're not coming into the office as regularly and that's where they get the support from' (Jessy).

Florence agreed that a richer level of supervision was needed to support development because at times 'there can be quite a lot of vicarious trauma' and with a high turnover of staff, timing and frequency of clinical supervision is an area that needs addressing.

The Harmful Sexual Behaviour Panel is a Safe Supportive Space, a Real Asset to CSA Practice but to Enhance Practice Further, More Training is Needed. The local authority in which this research was undertaken is believed to be the only one in which an HSB Panel consisting of HSB multi-disciplinary specialists, meet monthly to provide consultation to SWs who bring cases to discuss, learn and reflect. This opportunity for practitioners to consult and improve practice and outcomes for children and families with HSB experts is to be commended. In our retrospective case file analysis, many of the HSB cases had been presented to the local HSB panel. Our interview participants expressed gratitude 'that we've got the sexual harmful panel … I'm lucky that we have that' (Helena). Shannon felt 'the panel's really good, really experienced … the support they give, the advice they give' and that as a consultative reflective process it 'is a really good safe space and we share a lot of information, research studies, that type of thing' (Emlyn).

The panel provides 'information, guidance, support. "Why don't you look at this? Have you tried that? There's this piece of work, there's this piece of research"' (Helena) but it also works as a reflective tool in that 'I'd [Helena] have to produce a document as to what I've done, what my worries are, what I've tried, what I need help with, and then they as a panel would have that discussion and support me … for me it was massively useful'. Aubrey sits on the panel:

> 'One of the strengths of the panel is we challenge each other. If I say something about a case or a child and make a suggestion and you know what Emlyn from the Youth Offending Service is going 'ah I don't agree with you there Aubrey', that's fine and vice versa, or Annie from CAMHS might say

> something in a particular way that I hadn't considered or thought of before, so I think we're all very open … I love it because I think it's one of the safest places professionally, I work in and in terms of it's not safe because everybody agrees, it's safe because we challenge each other'

In addition to the HSB panel participants discussed training. They reported engaging in a variety of training opportunities throughout their careers, Alisia 'had extensive trauma training … at Barnardos … I've had AIM training … youth justice board sexual abuse training' others had undertaken specialist training with an independent social work consultant. Participants had opportunities to engage 'with supervision and professional development by my manager' (Jordan) and 'online training' (Shannon) or 'attend national conferences' (Aubrey). Seven of our participants had attended AIMS3 training. AIM3 is an HSB assessment tool and practice framework that assists practitioners in analysing, and creating profiles of risk and need that help to develop case formulation and inform effective safety plans (Keenan 2022).

While participants engaged in various types of training and development over the years, this tended to address one type of CSA (e.g. child sexual exploitation). Missing from the professional development programme is CSA as a whole, and the most common form of CSA: is intrafamilial. Yet, in partnership with Cheshire and Merseyside Social Work Teaching Partnership, the local authority taking part in this study provides a one-day training event titled 'Intra-familial Child Sexual Abuse: An introduction for Social Workers' which is endorsed by the Centre of expertise on child sexual abuse (CSA Centre: www.csacentre.org.uk). SW in this group had not attended this training, some were not aware of it. It was recognised that SW time is stretched opportunities can be missed as Jordan noted: 'when training comes up I'll be honest, I hardly ever read the emails because you're so busy, so it may well be that the training is there, but I certainly don't feel like it's been a massive focus'.

Discussion

We carried out an analysis of 41 CSA cases in one local authority in England, we also undertook nine semi-structured interviews examining the experiences of SW working with children and families in which CSA concerns were present. As described in our findings, we found CSA cases to be highly complex, with challenges often intensified by individual and family dynamics that were at times historic and intergenerational. This is unsurprising as we know that CSA does not exist in isolation, instead, multiple individual, social, and environmental factors influence both the onset and persistence of CSA (Ward and Beech 2016). When factors co-exist, and caregivers respond maladaptively, they become less able to provide a safe, stable, well-structured family setting, making opportunities more accessible to people prone to engaging in CSA and HSB (Seto 2019; Wortley and Smallbone 2006). Indeed, high levels of

disorganisation within the family create household chaos, which is linked to several adverse childhood outcomes (Marsh, Dobson, and Maddison 2020), as is, absent or ineffective guardianship (McKillop et al. 2015), and poor boundaries or inadequate rule keeping (Griffee et al. 2016; Yates and Allardyce 2022). Children who disclose CSA are more likely (80%) to live in violent homes (Kellogg and Menard 2003) and while co-existence rates between CSA and domestic abuse vary, they range between 12% and 70% (Bidarra, Lessard, and Dumont 2016); a conservative 40% median (Appel and Holden 1998). All these challenges were found across our study, both in the case files and as reported by SW themselves.

There were several cared-for children in our case file analysis. Although data about these children was scant, we know that as a group of children, those with care experience, tend to have the poorest outcomes across many life domains when compared to children who do not experience the care system (Bennett et al. 2022). Experiencing CSA and being a cared-for child means their level of need and vulnerability increases, including future CSA victimisation. Likewise, physical, learning disabilities, neurodevelopmental needs (Karsna and Kelly 2021) having mental health conditions such as anxiety, depression, and post-traumatic stress disorder (Thomason and Marusak 2017) all exacerbate the vulnerability of this group of children. Once sexually victimised, children are at greater risk of revictimisation, thus, prior experiences of abuse/neglect must be considered by SW when working with concerns of CSA (Fisher 2017). This is because the additional vulnerability and potential inability to cope following a traumatic event such as CSA may make the child a likely target for further abuse.

In addition, we found caregivers who were also survivors of CSA. This means, that many of the caregivers in our sample, responsible for safeguarding and protecting sexually abused children, will likely be experiencing additional psychological, social, physical, and interpersonal problems because of their own lived experiences. Although responses to CSA are unique to the individual, for some victims/survivors, these can be acute, chronic, and persist across the life span; becoming intergenerational (Isobel et al. 2021). If unsupported or untreated this can be detrimental to people's ability to effectively parent (Cavanaugh et al. 2015). Indeed, studies indicate that children of caregivers who have themselves experienced CSA are at an increased risk of harm, compared to caregivers with no experience of childhood abuse (Avery, Hutchinson, and Whitaker 2002; Black, Heyman, and Smith Slep 2001). It is worth noting however, that CSA experiences can also serve as a protective factor because some caregivers report greater awareness of the signs and indicators of CSA, are more open to discussing abuse, and are hypervigilant around potential threats (Cavanaugh et al. 2015). Thus, it is critical for SW to assess, understand, and respond to the multiple and often co-existing individual, social, and environmental factors present for the caregivers and other family members as these can serve as both risk and protective factors.

SW in our sample recognised the value and importance of multi-agency working, but they recalled numerous barriers to securing positive outcomes for children and families. SW engage with multiple external agencies, advocate on behalf of family members, and refer and help children and families to access services to address unmet needs. As reported by participants in our sample, they do this, within a challenging socio-economic climate, which over recent decades, has resulted in a complex, disparate service provision and an arguably 'flawed' commissioning system (Newbigging et al. 2020). The provision of services that respond to CSA includes a mix of national and locally provided statutory and third sector/charity agencies; a provision that is, however, inconsistent, and underfunded (Hughes 2024). The consequence of this fragmented service provision means that access to services is patchy across England, despite a growth in need (Parkinson and Steele 2024).

Appropriate and timely support for children harmed by CSA is critical for their recovery. Equally so is the help needed for caregivers of sexually abused children. During our interviews, SW recalled concerns for caregivers that are echoed across the literature. Caregivers of children who experience CSA report greater levels of psychiatric symptoms than comparison parents (Black, Heyman, and Smith Slep 2001). Indeed, mental health problems or psychiatric conditions are factors related to risk (Assink et al. 2019), while chronic conditions must not be considered in isolation (or viewed as causal) (Vilvens, Jones, and Vaughn 2021) SW must consider with equal importance the caregiver's capacity to positively deal with adversity (Gilligan 2004; Luthar, Cicchetti, and Becker 2000). Thus, understanding the caregivers' predispositions, psychological resilience, and resources is important (Cyr, McDuff, and Hébert 2013) because reduced resilience impairs caregivers' ability to identify signs of future harm (Holt, Buckley, and Whelan 2008). With the additional stressors that come with the discovery of CSA, their ability to cope may be compromised further (Black, Heyman, and Smith Slep 2001) thus, support for the caregiver, as well as the victimised child and other children, will be needed (McElvaney, McDonnell Murray, and Dunne 2022).

Finally, while the work of SW, in our study, was experienced positively, when working with CSA cases, the emotional burden was great. Some of our participants dismissed this as being part of the job, although it was widely accepted that ongoing support and training was essential to help secure positive outcomes for the children and families and keep themselves safe. The effort required to manage emotions and expressions while carrying out work as highly charged as child protection is likely to be related to several individual attitudinal variables (Roh et al. 2016). Many of our participants presented with adaptive coping strategies with this emotional labour, but for some, this was too great and without support, they faced psychological harm. In a context where the consequences of 'getting it wrong' are enormous (Munro 2019), it is unsurprising such intense emotions were experienced (Moesby-Jensen and Nielsen 2015). Examples of informal support from colleagues were

powerful (Graham and Rutherford 2016) although not available to all, given recent hybrid working arrangements. However, formal supervision was. We note, that supervision should be delivered by a supervisor who has the skills and attributes to facilitate a constructive supervisory relationship, it should be provided in an environment that is conducive to reflection and learning (Proctor 2010; Snowdon et al. 2019). It was encouraging that the HSB panel provided to SW in our study appeared to offer a unique and invaluable, reflective space.

Recommendations and Conclusion

One of the strengths of this work was the positive collaboration between SW practitioners and researchers. Working in partnership facilitated knowledge exchange that contributed to a robust and meaningful research design. Local and expert practitioner knowledge enabled an efficient data collection process, strengthening the quality of the final data set. However, our work is not without its limitations. Much of the information we had hoped to capture through the retrospective case file analysis was simply not present. This means we could only undertake a basic descriptive statistical analysis.

It is perhaps unsurprising, therefore, that our first recommendation echoes Jay et al. (2022) call to improve the recording of CSA data. We recommend local authorities go beyond the collection of basic characteristics of victims and those alleged to have harmed children but aim to collect data that includes historic and current accounts of the risk, need, and protective factors across the whole family and not just the child at the centre of the case. Our second recommendation speaks to the gap in knowledge and low confidence levels of practitioners in child protection services. We urge local authorities to support mandatory child sexual abuse training for all practitioners working with children and families. We ask that training and professional development improve basic understanding of the signs and indicators of child sexual abuse, as well as provide skills development for practitioners to respond to concerns of child sexual abuse. Our third recommendation calls on policymakers and commissioners of child sexual abuse services to examine local and national provision of services for victims of child sexual abuse as well as parents and family members and young people who harm others sexually and match this to the existing need. We recognise this is a challenge for policymakers and funders, given the absence of reliable data on population need (as found in our analysis). However, poor data recording must not be a barrier to the provision of services. Finally, we recognise the work to support children and families in which CSA has occurred is psychologically demanding for SWs. Thus, we recommend local authorities encourage informal peer support activities (recognising the challenges hybrid working brings), plus improve the well-being and resilience of SWs by providing more robust packages of (clinical) support and supervision.

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Professor Stephanie Kewley is a Professor of Forensic and Criminal Justice at Liverpool John Moores University. Her research portfolio centres on the prevention of sexual violence by supporting professionals working with marginalised and stigmatised populations involved and/or incarcerated by criminal justice structures and systems. Email: s.kewley@ljmu.ac.uk

Dr Victoria Blinkhorn is the Director of the MSc Forensic and Investigative Psychology in the Faculty of Health at Liverpool John Moores University. Her research examines how mental illnesses, personality disorders and traits help to explain offending behaviour in adults, specifically females.

Libby Thomas is a Research Assistant in the Faculty of Health at Liverpool John Moores University, with a background in International Public Health.